

Title 388 WAC

SOCIAL AND HEALTH SERVICES, DEPARTMENT OF

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Chapter 388-02 WAC

DSHS HEARING RULES (Formerly chapter 388-08 WAC)

WAC

388-02-0025	Where is the office of administrative hearings located?
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WAC 388-02-0025 Where is the office of administrative hearings located? (1)(a) The office of administrative hearings (OAH) headquarters location is:

Office of Administrative Hearings
2420 Bristol Court SW, 1st Floor
P.O. Box 42488
Olympia WA 98504-2488
(360) 664-8717
(360) 664-8721 (fax)

(b) The headquarters office is open from 8:00 am to 5:00 p.m. Mondays through Friday, except legal holidays.

(2) OAH field offices are at the following locations:

Olympia

Office of Administrative Hearings
2420 Bristol Court SW, 3rd Floor
P.O. Box 42489
Olympia, WA 98504-2489
(360) 753-2531
1-800-583-8271
fax: (360) 586-6563

Seattle

Office of Administrative Hearings
One Union Square
600 University Street, Suite 1500
Mailstop: TS-07
Seattle, WA 98101-1129
(206) 389-3400
1-800-845-8830
fax: (206) 587-5135

Vancouver

Office of Administrative Hearings
5300 MacArthur Blvd., Suite 100
Vancouver, WA 98661
(360) 690-7189
1-800-243-3451
fax: (360) 696-6255

Spokane

Office of Administrative Hearings
Old City Hall Building, 5th Floor
221 N. Wall Street, Suite 540
Spokane, WA 99201
(509) 456-3975
1-800-366-0955
fax: (509) 456-3997

Yakima

Office of Administrative Hearings
32 N 3rd Street, Suite 320
Yakima, WA 98901-2730
(509) 575-2147
1-800-843-3491
fax (509) 454-7281

(3) You should contact the Olympia field office, under subsection (2), if you do not know the correct field office.

(4) You can obtain further hearing information at the OAH web site: www.oah.wa.gov

[Statutory Authority: RCW 34.05.353, 09-05-032, § 388-02-0025, filed 2/11/09, effective 3/14/09. Statutory Authority: RCW 34.05.020 and chapter 34.05 RCW, Parts IV and V, 05-22-076, § 388-02-0025, filed 10/31/05, effective 12/1/05. Statutory Authority: RCW 34.05.020, chapter 34.05 RCW, Parts IV and V, 2002 c 371 § 211, 02-21-061, § 388-02-0025, filed 10/15/02, effective 11/15/02. Statutory Authority: RCW 34.05.020, 00-18-059, § 388-02-0025, filed 9/1/00, effective 10/2/00.]

Chapter 388-06 WAC BACKGROUND CHECKS

WAC

388-06-0010	What is the purpose of this chapter?
388-06-0110	Who must have background checks?
388-06-0150	What does the background check cover?
388-06-0160	Who pays for the background check?
388-06-0600	Must the DSHS secretary or designee conduct background checks on all employees in covered positions and applicants under consideration for a covered position?
388-06-0605	What is a covered position?
388-06-0610	Who are vulnerable adults, juveniles or children?
388-06-0615	What is unsupervised access?
388-06-0620	What information is considered in a background check conducted by DSHS and what are the results of the background check used for?
388-06-0625	Must an employee and/or applicant authorize the secretary of the department of social and health services or designee to conduct a background check and what happens if the employee or applicant does not provide authorization?
388-06-0630	What happens when a permanent DSHS employee is disqualified because of a background check or failure to authorize a background check?
388-06-0635	What are the DSHS secretary's responsibilities in carrying out the requirements to conduct background checks?
388-06-0640	Does a DSHS permanent employee who is disqualified from a covered position as a result of a background check have the right to request a review of the disqualification?

WAC 388-06-0010 What is the purpose of this chapter? (1) The purpose of this chapter is to establish rules for background checks conducted by children's administration (CA), and the division of developmental disabilities (DDD) at the department of social and health services (DSHS). The department does background checks on individuals who are licensed, certified, contracted, or authorized to care for or

have unsupervised access to children and to individuals with a developmental disability. Background checks are conducted to find and evaluate any history of criminal convictions and child abuse or neglect.

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

(3) WAC 388-06-0600 through 388-06-0640 of this chapter includes the background check requirements for DSHS employees and applicants seeking, working or serving in a covered position.

[Statutory Authority: RCW 43.43.832, 43.20A.710, and 2007 c 387, 09-03-003, § 388-06-0010, filed 1/8/09, effective 2/8/09. Statutory Authority: RCW 74.15.030, 01-18-025, § 388-06-0010, filed 8/27/01, effective 10/1/01.]

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

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

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

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

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

(5) A person not related to the child who the court has approved placement as allowed in RCW 13.34.130;

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

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

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

(9) Prospective adoptive parents.

[Statutory Authority: RCW 43.43.832, 26.33.190, 26.44.030, 74.15.030, 2007 c 387 and Adam Walsh Act of 2006, 09-06-028, § 388-06-0110, filed 2/24/09, effective 3/6/09. Statutory Authority: RCW 74.15.030, 01-18-025, § 388-06-0110, filed 8/27/01, effective 10/1/01.]

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

(a) Criminal convictions and pending charges based on identifying information provided by you. However, if you have lived in Washington State for less than three years prior to the check, the department must conduct a fingerprint based background check for you to have unsupervised access to children or to individuals with developmental disabilities.

(b) If the background check is being conducted for Children's Administration, it must also include:

(i) A review of child protective services case files information or other applicable information system.

(ii) Administrative hearing decisions related to any DSHS license that has been revoked, suspended, or denied.

(c) If the background check is being conducted by Children's Administration for placement of a child in out-of-home care, including foster homes, adoptive homes, relative placements, and placement with other suitable persons under chapter 13.34 RCW, the department must check the following in addition to the requirements above for each person over eighteen years of age residing in the home:

(i) Child abuse and neglect registries in each state a person has lived in the five years prior to conducting the background check.

(ii) Washington state patrol (WSP) and federal bureau of investigation (FBI) fingerprint based background checks regardless of how long you have resided in Washington.

(2) The department may also review:

(a) Any civil judgment, determination or disciplinary board final decisions of child abuse or neglect.

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

(i) You have lived in another state.

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

[Statutory Authority: RCW 43.43.832, 26.33.190, 26.44.030, 74.15.030, 2007 c 387 and Adam Walsh Act of 2006. 09-06-028, § 388-06-0150, filed 2/24/09, effective 3/6/09. Statutory Authority: RCW 74.15.030. 01-18-025, § 388-06-0150, filed 8/27/01, effective 10/1/01.]

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

(2) Children's administration pays the WSP and FBI-fingerprint processing fees for foster home applicants, CA relative and other suitable caregivers, CA adoptive home applicants, and other adults in the home who require fingerprinting under chapter 13.34 RCW.

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

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

[Statutory Authority: RCW 43.43.832, 26.33.190, 26.44.030, 74.15.030, 2007 c 387 and Adam Walsh Act of 2006. 09-06-028, § 388-06-0160, filed 2/24/09, effective 3/6/09. Statutory Authority: RCW 74.15.030. 01-18-025, § 388-06-0160, filed 8/27/01, effective 10/1/01.]

WAC 388-06-0600 Must the DSHS secretary or designee conduct background checks on all employees in covered positions and applicants under consideration for a covered position? (1) The secretary of the department of social and health services (DSHS) or designee must conduct a background check, which may include fingerprinting as authorized by statute, on all employees in covered positions and applicants under final consideration for a covered position.

(2) The requirement to conduct a background check must include the following:

(a) Any employee seeking a covered position because of a layoff, reallocation, transfer, promotion or demotion or otherwise requesting a move to a covered position.

(b) Any applicant prior to appointment to a covered position, except when the appointment is made on a conditional basis in accordance with agency procedures authorized by WAC 388-06-0635.

(3) Applicant means any person who has applied for work or serves in a covered position, including current employees requesting transfer, promotion, demotion, or otherwise requesting a move to a covered position.

[Statutory Authority: RCW 43.43.832, 43.20A.710, and 2007 c 387. 09-03-003, § 388-06-0600, filed 1/8/09, effective 2/8/09.]

WAC 388-06-0605 What is a covered position? A covered position is one in which a person will or may have unsupervised access to vulnerable adults, juveniles or children.

[Statutory Authority: RCW 43.43.832, 43.20A.710, and 2007 c 387. 09-03-003, § 388-06-0605, filed 1/8/09, effective 2/8/09.]

WAC 388-06-0610 Who are vulnerable adults, juveniles or children? (1) Vulnerable adult means a person who is a client of DSHS and/or is:

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

(b) Found incapacitated under chapter 11.88 RCW;

(c) Developmental disabled as defined under RCW 71A.10.020;

(d) Admitted to any facility that is operated by DSHS;

(e) Receiving services from a DSHS contracted, authorized, certified, licensed or individual provider, including those certified under chapter 70.96A RCW;

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

(g) Admitted to detoxification in a certified chemical dependency treatment facility in accordance with chapter 70.96A RCW.

(2) Juvenile means a person under the age of twenty-one under the juvenile rehabilitation administration's (JRA) jurisdiction, or under the department of corrections's jurisdiction while placed in a JRA facility.

(3) Child or children means any person under eighteen years of age.

[Statutory Authority: RCW 43.43.832, 43.20A.710, and 2007 c 387. 09-03-003, § 388-06-0610, filed 1/8/09, effective 2/8/09.]

WAC 388-06-0615 What is unsupervised access? Unsupervised access means a DSHS employee, volunteer or student intern who:

(1) Works or serves in a setting, such as an institution, that provides residential services to vulnerable adults, juveniles and children;

(2) Works or serves in a position where, during the course of his or her employment, the employee may transport, or visit the residence of, a vulnerable adult, juvenile or child; or

(3) Works or serves in a position, other than one described in (1) and (2) above, where the employee may be left alone with a vulnerable adult, juvenile or child. "Left alone" does not include the possibility of a public encounter, or public interaction.

[Statutory Authority: RCW 43.43.832, 43.20A.710, and 2007 c 387. 09-03-003, § 388-06-0615, filed 1/8/09, effective 2/8/09.]

WAC 388-06-0620 What information is considered in a background check conducted by DSHS and what are the results of the background check used for? (1) The background check information considered by the DSHS secretary will include but is not limited to conviction records, pending charges, and civil adjudications as defined in RCW 43.43.830.

(2) The background information must be used by DSHS to determine the character, competence, and suitability of the applicant and/or employee to have unsupervised access to vulnerable adults, juveniles and children.

[Statutory Authority: RCW 43.43.832, 43.20A.710, and 2007 c 387. 09-03-003, § 388-06-0620, filed 1/8/09, effective 2/8/09.]

WAC 388-06-0625 Must an employee and/or applicant authorize the secretary of the department of social and health services or designee to conduct a background check and what happens if the employee or applicant does not provide authorization? (1) An employee and/or applicant applying for or being considered for retention in a covered position must authorize the secretary of DSHS or designee to conduct a background check which may include fingerprinting.

(2) Failure to authorize the DSHS secretary or designee to conduct a background check disqualifies an employee or applicant from consideration for any covered position including their current covered position.

[Statutory Authority: RCW 43.43.832, 43.20A.710, and 2007 c 387. 09-03-003, § 388-06-0625, filed 1/8/09, effective 2/8/09.]

WAC 388-06-0630 What happens when a permanent DSHS employee is disqualified because of a background check or failure to authorize a background check? (1) A DSHS employee who fails to authorize a background check or who is disqualified based on a background check and character, competence, and suitability assessment will be denied unsupervised access to vulnerable adults, juveniles and children.

(2) A permanent employee with a background check disqualification or who fails to authorize a background check may be subject to any of the following actions in no specific order:

- (a) Denial of a transfer, promotion, demotion, or elevation;
- (b) Job restructuring;
- (c) Job reassignment or transfer to a noncovered position;
- (d) Nondisciplinary separation;
- (e) Disciplinary action;
- (f) Voluntary demotion to a noncovered position;
- (g) Voluntary resignation from employment.

(3) An appointing authority may use the following interim measures or any combination while deciding which action to take. Use of these interim measures will generally not exceed thirty calendar days except in the case of ongoing investigations or pending charges:

(a) Voluntary use of accrued vacation, exchange, and/or compensatory time;

(b) Authorized leave without pay, if there is no paid leave available, or if the employee chooses not to use paid leave; or

(c) Reassignment to another work location to prevent unsupervised access.

(d) When considering the above actions, the agency will consider the least restrictive means necessary to prevent unsupervised access.

(4) Before an appointing authority implements the non-disciplinary separation of a permanent employee, a search for a noncovered position that is vacant, funded and for which the employee meets the skills and abilities will occur for a period of thirty calendar days. The search will be conducted in accordance with the layoff requirements listed in applicable collective bargaining agreements and DSHS administrative policies.

[Statutory Authority: RCW 43.43.832, 43.20A.710, and 2007 c 387. 09-03-003, § 388-06-0630, filed 1/8/09, effective 2/8/09.]

WAC 388-06-0635 What are the DSHS secretary's responsibilities in carrying out the requirements to conduct background checks? (1) The DSHS secretary or designee will:

(a) Notify employees and applicants that a background check is required for covered positions;

(b) Develop procedures specifying when employees and applicants may be hired on a conditional basis pending the results of a background check; and

(c) Develop policies and procedures pertaining to background checks.

(d) Use information contained in a background check for the purpose of determining the character, competence, and suitability of the applicant and/or employee to have unsupervised access to vulnerable adults, juveniles and children.

(2) The DSHS secretary or designee will not further disseminate background check information unless authorized or required by law to do so. In addition, results of a background check may be discoverable pursuant to the rules of civil discovery, or subject to disclosure pursuant to a public records request.

[Statutory Authority: RCW 43.43.832, 43.20A.710, and 2007 c 387. 09-03-003, § 388-06-0635, filed 1/8/09, effective 2/8/09.]

WAC 388-06-0640 Does a DSHS permanent employee who is disqualified from a covered position as a result of a background check have the right to request a review of the disqualification? A DSHS permanent employee who is disqualified from a covered position as a result of a background check has the right to present the DSHS secretary or designee evidence that may mitigate the disqualifying background information identified by the department. The permanent employee may present additional information for consideration that includes, but is not limited to:

- (1) The employee's background check authorization and disclosure form;
- (2) The employee's age at the time of conviction, charge, or disciplinary board final decision;
- (3) The nature and severity of the conviction, charge, or disciplinary board final decision;
- (4) The length of time since the conviction, charge, or disciplinary board final decision;
- (5) The nature and number of previous offenses;
- (6) Vulnerability of the child, vulnerable adult, or individual with mental illness or developmental disabilities to which the employee will or may have unsupervised access; and
- (7) The relationship between the potentially disqualifying event and the duties of the employee.

[Statutory Authority: RCW 43.43.832, 43.20A.710, and 2007 c 387. 09-03-003, § 388-06-0640, filed 1/8/09, effective 2/8/09.]

Chapter 388-14A WAC

DIVISION OF CHILD SUPPORT RULES

WAC

388-14A-1020	What definitions apply to the rules regarding child support enforcement?
388-14A-2036	What does assigning my rights to support mean?
388-14A-2037	What are permanently assigned arrears?
388-14A-2038	What are temporarily assigned arrears?
388-14A-2039	What are conditionally assigned arrears?
388-14A-5000	What is the difference between distribution and disbursement of child support collections?
388-14A-5001	What procedures does DCS follow to distribute support collections?
388-14A-5002	How does DCS distribute support collections in a nonassistance case?
388-14A-5003	How does DCS distribute support collections in an assistance case?
388-14A-5004	How does DCS distribute support collections in a former assistance case?
388-14A-5005	How does DCS distribute federal tax refund offset collections?
388-14A-5006	How does DCS distribute support collections when the paying parent has more than one case?
388-14A-5010	How does the division of child support distribute federal tax refund offset collections from joint returns?
388-14A-5015	What is a pass-through payment?
388-14A-5100	How does the division of child support notify the custodial parent about support collections?

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

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

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

"Accessible coverage" means health insurance coverage which provides primary care services to the children with reasonable effort by the custodian.

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

"Administrative order" means a determination, finding, decree or order for support issued under RCW 74.20A.055, 74.20A.056, or 74.20A.059 or by another state's agency under an administrative process, establishing the existence of a support obligation (including medical support) and ordering

the payment of a set or determinable amount of money for current support and/or a support debt. Administrative orders include:

- (1) An order entered under chapter 34.05 RCW;
- (2) An agreed settlement or consent order entered under WAC 388-14A-3600; and
- (3) A support establishment notice which has become final by operation of law.

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

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

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

"Alternate recipient" means a child of the employee or retiree named within a support order as being entitled to coverage under an employer's group health plan.

"Annual fee" means the twenty-five dollar annual fee charged between October 1 and September 30 each year, required by the federal deficit reduction act of 2005 and RCW 74.20.040.

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

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

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

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

"Assistance unit" means a cash assistance unit as defined in WAC 388-408-0005. An assistance unit is the group of people who live together and whose income or resources the department counts to decide eligibility for benefits and the amount of benefits.

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

"Conditionally assigned arrears" means those temporarily assigned arrears remaining on a case after the period of public assistance ends.

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

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

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

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

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

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

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

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

"Dependent child" means a person:

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

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

(3) Eighteen years of age or older, but under nineteen years of age, for whom an administrative support order exists if the child is participating full-time in a secondary school program or the same level of vocational or technical training.

"Disbursement" means the amount of child support distributed to a case that is paid to the family, state, other child support enforcement agency in another state or foreign country, Indian tribe, or person or entity making the payment.

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

"Distribution" means how a collection is allocated or split within a case or among multiple cases.

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

(1) Wages or salary;

(2) Commissions and bonuses;

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

(4) Disability payments under Title 51 RCW;

(5) Unemployment compensation under RCW 50.40.-020, 50.40.050 and Title 74 RCW;

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

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

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

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

(1) Partnerships and associations;

(2) Trusts and estates;

(3) Joint stock companies and insurance companies;

(4) Domestic and foreign corporations;

(5) The receiver or trustee in bankruptcy; and

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

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

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

"Family arrears" means the amount of past-due support owed to the family, which has not been conditionally, temporarily or permanently assigned to a state. Also called "nonassistance arrears."

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

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

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

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

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

(2) The representation's materiality;

(3) The representation's falsity;

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

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

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

(7) The latter's:

(a) Reliance on the truth of the representation;

(b) Right to rely on it; and

(c) Subsequent damage.

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

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

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

"Health insurance" means insurance coverage for all medical services related to an individual's general health and well being. These services include, but are not limited to: Medical/surgical (inpatient, outpatient, physician) care, medical equipment (crutches, wheel chairs, prosthesis, etc.), pharmacy products, optometric care, dental care, orthodontic care, preventive care, mental health care, and physical therapy.

"Hearing" means an adjudicative proceeding authorized by this chapter, or chapters 26.23, 74.20 and 74.20A

RCW, conducted under chapter 388-02 WAC and chapter 34.05 RCW.

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

"Income" includes:

- (1) All gains in real or personal property;
- (2) Net proceeds from the sale or exchange of real or personal property;
- (3) Earnings;
- (4) Interest and dividends;
- (5) Proceeds of insurance policies;
- (6) Other periodic entitlement to money from any source; and
- (7) Any other property subject to withholding for support under the laws of this state.

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

- (1) Asserting liens under RCW 74.20A.060;
- (2) Serving and enforcing liens under chapter 74.20A RCW;
- (3) Issuing orders to withhold and deliver under chapter 74.20A RCW;
- (4) Issuing notices of payroll deduction under chapter 26.23 RCW; and
- (5) Obtaining wage assignment orders under RCW 26.18.080.

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

"Medical assistance" means medical benefits under Title XIX of the federal Social Security Act provided to families as an alternative or supplement to TANF.

"Medical expenses" for the purpose of establishing support obligations under RCW 74.20A.055 and 74.20A.056, or for the purpose of enforcement action under chapters 26.23, 74.20 and 74.20A RCW, including the notice of support debt and the notice of support owed, means:

- Medical costs incurred on behalf of a child, which include:
 - Medical services related to an individual's general health and well-being, including but not limited to, medical/surgical care, preventive care, mental health care and physical therapy; and
 - Prescribed medical equipment and prescribed pharmacy products;
 - Health care coverage, such as coverage under a health insurance plan, including the cost of premiums for coverage of a child;
 - Dental and optometrical costs incurred on behalf of a child; and
 - Copayments and/or deductibles incurred on behalf of a child.

Medical expenses are sometimes also called health care costs or medical costs.

"Medical support" means either or both:

- (1) Medical expenses; and
- (2) Health insurance coverage for a dependent child.

"National Medical Support Notice" or **"NMSN"** is a federally mandated form that DCS uses to enforce a health

insurance support obligation; the NMSN is a notice of enrollment as described in RCW 26.18.170.

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

"Obligated parent" means a parent who is required under a child support order to provide health insurance coverage or to reimburse the other parent for his or her share of medical expenses for a dependent child. The obligated parent could be either the NCP or the CP.

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

- (1) Directly benefits the dependent child; and
- (2) Relates to the parent's residential time or visitation with the child.

"Participant" means an employee or retiree who is eligible for coverage under an employer group health plan.

"Pass-through" means the portion of a support collection distributed to assigned support that the state pays to a family currently receiving TANF.

"Past support" means support arrears.

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

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

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

"Physical custodian" means custodial parent (CP).

"Plan administrator" means the person or entity which performs those duties specified under 29 USC 1002 (16)(A) for a health plan. If no plan administrator is specifically so designated by the plan's organizational documents, the plan's sponsor is the administrator of the plan. Sometimes an employer acts as its own plan administrator.

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

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

- (1) Mailing a support establishment notice to the noncustodial parent in the manner described in WAC 388-14A-3105;
- (2) Referral to a sheriff or other server of process, or to a locate service or department employee for locate activities;
- (3) Tracing activity such as:
 - (a) Checking local telephone directories and attempts by telephone or mail to contact the custodial parent, relatives of the noncustodial parent, past or present employers, or the post office;
 - (b) Contacting state agencies, unions, financial institutions or fraternal organizations;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) Delinquent support;

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

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

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

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

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

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

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

"Temporarily assigned arrears" means those arrears which accrue prior to the family receiving assistance, for assistance applications dated on or after October 1, 1997, but before October 1, 2008. After the family terminates assistance, temporarily assigned arrears become conditionally assigned arrears.

"Temporary assistance for needy families," or "TANF" means cash assistance under the temporary assistance for needy families (TANF) program under Title IV-A of the Social Security Act.

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

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

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

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

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

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

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

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

"Tribal TANF" means a temporary assistance for needy families (TANF) program run by a tribe.

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

"Uninsured medical expenses":

(1) For the purpose of enforcing support obligations under RCW 26.23.110, means

(a) Medical expenses not paid by insurance for medical, dental, prescription and optometrical costs incurred on behalf of a child; and

(b) Copayments, or deductibles incurred on behalf of a child; and

(2) Includes health insurance premiums that represent the only health insurance covering a dependent child when either:

(a) Health insurance for the child is not required by a support order or cannot be enforced by the division of child support (DCS); or

(b) The premium for covering the child exceeds the maximum limit provided in the support order.

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

"Unreimbursed medical expenses" means any amounts paid by one parent for uninsured medical expenses, which that parent claims the obligated parent owes under a child support order, which percentage share is stated in the child support order itself, not just in the worksheets.

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

"WSSR" is the Washington state support registry.

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

[Statutory Authority: RCW 26.18.170, 26.23.035, 26.23.050, [26.23.]1110, 74.20.040, 74.20A.030, [74.20A.]055, [74.20A.]056, and 74.20A.310. 09-02-059, § 388-14A-1020, filed 1/5/09, effective 1/27/09. Statutory Authority: 2007 c 143, §§ 1, 2, 3, 4, 5, 7, 8, and 9. 08-12-029, § 388-14A-1020, filed 5/29/08, effective 7/1/08. Statutory Authority: RCW 74.20A.310, 45 C.F.R. 302.31 and 302.33. 06-03-120, § 388-14A-1020, filed 1/17/06, effective 2/17/06. Statutory Authority: RCW 34.05.220(1), 74.08.090, 74.20A.055, 74.20A.056, 74.20A.310. 05-14-101, § 388-14A-1020, filed 6/30/05, effective 7/31/05. Statutory Authority: RCW 74.08.090, 74.20A.310, and 26.18.170, 42 U.S.C. 666 (a)(19), Child Support Performance and Incentives Act of 1998, 45 C.F.R. 303.31, and 45 C.F.R. 303.32. 04-17-119, § 388-14A-1020, filed 8/17/04, effective 9/17/04. Statutory Authority: RCW 74.08.090, 26.23.035, 34.05.220(1), 74.20A.055, 74.20A.056. 01-03-089, § 388-14A-1020, filed 1/17/01, effective 2/17/01. Formerly WAC 388-11-011 and 388-14-020.]

WAC 388-14A-2036 What does assigning my rights to support mean? (1) As a condition of eligibility for assistance, a family member must assign to the state the right to collect and keep, subject to the limitation in WAC 388-14A-2035(3):

(a) Any support owing to the family member or to any other person for whom the family member has applied for or is receiving assistance if the family applied for cash public assistance before October 1, 2008.

(b) Support owing to the family member, or to any other person for whom the family member has applied for or is receiving cash public assistance, for any month during which the family receives assistance.

(2) While your family receives assistance, support is distributed and disbursed in accordance with WAC 388-14A-5000 through 388-14A-5015.

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

(a) For assistance applications dated prior to October 1, 1997, you permanently assigned to the state all rights to support which accrued before the application date until the date your family terminated from assistance.

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

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

(ii) You temporarily assigned to the state all rights to support which accrued before the application date, until October 1, 2000, or when your family terminated from assistance, whichever date is later.

(c) For assistance applications dated on or after October 1, 2000, and before October 1, 2008:

(i) You permanently assigned to the state all rights to support which accrued while the family received assistance; and

(ii) You temporarily assigned to the state all rights to support which accrued before the application date, until the date your family terminated from assistance.

(d) For assistance applications dated on or after October 1, 2008, you permanently assign to the state all rights to support which accrue while the family receives assistance.

(4) When you assign your medical support rights to the state, you authorize the state on behalf of yourself and the children in your care to enforce the noncustodial parent's full duty to provide medical support.

[Statutory Authority: RCW 26.18.170, 26.23.035, 26.23.050, [26.23.]1110, 74.20.040, 74.20A.030, [74.20A.]055, [74.20A.]056, and 74.20A.310. 09-02-059, § 388-14A-2036, filed 1/5/09, effective 1/27/09. Statutory Authority: RCW 74.20A.310, 45 C.F.R. 302.31 and 302.33. 06-03-120, § 388-14A-2036, filed 1/17/06, effective 2/17/06. Statutory Authority: RCW 74.08.090, 26.23.035, 34.05.220(1), 74.20A.270, 74.20A.310. 01-03-089, § 388-14A-2036, filed 1/17/01, effective 2/17/01. Formerly WAC 388-14-200.]

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

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

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

[Statutory Authority: RCW 26.18.170, 26.23.035, 26.23.050, [26.23.]1110, 74.20.040, 74.20A.030, [74.20A.]055, [74.20A.]056, and 74.20A.310. 09-02-059, § 388-14A-2037, filed 1/5/09, effective 1/27/09. Statutory Authority: RCW 74.08.090. 01-03-089, § 388-14A-2037, filed 1/17/01, effective 2/17/01.]

WAC 388-14A-2038 What are temporarily assigned arrears? (1) Temporarily assigned arrears are arrears owed to the family at the time TANF started, for TANF periods beginning before October 1, 2008. These arrears remain temporarily assigned during the assistance period.

(2) Temporarily assigned arrears convert to conditionally assigned arrears when the TANF period ends. See WAC 388-14A-2039 for a description of conditionally assigned arrears.

(3) If any support collections are distributed to temporarily assigned arrears, those collections are retained by the state, up to the amount of unreimbursed assistance.

[Statutory Authority: RCW 26.18.170, 26.23.035, 26.23.050, [26.23.]1110, 74.20.040, 74.20A.030, [74.20A.]055, [74.20A.]056, and 74.20A.310. 09-02-059, § 388-14A-2038, filed 1/5/09, effective 1/27/09. Statutory Authority: RCW 74.08.090. 01-03-089, § 388-14A-2038, filed 1/17/01, effective 2/17/01.]

WAC 388-14A-2039 What are conditionally assigned arrears? (1) Conditionally assigned arrears are any temporarily assigned arrears that remain on a case after the family stops receiving TANF.

(2) These arrears remain conditionally assigned during TANF periods beginning on or after October 1, 2008.

(3) If federal tax refund offset collections are distributed to conditionally assigned arrears, those collections are retained by the state, up to the amount of unreimbursed assistance.

(4) If support collections other than federal tax refund offset collections are distributed to conditionally assigned arrears, those collections are disbursed to the family.

[Statutory Authority: RCW 26.18.170, 26.23.035, 26.23.050, [26.23.]110, 74.20.040, 74.20A.030, [74.20A.]055, [74.20A.]056, and 74.20A.310. 09-02-059, § 388-14A-2039, filed 1/5/09, effective 1/27/09.]

WAC 388-14A-5000 What is the difference between distribution and disbursement of child support collections? (1) Distribution of child support collections refers to how the division of child support (DCS) applies or allocates collections within a child support case or between child support cases.

(2) Disbursement of child support collections refers to DCS sending out or paying support collections to the appropriate recipient.

(3) WAC 388-14A-5001 through 388-14A-5015 explain how DCS distributes and disburses child support collections.

[Statutory Authority: RCW 26.18.170, 26.23.035, 26.23.050, [26.23.]110, 74.20.040, 74.20A.030, [74.20A.]055, [74.20A.]056, and 74.20A.310. 09-02-059, § 388-14A-5000, filed 1/5/09, effective 1/27/09. Statutory Authority: 2007 c 143, §§ 1, 2, 3, 4, 5, 7, 8, and 9. 08-12-029, § 388-14A-5000, filed 5/29/08, effective 7/1/08. Statutory Authority: RCW 26.23.035, 74.08.090, 74.20A.310, and 45 C.F.R. 303.72 (h)(5). 05-06-014, § 388-14A-5000, filed 2/22/05, effective 3/25/05. Statutory Authority: RCW 74.08.090, 34.05.310 (4)(d), 26.23.035, 74.20A.057, 74.20A.310. 03-20-072, § 388-14A-5000, filed 9/29/03, effective 10/30/03. Statutory Authority: RCW 74.08.090, 26.23.035, 74.20A.057, 74.20A.310. 01-03-089, § 388-14A-5000, filed 1/17/01, effective 2/17/01. Formerly WAC 388-14-250, 388-14-270, and 388-14-273.]

WAC 388-14A-5001 What procedures does DCS follow to distribute support collections? (1) When distributing support collections, the division of child support (DCS) records collections in exact amounts of dollars and cents.

(2) DCS distributes support collections within two days of the date DCS receives the collection, unless DCS is unable to distribute the collection for one or more of the following reasons:

(a) The location of the payee is unknown;

(b) DCS does not have sufficient information to identify the accounts against which or to which it should distribute the money;

(c) An action is pending before a court or agency which has jurisdiction over the issue to determine whether child support is owed or how DCS should distribute the collection.

(d) DCS receives prepaid child support and is holding it for distribution in future months under subsection (2)(e) of this section;

(e) DCS mails a notice of intent to distribute support money to the custodial parent (CP) under WAC 388-14A-5050;

(f) DCS may hold funds and not issue a check to the family for amounts under one dollar. DCS must give credit for the collection, but may delay disbursement of that amount until a future collection is received which increases the amount of the disbursement to the family to at least one dollar. If no future collections are received which increase the disbursement to the family to at least one dollar, DCS transfers the amount to the department of revenue under RCW 63.29.130. This subsection does not apply to disbursements which can be made by electronic funds transfer (EFT), or to refunds of federal tax refund offset collections; or

(g) Other circumstances exist which make a proper and timely distribution of the collection impossible through no fault or lack of diligence of DCS.

(3) DCS distributes support collections based on the date DCS receives the collection, except as provided under WAC 388-14A-5005. DCS distributes support collections based on the date of collection. DCS considers the date of collection to be the date that DCS receives the support collection, no matter when the money was withheld from the noncustodial parent (NCP).

(4) Under state and federal law, the division of child support (DCS) disburses support collections to the:

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

(b) Payee under the order, or to the custodial parent (CP) of the child according to WAC 388-14A-5050;

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

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

(e) Persons or entity making the payment when DCS is unable to identify the person to whom the support is payable after making reasonable efforts to obtain identification information.

(5) If DCS is unable to disburse a support collection because the location of the family or person is unknown, it must exercise reasonable efforts to locate the family or person. When the family or person cannot be located, DCS handles the collection in accordance with chapter 63.29 RCW, the uniform unclaimed property act.

(6) WAC 388-14A-5000 through 388-14A-5015 contain the rules for the distribution of support collections by DCS.

(7) DCS changes the distribution rules based on changes in federal statutes and regulations.

[Statutory Authority: RCW 26.18.170, 26.23.035, 26.23.050, [26.23.]110, 74.20.040, 74.20A.030, [74.20A.]055, [74.20A.]056, and 74.20A.310. 09-02-059, § 388-14A-5001, filed 1/5/09, effective 1/27/09. Statutory Authority: RCW 26.23.035, 74.08.090, 74.20A.310, and 45 C.F.R. 303.72 (h)(5). 05-06-014, § 388-14A-5001, filed 2/22/05, effective 3/25/05. Statutory Authority: RCW 26.23.035, 74.08.090, 74.20A.188, 74.20A.310, 42 U.S.C. 666(a)14. 01-24-078, § 388-14A-5001, filed 12/3/01, effective 1/3/02. Statutory Authority: RCW 74.08.090, 26.23.035, 74.20A.057, 74.20A.310. 01-03-089, § 388-14A-5001, filed 1/17/01, effective 2/17/01. Formerly WAC 388-14-270 and 388-14-273.]

WAC 388-14A-5002 How does DCS distribute support collections in a nonassistance case? (1) A nonassis-

tance case is one where the family has never received a cash public assistance grant.

(2) The division of child support (DCS) applies support collections within each Title IV-D nonassistance case:

(a) First, to satisfy the current support obligation for the month DCS received the collection;

(b) Second, to the noncustodial parent's support debts owed to the family;

(c) Third, to prepaid support as provided for under WAC 388-14A-5008.

(3) DCS uses the fee retained under WAC 388-14A-2200 to offset the fee amount charged by the federal government for IV-D cases that meet the fee criteria in WAC 388-14A-2200(1).

[Statutory Authority: RCW 26.18.170, 26.23.035, 26.23.050, [26.23.]110, 74.20.040, 74.20A.030, [74.20A.]055, [74.20A.]056, and 74.20A.310. 09-02-059, § 388-14A-5002, filed 1/5/09, effective 1/27/09. Statutory Authority: 2007 c 143, §§ 1, 2, 3, 4, 5, 7, 8, and 9. 08-12-029, § 388-14A-5002, filed 5/29/08, effective 7/1/08. Statutory Authority: RCW 74.08.090, 26.23.035, 74.20A.057, 74.20A.310. 01-03-089, § 388-14A-5002, filed 1/17/01, effective 2/17/01. Formerly WAC 388-14-270.]

WAC 388-14A-5003 How does DCS distribute support collections in an assistance case? (1) An assistance case is one where the family is currently receiving a TANF grant.

(2) The division of child support (DCS) distributes support collections within each Title IV-D assistance case:

(a) First, to satisfy the current support obligation for the month DCS received the collection;

(b) Second, to satisfy support debts which are permanently assigned to the department to reimburse the cumulative amount of assistance which has been paid to the family;

(c) Third:

(i) To satisfy support debts which are temporarily assigned to the department to reimburse the cumulative amount of assistance paid to the family; or

(ii) To satisfy support debts which are conditionally assigned to the department. Support collections distributed to conditionally assigned arrears are disbursed according to WAC 388-14A-2039.

(d) Fourth, to satisfy support debts owed to the family;

(e) Fifth, to prepaid support as provided for under WAC 388-14A-5008.

[Statutory Authority: RCW 26.18.170, 26.23.035, 26.23.050, [26.23.]110, 74.20.040, 74.20A.030, [74.20A.]055, [74.20A.]056, and 74.20A.310. 09-02-059, § 388-14A-5003, filed 1/5/09, effective 1/27/09. Statutory Authority: RCW 26.23.035, 74.08.090, 74.20A.188, 74.20A.310, 42 U.S.C. 666(a)14. 01-24-078, § 388-14A-5003, filed 12/3/01, effective 1/3/02. Statutory Authority: RCW 74.08.090, 26.23.035, 74.20A.057, 74.20A.310. 01-03-089, § 388-14A-5003, filed 1/17/01, effective 2/17/01. Formerly WAC 388-14-270.]

WAC 388-14A-5004 How does DCS distribute support collections in a former assistance case? (1) A former assistance case is one where the family is not currently receiving a TANF grant, but has at some time in the past.

(2) Subject to the exceptions provided under WAC 388-14A-5005, the division of child support (DCS) distributes support collections within each Title IV-D former-assistance case:

(a) First, to satisfy the current support obligation for the month DCS received the collection;

(b) Second, to satisfy support debts owed to the family;

(c) Third, to satisfy support debts which are conditionally assigned to the department. These collections are disbursed according to WAC 388-14A-2039;

(d) Fourth, to satisfy support debts which are permanently assigned to the department to reimburse the cumulative amount of assistance which has been paid to the family; and

(e) Fifth, to prepaid support as provided for under WAC 388-14A-5008.

[Statutory Authority: RCW 26.18.170, 26.23.035, 26.23.050, [26.23.]110, 74.20.040, 74.20A.030, [74.20A.]055, [74.20A.]056, and 74.20A.310. 09-02-059, § 388-14A-5004, filed 1/5/09, effective 1/27/09. Statutory Authority: RCW 74.08.090, 26.23.035, 74.20A.057, 74.20A.310. 01-03-089, § 388-14A-5004, filed 1/17/01, effective 2/17/01. Formerly WAC 388-14-270.]

WAC 388-14A-5005 How does DCS distribute federal tax refund offset collections? The division of child support (DCS) distributes federal tax refund offset collections in accordance with 42 U.S.C. Sec. 657, as follows:

(1) First, to satisfy the current support obligation for the month in which DCS received the collection.

(2) Second, DCS distributes any amounts over current support depending on the type of case to which the collection is distributed:

(a) In a never assistance case, all remaining amounts are distributed to family arrears, meaning those arrears which have never been assigned.

(b) In a former assistance case, all remaining amounts are distributed first to family arrears, then to permanently assigned arrears, then to conditionally assigned arrears.

(c) In a current assistance case, all remaining amounts are distributed first to permanently assigned arrears, then to temporarily assigned arrears (if they exist), then to conditionally assigned arrears, and then to family arrears.

(3) Federal tax refund offset collections distributed to assigned support are retained by the state to reimburse the cumulative amount of assistance which has been paid to the family.

(4) DCS may distribute federal tax refund offset collections only to certified support debts and to current support obligations on cases with certified debts. DCS must refund any excess to the noncustodial parent (NCP).

(5) DCS may retain the twenty-five dollar annual fee required under the federal deficit reduction act of 2005 and RCW 74.20.040 from federal tax refund offset collections distributed to nonassistance cases.

(6) When the Secretary of the Treasury, through the federal Office of Child Support Enforcement (OCSE), notifies DCS that a collection from a federal tax refund offset is from a tax refund based on a joint return, DCS follows the procedures set forth in WAC 388-14A-5010.

[Statutory Authority: RCW 26.18.170, 26.23.035, 26.23.050, [26.23.]110, 74.20.040, 74.20A.030, [74.20A.]055, [74.20A.]056, and 74.20A.310. 09-02-059, § 388-14A-5005, filed 1/5/09, effective 1/27/09. Statutory Authority: 2007 c 143, §§ 1, 2, 3, 4, 5, 7, 8, and 9. 08-12-029, § 388-14A-5005, filed 5/29/08, effective 7/1/08. Statutory Authority: RCW 26.23.035, 74.08.090, 74.20A.310, and 45 C.F.R. 303.72 (h)(5). 05-06-014, § 388-14A-5005, filed 2/22/05, effective 3/25/05. Statutory Authority: RCW 74.08.090, 26.23.035, 74.20A.057, 74.20A.310. 01-03-089, § 388-14A-5005, filed 1/17/01, effective 2/17/01. Formerly WAC 388-14-270.]

WAC 388-14A-5006 How does DCS distribute support collections when the paying parent has more than one case? When the NCP has more than one Title IV-D case, the division of child support (DCS) distributes support collections:

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

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

(3) Third, within each Title IV-D case according to WAC 388-14A-5002, 388-14A-5003, or 388-14A-5004.

[Statutory Authority: RCW 26.18.170, 26.23.035, 26.23.050, [26.23.]110, 74.20.040, 74.20A.030, [74.20A.]055, [74.20A.]056, and 74.20A.310. 09-02-059, § 388-14A-5006, filed 1/5/09, effective 1/27/09. Statutory Authority: RCW 26.23.035, 74.08.090, 74.20A.188, 74.20A.310, 42 U.S.C. 666(a) 14. 01-24-078, § 388-14A-5006, filed 12/3/01, effective 1/3/02. Statutory Authority: RCW 74.08.090, 26.23.035, 74.20A.057, 74.20A.310. 01-03-089, § 388-14A-5006, filed 1/17/01, effective 2/17/01. Formerly WAC 388-14-270.]

WAC 388-14A-5010 How does the division of child support distribute federal tax refund offset collections from joint returns? (1) The division of child support (DCS) collects child support through the interception of federal tax refunds. This section deals with the issues that arise when the Secretary of the Treasury intercepts a tax refund based on a joint tax return filed by a noncustodial parent (NCP) and the NCP's spouse who does not owe child support.

(2) When the Secretary of the Treasury, through the federal Office of Child Support Enforcement (OCSE), notifies DCS that a collection on behalf of an NCP is from an intercepted tax refund based on a joint return, DCS may distribute fifty percent of that collection and hold the remainder for up to six months in case the NCP's spouse is entitled to a share of the federal tax refund.

(3) DCS distributes fifty percent of the collection according to WAC 388-14A-5005.

(4) DCS holds the other fifty percent of the collection in suspense until the earlier of the following:

(a) DCS is notified by OCSE or the Secretary of the Treasury whether DCS must pay back the unobligated spouse's portion of the refund; or

(b) For a period not to exceed six months from notification of the offset.

(5) After DCS holds part of a collection under subsection (4) of this section, DCS distributes the remainder of the collection to the NCP's support obligations if DCS is not required to return the unobligated spouse's portion of the refund. The CP may:

(a) Request that DCS distribute the payment to the NCP's support obligation sooner upon a showing of hardship to the CP; and

(b) Request a conference board if the CP disagrees with DCS' denial of a hardship claim.

[Statutory Authority: RCW 26.18.170, 26.23.035, 26.23.050, [26.23.]110, 74.20.040, 74.20A.030, [74.20A.]055, [74.20A.]056, and 74.20A.310. 09-02-059, § 388-14A-5010, filed 1/5/09, effective 1/27/09. Statutory Authority: RCW 26.23.035, 74.08.090, 74.20A.310, and 45 C.F.R. 303.72 (h)(5). 05-06-014, § 388-14A-5010, filed 2/22/05, effective 3/25/05.]

WAC 388-14A-5015 What is a pass-through payment? (1) A pass-through payment is the portion of a support collection applied to assigned support that the state elects to pay to a family currently receiving TANF. The pass-through payment is paid in the following amounts:

(a) Up to one hundred dollars per month to a family with one child in the assistance unit.

(b) Up to two hundred dollars per month to a family with two or more children in the assistance unit.

(2) The pass-through is paid from collections which are distributed to either current support or assigned arrears.

(3) The pass-through amount can never exceed the amount collected in the month.

[Statutory Authority: RCW 26.18.170, 26.23.035, 26.23.050, [26.23.]110, 74.20.040, 74.20A.030, [74.20A.]055, [74.20A.]056, and 74.20A.310. 09-02-059, § 388-14A-5015, filed 1/5/09, effective 1/27/09.]

WAC 388-14A-5100 How does the division of child support notify the custodial parent about support collections? (1) The division of child support (DCS) mails a distribution and disbursement statement once each month to the last known address of a person for whom it received a support collection during the month, except as provided under subsection (6) of this section.

(2) DCS includes the following information in the distribution and disbursement statement:

(a) The amount of support collections DCS received and the date of collection;

(b) A description of how DCS distributed each support collection between current support and the support debt and any fees required by state or federal law;

(c) The amount DCS claims as reimbursement for public assistance paid, if applicable;

(d) The amount kept by the state to repay public assistance paid to the family;

(e) The amount disbursed to the family as a pass-through payment under WAC 388-14A-5015;

(f) The amount disbursed to the family as a payment on support owed to the family;

(g) The amount kept by the state to pay the twenty-five dollar annual fee, if applicable; and

(h) The amount kept by the state to repay child support paid to the family in error.

(3) The person to whom a distribution and disbursement statement is sent may file a request for a hearing under subsection (4) of this section within ninety days of the date of the statement to contest how DCS distributed the support collections, and must make specific objections to the statement. The effective date of a hearing request is the date DCS receives the request.

(4) A hearing under this section is for the limited purpose of determining if DCS correctly distributed the support money described in the contested statement.

(a) There is no hearing right regarding fees that have been charged on a case.

(b) If a custodial parent (CP) wants to request a hardship waiver of the fee, the CP may request a conference board under WAC 388-14A-6400.

(5) A person who requests a late hearing must show good cause for being late.

(6) This section does not require DCS to send a distribution and disbursement statement to a recipient of payment services only.

[Statutory Authority: RCW 26.18.170, 26.23.035, 26.23.050, [26.23.]110, 74.20.040, 74.20A.030, [74.20A.]055, [74.20A.]056, and 74.20A.310. 09-02-059, § 388-14A-5100, filed 1/5/09, effective 1/27/09. Statutory Authority: 2007 c 143, §§ 1, 2, 3, 4, 5, 7, 8, and 9. 08-12-029, § 388-14A-5100, filed 5/29/08, effective 7/1/08. Statutory Authority: RCW 74.08.090, 26.23.035, 74.20A.057, 74.20A.310. 01-03-089, § 388-14A-5100, filed 1/17/01, effective 2/17/01. Formerly WAC 388-14-270 and 388-14-274.]

Chapter 388-15 WAC

CHILD PROTECTIVE SERVICES

WAC

388-15-021 How does CPS respond to reports of alleged child abuse or neglect?

WAC 388-15-021 How does CPS respond to reports of alleged child abuse or neglect? (1) CPS must assess all reports that meet the definition of child abuse or neglect using a risk assessment process to determine level of risk and response time.

(2) CPS must provide an in-person response to alleged victims and must attempt an in-person response to the alleged perpetrator of child abuse and neglect in referrals assessed at moderate to high risk.

(3) CPS may refer reports assessed at low to moderately low risk to an alternative response system.

(4) CPS may interview a child, outside the presence of the parent, without prior parental notification or consent (RCW 26.44.030(10)).

(5) Unless the child objects, CPS must make reasonable efforts to have a third party present at the interview so long as the third party does not jeopardize the investigation (RCW 26.44.030).

(6) CPS may photograph the alleged child victim to document the physical condition of the child (RCW 26.44.050).

(7) CPS attempts to complete investigations within forty-five days. In no case shall the investigation extend beyond ninety days unless the investigation is being conducted under local protocol, established pursuant to chapter 26.44 RCW, and a law enforcement agency or prosecuting attorney has determined that a longer investigation period is necessary.

[Statutory Authority: Chapter 26.44 RCW, RCW 74.08.090, 74.13.031, 74.04.050, and 2007 c 220. 09-07-001, § 388-15-021, filed 3/4/09, effective 4/4/09. Statutory Authority: RCW 74.13.031, 74.04.050 and chapter 26.44 RCW. 02-15-098 and 02-17-045, § 388-15-021, filed 7/16/02 and 8/14/02, effective 2/10/03.]

Chapter 388-25 WAC

CHILD WELFARE SERVICES—FOSTER CARE

WAC

388-25-0001 What kinds of financial support are available to licensed foster care providers?

388-25-0003 What is the purpose of the foster care maintenance payment?

388-25-0011 What method does the department use to determine what foster care rate will be paid for a foster child?

388-25-0016 What are the essential features of the foster care rate assessment system?

388-25-0022 How does the foster care rate assessment work?

388-25-0027 What factors are considered in the foster care rate assessment?

388-25-0032 How often do the foster parent and social worker meet to complete the rate assessment?

388-25-0037 What are the reimbursement levels?

388-25-0042 Can the child be assessed at a different level, depending on the foster home?

388-25-0047 Can the assessment change if the child's needs change?

388-25-0052 How will the foster parent be notified of the rate the child will receive?

388-25-0057 Can a foster parent challenge the rate assessment?

388-25-0062 How does a foster parent seek a department review of the rate assessment?

388-25-0067 What does the department consider in reviewing the request?

388-25-0072 How does the foster parent learn about the department's decision on review?

388-25-0077 How does the foster parent appeal the department's decision on review?

388-25-0082 What law and rules govern the administrative law judge?

388-25-0087 What issues may be decided by the administrative law judge?

388-25-0095 What are the requirements for release of foster parents' licensing records?

388-25-0107 What is the beginning date for payment of foster care?

388-25-0195 How does the department make reimbursement for foster care for a child served by the department who moves out-of-state with the foster family?

388-25-0200 What payment procedures must the department follow for children placed across state borders?

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-25-0070 When does the department authorize foster care payments? [Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0070, filed 3/30/01, effective 4/30/01.] Repealed by 09-16-045, filed 7/28/09, effective 8/28/09. Statutory Authority: RCW 74.08.090.

388-25-0080 Are dependency guardians who are licensed foster parents able to receive payment from more than one source? [Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0080, filed 3/30/01, effective 4/30/01.] Repealed by 09-16-045, filed 7/28/09, effective 8/28/09. Statutory Authority: RCW 74.08.090.

388-25-0085 What happens if the dependency guardian receives payments from more than one source? [Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0085, filed 3/30/01, effective 4/30/01.] Repealed by 09-16-045, filed 7/28/09, effective 8/28/09. Statutory Authority: RCW 74.08.090.

388-25-0120 What is the department's reimbursement schedule for regular family foster care? [Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0120, filed 3/30/01, effective 4/30/01.] Repealed by 09-16-045, filed 7/28/09, effective 8/28/09. Statutory Authority: RCW 74.08.090.

388-25-0160 What are the reimbursement standards for payments above the basic foster care rate? [Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0160, filed 3/30/01, effective 4/30/01.] Repealed by 09-16-045, filed 7/28/09, effective 8/28/09. Statutory Authority: RCW 74.08.090.

388-25-0170 What other services and reimbursements may be provided for the support of children placed in foster care by the department? [Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0170, filed 3/30/01, effective 4/30/01.] Repealed by 09-16-045, filed 7/28/09, effective 8/28/09. Statutory Authority: RCW 74.08.090.

388-25-0180 Under what circumstances may the department provide reimbursement for foster care if the child is temporarily absent from the foster home or facility? [Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0180, filed 3/30/01, effective 4/30/01.] Repealed by 09-16-045, filed 7/28/09, effective 8/28/09. Statutory Authority: RCW 74.08.090.

388-25-0205 How does the department treat the earnings of a child in foster care? [Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0205, filed 3/30/01, effective 4/30/01.] Repealed by 09-16-045, filed 7/28/09, effective 8/28/09. Statutory Authority: RCW 74.08.090.

WAC 388-25-0001 What kinds of financial support are available to licensed foster care providers? In addition to medical assistance and other services that may be provided to meet the specific needs of a foster child, the department provides licensed foster parents with a monthly foster care maintenance payment. This payment is for the benefit of the child.

[Statutory Authority: RCW 74.08.090. 09-16-045, § 388-25-0001, filed 7/28/09, effective 8/28/09.]

WAC 388-25-0003 What is the purpose of the foster care maintenance payment? The purpose of the foster care maintenance payment is to assist licensed foster parents in meeting the needs of their foster child. A basic rate payment (level 1) is paid to all foster parents to help cover the cost of food, clothing, shelter, and personal incidentals. In addition, there are three levels of supplemental payments (levels 2, 3 and 4) which are paid to foster parents who care for children with varying degrees of physical, mental, behavioral or emotional conditions that require increased effort, care or supervision that are above the needs of a typically developing child.

[Statutory Authority: RCW 74.08.090. 09-16-045, § 388-25-0003, filed 7/28/09, effective 8/28/09.]

WAC 388-25-0011 What method does the department use to determine what foster care rate will be paid for a foster child? The department uses a standardized assessment tool, the foster care rate assessment, to determine the foster care rate that will be paid on behalf of the child. The tool assesses the needs of the child and the foster parent's ability and time required to meet those needs.

[Statutory Authority: RCW 74.08.090. 09-16-045, § 388-25-0011, filed 7/28/09, effective 8/28/09.]

WAC 388-25-0016 What are the essential features of the foster care rate assessment system? The foster care rate assessment system includes the following essential features:

- (1) Foster care maintenance payments are based on foster parent time and the nature of activities needed to meet the needs of the child.
- (2) A standardized assessment tool is used for all children.
- (3) The assessment tool is completed jointly by foster parent and social worker or a rate assessment specialist.
- (4) Assessments are updated periodically, in accordance with WAC 388-25-0032.
- (5) The assessment process is automated.

[Statutory Authority: RCW 74.08.090. 09-16-045, § 388-25-0016, filed 7/28/09, effective 8/28/09.]

WAC 388-25-0022 How does the foster care rate assessment work? The foster care rate assessment is a two-step process that includes the participation of the child's foster parent.

(1) Step one: The child's social worker or designated rate assessment specialist will meet with the foster parent in person or telephonically to jointly complete the standardized assessment form.

(2) Step two: After step one has been completed, the child's social worker or designated rate assessment specialist

enters the information from the assessment into the computer and, based on the responses to the questions in the standardized assessment, the rate assessment software program automatically calculates the foster care rate that will be paid on behalf of the child.

[Statutory Authority: RCW 74.08.090. 09-16-045, § 388-25-0022, filed 7/28/09, effective 8/28/09.]

WAC 388-25-0027 What factors are considered in the foster care rate assessment? The assessment tool considers the average number of hours, beyond those expected for a typically developing child of the same age, the foster parent spends in:

- (1) Caring and/or advocating for the child to meet the child's physical and behavioral needs;
- (2) Participating in parenting activities related to the child's physical or emotional/behavioral therapeutic plan;
- (3) Engaging in parenting activities related to supervising and supporting the educational needs of the child;
- (4) Participating in parenting activities related to scheduling, arranging, and supervising activities, such as medical and dental appointments for the child, visits between the child and his or her parents and/or siblings, or other school or recreational activities;
- (5) Repairing, cleaning or replacing household items, over and above normal repair, due to the child's chronic physical problems or destructive behavior; and
- (6) Preparing the child to transition back to the child's parents or to an adoptive or other foster care placement.

[Statutory Authority: RCW 74.08.090. 09-16-045, § 388-25-0027, filed 7/28/09, effective 8/28/09.]

WAC 388-25-0032 How often do the foster parent and social worker meet to complete the rate assessment?

The social worker or designated rate assessment specialist will meet with the foster parent in person or telephonically to complete the assessment:

- (1) Within thirty days of the child's placement in the foster parent's home;
- (2) At least every six months after the first assessment; and
- (3) When there is a significant change in circumstances for the child or in the foster parent's ability or time required to meet the child's needs.

[Statutory Authority: RCW 74.08.090. 09-16-045, § 388-25-0032, filed 7/28/09, effective 8/28/09.]

WAC 388-25-0037 What are the reimbursement levels? The amount of foster care maintenance payments may change slightly from year to year. A basic rate payment (level 1) is paid to all foster parents to help cover the cost of food, clothing, shelter, and personal incidentals. In addition, there are three levels of supplemental payments that are paid to foster parents who care for children with varying degrees of physical, mental, behavioral, emotional and/or intellectual conditions that require increased effort, care or supervision. The levels of payments are as follows:

- (1) **Level 1:** Children assessed at this level receive the basic foster care maintenance rate. The payment is based on the time typically spent by a foster parent to meet the needs of

a child, who is developing comparably to children in the same age range. The payments are based on three age categories: birth to five years old, six to eleven years old, and twelve to eighteen years old.

(2) **Level 2:** Children assessed at this level require the foster parent's increased attention, time and supervision, beyond that required to meet the child's basic or routine needs, to address specific physical, mental, behavioral, emotional and/or intellectual challenges.

(3) **Levels 3 and 4:** Children assessed at these levels have the highest needs for attention and care. These children require significantly more time from the foster parent because of the severity of their issues. These children often will be participating in more than one treatment program, and may need to participate in treatment in the foster parent's home. A child assessed at level 3 or 4 may have serious medical, behavioral or psychiatric issues or behaviors that require a safety plan.

[Statutory Authority: RCW 74.08.090. 09-16-045, § 388-25-0037, filed 7/28/09, effective 8/28/09.]

WAC 388-25-0042 Can the child be assessed at a different level, depending on the foster home? The assessment is based on both the child's needs and the foster parent's ability and time required to meet those needs. It is possible that a child would be assessed at a different rate in one home than in another, depending on the foster parent's abilities or circumstances as well as the resources and support services available to the child and foster family.

[Statutory Authority: RCW 74.08.090. 09-16-045, § 388-25-0042, filed 7/28/09, effective 8/28/09.]

WAC 388-25-0047 Can the assessment change if the child's needs change? The child will always receive at least the basic rate (level 1) for the child's age category. However, the child may be assessed at level 2, 3, or 4, as the child's needs change or the circumstances of the foster parents change.

For example: In cases where the child's needs decrease or the time required of the foster parent to meet the child's needs decreases, the standardized assessment may assess the child at a lower rate. For example, on a reassessment a child might be assessed at level 2, when the child's previous rate had been at level 3. In cases where the child's needs or the demands on the foster parent increase, the standardized assessment may assess the child at a higher level.

[Statutory Authority: RCW 74.08.090. 09-16-045, § 388-25-0047, filed 7/28/09, effective 8/28/09.]

WAC 388-25-0052 How will the foster parent be notified of the rate the child will receive? The foster parent will receive a written letter and payment plan, generated by the department's foster care rate assessment computer program, which will notify the foster parent of

- (1) The amount of the monthly foster care maintenance payment that will be paid on behalf of the child;
- (2) The right to review of the assessment and;
- (3) How to exercise the right of review.

[Statutory Authority: RCW 74.08.090. 09-16-045, § 388-25-0052, filed 7/28/09, effective 8/28/09.]

WAC 388-25-0057 Can a foster parent challenge the rate assessment? A foster parent, acting on behalf of the foster child, may request a review of the rate assessment for the child.

[Statutory Authority: RCW 74.08.090. 09-16-045, § 388-25-0057, filed 7/28/09, effective 8/28/09.]

WAC 388-25-0062 How does a foster parent seek a department review of the rate assessment? (1) The foster parent must make a written request for department review of the assessment.

(2) The request must be received by CA within twenty calendar days of the date of the letter informing the foster parent of the rate assessed for the child. If a request is not made within twenty days, the department will not review the assessment.

(a) The department may grant a twenty-day extension of time for filing the request for review, if the foster parent has contacted a regional foster parent liaison within the initial twenty-day time period and asked for assistance in informally resolving any disagreement as to the rate assessed.

(b) The department has the discretion and may grant a twenty-day extension for good cause.

(3) The request must include a statement explaining why the foster parent believes the assessed rate is incorrect. The foster parent may provide additional information that he or she believes is relevant to the questions asked on the foster care rate assessment standardized form.

(4) The request must be sent to the individual and address identified in the letter informing the foster parent of the rate assessed for the child.

[Statutory Authority: RCW 74.08.090. 09-16-045, § 388-25-0062, filed 7/28/09, effective 8/28/09.]

WAC 388-25-0067 What does the department consider in reviewing the request? (1) The review will be conducted by department management level staff, or by a designee who was not involved in the rate assessment process.

(2) The review will be conducted within ten days of receiving the request for review.

(3) The reviewer will consider:

(a) Whether the foster parent and the social worker or designated rate assessment specialist met in person or telephonically to jointly complete the standardized assessment form;

(b) Whether the information obtained through the conversation between the social worker or rate assessment specialist and the foster parent was accurately recorded on the form;

(c) Whether any additional information provided by the foster parent, as authorized in WAC 388-25-0060(3) is relevant to the automated assessment;

(d) Whether the information was accurately entered into the computer program; and

(e) Whether the computer program was properly functioning in calculating the rate and providing the written report of the assessment.

(4) The department will not consider information about the child or the foster family that is outside the standardized assessment form and will not alter the computerized calculation that is based on a properly completed form.

[Statutory Authority: RCW 74.08.090. 09-16-045, § 388-25-0067, filed 7/28/09, effective 8/28/09.]

WAC 388-25-0072 How does the foster parent learn about the department's decision on review? (1) The department will send the foster parent a written letter notifying the foster parent that the department either:

- (a) Upholds the rate assessment; or
- (b) Agrees the rate was properly calculated and adjusts the rate to the proper level.

(2) If the department upholds the rate assessment, the notice will provide information about further review.

[Statutory Authority: RCW 74.08.090. 09-16-045, § 388-25-0072, filed 7/28/09, effective 8/28/09.]

WAC 388-25-0077 How does the foster parent appeal the department's decision on review? (1) If the department upholds the rate assessment on review, the foster parent has the right to further challenge the assessment by timely requesting an administrative hearing.

(2) The request must be in writing and sent to the office of administrative hearings (OAH). WAC 388-02-0025 lists the current addresses for OAH.

(3) The request must be received by OAH within twenty days from the date of the letter notifying the foster parent of the department's decision on review.

(4) Foster care providers and recipients of foster care funds do not have a right to request an administrative hearing to challenge or dispute the established rates of the foster care program or to challenge the foster care rate assessment standardized form or program.

[Statutory Authority: RCW 74.08.090. 09-16-045, § 388-25-0077, filed 7/28/09, effective 8/28/09.]

WAC 388-25-0082 What law and rules govern the administrative law judge? Chapter 34.05 RCW, chapter 388-02 WAC, and the sections of this chapter relating to foster care rate assessments govern any administrative hearing to review a child's foster care rate assessment. In the event of a conflict between the provisions of this chapter and chapter 388-02 WAC, the provisions of this chapter prevail.

[Statutory Authority: RCW 74.08.090. 09-16-045, § 388-25-0082, filed 7/28/09, effective 8/28/09.]

WAC 388-25-0087 What issues may be decided by the administrative law judge? (1) The administrative law judge (ALJ) will consider only:

(a) Whether the foster parent and the social worker or designated rate assessment specialist met in person or telephonically to jointly complete the standardized assessment form;

(b) Whether the information obtained in the meeting between the social worker or rate assessment specialist and foster parent was accurately recorded on the form;

(c) Whether additional information provided by the foster parent on review to the department was accurately recorded on the form, if applicable;

(d) Whether the information was accurately entered into the computer program; and

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(e) Whether the computer program was properly functioning in calculating the rate and providing the written report of the assessment.

(2) The ALJ must not consider information about the child or the foster family that is outside the standardized assessment form or that was not provided to the department at the time of the assessment or at the time of the department's review of the assessment.

(3) The ALJ must not make a determination that conflicts with a properly completed standardized foster care rate assessment.

(4) The ALJ must not consider a challenge to the department's established foster care rates or to the foster care rate assessment standardized form or program.

[Statutory Authority: RCW 74.08.090. 09-16-045, § 388-25-0087, filed 7/28/09, effective 8/28/09.]

WAC 388-25-0095 What are the requirements for release of foster parents' licensing records? Foster parent licensing records may be disclosed upon request in accordance with RCW 42.56.070.

[Statutory Authority: RCW 74.08.090. 09-16-045, § 388-25-0095, filed 7/28/09, effective 8/28/09. Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0095, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0107 What is the beginning date for payment of foster care? (1) The department begins foster care payment for a child on the date the department or its authorized designee places the child in the licensed foster home.

(2) The department pays for each night a child resides in foster care.

[Statutory Authority: RCW 74.08.090. 09-16-045, § 388-25-0107, filed 7/28/09, effective 8/28/09.]

WAC 388-25-0195 How does the department make reimbursement for foster care for a child served by the department who moves out-of-state with the foster family? When the foster family moves to another state, the department must arrange with the other state or local social service agency to license and supervise the home and the placement (see chapter 26.34 RCW).

After receiving a copy of the foster family home license from the other state, the DCFS supervising social worker authorizes payment.

[Statutory Authority: RCW 74.08.090. 09-16-045, § 388-25-0195, filed 7/28/09, effective 8/28/09. Statutory Authority: RCW 74.13.031. 01-08-047, § 388-25-0195, filed 3/30/01, effective 4/30/01.]

WAC 388-25-0200 What payment procedures must the department follow for children placed across state borders? (1) When the department places a child into a new placement with a family residing and licensed in another state, the DCFS social worker must obtain the payment rates from that state. Following receipt of the other state's rates, the department will pay that state's rates.

(2) The children's administration interstate compact on placement of children (ICPC) program manager must approve out-of-state placement before the department makes payment for foster care.

[Statutory Authority: RCW 74.08.090, 09-16-045, § 388-25-0200, filed 7/28/09, effective 8/28/09. Statutory Authority: RCW 74.13.031, 01-08-047, § 388-25-0200, filed 3/30/01, effective 4/30/01.]

Chapter 388-71 WAC HOME AND COMMUNITY SERVICES AND PROGRAMS

WAC

388-71-0520	Are there training requirements for an individual provider or a home care agency provider of an adult client?
388-71-05665	What definitions apply to WAC 388-71-05670 through 388-71-05909?
388-71-05690	What documentation is required for orientation?
388-71-05695	Who is required to complete orientation, and when must it be completed?
388-71-05775	What is continuing education?
388-71-05810	What knowledge and skills must nurse delegation core training include?
388-71-05850	What training must include the DSHS-developed competency test?
388-71-05860	What form of identification must providers show a tester before taking a competency or challenge test?
388-71-05875	Must instructors be approved by DSHS?
388-71-05880	Can DSHS deny or terminate a contract with an instructor or training entity?
388-71-05890	What are the minimum qualifications for an instructor for basic, modified basic or nurse delegation core and specialized diabetes training?
388-71-05895	What additional qualifications are required for instructors of nurse delegation core training and specialized diabetes nurse delegation training?
388-71-0801	What is specialized diabetes nurse delegation training?
388-71-0806	What knowledge and skills must specialized diabetes nurse delegation training include?
388-71-0811	Is competency testing required for the specialized diabetes nurse delegation training?
388-71-0816	Is there a challenge test for specialized diabetes nurse delegation training?
388-71-0821	What documentation is required for successful completion of specialized diabetes nurse delegation training?
388-71-0826	Who is required to complete the specialized diabetes nurse delegation training, and when?

WAC 388-71-0520 Are there training requirements for an individual provider or a home care agency provider of an adult client? An individual provider or a home care agency provider for an adult client must meet the training requirements in WAC 388-71-05665 through 388-71-05865 and WAC 388-71-0801 through 388-71-0826.

[Statutory Authority: 2008 c 146, RCW 18.20.090, 74.08.090, chapter 70.128 RCW, 09-03-066, § 388-71-0520, filed 1/14/09, effective 2/14/09. Statutory Authority: RCW 74.08.090, 74.09.520, 05-11-082, § 388-71-0520, filed 5/17/05, effective 6/17/05. Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW, 04-02-001, § 388-71-0520, filed 12/24/03, effective 1/24/04. Statutory Authority: Chapter 74.39A RCW and 2000 c 121, 02-10-117, § 388-71-0520, filed 4/30/02, effective 5/31/02. Statutory Authority: RCW 74.08.090, 74.09.520, 43.20A.050, 43.43.842, 74.39A.090, 43.20A.710, 74.39.050, 43.43.830, 00-03-043, § 388-71-0520, filed 1/13/00, effective 2/13/00.]

WAC 388-71-05665 What definitions apply to WAC 388-71-05670 through 388-71-05909? "Client" means an individual age eighteen or older, receiving in-home services through medicaid personal care, COPES, MNIW, or Chore programs.

"Competency" means the minimum level of information and skill trainees are required to know and be able to demonstrate.

"DSHS" refers to the department of social and health services.

"Learning outcomes" means the specific information, skills and behaviors desired of the learner as a result of a specific unit of instruction, such as what they would learn by the end of a single class or an entire course. Learning outcomes are generally identified with a specific lesson plan or curriculum.

"Routine interaction" means contact with clients that happens regularly.

"Training partnership" means a joint partnership or trust that includes the office of the governor and the exclusive bargaining representative of individual providers under RCW 74.39A.270 with the capacity to provide training, peer mentoring, and workforce development, or other services to individual providers.

[Statutory Authority: RCW 74.08.090 and 74.39A.360, 09-24-092, § 388-71-05665, filed 12/1/09, effective 1/1/10. Statutory Authority: 2004 c 276 § 206 (6)(b) and *Townsend vs. DSHS*, U.S. District Court, Western District of Washington, No. C 00-0944Z, 04-16-029, § 388-71-05665, filed 7/26/04, effective 8/26/04. Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW, 04-02-001, amended and recodified as § 388-71-05665, filed 12/24/03, effective 1/24/04. Statutory Authority: Chapter 74.39A RCW and 2000 c 121, 02-10-117, § 388-71-05910, filed 4/30/02, effective 5/31/02.]

WAC 388-71-05690 What documentation is required for orientation? The home care agency or individual provider must maintain documentation of completion of orientation, issued by the home care agency or the training entity that provides the orientation, that includes:

- (1) The trainee's name;
- (2) A list of the specific information taught;
- (3) Name of the person or training entity overseeing the orientation indicating completion of the required information;
- (4) The trainee's date of employment;
- (5) The location of the orientation; and
- (6) The date(s) of orientation.

[Statutory Authority: RCW 74.08.090 and 74.39A.360, 09-24-092, § 388-71-05690, filed 12/1/09, effective 1/1/10. Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW, 04-02-001, recodified as § 388-71-05690, filed 12/24/03, effective 1/24/04. Statutory Authority: Chapter 74.39A RCW and 2000 c 121, 02-10-117, § 388-71-05915, filed 4/30/02, effective 5/31/02.]

WAC 388-71-05695 Who is required to complete orientation, and when must it be completed? (1) Home care agency providers must complete orientation before working with the agency's clients. Orientation must be provided by appropriate agency staff or the training entity.

(2) Individual providers must complete orientation provided by the training partnership no later than fourteen calendar days after beginning to work with their first DSHS client. Individual providers may be oriented by distance learning, with phone contact by the person overseeing the orientation to answer questions.

(3) Parents who are individual providers for their adult children are exempt from the orientation requirement.

[Statutory Authority: RCW 74.08.090 and 74.39A.360, 09-24-092, § 388-71-05695, filed 12/1/09, effective 1/1/10. Statutory Authority: RCW 74.08.090, 74.09.520, 74.39A.010 and 74.39A.020, 06-05-022, § 388-71-05695, filed 2/6/06, effective 3/9/06. Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW, 04-02-001, recodified as § 388-71-05695, filed 12/24/03, effective 1/24/04. Statutory Authority: Chapter

74.39A RCW and 2000 c 121. 02-10-117, § 388-71-05916, filed 4/30/02, effective 5/31/02.]

WAC 388-71-05775 What is continuing education?

Continuing education is additional caregiving-related training designed to increase and keep current a person's knowledge and skills. Training entities and home care agencies may provide continuing education without prior approval of curricula or instructors by the department.

[Statutory Authority: RCW 74.08.090 and 74.39A.360. 09-24-092, § 388-71-05775, filed 12/1/09, effective 1/1/10. Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. 04-02-001, recodified as § 388-71-05775, filed 12/24/03, effective 1/24/04. Statutory Authority: Chapter 74.39A RCW and 2000 c 121. 02-10-117, § 388-71-05932, filed 4/30/02, effective 5/31/02.]

WAC 388-71-05810 What knowledge and skills must nurse delegation core training include? Only the curriculum developed by DSHS, "Nurse Delegation for Nursing Assistants," meets the training requirement for nurse delegation core training.

[Statutory Authority: 2008 c 146, RCW 18.20.090, 74.08.090, chapter 70.128 RCW. 09-03-066, § 388-71-05810, filed 1/14/09, effective 2/14/09. Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. 04-02-001, § 388-71-05810, filed 12/24/03, effective 1/24/04.]

WAC 388-71-05850 What training must include the DSHS-developed competency test? Basic training, modified basic training, and nurse delegation core and specialized diabetes training must include the DSHS-developed competency test.

[Statutory Authority: RCW 74.08.090 and 74.39A.360. 09-24-092, § 388-71-05850, filed 12/1/09, effective 1/1/10. Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. 04-02-001, amended and recodified as § 388-71-05850, filed 12/24/03, effective 1/24/04. Statutory Authority: Chapter 74.39A RCW and 2000 c 121. 02-10-117, § 388-71-05941, filed 4/30/02, effective 5/31/02.]

WAC 388-71-05860 What form of identification must providers show a tester before taking a competency or challenge test? Providers must show a tester photo identification before taking a competency test (or challenge test, when applicable) for basic training, modified basic training, or nurse delegation core and specialized diabetes training.

[Statutory Authority: RCW 74.08.090 and 74.39A.360. 09-24-092, § 388-71-05860, filed 12/1/09, effective 1/1/10. Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. 04-02-001, amended and recodified as § 388-71-05860, filed 12/24/03, effective 1/24/04. Statutory Authority: Chapter 74.39A RCW and 2000 c 121. 02-10-117, § 388-71-05943, filed 4/30/02, effective 5/31/02.]

WAC 388-71-05875 Must instructors be approved by DSHS? (1) DSHS must approve any instructor through a contract with DSHS to conduct basic training, modified basic training, or nurse delegation core and specialized diabetes training classes using the training curricula developed by DSHS. DSHS may select contracted instructors using any applicable contracting procedures. Contractors must meet the minimum qualifications for instructors under this chapter and any additional qualifications established through the contracting procedure.

(2) The training partnership is legislatively mandated to provide orientation, basic, modified basic, six hour DDD parent provider training, nurse delegation core and specialized

diabetes training, and continuing education training programs for individual providers. The training partnership will ensure instructors meet the minimum qualifications under this chapter. The training partnership or their contracted training entity must maintain a record for each instructor which, at a minimum must contain:

- (a) Copy of current professional licenses, as required.
- (b) Documentation to verify the instructor meets the required minimum instructor qualifications.
- (3) Home care agencies shall utilize a DSHS approved instructor or training entity.

[Statutory Authority: RCW 74.08.090 and 74.39A.360. 09-24-092, § 388-71-05875, filed 12/1/09, effective 1/1/10. Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. 04-02-001, amended and recodified as § 388-71-05875, filed 12/24/03, effective 1/24/04. Statutory Authority: Chapter 74.39A RCW and 2000 c 121. 02-10-117, § 388-71-05946, filed 4/30/02, effective 5/31/02.]

WAC 388-71-05880 Can DSHS deny or terminate a contract with an instructor or training entity? (1) DSHS may determine not to accept an offer by a person or organization seeking a contract with DSHS to conduct training programs. No administrative remedies are available to dispute DSHS' decision not to accept an offer, except as may be provided through the contracting process.

(2) DSHS may terminate any training contract in accordance with the terms of the contract. The contractor's administrative remedies shall be limited to those specified in the contract.

[Statutory Authority: RCW 74.08.090 and 74.39A.360. 09-24-092, § 388-71-05880, filed 12/1/09, effective 1/1/10. Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. 04-02-001, amended and recodified as § 388-71-05880, filed 12/24/03, effective 1/24/04. Statutory Authority: Chapter 74.39A RCW and 2000 c 121. 02-10-117, § 388-71-05947, filed 4/30/02, effective 5/31/02.]

WAC 388-71-05890 What are the minimum qualifications for an instructor for basic, modified basic or nurse delegation core and specialized diabetes training? An instructor for basic, modified basic, or nurse delegation core and specialized diabetes training must meet the following minimum qualifications:

- (1) General qualifications:
 - (a) Twenty-one years of age;
 - (b) Has not had a professional health care or social services license or certification revoked in Washington state (however, no license or certification is required).
- (2) Education and work experience:
 - (a) Upon initial approval or hire, must have:
 - (i) A high school diploma and one year of professional or caregiving experience within the last five years in an adult family home, boarding home, supported living through DDD per chapter 388-820 WAC, or home care setting; or
 - (ii) An associate degree in a health field and six months of professional or caregiving experience within the last five years in an adult family home, boarding home, supported living through DDD per chapter 388-820 WAC, or home care setting.
 - (3) Teaching experience:
 - (a) Must have one hundred hours of experience teaching adults on topics directly related to the basic training; or

(b) Must have forty hours of teaching while being mentored by an instructor who meets these qualifications, and must attend a class on adult education that meets the requirements of WAC 388-71-05899.

(4) The instructor must be experienced in caregiving practices and capable of demonstrating competency with respect to the course content or units being taught;

(5) Instructors who will administer tests must have experience or training in assessment and competency testing; and

(6) If required under WAC 388-71-05730 or 388-71-05760, instructors must successfully complete basic or modified basic training prior to beginning to train others.

[Statutory Authority: RCW 74.08.090 and 74.39A.360. 09-24-092, § 388-71-05890, filed 12/1/09, effective 1/1/10. Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. 04-02-001, amended and recodified as § 388-71-05890, filed 12/24/03, effective 1/24/04. Statutory Authority: Chapter 74.39A RCW and 2000 c 121. 02-15-064, § 388-71-05949, filed 7/11/02, effective 8/1/02.]

WAC 388-71-05895 What additional qualifications are required for instructors of nurse delegation core training and specialized diabetes nurse delegation training? An instructor for nurse delegation core training and specialized diabetes nurse delegation training must have a current RN license in good standing.

[Statutory Authority: 2008 c 146, RCW 18.20.090, 74.08.090, chapter 70.128 RCW. 09-03-066, § 388-71-05895, filed 1/14/09, effective 2/14/09. Statutory Authority: RCW 74.39A.050, 2003 c 140, chapters 18.79, 18.88A RCW. 04-02-001, § 388-71-05895, filed 12/24/03, effective 1/24/04.]

WAC 388-71-0801 What is specialized diabetes nurse delegation training? Specialized diabetes nurse delegation training is the required training for nursing assistants, certified or registered, who will be delegated the task of insulin injections. DSHS approves the instructors for the specialized diabetes nurse delegation training.

[Statutory Authority: 2008 c 146, RCW 18.20.090, 74.08.090, chapter 70.128 RCW. 09-03-066, § 388-71-0801, filed 1/14/09, effective 2/14/09.]

WAC 388-71-0806 What knowledge and skills must specialized diabetes nurse delegation training include? Specialized diabetes nurse delegation training consists of three modules on diabetes, insulin, and injections. Only the curriculum developed by DSHS, "Nurse Delegation for Nursing Assistants: Special Focus on Diabetes," may be used for the specialized diabetes nurse delegation training.

[Statutory Authority: 2008 c 146, RCW 18.20.090, 74.08.090, chapter 70.128 RCW. 09-03-066, § 388-71-0806, filed 1/14/09, effective 2/14/09.]

WAC 388-71-0811 Is competency testing required for the specialized diabetes nurse delegation training? Passing the DSHS competency test is required for successful completion of specialized diabetes nurse delegation training, as provided under WAC 388-71-05835 through 388-71-05865.

[Statutory Authority: 2008 c 146, RCW 18.20.090, 74.08.090, chapter 70.128 RCW. 09-03-066, § 388-71-0811, filed 1/14/09, effective 2/14/09.]

WAC 388-71-0816 Is there a challenge test for specialized diabetes nurse delegation training? There is no challenge test for specialized diabetes nurse delegation training.

[Statutory Authority: 2008 c 146, RCW 18.20.090, 74.08.090, chapter 70.128 RCW. 09-03-066, § 388-71-0816, filed 1/14/09, effective 2/14/09.]

WAC 388-71-0821 What documentation is required for successful completion of specialized diabetes nurse delegation training? (1) Specialized diabetes nurse delegation training must be documented by a certificate of successful completion of training, issued by the instructor or training entity, that includes:

- (a) The name of the trainee;
 - (b) The name of the training;
 - (c) The name of the training entity giving the training;
 - (d) The instructor's name and signature; and
 - (e) The date(s) of training.
- (2) The trainee must be given an original certificate.

[Statutory Authority: 2008 c 146, RCW 18.20.090, 74.08.090, chapter 70.128 RCW. 09-03-066, § 388-71-0821, filed 1/14/09, effective 2/14/09.]

WAC 388-71-0826 Who is required to complete the specialized diabetes nurse delegation training, and when? Specialized diabetes nurse delegation training is required before a nursing assistant, certified or registered, who meets the qualifications in WAC 388-71-05830, may be delegated the task of insulin injections.

[Statutory Authority: 2008 c 146, RCW 18.20.090, 74.08.090, chapter 70.128 RCW. 09-03-066, § 388-71-0826, filed 1/14/09, effective 2/14/09.]

Chapter 388-76 WAC

ADULT FAMILY HOME MINIMUM LICENSING REQUIREMENTS

WAC

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388-76-10040	License requirements—Qualified person must live-in or be on-site.
388-76-10070	Application—Fees required.
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388-76-10784	Water hazards—Fences, gates and alarms.
388-76-10840	Emergency food supply.
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388-76-10870	Resident evacuation capability levels—Identification required.
388-76-10930	Plan of correction (POC)—Required.
388-76-10955	Remedies—Department must impose remedies.

388-76-10960	Remedies—Department may impose remedies.
388-76-10995	Notice, hearing rights, and effective dates relating to imposition of remedies.
388-76-11015	Resident protection program—Disputing a preliminary finding.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-76-10785	Water hazards—Enclosures and safety devices. [Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW, 07-21-080, § 388-76-10785, filed 10/16/07, effective 1/1/08.] Repealed by 09-03-030, filed 1/12/09, effective 2/12/09. Statutory Authority: RCW 70.128.040.
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WAC 388-76-10000 Definitions. "Abandonment" means action or inaction by a person or entity with a duty of care for a frail elder or vulnerable adult that leaves the vulnerable person without the means or ability to obtain necessary food, clothing, shelter, or health care.

"Abuse" means the willful action or inaction that inflicts injury, unreasonable confinement, intimidation, or punishment on a vulnerable adult:

(1) In instances of abuse of a vulnerable adult who is unable to express or demonstrate physical harm, pain, or mental anguish, the abuse is presumed to cause physical harm, pain or mental anguish; and

(2) Abuse includes sexual abuse, mental abuse, physical abuse, and exploitation of a vulnerable adult, which have the following meanings:

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

(b) **"Physical abuse"** means a willful action of inflicting bodily injury or physical mistreatment. Physical abuse includes, but is not limited to, striking with or without an object, slapping, pinching, choking, kicking, shoving, prodding, or chemical restraints unless the restraints are consistent with licensing requirements, and includes restraints that are otherwise being used inappropriately.

(c) **"Mental abuse"** means any willful action or inaction of mental or verbal abuse. Mental abuse includes, but is not limited to, coercion, harassment, inappropriately isolating a vulnerable adult from family, friends, or regular activity, and verbal assault that includes ridiculing, intimidating, yelling, or swearing.

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

"Adult family home" means:

(1) A residential home in which a person or entity are licensed to provide personal care, special care, room, and board to more than one but not more than six adults who are

not related by blood or marriage to the person or persons providing the services; and

(2) For the purposes of this chapter, any person or entity who has been granted a license to operate an adult family home.

"Affiliated with an applicant" means any person listed on the application as a partner, officer, director, resident manager, or majority owner of the applying entity, or is the spouse or domestic partner of the applicant.

"Applicant" means an individual, partnership, corporation, or other entity seeking a license to operate an adult family home.

"Capacity" means the maximum number of persons in need of personal or special care permitted in an adult family home at a given time and includes related children or adults in the home who receive personal or special care and services.

"Caregiver" for purposes other than training, means any person eighteen years of age or older responsible for providing direct personal or special care to a resident and who is not the provider, entity representative, a student or volunteer.

"Dementia" is defined as a condition documented through the assessment process required by WAC 388-76-10335.

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

"Department case manager" means the department authorized staff person or designee assigned to negotiate, monitor, and facilitate a care and services plan for residents receiving services paid for by the department.

"Developmental disability" means:

(1) A person who meets the eligibility criteria defined by the division of developmental disabilities under WAC 388-823-0040; or

(2) A person with a severe, chronic disability which is attributable to cerebral palsy or epilepsy, or any other condition, other than mental illness, found to be closely related to mental retardation which results in impairment of general intellectual functioning or adaptive behavior similar to that of a person with mental retardation, and requires treatment or services similar to those required for these persons (i.e., autism); and

(a) The condition was manifested before the person reached age eighteen;

(b) The condition is likely to continue indefinitely; and

(c) The condition results in substantial functional limitations in three or more of the following areas of major life activities:

(i) Self-care;

(ii) Understanding and use of language;

(iii) Learning;

(iv) Mobility;

(v) Self-direction; and

(vi) Capacity for independent living.

"Direct supervision" means oversight by a person who has demonstrated competency in the basic training and specialty training if required, or who has been exempted from the basic training requirements and is:

(1) On the premises; and

(2) Quickly and easily available to the caregiver.

"Domestic partners" means two adults who meet the requirements for a valid state registered domestic partnership as established by RCW 26.60.030 and who have been issued a certificate of state registered domestic partnership.

"Entity provider" means any corporation, partnership, association, or limited liability company that is licensed under this chapter to operate an adult family home.

"Financial exploitation" means the illegal or improper use of the property, income, resources, or trust funds of the vulnerable adult by any person for any person's profit or advantage other than for the vulnerable adult's profit or advantage.

"Entity representative" means the individual designated by an entity provider who is responsible for the daily operation of the adult family home.

"Home" means adult family home.

"Indirect supervision" means oversight by a person who:

- (1) Has demonstrated competency in the basic training and specialty training if required; or
- (2) Has been exempted from the basic training requirements; and
- (3) Is quickly and easily available to the care giver, but not necessarily on-site.

"Inspection" means a review by department personnel to determine the adult family home's compliance with this chapter and chapters 70.128, 70.129, 74.34 RCW, and other applicable rules and regulations. The department's review may include an on-site visit.

"Mandated reporter" means an employee of the department, law enforcement, officer, social worker, professional school personnel, individual provider, an employee of a facility, an employee of a social service, welfare, mental health, adult day health, adult day care, or hospice agency, county coroner or medical examiner, Christian Science practitioner, or health care provider subject to chapter 18.130 RCW. For the purpose of the definition of a mandated reporter, **"Facility"** means a residence licensed or required to be licensed under chapter 18.20 RCW (boarding homes), chapter 18.51 RCW (nursing homes), chapter 70.128 RCW (adult family homes), chapter 72.36 RCW (soldiers' homes), chapter 71A.20 RCW (residential habilitation centers), or any other facility licensed by the department.

"Medical device" as used in this chapter, means any piece of medical equipment used to treat a resident's assessed need.

- (1) A medical device is not always a restraint and should not be used as a restraint;
- (2) Some medical devices have considerable safety risks associated with use; and
- (3) Examples of medical devices with known safety risks when used are transfer poles, Posey or lap belts, and side rails.

"Medication administration" means giving resident medications by a person legally authorized to do so, such as a physician, pharmacist or nurse.

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

"Mental illness" is defined as an Axis I or II diagnosed mental illness as outlined in volume IV of the Diagnostic and

Statistical Manual of Mental Disorders (a copy is available for review through the aging and disability services administration).

"Multiple facility provider" means an individual or entity provider who is licensed to operate more than one adult family home.

"Neglect" means:

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

(2) An act or omission that demonstrates a serious disregard of consequences of such a magnitude as to constitute a clear and present danger to the vulnerable adult's health, welfare, or safety, including but not limited to conduct prohibited under RCW 9A.41.100.

"Nurse delegation" means a registered nurse transfers the performance of selected nursing tasks to competent nursing assistants in selected situations. The registered nurse delegating the task retains the responsibility and accountability for the nursing care of the resident.

"Over-the-counter medication" is any medication that can be purchased without a prescriptive order, including but not limited to vitamin, mineral, or herbal preparations.

"Personal care services" means both physical assistance and/or prompting and supervising the performance of direct personal care tasks as determined by the resident's needs and does not include assistance with tasks performed by a licensed health professional.

"Physical restraint" means a manual method, obstacle, or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that restricts freedom of movement or access to his or her body, is used for discipline or convenience, and is not required to treat the resident's medical symptoms.

"Practitioner" includes a physician, osteopathic physician, podiatric physician, pharmacist, licensed practical nurse, registered nurse, advanced registered nurse practitioner, dentist, and physician assistant licensed in the state of Washington.

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

"Provider" means any person or entity that is licensed under this chapter to operate an adult family home.

"Qualified staff" means a person who:

- (1) Is employed, directly or by contract, by an adult family home; and
- (2) Meets all of the requirements of a provider, entity representative, resident manager or caregiver.

"Resident" means any adult unrelated to the provider who lives in the adult family home and who is in need of care. Except as specified elsewhere in this chapter, for decision-making purposes, the term "resident" includes the resident's surrogate decision maker acting under state law.

"Resident manager" means a person employed or designated by the provider or entity representative to manage the adult family home.

"Significant change" means:

- (1) A lasting change, decline or improvement in the resident's baseline physical, mental or psychosocial status;
- (2) The change is significant enough so the current assessment and/or negotiated care plan do not reflect the resident's current status; and
- (3) A new assessment may be needed when the resident's condition does not return to baseline within a two week period of time.

"Special care" means care beyond personal care services as defined in this section.

"Staff" means any person who:

- (1) Is employed, directly or by contract, by an adult family home; and
- (2) Provides care and services to any resident.

"Unsupervised" means not in the presence of:

- (1) Another employee or volunteer from the same business or organization; or
- (2) Any relative or guardian of any of the children or developmentally disabled persons or vulnerable adults to which the employee, student or volunteer has access during the course of his or her employment or involvement with the business or organization.

"Usable floor space" means resident bedroom floor space exclusive of:

- (1) Toilet rooms;
- (2) Closets;
- (3) Lockers;
- (4) Wardrobes;
- (5) Vestibules; and
- (6) The space required for the door to swing if the bedroom door opens into the resident bedroom.

"Water hazard" means any body of water over twenty-four inches in depth that can be accessed by a resident, and includes but not limited to:

- (1) In-ground, above-ground, and on-ground pools;
- (2) Hot tubs, spas;
- (3) Fixed-in-place wading pools;
- (4) Decorative water features;
- (5) Ponds; or
- (6) Natural bodies of water such as streams, lakes, rivers, and oceans.

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

"Vulnerable adult" includes a person:

- (1) Sixty years of age or older who has the functional, mental, or physical inability to care for himself or herself;
- (2) Found incapacitated under chapter 11.88 RCW;
- (3) Who has a developmental disability as defined under RCW 71A.10.020;
- (4) Admitted to any facility;
- (5) Receiving services from home health, hospice, or home care agencies licensed or required to be licensed under chapter 70.127 RCW;
- (6) Receiving services from an individual provider; or
- (7) With a functional disability who lives in his or her own home, who is directing and supervising a paid personal aide to perform a health care task as authorized by RCW 74.39.050.

[Statutory Authority: RCW 70.128.040. 09-03-029, § 388-76-10000, filed 1/12/09, effective 2/12/09. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10000, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10025 License annual fee. (1) The adult family home must pay an annual license fee as required in chapter 70.128 RCW.

(2) The home must send the annual license fee to the department upon receipt of notice of fee due.

[Statutory Authority: RCW 70.128.040. 09-21-075, § 388-76-10025, filed 10/16/09, effective 11/16/09. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10025, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10036 License requirements—Multiple adult family home management. When there is more than one home licensed to a provider or entity the adult family home must ensure that:

- (1) Each home has one person responsible for managing the overall delivery of care to all residents in the home;
- (2) The designated responsible person is the provider, entity representative or a qualified resident manager; and
- (3) Each responsible person is designated to manage only one adult family home at a given time.

[Statutory Authority: RCW 70.128.040. 09-03-030, § 388-76-10036, filed 1/12/09, effective 2/12/09.]

WAC 388-76-10040 License requirements—Qualified person must live-in or be on-site. (1) The adult family home provider or entity representative must:

- (a) Live in the home; or
- (b) Employ or contract with a qualified resident manager who lives in the home and is responsible for the care and services of each resident at all times.
- (2) The provider, entity representative, or qualified resident manager is exempt from the requirement to live in the home if:
 - (a) The home has twenty-four hour staffing coverage; and
 - (b) A qualified staff person who can make needed decisions is always present in the home.

[Statutory Authority: RCW 70.128.040. 09-03-030, § 388-76-10040, filed 1/12/09, effective 2/12/09. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10040, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10070 Application—Fees required. (1) The applicant must pay all processing and license fees established by chapter 70.128 RCW.

- (2) The applicant must submit the required fees with the application form.
- (3) The processing fee will be returned as required by chapter 70.128 RCW.
- (4) The license fee will be returned to the applicant if the application is withdrawn, voided or the license is denied.

[Statutory Authority: RCW 70.128.040. 09-21-075, § 388-76-10070, filed 10/16/09, effective 11/16/09. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10070, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10073 Application—Processing fees required. The processing fee, required in chapter 70.128 RCW, applies to any application submitted to the department, including but not limited to an application for licensure, change of ownership, or a change of location.

[Statutory Authority: RCW 70.128.040, 09-21-075, § 388-76-10073, filed 10/16/09, effective 11/16/09.]

WAC 388-76-10080 Application—Coprovider. Couples considered legally married or domestic partners under Washington state law:

- (1) May not apply for separate licenses; and
- (2) May apply jointly as coproviders.

[Statutory Authority: RCW 70.128.040, 09-03-030, § 388-76-10080, filed 1/12/09, effective 2/12/09. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW, 07-21-080, § 388-76-10080, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10105 Application—Change of ownership. (1) A change of ownership of an adult family home requires both a new license application and a new license.

(2) A change of ownership occurs when there is a change in:

- (a) The provider or entity provider; or
- (b) Control of an entity provider.
- (3) Events which constitute a change of ownership include, but are not limited to:
 - (a) The form of legal organization of the provider is changed, such as when a provider forms:
 - (i) A partnership;
 - (ii) A corporation;
 - (iii) An association; or
 - (iv) A dissolution or merger of a licensed entity with another legal organization.
 - (b) The provider or entity provider transfers business operations and management responsibility to another party, whether there is a partial or whole transfer of adult family home real property and/or personal property assets.
 - (c) Two people are both licensed as a married couple or domestic partners to operate an adult family home and an event, such as a separation, divorce, or death results in only one person operating the home.
 - (d) An event dissolves the partnership, if the provider or entity provider is in a business partnership.
 - (e) If the provider or entity 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 corporations to form a new corporation;
 - (iv) Whether by a single transaction or multiple transactions within a continuous twenty-four month period, transfers fifty percent or more of the stock to one or more:
 - (A) New or former stockholders; or
 - (B) Present stockholders each having less than five percent of the stock before the initial transaction.
 - (f) Any other event or combination of events which results in a substitution of or control of the provider or entity provider.

(4) The new owner:

(a) Must correct all deficiencies that exist at the time of the ownership change;

(b) Is subject to the provisions of chapters 70.128, 70.129, 74.34 RCW, this chapter and other applicable laws and regulations;

(c) Must obtain a new license from the department before the transfer of ownership; and

(d) Must not begin operation of the adult family home as the new owner, provider or entity provider until the department has granted the license.

(5) The home must notify each resident, in writing at least thirty days before the effective date of the ownership change.

(6) If a currently licensed provider or entity provider seeking to change ownership wants the department to give priority to processing an application to minimize or prevent disruption of residents that live in the existing home, the applicant must:

(a) Make the request to the department in writing, including the reason for changing the ownership of the home; and

(b) Explain how or why the reason for the change is beyond the control of the home.

[Statutory Authority: RCW 70.128.040, 09-03-030, § 388-76-10105, filed 1/12/09, effective 2/12/09. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW, 07-21-080, § 388-76-10105, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10120 License—Must be denied. (1)

The department must not grant a license until the applicant has successfully completed a department-approved forty-eight hour adult family home administration and business planning class.

(2) The department must deny a license if the department finds that it has been less than twenty years since the applicant surrendered or relinquished an adult family home license after receiving notice that the department intended to deny, suspend, not renew or revoke the license.

(3) The department must deny a license if the department finds that the applicant or the applicant's spouse, domestic partner, or any partner, officer, director, managerial employee or majority owner of the applying entity:

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

(b) Has been convicted of a crime in federal court or in any other state, and the department determines that the crime is equivalent to a crime under subsections (3)(c) and (3)(d), below;

(c) Has been convicted of a "crime against children or other persons" as defined in RCW 43.43.830, unless the crime is simple assault, assault in the fourth degree, or prostitution and more than three years has passed since conviction;

(d) Has been convicted of "crimes relating to financial exploitation" as defined in RCW 43.43.830, unless the crime is theft in third degree and more than three years have passed since conviction, or unless the crime is forgery or theft in the second degree and more than five years has passed since conviction;

(e) Has been found in any final decision issued by a disciplining authority to have abused, neglected, exploited, or abandoned a minor or vulnerable adult;

(f) Is listed on a state registry with a finding of abuse, neglect, financial exploitation, or abandonment of a minor or vulnerable adult; or

(g) Has been the subject of a finding or conclusion by a court of law, or any comparable state or federal law, that the individual abused, neglected, financially exploited or abandoned a minor or vulnerable adult. Examples of legal proceedings in which such findings could be made include juvenile court proceedings under chapter 13.34 RCW, domestic relations proceeding under Title 26 RCW, and vulnerable adult protection proceedings under chapter 74.34 RCW.

[Statutory Authority: RCW 70.128.040, 09-03-028, § 388-76-10120, filed 1/12/09, effective 2/12/09. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW, 07-21-080, § 388-76-10120, filed 10/16/07, effective 1/1/08.]

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

(1) Has been convicted of:

(a) Simple assault, theft in third degree, assault in the fourth degree, or prostitution and more than three years has passed since conviction;

(b) Forgery or theft in the second degree and more than five years has passed since conviction;

(c) Any felony that the department determines is reasonably related to the competency of the person to be involved in the ownership or operation of an adult family home; or

(d) A crime involving a firearm used in commission of a felony or in any act of violence against a person.

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

(3) Has committed an act of domestic violence toward a family or household member;

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

(5) Has had a license for the care of children or vulnerable adults denied, suspended, revoked, or not renewed;

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

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

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

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

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

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

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

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

(14) Failed or refused to comply with:

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

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

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

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

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

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

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

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

(21) Has failed to meet personal financial obligations;

(22) Interfered with a long-term care ombudsman or department staff in the performance of his or her duties;

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

(24) The home is currently licensed:

(a) As a boarding home; or

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

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

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

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

[Statutory Authority: RCW 70.128.040. 09-03-028, § 388-76-10125, filed 1/12/09, effective 2/12/09. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10125, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10170 Criminal history background check—Information—Confidentiality—Use restricted.

The adult family home must:

- (1) Establish and implement procedures that ensure:
 - (a) All disclosure statements, background inquiry applications, responses, related information, and all copies are kept in a confidential and secure manner;
 - (b) All background inquiry results and disclosure statements are used for employment purposes only;
 - (c) Background inquiry results and disclosure statements are not disclosed to any person except:
 - (i) The person about whom the home made the disclosure or background inquiry;
 - (ii) Licensed facilities, an employer of an authorized program, or an in-home services agency employer identified in WAC 388-76-10173;
 - (iii) Authorized state and federal employees; and
 - (iv) The Washington state patrol auditor.
- (2) Keep a record of inquiry results for eighteen months after the date an employee either quits or is terminated.

[Statutory Authority: RCW 70.128.040. 09-03-030, § 388-76-10170, filed 1/12/09, effective 2/12/09. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10170, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10173 Disclosure of employee information—Employer immunity—Rebuttable presumption. (1) A provider of the following, who discloses information about a former or current employee to the prospective employer of the following, is presumed to act in good faith and is immune from civil and criminal liability for such disclosure or its consequences:

- (a) Boarding homes licensed under chapter 18.20 RCW;
- (b) Nursing homes licensed under chapter 18.51 RCW;
- (c) Adult family homes licensed under chapter 70.128 RCW;
- (d) An employer of a program authorized under RCW 71A.12.040(10); or
- (e) An in-home services agency employer of a program licensed under chapter 70.127 RCW.

(2) The immunity provided in this section only applies if the disclosure relates to:

- (a) The employee's ability to perform his or her job;
- (b) The diligence, skill or reliability with which the employee carried out the duties of his or her job; or
- (c) Any illegal or wrongful act committed by the employee when related to his or her ability to care for a vulnerable adult.

(3) For the purposes of this section:

(a) The presumption of good faith may only be rebutted by a showing of clear and convincing evidence that the information disclosed by the provider was knowingly false or made with reckless disregard for the truth of the information disclosed.

(b) Should the employee successfully rebut the presumption of good faith standard in court, the employee shall be

entitled to recover reasonable attorneys' fees against the employer.

[Statutory Authority: RCW 70.128.040. 09-03-030, § 388-76-10173, filed 1/12/09, effective 2/12/09.]

WAC 388-76-10174 Background checks—Disclosure of information—Sharing of criminal background information by health care facilities. In accordance with RCW 43.43.832 a health care facility may share criminal background information with other health care facilities. For the purposes of this section health care facility means a nursing home licensed under chapter 18.51 RCW, a boarding home licensed under chapter 18.20 RCW, or an adult family home licensed under chapter 70.128 RCW.

(1) A health care facility may, upon request from another health care facility, share copies of completed criminal background inquiry information.

(2) A health care facility may share completed criminal background inquiry information only if:

(a) The health care facility sharing the criminal background inquiry information is reasonably known to be the person's most recent employer;

(b) No more than twelve months has elapsed from the date the person was last employed at a licensed health care facility to the date of their current employment application; and

(c) The criminal background information is no more than two years old.

(3) If criminal background inquiry information is shared, the health care facility employing the subject of the inquiry must require the applicant to sign a disclosure statement indicating that there has been no conviction or finding as described in RCW 43.43.842 since the completion date of the most recent criminal background inquiry.

(4) Any health care facility that knows or has reason to believe that an applicant has or may have a disqualifying conviction or finding as described in RCW 43.43.842, after the completion date of their most recent criminal background inquiry:

(a) Cannot rely on the applicant's previous employer's criminal background inquiry information; and

(b) Must request a new criminal background inquiry pursuant to RCW 43.43.830 through 43.43.842.

(5) Health care facilities that share criminal background inquiry information shall be immune from any claim of defamation, invasion of privacy, negligence, or any other claim in connection with any dissemination of this information in accordance with this section.

(6) Health care facilities must send and receive the criminal background inquiry information in a manner that reasonably protects the subject's rights to privacy and confidentiality.

[Statutory Authority: RCW 70.128.040. 09-03-030, § 388-76-10174, filed 1/12/09, effective 2/12/09.]

WAC 388-76-10230 Pets. The adult family home must ensure any animal visiting or living on the premises:

(1) Does not compromise any resident rights, preferences or medical needs;

(2) Has a suitable temperament, is clean and healthy, and otherwise poses no significant health or safety risks to any resident, staff, or visitors; and

(3) Has proof of up-to-date rabies vaccinations.

[Statutory Authority: RCW 70.128.040, 09-03-029, § 388-76-10230, filed 1/12/09, effective 2/12/09. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW, 07-21-080, § 388-76-10230, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10235 Guardianship. (1) Effective February 1, 2009, the adult family home must ensure that no provider, entity representative, resident manager, or staff becomes any resident's guardian.

(2) Provider, entity representative, resident manager or staff who is a resident's guardian before February 1, 2009 may continue to be that resident's guardian.

[Statutory Authority: RCW 70.128.040, 09-03-029, § 388-76-10235, filed 1/12/09, effective 2/12/09. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW, 07-21-080, § 388-76-10235, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10330 Resident assessment. The adult family home must:

(1) Obtain a written assessment that contains accurate information about the prospective resident's current needs and preferences before admitting a resident to the home;

(2) Not admit a resident without an assessment except in cases of a genuine emergency;

(3) Ensure the assessment contains all of the information required in WAC 388-76-10335 unless the assessor can not:

(a) Obtain an element of the required assessment information; and

(b) The assessor documents the attempt to obtain the information in the assessment.

(4) Be knowledgeable about the needs and preferences of each resident documented in the assessment.

[Statutory Authority: RCW 70.128.040, 09-03-029, § 388-76-10330, filed 1/12/09, effective 2/12/09. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW, 07-21-080, § 388-76-10330, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10335 Resident assessment topics. The adult family home must ensure that each resident's assessment includes the following minimum information:

(1) Recent medical history;

(2) Current prescribed medications, and contraindicated medications, including but not limited to, medications known to cause adverse reactions or allergies;

(3) Medical diagnosis reported by the resident, the resident representative, family member, or by a licensed medical professional;

(4) Medication management:

(a) The ability of the resident to be independent in managing medications;

(b) The amount of medication assistance needed;

(c) If medication administration is required; or

(d) If a combination of the elements in (a) through (c) above is required.

(5) Food allergies or sensitivities;

(6) Significant known behaviors or symptoms that may cause concern or require special care, including:

(a) The need for and use of medical devices;

(b) The refusal of care or treatment; and

(c) Any mood or behavior symptoms that the resident has had within the last five years.

(7) Cognitive status, including an evaluation of disorientation, memory impairment, and impaired judgment;

(8) History of depression and anxiety;

(9) History of mental illness, if applicable;

(10) Social, physical, and emotional strengths and needs;

(11) Functional abilities in relationship to activities of daily living including:

(a) Eating;

(b) Toileting;

(c) Walking;

(d) Transferring;

(e) Positioning;

(f) Personal hygiene;

(g) Dressing; and

(h) Bathing.

(12) Preferences and choices about daily life that are important to the resident, including but not limited to:

(a) The food that the resident enjoys;

(b) Meal times; and

(c) Sleeping and nap times.

(13) Activities.

[Statutory Authority: RCW 70.128.040, 09-03-030, § 388-76-10335, filed 1/12/09, effective 2/12/09. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW, 07-21-080, § 388-76-10335, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10355 Negotiated care plan. The adult family home must use the resident assessment and preliminary care plan to develop a written negotiated care plan. The home must ensure each resident's negotiated care plan includes:

(1) A list of the care and services to be provided;

(2) Identification of who will provide the care and services;

(3) When and how the care and services will be provided;

(4) How medications will be managed, including how the resident will get their medications when the resident is not in the home;

(5) The resident's activities preferences and how the preferences will be met;

(6) Other preferences and choices about issues important to the resident, including, but not limited to:

(a) Food;

(b) Daily routine;

(c) Grooming; and

(d) How the home will accommodate the preferences and choices.

(7) If needed, a plan to:

(a) Follow in case of a foreseeable crisis due to a resident's assessed needs;

(b) Reduce tension, agitation and problem behaviors;

(c) Respond to resident's special needs, including, but not limited to medical devices and related safety plans;

(d) Respond to a resident's refusal of care or treatment, including when the resident's physician or practitioner should be notified of the refusal;

(8) Identification of any communication barriers the resident may have and how the home will use behaviors and nonverbal gestures to communicate with the resident;

(9) A statement of the ability for resident to be left unattended for a specific length of time; and

(10) A hospice care plan if the resident is receiving services for hospice care delivered by a licensed hospice agency.

[Statutory Authority: RCW 70.128.040. 09-03-029, § 388-76-10355, filed 1/12/09, effective 2/12/09. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10355, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10645 Resident rights—Quality of life—Reasonable accommodation. The adult family home must ensure each resident:

(1) Receives reasonable accommodation to meet the needs and preferences of the resident, except when the reasonable accommodation endangers the health or safety of the individual or other residents; and

(2) Has the ability to share a double room with his or her spouse or domestic partner when both spouses or domestic partners consent to the arrangement.

[Statutory Authority: RCW 70.128.040. 09-03-030, § 388-76-10645, filed 1/12/09, effective 2/12/09. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10645, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10650 Medical devices. Before the adult family home uses medical devices for any resident, the home must:

(1) Review the resident assessment to determine the resident's need for and use of a medical device;

(2) Ensure the resident negotiated care plan includes the resident use of a medical device or devices; and

(3) Provide the resident and family with enough information about the significance and level of the safety risk of use of the device to enable them to make an informed decision about whether or not to use the device.

[Statutory Authority: RCW 70.128.040. 09-03-029, § 388-76-10650, filed 1/12/09, effective 2/12/09. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10650, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10720 Electronic monitoring equipment—Audio monitoring and video monitoring. (1) Except as provided in this section or in WAC 388-76-10725, the adult family home must not use the following in the home:

(a) Audio monitoring equipment; or

(b) Video monitoring equipment if it includes an audio component.

(2) The home may video monitor and video record activities in the home, without an audio component, only in the following areas:

(a) Entrances and exits if the cameras are:

(i) Focused only on the entrance or exit doorways; and

(ii) Not focused on areas where residents gather.

(b) Outdoor areas not commonly used by residents; and

(c) Designated smoking areas, subject to the following conditions:

(i) Residents are assessed as needing supervision for smoking;

(ii) A staff person watches the video monitor at any time the area is used by such residents;

(iii) The video camera is clearly visible;

(iv) The video monitor is not viewable by general public; and

(v) The home notifies all residents in writing of the video monitoring equipment.

[Statutory Authority: RCW 70.128.040. 09-03-029, § 388-76-10720, filed 1/12/09, effective 2/12/09. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10720, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10725 Electronic monitoring equipment—Resident requested use. (1) The adult family home must not use audio or video monitoring equipment to monitor any resident unless:

(a) The resident has requested the monitoring; and

(b) The monitoring is only used in the sleeping room of the resident who requested the monitoring.

(2) If the resident requests audio or video monitoring, before any electronic monitoring occurs the home must ensure:

(a) That the electronic monitoring does not violate chapter 9.73 RCW;

(b) The resident has identified a threat to the resident's health, safety or personal property;

(c) The resident's roommate has provided written consent to electronic monitoring, if the resident has a roommate; and

(d) The resident and the home have agreed upon a specific duration for the electronic monitoring documented in writing.

(3) The home must:

(a) Reevaluate the need for the electronic monitoring with the resident at least quarterly; and

(b) Have each reevaluation in writing signed and dated by the resident.

(4) The home must immediately stop electronic monitoring if the:

(a) Resident no longer wants electronic monitoring;

(b) Roommate objects or withdraws the consent to the electronic monitoring, or

(c) Resident becomes unable to give consent.

(5) For the purposes of consenting to video electronic monitoring, without an audio component, the term "resident" includes the resident's decision maker.

(6) For the purposes of consenting to audio electronic monitoring, the term "resident includes only:

(a) The resident residing in the home; or

(b) The resident's court-appointed guardian or attorney-in-fact who has obtained a court order specifically authorizing the court-appointed guardian or attorney-in-fact to consent to audio electronic monitoring of the resident.

(7) If the resident's decision maker consents to audio electronic monitoring as specified in subsection (6) above, the home must maintain a copy of the court order authorizing such consent in the resident's record.

[Statutory Authority: RCW 70.128.040. 09-03-029, § 388-76-10725, filed 1/12/09, effective 2/12/09. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10725, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10775 Temperature and ventilation.

The adult family home must:

- (1) Ensure that the maximum and minimum temperature of any room used by a resident is comfortable for the resident and does not compromise the resident's health and safety.
- (2) At a minimum, keep room temperature at:
 - (a) Sixty-eight degrees Fahrenheit or more during waking hours; and
 - (b) Sixty degrees Fahrenheit or more during sleeping hours.
- (3) Provide ventilation in the home to ensure the health and comfort of each resident is met.

[Statutory Authority: RCW 70.128.040. 09-03-029, § 388-76-10775, filed 1/12/09, effective 2/12/09. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10775, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10783 Water hazards and bodies of water—Resident safety. The adult family home must protect each resident:

- (1) From risks associated with water hazards or bodies of water of any depth at the home; and
- (2) When accompanying or escorting the resident at other locations where there are water hazards or bodies of water of any depth.

[Statutory Authority: RCW 70.128.040. 09-03-030, § 388-76-10783, filed 1/12/09, effective 2/12/09.]

WAC 388-76-10784 Water hazards—Fences, gates and alarms. For any adult family home newly licensed after July 1, 2007 or any currently licensed adult family home that adds or modifies a new or existing water hazard after July 1, 2007 must:

- (1) Comply with this section and the requirements of the:
 - (a) International Residential Code (IRC); and
 - (b) Washington state amendments to the International Residential Code (IRC).
- (2) Enclose water hazards over twenty four inches deep with:
 - (a) Fences and gates at least forty-eight inches high; and
 - (b) Audible alarms when doors, screens, and gates that directly lead to or surround the water hazard, are opened.

[Statutory Authority: RCW 70.128.040. 09-03-030, § 388-76-10784, filed 1/12/09, effective 2/12/09.]

WAC 388-76-10840 Emergency food supply. The adult family home must have an on-site emergency food supply that can be stored with other food in the home and that:

- (1) Will last for a minimum of seventy-two hours for each resident and each household member; and
- (2) Meets the dietary needs of each resident, including any specific dietary restrictions any resident may have.

[Statutory Authority: RCW 70.128.040. 09-03-029, § 388-76-10840, filed 1/12/09, effective 2/12/09. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10840, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10845 Emergency drinking water supply. The adult family home must have an on-site emergency supply of drinking water that:

- (1) Will last for a minimum of seventy-two hours for each resident and each household member;
- (2) Is at least three gallons for each resident and each household member;
- (3) Is stored in food grade or glass containers;
- (4) Is chemically treated or replaced every six months; and
- (5) Is stored appropriately.

[Statutory Authority: RCW 70.128.040. 09-03-029, § 388-76-10845, filed 1/12/09, effective 2/12/09. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10845, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10870 Resident evacuation capability levels—Identification required. The adult family home must ensure that each resident preliminary care plan and negotiated care plan contains the resident's ability to evacuate the home according to the following levels:

- (1) **Level 1** - resident is able to get out of the home safely and independently without mobility aids or any assistance from another individual;
- (2) **Level 2** - resident is physically and mentally capable of traversing a normal pathway to safety with mobility aids, but unable to ascend or descend stairs without the physical assistance of another individual; and
- (3) **Level 3** - resident is unable to walk or transverse [traverse] a normal pathway to safety without the physical assistance of another individual.

[Statutory Authority: RCW 70.128.040. 09-03-029, § 388-76-10870, filed 1/12/09, effective 2/12/09. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. 07-21-080, § 388-76-10870, filed 10/16/07, effective 1/1/08.]

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

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

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

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

- (a) Has or will correct each cited deficiency; and
 - (b) Will maintain correction of each cited deficiency.
- (5) The home must be able to show to the department, upon request, that, for each deficiency cited, the home has:
- (a) A plan of correction and maintaining correction;
 - (b) Corrected or is correcting each deficiency; and
 - (c) Maintained or is maintaining compliance.
- (6) On each attestation of correction statement, the home must:

- (a) Give a date, approved by the department, showing when the cited deficiency has been or will be corrected; and
- (b) By signature and date show that the home has or will correct, and maintain correction, of each deficiency.

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

[Statutory Authority: RCW 70.128.040, 09-03-029, § 388-76-10930, filed 1/12/09, effective 2/12/09. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW, 07-21-080, § 388-76-10930, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10955 Remedies—Department must impose remedies. (1) The department must impose a remedy or remedies if the department substantiates a complaint involving harm to a resident and violation of an applicable law or rule.

(2) The department must impose a remedy or remedies if the department substantiates, after licensure, that it has been less than twenty years since the adult family home provider voluntarily surrendered or relinquished an adult family home license in lieu of department initiated denial, suspension, nonrenewal, or revocation of a license.

(3) The department must impose a remedy or remedies if the department finds any person listed in WAC 388-76-10950:

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

(b) Has been convicted of a "crime against children or other persons" as defined in RCW 43.43.830, unless the crime is simple assault, assault in the fourth degree, or prostitution and more than three years has passed since conviction;

(c) Has been convicted of "crimes relating to financial exploitation" as defined in RCW 43.43.830, unless the crime is theft in third degree and more than three years have passed since conviction, or unless the crime is forgery or theft in the second degree and more than five years has passed since conviction;

(d) Has been found in any final decision issued by a disciplining authority to have abused, neglected, financially exploited, or abandoned a minor or vulnerable adult;

(e) Has been convicted of a crime in federal court or in the court of any other state, and the department determines that the conviction is equivalent to a conviction under subsection (3)(b) or (3)(c) above;

(f) Is listed on a state registry with a finding of abuse, neglect, financial exploitation, or abandonment of a minor or vulnerable adult; or

(g) Has been the subject of a finding or conclusion by a court of law that the individual abused, neglected, financially exploited, or abandoned a minor or vulnerable adult. Examples of legal proceedings in which such findings could be made include juvenile court proceedings under chapter 13.34 RCW, domestic relations proceedings under Title 26 RCW, and vulnerable adult protection proceedings under chapter 74.34 RCW.

[Statutory Authority: RCW 70.128.040, 09-03-028, § 388-76-10955, filed 1/12/09, effective 2/12/09. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW, 07-21-080, § 388-76-10955, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10960 Remedies—Department may impose remedies. The department may impose a remedy or

remedies if the department finds any person listed in WAC 388-76-10950:

(1) Has been convicted of:

(a) Any felony that the department determines is reasonably related to the competency of the person to be involved in the ownership or operation of an adult family home; or

(b) A crime involving a firearm used in the commission of a felony or in any act of violence against a person.

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

(3) Has committed an act of domestic violence toward a family or household member;

(4) Has been found in any final decision of a federal or state agency to have abandoned, neglected, abused, or financially exploited a vulnerable adult, unless such decision requires imposition of a remedy under WAC 388-76-10955;

(5) Has had a license for the care of children or vulnerable adults denied, suspended, revoked, or not renewed;

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

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

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

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

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

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

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

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

(14) Failed or refused to comply with:

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

(b) The requirements of chapters 70.128, 70.129, 74.34 RCW, this chapter or any other applicable laws.

(15) Misappropriated property of a resident, unless such action requires a remedy under WAC 388-76-10955;

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

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

(18) In connection with the operation of any facility for the care of children or adults, relinquished or returned a license, or did not seek license renewal following written

notification that the licensing agency intends to deny, suspend, cancel or revoke the license, unless such action requires imposition of a remedy under WAC 388-76-10955;

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

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

(21) Has failed to meet personal financial obligations and that failure has resulted in a failure to provide necessary care and services to the residents; or

(22) Interfered with a long-term care ombudsman or department staff in the performance of his or her duties.

[Statutory Authority: RCW 70.128.040, 09-03-028, § 388-76-10960, filed 1/12/09, effective 2/12/09. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW, 07-21-080, § 388-76-10960, filed 10/16/07, effective 1/1/08.]

WAC 388-76-10995 Notice, hearing rights, and effective dates relating to imposition of remedies. (1) Chapter 34.05 RCW applies to department actions under this chapter and chapter 70.128 RCW, except that orders of the department imposing license suspension, stop placement, or conditions on license are effective immediately upon notice and must continue pending a final administrative decision.

(2) A provider contesting any decision by the department to impose a remedy must within twenty-eight days of receipt of the decision:

(a) File a written application for an adjudicative proceeding by a method showing proof of receipt to the agency at the mailing address contained in the department's notice imposing the remedy; and

(b) Include in or with the application:

(i) The reasons for contesting the department decision; and

(ii) A copy of the contested department decision.

(3) Administrative proceedings are governed by chapter 34.05 RCW, RCW 43.20A.215, where applicable, this section, 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: RCW 70.128.040, 09-03-029, § 388-76-10995, filed 1/12/09, effective 2/12/09. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW, 07-21-080, § 388-76-10995, filed 10/16/07, effective 1/1/08.]

WAC 388-76-11015 Resident protection program—Disputing a preliminary finding. (1) The individual alleged to have abandoned, abused, neglected, exploited, or financially exploited a resident may request an administrative hearing to challenge a preliminary finding made by the department.

(2) The request must be made in writing to the office of administrative hearings.

(3) The office of administrative hearings must receive the individual's written request for an administrative hearing within thirty calendar days of the date written on the notice of the preliminary finding.

(4) The written request for a hearing must include the individual's full legal name and current mailing address and should include:

(a) The individual's telephone number;

(b) A brief explanation of why the individual alleged to have abandoned, abused, neglected, exploited, or financially exploited a resident disagrees with the preliminary finding;

(c) A description of any assistance needed in the administrative appeal process by the individual, including a foreign or sign language interpreter or any reasonable accommodation for a disability; and

(d) The individual's signature.

[Statutory Authority: RCW 70.128.040, 09-03-030, § 388-76-11015, filed 1/12/09, effective 2/12/09. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW, 08-05-098, § 388-76-11015, filed 2/15/08, effective 3/17/08.]

Chapter 388-78A WAC BOARDING HOME LICENSING RULES (Formerly chapter 246-316 WAC)

WAC

388-78A-2770	Change in licensee/change of ownership—When change in licensee is required.
388-78A-2773	Change in licensee/change of ownership—When change in licensee not required.
388-78A-2775	Change in licensee/change of ownership—Application.
388-78A-2777	Change in licensee/change of ownership—Revised application.
388-78A-2780	Change in licensee/change of ownership—Notice to department and residents.
388-78A-2783	Change in licensee/change of ownership—Relinquishment of license.
388-78A-2785	Change in licensee/change of ownership—Ninety days notice.
388-78A-2787	Change in licensee/change of ownership—Sixty days notice.

WAC 388-78A-2770 Change in licensee/change of ownership—When change in licensee is required. The licensee of a boarding home must change whenever the following events occur, including, but not limited to:

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

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

(3) The licensee dissolves, or consolidates or merges with another legal organization and the licensee's legal organization does not survive;

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

(a) A different person (e.g., new or former shareholders or partners); or

(b) A person that had less than a five percent ownership interest in the boarding home at the time of the first transaction.

(5) Any other event or combination of events that results in a substitution, elimination, or withdrawal of the licensee's control of the boarding home. As used in this section, "control" means the possession, directly or indirectly, of the

power to direct the management, operation and/or policies of the licensee or boarding home, whether through ownership, voting control, by agreement, by contract or otherwise.

[Statutory Authority: Chapter 18.20 RCW. 09-06-063, § 388-78A-2770, filed 3/2/09, effective 4/2/09. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2770, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-2773 Change in licensee/change of ownership—When change in licensee not required. The licensee is not required to change when only the following, without more, occur:

(1) The licensee contracts with a party to manage the boarding home enterprise for the licensee pursuant to an agreement as specified in WAC 388-78A-2590; or

(2) The real property or personal property assets of the boarding home are sold or leased, or a lease of the real property or personal property assets is terminated, as long as there is not a substitution or substitution of control of the licensee or boarding home.

[Statutory Authority: Chapter 18.20 RCW. 09-06-063, § 388-78A-2773, filed 3/2/09, effective 4/2/09.]

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

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

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

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

(b) Any other information requested by the department.

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

[Statutory Authority: Chapter 18.20 RCW. 09-06-063, § 388-78A-2775, filed 3/2/09, effective 4/2/09.]

WAC 388-78A-2777 Change in licensee/change of ownership—Revised application. The prospective licensee must submit a revised application to the department if:

(1) Any information included on the original application is no longer accurate; or

(2) Requested by the department.

[Statutory Authority: Chapter 18.20 RCW. 09-06-063, § 388-78A-2777, filed 3/2/09, effective 4/2/09.]

WAC 388-78A-2780 Change in licensee/change of ownership—Notice to department and residents. (1) In order to change the licensee of a boarding home, the current licensee must notify the following in writing of the proposed change in licensee:

(a) The department; and

(b) All residents, or resident representatives (if any).

(2) The licensee must include the following information in the written notice:

(a) Name of the present licensee and prospective licensee;

(b) Name and address of the boarding home for which the licensee is being changed;

(c) Date of proposed change; and

(d) If the boarding home contracts with the department or other public agencies that may make payments for residential care on behalf of residents, the anticipated effect, such as discharge from the boarding home, the change of licensee will have on residents whose care and services are supported through these contracts.

[Statutory Authority: Chapter 18.20 RCW. 09-06-063, § 388-78A-2780, filed 3/2/09, effective 4/2/09. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. 04-16-065, § 388-78A-2780, filed 7/30/04, effective 9/1/04.]

WAC 388-78A-2783 Change in licensee/change of ownership—Relinquishment of license. (1) On the effective date of the change in licensee, the current boarding home licensee is required to relinquish their boarding home license.

(2) To relinquish a license, the licensee must mail the department the boarding home license along with a letter, addressed to the department, stating licensee's intent to relinquish the boarding home license to the department.

[Statutory Authority: Chapter 18.20 RCW. 09-06-063, § 388-78A-2783, filed 3/2/09, effective 4/2/09.]

WAC 388-78A-2785 Change in licensee/change of ownership—Ninety days notice. The current boarding home licensee must provide written notice to the department and residents, or resident representatives (if any), ninety calendar days prior to the date of the change of licensee, if the proposed change of boarding home licensee is anticipated to result in the discharge or transfer of any resident.

[Statutory Authority: Chapter 18.20 RCW. 09-06-063, § 388-78A-2785, filed 3/2/09, effective 4/2/09.]

WAC 388-78A-2787 Change in licensee/change of ownership—Sixty days notice. The current boarding home licensee must provide written notice to the department and residents, or resident representatives (if any), at least sixty calendar days prior to the date of the change of licensee, if the proposed change of boarding home licensee is not anticipated to result in the discharge or transfer of any resident.

[Statutory Authority: Chapter 18.20 RCW. 09-06-063, § 388-78A-2787, filed 3/2/09, effective 4/2/09.]

Chapter 388-96 WAC

NURSING FACILITY MEDICAID PAYMENT SYSTEM

WAC

388-96-758

388-96-759

Add-on for low-wage workers.

Standards for low-wage workers add-on.

WAC 388-96-758 Add-on for low-wage workers. (1) Under section 206, chapter 329, Laws of 2008, effective July 1, 2008, the department will grant a low wage add-on payment not to exceed one dollar and fifty-seven cents per resident day to any nursing home provider that has indicated a desire to receive the add-on by May 30, 2008. A nursing

home may use the add-on only for in-house staff and not for allocated, home office, or purchased service increases. A nursing home may use the add on to:

(a) Increase wages, benefits, and/or staffing levels for certified nurse aides;

(b) Increase wages and/or benefits but not staffing levels for dietary aides, housekeepers, laundry aides, or any other category of worker whose statewide average dollars-per-hour wage was less than fifteen dollars in calendar year 2006, according to cost report data. The department has determined that the additional categories of workers qualifying under this standard are:

- (i) Activities directors and assistants;
- (ii) Patient choices coordinators;
- (iii) Central supply/ward clerks;
- (iv) Expanded community service workers; and
- (v) Social workers; and

(c) Address wage compression for related job classes immediately affected by wage increases to low-wage workers.

(2) A nursing home that received effective July 1, 2008 a low-wage add-on under chapter 329, Laws of 2008 shall report to the department its expenditure of that add-on by:

- (a) Completing Cost Report Schedule L 1; and
- (b) Returning it to the department by January 31, 2009.

(3) By examining Cost Report Schedule L 1, the department will determine whether the nursing home complied with the statutory requirements for distribution of the low wage add-on. When the department is unable to determine or unsure that the statutory requirements have been met, it will conduct an on site audit.

(4) When the department determines that the statutory requirements have been met, the low wage add-on will be reconciled at the same time as the regular settlement process but as a separate reconciliation. The reconciliation process will compare gross dollars received in the add-on to gross dollars spent.

(5) When the department determines that the low wage add-on has not been spent in compliance with the statutory requirements, then it will recoup the noncomplying amount as an overpayment.

(6) The department also will require the completing of Cost Report Schedule L 1 for any calendar year in which the low wage add-on is paid for six months or more. Subsections (1) through (5) of this section will apply to all completions of Cost Report Schedule L 1 irrespective of the calendar year in which it is paid.

(7) If the legislature extends the low-wage worker add-on in the state fiscal year 2010 budget, nursing home providers will have the opportunity again to elect whether they wish to receive the add-on in their July 1, 2009 rates.

[Statutory Authority: 2008 c 329 § 206(9). 09-08-081, § 388-96-758, filed 3/30/09, effective 4/30/09.]

WAC 388-96-759 Standards for low-wage workers add-on. (1) In accordance with WAC 388-96-758, the low-wage worker add-on must be used to provide increases in wages or benefits, or to address resulting wage compression beginning on or after the date on which the add-on is first included in the rate. For the first year, that date is July 1, 2008. It may be used to increase staffing levels for certified

nurse aides only. The add-on may not be used after July 1 to pay for increases beginning before that date.

(2) Any type of traditional employee benefit is allowable. Such benefits typically fall in one of two categories: retirement, and life or health insurance. However, nontraditional benefits are also allowable (for example, wellness benefits, subsidized meals, or assistance with daycare).

(3) The employer's share of payroll taxes associated with wages and benefits may be covered with the add-on.

(4) For purposes of wage compression, an "immediately affected" job class is one that is related to the low-wage worker category, either in the organizational structure (for example, it supervises the low-wage worker category) or by existing practice (for example, the facility has a benchmark of paying that job class a certain percentage more than the low-wage worker category). Facilities must be able to explain the basis of the relationship if requested. Because the statute refers to "resulting wage compression," a facility must use a portion of the add-on to increase wages or benefits before it may use any of the add-on to address any wage compression caused by such increase.

(5) A facility may use the add-on in relation to any of the job categories listed in WAC 388-96-758, regardless of whether the average wage it pays to its own employees is above fifteen dollars per hour, either before or after including the additional wages funded by the add-on.

(6) Wages or benefits, including employee bonuses, otherwise properly paid with the add on will not be considered as unallowable costs per RCW 74.46.410 (2)(x).

[Statutory Authority: 2008 c 329 § 206(9). 09-08-081, § 388-96-759, filed 3/30/09, effective 4/30/09.]

Chapter 388-97 WAC NURSING HOMES

WAC

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DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-97-1420 Tuberculosis—Mantoux skin testing. [Statutory Authority: Chapters 18.51 and 74.42 RCW and 42 C.F.R. 489.52. 08-20-062, § 388-97-1420, filed 9/24/08, effective 11/1/08.] Repealed by 10-02-021, filed 12/29/09, effective 1/29/10. Statutory Authority: Chapters 18.51 and 74.42 RCW.

388-97-3820 Stairways, ramps, and corridors in new construction. [Statutory Authority: Chapters 18.51 and 74.42 RCW and 42 C.F.R. 489.52. 08-20-062, § 388-97-3820, filed 9/24/08, effective 11/1/08.] Repealed by 10-02-021, filed 12/29/09, effective 1/29/10. Statutory Authority: Chapters 18.51 and 74.42 RCW.

WAC 388-97-0001 Definitions. "Abandonment" means action or inaction by an individual or entity with a duty of care for a vulnerable adult that leaves the vulnerable individual without the means or ability to obtain necessary food, clothing, shelter, or health care.

"Abuse" means the willful action or inaction that inflicts injury, unreasonable confinement, intimidation, or punishment of a vulnerable adult. In instances of abuse of a vulnerable adult who is unable to express or demonstrate physical harm, pain or mental anguish, the abuse is presumed to cause physical harm, pain, or mental anguish. Abuse includes sexual abuse, mental abuse, physical abuse, and exploitation of a vulnerable adult, which have the following meanings:

(1) **"Mental abuse"** means any willful action or inaction of mental or verbal abuse. Mental abuse includes, but is not limited to, coercion, harassment, inappropriately isolating a resident from family, friends, or regular activity, and verbal assault that includes ridiculing, intimidating, yelling, or swearing.

(2) **"Physical abuse"** means the willful action of inflicting bodily injury or physical mistreatment. Physical abuse includes, but is not limited to, striking with or without an object, slapping, pinching, choking, kicking, shoving, prodding, or restraints including chemical restraints, unless the restraint is consistent with licensing requirements.

(3) **"Sexual abuse"** means any form of nonconsensual, sexual contact, including, but not limited to, unwanted or inappropriate touching, rape, sodomy, sexual coercion, sexually explicit photographing, and sexual harassment. Sexual abuse includes any sexual contact between a staff person and a resident, whether or not it is consensual.

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

"Administrative hearing" is a formal hearing proceeding before a state administrative law judge that gives:

(1) A licensee an opportunity to be heard in disputes about licensing actions, including the imposition of remedies, taken by the department; or

(2) An individual an opportunity to appeal a finding of abandonment, abuse, neglect, financial exploitation of a resident, or misappropriation of a resident's funds.

"Administrative law judge (ALJ)" means an impartial decision-maker who presides over an administrative hearing. ALJs are employed by the office of administrative hearings (OAH), which is a separate state agency. ALJs are not DSHS employees or DSHS representatives.

"Administrator" means a nursing home administrator, licensed under chapter 18.52 RCW, who must be in active administrative charge of the nursing home, as that term is defined in the board of nursing home administrator's regulations.

"Advanced registered nurse practitioner (ARNP)" means an individual who is licensed to practice as an advanced registered nurse practitioner under chapter 18.79 RCW.

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

"ASHRAE" means the American Society of Heating, Refrigerating, and Air Conditioning Engineers, Inc.

"Attending physician" means the doctor responsible for a particular individual's total medical care.

"Berm" means a bank of earth piled against a wall.

"Chemical restraint" means a psychopharmacologic drug that is used for discipline or convenience and is not required to treat the resident's medical symptoms.

"Civil adjudication proceeding" means judicial or administrative adjudicative proceeding that results in a finding of, or upholds an agency finding of, domestic violence, abuse, sexual abuse, neglect, abandonment, violation of a professional licensing standard regarding a child or vulnerable adult, or exploitation or financial exploitation of a child or vulnerable adult under any provision of law, including but not limited to chapter 13.34, 26.44, or 74.34 RCW, or rules adopted under chapters 18.51 and 74.42 RCW. "Civil adjudication proceeding" also includes judicial or administrative findings that become final due to the failure of the alleged perpetrator to timely exercise a legal right to administratively challenge such findings.

"Civil fine" is a civil monetary penalty assessed against a nursing home as authorized by chapters 18.51 and 74.42 RCW. There are two types of civil fines, "per day" and "per instance."

(1) **"Per day fine"** means a fine imposed for each day that a nursing home is out of compliance with a specific requirement. Per day fines are assessed in accordance with WAC 388-97-4580(1); and

(2) **"Per instance fine"** means a fine imposed for the occurrence of a deficiency.

"Condition on a license" means that the department has imposed certain requirements on a license and the licensee cannot operate the nursing home unless the requirements are observed.

"Deficiency" is a nursing home's failed practice, action or inaction that violates any or all of the following:

(1) Requirements of chapters 18.51 or 74.42 RCW, or the requirements of this chapter; and

(2) In the case of a medicare and medicaid contractor, participation requirements under Title XVIII and XIX of the Social Security Act and federal medicare and medicaid regulations.

"Deficiency citation" or **"cited deficiency"** means written documentation by the department that describes a nursing home's deficiency(ies); the requirement that the deficiency(ies) violates; and the reasons for the determination of noncompliance.

"Deficient facility practice" or **"failed facility practice"** means the nursing home action(s), error(s), or lack of action(s) that provide the basis for the deficiency.

"Dementia care" means a therapeutic modality or modalities designed specifically for the care of persons with dementia.

"Denial of payment for new admissions" is an action imposed on a nursing home (facility) by the department that prohibits payment for new medicaid admissions to the nursing home after a specified date. Nursing homes certified to provide medicare and medicaid services may also be subjected to a denial of payment for new admissions by the federal Centers for Medicare and Medicaid Services.

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

"Department on-site monitoring" means an optional remedy of on-site visits to a nursing home by department staff according to department guidelines for the purpose of monitoring resident care or services or both.

"Dietitian" means a qualified dietitian. A qualified dietitian is one who is registered by the American Dietetic Association or certified by the state of Washington.

"Disclosure statement" means a signed statement by an individual in accordance with the requirements under RCW 43.43.834. The statement should include a disclosure of whether or not the individual has been convicted of certain crimes or has been found by any court, state licensing board, disciplinary board, or protection proceeding to have neglected, sexually abused, financially exploited, or physically abused any minor or adult individual.

"Drug" means a substance:

(1) Recognized as a drug in the official *United States Pharmacopoeia*, *Official Homeopathic Pharmacopoeia of the United States*, *Official National Formulary*, or any supplement to any of them; or

(2) Intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease.

"Drug facility" means a room or area designed and equipped for drug storage and the preparation of drugs for administration.

"Emergency closure" is an order by the department to immediately close a nursing home.

"Emergency transfer" means immediate transfer of residents from a nursing home to safe settings.

"Entity" means any type of firm, partnership, corporation, company, association, or joint stock association.

"Financial exploitation" means the illegal or improper use of the property, income, resources, or trust funds of the vulnerable adult by any individual for his or her profit or advantage.

"Habilitative services" means the planned interventions and procedures which constitute a continuing and comprehensive effort to teach an individual previously undeveloped skills.

"Highest practicable physical, mental, and psychosocial well-being" means providing each resident with the nec-

essary individualized care and services to assist the resident to achieve or maintain the highest possible health, functional and independence level in accordance with the resident's comprehensive assessment and plan of care. Care and services provided by the nursing home must be consistent with all requirements in this chapter, chapters 74.42 and 18.51 RCW, and the resident's informed choices. For medicaid and medicare residents, care and services must also be consistent with Title XVIII and XIX of the Social Security Act and federal medicare and medicaid regulations.

"Informal department review" is a dispute resolution process that provides an opportunity for the licensee or administrator to informally present information to a department representative about disputed, cited deficiencies. Refer to WAC 388-97-4420.

"Inspection" or **"survey"** means the process by which department staff evaluates the nursing home licensee's compliance with applicable statutes and regulations.

"Intermediate care facility for the mentally retarded (ICF/MR)" means an institution certified under chapter 42 C.F.R., Part 483, Subpart I, and licensed under chapter 18.51 RCW.

"License revocation" is an action taken by the department to cancel a nursing home license in accordance with RCW 18.51.060 and WAC 388-97-4220.

"License suspension" is an action taken by the department to temporarily revoke a nursing home license in accordance with RCW 18.51.060 and this chapter.

"Licensee" means an individual, partnership, corporation, or other legal entity licensed to operate a nursing home.

"Licensed practical nurse" means an individual licensed to practice as a licensed practical nurse under chapter 18.79 RCW;

"Mandated reporter" as used in this chapter means any employee of a nursing home, any health care provider subject to chapter 18.130 RCW, the Uniform Disciplinary Act, and any licensee or operator of a nursing home. Under RCW 74.34.020, mandated reporters also include any employee of the department of social and health services, law enforcement officers, social workers, professional school personnel, individual providers, employees and licensees of boarding home, adult family homes, soldiers' homes, residential habilitation centers, or any other facility licensed by the department, employees of social service, welfare, mental health, adult day health, adult day care, home health, home care, or hospice agencies, county coroners or medical examiners, or Christian Science practitioners.

"Misappropriation of resident property" means the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money.

"NFPA" means National Fire Protection Association, Inc.

"Neglect":

(1) In a nursing home licensed under chapter 18.51 RCW, neglect means that an individual or entity with a duty of care for nursing home residents has:

(a) By a pattern of conduct or inaction, failed to provide goods and services to maintain physical or mental health or to avoid or prevent physical or mental harm or pain to a resident; or

(b) By an act or omission, demonstrated a serious disregard of consequences of such magnitude as to constitute a clear and present danger to the resident's health, welfare, or safety.

(2) In a skilled nursing facility or nursing facility, neglect also means a failure to provide a resident with the goods and services necessary to avoid physical harm, mental anguish, or mental illness.

"Noncompliance" means a state of being out of compliance with state and/or federal requirements for nursing homes/facilities.

"Nursing assistant" means a nursing assistant as defined under RCW 18.88A.020 or successor laws.

"Nursing facility (NF)" or **"medicaid-certified nursing facility"** means a nursing home, or any portion of a hospital, veterans' home, or residential habilitation center, that is certified to provide nursing services to medicaid recipients under Section 1919(a) of the federal Social Security Act.

"Nursing home" means any facility licensed to operate under chapter 18.51 RCW.

"Officer" means an individual serving as an officer of a corporation.

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

(1) The individual, and if applicable, the individual's spouse, who operates, or is applying to operate, the nursing home as a sole proprietorship;

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

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

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

"Person" means any individual, firm, partnership, corporation, company, association or joint stock association.

"Pharmacist" means an individual licensed by the Washington state board of pharmacy under chapter 18.64 RCW.

"Pharmacy" means a place licensed under chapter 18.64 RCW where the practice of pharmacy is conducted.

"Physical restraint" means any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the resident cannot remove easily, and which restricts freedom of movement or access to the resident's body.

"Physician's assistant (PA)" means a physician's assistant as defined under chapter 18.57A or 18.71A RCW or successor laws.

"Plan of correction" is a nursing home's written response to cited deficiencies that explains how it will correct the deficiencies and how it will prevent their reoccurrence.

"Reasonable accommodation" and **"reasonably accommodate"** has the meaning given in federal and state antidiscrimination laws and regulations. For the purpose of this chapter:

(1) Reasonable accommodation means that the nursing home must:

(a) Not impose admission criteria that excludes individuals unless the criteria is necessary for the provision of nursing home services;

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

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

(2) Reasonable accommodations are not required if:

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

(b) The reasonable accommodations would fundamentally alter the nature of the services provided by the nursing home; or

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

"Receivership" is established by a court action and results in the removal of a nursing home's current licensee and the appointment of a substitute licensee to temporarily operate the nursing home.

"Recurring deficiency" means a deficiency that was cited by the department, corrected by the nursing home, and then cited again within fifteen months of the initial deficiency citation.

"Registered nurse" means an individual licensed to practice as a registered nurse under chapter 18.79 RCW.

"Rehabilitative services" means the planned interventions and procedures which constitute a continuing and comprehensive effort to restore an individual to the individual's former functional and environmental status, or alternatively, to maintain or maximize remaining function.

"Resident" generally means an individual residing in a nursing home. Except as specified elsewhere in this chapter, for decision-making purposes, the term "resident" includes the resident's surrogate decision maker acting under state law. The term resident excludes outpatients and individuals receiving adult day or night care, or respite care.

"Resident care unit" means a functionally separate unit including resident rooms, toilets, bathing facilities, and basic service facilities.

"Respiratory isolation" is a technique or techniques instituted to prevent the transmission of pathogenic organisms by means of droplets and droplet nuclei coughed, sneezed, or breathed into the environment.

"Siphon jet clinic service sink" means a plumbing fixture of adequate size and proper design for waste disposal with siphon jet or similar action sufficient to flush solid matter of at least two and one-eighth inches in diameter.

"Skilled nursing facility (SNF)" or **"medicare-certified skilled nursing facility"** means a nursing home or a long-term care wing or unit of a hospital that has been certified to provide nursing services to medicare recipients under Section 1819(a) of the federal Social Security Act.

"Social/therapeutic leave" means leave which is for the resident's social, emotional, or psychological well-being; it does not include medical leave.

"Staff work station" means a location at which nursing and other staff perform charting and related activities throughout the day.

"Stop placement" or **"stop placement order"** is an action taken by the department prohibiting nursing home admissions, readmissions, and transfers of patients into the nursing home from the outside.

"Substantial compliance" means the nursing home has no deficiencies higher than severity level 1 as described in WAC 388-97-4500, or for medicaid certified facility, no deficiencies higher than a scope and severity "C."

"Surrogate decision maker" means a resident representative or representatives as outlined in WAC 388-97-0240, and as authorized by RCW 7.70.065.

"Survey" means the same as **"inspection"** as defined in this section.

"Temporary manager" means an individual or entity appointed by the department to oversee the operation of the nursing home to ensure the health and safety of its residents, pending correction of deficiencies or closure of the facility.

"Termination" means an action taken by:

(1) The department, or the nursing home, to cancel a nursing home's medicaid certification and contract; or

(2) The department of health and human services Centers for Medicare and Medicaid Services, or the nursing home, to cancel a nursing home's provider agreement to provide services to medicaid or medicare recipients, or both.

"Toilet room" means a room containing at least one toilet fixture.

"Uncorrected deficiency" is a deficiency that has been cited by the department and that is not corrected by the licensee by the time the department does a revisit.

"Violation" means the same as **"deficiency"** as defined in this section.

"Volunteer" means an individual who is a regularly scheduled individual not receiving payment for services and having unsupervised access to a nursing home resident.

"Vulnerable adult" includes a person:

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

(2) Found incapacitated under chapter 11.88 RCW; or

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

(4) Admitted to any facility, including any boarding home; or

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

(6) Receiving services from an individual provider; or

(7) With a functional disability who lives in his or her own home, who is directing and supervising a paid personal aide to perform a health care task as authorized by RCW 74.39.050.

"Whistle blower" means a resident, employee of a nursing home, or any person licensed under Title 18 RCW, who in good faith reports alleged abandonment, abuse, financial exploitation, or neglect to the department, the department of health or to a law enforcement agency.

[Statutory Authority: Chapters 18.51 and 74.42 RCW. 10-02-021, § 388-97-0001, filed 12/29/09, effective 1/29/10. Statutory Authority: Chapters 18.51 and 74.42 RCW and 42 C.F.R. 489.52. 08-20-062, § 388-97-0001, filed 9/24/08, effective 11/1/08.]

WAC 388-97-0100 Utilization review. (1) To assure appropriate use of medicaid services, the nursing facility must determine whether each medicaid resident's health has improved sufficiently so the resident no longer needs nursing facility care.

(a) The nursing facility must base its determination on:

(i) An accurate, comprehensive assessment process; and

(ii) Documentation by the resident's physician.

(b) The nursing facility is not responsible to assess under WAC 388-97-1960, PASSR level II screening assessment.

(2) When the nursing facility determines a resident no longer needs nursing facility care under subsection (1) of this section, the nursing facility must initiate transfer or discharge in accordance with WAC 388-97-0120, 388-97-0140, and 42 C.F.R. § 483.12, or successor laws, unless the resident voluntarily chooses to transfer or discharge.

(3) When a nursing facility initiates a transfer or discharge of a medicaid recipient under subsection (2) of this section:

(a) The resident will be ineligible for medicaid nursing facility payment:

(i) Thirty days after the receipt of written notice of transfer or discharge; or

(ii) If the resident appeals the facility determination, thirty days after the final order is entered upholding the nursing home's decision to transfer or discharge a resident.

(b) The department's home and community services may grant extension of a resident's medicaid nursing facility payment after the time specified in subsection (3)(a) of this section, when the department's home and community services staff determine:

(i) The nursing facility is making a good faith effort to relocate the resident; and

(ii) A location appropriate to the resident's medical and other needs is not available.

(4) Department designees may review any assessment or determination made by a nursing facility of a resident's need for nursing facility care.

[Statutory Authority: Chapters 18.51 and 74.42 RCW. 10-02-021, § 388-97-0100, filed 12/29/09, effective 1/29/10. Statutory Authority: Chapters 18.51 and 74.42 RCW and 42 C.F.R. 489.52. 08-20-062, § 388-97-0100, filed 9/24/08, effective 11/1/08.]

WAC 388-97-0280 Advance directives. (1) **"Advance directive"** as used in this chapter means any document indicating a resident's choice with regard to a specific service, treatment, medication or medical procedure option that may be implemented in the future such as power of attorney, health care directive, limited or restricted treatment cardiopulmonary resuscitation (CPR), do not resuscitate (DNR), and organ tissue donation.

(2) The nursing home must carry out the provisions of this section in accordance with the applicable provisions of WAC 388-97-0240 and 388-97-0260, and with state law.

(3) The nursing home must:

(a) Document in the clinical record whether or not the resident has an advance directive;

(b) Not request or require the resident to have any advance directives and not condition the provision of care or otherwise discriminate against a resident on the basis of whether or not the resident has executed an advance directive;

(c) In a language and words the resident understands, inform the resident in writing and orally at the time of admission, and thereafter as necessary to ensure the resident's right to make informed choices, about:

- (i) The right to make health care decisions, including the right to change his or her mind regarding previous decisions;
- (ii) Nursing home policies and procedures concerning implementation of advance directives; and
- (d) Review and update as needed the resident advance directive information:

- (i) At the resident's request;
- (ii) When the resident's condition warrants review; and
- (iii) When there is a significant change in the resident's condition.

(4) When the nursing home becomes aware that a resident's health care directive is in conflict with facility practices and policies which are consistent with state and federal law, the nursing home must:

(a) Inform the resident of the existence of any nursing home practice or policy which would preclude implementing the health care directive;

(b) Provide the resident with written policies and procedures that explain under what circumstances a resident's health care directive will or will not be implemented by the nursing home;

(c) Meet with the resident to discuss the conflict; and

(d) Determine, in light of the conflicting practice or policy, whether the resident chooses to remain at the nursing home:

(i) If the resident chooses to remain in the nursing home, develop with the resident a plan in accordance with chapter 70.122 RCW to implement the resident's wishes. The nursing home may need to actively participate in ensuring the execution of the plan, including moving the resident at the time of implementation to a care setting that will implement the resident's wishes. Attach the plan to the resident's directive in the resident's clinical record; or

(ii) If, after recognizing the conflict between the resident's wishes and nursing home practice or policy the resident chooses to seek other long-term care services, or another physician who will implement the directive, the nursing home must assist the resident in locating other appropriate services.

(5) If a terminally ill resident, in accordance with state law, wishes to die at home, the nursing home must:

(a) Use the informed consent process as described in WAC 388-97-0260, and explain to the resident the risks associated with discharge; and

(b) Discharge the resident as soon as reasonably possible.

[Statutory Authority: Chapters 18.51 and 74.42 RCW. 10-02-021, § 388-97-0280, filed 12/29/09, effective 1/29/10. Statutory Authority: Chapters 18.51 and 74.42 RCW and 42 C.F.R. 489.52. 08-20-062, § 388-97-0280, filed 9/24/08, effective 11/1/08.]

WAC 388-97-0580 Roommates/rooms. (1) A resident has the right to:

(a) Share a room with his or her spouse or state registered domestic partners when both residents live in the same facility and both consent to the arrangement and the room complies with the requirements for two occupants; and

(b) Receive three days notice of change in room or roommate except:

(i) For room changes: The move is at the resident's request; and

(ii) For room or roommate changes: A longer or shorter notice is required to protect the health or safety of the resident or another resident; or an admission to the facility is necessary, and the resident is informed in advance. The nursing home must recognize that the change may be traumatic for the resident and take steps to lessen the trauma.

(2) The nursing home must make reasonable efforts to accommodate residents wanting to share the same room.

[Statutory Authority: Chapters 18.51 and 74.42 RCW. 10-02-021, § 388-97-0580, filed 12/29/09, effective 1/29/10. Statutory Authority: Chapters 18.51 and 74.42 RCW and 42 C.F.R. 489.52. 08-20-062, § 388-97-0580, filed 9/24/08, effective 11/1/08.]

WAC 388-97-0720 Notice to individual of preliminary findings. (1) The department will serve notice of the preliminary finding as provided in WAC 388-97-4425.

(2) The department may establish proof of service as provided in WAC 388-97-4430.

[Statutory Authority: Chapters 18.51 and 74.42 RCW. 10-02-021, § 388-97-0720, filed 12/29/09, effective 1/29/10. Statutory Authority: Chapters 18.51 and 74.42 RCW and 42 C.F.R. 489.52. 08-20-062, § 388-97-0720, filed 9/24/08, effective 11/1/08.]

WAC 388-97-0725 Notice to others of preliminary findings. Consistent with confidentiality requirements concerning the resident, witnesses, and the reporter, the department may provide notification of a preliminary finding to:

(1) Other divisions within the department;

(2) The agency, program or employer where the incident occurred;

(3) The employer or program that is currently associated with the individual;

(4) Law enforcement;

(5) Other entities as authorized by law including chapter 74.34 RCW and this chapter; and

(6) The appropriate licensing agency.

[Statutory Authority: Chapters 18.51 and 74.42 RCW. 10-02-021, § 388-97-0725, filed 12/29/09, effective 1/29/10.]

WAC 388-97-1400 Tuberculosis—Testing method—Required. The nursing home must ensure that all tuberculosis testing is done through either:

(1) Intradermal (Mantoux) administration with test results read:

(a) Within forty-eight to seventy-two hours of the test; and

(b) By a trained professional; or

(2) A blood test for tuberculosis called interferon-gamma release assay (IGRA).

[Statutory Authority: Chapters 18.51 and 74.42 RCW. 10-02-021, § 388-97-1400, filed 12/29/09, effective 1/29/10. Statutory Authority: Chapters 18.51 and 74.42 RCW and 42 C.F.R. 489.52. 08-20-062, § 388-97-1400, filed 9/24/08, effective 11/1/08.]

WAC 388-97-1440 Tuberculosis—No testing. The nursing home is not required to have a person tested for tuberculosis if the person has:

(1) A documented history of a previous positive skin test results;

(2) A documented history of a previous positive blood test; or

(3) Documented evidence of:

- (a) Adequate therapy for active disease; or
- (b) Completion of treatment for latent tuberculosis infection preventive therapy.

[Statutory Authority: Chapters 18.51 and 74.42 RCW. 10-02-021, § 388-97-1440, filed 12/29/09, effective 1/29/10. Statutory Authority: Chapters 18.51 and 74.42 RCW and 42 C.F.R. 489.52. 08-20-062, § 388-97-1440, filed 9/24/08, effective 11/1/08.]

WAC 388-97-1460 Tuberculosis—One test. The nursing home is only required to have a person take one test if the person has any of the following:

- (1) A documented history of a negative result from a previous two step test done no more than one to three weeks apart; or
- (2) A documented negative result from one skin or blood test in the previous twelve months.

[Statutory Authority: Chapters 18.51 and 74.42 RCW. 10-02-021, § 388-97-1460, filed 12/29/09, effective 1/29/10. Statutory Authority: Chapters 18.51 and 74.42 RCW and 42 C.F.R. 489.52. 08-20-062, § 388-97-1460, filed 9/24/08, effective 11/1/08.]

WAC 388-97-1480 Tuberculosis—Two-step skin testing. Unless the person meets the requirement for having no skin testing or only one test, the nursing home, choosing to do skin testing, must ensure that each person has the following two-step skin testing:

- (1) An initial skin test within three days of employment; and
- (2) A second test done one to three weeks after the first test.

[Statutory Authority: Chapters 18.51 and 74.42 RCW. 10-02-021, § 388-97-1480, filed 12/29/09, effective 1/29/10. Statutory Authority: Chapters 18.51 and 74.42 RCW and 42 C.F.R. 489.52. 08-20-062, § 388-97-1480, filed 9/24/08, effective 11/1/08.]

WAC 388-97-1500 Tuberculosis—Positive test result. When there is a positive result to tuberculosis skin or blood testing the nursing home must:

- (1) Ensure that the person has a chest X ray within seven days;
- (2) Evaluate each resident or person with a positive test result for signs and symptoms of tuberculosis; and
- (3) Follow the recommendation of the person's health care provider.

[Statutory Authority: Chapters 18.51 and 74.42 RCW. 10-02-021, § 388-97-1500, filed 12/29/09, effective 1/29/10. Statutory Authority: Chapters 18.51 and 74.42 RCW and 42 C.F.R. 489.52. 08-20-062, § 388-97-1500, filed 9/24/08, effective 11/1/08.]

WAC 388-97-1520 Tuberculosis—Negative test result. The nursing home may be required by the public health provider or licensing authority to ensure that persons with negative test results have follow-up testing in certain circumstances, such as:

- (1) After exposure to active tuberculosis;
- (2) When tuberculosis symptoms are present; or
- (3) For periodic testing as determined by the health provider.

[Statutory Authority: Chapters 18.51 and 74.42 RCW. 10-02-021, § 388-97-1520, filed 12/29/09, effective 1/29/10. Statutory Authority: Chapters 18.51 and 74.42 RCW and 42 C.F.R. 489.52. 08-20-062, § 388-97-1520, filed 9/24/08, effective 11/1/08.]

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WAC 388-97-1540 Tuberculosis—Declining a skin test. The nursing home must ensure that a person take the blood test for tuberculosis if they decline the skin test.

[Statutory Authority: Chapters 18.51 and 74.42 RCW. 10-02-021, § 388-97-1540, filed 12/29/09, effective 1/29/10. Statutory Authority: Chapters 18.51 and 74.42 RCW and 42 C.F.R. 489.52. 08-20-062, § 388-97-1540, filed 9/24/08, effective 11/1/08.]

WAC 388-97-1560 Tuberculosis—Reporting—Required. The nursing home must:

- (1) Report any person with tuberculosis symptoms or a positive chest X ray to the appropriate health care provider or public health provider;
- (2) Follow the infection control and safety measures ordered by the person's health care provider, including a public health provider;
- (3) Institute appropriate measures for the control of the transmission of droplet nuclei;
- (4) Apply living or work restrictions where residents or personnel are, or may be, infectious and pose a risk to other residents and personnel; and
- (5) Ensure that personnel caring for a resident with suspected tuberculosis comply with the WISHA standard for respiratory protection found in chapter 296-842 WAC.

[Statutory Authority: Chapters 18.51 and 74.42 RCW. 10-02-021, § 388-97-1560, filed 12/29/09, effective 1/29/10. Statutory Authority: Chapters 18.51 and 74.42 RCW and 42 C.F.R. 489.52. 08-20-062, § 388-97-1560, filed 9/24/08, effective 11/1/08.]

WAC 388-97-1580 Tuberculosis—Test records. The nursing home must:

- (1) Keep the records of tuberculin test results, reports of X-ray findings, and any physician or public health provider orders in the nursing home;
- (2) Make the records readily available to the appropriate health authority and licensing agency;
- (3) Retain the records for eighteen months beyond the date of employment termination; and
- (4) Provide the person a copy of his/her test results.

[Statutory Authority: Chapters 18.51 and 74.42 RCW. 10-02-021, § 388-97-1580, filed 12/29/09, effective 1/29/10. Statutory Authority: Chapters 18.51 and 74.42 RCW and 42 C.F.R. 489.52. 08-20-062, § 388-97-1580, filed 9/24/08, effective 11/1/08.]

WAC 388-97-1600 Care of residents with active tuberculosis. (1) When the nursing home accepts the care of a resident with suspected or confirmed tuberculosis, the nursing home must:

- (a) Coordinate the resident's admission, nursing home care, discharge planning, and discharge with the health care provider;
 - (b) Provide necessary education about tuberculosis for staff, visitors, and residents; and
 - (c) Ensure that personnel caring for a resident with active tuberculosis comply with the WISHA standards for respiratory protection, chapter 296-842 WAC.
- (2) For a resident who requires respiratory isolation for tuberculosis, the nursing home must:
- (a) Provide a private or semiprivate isolation room:
 - (i) In accordance with WAC 388-97-2480;
 - (ii) In which, construction review of the department of health determines that room air is maintained under negative

pressure; and appropriately exhausted, either directly to the outside away from intake vents or through properly designed, installed, and maintained high efficiency particulate air (HEPA) filters, or other measures deemed appropriate to protect others in the facility;

(iii) However, when a semiprivate isolation room is used, only residents requiring respiratory isolation for confirmed or suspected tuberculosis are placed together.

(b) Provide supplemental environment approaches, such as ultraviolet lights, where deemed to be necessary;

(c) Provide appropriate protective equipment for staff and visitors; and

(d) Have measures in place for the decontamination of equipment and other items used by the resident.

[Statutory Authority: Chapters 18.51 and 74.42 RCW. 10-02-021, § 388-97-1600, filed 12/29/09, effective 1/29/10. Statutory Authority: Chapters 18.51 and 74.42 RCW and 42 C.F.R. 489.52. 08-20-062, § 388-97-1600, filed 9/24/08, effective 11/1/08.]

WAC 388-97-1800 Criminal history disclosure and background inquiries. (1) As used in this section, the term "nursing home" includes a nursing facility and a skilled nursing facility.

(2) The nursing home must:

(a) Have a valid criminal history background check for any individual employed, directly or by contract, or any individual accepted as a volunteer or student who may have unsupervised access to any resident; and

(b) Repeat the check every two years.

(3) A nursing home licensed under chapter 18.51 RCW must make a background inquiry request to one of the following:

(a) The Washington state patrol;

(b) The department;

(c) The most recent employer licensed under chapters 18.51, 18.20, and 70.128 RCW provided termination of that employment was within twelve months of the current employment application and provided the inquiry was completed by the department or the Washington state patrol within the two years of the current date of application; or

(d) A nurse pool agency licensed under chapter 18.52C RCW, or hereafter renamed, provided the background inquiry was completed by the Washington state patrol within two years before the current date of employment in the nursing home.

(4) A nursing home may not rely on a criminal background inquiry from a former employer, including a nursing pool, if the nursing home knows or has reason to know that the individual applying for the job has, or may have, a disqualifying conviction or finding.

(5) Nursing homes must:

(a) Request a background inquiry of any individual employed, directly or by agreement or contract, or accepted as a volunteer or student; and

(b) Notify appropriate licensing or certification agency of any individual resigning or terminated as a result of a criminal conviction or a civil adjudication proceeding.

(6) Before a nursing home employs any individual, directly or by contract, or accepts any individual as a volunteer or student, a nursing home must:

(a) Inform the individual that the nursing home must make a background inquiry and require the individual to sign a disclosure statement, under penalty or perjury and in accordance with RCW 43.43.834;

(b) Inform the individual that he or she may request a copy of the results of the completed background inquiry described in this section; and

(c) Require the individual to sign a statement authorizing the nursing home, the department, and the Washington state patrol to make a background inquiry; and

(d) Verbally inform the individual of the background inquiry results within seventy-two hours of receipt.

(7) The nursing home must establish procedures ensuring that:

(a) The individual is verbally informed of the background inquiry results within seventy-two hours of receipt;

(b) All disclosure statements and background inquiry responses and all copies are maintained in a confidential and secure manner;

(c) Disclosure statements and background inquiry responses are used for employment purposes only;

(d) Disclosure statements and background inquiry responses are not disclosed to any individual except:

(i) The individual about whom the nursing home made the disclosure or background inquiry;

(ii) Authorized state employees including the department's licensure and certification staff, resident protection program staff and background inquiry unit staff;

(iii) Authorized federal employees including those from the Department of Health and Human Services, Centers for Medicare and Medicaid Services;

(iv) The Washington state patrol auditor; and

(v) Potential employers licensed under chapters 18.51, 18.20, and 70.128 RCW who are making a request as provided for under subsection (1) of this section.

(e) A record of findings be retained by the nursing home for twelve months beyond the date of employment termination.

(8) The nursing home must not employ individuals who are disqualified under the requirements of WAC 388-97-1820.

[Statutory Authority: Chapters 18.51 and 74.42 RCW. 10-02-021, § 388-97-1800, filed 12/29/09, effective 1/29/10. Statutory Authority: Chapters 18.51 and 74.42 RCW and 42 C.F.R. 489.52. 08-20-062, § 388-97-1800, filed 9/24/08, effective 11/1/08.]

WAC 388-97-1820 Disqualification from nursing home employment. (1) The nursing home must not employ directly or by contract, or accept as a volunteer or student, any individual:

(a) Who has been found to have abused, neglected, exploited or abandoned a minor or vulnerable adult by a court of law, by a disciplining authority, including the state department of health;

(b) With a finding of abuse or neglect of a child that is:

(i) Listed on the department's background check central unit (BCCU) report; or

(ii) Disclosed by the individual, except for findings made before December, 1998.

(c) With a finding of abandonment, abuse, neglect, or financial exploitation of a vulnerable adult that is:

(i) Listed on any registry, including the department registry;

(ii) Listed on the department's background check central unit (BCCU) report; or

(iii) Disclosed by the individual, except for adult protective services findings made before October, 2003.

(2) Except as provided in this section, the nursing home must not employ directly or by contract, or accept as a volunteer or student, any individual who may have unsupervised access to residents if the individual:

(a) Has been convicted of a "crime against children and other persons" as defined in RCW 43.43.830, unless the individual has been convicted of one of the two crimes listed below and the required number of years has passed between the most recent conviction and the date of the application for employment:

(i) Simple assault, assault in the fourth degree, or the same offense as it may hereafter be renamed, and three or more years have passed; or

(ii) Prostitution, or the same offense as it may hereafter be renamed, and three or more years have passed.

(b) Has been convicted of crimes relating to financial exploitation as defined in RCW 43.43.830, unless the individual has been convicted of one of the three crimes listed below and the required number of years has passed between the most recent conviction and the date of the application for employment:

(i) Theft in the second degree, or the same offense as it may hereafter be renamed, and five or more years have passed;

(ii) Theft in the third degree, or the same offense as it may hereafter be renamed, and three or more years have passed; or

(iii) Forgery, or the same offense as forgery may hereafter be renamed, and five or more years have passed.

(c) Has been convicted of:

(i) Violation of the imitation controlled substances act (VICSA);

(ii) Violation of the uniform controlled substances act (VUCSA);

(iii) Violation of the uniform legend drug act (VULDA); or

(iv) Violation of the uniform precursor drug act (VUPDA).

(d) Has been convicted of sending or bringing into the state depictions of a minor engaged in sexually explicit conduct.

(e) Has been convicted of criminal mistreatment.

(f) Has been convicted in another state of a crime that is equivalent to a crime listed in subsection (2)(a) through (e) of this section.

(3) The term "**vulnerable adult**" is defined in RCW 74.34.020; the term "**unsupervised access**" is defined in RCW 43.43.830.

(4) In addition to chapters 18.51 and 74.42 RCW, these rules are authorized by RCW 43.20A.710, 43.43.830 through 43.43.842 and 74.39A.050(8).

[Statutory Authority: Chapters 18.51 and 74.42 RCW. 10-02-021, § 388-97-1820, filed 12/29/09, effective 1/29/10. Statutory Authority: Chapters 18.51 and 74.42 RCW and 42 C.F.R. 489.52. 08-20-062, § 388-97-1820, filed 9/24/08, effective 11/1/08.]

WAC 388-97-1900 Dialysis services. (1) The nursing home must ensure that appropriate care, treatment, and services are provided to each nursing home resident who receives dialysis in the nursing home.

(2) For the purposes of this section the following definitions apply:

(a) "Dialysis" means the process of separating crystalloids and colloids in solution by means of the crystalloids and colloids unequal diffusion through a natural or artificial semi-permeable membrane. This includes both peritoneal and hemodialysis.

(b) A "kidney center" means a facility as defined and certified by the federal government to provide end stage renal (ESRD) services.

(3) The nursing home must not administer dialysis for a resident with acute renal failure in the nursing home.

(4) A nursing home may only administer maintenance dialysis in the nursing home after:

(a) Other options have been analyzed and rejected, based on the resident's best interest; and

(b) A decision is made jointly by a team of individuals representing the kidney center and the nursing home, the resident, and the resident's nephrologist.

(5) The nursing home must ensure that a current written agreement is in effect with each kidney center responsible for the management and care of each nursing home resident undergoing dialysis. The agreement must include all aspects of how the resident's care is to be managed including:

(a) Medical and nonmedical emergencies;

(b) Development and implementation of the resident's care plan related to dialysis issues;

(c) Interchange of information useful/necessary for the care of the resident; and

(d) The responsibility for waste handling, sterilization, and disinfection of equipment for dialysis done in the nursing home.

(6) The nursing home must ensure implementation of policies and procedures developed with the kidney center that:

(a) Meet current standards of practice;

(b) Addresses both dialysis provided by or in the nursing home as well as dialysis provided by the kidney center; and

(c) Addresses all of the nursing home responsibilities related to a resident on dialysis.

[Statutory Authority: Chapters 18.51 and 74.42 RCW. 10-02-021, § 388-97-1900, filed 12/29/09, effective 1/29/10. Statutory Authority: Chapters 18.51 and 74.42 RCW and 42 C.F.R. 489.52. 08-20-062, § 388-97-1900, filed 9/24/08, effective 11/1/08.]

WAC 388-97-2060 New construction compliance. The nursing home must ensure that:

(1) New construction, as defined in WAC 388-97-2160, complies with all the requirements of subchapter II of this chapter;

(2) New construction must maintain compliance with the regulations in effect at the time of initial submission to the department of health, certificate of need and construction review services; except if the previous construction jeopardizes resident health and safety, the department may require compliance with current construction rules;

(3) The department of health, certificate of need and construction review programs, are contacted for review and that the programs issue applicable determinations and approvals for all new construction; and

(4) Construction is completed in compliance with the final construction review services approved documents. Compliance with these standards and regulations does not relieve the nursing home of the need to comply with applicable state and local building and zoning codes.

(5) The department has done a pre-occupancy survey and has notified the nursing home that it may begin admitting residents.

[Statutory Authority: Chapters 18.51 and 74.42 RCW. 10-02-021, § 388-97-2060, filed 12/29/09, effective 1/29/10. Statutory Authority: Chapters 18.51 and 74.42 RCW and 42 C.F.R. 489.52. 08-20-062, § 388-97-2060, filed 9/24/08, effective 11/1/08.]

WAC 388-97-2280 Call systems on resident care units. The nursing home must provide a system that meets the following standards:

(1) A wired or wireless communication system which registers a call by distinctive light at the room door and by distinctive light and audible tone at the staff work station. The system must be equipped to receive resident calls from:

- (a) The bedside of each resident;
- (b) Every common area, dining and activity areas, common use toilet rooms, and other areas used by residents; and
- (c) Resident toilet, bath and shower rooms.

(2) An emergency signal device that meets the needs of the resident and adapted for easy reach by the resident. A signal device must be adapted to meet resident needs and, in the dementia unit, may be adapted for staff and family use, see WAC 388-97-2900.

[Statutory Authority: Chapters 18.51 and 74.42 RCW. 10-02-021, § 388-97-2280, filed 12/29/09, effective 1/29/10. Statutory Authority: Chapters 18.51 and 74.42 RCW and 42 C.F.R. 489.52. 08-20-062, § 388-97-2280, filed 9/24/08, effective 11/1/08.]

WAC 388-97-4166 Liability insurance required. The nursing home must:

(1) Obtain liability insurance upon licensure and maintain the insurance as required in WAC 388-97-4167 and 388-97-4168; and

(2) Have evidence of liability insurance coverage available if requested by the department.

[Statutory Authority: Chapters 18.51 and 74.42 RCW. 10-02-021, § 388-97-4166, filed 12/29/09, effective 1/29/10.]

WAC 388-97-4167 Liability insurance required—Commercial general liability insurance or business liability insurance coverage. The nursing home must have commercial general liability insurance or business liability insurance that includes:

(1) Coverage for the acts and omissions of any employee and volunteer;

(2) Coverage for bodily injury, property damage, and contractual liability;

(3) Coverage for premises, operations, independent contractors, products-completed operations, personal injury, advertising injury, and liability assumed under an insured contract; and

(4) Minimum limits of:

(a) Each occurrence at one million dollars; and

(b) General aggregate at two million dollars.

[Statutory Authority: Chapters 18.51 and 74.42 RCW. 10-02-021, § 388-97-4167, filed 12/29/09, effective 1/29/10.]

WAC 388-97-4168 Liability insurance required—Professional liability insurance coverage. The nursing home must have professional liability insurance or errors and omissions insurance. The insurance must include:

(1) Coverage for losses caused by errors and omissions of the nursing home, its employees, and volunteers; and

(2) Minimum limits of:

(a) Each occurrence at one million dollars; and

(b) Aggregate at two million dollars.

[Statutory Authority: Chapters 18.51 and 74.42 RCW. 10-02-021, § 388-97-4168, filed 12/29/09, effective 1/29/10.]

WAC 388-97-4200 Department review of initial nursing home license applications. (1) All initial nursing home license applications must be reviewed by the department under this chapter.

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

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

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

(a) The information contained in the application;

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

(c) Compliance history;

(d) Financial assessments;

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

(f) All criminal convictions, and relevant civil or administrative actions or findings including, but not limited to, findings, including professional disciplinary actions, and findings of abuse, neglect, exploitation, abandonment, or domestic violence resulting from a civil adjudication proceeding; and

(g) Other relevant information.

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

[Statutory Authority: Chapters 18.51 and 74.42 RCW. 10-02-021, § 388-97-4200, filed 12/29/09, effective 1/29/10. Statutory Authority: Chapters 18.51 and 74.42 RCW and 42 C.F.R. 489.52. 08-20-062, § 388-97-4200, filed 9/24/08, effective 11/1/08.]

WAC 388-97-4220 Reasons for denial, suspension, modification, revocation of, or refusal to renew a nursing home license. (1) The department may deny, suspend, modify, revoke, or refuse to renew a nursing home license when the department finds the proposed or current licensee, or any partner, officer, director, managing employee, owner of five percent or more of the proposed or current licensee of the

nursing home, owner of five percent or more of the assets of the nursing home, proposed or current administrator, or employee or individual providing nursing home care or services has:

- (a) Failed or refused to comply with the:
 - (i) Requirements established by chapters 18.51, 74.42, or 74.46 RCW and regulations adopted under these chapters; or
 - (ii) Medicaid requirements of Title XIX of the Social Security Act and medicaid regulations, including 42 CFR, Part 483.
- (b) A history of significant noncompliance with federal or state regulations in providing nursing home care;
- (c) No credit history or a poor credit history;
- (d) Engaged in the illegal use of drugs or the excessive use of alcohol or been convicted of "crimes relating to drugs" as defined in RCW 43.43.830, unless subsection (3)(c) applies;
- (e) Unlawfully operated a nursing home, or long term care facility as defined in RCW 70.129.010, without a license or under a revoked or suspended license;
- (f) Previously held a license to operate a hospital or any facility for the care of children or vulnerable adults, and that license has been revoked, or suspended, or the licensee did not seek renewal of the license following written notification of the licensing agency's initiation of revocation or suspension of the license;
- (g) Obtained or attempted to obtain a license by fraudulent means or misrepresentation;
- (h) Permitted, aided, or abetted the commission of any illegal act on the nursing home premises;
- (i) Been convicted of a felony or other crime that would not be automatically disqualifying under RCW 74.39A.050(8) or this chapter, if the conviction reasonably relates to the competency of the individual to own or operate a nursing home;
- (j) Had a sanction, corrective, or remedial action taken by federal, state, county or municipal officials or safety officials related to the care or treatment of children or vulnerable adults;
- (k) Failed to:
 - (i) Provide any authorization, documentation, or information the department requires in order to verify information contained in the application;
 - (ii) Meet financial obligations as the obligations fall due in the normal course of business;
 - (iii) Verify additional information the department determines relevant to the application;
 - (iv) Report abandonment, abuse, neglect or financial exploitation in violation of chapter 74.34 RCW; or in the case of a skilled nursing facility or nursing facilities, failure to report as required by 42 C.F.R. 483.13; or
 - (v) Pay a civil fine the department assesses under this chapter within ten days after assessment becomes final.
- (l) Been certified pursuant to RCW 74.20A.320 as a person who is not in compliance with a child support order (license suspension only);
- (m) Knowingly or with reason to know makes a false statement of a material fact in the application for a license or license renewal, in attached data, or in matters under department investigation;

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

(o) Willfully prevented, interfered with, or attempted to impede the work of authorized department representatives in the:

- (i) Lawful enforcement of provisions under this chapter or chapters 18.51 or 74.42 RCW; or
 - (ii) Preservation of evidence of violations of provisions under this chapter or chapters 18.51 or 74.42 RCW.
- (p) Retaliated against a resident or employee initiating or participating in proceedings specified under RCW 18.51.220; or
- (q) Discriminated against medicaid recipients as prohibited under RCW 74.42.055.

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

- (a) Whether the violation resulted in a significant harm or a serious and immediate threat to the health, safety, or welfare of any resident;
- (b) Whether the proposed or current licensee promptly investigated the circumstances surrounding any violation and took steps to correct and prevent a recurrence of a violation;
- (c) The history of surveys and complaint investigation findings and any resulting enforcement actions;
- (d) Repeated failure to comply with regulations;
- (e) Inability to attain compliance with cited deficiencies within a reasonable period of time; and
- (f) The number of violations relative to the number of facilities the proposed or current licensee, or any partner, officer, director, managing employee, employee or individual providing nursing home care or services has been affiliated within the past ten years, or owner of five percent or more of the proposed or current licensee or of the assets of the nursing home.

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

- (a) Convicted of a "crime against children or other persons" as defined under RCW 43.43.830 unless the individual has been convicted of one of the two crimes listed below and the required number of years has passed between the most recent conviction and the date of the application for employment:
 - (i) Simple assault, assault in the fourth degree, or the same offense as it may hereafter be renamed, and three or more years have passed;
 - (ii) Prostitution, or the same offense as it may hereafter be renamed, and three or more years have passed.
- (b) Convicted of a "crime relating to financial exploitation" as defined under RCW 43.43.830 unless the individual has been convicted of one of the three crimes listed below and the required number of years has passed between the

most recent conviction and the date of the application for employment:

(i) Theft in the second degree, or the same offense as it may hereafter be renamed, and five or more years have passed;

(ii) Theft in the third degree, or the same offense as it may hereafter be renamed, and three or more years have passed; or

(iii) Forgery, or the same offense as it may hereafter be renamed, and five or more years have passed.

(c) Convicted of:

(i) Violation of the imitation controlled substances act (VICSA);

(ii) Violation of the uniform controlled substances act (VUCSA);

(iii) Violation of the uniform legend drug act (VULDA); or

(iv) Violation of the uniform precursor drug act (VUPDA).

(d) Convicted of sending or bringing into the state depictions of a minor engaged in sexually explicit conduct;

(e) Convicted of criminal mistreatment;

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

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

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

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

(j) Found to have abused or neglected a child, and the finding is:

(i) Listed on the department's background check central unit (BCCU) report; or

(ii) Disclosed by the individual, except for findings made before December, 1998.

(k) Found to have abandoned, abused, neglected, or financially exploited a vulnerable adult, and the finding is:

(i) Listed on any registry, including the department registry;

(ii) Listed on the department's background check central unit (BCCU) report; or

(iii) Disclosed by the individual, except for adult protective services findings made before October, 2003.

[Statutory Authority: Chapters 18.51 and 74.42 RCW. 10-02-021, § 388-97-4220, filed 12/29/09, effective 1/29/10. Statutory Authority: Chapters 18.51 and 74.42 RCW and 42 C.F.R. 489.52. 08-20-062, § 388-97-4220, filed 9/24/08, effective 11/1/08.]

WAC 388-97-4320 Relocation of residents. (1) In the event of license revocation or suspension, decertification, or other emergency closures the department will:

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

(b) Assist with residents' relocation and identify possible alternative living choices and locations; and

(c) The nursing home will assist the residents to the extent it is directed to do so by the department.

(2) When a resident's relocation occurs due to an emergency closure from a natural disaster, the nursing home may not be required to cease its business operations unless directed to do so by the department.

(3) When a resident's relocation occurs due to a nursing home's voluntary closure, or voluntary termination of its medicare or medicaid contract or both, the nursing home must:

(a) Notify the department and all residents and resident representatives in accordance with WAC 388-97-1640;

(b) Notify the Centers for Medicare and Medicaid Services and the public as required by 42 C.F.R. 489.52, or a successor regulation, if the closure or termination affects the provision of medicare services; and

(c) Provide appropriate discharge planning and coordination for all residents including a plan to the department for safe and orderly transfer or discharge of residents from the nursing home.

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

[Statutory Authority: Chapters 18.51 and 74.42 RCW. 10-02-021, § 388-97-4320, filed 12/29/09, effective 1/29/10. Statutory Authority: Chapters 18.51 and 74.42 RCW and 42 C.F.R. 489.52. 08-20-062, § 388-97-4320, filed 9/24/08, effective 11/1/08.]

WAC 388-97-4340 License relinquishment. (1) A nursing home licensee must voluntarily relinquish its license when:

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

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

(2) The nursing home may not be required to relinquish its license when residents must be relocated due to emergency closures from natural disasters.

(3) The relinquished license must be returned to the department.

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

[Statutory Authority: Chapters 18.51 and 74.42 RCW. 10-02-021, § 388-97-4340, filed 12/29/09, effective 1/29/10. Statutory Authority: Chapters 18.51 and 74.42 RCW and 42 C.F.R. 489.52. 08-20-062, § 388-97-4340, filed 9/24/08, effective 11/1/08.]

WAC 388-97-4425 Notice—Service complete. Service of the department notices is complete when:

(1) Personal service is made;

(2) The notice is addressed to the facility or to the individual at his or her last known address, and deposited in the United States mail;

(3) The notice is faxed and the department receives evidence of transmission;

(4) Notice is delivered to a commercial delivery service with charges prepaid; or

(5) Notice is delivered to a legal messenger service with charges prepaid.

[Statutory Authority: Chapters 18.51 and 74.42 RCW. 10-02-021, § 388-97-4425, filed 12/29/09, effective 1/29/10.]

WAC 388-97-4430 Notice—Proof of service. The department may establish proof of service by any of the following:

- (1) A declaration of personal service;
- (2) An affidavit or certificate of mailing to the nursing home or to the individual to whom the notice is directed;
- (3) A signed receipt from the person who accepted the certified mail, the commercial delivery service, or the legal messenger service package; or
- (4) Proof of fax transmission.

[Statutory Authority: Chapters 18.51 and 74.42 RCW. 10-02-021, § 388-97-4430, filed 12/29/09, effective 1/29/10.]

WAC 388-97-4440 Appeal rights. (1) The appeal rights in this section apply to any appealable action taken by the department under chapters 18.51, 74.42 and 74.39A RCW. Notice and appeal requirements for resident protection program findings are described in WAC 388-97-0720 and 388-97-0740.

(2) The following actions may be appealed:

(a) Imposition of a penalty under RCW 18.51.060 or 74.42.580;

(b) A denial of a license under RCW 18.51.054, a license suspension under RCW 18.51.067 or a condition on a license under RCW 74.39A.050; or

(c) Deficiencies cited on the state survey report.

(3) The appeal process will be governed by the Administrative Procedure Act (chapter 34.05 RCW), RCW 18.51.065 and 74.42.580, chapter 388-02 WAC and this chapter. If there is a conflict between chapter 388-02 WAC and this chapter, this chapter will govern.

(4) The purpose of an administrative hearing will be to review actions taken by the department under chapters 18.51, 74.42 or 74.39A RCW, and under this chapter.

(5) The office of administrative hearings must receive an administrative hearing request from the applicant, licensee or nursing home within twenty days of receipt of written notification of the department's action listed in subsection (2) of this section. Further information about administrative hear-

ings is available in chapter 388-02 WAC and at the office of administrative hearing (OAH) web site: www.oah.wa.gov.

(6) Orders of the department imposing a stop placement, license suspension, emergency closure emergency transfer of residents, temporary management or conditions on a license are effective immediately upon verbal or written notice and must remain in effect until they are rescinded by the department or through the state administrative appeals process.

(7) Deficiencies cited on the federal survey report may not be appealed through the state administrative appeals process. If a federal remedy is imposed, the Centers for Medicare and Medicaid Services will notify the nursing facility of appeal rights under the federal administrative appeals process.

[Statutory Authority: Chapters 18.51 and 74.42 RCW. 10-02-021, § 388-97-4440, filed 12/29/09, effective 1/29/10. Statutory Authority: Chapters 18.51 and 74.42 RCW and 42 C.F.R. 489.52. 08-20-062, § 388-97-4440, filed 9/24/08, effective 11/1/08.]

Chapter 388-105 WAC

MEDICAID RATES FOR CONTRACTED HOME AND COMMUNITY RESIDENTIAL CARE SERVICES

WAC

- 388-105-0005 The daily medicaid payment rates for clients assessed using the comprehensive assessment reporting evaluation (CARE) tool and that reside in adult family homes (AFH) and boarding homes contracted to provide assisted living (AL), adult residential care (ARC), and enhanced adult residential care (EARC) services.
- 388-105-0045 Bed or unit hold—Medicaid resident discharged for a hospital or nursing home stay from an adult family home (AFH) or a boarding home contracted to provide adult residential care (ARC), enhanced adult residential care (EARC), or assisted living services (AL).

WAC 388-105-0005 The daily medicaid payment rates for clients assessed using the comprehensive assessment reporting evaluation (CARE) tool and that reside in adult family homes (AFH) and boarding homes contracted to provide assisted living (AL), adult residential care (ARC), and enhanced adult residential care (EARC) services. For contracted AFH and boarding homes contracted to provide AL, ARC, and EARC services, the department pays the following daily rates for care of a medicaid resident:

COMMUNITY RESIDENTIAL DAILY RATES FOR CLIENTS ASSESSED USING CARE					
KING COUNTY					
CARE CLASSIFICATION	AL Without Capital	AL With Capital	ARC	EARC	AFH
	Add-on	Add-on			
A Low	\$66.45	\$71.87	\$46.99	\$46.99	\$46.39
A Med	\$71.95	\$77.37	\$53.32	\$53.32	\$52.64
A High	\$80.74	\$86.16	\$58.56	\$58.56	\$58.90
B Low	\$66.45	\$71.87	\$46.99	\$46.99	\$46.62
B Med	\$74.15	\$79.57	\$59.65	\$59.65	\$59.19
B Med-High	\$83.98	\$89.40	\$63.43	\$63.43	\$63.42
B High	\$88.41	\$93.83	\$72.51	\$72.51	\$72.51
C Low	\$71.95	\$77.37	\$53.32	\$53.32	\$52.64
C Med	\$80.74	\$86.16	\$66.93	\$66.93	\$67.22
C Med-High	\$100.51	\$105.93	\$89.22	\$89.22	\$88.06
C High	\$101.51	\$106.93	\$90.07	\$90.07	\$89.29

Medicaid Rates for Contracted Services

388-105-0005

CARE CLASSIFICATION	AL Without Capital	AL With Capital	ARC	EARC	AFH
	Add-on	Add-on			
D Low	\$74.15	\$79.57	\$72.07	\$72.07	\$68.52
D Med	\$82.39	\$87.81	\$83.50	\$83.50	\$83.87
D Med-High	\$106.54	\$111.96	\$106.19	\$106.19	\$100.92
D High	\$114.81	\$120.23	\$114.81	\$114.81	\$114.90
E Med	\$138.75	\$144.17	\$138.75	\$138.75	\$138.84
E High	\$162.69	\$168.11	\$162.69	\$162.69	\$162.79

COMMUNITY RESIDENTIAL DAILY RATES FOR CLIENTS ASSESSED USING CARE METROPOLITAN COUNTIES*					
CARE CLASSIFICATION	AL Without Capital	AL With Capital	ARC	EARC	AFH
	Add-on	Add-on			
A Low	\$60.95	\$65.87	\$46.99	\$46.99	\$46.39
A Med	\$64.26	\$69.18	\$51.21	\$51.21	\$50.55
A High	\$78.54	\$83.46	\$55.84	\$55.84	\$55.76
B Low	\$60.95	\$65.87	\$46.99	\$46.99	\$46.62
B Med	\$69.74	\$74.66	\$56.49	\$56.49	\$56.04
B Med-High	\$79.00	\$83.92	\$60.07	\$60.07	\$60.10
B High	\$86.22	\$91.14	\$70.46	\$70.46	\$70.46
C Low	\$64.26	\$69.18	\$51.42	\$51.42	\$50.93
C Med	\$78.54	\$83.46	\$66.07	\$66.07	\$65.58
C Med-High	\$97.20	\$102.12	\$82.89	\$82.89	\$81.82
C High	\$98.17	\$103.09	\$88.17	\$88.17	\$86.81
D Low	\$69.74	\$74.66	\$71.08	\$71.08	\$67.01
D Med	\$80.14	\$85.06	\$81.83	\$81.83	\$81.61
D Med-High	\$103.04	\$107.96	\$103.56	\$103.56	\$97.84
D High	\$111.65	\$116.57	\$111.65	\$111.65	\$111.16
E Med	\$134.44	\$139.36	\$134.44	\$134.44	\$133.95
E High	\$157.23	\$162.15	\$157.23	\$157.23	\$156.74

*Benton, Clark, Franklin, Island, Kitsap, Pierce, Snohomish, Spokane, Thurston, Whatcom, and Yakima counties.

COMMUNITY RESIDENTIAL DAILY RATES FOR CLIENTS ASSESSED USING CARE NONMETROPOLITAN COUNTIES**					
CARE CLASSIFICATION	AL Without Capital	AL With Capital	ARC	EARC	AFH
	Add-on	Add-on			
A Low	\$59.87	\$65.11	\$46.99	\$46.99	\$46.39
A Med	\$64.26	\$69.50	\$50.16	\$50.16	\$49.52
A High	\$78.54	\$83.78	\$54.94	\$54.94	\$54.73
B Low	\$59.87	\$65.11	\$46.99	\$46.99	\$46.62
B Med	\$69.74	\$74.98	\$55.44	\$55.44	\$55.00
B Med-High	\$79.00	\$84.24	\$58.94	\$58.94	\$58.92
B High	\$86.22	\$91.46	\$66.64	\$66.64	\$66.64
C Low	\$64.26	\$69.50	\$50.16	\$50.16	\$49.52
C Med	\$78.54	\$83.78	\$62.45	\$62.45	\$63.07
C Med-High	\$97.20	\$102.44	\$79.72	\$79.72	\$78.70
C High	\$98.17	\$103.41	\$83.34	\$83.34	\$82.10
D Low	\$69.74	\$74.98	\$67.19	\$67.19	\$63.37
D Med	\$80.14	\$85.38	\$77.35	\$77.35	\$77.17
D Med-High	\$103.04	\$108.28	\$97.88	\$97.88	\$92.52
D High	\$105.53	\$110.77	\$105.53	\$105.53	\$105.10
E Med	\$127.07	\$132.31	\$127.07	\$127.07	\$126.64
E High	\$148.61	\$153.85	\$148.61	\$148.61	\$148.19

**** Nonmetropolitan counties:** Adams, Asotin, Chelan, Clallam, Columbia, Cowlitz, Douglas, Ferry, Garfield, Grant, Grays Harbor, Jefferson, Kittitas, Klickitat, Lewis, Lincoln, Mason, Okanogan, Pacific, Pend Orielle, San Juan, Skagit, Skamania, Stevens, Wahkiakum, Walla Walla and Whitman.

[Statutory Authority: RCW 74.39A.030(3), 18.20.290, and 2009 c 564 § 206(4). 09-20-011, § 388-105-0005, filed 9/25/09, effective 10/26/09. Statutory Authority: RCW 74.39A.030 (3)(a). 09-11-053, § 388-105-0005, filed 5/13/09, effective 6/13/09. Statutory Authority: Chapter 74.39A RCW, RCW 18.20.290, 2006 c 372, 260, and 64. 06-19-017, § 388-105-0005, filed 9/8/06, effective 10/9/06. Statutory Authority: Chapter 74.39A RCW. 06-07-013, § 388-105-0005, filed 3/3/06, effective 4/3/06. Statutory Authority: RCW 74.39A.030, 2003 c 231. 04-09-092, § 388-105-0005, filed 4/20/04, effective 5/21/04. Statutory Authority: 2002 c 371. 02-22-058, § 388-105-0005, filed 10/31/02, effective 12/1/02. Statutory Authority: 2001 c 7 § 206. 01-21-077, § 388-105-0005, filed 10/18/01, effective 11/18/01. Statutory Authority: Chapter 74.39A RCW. 01-14-056, § 388-105-0005, filed 6/29/01, effective 7/30/01.]

WAC 388-105-0045 Bed or unit hold—Medicaid resident discharged for a hospital or nursing home stay from an adult family home (AFH) or a boarding home contracted to provide adult residential care (ARC), enhanced adult residential care (EARC), or assisted living services (AL). (1) When an AFH, ARC, EARC, or AL contracts to provide services under chapter 74.39A RCW, the AFH, ARC, EARC, and AL contractor must hold a medicaid eligible resident's bed or unit when:

(a) Short-term care is needed in a nursing home or hospital;

(b) The resident is likely to return to the AFH, ARC, EARC, or AL; and

(c) Payment is made under subsection (3) of this section.

(2)(a) When the department pays the contractor to hold the medicaid resident's bed or unit during the resident's short-term nursing home or hospital stay, the contractor must hold the bed or unit for up to twenty days. If during the twenty day bed hold period, a department case manager determines that the medicaid resident's hospital or nursing home stay is not short term and the medicaid resident is unlikely to return to the AFH, ARC, EARC or AL facility, the department will cease paying for the bed hold the day the case manager notifies the contractor of his/her decision.

(b) A medicaid resident's discharge from an AFH, ARC, EARC, or an AL facility for a short term stay in a nursing home or hospital must be longer than twenty-four hours before subsection (3) of WAC 388-105-0045 applies.

(c) When a medicaid resident on bed hold leave returns to an AFH, ARC, EARC, or an AL facility but remains less than twenty-four hours, the bed hold leave on which the resident returned applies after the resident's discharge. A new bed hold leave will begin only when the returned resident has resided in the facility for more than twenty-four hours before the resident's next discharge.

(d) When an AFH, ARC, EARC, or AL facility discharges a resident to a nursing home or hospital and the resident is out of the facility for more than twenty-four hours, then by using e-mail, fax or telephone, the facility must notify the department of the resident's discharge within twenty-four hours after the initial twenty-four hours has passed. When the end of the initial twenty-four hours falls on a weekend or state holiday, then the facility must notify the department of

the discharge within twenty-four hours after the weekend or holiday.

(3) The department will compensate the contractor for holding the bed or unit for the:

(a) First through seventh day at seventy percent of the medicaid daily rate paid for care of the resident before the hospital or nursing home stay; and

(b) Eighth through the twentieth day, at eleven dollars a day.

(4) The AFH, ARC, EARC, or AL facility may seek third-party payment to hold a bed or unit for twenty-one days or longer. The third-party payment shall not exceed the medicaid daily rate paid to the facility for the resident. If third-party payment is not available and the returning medicaid resident continues to meet the admission criteria under chapter 388-71 and/or 388-106 WAC, then the medicaid resident may return to the first available and appropriate bed or unit.

(5) The department's social worker or case manager determines whether the:

(a) Stay in a nursing home or hospital will be short-term; and

(b) Resident is likely to return to the AFH, ARC, EARC, or AL facility.

(6) When the resident's stay in the hospital or nursing home exceeds twenty days or the department's social worker or case manager determines that the medicaid resident's stay in the nursing home or hospital is not short-term and the resident is unlikely to return to the AFH, ARC, EARC, or AL facility, then only subsection (4) of this section applies to any private contractual arrangements that the contractor may make with a third party in regard to the discharged resident's unit or bed.

[Statutory Authority: RCW 74.39A.030(3), 18.20.290, and 2009 c 564 § 206(4). 09-20-011, § 388-105-0045, filed 9/25/09, effective 10/26/09. Statutory Authority: RCW 74.39A.030 (3)(a). 09-11-053, § 388-105-0045, filed 5/13/09, effective 6/13/09. Statutory Authority: Chapter 74.39A RCW, RCW 18.20.290, 2006 c 372, 260, and 64. 06-19-017, § 388-105-0045, filed 9/8/06, effective 10/9/06. Statutory Authority: Chapter 74.39A RCW. 06-07-013, § 388-105-0045, filed 3/3/06, effective 4/3/06. Statutory Authority: RCW 74.39A.030, 2003 c 231. 04-09-092, § 388-105-0045, filed 4/20/04, effective 5/21/04.]

Chapter 388-110 WAC

CONTRACTED RESIDENTIAL CARE SERVICES

WAC

388-110-140 Assisted living services facility physical requirements.

WAC 388-110-140 Assisted living services facility physical requirements. (1) Licensed boarding homes with an assisted living services contract are required to:

(a) Meet the physical requirements that were in effect at the time of initial contracting; or

(b) If there is a break in contract, meet the requirements in effect at the time of the new contract.

(2) The contractor must ensure each resident has a private apartment-like unit. Each unit must have at least the following:

(a) A minimum area of two hundred twenty square feet. The minimum area may include counters, closets and built-ins, but must exclude the bathroom;

(b) A private bathroom. The private bathroom must be equipped with a sink, a toilet, and a shower or bathtub. At least one wheelchair accessible bathroom with a roll-in shower that is at least forty-eight inches by thirty-six inches must be provided for every two residents whose care is partially or fully funded through the assisted living contract;

(c) A lockable entry door;

(d) A kitchen area. The kitchen area must be equipped with:

(i) A refrigerator;

(ii) A microwave oven, range or cooktop;

(iii) A counter mounted kitchen sink, with inside dimensions of at least twenty-one inches by fifteen inches, and a minimum depth of seven inches;

(iv) A storage space for utensils and supplies; and [a]

(v) A work counter surface, with a minimum usable surface area of thirty inches in length by twenty-four inches deep, a maximum height of thirty-four inches, and having a clear knee space beneath at least twenty-seven inches in height and thirty inches in length; and

(e) A living area wired for telephone and, where available in the geographic location, wired for television service.

(3) Married couples may share an apartment-like unit under an assisted living contract if:

(a) Both residents understand they are each entitled to live in a separate private unit; and

(b) Both residents mutually request to share a single apartment-like unit.

(4) The contractor must provide a private accessible mailbox for each resident whose care is partially or fully funded through the assisted living contract.

(5) The contractor must provide homelike smoke-free common areas with sufficient space for socialization designed to meet resident needs. Common areas must be available for resident use at any time provided such use does not disturb the health or safety of other residents. The contractor must make access to outdoor areas available to all residents.

(6) The contractor must provide a space for residents to meet with family and friends outside the resident's living unit.

(7) The department may grant an exemption to the requirements of this section in accordance with WAC 388-78A-2820.

[Statutory Authority: Chapters 74.39A and 18.20 RCW. 09-19-042, § 388-110-140, filed 9/10/09, effective 10/11/09. Statutory Authority: RCW 74.39A.010, 74.39A.020, 74.39A.060, 74.39A.070, and chapter 74.39A RCW. 04-16-063 and 04-18-001, § 388-110-140, filed 7/30/04 and 8/19/04, effective 9/19/04. Statutory Authority: RCW 74.39A.010, 74.39A.020, 74.39A.060, 74.39A.080, 74.39A.170, 18.88A.210-[18.88A.]240 and 70.129.040. 96-11-045 (Order 3979), § 388-110-140, filed 5/8/96, effective 6/8/96.]

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 388-112 WAC

RESIDENTIAL LONG-TERM CARE SERVICES

WAC

388-112-0175 What knowledge and skills must nurse delegation core training include?

388-112-0180	Is competency testing required for nurse delegation core training?
388-112-0196	What is specialized diabetes nurse delegation training?
388-112-01961	What knowledge and skills must specialized diabetes nurse delegation training include?
388-112-01962	Is competency testing required for the specialized diabetes nurse delegation training?
388-112-01963	Is there a challenge test for specialized diabetes nurse delegation training?
388-112-01964	What documentation is required for successful completion of specialized diabetes nurse delegation training?
388-112-01965	Who is required to complete the specialized diabetes nurse delegation training, and when?
388-112-0250	What is CPR training?
388-112-02610	What is HIV/AIDS training?
388-112-02615	Is competency testing required for HIV/AIDS training?
388-112-02620	Is there a challenge test for HIV/AIDS training?
388-112-02625	What documentation is required for completion of HIV/AIDS training?
388-112-02630	Who is required to complete HIV/AIDS training, and when?

WAC 388-112-0175 What knowledge and skills must nurse delegation core training include? Only the curriculum developed by DSHS, "Nurse Delegation for Nursing Assistants," meets the training requirement for nurse delegation core training.

[Statutory Authority: 2008 c 146, RCW 18.20.090, 74.08.090, chapter 70.128 RCW. 09-03-066, § 388-112-0175, filed 1/14/09, effective 2/14/09. Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233. 02-15-065, § 388-112-0175, filed 7/11/02, effective 8/11/02.]

WAC 388-112-0180 Is competency testing required for nurse delegation core training? Passing the DSHS competency test is required for successful completion of nurse delegation core training, as provided under WAC 388-112-0290 through 388-112-0315.

[Statutory Authority: 2008 c 146, RCW 18.20.090, 74.08.090, chapter 70.128 RCW. 09-03-066, § 388-112-0180, filed 1/14/09, effective 2/14/09. Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233. 02-15-065, § 388-112-0180, filed 7/11/02, effective 8/11/02.]

WAC 388-112-0196 What is specialized diabetes nurse delegation training? Specialized diabetes nurse delegation training is the required training for nursing assistants, certified or registered, who will be delegated the task of insulin injections. DSHS approves the instructors for specialized diabetes nurse delegation training.

[Statutory Authority: 2008 c 146, RCW 18.20.090, 74.08.090, chapter 70.128 RCW. 09-03-066, § 388-112-0196, filed 1/14/09, effective 2/14/09.]

WAC 388-112-01961 What knowledge and skills must specialized diabetes nurse delegation training include? Specialized diabetes nurse delegation training consists of three modules on diabetes, insulin, and injections. Only the curriculum developed by DSHS, "Nurse Delegation for Nursing Assistants: Special Focus on Diabetes," may be used for the specialized diabetes nurse delegation training.

[Statutory Authority: 2008 c 146, RCW 18.20.090, 74.08.090, chapter 70.128 RCW. 09-03-066, § 388-112-01961, filed 1/14/09, effective 2/14/09.]

WAC 388-112-01962 Is competency testing required for the specialized diabetes nurse delegation training? Passing the DSHS competency test is required for successful

completion of the specialized diabetes nurse delegation training, as provided under WAC 388-112-0290 through 388-112-0315.

[Statutory Authority: 2008 c 146, RCW 18.20.090, 74.08.090, chapter 70.128 RCW. 09-03-066, § 388-112-01962, filed 1/14/09, effective 2/14/09.]

WAC 388-112-01963 Is there a challenge test for specialized diabetes nurse delegation training? There is no challenge test for specialized diabetes nurse delegation training.

[Statutory Authority: 2008 c 146, RCW 18.20.090, 74.08.090, chapter 70.128 RCW. 09-03-066, § 388-112-01963, filed 1/14/09, effective 2/14/09.]

WAC 388-112-01964 What documentation is required for successful completion of specialized diabetes nurse delegation training? (1) Specialized diabetes nurse delegation training must be documented by a certificate of successful completion of training, issued by the instructor or training entity, that includes:

- (a) The name of the trainee;
- (b) The name of the training;
- (c) The name of the training entity giving the training;
- (d) The instructor's name and signature; and
- (e) The date(s) of training.

(2) The trainee must be given an original certificate. Adult family homes and boarding homes must keep a copy of the certificate on file.

[Statutory Authority: 2008 c 146, RCW 18.20.090, 74.08.090, chapter 70.128 RCW. 09-03-066, § 388-112-01964, filed 1/14/09, effective 2/14/09.]

WAC 388-112-01965 Who is required to complete the specialized diabetes nurse delegation training, and when? Specialized diabetes nurse delegation training is required before a nursing assistant, certified or registered, who meets the qualifications in WAC 388-112-0195, may be delegated the task of insulin injections.

[Statutory Authority: 2008 c 146, RCW 18.20.090, 74.08.090, chapter 70.128 RCW. 09-03-066, § 388-112-01965, filed 1/14/09, effective 2/14/09.]

WAC 388-112-0250 What is CPR training? Cardiopulmonary resuscitation (CPR) training is training provided by an authorized CPR instructor. Trainees must successfully complete the written and skills demonstrations tests.

[Statutory Authority: 2008 c 146, RCW 18.20.090, 74.08.090, chapter 70.128 RCW. 09-03-066, § 388-112-0250, filed 1/14/09, effective 2/14/09. Statutory Authority: RCW 18.20.090, 70.128.040, 70.128.230. 06-16-072, § 388-112-0250, filed 7/28/06, effective 8/28/06. Statutory Authority: RCW 18.20.090, 70.128.040, 74.39A.050, 34.05.020, 2000 c 121, and 2002 c 233. 02-15-066, § 388-112-0250, filed 7/11/02, effective 8/11/02.]

WAC 388-112-02610 What is HIV/AIDS training? It is recommended that the HIV/AIDS training be taught in classroom style by an experienced and knowledgeable instructor who can answer technical questions. The Washington state department of health's "KNOW HIV Prevention Education for Health Care Facility Employees" manual is the state model, designed as a complete training. HIV/AIDS

training must be based on this curriculum, be a minimum of two to three hours, and include the following topics:

- (1) Causes of HIV and how it is spread, including:
 - (a) Reported cases in the United States and Washington state; and
 - (b) Risk groups and risky behaviors.
- (2) Transmission and infection control, including:
 - (a) Infection control precautions;
 - (b) Factors affecting the risk for transmission; and
 - (c) Risks for transmission to health care workers.
- (3) Legal and ethical issues, including:
 - (a) Confidentiality;
 - (b) Informed consent;
 - (c) Legal reporting requirements;
 - (d) Ethical issues; and
 - (e) Civil rights.
- (4) Psychosocial issues, including:
 - (a) Personal impact of HIV continuum;
 - (b) The human response to death and dying;
 - (c) Issues for care providers;
 - (d) Family issues; and
 - (e) Special populations.

[Statutory Authority: 2008 c 146, RCW 18.20.090, 74.08.090, chapter 70.128 RCW. 09-03-066, § 388-112-02610, filed 1/14/09, effective 2/14/09.]

WAC 388-112-02615 Is competency testing required for HIV/AIDS training? No competency testing is required for HIV/AIDS training.

[Statutory Authority: 2008 c 146, RCW 18.20.090, 74.08.090, chapter 70.128 RCW. 09-03-066, § 388-112-02615, filed 1/14/09, effective 2/14/09.]

WAC 388-112-02620 Is there a challenge test for HIV/AIDS training? There is no challenge test for HIV/AIDS training.

[Statutory Authority: 2008 c 146, RCW 18.20.090, 74.08.090, chapter 70.128 RCW. 09-03-066, § 388-112-02620, filed 1/14/09, effective 2/14/09.]

WAC 388-112-02625 What documentation is required for completion of HIV/AIDS training? HIV/AIDS training must be documented by:

- (1) Proof of registration, certification or licensure from the department of health; or
- (2) A certificate of completion of the state developed twenty-eight hour revised fundamentals of caregiving, completed after December 19, 2003; or
- (3) A certificate of completion of HIV/AIDS training issued by the instructor or training entity that includes:
 - (a) The name of the trainee;
 - (b) The name of the training curriculum;
 - (c) The name of the home or training entity giving the training;
 - (d) The instructor's name and signature; and
 - (e) The date(s) of the training session(s).
- (4) The trainee must be given an original certificate. The facility or entity must keep a copy of the certificate on file.

[Statutory Authority: 2008 c 146, RCW 18.20.090, 74.08.090, chapter 70.128 RCW. 09-03-066, § 388-112-02625, filed 1/14/09, effective 2/14/09.]

WAC 388-112-02630 Who is required to complete HIV/AIDS training, and when? Adult family home and boarding home staff who have potential exposure to bodily fluids must complete HIV/AIDS training.

(1) Licensed, certified or registered staff must meet the HIV/AIDS training requirements for their specific department of health license, certification or registration prior to obtaining a health care credential.

(2) All other adult family home and boarding home staff must complete the HIV/AIDS training, as defined in WAC 388-112-02610 within thirty days of employment.

[Statutory Authority: 2008 c 146, RCW 18.20.090, 74.08.090, chapter 70.128 RCW. 09-03-066, § 388-112-02630, filed 1/14/09, effective 2/14/09.]

Chapter 388-310 WAC WORKFIRST

WAC

388-310-0200	WorkFirst—Activities.
388-310-0350	WorkFirst—Other exemptions from mandatory participation.
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388-310-0500	WorkFirst—Individual responsibility plan.
388-310-0700	WorkFirst—Comprehensive evaluation.
388-310-0800	WorkFirst—Support services.
388-310-0900	WorkFirst—Basic education.
388-310-1000	WorkFirst—Vocational education.
388-310-1050	WorkFirst—Skills enhancement training.

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

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

(i) Are receiving TANF or SFA cash assistance because you are pregnant or the parent or adult in the home; and

(ii) 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):

(a) Paid employment (see WAC 388-310-0400 (2)(a) and 388-310-1500);

(b) Self employment (see WAC 388-310-1700);

(c) Job search (see WAC 388-310-0600);

(d) Community jobs (see WAC 388-310-1300)

(e) Work experience (see WAC 388-310-1100);

(f) On-the-job training (see WAC 388-310-1200);

(g) Vocational educational training (see WAC 388-310-1000);

(h) Basic education activities (see WAC 388-310-0900);

(i) Job skills training (see WAC 388-310-1050);

(j) Community service (see WAC 388-310-1400);

(k) Activities provided by tribal governments for tribal members and other American Indians (see WAC 388-310-1400(1) and 388-310-1900);

(l) 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

(m) 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; and/or

(n) Up to ten hours of financial literacy activities to help you become self-sufficient and financially stable.

(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:

(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 74.04.050, 74.04.055, 74.04.057, 74.08.090, and 74.08A.340. 09-15-084, § 388-310-0200, filed 7/14/09, effective 8/14/09. Statutory Authority: RCW 74.04.050, 74.08.090, 74.08A.340, and 2006 c 107. 06-24-023, § 388-310-0200, filed 11/29/06, effective 12/30/06. 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 388-310-0350 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 may 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 a 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.)

(7) For time-limited extensions, see WAC 388-484-0006.

[Statutory Authority: RCW 74.04.050, 74.08.090, and 74.08A.340. 09-16-079, § 388-310-0350, filed 7/31/09, effective 9/1/09; 03-24-057, § 388-310-0350, filed 12/1/03, effective 1/1/04. 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 you have participated in a comprehensive evaluation of elements related to 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.

If you are a mandatory participant, your case manager will refer you to WorkFirst 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 participate the equivalent of twenty or more hours a week in job search, vocational education, issue resolution, or paid or unpaid work that meets the federal defini-

tion of core activities, which may include work of 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) How will I know what my participation requirements are?

(a) Your individual responsibility plan will describe what you need to do to be able to enter job search or other WorkFirst activities and then find a job (see WAC 388-310-0500 and 388-310-0700).

(b) If you enter the pregnancy to employment pathway (described in WAC 388-310-1450(3)), you must take part in an assessment.

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

If you do not participate in creating an individual responsibility plan, job search, or in the activities listed in your individual responsibility plan, and you do not have a good reason, the department will follow the sanction rules in WAC 388-310-1600.

[Statutory Authority: 45 C.F.R. 260, 42 U.S.C. 601, chapters 74.08A and 74.12 RCW, RCW 74.04.050, 74.04.055, 74.08.090, and 74.04.057. 09-14-019, § 388-310-0400, filed 6/22/09, effective 7/23/09. Statutory Authority: RCW 74.04.050, 74.04.055, 74.08.090. 08-07-046, § 388-310-0400, filed 3/14/08, effective 5/1/08. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 06-08-044, § 388-310-0400, filed 3/30/06, effective 6/1/06. 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

(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 or to provide proof of your employment hours.

(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 comprehensive evaluation (see WAC 388-310-0700) when available 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.

(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 when possible to explain your situation, or as soon as possible thereafter. 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 when possible, or as soon as possible thereafter, 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: 45 C.F.R. 260, 42 U.S.C. 601, chapters 74.08A and 74.12 RCW, RCW 74.04.050, 74.04.055, 74.08.090, and 74.04.057. 09-14-019, § 388-310-0500, filed 6/22/09, effective 7/23/09. Statutory Authority: RCW 74.04.050, 74.04.055, 74.08.090. 08-07-046, § 388-310-0500, filed 3/14/08, effective 5/1/08. Statutory Authority: RCW 74.04.050, 74.04.055, 74.08.090. 06-08-044, § 388-310-0500, filed 3/30/06, effective 6/1/06. 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 388-310-0700 WorkFirst—Comprehensive evaluation. (1) Why do I receive a comprehensive evaluation?

You participate in a comprehensive evaluation with your case manager and other WorkFirst staff to determine:

- (a) Your employment strengths, your educational background, family situation and other factors; and
- (b) Which WorkFirst activities you need to become employed.

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

(a) The comprehensive evaluation is a series of questions, answers and evaluations focused on your strengths, job skills, education and other relevant elements. The results of the comprehensive evaluation are used to determine your ability to find and keep a job in your local labor market and what WorkFirst activities will help you prepare for and find work. It includes:

(i) An employability evaluation with your case manager, discussing important issues that can affect your ability to find a job, like educational background, employment history, child care, family violence or substance abuse. Your case manager will also ask you a few questions to find out if you might benefit from engaging in financial literacy activities such as money management training or any other type of credit counseling service. If so, we will tell you how to get this information.

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

(c) After your comprehensive evaluation, you may receive more assessments to find out if you need additional services. For example, you may receive an educational skills assessment and/or evaluation after referral to an education and training activity.

[Statutory Authority: RCW 74.04.050, 74.08.090, and 74.08A.340. 09-16-100, § 388-310-0700, filed 8/4/09, effective 9/4/09. Statutory Authority: RCW 74.04.050, 74.08.090, 74.08A.340, and 2006 c 107. 06-24-023, § 388-310-0700, filed 11/29/06, effective 12/30/06. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 06-08-044, § 388-310-0700, filed 3/30/06, effective 6/1/06. 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?

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People who can get support services include:

(a) WorkFirst participants who receive a TANF cash grant;

(b) Sanctioned WorkFirst participants during the required participation before the sanction is lifted or applicants who were terminated by a sanction review panel who are doing activities required to reopen cash assistance (WAC 388-310-1600);

(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 arrangement and/or meeting the school requirements.

(d) Former WorkFirst recipients who are working at least twenty hours or more per week for up to six months 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);

(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 170-290 WAC describes the rules for this child care assistance program.)

(3) What type of support services may I receive and what limits apply?

There is a limit of three thousand dollars per person per program year (July 1st to June 30th) for WorkFirst support services you may receive. Most types of support services have dollar limits.

The chart below shows the types of support services that are available for the different activities (as indicated by an "x") and the limits that apply.

Definitions:

- Work-related activities include looking for work or participating in workplace activities, such as community jobs or a work experience position.

- Safety-related activities include meeting significant or emergency family safety needs, such as dealing with family violence. When approved, safety-related support services can exceed the dollar or category limits listed below.

- Some support services are available if you need them for other required activities in your IRP.

Type of support service	Limit	• Work	•• Safety	••• Other
Reasonable accommodation for employment	\$1,000 for each request	x		
Clothing/uniforms	\$75 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	\$250 per program year	x	x	
License/fees	\$130 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: \$25 for immediate need, or \$40 twice a month if you live within 40 miles of your local WorkFirst office, or \$60 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 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 74.04.050, 74.04.055, 74.04.057, and 74.08.090. 09-06-053, § 388-310-0800, filed 2/26/09, effective 4/1/09. Statutory Authority: RCW 74.04.050 and 74.04.055. 08-18-045, § 388-310-0800, filed 8/29/08, effective 10/1/08. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, 74.08A.260, chapter 74.08A RCW. 06-10-035, § 388-310-0800, filed 4/27/06, effective 6/1/06. Statutory Authority: RCW 74.08.090, 74.04.050, 74.08A.340. 05-02-014, § 388-310-0800, filed 12/27/04, effective 1/27/05. Statutory Authority: RCW 74.08.090, 74.04.-050, 74.08A.340, and 2003 c 10 § 207. 03-21-154, § 388-310-0800, filed 10/22/03, effective 10/27/03. 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), testing to acquire GED certification, adult basic education (ABE) or English as a second language (ESL) training. Basic education also includes approved homework and study activities associated with the educational activity.

(2) When do I participate in basic education as part of WorkFirst?

You may participate in basic education as part of WorkFirst under any of the following circumstances:

(a) You are twenty years of age or older and your comprehensive evaluation shows you need this education to become employed or get a better job and:

(i) You are participating the equivalent of twenty hours or more per week in job search, vocational education, issue resolution, paid work or unpaid work that meets the federal definition of core activities; or

(ii) You have limited-English proficiency and you lack language skills that are needed to qualify for entry level jobs.

(b) You may be required to participate if you are a mandatory participant, a parent eighteen or nineteen years of age, you do not have a high school diploma or GED certificate and you need this education in order to find employment.

(c) You will be required to be in high school or a GED certification program if you are a mandatory participant, sixteen or seventeen years old and you do not have a high school diploma or GED certificate.

(d) You are enrolled in the pregnancy to employment pathway and your comprehensive evaluation shows basic education would help you find and keep employment. (See WAC 388-310-1450.)

[Statutory Authority: 45 C.F.R. 260, 42 U.S.C. 601, chapters 74.08A and 74.12 RCW, RCW 74.04.050, 74.04.055, 74.08.090, and 74.04.057. 09-14-019, § 388-310-0900, filed 6/22/09, effective 7/23/09. Statutory Authority: RCW 74.04.050, 74.04.055, 74.08.090. 08-07-046, § 388-310-0900, filed 3/14/08, effective 5/1/08. Statutory Authority: RCW 74.04.050, 74.04.055, 74.08.090. 06-08-048, § 388-310-0900, filed 3/30/06, effective 5/1/06. 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, not to result in a baccalaureate or advanced degree unless otherwise indicated below, and is offered by an accredited:

- (a) Public and private technical college or school;
- (b) Community college;
- (c) Tribal college; or
- (d) For customized job skills training (formerly known as preemployment training), community based organizations.

(2) Vocational education may include:

- (a) Customized job skills training;
- (b) High-wage/high-demand training;
- (c) Approved homework and study activities associated with the educational activity; and/or
- (d) Remedial/developmental education, prerequisites, basic education and/or English as a second language training deemed a necessary part of the vocational education program.

(3) What is customized job skills training?

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

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

(b) You can find out about current customized job skills training opportunities by asking your employment services counselor, your case manager or staff at your local community and technical college.

(4) 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 or other professional-technical programs: This option allows you to start

and finish a one-year or shorter state community or technical college training program in the information technology, health care fields or other professional-technical programs that meet high-wage/high-demand criteria; and/or

(ii) Certificate/degree completion: This option allows you to finish up the last year of any certificate or degree program, not to exceed a baccalaureate 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).

(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 WorkFirst staff during the last quarter of training for job placement; and
- (v) Return to job search once you complete the educational program if still unemployed.

(5) 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) Your comprehensive evaluation shows you need this education to become employed or get a better job and you participate full time in vocational education or combine vocational education with any approved WorkFirst work activity; or

(b) 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 program; or

(c) 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 these skills (because there is no available work experience, community service or on-the-job training that can teach you these skills); or

(d) You are in the pregnancy to employment pathway and your comprehensive evaluation shows vocational education would help you find and keep employment. (See WAC 388-310-1450.)

(6) 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: 45 C.F.R. 260, 42 U.S.C. 601, chapters 74.08A and 74.12 RCW, RCW 74.04.050, 74.04.055, 74.08.090, and 74.04.057. 09-14-019, § 388-310-1000, filed 6/22/09, effective 7/23/09. Statutory Authority: RCW 74.04.050, 74.04.055, 74.08.090. 08-07-046, § 388-310-1000, filed 3/14/08, effective 5/1/08. Statutory Authority: RCW 74.04.050, 74.04.055, 74.08.090. 06-08-048, § 388-310-1000, filed 3/30/06, effective

5/1/06. 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—Skills enhancement training. (1) What is skills enhancement training?

Skills enhancement training (formerly known as job skills training) is training or education for job skills required by an employer to provide a person with the ability to obtain employment or to advance or adapt to the changing demands of the workplace. Skills enhancement training may include:

- (a) Customized training programs to meet the needs of a specific employer;
- (b) General education and training that prepares a person for employment to include vocational education and courses explicitly required for program entry;
- (c) Basic education and English as a second language training when such instruction is focused on skills needed for employment, combined in a unified whole with job training or needed to enable the person to perform a specific job or engage in a specific job training program;
- (d) Four-year bachelor degree programs at any state-certified college or university; and
- (e) Approved homework and study activities.

(2) Who may provide skills enhancement 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.

(3) When can skills enhancement training be included in my individual responsibility plan?

We may add skills enhancement training in your individual responsibility plan if you are participating the equivalent of twenty or more hours a week in job search, vocational education, issue resolution, paid work or unpaid work that meets the federal definition of core activities.

(4) Can I get help with paying the costs of skills enhancement training?

WorkFirst may pay your costs, such as tuition or books, if skills enhancement 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: 45 C.F.R. 260, 42 U.S.C. 601, chapters 74.08A and 74.12 RCW, RCW 74.04.050, 74.04.055, 74.08.090, and 74.04.057. 09-14-019, § 388-310-1050, filed 6/22/09, effective 7/23/09. Statutory Authority: RCW 74.04.050, 74.04.055, 74.08.090, 08-07-046, § 388-310-1050, filed 3/14/08, effective 5/1/08. 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.]

Chapter 388-400 WAC PROGRAM SUMMARY

WAC

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| 388-400-0040 | Am I eligible for benefits through the Washington Basic Food program? |
| 388-400-0045 | If I am not eligible for federal benefits through Washington Basic Food program because of my alien status, can I receive state-funded Basic Food? |

WAC 388-400-0040 Am I eligible for benefits through the Washington Basic Food program? The Washington Basic Food program (Basic Food) is a nutrition program to help low-income individuals and families buy food. This rule is a summary of the rules for Basic Food.

(1) When you apply for Basic Food, we decide who is in your assistance unit (AU) based on the requirements under WAC 388-408-0034 and 388-408-0035.

(2) To be eligible for Basic Food benefits, your AU must meet the eligibility requirements of:

(a) The most current version of the Food and Nutrition Act of 2008;

(b) Federal regulations adopted by the U.S. Department of Agriculture, Food and Nutrition Services (FNS) related to the supplemental nutrition assistance program (SNAP); and

(c) Standards FNS publishes each year for income limits, resource limits, income deductions, and benefit amounts for SNAP.

(3) To be eligible for **federal** Basic Food benefits, each AU member must meet the citizenship or alien status requirements for federal benefits as described under WAC 388-424-0020.

(4) An AU member who is not eligible for federal benefits may be eligible for **state-funded** Basic Food benefits if they meet the requirements described under WAC 388-400-0045.

(5) To be eligible for **federal** or **state** Basic Food benefits, each AU member must:

(a) Be a resident of the state of Washington as required under WAC 388-468-0005;

(b) Meet the citizenship or alien status requirements of either WAC 388-424-0020 or 388-424-0025;

(c) Give us their Social Security number as required under WAC 388-476-0005;

(d) Give us proof of identity as required under WAC 388-490-0005;

(e) Participate in the Basic Food employment and training program (BFE&T) if required under chapter 388-444 WAC; and

(f) Meet the eligibility criteria for strikers as described under WAC 388-480-0001.

(6) To be eligible for Basic Food, your AU must:

(a) Have total monthly income before taxes and deductions at or under the gross monthly income standard under WAC 388-478-0060. We don't use income that isn't counted under WAC 388-450-0015 as part of your AU's gross monthly income;

(b) Have net income at or under the net monthly income standard under WAC 388-478-0060. We subtract deductions allowed under WAC 388-450-0185 to determine your AU's net monthly income.

(c) Have resources we must count under WAC 388-470-0055 that are at or below your AU's resource limit under WAC 388-470-0005;

(d) Report changes of circumstances as required under WAC 388-418-0005; and

(e) Complete a mid-certification review and provide proof of any changes if required under WAC 388-418-0011.

(7) If your AU is categorically eligible for Basic Food under WAC 388-414-0001, your AU can have income over the gross or net income standard, and have resources over the resource limit and still be eligible for benefits.

(8) If your AU has income at or under the gross income standard or is categorically eligible for Basic Food, we determine if you are eligible for Basic Food and calculate your monthly benefits as described under WAC 388-450-0162.

(9) If an eligible person in your AU is elderly or disabled, some rules may help your AU to be eligible for Basic Food or to receive more Basic Food benefits. These include:

(a) Resources limits and excluding certain resources under chapter 388-470 WAC;

(b) An excess shelter deduction over the limit set for AUs without an elderly or disabled individual under WAC 388-450-0190;

(c) A deduction for out-of-pocket medical expenses for the elderly or disabled individual if they are over thirty-five dollars a month under WAC 388-450-0200; and

(d) Being exempt from the **gross monthly income** standard under WAC 388-478-0060.

(10) For Basic Food, **elderly** means a person who is age sixty or older;

(11) For Basic Food, **disabled** means a person who:

(a) Receives SSI;

(b) Receives disability payments or blindness payments under Title I, II, XIV, or XVI of the Social Security Act;

(c) Receives disability retirement benefits from a state, local or federal government agency because of a disability considered permanent under section 221(i) of the Social Security Act;

(d) Receives disability benefits from the Railroad Retirement Act under sections 2 (a)(1)(iv) and (v) and:

(i) Meets Title XIX disability requirements; or

(ii) Is eligible for medicare.

(e) Receives disability-related medical assistance under Title XIX of the Social Security Act;

(f) Is a veteran and receives disability payments based on one hundred percent disability;

(g) Is a spouse of a veteran and:

(i) Either needs an attendant or is permanently housebound; or

(ii) Has a disability under section 221(i) of the Social Security Act and is eligible for death or pension payments under Title 38 of the USC.

(12) If a person in your household attends an institution of higher education and does not meet the requirements to be an eligible student under WAC 388-482-0005, we do not count this person as a member of your AU under WAC 388-408-0035.

(13) If your AU currently receives food benefits under WASHCAP or lives on or near an Indian reservation and receives benefits from a tribal food distribution program approved by Food and Nutrition Service (FNS), your AU is

not eligible for food assistance benefits through the Washington Basic Food program.

(14) If a person in your AU is ineligible for any of the following reasons, we count the ineligible person's income as described under WAC 388-450-0140:

(a) Able-bodied adults without dependents who are no longer eligible under WAC 388-444-0030;

(b) Persons fleeing a felony prosecution, conviction, or confinement under WAC 388-442-0010;

(c) Persons who do not attest to citizenship or alien status as defined in WAC 388-424-0001;

(d) Persons who are ineligible aliens under WAC 388-424-0020;

(e) Persons disqualified for an intentional program violation under WAC 388-446-0015;

(f) Persons who do not provide a Social Security number when required under WAC 388-476-0005; or

(g) Persons who failed to meet work requirements under chapter 388-444 WAC.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090, 74.08A.120, and Food and Nutrition Act of 2008, Title 7 Part 273 of the C.F.R. 09-07-054, § 388-400-0040, filed 3/11/09, effective 4/11/09. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090, 06-13-043, § 388-400-0040, filed 6/15/06, effective 7/17/06. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 2004 c 54, 04-21-025, § 388-400-0040, filed 10/13/04, effective 11/13/04. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, 04-15-057, § 388-400-0040, filed 7/13/04, effective 8/13/04. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 2004 c 54, 04-14-040, § 388-400-0040, filed 6/29/04, effective 7/30/04. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, and 74.04.510, 03-05-028, § 388-400-0040, filed 2/10/03, effective 4/1/03. 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 If I am not eligible for federal benefits through Washington Basic Food program because of my alien status, can I receive state-funded Basic Food? (1) If you are not eligible for federally-funded Basic Food benefits because you do not meet the alien status requirements under WAC 388-424-0020, you may be eligible for state-funded Basic Food if you meet both of the following requirements:

(a) You are a Washington state resident; and

(b) You meet the immigrant eligibility requirements under WAC 388-424-0025.

(2) State-funded Basic Food follows the same eligibility rules as federally-funded Basic Food except for rules related to alien status. A summary of the rules for Basic Food is found in WAC 388-400-0040.

(3) Some assistance units (AUs) include both people who are eligible for federal Basic Food benefits and those who are eligible for state-funded benefits. In these cases, we determine the federal and state portion of your Basic Food benefits by applying the following process to the monthly benefit calculation under WAC 388-450-0162:

(a) We calculate your AU's monthly benefits **as if** all the eligible persons in your AU could receive benefits under the federal program; and

(b) We then calculate the monthly benefits for the persons in your AU **who are** eligible for federal benefits.

If step A is more than step B	If step B is more than step A
Your AU receives: <ul style="list-style-type: none"> • Federal benefits in the amount calculated using step (b); and • State-funded benefits for the difference between the amount calculated using step (a) and step (b). 	Your AU receives federal benefits in the amount calculated using step (b).

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090, 74.08A.120, and Food and Nutrition Act of 2008, Title 7 Part 273 of the C.F.R. 09-07-054, § 388-400-0045, filed 3/11/09, effective 4/11/09. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, and 74.04.510. 03-05-028, § 388-400-0045, filed 2/10/03, effective 4/1/03. 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 388-406 WAC APPLICATIONS

WAC

388-406-0005	Can I apply for cash, medical, or Basic Food?
388-406-0035	How long does the department have to process my application?
388-406-0045	Is there a good reason my application for cash or medical assistance has not been processed?
388-406-0055	When do my benefits start?

WAC 388-406-0005 Can I apply for cash, medical, or Basic Food? (1) You can apply for any benefit the department offers, including cash assistance, medical assistance, or Basic Food.

(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 for:

- (i) A dependent child;
- (ii) An incapacitated person; or
- (iii) Someone who is deceased.

(b) Applying for someone who cannot apply for some other reason. We may ask why the applicant is unable to apply on their own behalf.

(4) If you get Supplemental Security Income (SSI), you do not need to apply for medical benefits. We automatically open medical benefits for you.

(5) A person or agency may apply for GAU or medical assistance for you if:

- (a) You temporarily live out-of-state; and
- (b) You are a Washington state resident.

(6) When you are confined or incarcerated in a Washington state public institution, you may apply for cash or medical assistance if you meet the following criteria:

(a) You are confined by or in the following public institutions:

- (i) Department of corrections;
- (ii) City or county jail; or
- (iii) Institution for mental diseases (IMD).

(b) Staff at the public institution provide medical records including diagnosis by a mental health professional that you have a mental disorder (as defined in the Diagnostic and Sta-

tistical Manual of Psychiatric Disorders, most recent edition) that affects your thoughts, mood or behavior so severely that it prevents you from performing any kind of work.

(7) We will make an eligibility determination for medical assistance prior to your release from confinement and will authorize medical benefits upon your release from confinement when you:

(a) Meet the criteria of subsection (6) in this section; and

(b) Were receiving medicaid or general assistance benefits immediately before confinement or within the five years prior to confinement.

(8) If you meet the criteria in subsection (6) but did not receive medicaid or general assistance benefits within the five years prior to confinement, the department will process your request for medical assistance within the time frames in WAC 388-406-0035.

(9) If you are applying for assistance for a youth leaving incarceration in a juvenile rehabilitation administration or county juvenile detention facility, you may apply for assistance within forty-five days prior to release. We will process your application for medical assistance when we receive it, and if eligible, we will authorize medical benefits upon the youth's release from confinement.

[Statutory Authority: RCW 74.08.060, 74.04.050, 74.04.057, 74.08.090, and 2009 c 198. 09-19-129, § 388-406-0005, filed 9/22/09, effective 11/1/09. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.060, 74.08.090, 74.09.555, and 2007 c 359. 08-09-042, § 388-406-0005, filed 4/10/08, effective 5/11/08. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, 74.09.555. 06-08-047, § 388-406-0005, filed 3/30/06, effective 4/30/06. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510. 03-22-039, § 388-406-0005, filed 10/28/03, effective 12/1/03. 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 388-406-0035 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 cannot delay processing your request by using the time limits stated in this section as a waiting period for determining eligibility.

(2) Unless your eligibility determination is delayed for good cause under WAC 388-406-0040, we process your application for benefits within thirty calendar days, except:

(a) If you are pregnant, we must process your application for medical within fifteen working days;

(b) If you are applying for general assistance (GA-U), alcohol or drug addiction treatment (ADATSA), or medical assistance, we must process your application within forty-five calendar days unless there is good cause as described in WAC 388-406-0045; and

(c) If you are applying for medical assistance that requires a disability decision, we must process your application within sixty calendar days.

(3) For calculating time limits, "day one" is the date following the date:

(a) The department received your application for benefits under WAC 388-406-0010;

(b) Social Security gets a request for food benefits from a Basic Food assistance unit 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 Basic Food through Social Security prior to your release.

[Statutory Authority: RCW 74.08.060, 74.04.050, 74.04.057, 74.08.090, and 2009 c 198. 09-19-129, § 388-406-0035, filed 9/22/09, effective 11/1/09. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510. 03-22-039, § 388-406-0035, filed 10/28/03, effective 12/1/03. 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 388-406-0045 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.

(4) For general assistance (GA), good cause exists if you apply when you are confined in a Washington State public institution as defined in WAC 388-406-0005 (6)(a).

[Statutory Authority: RCW 74.08.060, 74.04.050, 74.04.057, 74.08.090, and 2009 c 198. 09-19-129, § 388-406-0045, filed 9/22/09, effective 11/1/09. 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 388-406-0055 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 (GA) unless you are confined in a Washington state public institution as defined in WAC 388-406-0005 (6)(a) on the forty-fifth day, in which case your benefits will start on the date you are released from confinement.

(2) Basic Food, your benefits start from the date you applied unless:

(a) You are recertified for Basic Food. If you are recertified for Basic Food, we determine the date your benefits start under WAC 388-434-0010;

(b) You applied for Basic Food while living in an institution. If you apply for Basic Food while living in an institution, the date you are released from the institution determines your start date as follows. If you are expected to leave the institution:

(i) Within thirty days of the date we receive your application, your benefits start on the date you leave the institution; or

(ii) More than thirty days from the date we receive your application, we deny your application for Basic Food. You may apply for Basic Food again when your date of release from the institution is closer.

(c) We were unable to process your application within thirty days because of a delay on your part. If you caused the delay, but submit required verification by the end of the second thirty-day period, we approve your benefits starting the first day of the month following the month you applied for benefits. We start your benefits from this date even if we denied your application for Basic Food.

(d) We initially denied your application for Basic Food and your assistance unit (AU) becomes categorically eligible (CE) within sixty days from the date you applied. If your AU becoming CE under WAC 388-414-0001 makes you eligible for Basic Food, the date we approve Basic Food is the date your AU became CE.

(e) You are approved for transitional food assistance under chapter 388-489 WAC. We determine the date transitional benefits start as described under WAC 388-489-0015.

(f) You receive transitional food assistance with people you used to live with, and are now approved to receive Basic Food in a different assistance unit:

(i) We must give the other assistance unit ten days notice as described under WAC 388-458-0025 before we remove you from the transitional food assistance benefits.

(ii) Your Basic Food benefits start the first of the month after we remove you from the transitional benefits. For example, if we remove you from transitional benefits on November 30th, you are eligible for Basic Food on December 1st.

(3) Medical assistance, the date your benefits start is stated in chapter 388-416 WAC.

[Statutory Authority: RCW 74.08.060, 74.04.050, 74.04.055, 74.04.057, 74.08.090, and 2009 c 198. 09-20-031, § 388-406-0055, filed 9/29/09, effective 11/1/09. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057,

74.04.510, 74.08.090, and 74.08A.010. 05-19-060, § 388-406-0055, filed 9/16/05, effective 11/1/05. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510. 03-22-039, § 388-406-0055, filed 10/28/03, effective 12/1/03. 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.]

Chapter 388-412 WAC BENEFIT ISSUANCES

WAC

388-412-0015	General information about your Basic Food allotments.
388-412-0025	How do I get my benefits?
388-412-0040	Can I get my benefits replaced?

WAC 388-412-0015 General information about your Basic Food allotments. (1) Your monthly Basic Food benefits are called an allotment. An allotment is the total dollar value of benefits your eligible assistance unit (AU) gets for a calendar month.

(2) If your AU does not have countable income as described under WAC 388-450-0162, you get the maximum allotment for the number of eligible people in your AU under WAC 388-478-0060.

(3) If your AU has countable income, we calculate your monthly allotment as described under WAC 388-450-0162.

(4) If we determine you are eligible for Basic Food, your first month's benefits are from the date you applied for benefits through the end of the month of your application. If there was a delay in processing your application, we determine when your benefits start under WAC 388-406-0055. This is called proration and is based on a thirty-day month.

(5) If you apply for benefits on or after the sixteenth of the month, and we determine you are eligible for Basic Food, we issue both your first and second months benefits in one allotment if you are eligible for both months.

(6) If your prorated benefits for the first month are under ten dollars, you will not receive an allotment for the first month.

(7) If your AU has one or two members, your monthly allotment will be at least sixteen dollars unless:

(a) It is the first month of your certification period;

(b) Your AU is eligible for only a partial month; and

(c) We reduced your first month's allotment below six-teen dollars based on the date you became eligible for Basic Food under WAC 388-406-0055.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090, 74.04.500, 74.08A.120, and American Recovery and Reinvestment Act of 2009. 09-14-018, § 388-412-0015, filed 6/22/09, effective 7/23/09. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090. 08-24-051, § 388-412-0015, filed 11/25/08, effective 12/26/08. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 05-02-016, § 388-412-0015, filed 12/27/04, effective 1/27/05. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510. 03-22-038, § 388-412-0015, filed 10/28/03, effective 12/1/03. 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 388-412-0025 How do I get my benefits? (1) We send your cash benefits to you by either:

(a) Electronic benefit transfer (EBT), which is a direct deposit into a DSHS account that you access with a debit card called the Washington EBT Quest card;

(b) Electronic funds transfer (EFT), which is a direct deposit into your own bank account;

(c) A warrant (check) to a payee who is not approved for direct deposit; or

(d) A warrant (check) to you if you get:

(i) Diversion cash assistance (DCA) that cannot be paid directly to a vendor;

(ii) Additional requirements for emergent needs (AREN) that cannot be paid directly to a vendor;

(iii) Ongoing additional requirements (OAR) that cannot be paid directly to a vendor;

(iv) Clothing and personal incidentals (CPI) payments; or

(v) State supplemental payment (SSP) and you do not receive your benefit through EFT.

(2) We send your **Basic Food** benefits to you by EBT.

(3) We set up an EBT account for the head of household of each AU that receives benefits by EBT.

(4) You use a Quest debit card to access your benefits in your EBT account. You select a personal identification number (PIN) that you must enter when using this card.

(5) You must use your cash and Basic Food benefits from your EBT account. We do not convert cash or Basic Food benefits to checks.

(6) We deposit your Basic Food benefits into your EBT account by the tenth day of the month based on your Basic Food assistance unit number as described in WAC 388-412-0020.

(7) **Unused EBT benefits:** If you do not use your EBT account for three hundred sixty-five days, we cancel the cash and Basic Food benefits on your account.

(a) **Replacing Basic Food benefits:**

(i) We **can replace** cancelled benefits we deposited **less than three hundred sixty-five days** from the date you ask for us to replace your benefits.

(ii) We **cannot replace** cancelled benefits deposited **three hundred sixty-five or more days** from the date you ask us to replace your benefits.

(b) **Replacing cash benefits:** We **can replace** cancelled cash benefits for you or another member of your assistance unit. Cash benefits are not transferable to someone outside of your assistance unit.

(8) **Replacing cash warrants:** If we issued you cash benefits as a warrant we can replace these benefits for you or a member of your assistance unit. Cash benefits are not transferable to someone outside of your assistance unit.

(a) If we issued the benefits as a warrant one hundred sixty or fewer days ago, your local office can replace the warrant.

(b) If we issued the benefits as a warrant more than one hundred sixty days ago, the Office of Accounting Services can replace the warrant.

(9) **Correcting your EBT balance:** When you make a purchase with your EBT card a system error can occur where the purchase amount is not deducted from your EBT account. When the error is discovered the following will happen:

(a) You will be notified in writing of the system error before the money is removed from your account; and

(b) You will have ninety days to request an administrative hearing. If you ask for an administrative hearing within ten calendar days, the money will not be removed from your EBT account unless:

(i) You withdraw your administrative hearing request in writing;

(ii) You do not follow through with the administrative hearing process; or

(iii) The administrative law judge tells us in writing to remove the money.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.500, 74.04.510, 74.04.005, 74.08.090, 74.08A.020, 7 C.F.R. 274.12 and Quest operating rules. 09-21-071, § 388-412-0025, filed 10/16/09, effective 11/16/09. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.500, 74.04.510, 74.04.515, 74.08.090, and 7 C.F.R. 274.12. 07-04-029, § 388-412-0025, filed 1/29/07, effective 3/1/07. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090. 05-17-089, § 388-412-0025, filed 8/12/05, effective 9/12/05. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510. 03-22-038, § 388-412-0025, filed 10/28/03, effective 12/1/03. 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.]

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 Basic Food benefits 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 Basic Food benefits was destroyed in a disaster.

(2) If you want a replacement, you must report the loss to your local office within ten days from the date of the loss.

(3) For Basic Food, we replace the loss up to a one-month benefit amount.

(4) We will not replace your benefits if your loss is for a reason other than those listed in subsection (1) above or:

(a) We decided that your request is fraudulent;

(b) Your Basic Food benefits were lost, stolen or misplaced after you received them;

(c) You already got two countable replacements of Basic Food benefits within the last five months; or

(d) You got disaster food stamp benefits for the same month you requested a replacement for Basic Food.

(5) Your replacement does not count if:

(a) Your benefits are returned to us; or

(b) We replaced your benefits because we made an error.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090. 09-21-009, § 388-412-0040, filed 10/8/09, effective 11/15/09. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, and 74.04.510. 08-14-047, § 388-412-0040, filed 6/24/08, effective 7/25/08; 03-22-038, § 388-412-0040, filed 10/28/03, effective 12/1/03. 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 388-416 WAC CERTIFICATION PERIODS

WAC

388-416-0015 Certification periods for categorically needy (CN) scope of care medical assistance programs.

WAC 388-416-0015 Certification periods for categorically needy (CN) scope of care medical assistance programs. (1) A certification period is the period of time a person is determined eligible for a categorically needy (CN) scope of care 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 the certification period is twelve months with a six-month report required as a condition of eligibility as described in WAC 388-418-0011.

(5) For children, the certification period is twelve months. Eligibility is continuous without regard to changes in circumstances other than aging out of the program, moving out-of-state, failing to pay a required premium(s), incarceration or death.

(6) 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 (see WAC 388-505-0230) 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.

(7) For an SSI-related person the certification period is twelve months.

(8) 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.

(9) 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 388-501-0060 and 388-501-0065.

(10) If the client is eligible only during the three-month retroactive period, that period is the only period of certification, except when:

(a) A pregnant woman is eligible in one of the three months preceding the month of application, but no earlier than the month of conception. Eligibility continues as described in subsection (3);

(b) A child is eligible for a CN medical program as described in WAC 388-505-0210 (1) through (4) and (6) in one of the three months preceding the month of application. Eligibility continues for twelve months from the earliest month that the child is determined eligible.

(11) Any months of a retroactive certification period are added to the designated certification periods described in this section.

(12) Coverage under premium-based programs included in apple health for kids as described in WAC 388-505-0210 and chapter 388-542 WAC begins no sooner than the month after creditable coverage ends.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.402, 74.09.470, and 2008 session law. 09-07-086, § 388-416-0015, filed 3/17/09, effective 4/17/09. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.-090, 74.09.530, 74.09.700, and 2007 c 5. 08-05-018, § 388-416-0015, filed 2/12/08, effective 3/14/08. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 06-24-036, § 388-416-0015, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.08.090, 74.09.530, and 74.09.415. 05-19-031, § 388-416-0015, filed 9/12/05, effective 10/13/05. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 2004 c 54. 04-21-064, § 388-416-0015, filed 10/18/04, effective 11/18/04. Statutory Authority: RCW 74.08.090, 74.09.530, and 2003 c 10. 04-03-019, § 388-416-0015, filed 1/12/04, effective 2/12/04. 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.]

Chapter 388-418 WAC CHANGE OF CIRCUMSTANCE

WAC

388-418-0025 Effect of changes on medical program eligibility.

WAC 388-418-0025 Effect of changes on medical program eligibility. (1) You continue to be eligible for medical assistance until the department determines your ineligibility or eligibility for another medical program. This applies to you if, during a certification period, you become ineligible for, or are terminated from, or request termination from:

- (a) A CN medicaid program;
- (b) A program included in apple health for kids; or
- (c) 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) If you become ineligible for refugee cash assistance, refugee medical assistance can be continued through the eight-month limit, as described in WAC 388-400-0035(4).

(3) If you receive a TANF cash grant or family medical, you are eligible for a medical extension, as described under WAC 388-523-0100, when your cash grant or family medical program is terminated as a result of:

- (a) Earned income; or

(b) Collection of child or spousal support.

(4) A change in income during a certification period does affect eligibility for all medical programs except:

- (a) Pregnant women's medical programs;
- (b) A program included in apple health for kids, except as specified in subsection (5); or
- (c) The first six months of the medical extension benefits.

(5) For a child receiving premium-based coverage under a program included in apple health for kids as described in WAC 388-505-0210 and chapter 388-542 WAC, the department must redetermine eligibility for nonpremium-based coverage when the family reports:

- (a) Family income has decreased to less than two hundred percent federal poverty level (FPL);
- (b) The child becomes pregnant;
- (c) A change in family size; or
- (d) The child receives SSI.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.402, 74.09.470, and 2008 session law. 09-07-086, § 388-418-0025, filed 3/17/09, effective 4/17/09. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.-090, 74.09.530, 74.09.700, and 2007 c 5. 08-05-018, § 388-418-0025, filed 2/12/08, effective 3/14/08. Statutory Authority: RCW 74.08.090, 74.09.530, and 74.09.415. 05-23-013, § 388-418-0025, filed 11/4/05, effective 1/1/06. Statutory Authority: RCW 74.08.090, 74.09.530, and 2003 c 10. 04-03-019, § 388-418-0025, filed 1/12/04, effective 2/12/04. 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 388-422 WAC CHILD SUPPORT

WAC

388-422-0005 What happens to my child, spousal and medical support when I get public assistance?

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 permanently assign to the state your current support for the months you get assistance. If you applied for TANF or SFA cash benefits before October 1, 2008, support for months before you begin receiving assistance (also called "arrear" under WAC 388-14A-2036) 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 your application for benefits is approved by the department.

(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 during the month you apply, you must report these payments and we may count them as unearned income in determining your eligibility for benefits.

(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 74.04.005, 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090, and 74.20.330. 10-02-037, § 388-422-0005, filed 12/30/09, effective 1/30/10. 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.]

Chapter 388-424 WAC

CITIZENSHIP/ALIEN STATUS

WAC

388-424-0006	Citizenship and alien status—Date of entry.
388-424-0010	Citizenship and alien status—Eligibility restrictions for TANF, nonemergency medicaid, and SCHIP.
388-424-0016	Citizenship and alien status—Immigrant eligibility restrictions for state medical benefits.
388-424-0020	How does my alien status impact my eligibility for the federally funded Washington Basic Food program benefits?

WAC 388-424-0006 Citizenship and alien status—Date of entry. (1) A person who physically entered the U.S. prior to August 22, 1996 and who continuously resided in the U.S. prior to becoming a "qualified alien" (as defined in WAC 388-424-0001) is not subject to the five-year bar on TANF, nonemergency medicaid, and SCHIP.

(2) A person who entered the U.S. prior to August 22, 1996 but became "qualified" on or after August 22, 1996, or who physically entered the U.S. on or after August 22, 1996 and who requires five years of residency to be eligible for federal Basic Food, can only count years of residence during which they were a "qualified alien."

(3) A person who physically entered the U.S. on or after August 22, 1996 is subject to the five-year bar on TANF, nonemergency medicaid, and SCHIP unless exempt. The five-year bar starts on the date that "qualified" status is obtained.

(4) The following "qualified aliens," as defined in WAC 388-424-0001, are exempt from the five-year bar:

- (a) Amerasian lawful permanent residents;
- (b) Asylees;
- (c) Cuban/Haitian entrants;
- (d) Persons granted withholding of deportation or removal;
- (e) Refugees;
- (f) Victims of trafficking who have been certified or had their eligibility approved by the office of refugee resettlement (ORR); and
- (g) Lawful permanent residents, parolees, or battered aliens, as defined in WAC 388-424-0001, who are also an armed services member or veteran as described in WAC 388-424-0007.

(5) In addition to subsection (4) of this section, the following "qualified aliens" are also exempt from the five-year bar on nonemergency medicaid and SCHIP:

- (a) Pregnant women;
- (b) Children under nineteen years of age; and
- (c) Children under twenty-one years of age who are residing in a medical institution as described in WAC 388-505-0230.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090, 74.08A.120, and P.L. No. 111-3 (H.R. 2, Title II, Sec. 214 - Children's Health Insurance Program Reauthorization Act of 2009); P.L. No. 111-08 Omnibus Appropriations Act of 2009, Office of Refugee Resettlement State Letter #09-17. 09-15-082, § 388-424-0006, filed 7/14/09, effective 8/14/09. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530. 07-07-023, § 388-424-0006, filed 3/9/07, effective 4/9/07. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 05-16-055, § 388-424-0006, filed 7/28/05, effective 8/28/05; 04-15-004, § 388-424-0006, filed 7/7/04, effective 8/7/04.]

WAC 388-424-0010 Citizenship and alien status—Eligibility restrictions for TANF, nonemergency medicaid, and SCHIP. (1) To receive TANF, nonemergency medicaid, or SCHIP, you must meet all other eligibility requirements and be one of the following as defined in WAC 388-424-0001:

- (a) A U.S. citizen;
- (b) A U.S. national;
- (c) An American Indian born outside the U.S.;
- (d) A "qualified alien";
- (e) A victim of trafficking;
- (f) A Hmong or Highland Lao; or
- (g) A special immigrant from Iraq or Afghanistan eligible for eight months of federally funded assistance from your date of entry into the United States or from the date you received special immigrant status.

(2) A "qualified alien" who first physically entered the U.S. before August 22, 1996 as described in WAC 388-424-0006(1) may receive TANF, nonemergency medicaid, and SCHIP.

(3) A "qualified alien" who first physically entered the U.S. on or after August 22, 1996 cannot receive TANF, non-

emergency medicaid, or SCHIP for five years after obtaining status as a qualified alien unless:

(a) He or she is an alien as described in WAC 388-424-0006(4); or

(b) He or she is an alien as described in WAC 388-424-0006(5) applying for nonemergency medicaid or SCHIP.

(4) An alien who is ineligible for TANF because of the five-year bar or because of their immigration status may be eligible for:

(a) Emergency benefits as described in WAC 388-436-0015 (consolidated emergency assistance program) and WAC 388-438-0110 (alien emergency medical program); or

(b) State-funded cash or chemical dependency benefits as described in WAC 388-424-0015 (SFA, GA and ADATSA) and medical benefits as described in WAC 388-424-0016; or

(c) Pregnancy medical benefits as described in WAC 388-462-0015; or

(d) Children's healthcare benefits as described in WAC 388-505-0210.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090, 74.08A.120, and P.L. No. 111-3 (H.R. 2, Title II, Sec. 214 - Children's Health Insurance Program Reauthorization Act of 2009); P.L. No. 111-08 Omnibus Appropriations Act of 2009, Office of Refugee Resettlement State Letter #09-17. 09-15-082, § 388-424-0010, filed 7/14/09, effective 8/14/09. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08A.320, 74.08.090, and Public Law 110-161 Section 525; Public Law 110-181 Section 1244; FNS Admin Notice 08-17; State Letter 04-12 from the Office of Refugee Resettlement. 08-14-116, § 388-424-0010, filed 6/30/08, effective 8/1/08. Statutory Authority: RCW 74.08.090, 74.09.530, and 74.09.415. 05-23-013, § 388-424-0010, filed 11/4/05, effective 1/1/06. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 04-15-004, § 388-424-0010, filed 7/7/04, effective 8/7/04. 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 388-424-0016 Citizenship and alien status—Immigrant eligibility restrictions for state medical benefits. To receive general assistance medical (medical care services) you must meet the alien requirements of general assistance as described in WAC 388-424-0015(2) and be a recipient of general assistance cash.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090, 74.08A.120, and P.L. No. 111-3 (H.R. 2, Title II, Sec. 214 - Children's Health Insurance Program Reauthorization Act of 2009); P.L. No. 111-08 Omnibus Appropriations Act of 2009, Office of Refugee Resettlement State Letter #09-17. 09-15-082, § 388-424-0016, filed 7/14/09, effective 8/14/09. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 04-15-004, § 388-424-0016, filed 7/7/04, effective 8/7/04.]

WAC 388-424-0020 How does my alien status impact my eligibility for the federally funded Washington Basic Food program benefits? (1) If you are a U.S. citizen or U.S. national as defined in WAC 388-424-0001 and meet all other eligibility requirements, you may receive federal Basic Food benefits.

(2) If you are not a U.S. citizen or U.S. national, you must fall within (a), (b), or (c) of this subsection, and meet all

other eligibility requirements, in order to receive federal Basic Food benefits:

(a) You are a member of one of the following groups of "qualified aliens" or similarly defined lawful immigrants as defined in WAC 388-424-0001:

- (i) Amerasian;
- (ii) Asylee;
- (iii) Cuban or Haitian entrant;
- (iv) Deportation or removal withheld;
- (v) Refugee;
- (vi) Victim of trafficking;
- (vii) Noncitizen American Indian; or
- (viii) Hmong or Highland Lao tribal member.

(b)(i) You are a member of one of the following groups of qualified aliens as defined in WAC 388-424-0001:

- (A) Conditional entrant;
- (B) Lawful permanent resident (LPR);
- (C) Paroled for one year or more; or
- (D) Victim of domestic violence or parent or child of a victim.

(ii) And, one of the following also applies to you:

(A) You have worked or can get credit for forty Social Security Administration (SSA) work quarters - as described in WAC 388-424-0008;

(B) You are an active duty personnel or honorably discharged veteran of the U.S. military or you are the spouse, unmarried surviving spouse, or unmarried dependent child of someone who meets this requirement, as described in WAC 388-424-0007(1);

(C) You receive cash or medical benefits based on Supplemental Security Income (SSI) criteria for blindness or disability;

(D) You have lived in the U.S. as a "qualified alien" as described in WAC 388-424-0001 for at least five years;

(E) You are under age eighteen; or

(F) You were lawfully residing in the U.S. on August 22, 1996 and were born on or before August 22, 1931.

(c) You are a special immigrant from Iraq or Afghanistan eligible for eight months of federally funded assistance from the date of your entry into the United States or from the date you received special immigrant status if this occurred after your U.S. entry.

(3) If you are ineligible for federal Basic Food benefits due to your alien status, you may be eligible for state Basic Food benefits (see WAC 388-424-0025).

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, 74.08A.320, Pub. L. No. 110-181, National Defense Authorization Act for Fiscal Year 2008, Pub. L. No. 111-08, the Omnibus Appropriations Act of 2009, Division F, Title VI, Section 602; Office of Refugee Resettlement State Letter 09-17 from April 9, 2009; and federal guidance issued on May 15, 2009, by the Food and Nutrition Service, United States Department of Agriculture. 09-21-046, § 388-424-0020, filed 10/14/09, effective 11/4/09. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08A.320, 74.08.090, and Public Law 110-161 Section 525; Public Law 110-181 Section 1244; FNS Admin Notice 08-17; State Letter 04-12 from the Office of Refugee Resettlement. 08-14-116, § 388-424-0020, filed 6/30/08, effective 8/1/08. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 04-15-004, § 388-424-0020, filed 7/7/04, effective 8/7/04. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, and 74.04.510. 03-05-029, § 388-424-0020, filed 2/10/03, effective 4/1/03. 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.]

Chapter 388-436 WAC EMERGENCY CASH ASSISTANCE

WAC

388-436-0050 Determining financial need and benefit amount for CEAP.

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:

Need Item: Maximum allowable amount by assistance unit size:

	1	2	3	4	5	6	7	8 or more
Food	\$217	\$276	\$341	\$402	\$463	\$526	\$600	\$664
Shelter	265	334	416	490	564	639	740	818
Clothing	31	39	48	57	65	75	85	96
Minor Medical Care	184	234	290	341	393	444	516	570
Utilities	89	113	140	164	189	216	250	276
Household maintenance	65	83	103	121	140	159	183	202
Job related transportation	359	453	562	661	762	866	1000	1107
Child related transportation	359	453	562	661	762	866	1000	1107

(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, 74.04.660. 09-14-040, § 388-436-0050, filed 6/24/09, effective 7/25/09. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, and 74.08.090. 08-18-009, § 388-436-0050, filed 8/22/08, effective 9/22/08; 98-16-044, § 388-436-0050, filed 7/31/98, effective 9/1/98.]

Chapter 388-444 WAC

FOOD STAMP EMPLOYMENT AND TRAINING

WAC

388-444-0005 Food stamp employment and training (FS E&T) program—General requirements.
388-444-0030 Work requirements for persons who are able-bodied adults without dependents (ABAWDs).
388-444-0040 Work programs for ABAWDs in the food stamp employment and training program.

WAC 388-444-0005 Food stamp employment and training (FS E&T) program—General requirements. (1) To receive Basic Food some people must register for work

Assistance
Unit Members
1
2
3
4
5
6
7
8 or more

Net Income Limit
\$ 323
407
505
594
685
779
900
996

(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:

and participate in the food stamp employment and training (FS E&T) program.

(2) We determine if you must register for work and participate in FS E&T under WAC 388-444-0010:

(a) If we require you to register for work and participate in FS E&T you are nonexempt from FS E&T.

(b) If you meet one of the conditions under WAC 388-444-0015, you are exempt from FS E&T. If you are exempt, you may choose to receive services through the FS E&T program.

(3) If you are nonexempt from FS E&T requirements, we register you for work:

(a) When you apply for Basic Food benefits or are added to someone's assistance unit; and

(b) Every twelve months thereafter.

(4) If you are nonexempt, you must meet all the FS E&T program requirements in subsections (5) through (7) of this section. If you fail to meet the requirements without good cause, we disqualify you from receiving Basic Food benefits:

(a) We define good cause for not meeting FS E&T requirements under WAC 388-444-0050; and

(b) We disqualify nonexempt persons who fail to meet E&T requirements as described under WAC 388-444-0055.

(5) If you are nonexempt, you must:

(a) Report to us or your FS E&T service provider and participate as required;

(b) Provide information regarding your employment status and availability for work when we ask for it;

(c) Report to an employer when we refer you; and

(d) Accept a bona fide offer of suitable employment. We define unsuitable employment under WAC 388-444-0060.

(6) If you are nonexempt, you must participate in one or more of the following FS E&T activities:

- (a) Job search;
- (b) Paid or unpaid work;
- (c) Training or work experience;
- (d) General education development (GED) classes; or
- (e) English as a second language (ESL) classes.

(7) If you must participate in WorkFirst under WAC 388-310-0200, you have certain requirements for the Food Stamp Employment and Training Program:

(a) Your FS E&T requirement is to fully participate in the WorkFirst activities approved in your Individual Responsibility Plan (IRP) under WAC 388-310-0500; and

(b) If your IRP includes unpaid community service or work experience, we use your TANF grant and the Basic Food benefits received by members of your TANF assistance unit to determine the maximum hours of unpaid work we include in your plan.

(8) Exempt or nonexempt FS E&T participants **will not be required** to participate more than one hundred and twenty hours per month, but exempt or nonexempt FS E&T participants may **volunteer** to participate beyond one hundred and twenty hours.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.500, 74.04.510, 74.04.515, 74.08.090, 74.08A.903 and Food, Conservation and Energy Act of 2008. 09-04-009, § 388-444-0005, filed 1/22/09, effective 2/22/09. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090, and 7 C.F.R. 273.7 and 273.25. 07-14-125, § 388-444-0005, filed 7/3/07, effective 8/3/07; 06-24-026, § 388-444-0005, filed 11/29/06, effective 1/1/07. 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 388-444-0030 Work requirements for persons who are able-bodied adults without dependents (ABAWDs). (1) Able-bodied adults without dependents (ABAWDs) are age eighteen to fifty and have no dependents.

They must, unless determined exempt, participate in specific employment and training activities to receive food assistance.

(2) Nonexempt ABAWDs who fail to participate may continue to receive food assistance until September 30, 2010.

(3) Beginning October 1, 2010, an ABAWD is not eligible to receive food assistance for more than three full months in a thirty-six month period, except as provided in WAC 388-444-0035, 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, 74.04.510, 74.08.090, 74.04.500, 74.08A.120, and American Recovery and Reinvestment Act of 2009. 09-14-018, § 388-444-0030, filed 6/22/09, effective 7/23/09. 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 388-444-0040 Work programs for ABAWDs in the food stamp employment and training program. Work

programs are available to clients eighteen to fifty years of age who are able to work and have no dependents.

(1) The following are considered work programs:

(a) Workfare consists of:

(i) Thirty days of job search activities in the first month beginning with the first day of application, or sixteen hours of volunteer work with a public or private nonprofit agency; and

(ii) In subsequent months, sixteen hours per month of volunteer work with a public or private nonprofit agency allows the client to remain eligible for food stamps. Workfare is not enforced community service or for paying fines or debts due to legal problems.

(b) Work experience (WEX) is supervised, unpaid work for at least twenty hours a week. The work must be for a nonprofit agency or governmental or tribal entity. This work is to improve the work skills of the client.

(c) On-the-job training (OJT) is paid employment for at least twenty hours a week. It is job training provided by an employer at the employer's place of business and may include some classroom training time.

(2) The department may not **require** you to participate more than one hundred and twenty hours per month in a work program, paid work, or a combination of activities. ABAWDs may volunteer to participate in activities beyond one hundred and twenty hours per month.

(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 74.04.050, 74.04.055, 74.04.057, 74.04.500, 74.04.510, 74.04.515, 74.08.090, 74.08A.903 and Food, Conservation and Energy Act of 2008. 09-04-009, § 388-444-0040, filed 1/22/09, effective 2/22/09. 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.]

**Chapter 388-448 WAC
INCAPACITY**

WAC

388-448-0050

PEP step II—How we determine the severity of mental impairments.

WAC 388-448-0050 PEP step II—How we determine the severity of mental impairments. If you are diagnosed with a mental impairment by a professional described in WAC 388-448-0020, we use information from the provider to determine if your impairment prevents you from being able to work.

(1) We review the following psychological evidence to determine the severity of your mental impairment:

(a) Psychosocial and treatment history records;

(b) Clinical findings of specific abnormalities of behavior, mood, thought, orientation, or perception;

(c) Results of psychological tests; and

(d) Symptoms observed by the examining practitioner that show how your impairment affects your ability to perform basic work-related activities.

(2) We exclude diagnosis and related symptoms of alcohol or substance abuse or addiction;

(3) 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

(4) If you are diagnosed with a mental impairment with physical causes, we assign a severity rating based on the most severe of the following four areas of impairment:

- (a) Short term memory impairment;
- (b) Perceptual or thinking disturbances;
- (c) Disorientation to time and place; or
- (d) Labile, shallow, or coarse affect.

(5) We base the severity of a functional disorder on a clinical assessment of the intensity and frequency of symptoms that:

(a) Affect your ability to perform basic work related activities; and

(b) Are consistent with a diagnosis of a mental impairment as listed in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV).

(6) We base the severity rating for a functional mental impairment on accumulated severity ratings for the symptoms in subsection (5)(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

(7) If you are diagnosed with any combination of mental retardation, mental impairment with physical causes, or functional 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

(8) We deny incapacity when you haven't been diagnosed with a significant physical impairment and your overall mental severity rating is one or two;

(9) We approve incapacity when you have an overall mental severity rating of five.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 09-11-078, § 388-448-0050, filed 5/18/09, effective 6/18/09; 00-16-113, § 388-448-0050, filed 8/2/00, effective 9/1/00.]

Chapter 388-450 WAC

INCOME

WAC

388-450-0015	What types of income does the department not use to figure out my benefits?
388-450-0162	How does the department count my income to determine if my assistance unit is eligible and calculate the amount of my cash and Basic Food benefits?
388-450-0175	Does the department offer an income deduction for the general assistance program as an incentive for clients to work?
388-450-0185	What income deductions does the department allow when determining if I am eligible for food benefits and the amount of my monthly benefits?
388-450-0190	How does the department figure my shelter cost income deduction for Basic Food?
388-450-0195	Utility allowances for Basic Food programs.

WAC 388-450-0015 What types of income does the department not use to figure out my benefits? This section applies to cash assistance, children's, family, or pregnancy medical, and basic food benefits.

(1) There are some types of income we do not count to figure 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 388-470-0045, except certain student loans as specified under WAC 388-450-0035;

(b) Federal earned income tax credit (EITC) payments;

(c) Federal economic stimulus payments that are excluded for federal and federally assisted state programs;

(d) Title IV-E and state foster care maintenance payments if you choose not to include the foster child in your assistance unit;

(e) Energy assistance payments;

(f) Educational assistance we do not count under WAC 388-450-0035;

(g) Native American benefits and payments we do not count under WAC 388-450-0040;

(h) Income from employment and training programs we do not count under WAC 388-450-0045;

(i) Money withheld from a benefit to repay an overpayment from the same income source. For Basic Food, we **do not** exclude money that is withheld because you were overpaid for purposely not meeting requirements of a federal, state, or local means tested program such as TANF/SFA, GA, and SSI;

(j) Legally obligated child support payments received by someone who gets TANF/SFA benefits;

(k) One-time payments issued under the Department of State or Department of Justice Reception and Replacement Programs, such as Voluntary Agency (VOLAG) payments; and

(l) Payments we are directly told to exclude as income under state or federal law.

(m) **For cash and Basic Food:** Payments made to someone outside of the household for the benefits of the assistance unit using funds that are not owed to the household;

(n) **For Basic Food only:** The total monthly amount of all legally obligated current or back child support payments paid by the assistance unit to someone outside of the assistance unit for:

(i) A person who is not in the assistance unit; or

(ii) A person who is in the assistance unit to cover a period of time when they were not living with the member of the assistance unit responsible for paying the child support on their behalf.

(o) **For medical assistance:** Only the portion of income used to repay the cost of obtaining that income source.

(2) For children's, family, or pregnancy medical, 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 74.04.005, 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090, and P.L. 107-171, section 4101. 09-15-085 and 09-16-095, § 388-450-0015, filed 7/14/09 and 8/4/09, effective 11/15/09. Statutory Authority: RCW 74.04.005, 74.04.050, 74.04.055, 74.04.057, 74.04.510 and 74.08.090. 09-09-103, § 388-450-0015, filed 4/20/09, effective 4/21/09; 06-07-078, § 388-450-0015, filed 3/13/06, effective 5/1/06. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090 and Public Law 106-419. 05-03-078, § 388-450-0015, filed 1/17/05, effective 2/17/05. 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 388-450-0162 How does the department count my income to determine if my assistance unit is eligible and calculate the amount of my cash and Basic Food benefits? (1) Countable income is all income your assistance unit (AU) has after we subtract the following:

(a) Excluded or disregarded income under WAC 388-450-0015;

(b) For **cash assistance**, earned income incentives and deductions allowed for specific programs under WAC 388-450-0170 and 388-450-0175;

(c) For **Basic Food**, deductions allowed under WAC 388-450-0185; and

(d) Income we allocate to someone outside of the assistance unit under WAC 388-450-0095 through 388-450-0160.

(2) Countable income includes all income that we must deem or allocate from financially responsible persons who are not members of your AU under WAC 388-450-0095 through 388-450-0160.

(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 AU'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 AU's countable income.

(4) For **Basic Food**, if you meet all other eligibility requirements for the program under WAC 388-400-0040, we determine if you meet the income requirements for benefits and calculate your AU's monthly benefits as specified under Title 7 Part 273 of code of federal regulations for the supplemental nutrition assistance program (SNAP). The process is described in brief below:

(a) How we determine if your AU is income eligible for Basic Food:

(i) We compare your AU's total monthly income to the gross monthly income standard under WAC 388-478-0060. We don't use income that isn't counted under WAC 388-450-0015 as a part of your gross monthly income.

(ii) We then compare your AU's countable monthly income to the net income standard under WAC 388-478-0060.

(A) If your AU is categorically eligible for Basic Food under WAC 388-414-0001, your AU can have income over the gross or net income standard and still be eligible for benefits.

(B) If your AU includes a person who is sixty years of age or older or has a disability, your AU can have income over the gross income standard, but must have income under the net income standard to be eligible for benefits.

(C) **All other AUs** must have income at or below the gross and net income standards as required under WAC 388-478-0060 to be eligible for Basic Food.

(b) How we calculate your AU's monthly Basic Food benefits:

(i) We start with the maximum allotment for your AU under WAC 388-478-0060.

(ii) We then subtract thirty percent of your AU's countable income from the maximum allotment and round the benefit down to the next whole dollar to determine your monthly benefit.

(iii) If your AU is eligible for benefits and has one or two persons, your AU will receive at least the minimum allotment as described under WAC 388-412-0015, even if the monthly benefit we calculate is lower than the minimum allotment.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090, 74.08A.120, and Food and Nutrition Act of 2008, Title 7 Part 273 of the C.F.R. 09-07-054, § 388-450-0162, filed 3/11/09, effective 4/11/09. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, and 7 C.F.R. 273.9 and 273.10. 08-15-009, § 388-450-0162, filed 7/3/08, effective 8/3/08. 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 388-450-0175 Does the department offer an income deduction for the general assistance program as an incentive for clients to work? The department gives a deduction to people who receive income from work while receiving general assistance. The deduction applies to general assistance cash benefits only. We allow the following income deduction when we determine the amount of your benefits:

(1) We only count fifty percent of your monthly gross earned income. We do this to encourage you to work.

[Statutory Authority: RCW 74.04.266, 74.04.050, 74.04.055, 74.04.057, 74.08.090, 74.04.510, and 2009 c 564. 09-18-079, § 388-450-0175, filed

8/31/09, effective 10/1/09. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090, and Title 45 C.F.R., Part 261.2 as published in Federal Register on June 29, 2006. 08-12-031, § 388-450-0175, filed 5/29/08, effective 7/1/08. Statutory Authority: RCW 74.04.005, 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090. 06-07-078, § 388-450-0175, filed 3/13/06, effective 5/1/06. 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 What income deductions does the department allow when determining if I am eligible for food benefits and the amount of my monthly benefits? We determine if your assistance unit (AU) is eligible for Basic Food and calculate your monthly benefits according to requirements of the Food and Nutrition Act of 2008 and federal regulations related to the supplemental nutrition assistance program (SNAP).

These federal laws allow us to subtract **only** the following amounts from your AU's total monthly income to determine your countable monthly income under WAC 388-450-0162:

(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	\$141
2	\$141
3	\$141
4	\$153
5	\$179
6 or more	\$205

(2) Twenty percent of your AU's gross earned income (earned income deduction);

(3) Your AU's expected monthly dependent care expense needed for an AU member to:

(a) Keep work, look for work, or accept work;

(b) Attend training or education to prepare for employment; or

(c) Meet employment and training requirements under chapter 388-444 WAC.

(4) Medical expenses over thirty-five dollars a month owed or anticipated by an elderly or disabled person in your AU as allowed under WAC 388-450-0200.

(5) A portion of your shelter costs as described in WAC 388-450-0190.

[Statutory Authority: RCW 74.04.005, 74.04.050, 74.04.055, 74.04.057, 74.04.500, 74.04.510, 74.08.090, and P.L. 107 - 171 § 4101. 09-23-004, § 388-450-0185, filed 11/5/09, effective 11/15/09. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090, 74.08A.120, and Food and Nutrition Act of 2008, Title 7 Part 273 of the C.F.R. 09-07-054, § 388-450-0185, filed 3/11/09, effective 4/11/09. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090. 08-24-051, § 388-450-0185, filed 11/25/08, effective 12/26/08. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510 and 7 C.F.R. § 273.9. 07-22-035, § 388-450-0185, filed 10/30/07, effective 11/30/07. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090 and 7 C.F.R. § 273.9. 06-21-012, § 388-450-0185, filed 10/6/06, effective 11/6/06. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090. 05-21-101, § 388-450-0185, filed 10/18/05, effective 11/18/05. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057. 04-23-025, § 388-450-0185, filed 11/8/04, effective 12/9/04. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510. 03-21-030, § 388-450-0185, filed 10/7/03, effective 12/1/03. 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.]

tive 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 Basic Food? 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 mortgage payments you make ahead of time as an allowable cost. We count the following expenses as an allowable shelter cost in the month the expense is due:

(a) Monthly 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 Basic Food 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 four hundred fifty-nine dollars if no one in your AU is elderly or disabled; or

(b) The entire amount if an eligible person in your AU is elderly or disabled, even if the amount is over four hundred fifty-nine dollars.

[Statutory Authority: RCW 74.04.005, 74.04.050, 74.04.055, 74.04.057, 74.04.500, 74.04.510, 74.08.090, and 7 C.F.R. 273.9. 09-24-001, § 388-450-0190, filed 11/18/09, effective 12/19/09. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090. 08-24-050, § 388-450-0190, filed 11/25/08, effective 12/26/08. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510 and 7 C.F.R. § 273.9. 07-22-035, § 388-450-0190, filed 10/30/07, effective 11/30/07. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090 and 7 C.F.R. § 273.9. 06-21-012, § 388-450-0190, filed 10/6/06, effective 11/6/06. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090. 05-21-101, § 388-450-0190, filed 10/18/05, effective 11/18/05. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057. 04-23-025, § 388-450-0190, filed 11/8/04, effective 12/9/04. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510. 04-07-138, § 388-450-0190, filed 3/22/04, effective 5/1/04; 03-21-030, § 388-450-0190, filed 10/7/03, effective 12/1/03. 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 Basic Food programs. (1) For Basic Food, "utilities" include the following:

- (a) Heating or cooling fuel;
- (b) Electricity or gas;
- (c) Water or sewer;
- (d) Well or septic tank installation/maintenance;
- (e) Garbage/trash collection; and
- (f) 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 Basic Food benefits.

(a) If you have heating or cooling costs or receive a low income home energy assistance program (LIHEAP) benefit during the year you get a standard utility allowance (SUA) that depends on your assistance unit's size.

Assistance Unit (AU) Size	Utility Allowance
1	\$352
2	\$362
3	\$373
4	\$384
5	\$394
6 or more	\$405

(b) If your AU does not qualify for the SUA and you have any two utility costs listed above, you get a limited utility allowance (LUA) of two hundred seventy-six dollars.

(c) If your AU has only telephone costs and no other utility costs, you get a telephone utility allowance (TUA) of forty-two dollars.

[Statutory Authority: RCW 74.04.005, 74.04.050, 74.04.055, 74.04.057, 74.04.500, 74.04.510, 74.08.090, and 7 C.F.R. 273.9. 09-24-001, § 388-450-0195, filed 11/18/09, effective 12/19/09. Statutory Authority: RCW 74.04.-050, 74.04.055, 74.04.057, 74.04.510, 74.08.090, and 7 C.F.R. 273.9. 08-21-106, § 388-450-0195, filed 10/16/08, effective 11/16/08. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510 and 7 C.F.R. § 273.9. 07-22-036, § 388-450-0195, filed 10/30/07, effective 11/30/07. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090 and 7 C.F.R. 273.9 (d)(6)(iii)(b). 06-21-011, § 388-450-0195, filed 10/6/06, effective 11/6/06. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.-057, 74.04.510, 74.08.090. 06-10-056, § 388-450-0195, filed 5/1/06, effective 6/1/06. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.-057, 74.04.510, 74.08.090, and 7 C.F.R. § 273.9. 05-19-062, § 388-450-0195, filed 9/16/05, effective 10/17/05. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090. 05-09-087, § 388-450-0195, filed 4/19/05, effective 6/1/05. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057. 04-23-025, § 388-450-0195, filed 11/8/04, effective 12/9/04. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510. 03-21-030, § 388-450-0195, filed 10/7/03, effective 12/1/03. 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.]

Chapter 388-452 WAC

INTERVIEW REQUIREMENTS

WAC

388-452-0005 Do I have to be interviewed in order to get benefits?

WAC 388-452-0005 Do I have to be interviewed in order to get benefits? (1) Unless you are applying for medical only, you or your authorized representative must have an interview with the department:

- (a) At initial certification; and
- (b) At least once every twelve months.

(2) An interview is not required if you are applying for or recertifying medical benefits only. If we deny your application for cash or Basic Food because you did not have an interview, we continue to process your request for medical benefits.

(3) You will have just one interview even if you are applying for or are having a review for benefits from more than one program.

(4) We hold interviews either in person or over the phone.

(5) If we do not interview you on the same day that we receive your application, we will schedule an interview appointment for you or have you contact us by phone during our business hours to complete your interview.

(6) If we schedule an interview, we will set your appointment to allow you 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 or recertifications.

(7) If you miss your first interview and ask for another interview within thirty days of the date you applied for benefits, we schedule a second interview or have you call us and complete the interview over the phone.

(8) If you must have an interview for benefits, you or someone who can give us the information we need about your AU must participate in the interview. You may ask any person you choose to help with your interview.

(9) For Basic Food only, your authorized representative as described in WAC 388-460-0005 may take your place during your interview.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.500, 74.04.510, 74.04.515, 74.08.090, 74.08A.120, 74.08A.903, and 7 CFR 273.9. 10-01-165, § 388-452-0005, filed 12/22/09, effective 1/22/10. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510. 04-10-102, § 388-452-0005, filed 5/4/04, effective 7/1/04. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 7 C.F.R. 273.2(e). 03-18-113, § 388-452-0005, filed 9/2/03, effective 11/1/03. 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.]

Chapter 388-466 WAC

REFUGEE PROGRAM

WAC

388-466-0120	Refugee cash assistance (RCA).
388-466-0130	Refugee medical assistance (RMA).

WAC 388-466-0120 Refugee cash assistance (RCA).

(1) Who can apply for refugee cash assistance (RCA)?

Anyone can apply to the department of social and health services (DSHS) for refugee cash assistance and have their eligibility determined within thirty days.

(2) Who is eligible for refugee cash assistance?

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) Who is not eligible for RCA?

You may not get RCA 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, what kind of documentation do I need to provide to be eligible for RCA?

You are eligible for RCA to the same extent as a refugee if you are:

(a) An adult victim, eighteen years of age or older, you provide the original certification letter from the U.S. Department of Health and Human Services (DHHS), and you meet eligibility requirements in subsections (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) A child victim under the age of eighteen, in which case you do not need to be certified. DHHS issues a special letter for children. Children also have to meet income eligibility requirement;

(c) A family member of a certified victim of human trafficking, you have a T-2, T-3, T-4, or T-5 Visa (Derivative T-Visas), and you meet the eligibility requirements in subsections (2)(c) and (d) of this section.

(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 with 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.

(a) Your spouse may be eligible for up to eight months of RCA based on his/her date of arrival into the United States.

(b) 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 an administrative hearing (WAC 388-02-0090). Your request must be made within ninety days of the date of the decision or action.

[Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, 74.08A.320, Pub. L. No. 110-181, National Defense Authorization Act for Fiscal Year 2008, Pub. L. No. 111-08, the Omnibus Appropriations Act of

2009, Division F, Title VI, Section 602; Office of Refugee Resettlement State Letter 09-17 from April 9, 2009; and federal guidance issued on May 15, 2009, by the Food and Nutrition Service, United States Department of Agriculture. 09-21-046, § 388-466-0120, filed 10/14/09, effective 11/4/09. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08A.320, 74.08.090, and Public Law 110-161 Section 525; Public Law 110-181 Section 1244; FNS Admin Notice 08-17; State Letter 04-12 from the Office of Refugee Resettlement. 08-14-116, § 388-466-0120, filed 6/30/08, effective 8/1/08. 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?

Anyone 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 388-466-0140;

(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:

(i) Receive refugee cash assistance (RCA) and are not eligible for medicaid or children's healthcare programs as described in WAC 388-505-0210; or

(ii) Choose not to apply for or receive RCA and are not eligible for medicaid or children's healthcare programs as described in WAC 388-505-0210, 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 children's healthcare programs as described in WAC 388-505-0210;

(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 a victim of human trafficking, what kind of documentation do I need to provide to be eligible for RMA?

You are eligible for RMA to the same extent as a refugee, if you are:

(a) An adult victim, eighteen years of age or older, and you provide the original certification letter from the U.S. Department of Health and Human Services (DHHS). You also have to meet eligibility requirements in subsections (2)(a) and (b) 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) A child victim under the age of eighteen, in which case you do not need to be certified. DHHS issues a special letter for children. Children also have to meet income eligibility requirements.

(c) A family member of a certified victim of human trafficking, you have a T-2, T-3, T-4, or T-5 Visa (Derivative T-Visas), and you meet eligibility requirements in subsections (2)(a) and (b) of this section.

(10) 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.

(11) 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 with 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.

(12) What happens if my earned income goes above the income standards?

(a) If you are getting RMA, your medical eligibility will not be affected 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.

(13) 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.

(a) If your spouse is eligible for RCA, he/she is automatically eligible for RMA.

(b) If your spouse is not eligible for RCA because your household's countable income exceeds the TANF income and resource standards described in chapter 388-450 and 388-470 WAC, he/she is eligible for RMA as long as the countable household income is below two hundred percent of federal poverty level (FPL) per WAC 388-466-0140(2).

(c) If your spouse is approved for RMA, he/she would have a maximum of eight months of RMA starting on the first day of the month of his/her arrival.

(14) 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 an administrative hearing (see WAC 388-02-0090). Your request must be made within ninety days of the date of the decision or action.

(15) 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 74.04.050, 74.04.055, 74.04.057, 74.08.090, 74.08A.320, Pub. L. No. 110-181, National Defense Authorization Act for Fiscal Year 2008, Pub. L. No. 111-08, the Omnibus Appropriations Act of 2009, Division F, Title VI, Section 602; Office of Refugee Resettlement State Letter 09-17 from April 9, 2009; and federal guidance issued on May 15, 2009, by the Food and Nutrition Service, United States Department of Agriculture. 09-21-046, § 388-466-0130, filed 10/14/09, effective 11/4/09. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08A.320, 74.08.090, and Public Law 110-161 Section 525; Public Law 110-181 Section 1244; FNS Admin Notice 08-17; State Letter 04-12 from the Office of Refugee Resettlement. 08-14-116, § 388-466-0130, filed 6/30/08, effective 8/1/08. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 04-05-010, § 388-466-0130, filed 2/6/04, effective 3/8/04. Statutory Authority: RCW 74.08.090, 74.08A.320, 00-21-065, § 388-466-0130, filed 10/16/00, effective 11/1/00.]

Chapter 388-470 WAC RESOURCES

WAC

388-470-0045 How do my resources count toward the resource limits for cash assistance and family medical programs?

WAC 388-470-0045 How do my resources count toward the resource limits for cash assistance and family medical programs? (1) We count the following resources toward your assistance unit's resource limits for cash assistance and family medical programs to decide if you are eligible for benefits under WAC 388-470-0005:

(a) Liquid resources not specifically excluded in subsection (2) below. These are resources that are easily changed into cash. Some examples of liquid resources are:

- (i) Cash on hand;
- (ii) Money in checking or savings accounts;
- (iii) Money market accounts or certificates of deposit (CDs) less any withdrawal penalty;
- (iv) Available retirement funds or pension benefits, less any withdrawal penalty;
- (v) Stocks, bonds, annuities, or mutual funds less any early withdrawal penalty;

(vi) Available trusts or trust accounts; or
(vii) Lump sum payments as described in chapter 388-455 WAC.

(b) The cash surrender value (CSV) of whole life insurance policies.

(c) The CSV over fifteen hundred dollars of revocable burial insurance policies or funeral agreements.

(d) The amount of a child's irrevocable educational trust fund that is over four thousand dollars per child.

(e) Funds withdrawn from an individual development account (IDA) if they were removed for a purpose other than those specified in RCW 74.08A.220.

(f) Any real property like a home, land or buildings not specifically excluded in subsection (3) below.

(g) The equity value of vehicles as described in WAC 388-470-0070.

(h) Personal property that is not:

- (i) A household good;
- (ii) Needed for self-employment; or
- (iii) Of "great sentimental value," due to personal attachment or hobby interest.

(i) Resources of a sponsor as described in WAC 388-470-0060.

(j) For cash assistance only, sales contracts.

(2) The following types of liquid resources do not count when we determine your eligibility:

- (a) Bona fide loans, including student loans;
- (b) Basic Food benefits;
- (c) Income tax refunds in the month of receipt;
- (d) Earned income tax credit (EITC) in the month received and the following month;
- (e) Advance earned income tax credit payments;
- (f) Federal economic stimulus payments that are excluded for federal and federally assisted state programs;
- (g) Individual development accounts (IDAs) established under RCW 74.08A.220;

(h) Retroactive cash benefits or TANF/SFA benefits resulting from a court order modifying a decision of the department;

(i) Underpayments received under chapter 388-410 WAC;

(j) Educational benefits that are excluded as income under WAC 388-450-0035;

(k) The income and resources of an SSI recipient;

(l) A bank account jointly owned with an SSI recipient if SSA already counted the money for SSI purposes;

(m) Foster care payments provided under Title IV-E and/or state foster care maintenance payments;

(n) Adoption support payments;

(o) Self-employment accounts receivable that the client has billed to the customer but has been unable to collect; and

(p) Resources specifically excluded by federal law.

(3) The following types of real property do not count when we determine your eligibility:

(a) Your home and the surrounding property that you, your spouse, or your dependents live in;

(b) A house you do not live in, if you plan on returning to the home and you are out of the home because of:

- (i) Employment;
- (ii) Training for future employment;
- (iii) Illness; or

- (iv) Natural disaster or casualty.
- (c) Property that:
 - (i) You are making a good faith effort to sell;
 - (ii) You intend to build a home on, if you do not already own a home;
 - (iii) Produces income consistent with its fair market value, even if used only on a seasonal basis; or
 - (iv) A household member needs for employment or self-employment. 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.
- (d) Indian lands held jointly with the Tribe, or land that can be sold only with the approval of the Bureau of Indian Affairs.

(4) If you deposit excluded liquid resources into a bank account with countable liquid resources, we do not count the excluded liquid resources for six months from the date of deposit.

(5) If you sell your home, you have ninety days to reinvest the proceeds from the sale of a home into an exempt resource.

(a) If you do not reinvest within ninety days, we will determine whether there is good cause to allow more time. Some examples of good cause are:

- (i) Closing on your new home is taking longer than anticipated;
- (ii) You are unable to find a new home that you can afford;
- (iii) Someone in your household is receiving emergent medical care; or

(iv) Your children are in school and moving would require them to change schools.

(b) If you have good cause, we will give you more time based on your circumstances.

(c) If you do not have good cause, we count the money you got from the sale as a resource.

[Statutory Authority: RCW 74.04.005, 74.04.050, 74.04.055, 74.04.057, 74.04.510 and 74.08.090. 09-09-103, § 388-470-0045, filed 4/20/09, effective 4/21/09. Statutory Authority: RCW 74.08.090 and 74.04.510. 03-05-015, § 388-470-0045, filed 2/7/03, effective 3/1/03; 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.]

Chapter 388-478 WAC

STANDARDS FOR PAYMENTS

WAC

- 388-478-0060 What are the income limits and maximum benefit amounts for Basic Food?
- 388-478-0075 Medical programs—Monthly income standards based on the federal poverty level (FPL).

WAC 388-478-0060 What are the income limits and maximum benefit amounts for Basic Food? If your assistance unit (AU) meets all other eligibility requirements for Basic Food, your AU must have income at or below the limits in column B and C to get Basic Food, 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 10-1-2009

Column A Number of Eligible AU Members	Column B Maximum Gross Monthly Income	Column C Maximum Net Monthly Income	Column D Maximum Allotment	Column E 165% of Poverty Level
1	\$1,174	\$903	\$200	\$1,490
2	1,579	1,215	367	2,004
3	1,984	1,526	526	2,518
4	2,389	1,838	668	3,032
5	2,794	2,150	793	3,547
6	3,200	2,461	952	4,061
7	3,605	2,773	1,052	4,575
8	4,010	3,085	1,202	5,089
9	4,416	3,397	1,352	5,604
10	4,822	3,709	1,502	6,119
Each Additional Mem- ber	+406	+312	+150	+515

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 Basic Food 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 74.04.005, 74.04.050, 74.04.055, 74.04.057, 74.04.500, 74.04.510, 74.08.090, and 7 C.F.R. 273.9. 09-24-001, § 388-478-0060, filed 11/18/09, effective 12/19/09. Statutory Authority: RCW 74.04.-050, 74.04.055, 74.04.057, 74.04.510, 74.08.090, 74.04.500, 74.08A.120, and American Recovery and Reinvestment Act of 2009. 09-14-018, § 388-478-0060, filed 6/22/09, effective 7/23/09. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090. 08-24-050, § 388-478-0060, filed 11/25/08, effective 12/26/08. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510 and 7 C.F.R. § 273.9. 07-22-035, § 388-478-0060, filed 10/30/07, effective 11/30/07. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090 and 7 C.F.R. § 273.9. 06-21-012, § 388-478-0060, filed 10/6/06, effective

11/6/06. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090. 05-21-101, § 388-478-0060, filed 10/18/05, effective 11/18/05. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 04-23-025, § 388-478-0060, filed 11/8/04, effective 12/9/04. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510. 03-21-030, § 388-478-0060, filed 10/7/03, effective 12/1/03. 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 388-478-0075 Medical programs—Monthly income standards based on the federal poverty level (FPL). (1) Each year, the federal government publishes new federal poverty level (FPL) income standards in the Federal Register found at <http://aspe.hhs.gov/poverty/index.shtml>. The income standards for the following medical programs change on the first day of April every year based on the new FPL:

- (a) Pregnant women's program up to one hundred eighty-percent of FPL;
- (b) A program included in apple health for kids up to two hundred percent of FPL;
- (c) Healthcare for workers with disabilities (HWD) up to two hundred twenty percent of FPL; and
- (d) Premium-based coverage under a program included in apple health for kids over two hundred percent of FPL, but not over three hundred percent of FPL.

(2) The department uses the FPL income standards to determine:

- (a) The mandatory or optional medicaid status of an individual; and
 - (b) Premium amount, if any, for a child.
- (3) There are no resource limits for the programs under this section.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.402, 74.09.470, and 2008 session law. 09-07-086, § 388-478-0075, filed 3/17/09, effective 4/17/09. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, 74.09.700, and 2007 c 5. 08-05-018, § 388-478-0075, filed 2/12/08, effective 3/14/08. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500 and 42 U.S.C. 9902(2). 06-16-026, § 388-478-0075, filed 7/24/06, effective 8/24/06. Statutory Authority: RCW 74.08.090, 74.09.415, 74.09.530 and 2005 c 279. 06-03-080, § 388-478-0075, filed 1/12/06, effective 2/12/06. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 42 U.S.C. 9902(2). 05-17-157, § 388-478-0075, filed 8/22/05, effective 9/22/05. Statutory Authority: RCW 74.08.090, 74.04.057, 74.04.050, and 74.09.530. 04-15-092, § 388-478-0075, filed 7/16/04, effective 8/16/04. Statutory Authority: RCW 74.08.090, 74.04.050, 74.04.057, 74.09.530, and 42 U.S.C. 9902(2). 03-15-088, § 388-478-0075, filed 7/17/03, effective 7/17/03. 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. For-

merly WAC 388-507-0805, 388-508-0810, 388-509-0910, 388-509-0920, 388-509-0940 and 388-509-0960.]

Chapter 388-490 WAC VERIFICATION

WAC

388-490-0005 The department requires proof before authorizing benefits for cash, medical, and Basic Food.

WAC 388-490-0005 The department requires proof before authorizing benefits for cash, medical, and Basic Food. This rule applies to cash, medical, and Basic Food.

(1) When you first apply for benefits, the department may require you to provide proof of things that help us decide if you are eligible for benefits. 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, confusing, or outdated.

(3) Whenever we ask for proof, we will give you a notice as described in WAC 388-458-0020.

(4) You must give us the proof within the time limits described in:

- (a) WAC 388-406-0030 if you are applying for benefits; and
- (b) WAC 388-458-0020 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, which may include providing a collateral statement. A "collateral statement" is from someone outside of your residence who knows your situation;

(b) Schedule a visit to come to your home and verify your circumstances; or

(c) Send an investigator from the Division of Fraud Investigations (DFI) to make an unannounced visit to your home to verify your circumstances.

(9) By signing the application, eligibility review, or change of circumstances form, you give us permission to contact other people, agencies, or institutions.

(10) If you do not give us all of the proof that we have asked for, we will determine if you are eligible based on the information that we already have. If we cannot determine that you are eligible based on this information, we will deny or stop your benefits.

(11) For all Medicaid programs, you must provide proof of citizenship and identity as specified at Section 6036 of the Deficit Reduction Act of 2005 (PL 106-171 amending USC 1396b). Exempt from this requirement are recipients of:

- (a) Title IV-B child welfare services, or Title IV-E adoption assistance or foster care payments;
- (b) SSI benefits;
- (c) Social Security benefits (based on their own disability); or
- (d) Medicare.

[Statutory Authority: RCW 74.04.057, 74.08.090, and 74.09.530. 09-02-057, § 388-490-0005, filed 1/5/09, effective 2/5/09. Statutory Authority: RCW 74.04.057, 74.08.090, 74.09.530, and Public Law 109-171, Section 6036. 07-02-066, § 388-490-0005, filed 12/29/06, effective 1/29/07. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, and 74.04.510. 03-21-029, § 388-490-0005, filed 10/7/03, effective 11/1/03. 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

388-492-0070 How are my WASHCAP food benefits calculated?

WAC 388-492-0070 How are my WASHCAP food benefits calculated? We calculate your food benefits as follows:

- (1) We begin with your gross income.
- (2) We subtract one hundred forty-one dollars from your gross income to get your countable income.
- (3) We figure your shelter cost based on information we receive from Social Security Administration (SSA), unless you report a change as described under WAC 388-492-0080. If you pay:
 - (a) Three hundred dollars or more a month for shelter, we use three hundred seventy-nine dollars as your shelter cost; or
 - (b) Less than three hundred dollars for shelter, we use one hundred eighty-two 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 and rounding the resulting figure up from fifty cents and down from forty-nine cents to the nearest whole dollar.
- (6) We figure your WASHCAP food 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, you will get at least the minimum monthly benefit for Basic Food under WAC 388-412-0015.

[Statutory Authority: RCW 74.04.005, 74.04.050, 74.04.055, 74.04.057, 74.04.500, 74.04.510, 74.08.090, and 7 C.F.R. 273.9. 09-24-001, § 388-492-0070, filed 11/18/09, effective 12/19/09. Statutory Authority: RCW 74.04.-

050, 74.04.055, 74.04.057, 74.04.500, 74.04.510, and 74.08.090. 09-12-068, § 388-492-0070, filed 5/29/09, effective 7/1/09. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090, and 7 C.F.R. 273.9. 08-21-106, § 388-492-0070, filed 10/16/08, effective 11/16/08. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510 and 7 C.F.R. § 273.9. 07-22-036, § 388-492-0070, filed 10/30/07, effective 11/30/07. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.-090 and 7 C.F.R. 273.9 (d)(6)(iii)(b). 06-21-011, § 388-492-0070, filed 10/6/06, effective 11/6/06. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, 74.08.090. 05-17-155, § 388-492-0070, filed 8/22/05, effective 10/1/05; 05-08-008, § 388-492-0070, filed 3/25/05, effective 4/25/05; 04-23-026, § 388-492-0070, filed 11/8/04, effective 12/9/04. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510. 03-21-030, § 388-492-0070, filed 10/7/03, effective 12/1/03. 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.]

Chapter 388-501 WAC

ADMINISTRATION OF MEDICAL PROGRAMS— GENERAL

WAC

388-501-0050	Healthcare general coverage.
388-501-0055	Healthcare coverage—How the department determines coverage of services for its healthcare programs using health technology assessments.
388-501-0070	Healthcare coverage—Noncovered services.
388-501-0163	Healthcare coverage—Process for submitting a valid request for authorization.
388-501-0169	Healthcare coverage—Limitation extension.

WAC 388-501-0050 Healthcare general coverage. WAC 388-501-0050 through 388-501-0065 describe the healthcare services available to a client on a fee-for-service basis or to a client enrolled in a managed care organization (MCO) (defined in WAC 388-538-050). For the purposes of this section, healthcare services includes treatment, equipment, related supplies, and drugs. WAC 388-501-0070 describes noncovered services.

(1) Healthcare service categories listed in WAC 388-501-0060 do not represent a contract for healthcare services.

(2) For the provider to receive payment, the client must be eligible for the covered healthcare service on the date the healthcare service is performed or provided.

(3) Under the department's fee-for-service programs, providers must be enrolled with the department and meet the requirements of chapter 388-502 WAC to be paid for furnishing healthcare services to clients.

(4) The department pays only for the healthcare services that are:

- (a) Within the scope of the client's medical program;
- (b) Covered - see subsection (8) of this section;
- (c) Ordered or prescribed by a healthcare provider who meets the requirements of chapter 388-502 WAC;
- (d) Medically necessary as defined in WAC 388-500-0005;
- (e) Submitted for authorization, when required, in accordance with WAC 388-501-0163;
- (f) Approved, when required, in accordance with WAC 388-501-0165;
- (g) Furnished by a provider according to chapter 388-502 WAC; and

(h) Billed in accordance with department program rules and the department's current published billing instructions and numbered memoranda.

(5) The department does not pay for any healthcare service requiring prior authorization from the department, if prior authorization was not obtained before the healthcare service was provided; unless:

(a) The client is determined to be retroactively eligible for medical assistance; and

(b) The request meets the requirements of subsection (4) of this section.

(6) The department does not reimburse clients for healthcare services purchased out-of-pocket.

(7) The department does not pay for the replacement of department-purchased equipment, devices, or supplies which have been sold, gifted, lost, broken, destroyed, or stolen as a result of the client's carelessness, negligence, recklessness, or misuse unless:

(a) Extenuating circumstances exist that result in a loss or destruction of department-purchased equipment, devices, or supplies, through no fault of the client that occurred while the client was exercising reasonable care under the circumstances; or

(b) Otherwise allowed under chapter 388-500 WAC.

(8) The department's refusal to pay for replacement of equipment, device, or supplies will not extend beyond the limitations stated in specific department program rules.

(9) Covered healthcare services

(a) Covered healthcare services are either:

(i) "Federally mandated" - means the state of Washington is required by federal regulation (42 CFR 440.210 and 220) to cover the healthcare service for medicaid clients; or

(ii) "State-option" - means the state of Washington is not federally mandated to cover the healthcare service but has chosen to do so at its own discretion.

(b) The department may limit the scope, amount, duration, and/or frequency of covered healthcare services. Limitation extensions are authorized according to WAC 388-501-0169.

(10) Noncovered healthcare services

(a) The department does not pay for any healthcare service:

(i) That federal or state laws or regulations prohibit the department from covering; or

(ii) Listed as noncovered in WAC 388-501-0070 or in any other program rule. The department evaluates a request for a noncovered healthcare service only if an exception to rule is requested according to the provisions in WAC 388-501-0160.

(b) When a noncovered healthcare services is recommended during the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) exam and then ordered by a provider, the department evaluates the healthcare service according to the process in WAC 388-501-0165 to determine if it is medically necessary, safe, effective, and not experimental (see WAC 388-534-0100 for EPSDT rules).

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 09-23-112, § 388-501-0050, filed 11/18/09, effective 12/19/09; 06-24-036, § 388-501-0050, filed 11/30/06, effective 1/1/07. 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 388-501-0055 Healthcare coverage—How the department determines coverage of services for its healthcare programs using health technology assessments. (1)

The department uses health technology assessments in determining whether a new technology, new indication, or existing technology approved by the Food and Drug Administration (FDA) is a covered service under department healthcare programs. The department only uses health technology assessments when coverage is not mandated by federal or state law. A health technology assessment may be conducted by or on behalf of:

(a) The department; or

(b) The health technology assessment clinical committee (HTACC) according to RCW 70.14.080 through 70.14.140.

(2) The department reviews available evidence relevant to a medical or dental service or healthcare-related equipment and uses a technology evaluation matrix, in order to:

(a) Determine its efficacy, effectiveness, and safety;

(b) Determine its impact on health outcomes;

(c) Identify indications for use;

(d) Identify potential for misuse or abuse; and

(e) Compare to alternative technologies to assess benefit vs. harm and cost effectiveness.

(3) The department may determine the technology, device, or technology-related supply is:

(a) Covered (See WAC 388-501-0060 for the scope of coverage for department medical assistance programs.);

(b) Covered with authorization (See WAC 388-501-0165 for the process on how authorization is determined.);

(c) Covered with limitations (See WAC 388-501-0169 for how limitations can be extended.); or

(d) Noncovered (See WAC 388-501-0070 for the services determined to be noncovered.).

(4) The department may periodically review existing technologies, devices, or technology-related supplies and reassign authorization requirements as necessary according to the same provisions as outlined above for new technologies, devices, or technology-related supplies.

(5) The department evaluates the evidence and criteria presented by HTACC to determine whether a service is covered in accordance with WAC 388-501-0050 (6) and (7) and this section.

[Statutory Authority: RCW 74.08.090 and 70.14.090. 09-17-004, § 388-501-0055, filed 8/6/09, effective 9/6/09.]

WAC 388-501-0070 Healthcare coverage—Noncovered services. (1)

The department does not pay for any healthcare service not listed or referred to as a covered healthcare service under the medical programs described in WAC 388-501-0060, regardless of medical necessity. For the purposes of this section, healthcare services includes treatment, equipment, related supplies, and drugs. Circumstances in which clients are responsible for payment of healthcare services are described in WAC 388-502-0160.

(2) This section does not apply to healthcare services provided as a result of the early and periodic screening, diagnosis, and treatment (EPSDT) program as described in chapter 388-534 WAC.

(3) The department does not pay for any ancillary healthcare service(s) provided in association with a noncovered healthcare service.

(4) The following list of noncovered healthcare services is not intended to be exhaustive. Noncovered healthcare services include, but are not limited to:

(a) Any healthcare service specifically excluded by federal or state law;

(b) Acupuncture, Christian Science practice, faith healing, herbal therapy, homeopathy, massage, massage therapy, naturopathy, and sanipractice;

(c) Chiropractic care for adults;

(d) Cosmetic, reconstructive, or plastic surgery, and any related healthcare services, not specifically allowed under WAC 388-531-0100(4).

(e) Discography;

(f) Ear or other body piercing;

(g) Face lifts or other facial cosmetic enhancements;

(h) Fertility, infertility or sexual dysfunction testing, and related care, drugs, and/or treatment including but not limited to:

(i) Artificial insemination;

(ii) Donor ovum, sperm, or surrogate womb;

(iii) In vitro fertilization;

(iv) Penile implants;

(v) Reversal of sterilization; and

(vi) Sex therapy.

(i) Gender reassignment surgery and any surgery related to trans-sexualism, gender identity disorders, and body dysmorphism, and related healthcare services or procedures, including construction of internal or external genitalia, breast augmentation, or mammoplasty;

(j) Hair transplants, epilation (hair removal), and electrolysis;

(k) Marital counseling;

(l) Motion analysis, athletic training evaluation, work hardening condition, high altitude simulation test, and health and behavior assessment;

(m) Nonmedical equipment;

(n) Penile implants;

(o) Prosthetic testicles;

(p) Psychiatric sleep therapy;

(q) Subcutaneous injection filling;

(r) Tattoo removal;

(s) Transport of Involuntary Treatment Act (ITA) clients to or from out-of-state treatment facilities, including those in bordering cities;

(t) Upright magnetic resonance imaging (MRI); and

(u) Vehicle purchase - new or used vehicle.

(5) For a specific list of noncovered healthcare services in the following service categories, refer to the WAC citation:

(a) Ambulance transportation and nonemergent transportation as described in chapter 388-546 WAC;

(b) Dental services for clients twenty years of age and younger as described in chapter 388-535 WAC;

(c) Dental services for clients twenty-one years of age and older as described in chapter 388-535 WAC;

(d) Durable medical equipment as described in chapter 388-543 WAC;

(e) Hearing care services as described in chapter 388-547 WAC;

(f) Home health services as described in WAC 388-551-2130;

(g) Hospital services as described in WAC 388-550-1600;

(h) Physician-related services as described in WAC 388-531-0150;

(i) Prescription drugs as described in chapter 388-530 WAC; and

(j) Vision care services as described in chapter 388-544 WAC.

(6) A client has a right to request an administrative hearing, if one is available under state and federal law. When the department denies all or part of a request for a noncovered healthcare service(s), the department sends the client and the provider written notice, within ten business days of the date the decision is made, that includes:

(a) A statement of the action the department intends to take;

(b) Reference to the specific WAC provision upon which the denial is based;

(c) Sufficient detail to enable the recipient to:

(i) Learn why the department's action was taken; and

(ii) Prepare a response to the department's decision to classify the requested healthcare service as noncovered.

(d) The specific factual basis for the intended action; and

(e) The following information:

(i) Administrative hearing rights;

(ii) Instructions on how to request the hearing;

(iii) Acknowledgement that a client may be represented at the hearing by legal counsel or other representative;

(iv) Instructions on how to request an exception to rule (ETR);

(v) Information regarding department-covered healthcare services, if any, as an alternative to the requested non-covered healthcare service; and

(vi) Upon the client's request, the name and address of the nearest legal services office.

(7) A client can request an exception to rule (ETR) as described in WAC 388-501-0160.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 09-23-112, § 388-501-0070, filed 11/18/09, effective 12/19/09; 07-04-036, § 388-501-0070, filed 1/29/07, effective 3/1/07.]

WAC 388-501-0163 Healthcare coverage—Process for submitting a valid request for authorization. (1) The department requires providers to obtain authorization for certain healthcare services in accordance with this section, chapters 388-501 and 388-502 WAC, other applicable department rules, current published department billing instructions, and/or numbered memoranda. For the purposes of this section, healthcare services include treatment, equipment, related supplies, and drugs.

(a) For healthcare services that require prior authorization (PA), a provider (as defined in WAC 388-500-0005) must submit a written, electronic, or telephonic request to the department. To be a valid request for prior authorization, the provider must submit the request and conform to the department's current published program billing instructions, numbered memoranda, and any additional requirements in Washington Administrative Code (WAC) and/or Revised Code of Washington (RCW).

(b) For expedited prior authorization (EPA), a provider must certify that the client's clinical condition meets the

appropriate EPA criteria outlined in the department's current published program billing instructions, numbered memoranda, and any additional requirements in WAC and/or RCW. The provider must use the department-assigned EPA number when submitting a claim for payment to the department.

(c) The department requires prior authorization for covered healthcare services when the applicable expedited prior authorization criteria are not met.

(d) Upon request, a provider must submit documentation to the department showing how the client's condition meets the required criteria for PA or EPA.

(2) Department authorization requirements for covered healthcare services are not a denial of service.

(3) The department returns invalid requests to the provider and takes no further action unless the request for authorization is resubmitted. The return of an invalid request is not a denial of service.

(4) Failure of a provider to request authorization for a healthcare service that requires it or a provider's failure to do so properly is not a denial of service.

(5) The department's authorization of healthcare service(s) does not guarantee payment. See WAC 388-501-0050 for other general requirements that must be satisfied before payment can be made for a healthcare service requested and authorized under this section.

(6) The department evaluates a request for an authorization of a healthcare service that exceeds identified limitations, on a case-by-case basis and in accordance with WAC 388-501-0169.

(7) The department may recoup any payment made to a provider if the department later determines the healthcare service was not properly authorized or did not meet EPA criteria. Refer to chapters 388-502 and 388-502A WAC.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 09-23-112, § 388-501-0163, filed 11/18/09, effective 12/19/09.]

WAC 388-501-0169 Healthcare coverage—Limitation extension. This section addresses requests for limitation extensions regarding scope, amount, duration and/or frequency of a covered healthcare service. For the purposes of this section, healthcare services includes treatment, equipment, related supplies, and drugs. The department does not authorize or pay for any covered healthcare services exceeding identified limitations unless authorization is obtained prior to client receiving the service.

(1) No limitation extension of covered healthcare services will be authorized when prohibited by specific program rules.

(2) When a limitation extension is not prohibited by specific program rules, the client's provider may request a limitation extension.

(3) The department evaluates requests for limitation extensions as follows:

(a) For a fee-for-service client, the process described in WAC 388-501-0165.

(b) For a managed care enrollee, the client's managed care organization (MCO) evaluates requests for limitation extensions according to the MCO's prior authorization process.

(c) Both the department and MCO consider the following in evaluating a request for a limitation extension:

(i) The level of improvement the client has shown to date related to the requested healthcare service and the reasonably calculated probability of continued improvement if the requested healthcare service is extended; and

(ii) The reasonably calculated probability the client's condition will worsen if the requested healthcare service is not extended.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 09-23-112, § 388-501-0169, filed 11/18/09, effective 12/19/09; 06-24-036, § 388-501-0169, filed 11/30/06, effective 1/1/07.]

Chapter 388-502 WAC

ADMINISTRATION OF MEDICAL PROGRAMS—PROVIDERS

WAC

388-502-0150 Time limits for providers to bill the department.

WAC 388-502-0150 Time limits for providers to bill the department. Providers must bill the department for covered services provided to eligible clients as follows:

(1) The department requires providers to submit initial claims and adjust prior claims in a timely manner. The department 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 and claims for major trauma services, see subsections (7) and (8) of this section;

(c) For resubmitted prescription drug claims, see subsections (9) and (10) of this section; and

(d) For resubmitting claims for major trauma services, see subsection (11) of this section.

(2) The provider must submit claims to the department as described in the department's current published billing instructions.

(3) Providers must submit the initial claim to the department and have an internal control number (ICN) assigned by the department within three hundred sixty-five calendar 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 the department to cover the service; or

(d) The date the department certifies a client eligible under delayed certification criteria.

(4) The department may grant exceptions to the time limit of three hundred sixty-five calendar days 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 the department's satisfaction that there are other extenuating circumstances.

(5) The department 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 the department's billing limits.

(6) When a client is covered by both medicare and medicaid, the provider must bill medicare for the service before billing the initial claim to the department. If medicare:

(a) Pays the claim the provider must bill the department within six months of the date medicare processes the claim; or

(b) Denies payment of the claim, the department 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) The following applies to claims with a date of service or admission before July 1, 2009:

(a) Within thirty-six months of the date the service was provided to the client, a provider may resubmit, modify, or adjust any claim, other than a prescription drug claim or a claim for major trauma services, with a timely ICN. This applies to any claim, other than a prescription drug claim or a claim for major trauma services, that met the time limits for an initial claim, whether paid or denied. The department does not accept any claim for resubmission, modification, or adjustment after the thirty-six-month period ends.

(b) After thirty-six months from the date the service was provided to the client, a provider cannot refund overpayments by claim adjustment; a provider must refund overpayments by a negotiable financial instrument, such as a bank check.

(8) The following applies to claims with a date of service or admission on or after July 1, 2009:

(a) Within twenty-four months of the date the service was provided to the client, a provider may resubmit, modify, or adjust an initial claim, other than a prescription drug claim or a claim for major trauma services.

(b) After twenty-four months from the date the service was provided to the client, the department does not accept any claim for resubmission, modification, or adjustment. This twenty-four-month period does not apply to overpayments that a provider must refund to the department by a negotiable financial instrument, such as a bank check.

(9) The department 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, the department 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) The department allows a provider of trauma care services to resubmit, modify, or adjust, within three hundred and sixty-five calendar days of the date of service, any trauma claim that meets the criteria specified in WAC 388-531-2000 (for physician claims) or WAC 388-550-5450 (for hospital claims) for the purpose of receiving payment from the trauma care fund (TCF).

(a) No increased payment from the TCF is allowed for an otherwise qualifying trauma claim that is resubmitted after three hundred sixty-five calendar days from the date of service.

(b) Resubmission of or any adjustments to a trauma claim for purposes other than receiving TCF payments are subject to the provisions of this section.

(12) The three hundred sixty-five-day period described in subsection (11) of this section does not apply to overpayments from the TCF that a trauma care provider must refund to the department. A provider must refund an overpayment for a trauma claim that received payment from TCF using a method specified by the department.

(13) If a provider fails to bill a claim according to the requirements of this section and the department denies payment of the claim, the provider or any provider's agent cannot bill the client or the client's estate. The client is not responsible for the payment.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 2009-11 Omnibus Operating Budget (ESHB 1244). 09-12-063, § 388-502-0150, filed 5/28/09, effective 7/1/09. 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.]

Chapter 388-505 WAC FAMILY MEDICAL

WAC

388-505-0210	Children's healthcare programs.
388-505-0211	Premium requirements for premium-based healthcare coverage under programs included in apple health for kids.
388-505-0230	Long-term care for families and children.
388-505-0235	Definitions.
388-505-0240	General eligibility for family institutional medical coverage.
388-505-0245	Resource eligibility for family institutional medical coverage.
388-505-0250	Eligibility for family institutional medical for individuals twenty-one years of age or older.
388-505-0255	Eligibility for family institutional medical for individuals nineteen and twenty years of age.
388-505-0260	Eligibility for family institutional medical for children eighteen years of age or younger.
388-505-0265	How the department determines how much of an institutionalized individual's income must be paid towards the cost of care.
388-505-0270	When an involuntary commitment to Eastern or Western State Hospital is covered by medicaid.

WAC 388-505-0210 Children's healthcare programs.

Funding for children's healthcare coverage may come through Title XIX (medicaid), Title XXI SCHIP, or through state-funded programs. There are no resource limits for children's healthcare programs. Children's healthcare programs that fall under the apple health for kids umbrella are described in subsections (1) through (4) below.

(1) Newborns are eligible for federally matched categorically needy (CN) coverage through their first birthday when:

(a) The child's mother was eligible for and receiving medical assistance 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 who are U.S. citizens, U.S. nationals, or qualified aliens as described in WAC 388-424-0001 and 388-424-0006 are eligible for federally matched CN coverage when they meet the following criteria:

(a) State residence as described in chapter 388-468 WAC;

(b) A Social Security number or application as described in chapter 388-476 WAC;

(c) Proof of citizenship or immigrant status and identity as required by WAC 388-490-0005(11);

(d) Family income is at or below two hundred percent federal poverty level (FPL), as described in WAC 388-478-0075 at each application or review; or

(e) They received supplemental security income (SSI) cash payments in August 1996 and would continue to be eligible for those payments except for the August 1996 passage of amendments to federal disability definitions; or

(f) They are eligible for SSI-related CN or MN coverage.

(3) Noncitizen children under the age of nineteen, who do not meet qualified alien status as described in WAC 388-424-0006, are eligible for state-funded CN coverage when they meet the following criteria:

(a) State residence as described in chapter 388-468 WAC; and

(b) Family income is at or below two hundred percent FPL at each application or review.

(4) Children under the age of nineteen are eligible for premium-based CN coverage as described in chapter 388-542 WAC when they meet the following criteria:

(a) State residence as described in chapter 388-468 WAC;

(b) Family income is over two hundred percent FPL, as described in WAC 388-478-0075, but not over three hundred percent FPL at each application or review;

(c) They do not have other creditable health insurance as described in WAC 388-542-0050; and

(d) They pay the required monthly premiums as described in WAC 388-505-0211

(5) Children under age nineteen are eligible for the medically needy (MN) medicaid program when they meet the following criteria:

(a) Citizenship or immigrant status, state residence, and Social Security number requirements as described in subsection (2)(a), (b), and (c);

(b) Are ineligible for other federal medicaid programs; and

(c) Meet their spenddown obligation as described in WAC 388-519-0100 and 388-519-0110.

(6) Children under the age of twenty-one who reside or expect to reside in a medical institution, intermediate care facility for the mentally retarded (ICF/MR), hospice care center, nursing home, or psychiatric facility may be eligible for healthcare coverage. See WAC 388-505-0230 "Family related institutional medical" and WAC 388-513-1320 "Determining institutional status for long-term care."

(7) Children who are in foster care under the legal responsibility of the state, or a federally recognized tribe located within the state, are eligible for federally matched CN medicaid coverage through the month of their:

(a) Eighteenth birthday;

(b) Twenty-first birthday if children's administration determines they remain eligible for continued foster care services; or

(c) Twenty-first birthday if they were in foster care on their eighteenth birthday and that birthday was on or after July 22, 2007.

(8) Children who receive subsidized adoption services are eligible for federally matched CN medicaid coverage.

(9) Children under age of nineteen may also be eligible for:

(a) Family medical as described in WAC 388-505-0220;

(b) Medical extensions as described in WAC 388-523-0100; or

(c) SSI-related MN if they:

(i) Meet the blind and/or disability criteria of the federal SSI program, or the condition of subsection (2)(e); and

(ii) Have countable income above the level described in WAC 388-478-0070(1).

(10) Children who are ineligible for other programs included in apple health for kids may be eligible for the alien emergency medical program (AEM) if they meet the following criteria:

(a) They have a documented emergent medical condition as defined in WAC 388-500-0005;

(b) They meet the other AEM program requirements as described in WAC 388-438-0110; and

(c) They have income that exceeds three hundred percent FPL; or

(d) They are disqualified from receiving premium-based coverage as described in subsection (4) of this section because of creditable coverage or nonpayment of premiums.

(11) Except for a client described in subsection (6), an inmate of a public institution, as defined in WAC 388-500-0005, is not eligible for any children's healthcare program.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.402, 74.09.470, and 2008 session law. 09-07-086, § 388-505-0210, filed 3/17/09, effective 4/17/09. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.-090, 74.09.530, 74.09.700, and 2007 c 5. 08-05-018, § 388-505-0210, filed 2/12/08, effective 3/14/08. Statutory Authority: RCW 74.08.090, 74.09.530, and 74.09.415. 05-23-013, § 388-505-0210, filed 11/4/05, effective 1/1/06. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 04-15-057, § 388-505-0210, filed 7/13/04, effective 8/13/04. Statutory Authority: RCW 74.08.090 and 74.04.050. 03-14-107, § 388-505-0210, filed 6/30/03, effective 7/31/03. 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 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 388-505-0211 Premium requirements for premium-based healthcare coverage under programs included in apple health for kids. (1) For the purposes of this chapter, "premium" means an amount paid for healthcare coverage under programs included in apple health for kids.

(2) Payment of a premium is required as a condition of eligibility for premium-based coverage under programs included in apple health for kids, as described in WAC 388-505-0210(4), unless the child is:

(a) Pregnant; or

(b) An American Indian or Alaska native.

(3) The premium requirement begins the first of the month following the determination of eligibility. There is no premium requirement for medical coverage received in a month or months before the determination of eligibility.

(4) The premium amount for the assistance unit is based on the net countable income as described in WAC 388-450-0210 and the number of children in the assistance unit. If the

household includes more than one assistance unit, the premium amount billed for the assistance units may be different amounts.

(5) The premium amount for each eligible child shall be:

(a) Twenty dollars per month per child for households with income above two hundred percent FPL, but not above two hundred and fifty percent FPL;

(b) Thirty dollars per month per child for households with income above two hundred and fifty percent FPL, but not above three hundred percent FPL; and

(c) Limited to a monthly maximum of two premiums for households with two or more children.

(6) All children in an assistance unit are ineligible for healthcare coverage when the head of household fails to pay required premium payments for three consecutive months.

(7) When the department terminates the medical coverage of a child due to nonpayment of premiums, the child has a three-month period of ineligibility beginning the first of the following month. The three-month period of ineligibility is rescinded only when the:

(a) Past due premiums are paid in full prior to the begin date of the period of ineligibility; or

(b) The child becomes eligible for coverage under a non-premium-based healthcare program. The department will not rescind the three-month period of ineligibility for reasons other than the criteria described in this subsection.

(8) The department writes off past-due premiums after twelve months.

(9) When the designated three-month period of ineligibility is over, all past due premiums that are an obligation of the head of household must be paid or written off before a child can become eligible for premium-based coverage under a program included in apple health for kids.

(10) A family cannot designate partial payment of the billed premium amount as payment for a specific child in the assistance unit. The full premium amount is the obligation of the head of household of the assistance unit. A family can decide to request healthcare coverage only for certain children in the assistance unit, if they want to reduce premium obligation.

(11) A change that affects the premium amount is effective the month after the change is reported and processed.

(12) A sponsor or other third party may pay the premium on behalf of the child or children in the assistance unit. The premium payment requirement remains the obligation of head of household of the assistance unit. The failure of a sponsor or other third party to pay the premium does not eliminate the:

(a) Establishment of the period of ineligibility described in subsection (7) of this section; or

(b) Obligation of the head of household to pay past-due premiums.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.402, 74.09.470, and 2008 session law. 09-07-086, § 388-505-0211, filed 3/17/09, effective 4/17/09. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, 74.09.700, and 2007 c 5. 08-05-018, § 388-505-0211, filed 2/12/08, effective 3/14/08. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.522, 74.09.450, and 2004 c 276. 04-16-064, § 388-505-0211, filed 7/30/04, effective 8/30/04. Statutory Authority: RCW 74.08.090, 74.09.055, 2004 c 276. 04-08-125, § 388-505-0211, filed 4/7/04, effective 5/8/04.]

WAC 388-505-0230 Long-term care for families and children. (1) The sections that follow describe the eligibility requirements for institutional medical benefits for parents and children who are not aged, blind or disabled, and who are admitted for a long-term stay to a medical institution, an inpatient psychiatric facility or an institution for mental diseases (IMD):

(a) WAC 388-505-0235 Definitions;

(b) WAC 388-505-0240 General eligibility for family institutional medical coverage;

(c) WAC 388-505-0245 Resource eligibility for family institutional medical coverage;

(d) WAC 388-505-0250 Eligibility for family institutional medical for individuals twenty-one years of age or older;

(e) WAC 388-505-0255 Eligibility for family institutional medical for individuals nineteen and twenty years of age;

(f) WAC 388-505-0260 Eligibility for family institutional medical for children eighteen years of age or younger;

(g) WAC 388-505-0265 How the department determines how much of an institutionalized individual's income must be paid towards the cost of care; and

(h) WAC 388-505-0270 When an involuntary commitment to Eastern or Western State Hospital is covered by Medicaid.

(2) Individuals who are already eligible for a noninstitutional family or children's medical program when they are admitted for long-term care do not need to submit a new application for institutional medical coverage. The department treats their admittance to the facility as a change of circumstances and determines their eligibility based upon the length of stay at the facility.

[Statutory Authority: RCW 74.04.055, 74.04.057, 74.08.090, 74.09.530, and 42 C.F.R. 441.151. 09-06-029, § 388-505-0230, filed 2/24/09, effective 3/27/09.]

WAC 388-505-0235 Definitions. The following terms are used in WAC 388-505-0230 through 388-505-0270:

"Categorically needy income level (CNIL)"—The standard used by the department to determine eligibility under a categorically needy medicaid program.

"Categorically needy (CN) medical"—Full scope of care medical benefits. CN medical may be either federally funded under Title XIX of the social security act or state-funded.

"Categorically needy (CN) medicaid"—Federally funded full scope of care medical benefits under Title XIX of the Social Security Act.

"Federal benefit rate (FBR)"—The payment standard set by the Social Security administration for recipients of Supplemental Security Income (SSI). This standard is adjusted annually in January.

"Federal poverty level"—The income standards published annually by the federal government in the Federal Register found at <http://aspe.hhs.gov/poverty/index.shtml>. The income standards change on April first every year.

"Institution for mental diseases (IMD)"—A hospital, nursing facility, or other institution of more than sixteen beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including med-

ical attention, nursing care, and related services. Inpatient chemical dependency facilities of more than sixteen beds which provide residential treatment for alcohol and substance abuse are also considered an IMD.

"Institutional status"—An individual meets institutional status when he or she is admitted to a medical institution, inpatient psychiatric facility, or IMD for a period of thirty days or longer. The time period is ninety days or longer for individuals seventeen years of age and younger who are admitted to an inpatient psychiatric facility or institution for mental diseases. Institutional status is described in WAC 388-513-1320.

"Legal dependent"—A minor child, seventeen years of age and younger, and an individual eighteen years of age and older claimed as a dependent for income tax purposes; or a parent of either the applicant or the applicant's spouse claimed as a dependent for income tax purposes; or the brother or sister (including half and adoptive siblings) claimed by either the applicant or the applicant's spouse as a dependent for income tax purposes.

"Medical institution"—A medical facility that provides twenty-four hour supervision and skilled nursing care. Facilities which meet this definition include:

- (1) Hospitals;
- (2) Nursing homes or the nursing home section of a state veteran's facility;
- (3) Hospice care centers;
- (4) An intermediate care facility for the mentally retarded (ICF/MR); or
- (5) A residential habilitation center (RHC).

"Medically needy income level (MNIL)"—The standard used by the department to determine eligibility under the medically needy medicaid program. The MNIL standards are described in WAC 388-478-0070.

"Medically needy (MN) medicaid"—Federally funded medical coverage under Title XIX of the Social Security Act. MN coverage has a more limited scope of care than CN coverage.

"Personal needs allowance (PNA)"—An amount designated to cover the expenses of an individual's clothing and personal incidentals while living in a medical institution, inpatient psychiatric facility, or institution for mental diseases.

"Psychiatric facility"—Designated long-term inpatient psychiatric residential treatment facilities, state psychiatric hospitals, designated distinct psychiatric units, and medicare-certified distinct units in acute care hospitals.

"Spendedown"—The amount of medical expenses an individual is required to incur prior to medical benefits being authorized. Spendedown is described in WAC 388-519-0100 and 388-519-0110.

"Title XIX"—The portion of the federal Social Security Act, 42 U.S.C. 1396, that authorizes grants to states for medical assistance programs. Title XIX is also called medicaid.

[Statutory Authority: RCW 74.04.055, 74.04.057, 74.08.090, 74.09.530, and 42 C.F.R. 441.151. 09-06-029, § 388-505-0235, filed 2/24/09, effective 3/27/09.]

WAC 388-505-0240 General eligibility for family institutional medical coverage. (1) This section applies to all individuals applying for long-term care services under the

family institutional medical program. Additional rules may apply based upon an individual's age at the time he or she applies for long-term care services and whether the facility the individual is admitted to is a medical institution, inpatient psychiatric facility, or an institution for mental diseases (IMD). Additional rules are described in WAC 388-505-0245 through 388-505-0265.

(2) Individuals must meet the following requirements to qualify for family institutional coverage:

(a) Institutional status described in WAC 388-513-1320. An individual meets institutional status if he or she is admitted to:

(i) A medical institution and resides, or is likely to reside, there for thirty days or longer, regardless of age;

(ii) An inpatient psychiatric facility or IMD and resides, or is likely to reside, there for thirty days or longer and is eighteen through twenty years of age; or

(iii) An inpatient psychiatric facility or IMD and resides, or is likely to reside, there for ninety days or longer and is seventeen years of age or younger.

(b) General eligibility requirements described in WAC 388-503-0505 (with the exception that subsections (3)(c) and (3)(d) of that section do not apply to individuals who are eligible under the alien emergency medical (AEM) program) and meet one of the following:

(i) Be a parent of, or a relative caring for, an eligible dependent child and meet the program requirements under:

(A) A family medical program described in WAC 388-505-0220;

(B) A transitional family medical program described in WAC 388-523-0100; or

(C) The temporary assistance for needy families (TANF) cash assistance program.

(ii) Be a child and meet the program requirements under apple health for kids as described in WAC 388-505-0210;

(iii) Be a pregnant woman and meet the program requirements for a pregnancy medical program as described in WAC 388-462-0015;

(iv) Meet the alien emergency medical (AEM) program requirements as described in WAC 388-438-0110 (with the exception that for family long-term care services, AEM coverage may be authorized for children through twenty-one years of age) and:

(A) Have a qualifying emergency condition; and

(B) For payment for long-term care services and room and board costs in the institution, request authorization from the department's medical consultant if the individual is admitted to a medical institution under hospice or is admitted to a nursing facility.

(v) Be an individual nineteen through twenty years of age but not eligible under subsections (i) through (iv) of this section.

(c) Resource requirements described in WAC 388-505-0245;

(d) Have countable income below the applicable standard described in WAC 388-505-0250(4), 388-505-0255(3) or 388-505-0260(4);

(e) Contribute income remaining after the post eligibility process described in WAC 388-505-0265 towards the cost of care in the facility; and

(f) Be assessed as needing nursing facility level of care as described in WAC 388-106-0355 if the admission is to a nursing facility. (This does not apply to nursing facility admissions under the hospice program.)

(3) Once the department determines an individual meets institutional status, it does not count the income of parent(s), a spouse, or dependent child(ren) when determining countable income. The department counts the following as the individual's income:

(a) Income received by the individual in his or her own name;

(b) Funds given to him or her by another individual towards meeting his or her needs; and

(c) Current child support received on behalf of the individual by his or her parents.

(4) Individuals eligible for a cash grant under the temporary assistance for needy families (TANF) program can remain eligible for a cash payment and the categorically needy (CN) medicaid program while in the institution. The expected length of stay in the institution may impact the amount of the TANF payment.

(a) When the institutionalized individual is expected to return to the home within one hundred and eighty days, the department considers this to be a temporary absence from the home and the individual remains eligible for their full TANF grant. Rules defining a temporary absence are described in WAC 388-454-0015.

(b) When the department determines that the institutionalized individual's stay in the facility is likely to exceed one hundred and eighty days, the department reduces his or her share of the TANF grant to the personal needs allowance (PNA) described in WAC 388-478-0040. This is also referred to as the clothing, personal maintenance and necessary incidentals (CPI) amount.

(5) Individuals who are not United States citizens or qualified aliens do not need to provide or apply for a social security number or meet the citizenship requirements under WAC 388-424-0010(1) or 388-424-0010(2) as long as the requirements in subsection (2) of this section are met.

(6) Individuals who are aged, blind or disabled under federal criteria may qualify for institutional benefits with income of up to three hundred percent of the federal benefit rate (FBR). Rules relating to institutional eligibility for aged, blind or disabled individuals are described in WAC 388-513-1315.

(7) If an individual does not meet institutional status, the department determines his or her eligibility for a noninstitutional medical program. An individual who is determined eligible for CN or medically needy (MN) coverage under a non-institutional program who is admitted to a nursing facility for less than thirty days is approved for coverage for the nursing facility room and board costs, as long as the individual is assessed by the department as meeting nursing home level of care as described in WAC 388-106-0355.

[Statutory Authority: RCW 74.04.055, 74.04.057, 74.08.090, 74.09.530, and 42 C.F.R. 441.151. 09-06-029, § 388-505-0240, filed 2/24/09, effective 3/27/09.]

WAC 388-505-0245 Resource eligibility for family institutional medical coverage. (1) The department does not restrict or limit resources available to individuals eighteen

years of age or younger when determining eligibility for family institutional medical coverage. The department does not consider, or count towards eligibility, any resources owned by the individual in this age category, or any resources owned by the individual's parent(s), spouse, or child(ren), if applicable.

(2) For individuals nineteen years of age or older, there is a one thousand dollar countable resource limit for new applicants for family medical coverage not meeting the additional resource exclusion of WAC 388-470-0026, and all of the following apply:

(a) In order to determine which resources it must count, the department follows rules in WAC 388-470-0026, 388-470-0045 (with the exception of subsection (3) relating to primary residence), 388-470-0060, and 388-470-0070.

(b) Applicants and current categorically needy (CN) or medically needy (MN) medical assistance clients receiving long-term care services under the family institutional medical program are subject to transfer of asset regulations as described in WAC 388-513-1363 through 388-513-1366.

(c) Individuals who apply for long-term care services on or after May 1, 2006, who have an equity interest greater than five hundred thousand dollars in their primary residence are not eligible for long-term care services. This does not apply if the individual's spouse or blind, disabled or dependent child under twenty-one years of age is lawfully residing in the primary residence. Individuals who are denied or terminated from long-term care services due to excess home equity may apply for an undue hardship waiver as described in WAC 388-513-1367.

(d) Once an individual has been determined eligible for any family medical program, the department does not consider any subsequent increase in that individual's resources after the month of application, as described in WAC 388-470-0026. Subsequent increases in a family's resources are not applied towards the cost of care in any month in which the resources have exceeded the eligibility standard.

(e) When both spouses of a legally married couple are institutionalized, the department determines resource eligibility for each spouse separately, as if each were a single individual.

(f) When only one spouse in a legally married couple applies for family institutional coverage, the rules in WAC 388-513-1350 (8) through (13) apply.

(g) For countable resources over one thousand dollars that are not otherwise excluded by WAC 388-470-0026:

(i) The department reduces the excess resources in an amount equal to medical expenses incurred by the institutionalized individual, such as:

(A) Premiums, deductibles, coinsurance or copayments for health insurance and medicare;

(B) Necessary medical care recognized under state law, but not covered under the state's medical plan; and

(C) Necessary medical care recognized under state law, but incurred prior to medicaid eligibility.

(ii) Medical expenses that the department uses to reduce excess resources must not:

(A) Be the responsibility of a third party payer;

(B) Have been used to satisfy a previous spenddown liability;

(C) Have been previously used to reduce excess resources;

(D) Have been used to reduce client responsibility toward cost of care;

(E) Have been incurred during a transfer of asset penalty; or

(F) Have been written off by the medical provider (the individual must be financially liable for the expense).

(h) If an individual has excess resources remaining, after using incurred medical expenses to reduce those resources, the department uses the following calculations to determine if an individual is eligible for family institutional medical coverage under the CN or MN program:

(i) If countable income is below the CN income standard, and the combination of countable income plus excess resources is below the monthly cost of care at the state medicaid rate, the individual is eligible for family institutional medical coverage under the CN program.

(ii) If countable income is below the CN income standard, but the combination of countable income plus excess resources is above the monthly cost of care at the state medicaid rate, the individual is not eligible for family institutional medical coverage.

(iii) If countable income is over the CN income standard, and the combination of countable income plus excess resources is below the monthly cost of care at the institution's private rate plus the amount of any recurring medical expenses for institutional services, the individual is eligible for family institutional coverage under the MN program. (MN coverage applies only to individuals twenty years of age or younger.)

(iv) If countable income is over the CN income standard, but the combination of countable income plus excess resources is higher than the monthly cost of care at the institution's private rate plus the amount of any recurring medical expenses for institutional services, the individual is not eligible for family institutional coverage under the MN program. (MN coverage applies only to individuals twenty years of age or younger.)

[Statutory Authority: RCW 74.04.055, 74.04.057, 74.08.090, 74.09.530, and 42 C.F.R. 441.151. 09-06-029, § 388-505-0245, filed 2/24/09, effective 3/27/09.]

WAC 388-505-0250 Eligibility for family institutional medical for individuals twenty-one years of age or older. (1) Individuals twenty-one years of age or older must meet the requirements in WAC 388-505-0240 to qualify for family institutional medical coverage.

(2) Individuals, twenty-one through sixty-four years of age who are admitted to an institution for mental diseases (IMD) are not eligible for coverage under this section. Individuals who are voluntarily admitted to a psychiatric hospital may be eligible for coverage under the psychiatric indigent inpatient program described in WAC 388-865-0217.

(3) Rules governing resources are described in WAC 388-505-0245. However, if an applicant has countable resources over the standard described in WAC 388-505-0245, he or she may spend down any excess amount towards his or her cost of care as described in WAC 388-505-0265(6).

(4) The categorically needy income level (CNIL) for individuals who qualify for family institutional medical cov-

erage under this section is the temporary assistance for needy families (TANF) one person payment standard based on the requirement to pay shelter costs described in WAC 388-478-0020. An individual's countable income must be at or below this amount to be eligible.

(5) If the individual's income exceeds the standards to be eligible under a categorically needy (CN) medicaid family program, he or she is not eligible for coverage under the medically needy (MN) medicaid program.

(6) Individuals eligible under the provisions of this section may be required to contribute a portion of their income towards the cost of care as described in WAC 388-505-0265.

[Statutory Authority: RCW 74.04.055, 74.04.057, 74.08.090, 74.09.530, and 42 C.F.R. 441.151. 09-06-029, § 388-505-0250, filed 2/24/09, effective 3/27/09.]

WAC 388-505-0255 Eligibility for family institutional medical for individuals nineteen and twenty years of age. (1) Individuals nineteen and twenty years of age must meet the requirements in WAC 388-505-0240 to qualify for family institutional medical coverage.

(2) Rules governing resources are described in WAC 388-505-0245. However, if an applicant has countable resources over the standard described in WAC 388-505-0245, he or she may spend down any excess resources over the standard by applying the excess amount towards his or her cost of care as described in WAC 388-505-0265(6).

(3) The categorically needy income level (CNIL) for individuals who qualify for family institutional medical coverage under this section is the temporary assistance for needy families (TANF) one person payment standard based on the requirement to pay shelter costs described in WAC 388-478-0020. An individual's countable income must be at or below this amount to be eligible.

(4) If an individual's countable income exceeds the standard described in subsection (3) of this section, the department determines whether he or she is eligible for coverage under the medically needy (MN) medicaid program.

(a) Individuals with countable income below the state monthly cost of care in the facility are eligible for MN without spenddown.

(b) If the individual's countable income exceeds the state monthly cost of care but is under the private cost of care plus the amount of any recurring medical expenses for institutional services, he or she may be required to spend down their income as described in WAC 388-519-0110.

(c) If the individual's countable income exceeds the private monthly cost of care plus the amount of any recurring medical expenses for institutional services, he or she is not eligible for family institutional medical coverage.

(5) If an individual is a medicaid applicant or current medical assistance client in the month of his or her twenty-first birthday and receives active inpatient psychiatric or inpatient chemical dependency treatment which extends beyond his or her twenty-first birthday, the department approves or continues CN or MN medicaid coverage until the date the individual is discharged from the facility or until his or her twenty-second birthday, whichever occurs first.

(6) Individuals eligible under the provisions of this section may be required to contribute a portion of their income towards the cost of care as described in WAC 388-505-0265.

[Statutory Authority: RCW 74.04.055, 74.04.057, 74.08.090, 74.09.530, and 42 C.F.R. 441.151. 09-06-029, § 388-505-0255, filed 2/24/09, effective 3/27/09.]

WAC 388-505-0260 Eligibility for family institutional medical for children eighteen years of age or younger. (1) Individuals eighteen years of age or younger must meet the requirements in WAC 388-505-0240 to qualify for family institutional medical coverage.

(2) When an individual eighteen years of age or younger is eligible for premium-based categorically needy (CN) coverage under apple health for kids as described in WAC 388-505-0210(4), the department redetermines his or her eligibility using the provisions of this section so that the individual is not required to pay the premium.

(3) The department does not restrict or limit the resources available to individuals eighteen years of age or younger when determining eligibility for family institutional medical coverage. The department does not consider, or count towards eligibility any resources owned by the individual in this age category, or any resources owned by the individual's parent(s), spouse, or child(ren), if applicable.

(4) The categorically needy income level (CNIL) for individuals who qualify for family institutional medical coverage under this section is two hundred percent of the federal poverty level income standard. Once the department determines an individual meets institutional status, it does not count the income of a parent(s), spouse, or dependent children (if applicable) when determining the individual's countable income.

(5) The department approves CN medical coverage under this section for twelve calendar months. If an individual is discharged from the facility before the end of his or her certification period, he or she remains continuously eligible for CN medical coverage through the end of the original certification date, unless he or she ages out of the program, moves out of state, is incarcerated, or dies.

(6) If an individual is not eligible for CN medical coverage under this section, the department determines his or her eligibility for coverage under the medically needy (MN) program.

(a) MN coverage is only available for an individual who meets the citizenship requirements under WAC 388-424-0010(1) or (2).

(b) Individuals with countable income below the state monthly cost of care in the facility are eligible for MN without spenddown.

(c) If the individual's countable income exceeds the state monthly cost of care, but is under the private monthly cost of care plus the amount of any recurring medical expenses for institutional services, the department may require the individual to spend down his or her income as described in WAC 388-519-0110.

(d) If the individual's countable income exceeds the private monthly cost of care plus the amount of any recurring medical expenses for institutional services, he or she is not eligible for family institutional medical coverage.

(7) The facility where the individual resides may submit an application on the individual's behalf and may act as an authorized representative for the individual if the individual is:

(a) In a court ordered, out-of-home placement under chapter 13.34 RCW; or

(b) Involuntarily committed to an inpatient treatment program by a court order under chapter 71.34 RCW.

(8) Individuals eligible for family institutional medical coverage under the provisions of this section may be required to contribute a portion of their income towards the cost of care as described in WAC 388-505-0265.

[Statutory Authority: RCW 74.04.055, 74.04.057, 74.08.090, 74.09.530, and 42 C.F.R. 441.151. 09-06-029, § 388-505-0260, filed 2/24/09, effective 3/27/09.]

WAC 388-505-0265 How the department determines how much of an institutionalized individual's income must be paid towards the cost of care. (1) Individuals who reside in a medical institution, inpatient psychiatric facility or an institution for mental diseases (IMD) may be required to pay a portion of their income towards the cost of care. This section explains how the department calculates how much an individual is required to pay to the facility. This process is known as the post-eligibility process. If an individual does not have income, he or she does not have to pay.

(2) The department determines available income by considering an individual's total gross income before any mandatory deductions from earnings. Income that was not counted in the initial eligibility process is counted for the post-eligibility process unless the income is excluded under federal or state law. See WAC 388-450-0015 for examples of excluded income types.

(3) The following income allocations and exemptions are deducted from an individual's total gross income to determine his or her available income. The department uses the rules described in WAC 388-513-1380 to calculate the amount of these allocations and exemptions, with the exception that under the family institutional medical program, there is no deduction for earned income in the post-eligibility process.

(a) Personal needs allowance (PNA) and maintenance allocation. The combined totals of all of the following deductions cannot exceed the medically needy income level (MNIL):

(i) PNA as allowed under WAC 388-478-0040;

(ii) Mandatory federal, state, or local income taxes owed by the client; and

(iii) Court ordered guardianship fees and administrative costs, including attorney fees, as described in chapter 388-79 WAC.

(b) Income garnished to comply with a court order for child support.

(c) Community spouse allocation.

(d) Family maintenance allocation if married with dependents.

(e) Legal dependent allocation for an unmarried client with dependents. The maximum allocation is based upon the MNIL standard for the number of dependents minus the dependent's income.

(f) Medical expense allocation. The department allows a deduction for unpaid medical expenses for which the individual is still liable. Medical expenses allowed for this allocation are described in WAC 388-513-1350.

(g) Housing maintenance exemption:

(i) For an individual who is financially responsible for the costs of maintaining a home while he or she is in an institution, the department allows a deduction, limited to a six-month period, of up to one hundred percent of the one-person poverty level per month, when a physician has certified that the individual is likely to return to the home within the six-month period.

(ii) An individual eighteen years of age or younger is not eligible for the housing maintenance exemption unless the housing expense is the individual's financial responsibility. Children are not financially responsible for the housing expenses incurred by their parents.

(4) Individuals may keep a personal needs allowance of up to the one person temporary assistance for needy families (TANF) payment standard (based upon the requirement to pay shelter costs) in the month they are admitted and in the month they are discharged from the facility.

(5) Any income which remains must be paid to the facility towards the cost of care.

(6) Individuals nineteen years of age or older who qualify for categorically needy (CN) or medically needy (MN) coverage but have countable resources in excess of the resource limits as described in WAC 388-505-0245 must pay an amount equal to the excess amount to the facility towards the cost of their care in the month of application. This amount is in addition to the amount calculated under subsections (2) through (4) of this section (if any).

[Statutory Authority: RCW 74.04.055, 74.04.057, 74.08.090, 74.09.530, and 42 C.F.R. 441.151. 09-06-029, § 388-505-0265, filed 2/24/09, effective 3/27/09.]

WAC 388-505-0270 When an involuntary commitment to Eastern or Western State Hospital is covered by medicaid. (1) Individuals admitted to Eastern or Western State Hospital for inpatient psychiatric treatment may qualify for categorically needy (CN) medicaid coverage and general assistance (GA) cash benefits to cover their personal needs allowance (PNA).

(2) To be eligible under this program, individuals must:

(a) Be eighteen through twenty years of age or sixty-five years of age or older;

(b) Meet institutional status under WAC 388-513-1320;

(c) Be involuntarily committed to an inpatient treatment program by a court order under chapter 71.34 RCW;

(d) Meet the general eligibility requirements for the GA cash program as described in WAC 388-400-0025;

(e) Have countable income below the payment standard described in WAC 388-478-0040; and

(f) Have countable resources below one thousand dollars. Individuals eligible under the provisions of this section may not apply excess resources towards the cost of care to become eligible. An individual with resources over the standard is not eligible for assistance under this section.

(3) GA clients who receive active psychiatric treatment in Eastern or Western State Hospital at the time of their twenty-first birthday continue to be eligible for medicaid coverage until the date they are discharged from the facility or until their twenty-second birthday, whichever occurs first.

[Statutory Authority: RCW 74.04.055, 74.04.057, 74.08.090, 74.09.530, and 42 C.F.R. 441.151. 09-06-029, § 388-505-0270, filed 2/24/09, effective 3/27/09.]

Chapter 388-513 WAC

CLIENT NOT IN OWN HOME—INSTITUTIONAL MEDICAL

WAC

388-513-1315	Eligibility for long-term care (institutional, waiver, and hospice) services.
388-513-1320	Determining institutional status for long-term care (LTC) services.
388-513-1340	Determining excluded income for long-term care (LTC) services.
388-513-1350	Defining the resource standard and determining resource eligibility for long-term care (LTC) services.
388-513-1380	Determining a client's financial participation in the cost of care for long-term care (LTC) services.

WAC 388-513-1315 Eligibility for long-term care (institutional, waiver, and hospice) services. This section describes how the department determines a client's eligibility for medical for clients residing in a medical institution, on a waiver, or receiving hospice services under the categorically needy (CN) or medically needy (MN) programs. Also described are the eligibility requirements for these services under the general assistance (GA) program in subsection (12) and the state funded nursing facility program described in subsection (11).

(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;

(c) Meet functional eligibility described in chapter 388-106 WAC for waiver and nursing facility coverage;

(d) Not have a penalty period of ineligibility as described in WAC 388-513-1363, 388-513-1364, 388-513-1365 or 388-513-1366;

(e) Not have equity interest greater than five hundred thousand dollars in their primary residence as described in WAC 388-513-1350; and

(f) Must disclose to the state any interest the applicant or spouse has in an annuity and meet annuity requirements described in chapter 388-561 WAC:

(i) This is required for all institutional or waiver services and includes those individuals receiving supplemental security income (SSI).

(ii) A signed and completed eligibility review for long term care benefits or application for benefits form can be accepted for SSI individuals applying for long-term care services.

(2) To be eligible for institutional, waiver, 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 388-475-0050 (1), (2) and (3) and meet the following financial requirements, by having:

(i) Gross nonexcluded income described in subsection (8)(a) that does not exceed the special income level (SIL) (three hundred percent of the federal benefit rate (FBR)); and

(ii) Countable resources described in subsection (7) that do not exceed the resource standard described in WAC 388-513-1350; or

(b) Be approved and receiving the general assistance expedited medicaid disability (GA-X) or general assistance aged (GA-A) or general assistance disabled (GA-D) described in WAC 388-505-0110(6); or

(c) Be eligible for CN apple health for kids described in WAC 388-505-0210; or CN family medical described in WAC 388-505-0220; or family and children's institutional medical described in WAC 388-505-0230 through 388-505-0260. Clients not meeting the citizenship requirements for federally funded medicaid described in WAC 388-424-0010 are not eligible to receive waiver services. Nursing facility services require prior approval for the state funded nursing facility program described in WAC 388-438-0125 for noncitizen children; or

(d) Be eligible for the temporary assistance for needy families (TANF) program as described in WAC 388-400-0005. Clients not meeting disability or blind criteria described in WAC 388-475-0050 are not eligible for waiver services.

(3) The department allows a client to reduce countable resources in excess of the standard. This is described in WAC 388-513-1350.

(4) To be eligible for waiver services, a client must meet the program requirements described in:

(a) WAC 388-515-1505 through 388-515-1509 for COPES, New Freedom, PACE, and WMIP services; or

(b) WAC 388-515-1510 through 388-515-1514 for DDD waivers; or

(c) WAC 388-515-1540 for the medically needy residential waiver (MNRW); or

(d) WAC 388-515-1550 for the medically needy in-home waiver (MNIW).

(5) To be eligible for hospice services under the CN program, a client must:

(a) Meet the program requirements described in chapter 388-551 WAC; and

(b) Be eligible for a noninstitutional categorically needy program (CN-P) if not residing in a medical institution thirty days or more; or

(c) Reside at home and benefit by using home and community based waiver rules described in WAC 388-515-1505 through 388-515-1509 (SSI related clients with income over the MNIL and at or below the 300 percent of the FBR or clients with a community spouse); or

(d) Receive home and community waiver (HCS) or DDD waiver services in addition to hospice services. The client's responsibility to pay toward the cost of care (participation) is applied to the waiver service provider first; or

(e) Be eligible for institutional CN if residing in a medical institution thirty days or more.

(6) To be eligible for institutional or hospice services under the MN program, a client must be:

(a) Eligible for MN children's medical program described in WAC 388-505-0210, 388-505-0255, or 388-505-0260; or

(b) Related to the SSI program as described in WAC 388-475-0050 and meet all requirements described in WAC 388-513-1395; or

(c) Eligible for the MN SSI related program described in WAC 388-475-0150 for hospice clients residing in a home setting; or

(d) Eligible for the MN SSI related program described in WAC 388-513-1305 for hospice clients not on a medically needy waiver and residing in an alternate living facility.

(e) Be eligible for institutional MN if residing in a medical institution thirty days or more described in WAC 388-513-1395.

(7) To determine resource eligibility for an SSI-related client under the CN or MN program, the department:

(a) Considers resource eligibility and standards described in WAC 388-513-1350; and

(b) Evaluates the transfer of assets as described in WAC 388-513-1363, 388-513-1364, 388-513-1365 or 388-513-1366.

(8) 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.

(9) A client who meets the requirements of the CN program is approved for a period of up to twelve months.

(10) A client who meets the requirements of the MN program is approved for a period of months described in WAC 388-513-1395(6) for:

(a) Institutional services in a medical institution; or

(b) Hospice services in a medical institution.

(11) The department determines eligibility for the state funded nursing facility program described in WAC 388-438-0110 and 388-438-0125. Nursing facility services under the state funded nursing facility program must be preapproved by aging and disability services administration (ADSA).

(12) 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 (9) 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 under the age of twenty-one at the time of application; or

(c) Is receiving active psychiatric treatment just prior to their twenty-first birthday and the services extend beyond this date and the client has not yet reached age twenty-two; or

(d) 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) If an individual under age twenty one is not eligible for medicaid under SSI related in WAC 388-475-0050 or general assistance (GA) described in WAC 388-448-0001 and 388-505-0110(6) consider eligibility under WAC 388-505-0255 or 388-505-0260.

(16) Noncitizen individuals under age nineteen can be considered for the apple health for kids program described in WAC 388-505-0210 if they are admitted to a medical institution for less than thirty days. Once an individual resides or is likely to reside in a medical institution for thirty days or more, the department determines eligibility under WAC 388-505-0260 and must be preapproved for coverage by ADSA as described in WAC 388-438-0125.

(17) The department determines a client's total responsibility to pay toward the cost of care for LTC services as follows:

(a) For SSI-related clients residing in a medical institution see WAC 388-513-1380;

(b) For clients receiving HCS CN waiver services see WAC 388-515-1509;

(c) For clients receiving DDD CN waiver services see WAC 388-515-1514;

(d) For clients receiving HCS MN waiver services see WAC 388-515-1540 or 388-515-1550; or

(e) For TANF related clients residing in a medical institution see WAC 388-505-0265.

(18) Clients not living in a medical institution who are considered to be receiving SSI benefits for the purposes of medicaid do not pay service participation toward their cost of care. Clients living in a residential setting do pay room and board as described in WAC 388-515-1505 through 388-515-1509 or WAC 388-515-1514. Groups deemed to be receiving SSI and for medicaid purposes are eligible to receive CN-P medicaid. These groups are described in WAC 388-475-0880.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 10-01-158, § 388-513-1315, filed 12/22/09, effective 1/22/10. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 74.09.575, and Deficit Reduction Act of 2005, 42 C.F.R. Section 435.09-07-036, § 388-513-1315, filed 3/10/09, effective 4/10/09. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 74.39.010, 07-19-129, § 388-513-1315, filed 9/19/07, effective 10/20/07. Statutory Authority: RCW 74.08.090, 06-07-077, § 388-513-1315, filed 3/13/06, effective 4/13/06. Statutory Authority: RCW 71A.12.030, 71A.10-020, chapters 71A.10 and 71A.12 RCW, 2004 c 276, 04-18-054, § 388-513-1315, filed 8/27/04, effective 9/27/04. 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. (1) Institutional status is an eligibility requirement for long-term care services (LTC) and institutional medical programs. To attain institutional status, you must:

(a) Be approved for and receiving home and community based waiver services or hospice services; or

(b) Reside or be likely to reside in a medical institution, institution for medical diseases (IMD) or inpatient psychiatric facility for a continuous period of:

(i) Thirty days if you are an adult eighteen and older;

(ii) Thirty days if you are a child seventeen years of age or younger admitted to a medical institution; or

(iii) Ninety days if you are a child seventeen years of age or younger receiving inpatient chemical dependency or inpatient psychiatric treatment.

(2) Once the department has determined that you meet institutional status, your status is not affected by:

(a) Transfers between medical facilities; or

(b) Changes from one kind of long-term care services (waiver, hospice or medical institutional services) to another.

(3) If you are absent from the medical institution or you do not receive waiver or hospice services for at least thirty consecutive days, you lose institutional status.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 74.09.575, and Deficit Reduction Act of 2005, 42 C.F.R. Section 435.09-07-036, § 388-513-1320, filed 3/10/09, effective 4/10/09. Statutory Authority: RCW 74.08.090, 06-07-077, § 388-513-1320, filed 3/13/06, effective 4/13/06. 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 388-513-1340 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 exception described in subsection (31).

(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 child living in the home are considered the income of the child;

(11) Self-employment income allowed as a deduction by the Internal Revenue Service (IRS);

(12) Payments to prevent fuel cut-offs and to promote energy efficiency that are excluded by federal statute;

(13) Assistance (other than wages or salary) received under the Older Americans Act;

(14) Assistance (other than wages or salary) received under the foster grandparent program;

(15) Certain cash payments a client receives from a governmental or nongovernmental medical or social service agency to pay for medical or social services;

(16) 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;

(17) Tax exempt payments received by Alaska natives under the Alaska Native Settlement Act established by P.L. 100-241;

(18) Compensation provided to volunteers in ACTION programs under the Domestic Volunteer Service Act of 1973 established by P.L. 93-113;

(19) Payments made from the Agent Orange Settlement Fund or any other funds to settle Agent Orange liability claims established by P.L. 101-201;

(20) Payments made under section six of the Radiation Exposure Compensation Act established by P.L. 101-426;

(21) Restitution payment, and interest earned on such payment to a civilian of Japanese or Aleut ancestry established by P.L. 100-383;

(22) Payments made under sections 500 through 506 of the Austrian General Social Insurance Act;

(23) Payments made from *Susan Walker v. Bayer Corporation, et, al.*, 95-C-5024 (N.D. Ill.) (May 8, 1997) settlement funds;

(24) Payments made from the Ricky Ray Hemophilia Relief Fund Act of 1998 established by P.L. 105-369;

(25) Payments made under the Disaster Relief and Emergency Assistance Act established by P.L. 100-387;

(26) Payments made under the Netherlands' Act on Benefits for Victims of Persecution (WUV);

(27) 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;

(28) Interest or dividends received by the client is excluded as income. Interest or dividends received by the community spouse of an institutional individual is counted as income of the community spouse. Dividends and interest are returns on capital investments such as stocks, bond, or savings accounts. Institutional status is defined in WAC 388-513-1320;

(29) Income received by an ineligible or nonapplying spouse from a governmental agency for services provided to an eligible client, e.g., chore services;

(30) 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 (31);

(31) Benefits described in subsection (30)(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 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, Social Security Act § 1611, 1902, and C.F.R. 435.725. 09-09-101, § 388-513-1340, filed 4/20/09, effective 5/21/09. 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 388-513-1350 Defining the resource standard and determining resource eligibility for long-term care (LTC) services. This section describes how the department defines the resource standard and countable or excluded 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:

(i) A single client; or

(ii) A legally married client with a community spouse, subject to the provisions described in subsections (8) through (11) of this section; or

(b) Three thousand dollars for a legally married couple, unless subsection (3) of this section applies.

(2) When both spouses apply for LTC services the department considers the resources of both spouses as available to each other through the month in which the spouses stopped living together.

(3) When both spouses are institutionalized, the department will determine the eligibility of each spouse as a single client the month following the month of separation.

(4) If the department has already established eligibility and authorized services for one spouse, and the community spouse needs LTC services in the same month, (but after eligibility has been established and services authorized for the institutional spouse), then the department applies the standard described in subsection (1)(a) of this section to each spouse. If doing this would make one of the spouses ineligible, then the department applies (1)(b) of this section for a couple.

(5) When a single institutionalized individual marries, the department will redetermine eligibility applying the rules for a legally married couple.

(6) The department applies the following rules when determining available resources for LTC services:

(a) WAC 388-475-0300, Resource eligibility;

(b) WAC 388-475-0250, How to determine who owns a resource; and

(c) WAC 388-470-0060(6), Resources of an alien's sponsor.

(7) For LTC services the department determines a client's countable resources as follows:

(a) The department determines countable resources for SSI-related clients as described in WAC 388-475-0350 through 388-475-0550 and resources excluded by federal law with the exception of:

(i) WAC 388-475-0550(16);

(ii) WAC 388-475-0350 (1)(b) clients who have submitted an application for LTC services on or after May 1, 2006 and have an equity interest greater than five hundred thousand dollars in their primary residence are ineligible for LTC services. This exception does not apply if a spouse or blind, disabled or dependent child under age twenty-one is lawfully residing in the primary residence. Clients denied or terminated LTC services due to excess home equity may apply for an undue hardship waiver described in WAC 388-513-1367.

(b) For an SSI-related client one automobile per household is excluded regardless of value if it is used for transportation of the eligible individual/couple.

(i) For an SSI-related client with a community spouse, the value of one automobile is excluded regardless of its use or value.

(ii) A vehicle not meeting the definition of automobile is a vehicle that has been junked or a vehicle that is used only as a recreational vehicle.

(c) For an SSI-related client, the department adds together the countable resources of both spouses if subsections (2), (5) and (8)(a) or (b) apply, but not if subsection (3) or (4) apply.

(d) For an SSI-related client, excess resources are reduced:

(i) In an amount equal to incurred medical expenses such as:

(A) Premiums, deductibles, and coinsurance/copayment charges for health insurance and medicare;

(B) Necessary medical care recognized under state law, but not covered under the state's medicaid plan;

(C) Necessary medical care covered under the state's medicaid plan incurred prior to medicaid eligibility.

(ii) As long as the incurred medical expenses:

(A) Are not subject to third-party payment or reimbursement;

(B) Have not been used to satisfy a previous spend down liability;

(C) Have not previously been used to reduce excess resources;

(D) Have not been used to reduce client responsibility toward cost of care;

(E) Were not incurred during a transfer of asset penalty described in WAC 388-513-1363, 388-513-1364, 388-513-1365 and 388-513-1366; and

(F) Are amounts for which the client remains liable.

(e) Expenses not allowed to reduce excess resources or participation in personal care:

(i) Unpaid expense(s) prior to waiver eligibility to an adult family home (AFH) or boarding home is not a medical expense.

(ii) Personal care cost in excess of approved hours determined by the CARE assessment described in chapter 388-106 WAC is not a medical expense.

(f) The amount of excess resources is limited to the following amounts:

(i) For LTC services provided under the categorically needy (CN) program:

(A) Gross income must be at or below the special income level (SIL), 300% of the federal benefit rate (FBR).

(B) In a medical institution, excess resources and income must be under the state medicaid rate.

(C) For CN waiver eligibility, incurred medical expenses must reduce resources within allowable resource limits for CN-waiver eligibility. The cost of care for the waiver services cannot be allowed as a projected expense.

(ii) For LTC services provided under the medically needy (MN) program when excess resources are added to nonexcluded income, the combined total is less than the:

(A) Private medical institution 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 in a medical institution.

(C) For MN waiver eligibility, incurred medical expenses must reduce resources within allowable resource limits for MN-waiver eligibility. The cost of care for the waiver services cannot be allowed as a projected expense.

(g) For a client not related to SSI, the department applies the resource rules of the program used to relate the client to medical eligibility.

(8) 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 countable 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.

(9) If subsection (8)(b) of this section applies, the department determines the amount of resources that are allocated to the community spouse before determining countable resources used to establish eligibility for the institutionalized spouse, as follows:

(a) If the client's current period of institutional status began on or after October 1, 1989 and before August 1, 2003, the department allocates the maximum amount of resources ordinarily allowed by law. Effective January 1, 2009, the maximum allocation is one hundred and nine thousand five hundred and sixty dollars. This standard increases annually on January 1st based on the consumer price index. (For the current standard starting January 2009 and each year thereafter, see long-term care standards at <http://www1.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandard-spna.shtml>); or

(b) If the client's current period of institutional status began on or after August 1, 2003, the department allocates the greater of:

(i) A spousal share equal to one-half of the couple's combined countable resources as of the beginning of the current period of institutional status, up to the amount described in subsection (9)(a) of this section; or

(ii) The state spousal resource standard of forty-five thousand one hundred four dollars effective July 1, 2007 through June 30, 2009. Effective July 1, 2009 this standard increases to forty-eight thousand six hundred thirty-nine dollars (this standard increases every odd year on July 1st). This increase is based on the consumer price index published by

the federal bureau of labor statistics. For the current standard starting July 2009 and each year thereafter, see long-term care standards at <http://www1.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml>.

(10) The amount of the spousal share described in (9)(b)(i) can be determined anytime between the date that the current period of institutional status began and the date that eligibility for LTC services is determined. The following rules apply to the determination of the spousal share:

(a) Prior to an application for LTC services, the couple's combined countable resources are evaluated from the date of the current period of institutional status at the request of either member of the couple. The determination of the spousal share is completed when necessary documentation and/or verification is provided; or

(b) The determination of the spousal share is completed as part of the application for LTC services if the client was institutionalized prior to the month of application, and declares the spousal share exceeds the state spousal resource standard. The client is required to provide verification of the couple's combined countable resources held at the beginning of the current period of institutional status.

(11) The amount of allocated resources described in subsection (9) of this section 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, that the amount is inadequate to provide a minimum monthly maintenance needs amount for the community spouse.

(12) The department considers resources of the community spouse unavailable to the institutionalized spouse the month after eligibility for LTC services is established, unless subsection (5) or (13)(a), (b), or (c) of this section applies.

(13) A redetermination of the couple's resources as described in subsection (7) 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 countable resources exceed the standard described in subsection (1)(a), if subsection (8)(b) applies; or

(c) The institutionalized spouse does not transfer the amount described in subsections (9) or (11) 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, 74.09.530, and 74.09.575. 09-12-058, § 388-513-1350, filed 5/28/09, effective 7/1/09. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 74.09.530. 08-13-072, § 388-513-1350, filed 6/16/08, effective 7/17/08. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.575, 74.09.500, and 74.09.530. 07-19-128, § 388-513-1350, filed 9/19/07, effective 10/20/07. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 74.09.575, 2005 Federal Deficit Reduction Act (DRA) Public Law 109-171, and Section 1924 of the Social Security Act (42 U.S.C. 1396r-5). 07-01-073, § 388-513-1350, filed 12/18/06, effective 1/18/07. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 42 U.S.C. 9902(2). 05-07-033, § 388-513-1350, filed 3/9/05, effective 4/9/05. Statutory Authority: RCW 74.04.050,

74.04.057, 74.08.090, 74.09.500, 74.09.575; 2003 1st sp.s. c 28, and section 1924 of the Social Security Act (42 U.S.C. 1396r-5). 04-04-072, § 388-513-1350, filed 2/2/04, effective 3/4/04. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500 and Section 1924 (42 U.S.C. 1396r-5). 01-18-055, § 388-513-1350, filed 8/30/01, effective 9/30/01. Statutory Authority: RCW 11.92.180, 43.20B.460, 48.85.020, 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 74.09.575, 74.09.585; 20 C.F.R. 416.1110-1112, 1123 and 1160; 42 C.F.R. 435.403 (j)(2) and 1005; and Sections 17, 1915(c), and 1924 (42 U.S.C. 1396) of the Social Security Act. 00-01-051, § 388-513-1350, filed 12/8/99, effective 1/8/00. Statutory Authority: RCW 74.08.090 and 74.09.500. 99-06-045, § 388-513-1350, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, 74.09.575 and Section 1924 (42 USC 1396r-5). 98-11-033, § 388-513-1350, filed 5/14/98, effective 6/14/98. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090 and 74.09.575. 97-09-112, § 388-513-1350, filed 4/23/97, effective 5/24/97. Statutory Authority: RCW 74.08.090 and Title XIX State Agency Letter 95-44. 96-09-033 (Order 3963), § 388-513-1350, filed 4/10/96, effective 5/11/96. Statutory Authority: RCW 74.08.090 and Title XIX State Agency Letter 94-49, notice of increase in SSI level. 95-05-022 (Order 3832), § 388-513-1350, filed 2/8/95, effective 3/11/95. Statutory Authority: RCW 74.08.090. 94-23-129 (Order 3808), § 388-513-1350, filed 11/23/94, effective 12/24/94; 94-10-065 (Order 3732), § 388-513-1350, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-95-337 and 388-95-340.]

WAC 388-513-1380 Determining a client's financial 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 (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 institution, the department applies all subsections of this rule.

(2) For a client receiving waiver 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, or in an alternate living facility, the department applies rules used for the community options program entry system (COPES) for hospice applicants with income under the medicaid special income level (SIL) (300% of the federal benefit rate (FBR)), if the client is not otherwise eligible for another non-institutional categorically needy medicaid program. (Note: For hospice applicants with income over the medicaid SIL, medically needy medicaid rules apply.)

(4) The department allocates nonexcluded income in the following order and the combined total of (4)(a), (b), (c), and (d) cannot exceed the medically needy income level (MNIL):

(a) A personal needs allowance (PNA) of:

(i) Seventy dollars for the following clients who live in a state veteran's home and receive a needs based veteran's pension in excess of ninety dollars:

(A) A veteran without a spouse or dependent child.

(B) A veteran's surviving spouse with no dependent children.

(ii) The difference between one hundred sixty dollars and the needs based veteran's pension amount for persons specified in subsection (4)(a)(i) of this section who receive a veteran's pension less than ninety dollars.

(iii) One hundred sixty dollars for a client living in a state veterans' home who does not receive a needs based veteran's pension;

(iv) Forty-one dollars and sixty-two cents for all clients in a medical institution receiving general assistance.

(v) Effective July 1, 2007 through June 30, 2008 fifty-five dollars and forty-five cents for all other clients in a medical institution. Effective July 1, 2008 this PNA increases to fifty-seven dollars and twenty-eight cents.

(vi) Current PNA and long-term care standards can be found at <http://www1.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml>.

(b) Mandatory federal, state, or local income taxes owed by the client.

(c) Wages for a client who:

(i) Is related to the Supplemental Security Income (SSI) program as described in WAC 388-475-0050(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.

(5) The department allocates nonexcluded income after deducting amounts described in subsection (4) in the following order:

(a) Income garnished for child support or withheld according to a child support order in the month of garnishment (for current and back support):

(i) For the time period covered by the PNA; and

(ii) Is not counted as the dependent member's income when determining the family allocation amount.

(b) A monthly maintenance needs allowance for the community spouse not to exceed, effective January 1, 2008, two thousand six hundred ten dollars, unless a greater amount is allocated as described in subsection (7) of this section. The community spouse maintenance allowance is increased each January based on the consumer price index increase (from September to September, <http://www.bls.gov/cpi/>). Starting January 1, 2008 and each year thereafter the community spouse maintenance allocation can be found in the long-term care standards chart at <http://www1.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml>. The monthly maintenance needs allowance:

(i) Consists of a combined total of both:

(A) One hundred fifty percent of the two person federal poverty level. This standard increases annually on July 1st (<http://aspe.os.dhhs.gov/poverty/>); and

(B) Excess shelter expenses as described under subsection (6) of this section.

(ii) Is reduced by the community spouse's gross countable income; and

(iii) 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 spouse or institutionalized person who:

(i) Resides with the community spouse:

(A) In an amount equal to one-third of one hundred fifty percent of the two person federal poverty level less the dependent family member's income. This standard increases annually on July 1st (<http://aspe.os.dhhs.gov/poverty/>).

(ii) Does not reside with the community spouse or institutionalized person, in an amount equal to the MNIL for the number of dependent family members in the home less the dependent family member's income.

(iii) Child support received from a noncustodial parent is the child's income.

(d) Medical expenses incurred by the institutional client and not used to reduce excess resources. Allowable medical expenses and reducing excess resources are described in WAC 388-513-1350.

(e) Maintenance of the home of a single institutionalized 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 the need for the income exemption.

(6) For the purposes of this section, "excess shelter expenses" means the actual expenses under subsection (6)(b) less the standard shelter allocation under subsection (6)(a). For the purposes of this rule:

(a) The standard shelter allocation is based on thirty percent of one hundred fifty percent of the two person federal poverty level. This standard increases annually on July 1st (<http://aspe.os.dhhs.gov/poverty/>); 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 for four persons, provided the utilities are not included in the maintenance charges for a condominium or cooperative.

(7) 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.

(8) 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.

(9) Standards described in this section for long-term care can be found at: <http://www1.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml>.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, and Deficit Reduction Act of 2005, 42 C.F.R. Section 435.09-07-037, § 388-513-1380, filed 3/10/09, effective 4/10/09. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 74.09.530. 08-13-072, § 388-513-1380, filed 6/16/08, effective 7/17/08. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, and 2006 c 372. 07-19-126, § 388-513-1380, filed 9/19/07, effective 10/20/07; 07-01-072, § 388-513-1380, filed 12/18/06, effective 1/18/07. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530 and 2005 c 518 § 207 and Sec. 1924 Social Security Act (42 U.S.C. 1396r-5). 06-07-144, § 388-513-1380, filed 3/21/06, effective 4/21/06. Statutory Authority:

RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 42 U.S.C. 9902(2). 05-07-033, § 388-513-1380, filed 3/9/05, effective 4/9/05. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.575; 2003 1st sp.s. c 28, and section 1924 of the Social Security Act (42 U.S.C. 1396R-5). 04-04-072, § 388-513-1380, filed 2/2/04, effective 3/4/04. 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 and Title XIX State Agency Letter 94-49, notice of increase in SSI level. 95-05-022 (Order 3832), § 388-513-1380, filed 2/8/95, effective 3/11/95. Statutory Authority: RCW 74.08.090, 94-10-065 (Order 3732), § 388-513-1380, filed 5/3/94, effective 6/3/94. Formerly WAC 388-95-360.]

Chapter 388-515 WAC

ALTERNATE LIVING—INSTITUTIONAL MEDICAL

WAC

388-515-1507 What are the financial requirements for home and community based (HCB) services when you are eligible for a noninstitutional categorically needy (CN) medicaid program?

WAC 388-515-1507 What are the financial requirements for home and community based (HCB) services when you are eligible for a noninstitutional categorically needy (CN) medicaid program? (1) You are eligible for medicaid under one of the following programs:

(a) Supplemental Security Income (SSI) eligibility described in WAC 388-474-0001. This includes SSI clients under 1619B status;

(b) SSI-related CN medicaid described in WAC 388-475-0100 (2)(a) and (b);

(c) SSI-related healthcare for workers with disabilities program (HWD) described in WAC 388-475-1000. If you are receiving HWD, you are responsible to pay your HWD premium as described in WAC 388-475-1250. This change is effective April 1, 2009;

(d) General assistance expedited medicaid disability (GAX) or general assistance based on aged/blind/disabled criteria described in WAC 388-505-0110(6) and are receiving CN medicaid.

(2) You do not have a penalty period of ineligibility for the transfer of an asset as described in WAC 388-513-1363 through 388-513-1366. This does not apply to PACE or hospice services.

(3) You do not have a home with equity in excess of the requirements described in WAC 388-513-1350.

(4) You do not have to meet the initial eligibility income test of having gross income at or below the special income level (SIL).

(5) You do not pay (participate) toward the cost of your personal care services.

(6) If you live in a department contracted facility listed in WAC 388-515-1506 (1)(g), you pay room and board up to the ADSA room and board standard. The ADSA room and board standard is based on the federal benefit rate (FBR) minus the current personal needs allowance (PNA) for HCS CN waivers in an alternate living facility.

(a) If you live in an assisted living (AL) facility, enhanced adult residential center (EARC), or adult family home (AFH) you keep a PNA of sixty-two dollars and seventy-nine cents and use your income to pay up to the room and board standard.

(b) If subsection (6)(a) applies and you are receiving HWD described in WAC 388-475-1000, you are responsible to pay your HWD premium as described in WAC 388-475-1250, in addition to the room and board standard.

(7) If you are eligible for general assistance expedited medicaid disability (GAX) or general assistance based on aged/blind/disabled criteria described in WAC 388-505-0110(6), you do not participate in the cost of personal care and you may keep the following:

(a) When you live at home, you keep the cash grant amount authorized under the general assistance program;

(b) When you live in an AFH, you keep a PNA of thirty-eight dollars and eighty-four cents, and pay any remaining income and general assistance grant to the facility for the cost of room and board up to the ADSA room and board standard; or

(c) When you live in an assisted living facility or enhanced adult residential center, you are only eligible to receive a cash grant of thirty-eight dollars and eighty-four cents, which you keep for your PNA.

(8) Current resource and income standards are located at: <http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml>.

(9) Current PNA and ADSA room and board standards are located at: <http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/lcstandardsPNAchartsufile.shtml>.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, and section 1915(c) of the Social Security Act. 09-14-043, § 388-515-1507, filed 6/24/09, effective 7/25/09. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 74.09.530 and Washington state 2007-09 operating budget (SHB 1128). 08-22-052, § 388-515-1507, filed 11/3/08, effective 12/4/08.]

Chapter 388-517 WAC

MEDICARE-RELATED MEDICAL ELIGIBILITY

WAC

388-517-0310 Eligibility for federal medicare savings and state-funded medicare buy-in programs.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-517-0400 Medicare coinsurance payment—Extended care patient. [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.] Repealed by 09-16-021, filed 7/24/09, effective 8/24/09. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, Section 1902 (a)(10)(E)(iii), and Section 1905 (p)(3)(A)(ii) of the Social Security Act.

WAC 388-517-0310 Eligibility for federal medicare savings and state-funded medicare buy-in programs. (1)

Persons eligible for any medicare savings programs (MSP) must:

(a) Be entitled to or receiving medicare Part A. Qualified disabled working individuals (QDWI) clients must be under age sixty-five;

(b) Meet program income standards, see WAC 388-478-0085; and

(c) Have resources equal to or less than the medicare Part D low-income subsidy resource standard found at: <http://hrsa.dshs.wa.gov/Eligibility/images/Standards%20Chart%20July%202008%20Final.pdf>.

(2) MSP follow categorically needy program rules for SSI related persons in chapter 388-475 WAC.

(3) MSP clients are entitled to a fair hearing when the department takes an adverse action such as denying or terminating MSP benefits.

(4) The department subtracts the allocations and deductions described under WAC 388-513-1380 from a long-term care client's countable income and resources when determining MSP eligibility:

(a) Allocations to a spouse and/or dependent family member; and

(b) Client participation in cost of care.

(5) Medicaid eligibility may affect MSP eligibility, as follows:

(a) Qualified medicare beneficiaries (QMB) and specified low income beneficiaries (SLMB) clients can receive medicaid and still be eligible to receive QMB or SLMB benefits.

(b) Qualified individuals (QI-1) and qualified disabled working individuals (QDWI) clients who begin to receive medicaid are no longer eligible for QI-1 or QDWI benefits.

(6) Every year, when the federal poverty level changes:

(a) The department adjusts income standards for MSP and state funded medicare buy-in programs, see WAC 388-478-0085.

(b) The department begins to count the annual Social Security cost-of-living (COLA) increase on April 1st each year when determining eligibility for MSP and state funded medicaid buy-in programs.

(7) There is no income limit for the state-funded medicare buy-in program. The state-funded medicare buy-in program is for clients who receive medicaid but do not qualify for the federal MSP.

[Statutory Authority: Public Law 110-275, Section 113 (Medicare Improvements for Patients and Providers Act), RCW 74.04.050, 74.04.057, 74.08.090, and 74.09.500. 09-20-027, § 388-517-0310, filed 9/29/09, effective 10/30/09. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530 and 42 U.S.C. Section 1396a. 07-15-032, § 388-517-0310, filed 7/12/07, effective 8/12/07. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, and 42 U.S.C. 1396a(a) (Section 1902 (n)(2) of the Social Security Act of 1924). 05-14-125, § 388-517-0310, filed 7/1/05, effective 8/1/05.]

Chapter 388-519 WAC

SPENDDOWN

WAC

388-519-0100	Eligibility for the medically needy program.
388-519-0110	Spenddown of excess income for the medically needy program.

WAC 388-519-0100 Eligibility for the medically needy program. (1) An individual who meets the following conditions may be eligible for medically needy (MN) coverage under the special rules in chapters 388-513 WAC and 388-515 WAC:

(a) Meets the institutional status requirements of WAC 388-513-1320;

(b) Resides in a medical institution as described in WAC 388-513-1395; or

(c) Receives waiver services under a medically needy in-home waiver (MNIW) according to WAC 388-515-1550 or a medically needy residential waiver (MNRW) according to WAC 388-515-1540.

(2) An SSI-related individual who lives in a department contracted alternate living facility may be eligible for MN coverage under the rules described in WAC 388-513-1305.

(3) An individual may be eligible for MN coverage under this chapter when he or she is:

(a) Not covered under subsection (1) and (2) of this section; and

(b) Eligible for categorically needy (CN) medical coverage in all other respects except that his or her CN countable income is above the CN income standard.

(4) MN coverage may be available if the individual is:

(a) A child;

(b) A pregnant woman;

(c) A refugee;

(d) An SSI-related individual including an aged, blind or disabled individual with countable income under the CN income standard, who is an ineligible spouse of an SSI recipient; or

(e) A hospice client with countable income which is above the special income level (SIL).

(5) An individual who is not eligible for CN medical and who is applying for MN coverage has the right to income deductions in addition to, or instead of, those used to arrive at CN countable income. Deductions to income are applied to each month of the base period to determine MN countable income. The following deductions are used to calculate countable income for MN:

(a) All health insurance premiums, with the exception of medicare Part A, Part B, Part C and Part D premiums expected to be paid by the individual or family member during the base period(s);

(b) Any allocations to a spouse or to dependents for an SSI-related individual who is married or who has dependent children. Rules for allocating income are described in WAC 388-475-0900;

(c) For an SSI-related individual who is married and lives in the same home as his or her spouse who receives home and community based waiver services under chapter 388-515 WAC, an income deduction equal to the medically needy income level (MNIL) minus the nonapplying spouse's income; and

(d) A child or pregnant woman who is applying for MN coverage is eligible for income deductions allowed under TANF/SFA rules and not under the rules for CN programs based on the federal poverty level. See WAC 388-450-0210(4) for exceptions to the TANF/SFA rules which apply to medical programs and not to the cash assistance program.

(6) The MNIL for individuals who qualify for MN coverage under subsection (1) of this section is based on rules in chapter 388-513 and 388-515 WAC.

(7) The MNIL for all other individuals is described in WAC 388-478-0070. If an individual has countable income which is at or below the MNIL, he or she is certified as eligible for up to twelve months of MN medical coverage.

(8) If an individual has countable income which is over the MNIL, the countable income that exceeds the department's MNIL standards is called "excess income."

(9) When individuals have "excess income" they are not eligible for MN coverage until they provide evidence to the department of medical expenses incurred by themselves, their spouse or family members who live in the home for whom they are financially responsible. See WAC 388-519-0110(8). An expense has been incurred when:

(a) The individual has received the medical treatment or medical supplies, is financially liable for the medical expense but has not yet paid the bill; or

(b) The individual has paid for the expense within the current or retroactive base period described in WAC 388-519-0110.

(10) Incurred medical expenses or obligations may be used to offset any portion of countable income that is over the MNIL. This is the process of meeting "spenddown."

(11) The department calculates the amount of an individual's spenddown by multiplying the monthly excess income amount by the number of months in the certification period as described in WAC 388-519-0110. The qualifying medical expenses must be greater than or equal to the total calculated spenddown amount.

(12) An individual who is considered for MN coverage under this chapter may not spenddown excess resources to become eligible for the MN program. Under this chapter individuals are ineligible for MN coverage if their resources exceed the program standard in WAC 388-478-0070. An individual who is considered for MN coverage under WAC 388-513-1395, 388-505-0250 or 388-505-0255 is allowed to spenddown excess resources.

(13) There is no automatic redetermination process for MN coverage. An individual must submit an application for each eligibility period under the MN program.

(14) An individual who requests a timely administrative hearing under WAC 388-458-0040 is not eligible for continued benefits beyond the end of the original certification date under the medically needy program.

[Statutory Authority: RCW 74.04.055, 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 42 C.F.R. 435.831 (3)(e) and (f). 09-08-003, § 388-519-0100, filed 3/19/09, effective 4/19/09. 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) An individual who applies for medical assistance and is eligible for medically needy (MN) coverage with a spenddown may choose a three month or a six month base period. A base period is a time period used to compute the amount of the spenddown liability. The months must be consecutive calendar months unless one of the conditions in subsection (4) of this section applies.

(2) A base period begins on the first day of the month, in which an individual applies for medical assistance, subject to the exceptions in subsection (4) of this section.

(3) An individual may request a separate base period to cover the time period up to three calendar months immediately prior to the month of application. This is called a retroactive base period.

(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) The individual has countable resources that are over the applicable standard for any part of 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 individual is 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) An individual's spenddown liability is calculated by the department. The MN countable income from each month of the base period is compared to the medically needy income level (MNIL). Income which is over the MNIL (based on the individual's household size) in each month in the base period is added together to determine the total spenddown amount. The MNIL standard is found at http://www.dshs.wa.gov/pdf/esa/manual/standards_C_MedAsstChart.pdf and is updated annually in January.

(6) If household income varies and an individual'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(7).

(7) If an individual's income decreases, the department approves CN coverage for each month in the base period when the individual's countable income and resources are equal to or below the applicable CN standards. Children under the age of nineteen and pregnant women who become CN eligible in any month of the base period remain continuously eligible for CN coverage for the remainder of the certification even if there is a subsequent increase in income.

(8) Once an individual's spenddown amount has been determined, qualifying medical expenses are deducted. To be considered a qualifying medical expense, the expense must:

(a) Be an expense for which the individual is financially liable;

(b) Not have been used to meet another spenddown;

(c) Not be the confirmed responsibility of a third party.

The department allows the entire expense if the third party has not confirmed its coverage of the expense within:

(i) Forty-five days of the date of service; or

(ii) Thirty days after the base period ends.

(d) Be an incurred expense for the individual:

(i) The individual's spouse;

(ii) A family member, residing in the home of the individual, for whom the individual is financially responsible; or

(iii) A relative, residing in the home of the individual, who is financially responsible for the individual.

(e) Meet one of the following conditions:

(i) Be an unpaid liability at the beginning of the base period;

(ii) Be for medical services either paid or unpaid and incurred during the base period;

(iii) Be for medical services incurred and paid during the three month retroactive base period if eligibility for medical assistance was not established in that base period. Paid expenses that meet this requirement may be applied towards the current base period; or

(iv) Be for medical services incurred during a previous base period and either unpaid or paid for, if it was necessary for the individual to make a payment due to delays in the certification for that base period.

(9) An exception to the provisions in subsection (8) of this section exists for qualifying medical expenses that have been paid on behalf of the individual by a publicly administered program during the current or the retroactive base period. The department uses the qualifying medical expenses to meet the spenddown liability. To qualify for this exception the program must:

(a) Not be federally funded or make the payments from federally matched funds;

(b) Not pay the expenses prior to the first day of the retroactive base period; and

(c) Provide proof of the expenses paid on behalf of the individual.

(10) Once the department has determined that the expenses meet the definition of a qualified expense as defined in subsection (8) or (9) of this section, the expenses are subtracted from the spenddown liability to determine the date the individual is eligible for medical coverage to begin. Qualifying medical expenses are deducted in the following order:

(a) First, medicare and other health insurance deductibles, coinsurance charges, enrollment fees, copayments and premiums that are the individual's responsibility under medicare Part A, Part B, Part C and Part D. (Health insurance premiums are income deductions under WAC 388-519-0100 (5));

(b) Second, medical expenses incurred and paid by the individual during the three month retroactive base period if eligibility for medical assistance was not established in that base period;

(c) Third, current payments on, or unpaid balance of, medical expenses incurred prior to the current base period which have not been used to establish eligibility for medical coverage in any other base period. The department sets no limit on the age of an unpaid expense; however, the expense must still be a current liability and be unpaid at the beginning of the base period;

(d) Fourth, other medical expenses that would not be covered by the department's medical programs, minus any third party payments which apply to the charges. The items or services allowed as a medical expense must have been provided or prescribed by a licensed health care provider;

(e) Fifth, other medical expenses which have been incurred by the individual during the base period that are potentially payable by the MN program (minus any confirmed third party payments that apply to the charges), even if payment is denied for these services because they exceed the department limits on amount, duration or scope of care.

Scope of care is described in WAC 388-501-0060 and 388-501-0065; and

(f) Sixth, other medical expenses that have been incurred by the individual during the base period that are potentially payable by the MN program (minus any confirmed third party payments that apply to the charges) and that are within the department limits on amount, duration or scope of care.

(11) If an individual submits verification of qualifying medical expenses with his or her application that meets or exceeds the spenddown liability, he or she is eligible for MN medical coverage for the remainder of the base period unless their circumstances change. See WAC 388-418-0005 to determine which changes must be reported to the department. The beginning of eligibility is determined as described in WAC 388-416-0020.

(12) If an individual cannot meet the spenddown amount at the time the application is submitted, the individual is not eligible until he or she provides proof of additional qualifying expenses that meet the spenddown liability.

(13) Each dollar of a qualifying medical expense may count once against a spenddown period that leads to eligibility for MN coverage. However, medical expenses may be used more than once under the following circumstances:

(a) The individual did not meet his or her total spenddown liability and become eligible in a previous base period and the bill remains unpaid; or

(b) The medical expense was a bill incurred and paid within three months of the current application and the department could not establish eligibility for medical assistance for the individual in the retroactive base period.

(14) The individual must provide the proof of qualifying medical expenses to the department. The deadline for providing medical expense information is thirty days after the base period ends unless there is a good reason for delay.

(15) Once an individual meets the spenddown requirement and the certification begin date has been established, newly identified expenses cannot be considered toward that spenddown unless there is a good reason for the delay in submitting the expense or there was a department error in determining the correct begin date.

(16) Good reasons for delay in providing medical expense information to the department include, but are not limited to:

(a) The individual did not receive a timely bill from his or her medical provider or insurance company;

(b) The individual has medical issues that prevents him or her from submitting proof in a timely manner; or

(c) The individual meets the criteria for needing a supplemental accommodation under chapter 388-472 WAC.

(17) The department is not responsible to pay for any expense or portion of an expense that has been used to meet an individual's spenddown liability. If an expense is potentially payable under the MN program, and only a portion of the medical expense has been assigned to meet spenddown, the medical provider may not bill the individual for more than the amount which was assigned to the remaining spenddown liability, or accept or retain any additional amount for the covered service from the individual. Any additional amount may be billed to the department. See WAC 388-502-0160 Billing a client.

(18) The department determines whether any payment is due to the medical provider on medical expenses that have been partially assigned to meet a spenddown liability, according to WAC 388-502-0100.

(19) If the medical expense assigned to spenddown was incurred outside of a period of MN eligibility, or if the expense is not the type that is covered by the department's medical assistance programs, the department is not responsible for any portion of the bill.

[Statutory Authority: RCW 74.04.055, 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 42 C.F.R. 435.831 (3)(e) and (f). 09-08-003, § 388-519-0110, filed 3/19/09, effective 4/19/09. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 06-24-036, § 388-519-0110, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 71.05.560, 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530. 06-13-042, § 388-519-0110, filed 6/15/06, effective 7/16/06. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, and 74.08.090. 05-08-093, § 388-519-0110, filed 4/1/05, effective 5/2/05; 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.]

Chapter 388-527 WAC

ESTATE RECOVERY AND PRE DEATH LIENS

WAC

388-527-2730	Definitions.
388-527-2737	Deferring recovery.
388-527-2750	Delay of recovery for undue hardship.
388-527-2820	Liens prior to death.

WAC 388-527-2730 Definitions. The following definitions apply to this chapter:

"Contract health service delivery area (CHSDA)" means the geographic area within which contract health services will be made available by the Indian Health Service to members of an identified Indian community who reside in the area as identified in 42 C.F.R. Sec. 136.21(d) and 136.22.

"Domestic partner" means an adult who meets the requirements for a valid registered domestic partnership as established by RCW 26.60.030 and who has been issued a certificate of state registered domestic partnership by the Washington Secretary of State. When the terms "domestic partner" or "domestic partnership" are used in this chapter, they mean "state registered domestic partner" or "state registered domestic partnership."

"Estate" means all 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. The value of the estate will be reduced by any valid liability against the decedent's property at the time of death. 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 and before September 14, 2006, nonprobate assets as defined by RCW 11.02.005.

(3) For a client who died on or after September 14, 2006, nonprobate assets as defined by RCW 11.02.005 and any life estate interest held by the recipient immediately before death.

"Heir" means the decedent's surviving spouse and children (natural and adopted); or those persons who are entitled

to inherit the decedent's property under a will properly executed under RCW 11.12.020 and accepted by the probate court as a valid will.

"Joint tenancy" means ownership of property held under circumstances that entitle one or more owners to the whole of the property on the death of the other owner(s), including, but not limited to, joint tenancy with right of survivorship.

"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.

"Lis pendens" means a notice filed in public records warning that title to certain real property is in litigation and the outcome of the litigation may affect the title.

"Long-term care services" means, for the purposes of this chapter only, the services administered directly or through contract by the department of social and health services for clients of the home and community services division and division of developmental disabilities including, but not limited to, nursing facility care and home and community services.

"Medicaid" means the state and federally funded program that provides medical services under Title XIX of the Federal Social Security Act.

"Medical assistance" means both medicaid and medical care services.

"Medicare Savings programs" means the programs described in WAC 388-517-0300 that help a client pay some of the costs that medicare does not cover.

"Property": Examples include, but are not limited to, personal property, real property, title property, and trust property as described below:

(1) **"Personal property"** means any property that is not classified as real, title, or trust property in the definitions provided here;

(2) **"Real property"** means land and anything growing on, attached to, or erected thereon;

(3) **"Title property"** means, for the purposes of this chapter only, property with a title such as motor homes, mobile homes, boats, motorcycles, and vehicles.

(4) **"Trust property"** means any type of property interest titled in, or held by, a trustee for the benefit of another person or entity.

"State-only funded long-term care" means the long-term care services that are financed with state funds only.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and chapter 26.60 RCW. 09-07-038, § 388-527-2730, filed 3/10/09, effective 4/10/09. Statutory Authority: 2005 c 292, RCW 43.20B.080, 74.39A.170, 42 U.S.C. Section 1396p. 06-17-075, § 388-527-2730, filed 8/14/06, effective 9/14/06. Statutory Authority: RCW 43.17.240, 43.20B.80 [43.20B.080], 74.08.090, 74.34.090, Section 1917(b) of the Social Security Act and 2001 2nd sp.s. c 7, Part II. 04-10-060, § 388-527-2730, filed 4/30/04, effective 6/1/04. 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 388-527-2737 Deferring recovery. (1) For a client who died after June 30, 1994, the department defers recovery from the estate until:

- (a) The death of the surviving spouse, if any; and
- (b) There is no surviving child who is:
 - (i) Twenty years of age or younger; or
 - (ii) Blind or disabled as defined under WAC 388-475-0050.

(2) The department may place a lien against property to evidence the department's right to recover after the deferral period specified in subsection (1) of this section.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and chapter 26.60 RCW. 09-07-038, § 388-527-2737, filed 3/10/09, effective 4/10/09. Statutory Authority: 2005 c 292, RCW 43.20B.080, 74.39A.170, 42 U.S.C. Section 1396p. 06-17-075, § 388-527-2737, filed 8/14/06, effective 9/14/06. 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 388-527-2750 Delay of recovery for undue hardship. The department delays recovery under this section when the department determines that recovery would cause an undue hardship for an heir. This delay is limited to the period during which the undue hardship exists. The undue hardship must exist at the time of the client's death in order to be considered for a delay of recovery.

(1) Undue hardship exists when:

(a) The estate subject to adjustment or recovery is the sole income-producing asset of one or more heirs and income is limited;

(b) Recovery would deprive an heir of shelter and the heir lacks the financial means to obtain and maintain alternative shelter; or

(c) The client is survived by a domestic partner.

(2) Undue hardship does not exist when:

(a) The adjustment or recovery of the decedent's cost of assistance would merely cause the heir inconvenience or restrict his or her lifestyle; or

(b) The undue hardship was created as a result of estate planning methods by which the heir or deceased client divested, transferred or otherwise encumbered assets, in whole or in part, to avoid recovery from the estate.

(3) When a delay in recovery is not granted, the department provides notice to the person who requested the delay of recovery. The department's notice includes information on how to request an administrative hearing to contest the department's denial.

(4) When a delay of recovery is granted under subsection (1)(a) or (1)(b) of this section, the department may revoke the delay of recovery if the heir(s):

(a) Fails to supply timely information and resource declaration when requested by the department;

(b) Sells, transfers, or encumbers title to the property;

(c) Fails to reside full-time on the premises;

(d) Fails to pay property taxes and utilities when due;

(e) Fails to identify the state of Washington as the primary payee on the property insurance policies. The person granted the delay of recovery must provide the department with documentation of the coverage status on an annual basis.

(f) Have a change in circumstances under subsection (1) of this section for which the delay of recovery due to undue hardship was granted; or

(g) Dies.

(5) When a delay of recovery is granted due to undue hardship, the department has the option to:

(a) Apply a lien; and/or

(b) Accept a payment plan.

(6) A person may request an administrative hearing to contest the department's denial of delay of recovery due to undue hardship when that person suffered a loss because the delay was not granted.

(7) A request for an administrative hearing under this section must:

(a) Be in writing;

(b) State the basis for contesting the department's denial of the request for a delay of recovery due to an undue hardship;

(c) Include a copy of the department's denial;

(d) Be signed by the requester and include the requester's address and telephone number; and

(e) Be served, as described in WAC 388-527-2870, on the office of financial recovery (OFR) within twenty-eight calendar days of the date that the department sent the decision denying the request for a delay of recovery.

(8) Upon receiving a request for an administrative hearing, the department notifies persons known to have title to the property and other assets of the time and place of the administrative hearing.

(9) An adjudicative proceeding held under this section is 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 74.04.050, 74.04.057, 74.08.090, and chapter 26.60 RCW. 09-07-038, § 388-527-2750, filed 3/10/09, effective 4/10/09. Statutory Authority: 2005 c 292, RCW 43.20B.080, 74.39A.170, 42 U.S.C. Section 1396p. 06-17-075, § 388-527-2750, filed 8/14/06, effective 9/14/06. Statutory Authority: RCW 43.17.240, 43.20B.80 [43.20B.080], 74.08.090, 74.34.090, Section 1917(b) of the Social Security Act and 2001 2nd sp.s. c 7, Part II. 04-10-060, § 388-527-2750, filed 4/30/04, effective 6/1/04. 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 388-527-2820 Liens prior to death. (1) Subject to the requirements of 42 USC Section 1396p and the conditions of this section, the department is authorized to file a lien against the property of a medical assistance client prior to his or her death, and to seek adjustment and recovery from the client's estate or sale of the property subject to the lien if:

(a) The client is permanently an inpatient in a nursing facility, intermediate care facility for individuals with mental retardation, or other medical institution as described in WAC 388-500-0005;

(b) The department determines, after notice and opportunity for a hearing, that the client cannot reasonably be expected to be discharged from the medical institution and return home; and

(c) None of the following are lawfully residing, in the client's home:

(i) The client's spouse or domestic partner;

(ii) The client's child who is twenty years of age or younger, or is blind or permanently and totally disabled as defined in Title 42 USC Section 1382c; or

(iii) A sibling of the client (who has an equity interest in such home and who was residing in the client's home for a period of at least one year immediately before the date of the client's admission to the medical institution).

(2) If the client is discharged from the medical facility and returns home, the department dissolves the lien.

(3) Prior to the department filing a lien under this section, the department sends a notice via first class mail to:

(a) The address of the property and other assets subject to the lien;

(b) The client's known address;

(c) Any other person known to have title to the affected property and the client's authorized representative, if any.

(4) The notice in subsection (3) of this section includes:

(a) The client's name, and the date the client began to receive services;

(b) The department's intent to file a lien against the client's property to recover the amount of medical assistance or state-only funded long-term care services, or both correctly paid on behalf of the client;

(c) The county in which the property and other assets are located; and

(d) The procedures to contest the department's decision to file a lien by applying for an administrative hearing.

(5) An administrative hearing only determines:

(a) Whether the medical assistance or state-only funded long-term care services, or both, on behalf of the decedent alleged by the department's notice is correct; and

(b) Whether the decedent had legal title to the identified property.

(6) A request for an administrative hearing must:

(a) Be in writing;

(b) State the basis for contesting the lien;

(c) Be signed by the requester and must include the requester's address and telephone number; and

(d) Be served to the office of financial recovery (OFR) as described in WAC 388-527-2870, within twenty-eight calendar days of the date the department mailed the notice.

(7) Upon receiving a request for an administrative hearing, the department notifies persons known to have title to the property of the time and place of the administrative hearing.

(8) An administrative hearing under this subsection is 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.

(9) If an administrative hearing is conducted in accordance with this regulation, and the final agency decision is issued, the department only files a lien against the client's property and other assets if upheld by the final agency decision.

(10) If no known title holder requests an administrative hearing, the department files a lien twenty-eight calendar days after the date the department mailed the notice described in subsection (3) of this section.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and chapter 26.60 RCW. 09-07-038, § 388-527-2820, filed 3/10/09, effective 4/10/09. Statutory Authority: 2005 c 292, RCW 43.20B.080, 74.39A.170, 42 U.S.C.

Section 1396p. 06-17-075, § 388-527-2820, filed 8/14/06, effective 9/14/06.]

Chapter 388-530 WAC

PRESCRIPTION DRUGS (OUTPATIENT)

WAC

388-530-1000	Outpatient drug program—General.
388-530-2000	Covered—Outpatient drugs, devices, and drug-related supplies.
388-530-2100	Noncovered—Outpatient drugs and pharmaceutical supplies.

WAC 388-530-1000 Outpatient drug program—

General. (1) The purpose of the outpatient drug program is to reimburse providers for outpatient drugs, vitamins, minerals, devices, and drug-related supplies according to department rules and subject to the limitations and requirements in this chapter.

(2) The department reimburses for outpatient drugs, vitamins, minerals, devices, and pharmaceutical supplies that are:

(a) Covered. Refer to WAC 388-530-2000 for covered drugs, vitamins, minerals, devices, and drug-related supplies and to WAC 388-530-2100 for noncovered drugs and drug-related supplies;

(b) Prescribed by a provider with prescriptive authority (see exceptions for family planning and emergency contraception for women eighteen years of age and older in WAC 388-530-2000 (1)(b), and over-the-counter (OTC) drugs to promote smoking cessation in WAC 388-530-2000 (1)(g);

(c) Within the scope of an eligible client's medical assistance program;

(d) Medically necessary as defined in WAC 388-500-0005 and determined according to the process found in WAC 388-501-0165; and

(e) Authorized, as required within this chapter;

(f) Billed according to WAC 388-502-0150 and 388-502-0160; and

(g) Billed according to the requirements of this chapter.

(3) Coverage determinations for the department are made by the department's pharmacists or medical consultants in accordance with applicable federal law. The department's determination may include consultation with the drug use review (DUR) board.

(4) The department may not reimburse for prescriptions written by healthcare practitioners whose application for a core provider agreement (CPA) has been denied, or whose CPA has been terminated.

(5) The department may not reimburse for prescriptions written by non-CPA healthcare practitioners who do not have a current core provider agreement with the department when the department determines there is a potential danger to the client's health and/or safety.

[Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 09-05-007, § 388-530-1000, filed 2/5/09, effective 3/8/09. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.700, 2008 c 245. 08-21-107, § 388-530-1000, filed 10/16/08, effective 11/16/08. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 07-20-049, § 388-530-1000, filed 9/26/07, effective 11/1/07; 06-24-036, § 388-530-1000, filed 11/30/06, effective 1/1/07. 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 388-530-2000 Covered—Outpatient drugs, devices, and drug-related supplies. (1) The department covers:

(a) Outpatient drugs, including over-the-counter drugs, as defined in WAC 388-530-1050, subject to the limitations and requirements in this chapter, when:

(i) The drug is approved by the Food and Drug Administration (FDA);

(ii) The drug is for a medically accepted indication as defined in WAC 388-530-1050;

(iii) The drug is not excluded from coverage under WAC 388-530-2100;

(iv) 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 388-530-7500 which describes the drug rebate program; and

(v) Prescribed by a provider with prescriptive authority (see exceptions for family planning and emergency contraception for women eighteen years of age and older in WAC 388-530-2000 (1)(b), and over-the-counter (OTC) drugs to promote smoking cessation in WAC 388-530-2000 (1)(g)).

(b) Family planning drugs, devices, and drug-related supplies per chapter 388-532 WAC and as follows:

(i) Over-the-counter (OTC) family planning drugs, devices, and drug-related supplies without a prescription when the department determines it necessary for client access and safety.

(ii) Family planning drugs that do not meet the federal drug rebate requirement in WAC 388-530-7500 on a case-by-case basis; and

(iii) Contraceptive patches, contraceptive rings, and oral contraceptives, only when dispensed in at least a three-month supply, unless otherwise directed by the prescriber. There is no required minimum for how many cycles of emergency contraception may be dispensed.

(c) Prescription vitamins and mineral products, only as follows:

(i) When prescribed for clinically documented deficiencies;

(ii) Prenatal vitamins, when prescribed and dispensed to pregnant women; or

(iii) Fluoride prescribed for clients under the age of twenty-one.

(d) OTC drugs, vitamins, and minerals when determined by the department to be the least costly therapeutic alternative for a medically accepted indication. The department will maintain and publish a list of the covered OTC drugs available to clients which have been determined to be the least costly therapeutic alternatives for medically accepted indications. Subsection (1)(d) does not apply to products prescribed for the treatment of cough or cold symptoms. See WAC 388-530-2000 (1)(i) and 388-530-2100 (1)(b)(v) for coverage of products prescribed for the treatment of cough and cold symptoms.

(e) Drug-related devices and drug-related supplies as an outpatient pharmacy benefit when:

(i) Prescribed by a provider with prescribing authority;

(ii) Essential for the administration of a covered drug;

(iii) Not excluded from coverage under WAC 388-530-2100; and

(iv) Determined by the department, that a product covered under chapter 388-543 WAC Durable medical equipment and supplies should be available at retail pharmacies.

(f) Preservatives, flavoring and/or coloring agents, only when used as a suspending agent in a compound.

(g) Over-the-counter (OTC) drugs, without a prescription, to promote smoking cessation only for clients who are eighteen years of age or older and participating in a department-approved smoking cessation program. Limitation extensions as described in WAC 388-501-0169 are prohibited for the age and counseling requirements in this section.

(h) Prescription drugs to promote smoking cessation only for clients who are eighteen years of age or older and participating in a department-approved smoking cessation program. Limitation extensions as described in WAC 388-501-0169 are prohibited for the age and counseling requirements in this section.

(i) For the treatment of cough and cold symptoms:

(i) Only the following generic, single ingredient formulations:

(A) Guaifenesin 100 mg/5 ml liquid or syrup;

(B) Dextromethorphan 15 mg/5 ml liquid or syrup;

(C) Pseudoephedrine 30 mg or 60 mg tablets;

(D) Saline nasal spray 0.65%; and

(ii) Generic combination product dextromethorphan-guaifenesin 10-100 mg/5 ml syrup, including sugar-free formulations.

(2) The department does not reimburse for any drug, device, or drug-related supply not meeting the coverage requirements under this section.

[Statutory Authority: RCW 74.04.050, 74.08.090, SSA § 1927 (42 U.S.C. 1396r-8(d)(2)(D)), and 2009 c 564 § 1109, 09-22-005, § 388-530-2000, filed 10/22/09, effective 11/22/09. Statutory Authority: RCW 74.04.050, 74.08.-090, 74.09.530, and 74.09.700, 09-05-007, § 388-530-2000, filed 2/5/09, effective 3/8/09. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.-700, 2008 c 245, 08-21-107, § 388-530-2000, filed 10/16/08, effective 11/16/08. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700, 07-20-049, § 388-530-2000, filed 9/26/07, effective 11/1/07.]

WAC 388-530-2100 Noncovered—Outpatient drugs and pharmaceutical supplies. (1) The department does not cover:

(a) A drug that is:

(i) Not approved by the Food and Drug Administration (FDA); or

(ii) Prescribed for a nonmedically accepted indication, including diagnosis, dose, or dosage schedule that is not evidenced-based.

(b) A drug prescribed:

(i) For weight loss or gain;

(ii) For infertility, frigidity, impotency;

(iii) For sexual or erectile dysfunction;

(iv) For cosmetic purposes or hair growth; or

(v) For treatment of cough or cold symptoms, except as listed in WAC 388-530-2000 (1)(i).

(c) Drugs used to treat sexual or erectile dysfunction, in accordance with section 1927 (d)(2)(K) of the Social Security Act, unless such drugs are used to treat a condition other than

sexual or erectile dysfunction, and these uses have been approved by the Food and Drug Administration.

(d) Drugs listed in the federal register as "less-than-effective" ("DESI" drugs) or which are identical, similar, or related to such drugs.

(e) 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.

(f) A product:

(i) With an obsolete national drug code (NDC) for more than two years;

(ii) With a terminated NDC;

(iii) Whose shelf life has expired; or

(iv) Which does not have an eleven-digit NDC.

(g) Over-the-counter (OTC) drugs, vitamins, and minerals, except as allowed under WAC 388-530-2000 (1)(i).

(h) Any drug regularly supplied by other public agencies as an integral part of program activity (e.g., immunization vaccines for children).

(i) Free pharmaceutical samples.

(j) Over-the-counter or prescription drugs to promote smoking cessation unless the client is eighteen years old or older and participating in a department-approved cessation program.

(2) If a noncovered drug is prescribed through the early and periodic screening, diagnosis, and treatment (EPSDT) process, an authorization request may be submitted indicating that the request is EPSDT related, and the request will be evaluated according to the process in WAC 388-501-0165. (See WAC 388-534-0100 for EPSDT rules).

(3) A client can request an exception to rule (ETR) as described in WAC 388-501-0160.

[Statutory Authority: RCW 74.04.050, 74.08.090, SSA § 1927 (42 U.S.C. 1396r-8(d)(2)(D)), and 2009 c 564 § 1109. 09-22-005, § 388-530-2100, filed 10/22/09, effective 11/22/09. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 09-05-007, § 388-530-2100, filed 2/5/09, effective 3/8/09. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.700, 2008 c 245. 08-21-107, § 388-530-2100, filed 10/16/08, effective 11/16/08. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 07-20-049, § 388-530-2100, filed 9/26/07, effective 11/1/07.]

Chapter 388-533 WAC MATERNITY-RELATED SERVICES

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-533-1000 First steps child care program. [Statutory Authority: RCW 74.08.090, 74.09.800. 03-19-010, § 388-533-1000, filed 9/4/03, effective 10/5/03; 01-15-008, § 388-533-1000, filed 7/6/01, effective 8/6/01.] Repealed by 09-23-111, filed 11/18/09, effective 12/19/09. Statutory Authority: RCW 74.08.090, 74.09.800, 2009 c 564.

Chapter 388-537 WAC SCHOOL SERVICES

WAC

388-537-0100 School-based healthcare services for children in special education—Purpose.
388-537-0200 School-based healthcare services for children in special education—Definitions.
388-537-0300 School-based healthcare services for children in special education—Client eligibility.

388-537-0350 School-based healthcare services for children in special education—Provider qualifications.
388-537-0400 School-based healthcare services for children in special education—Covered services.
388-537-0500 School-based healthcare services for children in special education—Noncovered services.
388-537-0600 School-based healthcare services for children in special education—School district requirements for billing and payment.
388-537-0700 School-based healthcare services for children in special education—School district documentation requirements.
388-537-0800 School-based healthcare services for children in special education—Program monitoring/audits.

WAC 388-537-0100 School-based healthcare services for children in special education—Purpose. (1) The department of social and health services (DSHS) pays school districts for school-based healthcare services provided to children in special education in accordance with the individuals with disabilities education act (IDEA). The services must:

(a) Address the physical and/or mental disabilities of a child;

(b) Be prescribed or recommended by a physician or other qualified healthcare provider within his or her scope of practice under state law; and

(c) Be included in the child's individualized education program (IEP).

[Statutory Authority: RCW 74.08.090, 74.09.500, and 42 C.F.R. 440.110. 09-07-004, § 388-537-0100, filed 3/4/09, effective 4/4/09. 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.]

WAC 388-537-0200 School-based healthcare services for children in special education—Definitions. The following definitions and those found in WAC 388-500-0005 apply to this chapter:

"Assessment"—For purposes of this chapter an assessment is made-up of tests given to an individual child by qualified professionals to evaluate whether a child is determined to be a child with a disability and in need of special education and related services. Assessments are a part of the evaluation and re-evaluation processes.

"Child with a disability"—For purposes of this chapter, a child with a disability means a child evaluated and determined to need special education and related services because of a disability in one or more of the following eligibility categories:

- Mental retardation;
- Hearing impairment (including deafness);
- Speech or language impairment;
- Serious emotional disturbance (emotional behavioral disability);
- Orthopedic impairment;
- Autism;
- Visual impairment (including blindness);
- Traumatic brain injury;
- Other health impairment;
- Specific learning disability;
- Deaf/blindness;
- Multiple disabilities; or

• A developmental delay for children ages three through nine, with an adverse educational impact, the results of which require special education and related direct services.

"Direct healthcare services"—Services provided directly to a child either one-on-one or in a group setting.

"Educational staff associate (ESA) certification"—The ESA certificate is an official document that attests to minimum prerequisites of age, moral character/fitness, education, experience, competence, and preparation program, depending on the certificate types. The ESA certification is required to serve in a Washington public school.

"Evaluation"—Procedures used according to WAC 392-172A-03005 through 392-172A-03080 to determine whether a student has a disability, and the nature and extent of the special education and related services needed.

"Fee-for-service"—For the purpose of this section, the general payment method the department uses to reimburse providers for covered medical services provided to medical assistance clients when those services are not covered under the department's managed care plans or state children's health insurance program (SCHIP).

"Individuals with Disabilities Education Act (IDEA)"—The IDEA is a United States federal law that governs how states and public agencies provide early intervention, special education, and related services to children with disabilities. It addresses the educational needs of children with disabilities from birth to age of twenty-one.

"Individualized education program (IEP)"—A written statement of an educational program for a student eligible for special education. (See WAC 392-172A-03090 through 392-172A-03135.)

"Qualified healthcare provider"—See WAC 388-537-0350.

"Reevaluation"—Procedures used to determine whether a student continues to be in need of special education and related services. (See WAC 392-172A-03015.)

"Related services"—Developmental, corrective, and other supportive services as may be required to assist a child with a disability to benefit from specially designed instruction. For purposes of this program, related services include: physical therapy, occupational therapy, speech-language therapy, audiology services, psychological assessments, counseling, and nursing services.

[Statutory Authority: RCW 74.08.090, 74.09.500, and 42 C.F.R. 440.110. 09-07-004, § 388-537-0200, filed 3/4/09, effective 4/4/09.]

WAC 388-537-0300 School-based healthcare services for children in special education—Client eligibility. Children in special education must be receiving Title XIX Medicaid under a categorically needy program (CNP) or medically needy program (MNP) to be eligible for school-based healthcare services. Eligible children enrolled in a managed care organization (MCO) receive school-based healthcare services on a fee-for-service basis.

[Statutory Authority: RCW 74.08.090, 74.09.500, and 42 C.F.R. 440.110. 09-07-004, § 388-537-0300, filed 3/4/09, effective 4/4/09.]

WAC 388-537-0350 School-based healthcare services for children in special education—Provider qualifications. The department pays school districts to provide certain healthcare services (see WAC 388-537-0400) to eligible

children (see WAC 388-567-0300). These services must be provided by qualified healthcare providers who meet Washington state and federal requirements and operate within the scope of their practitioner's license:

- (1) Audiology services delivered by:
 - (a) A licensed audiologist; or
 - (b) A school-based audiologist who:
 - (i) Meets the education and work experience necessary for a state professional license;
 - (ii) Holds a valid school audiologist educational staff associate certificate; and
 - (iii) Limits their audiology services to the school setting.
- (2) Counseling services delivered by:
 - (a) A licensed independent social worker;
 - (b) A licensed advanced social worker;
 - (c) A licensed mental health counselor; or
 - (d) A school-based social worker or mental health counselor who:
 - (i) Meets the education and work experience necessary for a state professional license;
 - (ii) Holds a valid school social worker or school counselor educational staff associate certificate; and
 - (iii) Limits their counseling services to the school setting.
- (3) Nursing services delivered by:
 - (a) A licensed registered nurse;
 - (b) A licensed practical nurse; or
 - (c) A noncredentialed school employee who is delegated certain limited healthcare tasks by a registered nurse and, trained and supervised according to professional practice standards.
- (4) Occupational therapy services delivered by:
 - (a) A licensed occupational therapist; or
 - (b) A certified occupational therapy assistant supervised by a licensed occupational therapist in accordance with professional practice standards.
- (5) Physical therapy services delivered by:
 - (a) A licensed physical therapist; or
 - (b) A licensed physical therapist assistant supervised by a licensed physical therapist in accordance with professional practice standards.
- (6) Psychological services delivered by:
 - (a) A licensed psychologist; or
 - (b) A school-based psychologist who:
 - (i) Holds a masters degree in school psychology;
 - (ii) Holds a valid school psychologist educational staff associate certificate; and
 - (iii) Limits their psychological services to the school setting.
 - (c) A school-based psychologist who:
 - (i) Holds a doctoral degree in psychology;
 - (ii) Holds a valid school psychologist educational staff associate certificate; and
 - (iii) Limits their psychological services to the school setting.
- (7) Speech therapy services delivered by:
 - (a) A licensed speech-language pathologist;
 - (b) A speech-language pathology assistant, who has graduated from a speech-language pathology assistant program, and is supervised by a speech-language pathologist

with a certificate of clinical competence (CCC) in accordance with professional practice standards; or

(c) A school-based speech-language pathologist who:

(i) Meets the education and work experience necessary for a state professional license;

(ii) Holds a valid school speech-language pathologist educational staff associate certificate; and

(iii) Limits their speech therapy services to the school setting.

(8) For services provided under the supervision of a physical therapist, occupational therapist or speech-language pathologist the following requirements apply:

(a) The nature, frequency and length of the supervision must be provided in accordance with professional practice standards and adequate to assure the child receives quality therapy services.

(b) At a minimum, supervision must be one-on-one communication between the supervisor and the supervised professional.

(c) Documentation of supervisory activities must be on record and available to the department upon request.

(9) It is the responsibility of the school district to assure providers meet the professional requirements necessary for reimbursement.

[Statutory Authority: RCW 74.08.090, 74.09.500, and 42 C.F.R. 440.110. 09-07-004, § 388-537-0350, filed 3/4/09, effective 4/4/09.]

WAC 388-537-0400 School-based healthcare services for children in special education—Covered services. Covered services include:

(1) Evaluations, when the child is determined to be a child with a disability and in need of special education and related services;

(2) Direct healthcare services including:

(a) Audiology;

(b) Counseling;

(c) Nursing;

(d) Occupational therapy;

(e) Physical therapy;

(f) Psychological assessments;

(g) Speech-language therapy.

(3) Reevaluations, to determine whether the child continues to need special education and related services.

[Statutory Authority: RCW 74.08.090, 74.09.500, and 42 C.F.R. 440.110. 09-07-004, § 388-537-0400, filed 3/4/09, effective 4/4/09.]

WAC 388-537-0500 School-based healthcare services for children in special education—Noncovered services. Noncovered services include, but are not limited to the following:

(1) Attending meetings;

(2) Charting;

(3) Equipment preparation;

(4) Instructional assistant contact;

(5) Parent consultation;

(6) Parent contact;

(7) Planning;

(8) Preparing and sending correspondence to parents or other professionals;

(9) Professional consultation;

(10) Report writing;

(11) Review of records;

(12) Set-up;

(13) Teacher contact;

(14) Test interpretation;

(15) Travel;

(16) Observation; and

(17) For the purposes of this chapter, the department does not reimburse school districts for a RN or LPN to monitor a child continuously throughout the school day.

[Statutory Authority: RCW 74.08.090, 74.09.500, and 42 C.F.R. 440.110. 09-07-004, § 388-537-0500, filed 3/4/09, effective 4/4/09.]

WAC 388-537-0600 School-based healthcare services for children in special education—School district requirements for billing and payment. To receive payment from the department for school-based healthcare services, a school district must:

(1) Have a current, signed core provider agreement with the department;

(2) Meet the applicable requirements in chapter 388-502 WAC; and

(3) Bill according to the department's published school-based healthcare services billing instructions.

[Statutory Authority: RCW 74.08.090, 74.09.500, and 42 C.F.R. 440.110. 09-07-004, § 388-537-0600, filed 3/4/09, effective 4/4/09.]

WAC 388-537-0700 School-based healthcare services for children in special education—School district documentation requirements. (1) The school districts must maintain sufficient documentation to support and justify the paid claims, to include, at a minimum:

(a) Professional assessment reports;

(b) Evaluation and reevaluation reports;

(c) Individualized education program (IEP); and

(d) Treatment notes for each date of service the provider billed to the department.

(2) All provider licenses and other credentials must be current and on file with the school district and available for review upon request.

(3) All records must be easily and readily available to the department upon request.

[Statutory Authority: RCW 74.08.090, 74.09.500, and 42 C.F.R. 440.110. 09-07-004, § 388-537-0700, filed 3/4/09, effective 4/4/09.]

WAC 388-537-0800 School-based healthcare services for children in special education—Program monitoring/audits. (1) School districts must participate in the monitoring process.

(2) The department monitors school-based healthcare services as established by the school-based healthcare services program manager and in compliance with the department's monitoring policy and plan.

(3) The department conducts audits of school-based healthcare services in accordance with chapter 388-502A WAC.

(4) The department authority to conduct audits and recover overpayments is found in RCW 74.09.200, 74.09.220 and 74.09.290.

[Statutory Authority: RCW 74.08.090, 74.09.500, and 42 C.F.R. 440.110. 09-07-004, § 388-537-0800, filed 3/4/09, effective 4/4/09.]

Chapter 388-542 WAC**STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)****WAC**

388-542-0010	Purpose and scope of premium-based healthcare coverage under programs included in apple health for kids.
388-542-0020	Other rules that apply to premium-based healthcare coverage under programs included in apple health for kids.
388-542-0050	Definitions for premium-based healthcare coverage under programs included in apple health for kids.
388-542-0300	Waiting period for premium-based healthcare coverage under programs included in apple health for kids following employer coverage.

WAC 388-542-0010 Purpose and scope of premium-based healthcare coverage under programs included in apple health for kids. The department administers the programs included in apple health for kids that provide premium-based coverage through a combination of state and federal funding sources as described below:

(1) Federally matched healthcare coverage as authorized by Title XXI of the Social Security Act state children's health insurance program (SCHIP) and RCW 74.09.450 for citizen and federally qualified immigrant children whose family income is above two hundred percent of the federal poverty level (FPL) but is not above three hundred percent FPL.

(2) State funded healthcare coverage for children with family income above two hundred percent FPL, but not above three hundred percent FPL, who are ineligible for Title XXI federally matched healthcare coverage due to immigration issues.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.402, 74.09.470, and 2008 session law. 09-07-086, § 388-542-0010, filed 3/17/09, effective 4/17/09. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, 74.09.700, and 2007 c 5. 08-05-018, § 388-542-0010, filed 2/12/08, effective 3/14/08. Statutory Authority: RCW 74.08.090, 74.09.050, and Title XXI of the Social Security Act. 06-15-134, § 388-542-0010, filed 7/19/06, effective 8/19/06. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.522, 74.09.450, and 2004 c 276. 04-16-064, § 388-542-0010, filed 7/30/04, effective 8/30/04.]

WAC 388-542-0020 Other rules that apply to premium-based healthcare coverage under programs included in apple health for kids. In addition to the rules of this chapter, children receiving premium-based coverage under programs included in apple health for kids are subject to the following rules:

(1) Chapter 388-538 WAC, Managed care (except WAC 388-538-061, 388-538-063, and 388-538-065) if the child is covered under federally matched CN coverage;

(2) WAC 388-505-0210(4), Children's healthcare program eligibility;

(3) WAC 388-505-0211, Premium requirements for premium-based coverage under programs included in apple health for kids;

(4) WAC 388-416-0015(12), Certification periods for categorically needy (CN) scope of care medical assistance programs; and

(5) WAC 388-418-0025, Effect of changes on medical program eligibility.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.402, 74.09.470, and 2008 session law. 09-07-086, § 388-542-0020, filed 3/17/09, effective 4/17/09. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, 74.09.700, and 2007 c 5. 08-05-018, § 388-542-0020, filed 2/12/08, effective 3/14/08. Statutory Authority: RCW 74.08.090, 74.09.050, and 2004 c 276. 04-16-064, § 388-542-0020, filed 7/30/04, effective 8/30/04.]

090, 74.09.530, 74.09.700, and 2007 c 5. 08-05-018, § 388-542-0020, filed 2/12/08, effective 3/14/08. Statutory Authority: RCW 74.08.090 and 74.09.522. 06-07-014, § 388-542-0020, filed 3/3/06, effective 4/3/06. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.522, 74.09.450, and 2004 c 276. 04-16-064, § 388-542-0020, filed 7/30/04, effective 8/30/04.]

WAC 388-542-0050 Definitions for premium-based healthcare coverage under programs included in apple health for kids. The following definitions, as well as those found in WAC 388-538-050 and in 388-500-0005 Medical definitions, apply to premium-based coverage under programs included in apple health for kids.

"Creditable coverage" means most types of public and private health coverage, except Indian health services, that provides access to physicians, hospitals, laboratory services, and radiology services. This term applies to the coverage whether or not the coverage is equivalent to that offered under premium-based programs included in apple health for kids. "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.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.402, 74.09.470, and 2008 session law. 09-07-086, § 388-542-0050, filed 3/17/09, effective 4/17/09. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, 74.09.700, and 2007 c 5. 08-05-018, § 388-542-0050, filed 2/12/08, effective 3/14/08. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.522, 74.09.450, and 2004 c 276. 04-16-064, § 388-542-0050, filed 7/30/04, effective 8/30/04. 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 388-542-0300 Waiting period for premium-based healthcare coverage under programs included in apple health for kids following employer coverage. (1) The department requires applicants to serve a waiting period of four full consecutive months before receiving premium-based coverage under programs included in apple health for kids 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; 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) The department does not require a waiting period prior to premium-based coverage under a program included in apple health for kids 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 cost for employer-sponsored dependent coverage is two and one-half percent or more of the family's countable monthly income;

(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 74.04.050, 74.04.057, 74.08.090, 74.09.402, 74.09.470, and 2008 session law. 09-07-086, § 388-542-0300, filed 3/17/09, effective 4/17/09. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, 74.09.700, and 2007 c 5. 08-05-018, § 388-542-0300, filed 2/12/08, effective 3/14/08. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.522, 74.09.450, and 2004 c 276. 04-16-064, § 388-542-0300, filed 7/30/04, effective 8/30/04. 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.]

Chapter 388-543 WAC

DURABLE MEDICAL EQUIPMENT AND RELATED SUPPLIES, PROSTHETICS, ORTHOTICS, MEDICAL SUPPLIES AND RELATED SERVICES

WAC

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.
388-543-1600	Items and services which require prior authorization.
388-543-2900	Medical supplies and nondurable medical equipment (MSE)—Reimbursement methodology.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-543-2300	Bathroom/shower equipment. [Statutory Authority: RCW 74.08.090, 74.09.530. 01-01-078, § 388-543-2300, filed 12/13/00, effective 1/13/01.] Repealed by 09-22-047, filed 10/28/09, effective 11/28/09. Statutory Authority: 2009 c 564 § 1109, RCW 74.04.050, 74.04.057, and 74.08.090.
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WAC 388-543-1150 Limits and limitation extensions.

The department covers non-DME (MSE), DME, and related supplies, prosthetics, orthotics, medical supplies, and related services as described in WAC 388-543-1100(1). The department 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). The department evaluates such requests for LE under the provisions of WAC 388-501-0169. Procedures for LE are found in department 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 pint 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; or

(e) 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;

(b) Spring-powered device for lancet - one in a six-month period.

(c) Test strips and lancets for an insulin dependent diabetic - one hundred of each, per month; and

(d) Test strips and lancets for a noninsulin dependent diabetic - one hundred of each, per three-month period.

(3) Braces, belts and supportive devices:

(a) Knee brace (neoprene, nylon, elastic, or with a hinged bar) - two per twelve-month period;

(b) Ankle, elbow, or wrist brace - two per twelve-month period;

(c) Lumbosacral brace, rib belt, or hernia belt - one per twelve-month period;

(d) Cervical head harness/halter, cervical pillow, pelvic belt/harness/boot, or extremity belt/harness - one per twelve-month period.

(4) Decubitus care products:

(a) Cushion (gel, sacroiliac, or accuback) and cushion cover (any size) - one per twelve-month period;

(b) Synthetic or lambs wool sheepskin pad - one per twelve-month period;

(c) Heel or elbow protectors - four per twelve-month period.

(5) Ostomy supplies:

(a) Adhesive for ostomy or catheter: Cement; powder; liquid (e.g., spray or brush); or paste (any composition, e.g., silicone or latex) - four total ounces per month.

(b) Adhesive or nonadhesive disc or foam pad for ostomy pouches - ten per month.

(c) Adhesive remover or solvent - three ounces per month.

(d) Adhesive remover wipes, fifty per box - one box per month.

(e) Closed pouch, with or without attached barrier, with a one- or two-piece flange, or for use on a faceplate - sixty per month.

(f) Closed ostomy pouch with attached standard wear barrier, with built-in one-piece convexity - ten per month.

(g) Continent plug for continent stoma - thirty per month.

(h) Continent device for continent stoma - one per month.

(i) Drainable ostomy pouch, with or without attached barrier, or with one- or two-piece flange - twenty per month.

(j) Drainable ostomy pouch with attached standard or extended wear barrier, with or without built-in one-piece convexity - twenty per month.

(k) Drainable ostomy pouch for use on a plastic or rubber faceplate (only one type of faceplate allowed) - ten per month.

(l) Drainable urinary pouch for use on a plastic, heavy plastic, or rubber faceplate (only one type of faceplate allowed) - ten per month.

(m) Irrigation bag - two every six months.

(n) Irrigation cone and catheter, including brush - two every six months.

(o) Irrigation supply, sleeve - one per month.

(p) Ostomy belt (adjustable) for appliance - two every six months.

(q) Ostomy convex insert - ten per month.

(r) Ostomy ring - ten per month.

(s) Stoma cap - thirty per month.

(t) Ostomy faceplate - ten per month. The department 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., briefs, diapers, pull-up pants, underpads for beds, liners, shields, guards, pads, and undergarments). 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;

(v) The product must meet the flammability requirements of both federal law and industry standards; and

(vi) All products are covered for client personal use only.

(b) In addition to the standards in subsection (a) of this section, 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 child diapers, at least two tapes, one on each side.

(B) 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 pants and briefs must meet the following specifications. They must:

(i) Be made like regular underwear with an elastic waist or have at least four tapes, two on each side or two large tapes, one on each side;

(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 are covered only for incontinent purposes in a client's bed and must meet the following specifications:

(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

(vi) Have four-ply, nonwoven facing, sealed on all four sides.

(e) In addition to the standards in subsection (a) of this section, liners, shields, guards, pads, and undergarments are covered for incontinence only and must meet the following specifications:

(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) The department covers the products in this subsection only when they are used alone; they cannot be used in combination with each other. The department approves a client's use of a combination of products only when the client uses different products for daytime and nighttime use (see department billing instructions for how to specify this when billing). The total quantity of all products in this section used in combination 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 diapers;

(ii) Disposable pull-up pants and briefs;

(iii) Disposable liners, shields, guards, pads, and undergarments;

(iv) Rented reusable diapers (e.g., from a diaper service); and

(v) Rented reusable briefs (e.g., from a diaper service), or pull-up pants.

(g) Purchased disposable diapers (any size) are limited to:

(i) Two hundred per month for a child three to eighteen years of age; and

(ii) Two hundred per month for an adult nineteen years of age and older.

(h) Reusable cloth diapers (any size) are limited to:

(i) Purchased - thirty-six per year; and

(ii) Rented - two hundred per month.

(i) Disposable briefs and pull-up pants (any size) are limited to:

(i) Two hundred per month for a child age three to eighteen years of age; and

(ii) One hundred fifty per month for an adult nineteen years of age and older.

(j) Reusable briefs, washable protective underwear, or pull-up pants (any size) are limited to:

(i) Purchased - four per year.

(ii) Rented - one hundred fifty per month.

(k) Disposable pant liners, shields, guards, pads, and undergarments are limited to two hundred per month.

(l) 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. The department 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) Nontoxic gel (e.g., LiceOut TM) for use with lice combs - one bottle per twelve month period.

(f) Nonsterile gloves - one hundred per box, two box per month.

(g) Sterile gloves - thirty pair, 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) Lightweight protective helmet/soft shell (including adjustable chin/mouth strap) - two per twelve-month period.

(e) 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.

(f) Pneumatic compressor - one in a five-year period.

(g) Positioning car seat - one in a five-year 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.

(f) All other prosthetics and orthotics are limited to one per twelve-month period per limb.

(12) Positioning devices:

(a) Positioning system/supine boards (small or large), including padding, straps adjustable armrests, footboard, and support blocks - one in a five-year period.

(b) Prone stander (child, youth, infant or adult size) - one in a five-year period.

(c) 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.

(13) Beds, mattresses, and related equipment:

(a) Pressure pad, alternating with pump - one in a five-year period.

(b) Dry pressure mattress - one in a five-year period.

(c) Gel or gel-like pressure pad for mattress - one in a five-year period.

(d) Gel pressure mattress - one in a five-year period.

(e) Water pressure pad for mattress - one in a five-year period.

(f) Dry pressure pad for mattress - one in a five-year period.

(g) Mattress, inner spring - one in a five-year period.

(h) Mattress, foam rubber - one in a five-year period.

(i) Hospital bed, semi-electric - one in a ten-year period.

(j) Bedside rails - one in a ten-year period.

(14) Other patient room equipment:

(a) Patient lift, hydraulic, with seat or sling - one in a five-year period.

(b) Traction equipment - one in a five year period.

(c) Trapeze bars - one in a five-year period.

(d) Fracture frames - one in a five-year period.

(e) Transfer board or devices - one in a five-year period.

(15) Noninvasive bone growth/nerve stimulators:

(a) Transcutaneous electrical nerve stimulation device (TNS) - one in a five-year period.

(b) Osteogenesis stimulators - one in a five-year period.

(16) Communication devices - artificial larynx, any type - one in a five-year period.

(17) Ambulatory aids:

(a) Canes - one in a five-year period.

(b) Crutches - one in a five-year period.

(c) Walkers - one in a five-year period.

[Statutory Authority: 2009 c 564 § 1109, RCW 74.04.050, 74.04.057, and 74.08.090. 09-22-047, § 388-543-1150, filed 10/28/09, effective 11/28/09. Statutory Authority: RCW 74.08.090 and 74.04.050. 07-17-062, § 388-543-1150, filed 8/13/07, effective 9/13/07. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 06-24-036, § 388-543-1150, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.04.050, 74.04.57 [74.04.057], and 74.08.090. 05-21-102, § 388-543-1150, filed 10/18/05, effective 11/18/05. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.-090, and Public Law 104-191. 03-19-082, § 388-543-1150, filed 9/12/03, effective 10/13/03. 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) The department requires a provider who supplies DME and related supplies, prosthetics, orthotics, medical supplies and related services to a client to meet all of the following. The provider must:

(a) Have the proper business license; and

(b) 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) The department 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. The department may pay separately for medical supplies, subject to the provisions in the

department's **resource based relative value scale (RBRVS)** fee schedule; and

(e) Out-of-state orthotics and prosthetics providers who meet their state regulations.

(3) The department 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, 09-05-008, § 388-543-1200, filed 2/5/09, effective 3/8/09. 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) The department 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) The department pays only for prosthetics or orthotics that are listed as such by the Centers for Medicare and Medicaid Services (CMS) 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) The department considers all requests for covered DME, related supplies and services, medical supplies, prosthetics, orthotics, and related services under the provisions of WAC 388-501-0165.

(4) The department evaluates a request for any DME item listed as noncovered in this chapter under the provisions of WAC 388-501-0160. When early and periodic screening, diagnosis and treatment (EPSDT) applies, the department evaluates a noncovered service, equipment, or supply according to the process in WAC 388-501-0165 to determine if it is medically necessary, safe, effective, and not experimental (see WAC 388-543-0100 for EPSDT rules).

(5) The department 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. The department reviews these requests according to the provisions of chapter 388-534 WAC.

(6) Excluded services and equipment include, but are not limited to:

(a) Services, procedures, treatment, devices, drugs, or the application of associated services that the Food and Drug Administration (FDA) and/or the Centers for Medicare and Medicaid Services (CMS) 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 the

department for the client contributes to an increased utility bill (refer to the aging and disability services administration's (ADSA) 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;

(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 ADSA 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, and light boxes;

(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, sharp containers, 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) Blood monitoring:

(i) Sphygmomanometer/blood pressure apparatus with cuff and stethoscope;

(ii) Blood pressure cuff only; and

(iii) Automatic blood pressure monitor.

(l) Bathroom equipment:

(i) Bath stools;

(ii) Bathtub wall rail (grab bars);

(iii) Bed pans;

(iv) Control unit for electronic bowel irrigation/evacuation system;

(v) Disposable pack for use with electronic bowel system;

(vi) Potty chairs;

(vii) Raised toilet seat;

(viii) Safety equipment (e.g. belt, harness or vest);

(ix) Shower/commode chairs;

(x) Sitz type bath or equipment;

(xi) Standard and heavy duty bath chairs;

(xii) Toilet rail;

(xiii) Transfer bench tub or toilet;

(xiv) Urinal male/female.

(m) Disinfectant spray - one twelve-ounce bottle or can per six-month period.

(n) Personal and **comfort items** 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, sheets, and bumper pads;

(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, socks, custom vascular supports (CVS), surgical stockings, gradient compression stockings, and graduated compression stockings for pregnancy support (pantyhose style);

(v) Clothing protectors, surgical masks, and other protective cloth furniture coverings;

(vi) Cosmetics, including corrective formulations, hair depilatories, and products for skin bleaching, commercial sun screens, and tanning;

(vii) Diverter valves and handheld showers 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 periodontal devices whether manual, battery-operated, or electric.

(o) Certain wheelchair features and options are not considered by the department 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: 2009 c 564 § 1109, RCW 74.04.050, 74.04.057, and 74.08.090. 09-22-047, § 388-543-1300, filed 10/28/09, effective 11/28/09. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 07-04-036, § 388-543-1300, filed 1/29/07, effective 3/1/07. 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 388-543-1600 Items and services which require prior authorization. (1) The department 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.) The department 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) The department requires providers to obtain prior authorization for certain items and services, except for dual-eligible medicare/medicaid clients when medicare is the primary payer. 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 the department'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 the department's published issuances, including billing instructions and numbered memoranda;
- (e) Decubitus care products and supplies;
- (f) 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) Other DME not specifically listed in the department's published issuances, including billing instructions and numbered memoranda, and submitted as a miscellaneous procedure code; and
- (p) Limitation extensions.

[Statutory Authority: 2009 c 564 § 1109, RCW 74.04.050, 74.04.057, and 74.08.090. 09-22-047, § 388-543-1600, filed 10/28/09, effective 11/28/09. Statutory Authority: RCW 74.08.090 and 74.04.050. 07-17-062, § 388-543-1600, filed 8/13/07, effective 9/13/07. Statutory Authority: RCW 74.08.090, 74.09.530. 01-01-078, § 388-543-1600, filed 12/13/00, effective 1/13/01.]

WAC 388-543-2900 Medical supplies and nondurable medical equipment (MSE)—Reimbursement methodology. (1) The department sets, evaluates and annually updates rates for each category of medical supplies and non-DME (MSE) in the medical assistance fee schedule using one or more of the following:

- (a) The medicare fee schedule, for those items that are included in the fee schedule for the medicare program, as established by the federal centers for medicare and medicaid services (CMS).
- (b) For those items not included in the medicare fee schedule, the department uses manufacturers' catalogs and commercial data bases to identify brands to comprise the

department's pricing cluster. When establishing the fee for products in a pricing cluster, the maximum allowable fee is the lesser of either:

(i) Eighty-five percent of the average manufacturer's list price; or

(ii) One hundred twenty-five percent of the average dealer cost.

(c) Input from stakeholders or other relevant sources that the department determines to be reliable and appropriate.

(2) The department's pricing cluster is made up of all the brands for which the department obtains pricing information. However, the department may limit the number of brands included in the pricing cluster if doing so is in the best interests of its clients as determined by the department. The department considers all of the following when establishing the pricing cluster:

- (a) A client's medical needs;
- (b) Product quality;
- (c) Cost; and
- (d) Available alternatives.

(3) The department's nursing facility per diem rate, established per chapter 74.46 RCW and chapter 388-96 WAC, includes any reusable and disposable medical supplies that may be required for a nursing facility client. The department 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) The department considers decubitus care products to be included in the nursing facility per diem rate and does not reimburse for these separately.

[Statutory Authority: 2009 c 564 § 1109, RCW 74.04.050, 74.04.057, and 74.08.090. 09-24-094, § 388-543-2900, filed 12/1/09, effective 1/1/10. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and Public Law 104-191. 03-19-083, § 388-543-2900, filed 9/12/03, effective 10/13/03. Statutory Authority: RCW 74.08.090, 74.09.530. 01-01-078, § 388-543-2900, filed 12/13/00, effective 1/13/01.]

Chapter 388-544 WAC

VISION CARE

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-544-1010 Definitions. [Statutory Authority: RCW 74.08.090. 00-23-068, § 388-544-1010, filed 11/15/00, effective 12/16/00.] Repealed by 09-12-034, filed 5/27/09, effective 7/1/09. Statutory Authority: RCW 74.08.090 and 74.09.530.

388-544-1100	Hearing aid services—General. [Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 06-24-036, § 388-544-1100, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.08.090. 00-23-068, § 388-544-1100, filed 11/15/00, effective 12/16/00.] Repealed by 09-12-034, filed 5/27/09, effective 7/1/09. Statutory Authority: RCW 74.08.090 and 74.09.530.
388-544-1200	Hearing aid services—For adults. [Statutory Authority: RCW 74.08.090. 00-23-068, § 388-544-1200, filed 11/15/00, effective 12/16/00.] Repealed by 09-12-034, filed 5/27/09, effective 7/1/09. Statutory Authority: RCW 74.08.090 and 74.09.530.
388-544-1300	Hearing aid services—For children. [Statutory Authority: RCW 74.08.090. 00-23-068, § 388-544-1300, filed 11/15/00, effective 12/16/00.] Repealed by 09-12-034, filed 5/27/09, effective 7/1/09. Statutory Authority: RCW 74.08.090 and 74.09.530.
388-544-1400	Hearing aid services—Noncovered services. [Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 06-24-036, § 388-544-1400, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.08.090. 00-23-068, § 388-544-1400, filed 11/15/00, effective 12/16/00.] Repealed by 09-12-034, filed 5/27/09, effective 7/1/09. Statutory Authority: RCW 74.08.090 and 74.09.530.

Chapter 388-547 WAC

HEARING AIDS

WAC

388-547-0100	Hearing aids—General.
388-547-0200	Hearing aids—Definitions.
388-547-0300	Hearing aids—Eligibility—Clients twenty-one years of age and older.
388-547-0400	Hearing aids—Covered services—Clients twenty-one years of age and older.
388-547-0500	Hearing aids—Noncovered services—Clients twenty-one years of age and older.
388-547-0600	Hearing aids—Prior authorization—Clients twenty-one years of age and older.
388-547-0700	Hearing aids—Eligibility—Clients twenty years of age and younger.
388-547-0800	Hearing aids—Covered services—Clients twenty years of age and younger.
388-547-0900	Hearing aids—Noncovered services—Clients twenty years of age and younger.
388-547-1000	Hearing aids—Prior authorization—Clients twenty years of age and younger.
388-547-1100	Hearing aids—Reimbursement—General.

WAC 388-547-0100 Hearing aids—General. Unless otherwise defined in WAC 388-547-0200, the terms within this chapter are intended to correspond with the terms in chapter 18.35 RCW.

(1) The department covers the hearing aid services listed in this chapter, according to department rules and subject to the limitations and requirements in this chapter.

(2) The department pays for hearing aids and services when:

(a) Covered. Refer to WAC 388-547-0400 for covered hearing aids and services for clients twenty-one years of age and older; and refer to WAC 388-547-0800 for covered hearing aids and services for clients twenty years of age and younger;

(b) Within the scope of an eligible client's medical care program;

(c) Medically necessary as defined under WAC 388-500-0005;

(d) Authorized, as required within this chapter, chapters 388-501 and 388-502 WAC, and the department's published billing instructions and numbered memoranda;

(e) Billed according to this chapter, chapters 388-501 and 388-502, and the department's published billing instructions and numbered memoranda; and

(f) The client:

(i) Completes a hearing evaluation, including an audiogram and/or developmentally appropriate diagnostic physiologic test results performed and/or interpreted by a hearing healthcare professional;

(ii) Is referred by a hearing healthcare professional for a hearing aid; and

(iii) For clients twenty-one years of age and older only, has an average degree of hearing loss at forty-five decibels (dBHL) in the better ear based on a pure-tone audiometric evaluation by a licensed audiologist or licensed hearing instrument fitter/dispenser at one thousand, two thousand, three thousand, and four thousand hertz (Hz) with effective masking as indicated.

(3) The department requires prior authorization for covered hearing aid services when the clinical criteria set forth in this chapter are not met. The department evaluates these requests on a case-by-case basis to determine whether they are medically necessary, according to the process found in WAC 388-501-0165.

[Statutory Authority: RCW 74.08.090 and 74.09.530. 09-12-034, § 388-547-0100, filed 5/27/09, effective 7/1/09.]

WAC 388-547-0200 Hearing aids—Definitions. "Digital hearing aids" - Hearing aids that use a digital circuit to analyze and process sound.

"FM systems" - Devices used to improve and augment access to auditory information in poor acoustic conditions (helps mitigate a negative impact of noise and reverberation on the ability to understand) that are found in classrooms, auditoriums, theaters, restaurants, etc. These devices use frequency modulated (FM) radio signals to transmit the primary auditory signal from a microphone/transmitter to a receiver worn by the person.

"Hearing aids" - Wearable sound-amplifying devices that are intended to compensate for hearing loss. Hearing aids are described by where they are worn in the ear as in-the-ear (ITE), behind-the-ear (BTE), etc. Hearing aids can also be described by how they process the amplified signal. This would include analog conventional, analog programmable, digital conventional, and digital programmable.

"Hearing healthcare professional" - An audiologist or hearing aid fitter/dispenser licensed under chapter 18.35 RCW, or an otorhinolaryngologist or otologist licensed under chapter 18.71 RCW.

"Maximum allowable fee" - The maximum dollar amount that the department will pay a provider for specific services, supplies and equipment.

"Prior authorization" - A form of authorization used by the provider to obtain approval for a specific hearing aid and service(s). The approval is based on medical necessity and must be received before the service(s) are provided to clients as a precondition for payment.

[Statutory Authority: RCW 74.08.090 and 74.09.530. 09-12-034, § 388-547-0200, filed 5/27/09, effective 7/1/09.]

WAC 388-547-0300 Hearing aids—Eligibility—Clients twenty-one years of age and older. (1) Hearing aid ser-

services are available to clients twenty one years of age or older covered under:

- (a) A categorically needy (CN) medicaid program; or
- (b) General assistance (GAU/ADATSA) (within Washington state and designated border cities.

(2) Clients who are enrolled in a department-contracted managed care plan are eligible under fee-for-service for covered hearing aid services that are not covered by their plan, subject to the provisions of this chapter and other applicable WAC.

[Statutory Authority: RCW 74.08.090 and 74.09.530. 09-12-034, § 388-547-0300, filed 5/27/09, effective 7/1/09.]

WAC 388-547-0400 Hearing aids—Covered services—Clients twenty-one years of age and older. The department covers all of the following for eligible clients twenty-one years of age and older, without prior authorization:

(1) One new, nonrefurbished, monaural hearing aid, which includes the ear mold, every five years when the hearing aid meets the client's specific hearing needs and is under warranty for a minimum of one year.

(2) One replacement hearing aid, which includes the ear mold, in a five year period when the client's hearing aid(s) is lost or beyond repair and all warranties are expired.

(3) A replacement ear mold once a year when the client's existing ear mold is damaged or no longer fits the client's ear.

(4) A maximum of two repairs, per hearing aid, per year, when the repair is less than fifty percent of the cost of a new hearing aid. To receive payment, all of the following must be met:

- (a) All warranties are expired; and
- (b) The repair is under warranty for a minimum of ninety days.

(5) Rental hearing aid(s) for up to two months while the client's own hearing aid is being repaired. In the case of a rental hearing aid(s), the department pays separately for an ear mold(s).

[Statutory Authority: RCW 74.08.090 and 74.09.530. 09-12-034, § 388-547-0400, filed 5/27/09, effective 7/1/09.]

WAC 388-547-0500 Hearing aids—Noncovered services—Clients twenty-one years of age and older. The department does not cover the following hearing and hearing aid-related items for eligible clients twenty-one years of age and older:

- (1) Batteries;
- (2) Tinnitus maskers;
- (3) FM systems; or
- (4) Pocket talkers or similar devices.

[Statutory Authority: RCW 74.08.090 and 74.09.530. 09-12-034, § 388-547-0500, filed 5/27/09, effective 7/1/09.]

WAC 388-547-0600 Hearing aids—Prior authorization—Clients twenty-one years of age and older. (1) The department requires prior authorization for binaural hearing aids for eligible clients twenty-one years of age and older.

(2) The department evaluates requests for covered services that are subject to limitations or other restrictions and

approves such services beyond those limitations or restrictions as described in WAC 388-501-0169.

(3) To request prior authorization from the department, a provider must fax the prior authorization request to the department using the appropriate fax number listed in published hearing aid services billing instructions.

(4) When the department authorizes hearing aids and/or services, the prior 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.

(5) To receive payment, hearing aids and/or services must be ordered and dispensed within the authorized time frame.

[Statutory Authority: RCW 74.08.090 and 74.09.530. 09-12-034, § 388-547-0600, filed 5/27/09, effective 7/1/09.]

WAC 388-547-0700 Hearing aids—Eligibility—Clients twenty years of age and younger. (1) Clients twenty years of age and younger who are receiving services under any medical assistance program, except for the family planning only program and the TAKE CHARGE program:

(a) Are eligible for covered hearing aids and services under this chapter and for the audiology services under WAC 388-545-0700;

(b) Must have a complete hearing evaluation, including an audiogram and/or developmentally appropriate diagnostic physiologic test results performed by a hearing healthcare professional; and

(c) Must be referred by a licensed audiologist, otorhinolaryngologist or otologist for a hearing aid.

(2) Clients who are enrolled in a department-contracted managed care plan are eligible under fee-for-service for covered hearing aid services that are not covered by their plan, subject to the provisions of this chapter and other applicable WAC.

[Statutory Authority: RCW 74.08.090 and 74.09.530. 09-12-034, § 388-547-0700, filed 5/27/09, effective 7/1/09.]

WAC 388-547-0800 Hearing aids—Covered services—Clients twenty years of age and younger. (1) The department covers new, nonrefurbished, monaural or binaural hearing aid(s), which includes the ear mold, for eligible clients twenty years of age and younger. In order for the provider to receive payment, the hearing aid must meet the client's specific hearing needs and be under warranty for a minimum of one year.

(2) The department pays for:

(a) Replacement hearing aid(s), which includes the ear mold, when:

(i) The client's hearing aid(s) are:

- (A) Lost;
- (B) Beyond repair; or
- (C) Not sufficient for the client's hearing loss; and
- (ii) All warranties are expired.

(b) Replacement ear mold(s) when the client's existing ear mold is damaged or no longer fits the client's ear.

(c) A maximum of two repairs, per hearing aid, per year, when the repair is less than fifty percent of the cost of a new hearing aid. To receive payment, all of the following must be met:

- (i) All warranties are expired; and
- (ii) The repair is under warranty for a minimum of ninety days.

(d) A rental hearing aid(s) for up to two months while the client's own hearing aid is being repaired. In the case of a rental hearing aid(s), the department pays separately for an ear mold(s).

[Statutory Authority: RCW 74.08.090 and 74.09.530. 09-12-034, § 388-547-0800, filed 5/27/09, effective 7/1/09.]

WAC 388-547-0900 Hearing aids—Noncovered services—Clients twenty years of age and younger. (1) The department does not cover the following hearing and hearing aid-related items and services for clients twenty years of age and younger:

- (a) Batteries or tinnitus maskers;
- (b) Group screenings for hearing loss, except as provided under the early and periodic screening, diagnosis and treatment (EPSDT) program under WAC 388-534-0100; or
- (c) Computer-aided hearing devices for FM systems used in school.

(2) When EPSDT applies, the department evaluates a noncovered service, equipment, or supply according to the process in WAC 388-501-0165 to determine if it is medically necessary, safe, effective, and not experimental (see WAC 388-534-0100 for EPSDT rules).

[Statutory Authority: RCW 74.08.090 and 74.09.530. 09-12-034, § 388-547-0900, filed 5/27/09, effective 7/1/09.]

WAC 388-547-1000 Hearing aids—Prior authorization—Clients twenty years of age and younger. (1) Prior authorization is not required for clients twenty years of age and under for hearing aid(s) and services. Providers should send claims for clients twenty years of age and younger directly to the department. Providers do not have to obtain authorization from the local children with special health care needs (CSHCN) coordinator.

(2) The department evaluates requests for covered services that are subject to limitations or other restrictions and approves such services beyond those limitations or restrictions as described in WAC 388-501-0169.

[Statutory Authority: RCW 74.08.090 and 74.09.530. 09-12-034, § 388-547-1000, filed 5/27/09, effective 7/1/09.]

WAC 388-547-1100 Hearing aids—Reimbursement—General. (1) The department's payment for purchased hearing aids includes:

- (a) A prefitting evaluation;
- (b) An ear mold; and
- (c) A minimum of three post-fitting consultations.

(2) The department denies payment for hearing aids and/or services when claims are submitted without the prior authorization number, when required, or the appropriate diagnosis or procedure code(s).

(3) The department does not pay for hearing aid charges paid by insurance or other payer source.

(4) To receive payment, the provider must keep documentation in the client's medical file to support the medical necessity for the specific make and model of the hearing aid ordered for the client. This documentation must include the

record of the audiology testing providing evidence that the client's hearing loss meets the eligibility criteria for a hearing aid.

[Statutory Authority: RCW 74.08.090 and 74.09.530. 09-12-034, § 388-547-1100, filed 5/27/09, effective 7/1/09.]

Chapter 388-550 WAC HOSPITAL SERVICES

WAC

388-550-1650	Adverse events, hospital-acquired conditions, and present on admission indicators.
388-550-2800	Payment methods and limits—Inpatient hospital services for medicaid and SCHIP clients.
388-550-3000	Payment method—DRG.
388-550-3010	Payment method—Per diem payment.
388-550-3020	Payment method—Bariatric surgery—Per case payment.
388-550-3460	Payment method—Per diem rate.
388-550-3600	Diagnosis-related group (DRG) payment—Hospital transfers.
388-550-3700	DRG high-cost and low-cost outliers, and new system DRG and per diem high outliers.
388-550-3900	Payment method—Bordering city hospitals and critical border hospitals.
388-550-4000	Payment method—Out-of-state hospitals.
388-550-4500	Payment method—Ratio of costs-to-charges (RCC).
388-550-4550	Administrative day rate and swing bed day rate.
388-550-7050	OPPS—Definitions.
388-550-7100	OPPS—Exempt hospitals.
388-550-7450	OPPS budget target adjustor.
388-550-7500	OPPS rate.
388-550-7600	OPPS payment calculation.

WAC 388-550-1650 Adverse events, hospital-acquired conditions, and present on admission indicators.

(1) The rules in this section apply to:

(a) Inpatient hospital claims with dates of admission on and after January 1, 2010;

(b) Payment or denial of payment for any inpatient hospital claims identified in (a) of this subsection, including medicaid supplemental or enhanced payments and medicaid disproportionate share hospital (DSH) payments or denial of payment;

(c) Adverse events, hospital-acquired conditions (HACs), and present on admission (POA) indicators (defined in subsection (2) of this section);

(d) Hospital requirements to report adverse events and HACs to the department (see subsection (4)(a) of this section);

(e) Hospital requests for retrospective utilization reviews and the related requirements to provide root cause analysis of events to the department (see subsection (4)(d) through (f) of this section); and

(f) Hospital requirements to use POA indicator codes on claims (see subsection (5)(a) of this section).

(2) The following definitions apply to this section:

(a) **"Adverse events"** (also known as "adverse health events" or "never events") are the events that must be reported to the department of health (DOH) under WAC 246-320-146. These serious reportable events are clearly identifiable, preventable, and serious in their consequences for patients, and frequently their occurrence is influenced by the policies and procedures of the healthcare organization.

(b) **"Hospital-acquired condition (HAC)"** is a condition that is reasonably preventable and was not present or identifiable at hospital admission but is either present at dis-

charge or documented after admission. For medicaid payment purposes, the department considers a HAC to be a condition that:

- (i) Is high cost or high volume, or both;
- (ii) Results in the assignment of a case to a diagnosis related group (DRG) that has a higher payment when present as a secondary diagnosis;
- (iii) Could reasonably have been prevented through the application of evidence-based guidelines; and
- (iv) Does not conflict with medicare's hospital-acquired conditions policy (http://www.cms.hhs.gov/HospitalAcq-Cond/06_Hospital-Acquired_Conditions.asp#TopOfPage).

(c) **"Serious disability"** means a physical or mental impairment that substantially limits the major life activities of a patient.

(d) **"Present on admission (POA) indicator"** is a status code the hospital uses on an inpatient hospital claim that indicates if a condition was present or incubating at the time the order for inpatient admission occurs. A POA indicator can also identify a condition that develops during an outpatient encounter. (Outpatient encounters include, but are not limited to, emergency department visits, diagnosis testing, observation, and outpatient surgery.)

(e) **"Root cause analysis"** is a class of problem-solving methods aimed at identifying the root causes of events instead of addressing the immediate, obvious symptoms.

(3) **Medicare crossover inpatient hospital claims.** The department applies the following rules for these claims:

(a) If medicare denies payment for a claim at a higher rate for the increased costs of care under its HAC and/or POA indicator policies:

- (i) The department limits payment to the maximum allowed by medicare;
- (ii) The department does not pay for care considered nonallowable by medicare; and
- (iii) The client cannot be held liable for payment.

(b) If medicare denies payment for a claim under its National Coverage Determination authority from Section 1862 (a)(1)(A) of the Social Security Act (42 U.S.C. 1395) for an adverse health event:

(i) The department does not pay the claim, any medicare deductible, and/or any co-insurance related to the inpatient hospital services; and

(ii) The client cannot be held liable for payment.

(4) **Inpatient hospital claims related to adverse events (excludes medicare crossover inpatient hospital claims discussed in subsection (3) of this section).** The department applies the following rules for these claims:

(a) When the department requests information from a hospital regarding adverse events identified by DOH, the hospital must provide the information requested for any affected medical assistance client (this includes both fee-for-service clients and clients enrolled in a managed care organization (MCO) contracted with the department). If no medical assistance client was affected by an adverse event, the hospital must provide a written response to the department with an assurance that no medical assistance clients were affected.

(b) The department does not pay for adverse events identified by DOH and/or identified through the department's retrospective utilization review process. Some HACs can become an adverse event if the:

- (i) Patient dies or is seriously disabled; or
- (ii) Level of severity is great, such as the patient develops level three or level four pressure ulcers.
- (c) The client cannot be held liable for payment.
- (d) A hospital may request a retrospective utilization review by the department, as described in WAC 388-550-1700 (6)(a) and (b)(iii), from the department or its designee to determine if the hospital is eligible for a partial payment for the adverse event.
- (e) A hospital that requests a department retrospective utilization review of an adverse event must provide the department with the hospital's root cause analysis, as described in WAC 246-320-146 (3) and (4), of the adverse event claim.

(f) The healthcare information that is part of the retrospective utilization review, including the root cause analysis of the adverse event claim, is exempt from public disclosure under RCW 42.56.360 (1)(c).

(5) Inpatient hospital claims related to hospital-acquired conditions that do not qualify as an adverse event (excludes medicare crossover inpatient hospital claims discussed in subsection (3) of this section). The department applies the following rules for these claims:

(a) The department reviews POA indicator codes on inpatient hospital claims in order to determine if a condition was present or incubating at the time the order for inpatient admission occurred, if a condition occurred during, or as a result of, hospital care, or if a condition developed during an outpatient encounter.

(i) All hospitals that have signed a core provider agreement with the department must provide information to the department by using POA indicator codes on each claim (refer to the table in this subsection).

(ii) These POA indicator codes must designate which procedures or complications were present on admission, and which occurred during, or as a result of, hospital care.

(iii) POA indicator codes are to be assigned to principal and secondary diagnosis (as defined in Section II of the Official Guidelines for Coding and Reporting), and the external cause of injury codes.

POA Indicator Codes	
Code	Reason for Code
Y	Diagnosis was present at time of inpatient admission.
N	Diagnosis was not present at time of inpatient admission.
U	Documentation insufficient to determine if condition was present at the time of inpatient admission.
W	Clinically undetermined. Provider unable to clinically determine whether or not the condition was present at the time of inpatient admission.

(b) The department does not make additional payments for services on inpatient hospital claims that are attributable to HACs and are coded with POA indicator codes "N" or "U." Specifically, for hospitals paid under the:

(i) Diagnostic related group (DRG) payment method, the department does not make additional payments for complica-

tions and comorbidities (CC) and major complications and comorbidities (MCC).

(ii) Per diem payment method, the department does not pay for days beyond the average length-of-stay (LOS) (defined in WAC 388-550-1050).

(iii) Departmental weighted costs-to-charges (DWCC) payment method, the department does not pay for services attributable to the HAC.

(iv) DRG and per diem outlier payment methods, the department does not pay for services attributable to the HAC.

(v) Ratio of costs-to-charges (RCC) payment method, the department does not pay for services attributable to the HAC.

(vi) Per case payment method, the department does not pay for services attributable to the HAC.

(6) The department denies payment for any HAC that results in death or serious disability.

(7) A hospital that disagrees with a department decision to deny payment or partial payment of an adverse event or hospital-acquired condition may follow the administrative appeal process in WAC 388-502-0220.

[Statutory Authority: RCW 74.08.090, 74.09.500, and Centers for Medicare and Medicaid Services (CMS). 09-24-061, § 388-550-1650, filed 11/25/09, effective 1/1/10.]

WAC 388-550-2800 Payment methods and limits—Inpatient hospital services for medicaid and SCHIP clients. The term "allowable" used in this section means the calculated allowed amount for payment based on the applicable payment method before adjustments, deductions, or add-ons.

(1) The department pays hospitals for medicaid and SCHIP inpatient hospital services using the rate setting methods identified in the department's approved state plan as follows:

Payment method used for medicaid and SCHIP inpatient hospital claims	Applicable providers/services	Process to adjust for third-party liability insurance and any other client responsibility
Diagnosis related group (DRG) negotiated conversion factor	Hospitals participating in the medicaid hospital selective contracting program under waiver from the federal government	Lesser of either the DRG billed amount minus the third-party payment amount and any client responsibility amount, or the allowed amount, minus the third-party payment amount and any client responsibility amount.
DRG cost-based conversion factor	Hospitals not participating in or exempt from the medicaid hospital selective contracting program	Lesser of either the DRG billed amount minus the third-party payment amount and any client responsibility amount, or the allowed amount, minus the third-party payment amount and any client responsibility amount.
Ratio of costs-to-charges (RCC)	Some services exempt from DRG payment methods	The allowable minus the third-party payment amount and any client responsibility amount.
Ratio of costs-to-charges (RCC) subject to cost settlement	Hospitals eligible to be paid through the certified public expenditure (CPE) payment program	The payment made is the federal share of costs after deducting any third party payment amount and any client responsibility amount.
Single case rate	Hospitals eligible to provide bariatric surgery to medical assistance clients	Lesser of either the billed amount minus the third-party payment amount and any client responsibility amount, or the single case rate allowed amount minus the third-party payment amount and any client responsibility amount.
Fixed per diem rate	Long-term acute care (LTAC) hospitals	Lesser of either the billed amount minus the third-party payment amount and any client responsibility amount, or the per diem allowed amount minus the third-party payment amount and any client responsibility amount.
Per diem rate	Some providers/services exempt from the DRG payment methods	Per diem allowed amount, and for some services a high outlier amount, minus the third-party payment amount and any client responsibility amount.
Cost settlement	DOH-approved critical access hospitals (CAHs)	The allowed amount, subject to retrospective cost settlement, minus the third-party payment amount and any client responsibility amount.

Payment method used for medicaid and SCHIP inpatient hospital claims	Applicable providers/services	Process to adjust for third-party liability insurance and any other client responsibility
Medicaid base community psychiatric hospitalization rate	Nonstate-owned free-standing psychiatric hospitals located in Washington state	Paid according to applicable payment method in WAC 388-550-2650 for medicaid and SCHIP clients, minus the third-party payment amount and any client responsibility amount.

See WAC 388-550-4800 for payment methods used by the department for inpatient hospital services provided to clients eligible under state-administered programs. The department's policy for payment on state-administered program claims that involve third-party liability (TPL) and/or client responsibility payments on claims is the same policy indicated in the table in subsection (1) of this section. However, to determine the department's payment on the claim, state-administered program rates, not medicaid or SCHIP rates, apply when comparing the lesser of either the billed amount minus the third-party payment and any client responsibility amount, or the allowed amount minus the third-party payment amount and any client responsibility amount.

(2) In response to direction from the legislature, the department may change any one or more payment methodologies outlined in chapter 388-550 WAC for the purpose of achieving the legislature's targeted expenditure levels. The legislative direction may take the form of express language in the biennial appropriations act or may be reflected in the level of funding appropriated to the department in the biennial appropriations act. In response to this legislative direction, the department may calculate an adjustment factor (known as an "inpatient adjustment factor") to apply to inpatient hospital rates.

(a) The inpatient adjustment factor is a specific multiplier calculated by the department and applied to existing inpatient hospital rates in order to meet targeted expenditure levels as directed by the legislature.

(b) The department will apply the inpatient adjustment factor when the department determines that its expenditures on inpatient hospital rates will exceed the legislature's targeted expenditure levels.

(c) The department will apply any such inpatient adjustment factor to each affected rate in a proportional manner.

(3) The department's annual aggregate medicaid and SCHIP payments to each hospital for inpatient hospital services provided to medicaid and SCHIP clients will not exceed the hospital's usual and customary charges to the general public for the services (42 CFR Sec. 447.271). The department recoups annual aggregate medicaid and SCHIP payments that are in excess of the usual and customary charges.

(4) The department's annual aggregate payments for inpatient hospital services, including payments to state-operated hospitals, will not exceed the estimated amounts that the department would have paid using medicare payment principles.

(5) 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).

(6) Hospitals participating in the department's medical assistance program must annually submit to the department:

(a) A copy of the hospital's CMS medicare cost report (form 2552-96) that is the official "as filed" cost report submitted to the medicare fiscal intermediary; and

(b) A disproportionate share hospital (DSH) application if the hospital wants to be considered for DSH payments. See WAC 388-550-4900 for the requirements for a hospital to qualify for a DSH payment.

(7) Reports referred to in subsection (6) 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 the department.

(8) The department requires hospitals to follow generally accepted accounting principles.

(9) Participating hospitals must permit the department to conduct periodic audits of their financial records, statistical records, and any other records as determined by the department.

(10) The department limits payment for private room accommodations to the semiprivate room rate. Room charges must not exceed the hospital's usual and customary charges to the general public as required by 42 C.F.R. Sec. 447.271.

(11) For a client's hospital stay that involves both regional support network (RSN)-approved voluntary inpatient and involuntary inpatient hospitalizations, the hospital must bill the department for payment, unless the hospital contracts directly with the RSN. In that case, the hospital must bill the RSN for payment.

(12) Refer to subsection (1) of this section for how the department adjusts inpatient hospital claims for third party payment amounts and any client responsibility amounts.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 2009-11 Omnibus Operating Budget (ESHB 1244). 09-12-063, § 388-550-2800, filed 5/28/09, effective 7/1/09. Statutory Authority: RCW 74.08.-090, 74.09.500, 07-14-018, § 388-550-2800, filed 6/22/07, effective 8/1/07. Statutory Authority: RCW 74.08.090, 74.09.500, and 2005 c 518, § 204, Part II. 07-06-043, § 388-550-2800, filed 3/1/07, effective 4/1/07. Statutory Authority: RCW 74.08.090, 74.09.520, 05-12-022, § 388-550-2800, filed 5/20/05, effective 6/20/05. Statutory Authority: RCW 74.08.090 and 74.09.-500, 04-19-113, § 388-550-2800, filed 9/21/04, effective 10/22/04. 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 388-550-3000 Payment method—DRG. (1) The department uses the diagnosis-related group (DRG) payment method to pay for covered inpatient hospital services, except as specified in WAC 388-550-4300 and 388-550-4400.

(2) The department uses the all-patient grouper (AP-DRG) to assign a DRG to each inpatient hospital stay. The department periodically evaluates which version of the AP-DRG to use.

(3) A DRG payment includes all covered hospital services provided to a client during days the client is eligible, but is not limited to:

(a) An inpatient hospital stay.

(b) Outpatient hospital services, including preadmission, emergency room, and observation services related to an inpatient hospital stay and provided within one calendar day of a client's inpatient hospital stay. These outpatient services must be billed on the inpatient hospital claim (see WAC 388-550-6000 (3)(c)).

(c) Any specific service(s), treatment(s), or procedure(s) (such as renal dialysis services) that the admitting hospital is unable to provide and:

(i) The admitting hospital sends the client to another facility or provider for the service(s), treatment(s), or procedure(s) during the client's inpatient hospital stay; and

(ii) The client returns as an inpatient to the admitting hospital.

(d) All transportation costs for an inpatient client when the client requires transportation to another facility or provider for a specific service(s), treatment(s), or procedure(s) that the admitting hospital is unable to provide and:

(i) The admitting hospital sends the client to another facility or provider for the service(s), treatment(s), or procedure(s); and

(ii) The client returns as an inpatient to the admitting hospital.

(4) The department's allowed amount for the DRG payment is determined by multiplying the assigned DRG's relative weight, as determined in WAC 388-550-3100, by the hospital's specific DRG conversion factor. See WAC 388-550-3450. The total allowed amount also includes any high outlier amount calculated for claims.

(5) When directed by the legislature to achieve targeted expenditure levels, as described in WAC 388-550-2800(2), the department may apply an inpatient adjustment factor to each hospital's specific DRG conversion factor rate used in calculating the DRG payment.

(6) The department's DRG payment to a hospital may be adjusted when one or more of the following occur:

(a) For dates of admission before August 1, 2007, a claim qualifies as a DRG high-cost or low-cost outlier, and for dates of admission on and after August 1, 2007, a claim qualifies as a DRG high outlier (see WAC 388-550-3700);

(b) A client transfers:

(i) Before July 1, 2009, from one acute care hospital or distinct unit to another acute care hospital or distinct unit; or

(ii) On and after July 1, 2009 from one acute care hospital or distinct unit to:

(A) Another acute care hospital or distinct unit;

(B) A skilled nursing facility (SNF);

(C) An intermediate care facility;

(D) Home care under the department's home health program;

(E) A long term acute care facility (LTAC);

(F) Hospice (facility-based or in the client's home);

(G) A hospital-based medicare-approved swing bed, or another distinct unit such as a rehabilitation or psychiatric unit (see WAC 388-550-3600); or

(H) A nursing facility certified under medicaid but not medicare.

(c) A client is not eligible for a medical assistance program on one or more days of the hospital stay;

(d) A client has third party liability coverage at the time of admission to the hospital or distinct unit;

(e) A client is eligible for Part B medicare and medicare has made a payment for the Part B hospital charges; or

(f) A client is discharged from an inpatient hospital stay and, within seven calendar days, is readmitted as an inpatient to the same hospital. The department or its designee performs a retrospective utilization review (see WAC 388-550-1700) on the initial admission and the readmission(s) to determine which inpatient hospital stay(s) qualify for DRG payment. Upon the department's retrospective review, an outlier payment may be made if the department determines the claim for combined hospital stays qualifies as a high-cost outlier or high outlier. See WAC 388-550-3700 for DRG high-cost outliers and high outliers.

(7) For dates of admission on and after July 1, 2009, the department pays inpatient claims assigned by the all-patient DRG grouper (AP-DRG) as cesarean section without complications and comorbidities, at the same rate as the vaginal birth with complicating diagnoses.

(8) The department does not pay for a client's day(s) of absence from the hospital.

(9) The department pays an interim billed hospital claim or covered inpatient hospital services provided to an eligible client only when the interim billed claim meets the criteria in WAC 388-550-2900.

(10) The department applies to the payment for each claim all applicable adjustments for client responsibility, any third party liability, medicare, and any other adjustments as determined by the department.

(11) The department pays hospitals in designated bordering cities for allowed covered services as described in WAC 388-550-3900.

(12) The department pays out-of-state hospitals for allowed covered services as described in WAC 388-550-4000.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 2009-11 Omnibus Operating Budget (ESHB 1244). 09-12-063, § 388-550-3000, filed 5/28/09, effective 7/1/09. Statutory Authority: RCW 74.08.-090 and 74.09.500. 07-14-055, § 388-550-3000, filed 6/28/07, effective 8/1/07. Statutory Authority: RCW 74.04.050, 74.08.090. 05-11-077, § 388-550-3000, filed 5/17/05, effective 6/17/05. 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 388-550-3010 Payment method—Per diem payment. (1) Effective for dates of admission on and after August 1, 2007, the department uses the per diem payment method to pay some covered inpatient hospital services as specified in this section and WAC 388-550-4300, 388-550-4400, and 388-550-3460.

(2) The per diem payment method is effective for dates of admission before, on, and after August 1, 2007, for the following:

- (a) Long term acute care (LTAC);
- (b) Hospital administrative day bed; and
- (c) Hospital swing bed.

(3) The department uses the all-patient diagnosis related group (AP-DRG) grouper to assign a DRG classification to each inpatient hospital stay. The department uses the per diem payment method to pay for hospital stays that have insufficient data available to determine stable relative weights and other specialty services identified in WAC 388-550-3460.

(4) A per diem payment includes, but is not limited to:

(a) A hospital covered service(s) provided to a client during the client's inpatient hospital stay.

(b) An outpatient hospital covered service(s), including preadmission, emergency room, and observation services related to an inpatient hospital stay and provided within one calendar day of a client's inpatient hospital admission. These outpatient services must be billed on the inpatient hospital claim (see WAC 388-550-6000 (3)(c)).

(c) Any specific service(s), treatment(s), or procedure(s) (such as renal dialysis services) that the admitting hospital is unable to provide when:

(i) The admitting hospital sends the client to another facility or provider for the service(s), treatment(s), or procedure(s) during the client's inpatient stay; and

(ii) The client returns as an inpatient to the admitting hospital.

(d) All transportation costs for an inpatient client when the client requires transportation to another facility or provider for a specific service(s), treatment(s), or procedure(s) that the admitting hospital is unable to provide when:

(i) The admitting hospital sends the client to another facility or provider for the service(s), treatment(s), or procedure(s); and

(ii) The client returns as an inpatient to the admitting hospital.

(5) The department establishes an average length of stay (ALOS) for each DRG classification during the rebasing process. The DRG ALOS is used as a benchmark to authorize and pay for inpatient hospital stays that are exempt from the DRG payment method. See WAC 388-550-4300(6).

(6) The department's per diem payments to a hospital may be adjusted when one or more of the following occur:

(a) A claim qualifies as a per diem high outlier claim (see WAC 388-550-3700). The outlier provision does not include a claim grouped to a DRG classification in a specialty service category. The specialty service categories include psychiatric, rehabilitation, detoxification, and CUP program services. Long term acute care (LTAC), administrative days and swing bed days do not qualify for high outlier payment.

(b) A client is not eligible for a medical assistance program on one or more of the days of the hospital stay.

(c) A client has third party liability coverage at the time of admission to the hospital or distinct unit.

(d) A client is eligible for medicare, and medicare has made a payment for the hospital charges.

(e) A client is discharged from an inpatient hospital stay and, within seven calendar days, is readmitted as an inpatient

to the same hospital or a different hospital. The department or its designee performs a retrospective utilization review (see WAC 388-550-1700) on the initial admission and the readmission(s) to determine which, if any, inpatient hospital stay(s) qualify for payment. An outlier payment may be made if the department determines the claim for the combined hospital stays qualifies as a high outlier. (See WAC 388-550-3700 for high outliers.)

(f) When directed by the legislature to achieve targeted expenditure levels, as described in WAC 388-550-2800(2), the department may apply an inpatient adjustment factor to the per diem rate payments.

(7) The department does not pay for a client's day(s) of absence from the hospital.

(8) The department pays an interim billed hospital claim for covered inpatient hospital services provided to an eligible client only when the interim billed claim meets the criteria in WAC 388-550-2900.

(9) The department applies to the payment for each claim, all applicable adjustments for client responsibility, any third party liability, medicare, and any other adjustments as determined by the department.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 2009-11 Omnibus Operating Budget (ESHB 1244). 09-12-063, § 388-550-3010, filed 5/28/09, effective 7/1/09. Statutory Authority: RCW 74.08-090, 74.09.500 and 2005 c 518. 07-14-051, § 388-550-3010, filed 6/28/07, effective 8/1/07.]

WAC 388-550-3020 Payment method—Bariatric surgery—Per case payment.

(1) The department pays designated department-approved hospitals for prior authorized bariatric surgery when the criteria in WAC 388-550-2301 are met. Claims grouped to a DRG classification in a bariatric surgery service category (diagnosis and procedure codes recognized by the department for bariatric surgery per case payment) do not qualify for outlier payments.

(2) The department pays for claims grouped to a DRG classification in a bariatric surgery service category (diagnosis and procedure codes recognized by the department for bariatric surgery per case payment) using a per case rate. See WAC 388-550-3470.

(3) The department applies to the payment for each claim, all applicable adjustments for client responsibility, any third party liability, medicare, and any other adjustments as determined by the department.

(4) When directed by the legislature to achieve targeted expenditure levels, as described in WAC 388-550-2800(2), the department may apply an inpatient adjustment factor to each hospital's specific per case rate.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 2009-11 Omnibus Operating Budget (ESHB 1244). 09-12-063, § 388-550-3020, filed 5/28/09, effective 7/1/09. Statutory Authority: RCW 74.08-090, 74.09.500 and 2005 c 518. 07-14-051, § 388-550-3020, filed 6/28/07, effective 8/1/07.]

WAC 388-550-3460 Payment method—Per diem rate. (1) For dates of admission before August 1, 2007 the department established per diem rates for:

(a) Inpatient chronic pain management as specified in WAC 388-550-2400;

(b) Long term acute care (LTAC) hospitals as specified in WAC 388-550-2595;

(c) Community psychiatric inpatient hospitalization as specified in WAC 388-550-2650; and

(d) Administrative day status, and nursing facility swing bed day status, as specified in WAC 388-550-4500 as it existed before July 1, 2009 or WAC 388-550-4550 for these services effective for dates of admission on and after July 1, 2009.

(2) For dates of admission on and after August 1, 2007, the department continues to pay per diem rates for the services identified in subsection (1), except for the community psychiatric inpatient hospitalization per diem indicated in subsection (1)(c).

(3) For dates of admission on and after August 1, 2007, with the exception of community psychiatric inpatient services, the department establishes per diem rates for specialty services that are generally based on statewide standardized average cost per day amounts, which are then adjusted to reflect the unique characteristic of hospitals in the state of Washington for payment purposes.

(a) The department calculates separate statewide standardized per diem rates for the following categories:

(i) Rehabilitation services—Rehabilitation claims are identified as all claims with a rehabilitation diagnosis (i.e., assigned to a rehabilitation AP-DRG classification) at acute care hospitals and freestanding rehabilitation hospitals including distinct part units;

(ii) Detoxification services—Detoxification claims are identified as all claims from hospital-based detoxification units, and all claims with a detoxification diagnosis (i.e., assigned to a detoxification AP-DRG classification) at acute care hospitals.

(iii) CUP women program services—Chemically using pregnant (CUP) women program services are identified as any claims with units of service (days) submitted to revenue code 129 in the claim record.

(b) The department calculates hospital-specific per diem rates for all medicaid services provided by free-standing psychiatric hospitals, and all psychiatric services provided by acute care hospitals, including distinct part units.

(c) To determine statewide standardized cost per day amounts for rehabilitation, detoxification and CUP women program services, the department uses the estimated costs of the claims identified for each category based on the department's cost finding process for the system. These claims include any statistical outliers. These statewide standardized amounts serve as the basis for calculating per diem rates for each hospital for each service. The department then makes adjustments to the cost amounts for each hospital to factor out differences related to approved medical education programs.

(i) For each in-state acute care hospital, excluding critical access hospitals (CAHs) and LTAC hospitals, the department estimates operating and capital costs for each of the three specialty services.

(ii) The department then adjusts these costs to remove the indirect costs associated with approved medical education programs. Medicare publishes separate indirect medical education factors for operating and capital components, so these adjustments are made separately for both of these components. These factors are intended to reflect the indirect costs incurred by hospitals in support of approved graduate medical education programs.

(A) For hospital-specific operating costs, the department adjusts the labor portion of the hospital-specific operating costs by the most current hospital-specific medicare wage index established and published by medicare at the time of the medicaid rebasing; then adds the nonlabor portion to the result; then divides the result by (1.0 plus the most currently available hospital-specific medicare operating indirect medical education factor established by medicare that exists at the time of the medicaid rebasing); then divides that result by the hospital-specific medicaid case-mix index; then

(B) For hospital-specific capital costs, the department divides hospital-specific capital costs by (1.0 plus the hospital-specific medicare capital indirect medical education factor); then divides the result by the hospital-specific medicaid case-mix; then

(iii) The department then sums the costs and days for all included hospitals for each service, and calculates each service's statewide standardized weighted average cost per day amounts, weighted based on number of days.

(d) Once the department establishes the statewide standardized amounts, hospital-specific per diem rates for each specialty service are calculated.

(i) Starting with the statewide standardized operating amount, the department multiplies the labor portion of the amount by the most current hospital-specific medicare wage index established and published by medicare at the time of the medicaid rebasing. (To determine the labor portion, the department uses the factor established by medicare multiplied by the statewide operating standardized amount.) This adjustment is made to reflect wage differences incurred by hospitals in different regions of the state. The department then adds the nonlabor portion to the result.

(ii) The department-adjusted operating and capital amounts reflect the indirect costs associated with approved teaching programs. The department adjusts for the indirect costs by multiplying the operating and capital amounts by (1.0 plus the most currently available hospital-specific medicare indirect medical education factor in the medicare final rule for the operating and capital components). These adjustments are made only at the time the rate setting calculation takes place during the rebasing process.

(iii) The department then adds to the operating and capital amounts the hospital-specific direct medical education cost per day (hospital-specific direct medical education cost per day adjusted for hospital-specific case-mix index).

(iv) Finally, the department adjusts the facility-specific combined operating, capital and medical education cost per day amounts to reflect increases in inflation between the base year and the implementation year using the CMS PPS Input Price Index. For purposes of this adjustment, the department applies the operating index to the operating and direct medical education components of the per diem rate, and the capital-related index to the capital component of the per diem rate.

(e) Specialty service claims are not eligible for high outlier payments. See WAC 388-550-3700.

(4) For dates of admission on and after August 1, 2007, the department establishes hospital-specific per diem rates for psychiatric services provided by instate noncritical access hospitals that are free-standing psychiatric hospitals, acute

care hospitals with psychiatric distinct part units, or other acute care hospitals.

(a) The department identifies psychiatric claims for hospitals meeting the criteria in this subsection as all claims from free-standing psychiatric hospitals, and all claims with a psychiatric diagnosis (i.e., assigned to a psychiatric AP-DRG classification) at the acute care hospitals. The department includes all claims from freestanding psychiatric hospitals, regardless of AP-DRG assignment.

(b) To determine a facility-specific payment rate per day for psychiatric services, the department uses the greater of the estimated costs per diem of the:

(i) Hospital's inpatient psychiatric claims in the base year dataset; or

(ii) Statewide average of the estimated costs of the hospital's inpatient psychiatric claims (as described in subsection (4)(a)) in the base year claims including adjustments for regional wage differences and for differences in medical education costs.

(c) The department calculates average cost per day amounts for each hospital and then makes adjustments to the average cost per day amounts to reflect changes in the indirect medical education factor and hospital-specific wage index between the base year and the implementation year.

(d) Finally, the department adjusts the hospital-specific combined operating, capital and medical education cost per day amounts to reflect increases in inflation between the base year and the implementation year using the CMS PPS Input Price Index. For purposes of this adjustment, the department applies the operating index to the operating and direct medical education components of the per diem rate, and the capital-related index to the capital component of the per diem rate.

(5) For dates of admission on and after August 1, 2007, for hospitals not meeting the criteria in subsection (4), the department calculates per diem rates using the same method used for rehabilitation, detoxification and CUP women program payments described in this section, except that the department uses only the psychiatric claims from those facilities identified as qualifying for hospital-specific rates.

(6) For dates of admission on and after August 1, 2007, for freestanding rehabilitation facilities, the department uses the per diem rate established for rehabilitative services rather than a facility-specific rate.

(7) For dates of admission on and after August 1, 2007, for claims that are classified into AP-DRG classifications that do not have enough claims volume to establish stable relative weights, and that are not specialty claims as described in this section, the department also uses a per diem rate.

(a) These types of claims are less homogeneous than the specialty claims described in this section, and the costs of these claims are more variable than the costs of those that are included under the DRG payment method. The department conducts significant analyses to establish per diem rates based on groupings that would distinguish between higher cost per day claims and lower cost per day claims. As part of this analysis, the department analyzes costs per day based on the following criteria for groupings, which are not mutually exclusive:

(i) Neonatal claims, based on assignment to major diagnostic category (MDC) 15;

(ii) Burn claims based on assignment to MDC 22;

(iii) AP-DRG assignments that include primarily medical procedures;

(iv) AP-DRG assignments that include primarily surgical procedures;

(v) Cranial procedure claims, based on specific cranial procedure AP-DRG classifications, and

(vi) MDC assignment.

(b) Based on the analyses of cost per day amounts for each grouping criteria identified in subsection (7)(a), the department identified four nonspecialty service groupings appropriate for establishing per diem payments. These are:

(i) Neonatal claims, based on assignment to MDC 15;

(ii) Burn claims based on assignment to MDC 22;

(iii) AP-DRG assignments that include primarily medical procedures, excluding any neonatal or burn classifications identified in this subsection; and

(iv) AP-DRG assignments that include primarily surgical procedures, excluding any neonatal or burn classifications identified in this subsection.

(c) For each service group, except for burn cases, the department calculates a per diem rate for each hospital based on the aggregate statewide weighted average cost per day for the service after adjusting costs for regional wage differences and differences in graduate medical education program costs. For burn cases, per diem rates are based on the average operating and capital cost per day for Harborview Medical Center, which had the vast majority of burn cases in the state.

(d) The per diem calculations are based on the estimated costs of the claims for each service group in the base year, including both fee-for-service and healthy options claims data. After determining the statewide weighted average cost per day after these adjustments, the department calculates the per diem rate for each hospital for each service group by adjusting the statewide weighted average cost per day amount for each hospital based on its hospital-specific wage index and medical education program costs.

(e) Because of the variability of the cost of claims in unstable AP-DRG classifications, the department developed an outlier policy for these per diem payments, similar to the outlier methodology recommended for the DRG payment method.

(f) Claims that are not in the specialty service groupings indicated in subsection (3)(a) and (b), may qualify for a high outlier payment if the claim qualifies under the high outlier criteria. See WAC 388-550-3700.

(8) For dates of admission on and after August 1, 2007, for inpatient chronic pain services, the department establishes per diem rates based on allowed charges data that the department obtains from the hospital. The department determines the hospital per diem rate by identifying costs and dividing the total cost by the number of days associated with the cost.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 2009-11 Omnibus Operating Budget (ESHB 1244). 09-12-063, § 388-550-3460, filed 5/28/09, effective 7/1/09. Statutory Authority: RCW 74.08.-090, 74.09.500 and 2005 c 518. 07-14-051, § 388-550-3460, filed 6/28/07, effective 8/1/07.]

WAC 388-550-3600 Diagnosis-related group (DRG) payment—Hospital transfers. (1) The rules in this section

apply when an eligible client transfers from an acute care hospital or distinct unit:

(a) Before July 1, 2009, to another acute care hospital or distinct unit; and

(b) On or after July 1, 2009, to one of the following:

(i) Another acute care hospital or distinct unit;

(ii) A skilled nursing facility (SNF);

(iii) An intermediate care facility (ICF);

(iv) Home care under the department's home health program;

(v) A long-term acute care facility (LTAC);

(vi) Hospice (facility-based or in the client's home);

(vii) A hospital-based medicare-approved swing bed, or another distinct unit such as a rehabilitation or psychiatric unit (see WAC 388-550-3000); or

(viii) A nursing facility certified under medicaid but not medicare.

(2) The department pays a hospital that transfers an emergency case to another acute care hospital, including an acute physical medicine and rehabilitation (acute PM&R) facility or distinct unit, an acute psychiatric facility or distinct unit, and a long-term acute care facility, the lesser of:

(a) The appropriate diagnosis-related group (DRG) payment based on a stable DRG; or

(b) A prorated DRG payment when the client's stay at the transferring hospital is less than the average length of stay (LOS) for the AP-DRG classification as determined by the department.

(3) The department pays a transferring hospital as follows:

(a) For dates of admission before August 1, 2007, 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 LOS.

(b) For dates of admission on and after August 1, 2007, a per diem rate multiplied by the number of medically necessary days the client stays at the transferring hospital plus one day, not to exceed the total calculated DRG-based payment amount including any outlier payment amount. The department determines the per diem by dividing the hospital's allowed payment amount for the appropriate DRG by that DRG's statewide average LOS (see WAC 388-550-4300) for the AP-DRG classification as determined by the department.

(4) 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) The department's LOS data to determine the number of medically necessary days for a client's hospital stay.

(5) When a post-acute care hospital transfer occurs to one of the locations listed in subsection (1)(b)(ii) through (viii) of this section, the department pays the transferring hospital the lesser of:

(a) The appropriate DRG payment; or

(b) For dates of admission on and after July 1, 2009, a per diem rate multiplied by the number of medically necessary days the client stays at the transferring hospital plus one day, not to exceed the total calculated DRG-based payment amount including any outlier payment amount. The department

determines the per diem by dividing the hospital's allowed payment amount for the appropriate DRG by that DRG's statewide average length of stay (see WAC 388-550-4300) for the AP-DRG classification as determined by the department.

(6) The department applies the outlier payment methodology if a transfer case qualifies:

(a) For dates of admission before August 1, 2007, as a high-cost or low-cost outlier; and

(b) For dates of admission on or after August 1, 2007, as a high-cost outlier.

(7) The department does not pay a transferring hospital for a nonemergency case when the transfer is to another acute care hospital.

(8) The department pays the full DRG payment to the discharging hospital for a discharge to home or self-care. This is the department's maximum payment to a discharging hospital.

(9) 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.

(10) The department pays the intervening hospital(s) a per diem payment based on the method described in subsection (3) of this section.

(11) The transfer payment policy described in this section does not apply to claims grouped into AP-DRG classifications that are paid based on the per diem, case rate, or ratio of costs-to-charges (RCC) payment methods.

(12) The department applies to the payment for each claim, all applicable adjustments for client responsibility, any third party liability, medicare, and any other adjustments as determined by the department.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 2009-11 Omnibus Operating Budget (ESHB 1244). 09-12-062, § 388-550-3600, filed 5/28/09, effective 7/1/09. Statutory Authority: RCW 74.08.090, 74.09.500 and 2005 c 518. 07-14-051, § 388-550-3600, filed 6/28/07, effective 8/1/07. Statutory Authority: RCW 74.08.090 and 42 U.S.C. 1395x(v), 42 C.F.R. 447.271, .11303, and .2652. 01-16-142, § 388-550-3600, filed 7/31/01, effective 8/31/01. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. 98-01-124, § 388-550-3600, filed 12/18/97, effective 1/18/98.]

WAC 388-550-3700 DRG high-cost and low-cost outliers, and new system DRG and per diem high outliers. This section applies to inpatient hospital claims paid under the diagnosis-related group (DRG) payment methodology, and for dates of admission on and after August 1, 2007. It also applies to inpatient hospital claims paid under the per diem payment methodology.

(1) For dates of admission before August 1, 2007, a medicaid or state-administered claim qualifies as a DRG high-cost outlier when:

(a) The client's admission date on 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 client's admission date on the claim 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) For dates of admission before August 1, 2007, if the claim qualifies as a DRG high-cost outlier, the high-cost outlier threshold, for payment purposes, 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 on or after January 1.

(3) For dates of admission before August 1, 2007, the department determines payment for medicaid claims that qualify as DRG high-cost outliers as follows:

(a) All qualifying claims, except for claims in psychiatric DRGs 424-432 and claims from instate children's hospitals,

are paid seventy-five percent of the allowed charges above the outlier threshold determined in subsection (2) of this section, multiplied by the hospital's RCC rate, plus the applicable DRG payment.

(b) Instate children's hospitals are paid eighty-five percent of the allowed charges above the outlier threshold determined in subsection (2) of this section, 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 determined in subsection (2) of this section, 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, and before August 1, 2007.)						
Allowed Charges	Applicable DRG Payment	Three times App. DRG Payment	Allowed Charges > \$33,000?	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%

Medicaid Payment calculation example for allowed charges of:	Nonpsych DRGs/Noninstate children's hospital (RCC is 64%)
*\$33,500	Allowed charges
- \$33,000	The greater amount of 3 x applicable DRG pymt (\$15,000) or \$33,000
\$500	
x 48%	75% of allowed charges x hospital RCC rate (nonpsych DRGs/noninstate children's) (75% x 64% = 48%)
\$240	Outlier portion
+ \$5,000	Applicable DRG payment
**\$5,240	Outlier payment

(4) For dates of admission before August 1, 2007, DRG high-cost outliers for state-administered programs are paid according to WAC 388-550-4800.

(5) For dates of admission before August 1, 2007, a medicaid or state-administered claim qualifies as a DRG low-cost outlier if:

(a) The client's admission date on the claim is before January 1, 2001, and the allowed charges are:

(i) Less than ten percent of the applicable DRG payment; or

(ii) Less than four hundred dollars.

(b) The client's admission date on 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.

(6) 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 (5)(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 (5)(b)(i) or (ii), whichever is greater.

(7) For dates of admission before August 1, 2007, the department determines payment for a medicaid claim that qualifies as a DRG low-cost outlier by multiplying the allowed charges for each claim by the hospital's RCC rate.

(8) For dates of admission before August 1, 2007, DRG low-cost outliers for state-administered programs are paid according to WAC 388-550-4800.

(9) For dates of admission before August 1, 2007, 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 that do not reach DRG high-cost outlier status. 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 (2) 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.

(10) For dates of admission before August 1, 2007 the department bases the day outlier payment on the number of days that exceed the day outlier threshold, multiplied by the administrative day rate.

(11) For dates of admission before August 1, 2007, the department's total payment for a day outlier claim is the applicable DRG payment plus the day outlier or administrative days payment.

(12) For dates of admission before August 1, 2007, a client's outlier claim is either a day outlier or a high-cost outlier, but not both.

(13) For dates of admission on and after August 1, 2007, the department does not identify a claim as a low cost outlier or day outlier. Instead, these claims are processed using the applicable payment method described in this chapter. The department may review claims with very low costs.

(14) For dates of admission on and after August 1, 2007, the department allows a high outlier payment for claims paid using the DRG payment method when high outlier qualifying criteria are met. The estimated costs of the claim are calculated by multiplying the total submitted charges, minus the noncovered charges on the claim, by the hospital's ratio of costs-to-charges (RCC) rate. The department identifies a DRG high outlier claim based on the claim's estimated costs. To qualify as a DRG high outlier claim, the department's estimated costs for the claim must be greater than both the fixed outlier cost threshold of fifty thousand dollars, and one hundred seventy-five percent of the applicable base DRG allowed amount for payment. These criteria are also used to determine if a transfer claim qualifies for high outlier payment when a transfer claim is submitted to the department by a transferring hospital.

For Children's Hospital Regional Medical Center, Mary Bridge Children's Hospital and Health Center, and claims grouped to neonatal and pediatric DRGs under the DRG payment method, the department identifies a high outlier claim based on the claim's estimated costs. To qualify as a high outlier claim, the claim's estimated cost amount must be greater than both the fixed outlier threshold of fifty thousand dollars and one hundred fifty percent of the applicable base DRG allowed amount for payment.

(15) For dates of admission on and after August 1, 2007, the department may allow an adjustment for a high outlier for per diem claims grouped to a DRG classification in one of the acute unstable DRG service categories, i.e., medical, surgical, burn, and neonatal. These service categories are described in subsection (16) of this section.

(a) The department identifies high outlier per diem claims for medical, surgical, burn, and neonatal DRG service categories based on the claim estimated costs. The claim estimated costs are the total submitted charges, minus the noncovered charges for the claim, multiplied by the hospital's ratio of costs-to-charges (RCC) related to the admission. Except as specified in (b) of this subsection, a claim that is grouped to a medical, surgical, or burn DRG service category qualifies as a high outlier when the claim's estimated cost is greater than both the fixed outlier threshold of fifty thousand dollars and one hundred seventy-five percent of the applicable per diem base allowed amount for payment.

(b) For Children's Hospital Regional Medical Center, Mary Bridge Children's Hospital and Health Center, and

claims grouped to neonatal and pediatric DRGs under medical, surgical, burn, and neonatal services categories, the department identifies high outlier claims based on the claim's estimated costs. To qualify as a high outlier claim, the claim's estimated cost must be greater than both the fixed outlier threshold of fifty thousand dollars and one hundred fifty percent of the applicable per diem base allowed amount for payment.

(c) The department may perform retrospective utilization reviews on all per diem outlier claims that exceed the department determined DRG average length of stay (LOS). If the department determines the entire LOS or part of the LOS is not medically necessary, the claim will be denied or the payment will be adjusted.

(16) For dates of admission on and after August 1, 2007, the term "unstable" is used generically to describe an AP-DRG classification that has fewer than ten occurrences (low volume), or that is unstable based on the statistical stability test indicated in this subsection, and to describe such claims in the major service categories of per diem paid claims identified in this section. The formula for the statistical stability test calculates the required size of a sample population of values necessary to estimate a mean cost value with ninety percent confidence and within an acceptable error of plus or minus twenty percent given the population's estimated standard deviation.

Specifically, this formula is:

$$N = (Z^2 * S^2) / R^2$$
, where

- The Z statistic for 90 percent confidence is 1.64
- S = the standard deviation for the AP-DRG classification, and
- R = acceptable error range, per sampling unit

If the actual number of claims within an AP-DRG classification is less than the calculated N size for that classification during relative weight recalibration, the department designates that DRG classification as unstable for purposes of calculating relative weights. And as previously stated, for relative weight recalibration, the department also designates any DRG classification having less than ten claims in total in the claims sample used to recalibrate the relative weights, as low volume and unstable.

The DRG classifications assigned to the per diem payment method, that are in one of the major service categories in subsection (16)(a) through (d) of this section, qualify for examination if a high outlier payment is appropriate. The department specifies those DRG classifications to be paid the per diem payment method because the DRG classification has low volume and/or unstable claims data for determination of an AP-DRG relative weight. A claim in a DRG classification that falls into one of the following major services categories that the department designates for per diem payment, may receive a per diem high outlier payment when the claim meets the high outlier criteria as described in subsection (15) of this section:

- (a) Neonatal claims, based on assignment to medical diagnostic category (MDC) 15;
- (b) Burn claims based on assignment to MDC 22;
- (c) AP-DRG groups that include primarily medical procedures, excluding any neonatal or burn per diem classifications identified in (a) and (b) of this subsection; and

(d) AP-DRG groups that include primarily surgical procedures, excluding any neonatal or burn per diem classifications identified in (a) and (b) of this subsection.

(17) For dates of admission on and after August 1, 2007, the high outlier claim payment processes for the general assistance-unemployable (GA-U) program are the same as those for the medicaid or SCHIP DRG paid and per diem paid claims, except that the DRG rates and per diem rates are reduced, and the percent of outlier adjustment factor applied to the payment may be reduced. The high outlier claim payment process for medicaid or SCHIP DRG paid and per diem paid claims is as follows:

(a) The department determines the claim estimated cost amount that is used in the determination of the high outlier claim qualification and the high outlier threshold for the calculation of outlier adjustment amount. The claim estimated cost is equal to the total submitted charges, minus the non-covered charges reported on the claim, multiplied by the hospital's inpatient ratio of costs-to-charges (RCC) related to the admission.

(b) The high outlier threshold when calculating the high outlier adjustment portion of the total payment allowed amount on the claim is:

(i) For DRG paid claims grouped to nonneonatal or non-pediatric DRG classifications, and for DRG paid claims that are not from Children's Hospital Regional Medical Center or Mary Bridge Children's Hospital and Health Center, the high outlier threshold is one hundred seventy-five percent of the base DRG payment allowed amount;

(ii) For DRG paid claims grouped to neonatal or pediatric DRG classifications, and for DRG paid claims that are from Children's Hospital Regional Medical Center or Mary Bridge Children's Hospital and Health Center, the high outlier threshold is one hundred fifty percent of the base DRG payment allowed amount;

(iii) For nonspecialty service category per diem paid claims grouped to nonneonatal and nonpediatric DRG classifications, and for nonspecialty service category per diem paid

claims that are not from Children's Hospital Regional Medical Center or Mary Bridge Children's Hospital and Health Center, the high outlier threshold is one hundred seventy-five percent of the base per diem payment allowed amount; and

(iv) For nonspecialty service category per diem paid claims grouped to neonatal and pediatric DRG classifications, and for all nonspecialty service category per diem paid claims from Children's Hospital Regional Medical Center and Mary Bridge Children's Hospital and Health Center, the high outlier threshold is one hundred fifty percent of the base per diem payment allowed amount;

(c) The high outlier payment allowed amount is equal to the difference between the department's estimated cost of services associated with the claim, and the high outlier threshold for payment indicated in (b)(i) through (iv) of this subsection, respectively, the resulting amount being multiplied by a percent of outlier adjustment factor. The percent of outlier adjustment factor is:

(i) Ninety-five percent for outlier claims that fall into one of the neonatal or pediatric AP-DRG classifications. Hospitals paid with the payment method used for out-of-state hospitals are paid using the percent of outlier adjustment factor identified in (c)(iii) of this subsection. All high outlier claims at Children's Hospital Regional Medical Center and Mary Bridge Children's Hospital and Health Center receive a ninety-five percent of outlier adjustment factor, regardless of AP-DRG classification assignment;

(ii) Ninety percent for outlier claims that fall into burn-related AP-DRG classifications;

(iii) Eighty-five percent for all other AP-DRG classifications; and

(iv) Used as indicated in WAC 388-550-4800 to calculate payment for state-administered programs' claims that are eligible for a high outlier payment.

(d) The high outlier payment allowed amount is added to the calculated allowed amount for the base DRG or base per diem payment, respectively, to determine the total payment allowed amount for the claim.

DRG high outlier						
Three examples for medicaid or SCHIP DRG high outlier claim qualification and payment calculation (admission dates are on or after August 1, 2007). Example dollar amounts are approximated and not based on real claims data.						
Total Submitted Charges Minus Noncovered Charges	Base DRG Payment Allowed Amount ¹	175% of Base DRG Payment Allowed Amount	Department Determined Estimated Costs Are Greater Than \$50,000? ²	Department Determined Estimated Costs Are Greater Than 175% of Base DRG Payment Allowed Amount?	Total DRG High Outlier Claim Payment Allowed Amount ^{3,4}	Hospital's Individual RCC Rate
\$95,600	\$28,837	\$50,465	Yes	Yes	\$38,761	65%
\$64,500	\$28,837	\$50,465	No	Yes	\$28,837	65%
\$77,000	\$28,837	\$50,465	Yes	No	\$28,837	65%

All examples represent a claim that is a nonpsychiatric claim and a claim that isn't from Children's Hospital Regional Medical Center or Mary Bridge Children's Hospital and Health Center.

Example one: The claim meets high cost outlier criteria. Example dollar amounts are approximated and not based on real claims data:

¹DRG conversion factor times DRG relative weight = Base DRG allowed amount

$\$6,300 \times 4.5773 = \$28,837 = \text{Base DRG allowed amount}$

²Total submitted charges minus total noncovered charges times RCC rate = Department determined estimated costs

$\$95,600 \times 65\% = \$62,140 = \text{Department determined estimated costs}$

³If department determined estimated costs are greater than the outlier qualifying criteria (in this example \$50,000), then (department determined estimated costs minus 175% of base DRG payment allowed amount (high outlier payment threshold)) times claim's percent of outlier adjustment factor (see subsection (17)(c)(i), (ii) and (iii)) = High outlier portion allowed amount, if greater than \$0, otherwise \$0.

$\$62,140 - \$50,465 = \$11,675 \times 85\% = \$9,924$ = High outlier portion allowed amount

⁴Base DRG payment allowed amount plus high outlier portion allowed amount = Total DRG high outlier claim payment amount

$\$28,837 + \$9,924 = \$38,761$

Example two: The claim does not meet high cost outlier criteria due to department-determined estimated cost being less than \$50,000. Example dollar amounts are approximated and not based on real claims data:

¹DRG conversion factor times DRG relative weight = Base DRG allowed amount

$\$6,300 \times 4.5773 = \$28,837$ = Base DRG allowed amount

²Total submitted charges minus total noncovered charges times RCC rate = Department determined estimated costs

$\$64,500 \times 65\% = \$41,925$ = Department determined estimated costs

³If department determined estimated costs are greater than the outlier qualifying criteria, then (department determined estimated costs minus 175% of base DRG payment allowed amount (high outlier payment threshold)) times claim's percent of outlier adjustment factor (see subsection (17)(c)(i), (ii) and (iii)) = High outlier portion allowed amount, if greater than \$0, otherwise \$0.

$(\$41,925 - \$50,465 = (\$8,540)) \times 85\% = (\$7,259)$, which is converted to \$0. Also, \$41,925 is not greater than \$50,000,

so the claim does not meet the high outlier qualifying criteria. Therefore, the high outlier portion allowed amount is \$0.

⁴Base DRG payment allowed amount plus high outlier portion allowed amount = Total DRG high outlier claim payment allowed amount

$\$28,837 + \$0 = \$28,837$

Example three: The claim does not meet high outlier criteria due to high DRG allowed amount. Example dollar amounts are approximated and not based on real claims data:

¹DRG conversion factor times DRG relative weight = Base DRG allowed amount

$\$6,300 \times 4.5773 = \$28,837$ = Base DRG allowed amount

²Total submitted charges minus total noncovered charges times RCC rate = Department determined estimated costs

$\$77,000 \times 65\% = \$50,050$ = Department determined estimated costs

³If department determined estimated costs are greater than the outlier qualifying criteria, then (department determined estimated costs minus 175% of base DRG payment allowed amount (high outlier payment threshold)) times claim's percent of outlier adjustment factor (see subsection (17)(c)(i), (ii) and (iii)) = high outlier portion allowed amount, if greater than \$0, otherwise \$0.

$(\$50,050 - \$50,465 = (\$415)) \times 85\% = (\$353)$, which is converted to \$0. Also, \$50,050 is greater than \$50,000, but not greater than \$50,465, so the claim does not meet the high outlier qualifying criteria. Therefore, the high outlier portion allowed amount is \$0.

⁴Base DRG payment allowed amount plus high outlier portion allowed amount = Total DRG high outlier claim payment allowed amount

$\$28,837 + \$0 = \$28,837$

Per Diem High Outlier

Three examples for medicaid and SCHIP per diem high outlier claim qualification and payment calculation (admission dates are on or after August 1, 2007). Example dollar amounts are approximated and not based on real claims data.

Total Submitted Charges Less Total Noncovered Charges	Base Per Diem Payment Allowed Amount ¹	175% of Base Per Diem Payment Allowed Amount	Department Determined Estimated Costs Are Greater Than \$50,000? ²	Department Determined Estimated Costs Are Greater Than 175% of Base Per Diem Payment Allowed Amount?	Total Per Diem High Outlier Claim's Payment Allowed Amount ^{3,4}	Hospital's Individual RCC Rate
\$100,000	\$25,000	\$43,750	Yes	Yes	\$47,313	70%
\$64,000	\$25,000	\$43,750	No	Yes	\$25,000	70%
\$75,000	\$35,000	\$61,250	Yes	No	\$35,000	70%

All examples represent a claim that is a nonpsychiatric claim and a claim that isn't from Children's Hospital Regional Medical Center or Mary Bridge Children's Hospital and Health Center.

Example one: The claim meets high cost outlier criteria. Example dollar amounts are approximated and not based on real claims data:

¹Per diem rate times client's department recognized length of stay for eligible days = Base per diem allowed amount

$\$1,000 \text{ (rate)} \times 25 \text{ (days)} = \$25,000$ = Base per diem allowed amount

²Total submitted charges minus total noncovered charges times RCC rate = Department determined estimated costs

$\$100,000 \times 70\% = \$70,000$ = Department determined estimated costs

³If department determined estimated costs are greater than the outlier qualifying criteria, then (department determined estimated costs minus 175% of base per diem payment allowed amount (high outlier payment threshold)) times claim's percent of outlier adjustment factor (see subsection (17)(c)(i), (ii) and (iii)) = High outlier portion allowed amount, if greater than \$0, otherwise \$0.

$(\$70,000 - \$43,750 = \$26,250) \times 85\% = \$22,313 =$ High outlier portion allowed amount

⁴Base per diem payment allowed amount plus high outlier portion allowed amount = Total per diem high outlier claim payment allowed amount

$\$25,000 + \$22,313 = \$47,313$

Example two: The claim does not meet high cost outlier criteria due to department-determined estimated cost being less than \$50,000. Example dollar amounts are approximated and not based on real claims data:

¹Per diem rate times client's department recognized length of stay for eligible days = Base per diem allowed amount

$\$1,000 \times 25 = \$25,000 =$ Base per diem allowed amount

²Total submitted charges minus total noncovered charges times RCC rate = Department determined estimated costs

$\$64,500 \times 70\% = \$45,150 =$ Department determined estimated costs

³If department determined estimated costs are greater than the outlier qualifying criteria, then (department determined estimated costs minus 175% of base per diem payment allowed amount (high outlier payment threshold)) times claim's percent of outlier adjustment factor (see subsection (17)(c)(i), (ii) and (iii)) = High outlier portion allowed amount, if greater than \$0, otherwise \$0.

$(\$45,150 - \$43,750 = \$1,400)$, but \$45,150 is not greater than \$50,000, so the claim does not meet the high outlier qualifying criteria. Therefore, the high outlier portion allowed amount is \$0.

⁴Base per diem payment allowed amount plus high outlier portion allowed amount = Total per diem high outlier claim payment allowed amount

$\$25,000 + \$0 = \$25,000$

Example three: (The claim does not meet high outlier criteria due to high DRG allowed amount. Example dollar amounts are approximated and not based on real claims data):

¹Per diem rate times client's department recognized length of stay for eligible days = Base per diem allowed amount

$\$1,000 \times 35 = \$35,000 =$ Base per diem allowed amount

²Total submitted charges minus total noncovered charges times RCC rate = Department determined estimated costs

$\$75,000 \times 70\% = \$52,500 =$ Department determined estimated costs

³If department determined estimated costs are greater than the outlier qualifying criteria, then (department determined estimated costs minus 175% of base DRG payment allowed amount (high outlier payment threshold)) times claim's percent of outlier adjustment factor (see subsection (17)(c)(i), (ii) and (iii)) = High outlier portion allowed amount, if greater than \$0, otherwise \$0.

$(\$52,500 - \$61,250 = (\$8,750)) \times 85\% = (\$7,438)$, which is converted to \$0. Also, \$52,500 is greater than \$50,000, but not greater than \$61,250, so the claim does not meet the high outlier qualifying criteria. Therefore, the high outlier portion allowed amount is \$0.

⁴Base per diem payment allowed amount plus high outlier portion allowed amount = Total per diem high outlier claim payment allowed amount

$\$35,000 + \$0 = \$35,000$

(18) When directed by the legislature to achieve targeted expenditure levels, as described in WAC 388-550-2800(2), the department may apply an inpatient adjustment factor to any of the high outlier thresholds and to any of the percentages of outlier adjustment factors described in this section.

(19) The department applies to the payment for each claim, all applicable adjustments for client responsibility, any third party liability, medicare, and any other adjustments as determined by the department.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 2009-11 Omnibus Operating Budget (ESHB 1244). 09-12-062, § 388-550-3700, filed 5/28/09, effective 7/1/09. Statutory Authority: RCW 74.08-090, 74.09.500 and 2005 c 518. 07-14-051, § 388-550-3700, filed 6/28/07, effective 8/1/07. Statutory Authority: RCW 74.08.090, 74.09.500. 03-13-053, § 388-550-3700, filed 6/12/03, effective 7/13/03. 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 388-550-3900 Payment method—Bordering city hospitals and critical border hospitals. The department uses the payment methods described in this section to pay bordering city hospitals and critical border hospitals for inpatient and outpatient claims. Bordering city hospitals and critical border hospitals are defined in WAC 388-550-1050.

(1) Bordering city hospitals—Inpatient hospital claim payment methods.

(a) For dates of admission before August 1, 2007, under the diagnosis related group (DRG) payment method:

(i) The department calculates the cost-based conversion factor (CBCF) of a bordering city hospital as defined in WAC 388-550-1050, in accordance with WAC 388-550-3450.

(ii) For a bordering city hospital with no medicare cost report (Form 2552-96) submitted for the rebasing year, the department assigns the department peer group average conversion factor. This is the average of all final conversion factors of hospitals in that group.

(b) For dates of admission before August 1, 2007, under the ratio of costs-to-charges (RCC) payment method:

(i) The department calculates the RCC in accordance with WAC 388-550-4500.

(ii) For a bordering city hospital with no medicare cost report (Form 2552-96) submitted for the rebasing year, the department bases the RCC on the Washington instate average RCC.

(c) For dates of admission on and after August 1, 2007:

(i) The department calculates the payment for allowed covered charges related to medically necessary services, using the lowest of the instate inpatient hospital rates without graduate medical education (GME) (excluding DWCC rates that are paid to instate critical access hospitals) for the DRG conversion factor, the per diem, per case, and RCC payment methods; and

(ii) The department pays the lesser of the:

(A) Billed charges; or

(B) Calculated payment amount.

(2) Bordering city hospitals—Outpatient hospital claim payment methods for allowed covered charges related to medically necessary services.

(a) For bordering city hospitals paid according to the outpatient prospective payment system (OPPS), refer to WAC 388-550-7000 through 388-550-7600. The department uses the following types of payment methods used in OPPS:

(i) Ambulatory payment classification (APC) method (the primary payment method for OPPS) (WAC 388-55-7200);

(A) Before August 1, 2007, the department determines the OPPS conversion factor using the methods described in WAC 388-550-7500.

(B) On and after August 1, 2007, the department pays using the lowest instate OPPS conversion factor.

(ii) OPPS maximum allowable fee schedule (WAC 388-550-7200).

(iii) Hospital outpatient RCC rate (WAC 388-550-4500).

(A) Before August 1, 2007, the department pays the instate average hospital outpatient RCC rate times the allowed covered charges for medically necessary services.

(B) On and after August 1, 2007, the department pays the lowest instate hospital outpatient RCC rate times the allowed covered charges for medically necessary services.

(b) For bordering city hospitals exempt from OPPS, the department uses the following payment methods:

(i) Outpatient maximum allowable fee schedule (WAC 388-550-6000); and

(ii) Hospital outpatient RCC rate (WAC 388-550-4500).

(c) When the RCC payment method described in WAC 388-550-4500 is used to pay for outpatient services provided:

(i) Before August 1, 2007, the department pays the instate average hospital outpatient RCC rate times the allowed covered charges for medically necessary services.

(ii) On and after August 1, 2007, the department pays the lowest instate hospital outpatient RCC rate times the allowed covered charges for medically necessary services.

(d) When the maximum allowable fee schedule method is used to pay for outpatient services provided, the department pays the lesser of the:

(i) Billed charges; or

(ii) Calculated payment amount.

(3) Designated critical border hospitals.

(a) Beginning August 1, 2007, the department designated certain qualifying hospitals located out-of-state as critical border hospitals. A designated critical border hospital must:

(i) Be a bordering city hospital as described in WAC 388-550-1050; and

(ii) Have submitted at least ten percent of the total non-emergency inpatient hospital claims that have been paid to bordering city hospitals for the prior state fiscal year (SFY) for clients eligible for Washington state medicaid and state-administered programs. Nonemergency inpatient hospital claims are defined as those that do not include emergency room charges (revenue code 045X series).

(b) The department analyzes bordering city hospitals' base period claims data during the rebasing process, and annually thereafter, to determine if a bordering city hospital qualifies or continues to qualify as a critical border hospital.

(4) Critical border hospitals—Inpatient hospital claim payment methods. The department pays inpatient critical border hospital claims with dates of services on and after August 1, 2007, as follows:

(a) The inpatient payment rates used to calculate payments to critical border hospitals are prospective payment rates. The rates are not used to pay for claims with dates of admission before the hospital qualified as a critical border hospital.

(b) The department pays inpatient critical border hospital claims using the same payment methods and rates as for instate hospital claims, including DRG, RCC, per diem, outliers, and per case rate, subject to the following:

(i) Inpatient payment rates used to pay critical border university hospitals for inpatient hospital claims cannot exceed the highest corresponding inpatient payment rate for an instate university hospital;

(ii) Inpatient payment rates used to pay critical border Level 1 trauma centers for inpatient hospital claims cannot exceed the highest corresponding inpatient payment rate for an instate Level 1 trauma center; and

(iii) Inpatient payment rates used to pay critical border hospitals not listed in (A) and (B) of this subsection for inpatient hospital claims cannot exceed the highest corresponding instate inpatient payment rate for instate hospitals that are not designated as:

(A) Critical access hospitals (CAHs);

(B) University hospitals; or

(C) Level 1 trauma centers.

(5) Critical border hospitals—Outpatient hospital claim payment methods. The department pays outpatient critical border hospital claims with dates of services on and after August 1, 2007, using the same payment methods as for instate outpatient hospital claims, including the APC method using the hospital's OPPS conversion factor, maximum allowable fee schedule method, and the hospital outpatient RCC rate method (refer to WAC 388-550-7000 through 388-550-7600 and WAC 388-550-4500), subject to the following:

(a) Outpatient rates used to pay critical border university hospitals for outpatient claims cannot exceed the highest corresponding rate for an instate university hospital.

(b) Outpatient rates used to pay critical border Level 1 trauma centers for outpatient claims cannot exceed the highest corresponding rate for an instate Level 1 trauma center.

(c) Outpatient rates used to pay the critical border hospitals not listed in (i) and (ii) of this subsection for outpatient claims cannot exceed the highest corresponding rate for instate hospitals that are not designated as:

(i) Critical access hospitals (CAH);

(ii) University hospitals; or

(iii) Level 1 trauma centers.

(6) Critical border hospitals are eligible to receive payment for graduate medical education (GME). All other bordering city hospitals are not eligible to receive payment for GME.

(7) The department makes:

(a) Claim payment adjustments, including but not limited to, third party liability, medicare, and client responsibility; and

(b) Other necessary adjustments as directed by the legislature (e.g., rate rebasing and other changes).

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 2009-11 Omnibus Operating Budget (ESHB 1244). 09-12-063, § 388-550-3900, filed 5/28/09, effective 7/1/09. Statutory Authority: RCW 74.08.-090, 74.09.500 and 2005 c 518. 07-14-051, § 388-550-3900, filed 6/28/07,

effective 8/1/07. 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 Payment method—Out-of-state hospitals. This section describes the payment methods the department uses to pay hospitals located out-of-state for providing services to eligible Washington state medical assistance clients. This section does not apply to hospitals located in any of the designated bordering cities listed in WAC 388-501-0175. Payment methods that apply to bordering city hospitals, including critical border hospitals, are described in WAC 388-550-3900.

(1) Emergency hospital services before August 1, 2007.

(a) For inpatient hospital claims for emergency services provided in out-of-state hospitals with dates of admission before August 1, 2007, the department limits the payment to the lesser of the:

(i) Billed charges; or

(ii) Weighted average of ratio of costs-to-charges (RCC) ratios for in-state hospitals multiplied by the allowed covered charges for medically necessary services.

(b) For outpatient hospital claims for emergency services provided in out-of-state hospitals with the first date of service before August 1, 2007, the department limits the payment to the lesser of the:

(i) Billed charges; or

(ii) Weighted average of hospital outpatient RCC rates for in-state hospitals multiplied by the allowed covered charges for medically necessary services.

(2) Emergency hospital services on and after August 1, 2007.

(a) For inpatient hospital claims for emergency services provided in out-of-state hospitals with dates of admission on and after August 1, 2007, the department:

(i) Pays using the same methods used to pay in-state hospitals:

(A) Diagnosis related group (DRG) (WAC 388-550-3000);

(B) Per diem (WAC 388-550-3010);

(C) DRG and per diem outliers (WAC 388-550-3700); and

(D) Ratio of costs-to-charges (RCC) (WAC 388-550-4500).

(ii) Pays using the lowest in-state inpatient hospital rate corresponding to the payment method used in (a)(i) of this subsection.

(iii) Limits payment to out-of-state hospitals to the lesser of the:

(A) Billed charges; or

(B) Calculated payment amount.

(b) For outpatient hospital claims for emergency services provided in out-of-state hospitals with dates of service on or after August 1, 2007, the department pays an out-of-state hospital using one or both of the following methods:

(i) The maximum allowable fee schedule method described in WAC 388-550-6000, and limits payment when the maximum allowable fee schedule method is used to the lesser of the:

(A) Billed charges; or

(B) Calculated payment amount.

(ii) The hospital outpatient RCC method described in WAC 388-550-4500. When using the RCC payment method, the department pays the lowest in-state hospital outpatient RCC rate, excluding departmental weighted costs-to-charges (DWCC) rates that are paid to in-state critical access hospitals.

(c) Out-of-state hospitals are not eligible to receive payment for graduate medical education (GME).

(3) The department makes:

(a) Claim payment adjustments, including but not limited to client responsibility, third party liability, and medicare; and

(b) Other necessary adjustments as directed by the legislature (e.g., rate rebasing and other changes).

(4) Nonemergency services. The department does not pay for nonemergency hospital services provided to a medical assistance client in a hospital located out-of-state unless the hospital is contracted and/or prior authorized by the department or the department's designee, for the specific service provided.

(a) Contracted services are paid according to the contract terms whether or not the hospital has signed a core provider agreement.

(b) Authorized services are paid according to subsections (1), (2), and (3) of this section.

(c) Bariatric surgery performed in a designated department-approved hospital is paid a per case rate and must be prior authorized by the department (see WAC 388-550-3020).

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 2009-11 Omnibus Operating Budget (ESHB 1244). 09-12-063, § 388-550-4000, filed 5/28/09, effective 7/1/09. Statutory Authority: RCW 74.08.-090, 74.09.500 and 2005 c 518. 07-14-051, § 388-550-4000, filed 6/28/07, effective 8/1/07. 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 388-550-4500 Payment method—Ratio of costs-to-charges (RCC). (1) Ratio of costs-to-charges (RCC) is defined in WAC 388-550-1050. The department uses:

(a) The RCC payment method to pay hospitals for hospital services that are exempt from the diagnosis related group (DRG), per diem, ambulatory payment classification (APC), maximum allowable fee schedule, and per case payment methods.

(b) The term "ratio of costs-to-charges" to refer to the factor (rate) applied to a hospital's allowed covered charges to determine estimated costs for medically necessary services.

(2) The department:

(a) Determines the payment due a hospital under the RCC payment method for:

(i) Inpatient claims by multiplying the hospital's inpatient RCC rate by the allowed covered charges for medically necessary services.

(ii) Outpatient claims by multiplying the hospital's outpatient RCC rate by the allowed covered charges for medically necessary services.

(b) Deducts from the amount derived in (a) of this subsection any:

(i) Client responsibility amount;

- (ii) Third-party liability (TPL) amount; and
- (iii) Other applicable payment program adjustment.
- (c) Limits the RCC payment to the hospital's allowable usual and customary charges.

(3) For inpatient hospital dates of admission before August 1, 2007, the department uses the RCC payment method to pay for inpatient hospital services that are:

(a) Provided in a hospital located in the state of Washington (see WAC 388-550-4000 for out-of-state hospital payment methods and WAC 388-550-3900 for payment methods to designated bordering city and critical border hospitals);

(b) Provided in a diagnosis related group (DRG)-exempt hospital identified in WAC 388-550-4300; and

(c) Identified in WAC 388-550-4400 as DRG-exempt services (see WAC 388-550-4400 (2)(g), (h), and (k) for exceptions).

(4) For inpatient hospital dates of admission on and after August 1, 2007, the department uses the RCC payment method to pay for:

(a) Organ transplant services identified in WAC 388-550-4400 (4)(h);

(b) High outlier qualifying claims (see WAC 388-550-3700 (14) and (15));

(c) Hospital services not covered under the LTAC per diem rate (see WAC 388-550-2596);

(d) Hospital services provided in hospitals eligible for certified public expenditure (CPE) payments (see WAC 388-550-4650(5)); and

(e) Any other hospital service identified and published by the department as being paid by the RCC payment method.

(5) When directed by the legislature to achieve targeted expenditure levels, as described in WAC 388-550-2800(2), the department may apply an inpatient adjustment factor to the inpatient RCC payments made for the services in subsection (4) of this section, except as provided in subsection (6) of this section.

(6) For hospitals paid under the certified public expenditure (CPE) payment method, the inpatient adjustment factor referred to in subsection (5) of this section does not apply, except to payments for repriced claims adjusted according to WAC 388-550-4670 (2)(a)(ii).

(7) The department calculates each instate and critical border hospital's RCC rate as follows. The department:

(a) Divides each hospital's allowable costs by patient-related revenues associated with these allowable costs. The department determines the allowable costs and associated revenues.

(b) Excludes, prior to calculating the RCC rate, department nonallowed costs and nonallowed revenue, such as costs and revenues attributable to a change in ownership.

(c) Bases the RCC rate calculation on data from the hospital's "as filed" annual medicare cost report (Form 2552-96) and applicable patient revenue reconciliation data provided by the hospital. The "as filed" medicare cost report must cover a period of twelve consecutive months in its medicare cost report year.

(d) Updates a hospital's inpatient RCC rate annually after the hospital sends its "as filed" hospital fiscal year medicare cost report to the centers for medicare and medicaid services (CMS) and the department. In the case where a delay in sub-

mission of the CMS medicare cost report to the medicare fiscal intermediary is granted by medicare, the department may adjust the RCC rate based on a department-determined method.

(e) Limits a noncritical access hospital's RCC payment to one hundred percent of its allowed covered charges.

(f) Determines an RCC rate, when a hospital is formed as a result of a merger (refer to WAC 388-550-4200), by combining the previous hospital's medicare cost reports and following the process in (a) of this subsection. The department does not use partial year cost reports for this purpose.

(g) Determines a new instate hospital's RCC rate by calculating and using the average RCC rate for all current noncritical access hospitals located in Washington state. The department annually calculates a weighted average instate RCC rate by identifying all instate hospitals with specific RCC rates and dividing the department-determined total patient-related revenues associated with those costs.

(8) The department calculates each hospital's outpatient RCC rate annually.

(a) The department calculates a hospital's outpatient RCC rate by multiplying the hospital's inpatient RCC rate by the outpatient adjustment factor (OAF).

(b) The department determines the weighted average instate hospital outpatient RCC rate by multiplying the instate weighted average inpatient RCC rate by the outpatient adjustment factor.

(9) The outpatient adjustment factor:

(a) Is the ratio between the outpatient and inpatient RCC payments, established in 1998 through negotiation with hospital providers;

(b) Is updated annually to adjust for cost and charge inflation;

(c) Must not exceed 1.0; and

(d) Is differentiated from the OPPI outpatient adjustment factor (defined in WAC 388-550-1050), and applies to hospitals exempt from OPPI.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 2009-11 Omnibus Operating Budget (ESHB 1244). 09-12-062, § 388-550-4500, filed 5/28/09, effective 7/1/09. Statutory Authority: RCW 74.08.090, 74.09.500 and 2005 c 518. 07-14-051, § 388-550-4500, filed 6/28/07, effective 8/1/07. Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.035(1), and 43.88.290. 03-13-055, § 388-550-4500, filed 6/12/03, effective 7/13/03. 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 388-550-4550 Administrative day rate and swing bed day rate. (1) Administrative day rate. The department allows hospitals an all-inclusive administrative day rate for those days of hospital stay in which a client does not meet criteria for acute inpatient level of care, but is not discharged because an appropriate placement outside the hospital is not available.

(a) The department uses the annual statewide weighted average nursing facility medicaid payment rate to update the all-inclusive administrative day rate on November 1 of each year.

(b) The department does not pay for ancillary services provided during administrative days.

(c) The department identifies administrative days during the length of stay review process after the client's discharge from the hospital.

(d) The department pays the hospital the administrative day rate starting with the date of hospital admission if the admission is solely for a stay until an appropriate sub-acute placement can be made.

(2) **Swing bed day rate.** The department allows hospitals a swing bed day rate for those days when a client is receiving department-approved nursing service level of care in a swing bed. The department's aging and disability services administration (ADSA) determines the swing bed day rate.

(a) The department does not pay a hospital the rate applicable to the acute inpatient level of care for those days of a hospital stay when a client is receiving department-approved nursing service level of care in a swing bed.

(b) The department's allowed amount for those ancillary services not covered under the swing bed day rate is based on the payment methods provided in WAC 388-550-6000 and 388-550-7200. These ancillary services may be billed by the hospital on an outpatient hospital claim, except for pharmacy services and pharmaceuticals.

(c) The department allows pharmacy services and pharmaceuticals not covered under the swing bed day rate, that are provided to a client receiving department-approved nursing service level of care, to be billed directly by a pharmacy through the point of sale system. The department does not allow those pharmacy services and pharmaceuticals to be paid to the hospital through submission of a hospital outpatient claim.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 2009-11 Omnibus Operating Budget (ESHB 1244). 09-12-062, § 388-550-4550, filed 5/28/09, effective 7/1/09.]

WAC 388-550-7050 OPSS—Definitions. The following definitions and abbreviations and those found in WAC 388-550-1050 apply to the department's outpatient prospective payment system (OPSS):

"Ambulatory payment classification (APC)" means a grouping that categorizes outpatient visits according to the clinical characteristics, the typical resource use, and the costs associated with the diagnoses and the procedures performed.

"Budget target" means the amount of money appropriated by the legislature or through the department's budget process to pay for a specific group of services, including anticipated caseload changes or vendor rate increases.

"Budget target adjustor" means a department-established component of the APC payment calculation applied to all payable ambulatory payment classifications (APCs) to allow the department to reach and not exceed the established budget target.

"Discount factor" means the percentage applied to additional significant procedures when a claim has multiple significant procedures or when the same procedure is performed multiple times on the same day. Not all significant procedures are subject to a discount factor.

"Medical visit" means diagnostic, therapeutic, or consultative services provided to a client by a healthcare professional in an outpatient setting.

"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 hospital 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.

"National payment rate (NPR)" means a rate for a given procedure code, published by the centers for medicare and medicaid (CMS), that does not include a state or location specific adjustment.

"Nationwide rate" see "national payment rate."

"Observation services" means services furnished by a hospital on the hospital's premises, including use of a bed and periodic monitoring by hospital staff, which are reasonable and necessary to evaluate an outpatient's condition or determine the need for possible admission to the hospital as an inpatient.

"Outpatient code editor (OCE)" means a software program that the department uses for classifying and editing claims in ambulatory payment classification (APC) based OPSS.

"Outpatient prospective payment system (OPPS)" means the payment system used by the department to calculate reimbursement to hospitals for the facility component of outpatient services. This system uses ambulatory payment classifications (APCs) as the primary basis of payment.

"Outpatient prospective payment system (OPPS) conversion factor" see "outpatient prospective payment system (OPPS) rate."

"Outpatient prospective payment system (OPPS) rate" means a hospital-specific multiplier assigned by the department that is one of the components of the APC payment calculation.

"Pass-throughs" means certain drugs, devices, and biologicals, as identified by centers for medicare and medicaid services (CMS), for which providers are entitled to additional separate payment until the drugs, devices, or biologicals are assigned their own ambulatory payment classification (APC).

"Significant procedure" means a procedure, therapy, or service provided to a client that constitutes the primary reason for the visit to the healthcare professional.

"Status indicator (SI)" means a code assigned to each medical procedure or service by the department that contributes to the selection of a payment method.

"SI" see "status indicator."

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 2009-11 Omnibus Operating Budget (ESHB 1244). 09-12-062, § 388-550-7050, filed 5/28/09, effective 7/1/09. Statutory Authority: RCW 74.08-090, 74.09.500. 07-13-100, § 388-550-7050, filed 6/20/07, effective 8/1/07; 04-20-061, § 388-550-7050, filed 10/1/04, effective 11/1/04.]

WAC 388-550-7100 OPSS—Exempt hospitals. (1) The department exempted the following hospitals from the initial implementation of the department's outpatient prospective payment system (OPSS) in 2004:

- (a) Cancer hospitals;
- (b) Critical access hospitals (CAHs);
- (c) Free-standing psychiatric hospitals;
- (d) Pediatric hospitals;

- (e) Peer group A hospitals;
- (f) Rehabilitation hospitals; and
- (g) Veterans' and military hospitals.

(2) Effective for dates of service on and after July 1, 2009:

- (a) Only CAHs remain exempt from OPPS; and
- (b) The department pays all covered outpatient hospital services (except for those provided in CAHs), under the OPPS methodology.

(3) Refer to the applicable sections in chapter 388-550 WAC for outpatient payment methods used to pay hospitals exempted from OPPS (see subsections (1) and (2) of this section).

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 2009-11 Omnibus Operating Budget (ESHB 1244). 09-12-062, § 388-550-7100, filed 5/28/09, effective 7/1/09. Statutory Authority: RCW 74.08.-090, 74.09.500. 07-13-100, § 388-550-7100, filed 6/20/07, effective 8/1/07; 04-20-061, § 388-550-7100, filed 10/1/04, effective 11/1/04.]

WAC 388-550-7450 OPPS budget target adjustor.

(1) The outpatient prospective payment system (OPPS) budget target adjustor is a component of the ambulatory payment classification (APC) payment calculation. The budget target adjustor allows the department to reach but not exceed the established budget target. The same OPPS budget target adjustor value is applied to payments for all hospitals.

(2) The department calculates the OPPS budget target adjustor using:

- (a) A payment system model developed by the department;
- (b) The department's budget target;
- (c) The department's outpatient fee schedule;
- (d) Addendum B to 42 CFR Part 410 (medicare's hospital outpatient regulations and notices); and
- (e) The wage index established and published by the centers for medicare and medicaid services (CMS) at the time the OPPS budget target adjustor is set for the upcoming year.

(3) In response to direction from the legislature, the department may change the method for calculating the OPPS budget target adjustor to achieve the legislature's targeted expenditure levels for outpatient hospital services. The legislative direction may take the form of express language in the biennial appropriations act or may be reflected in the level of funding appropriated to the department in the biennial appropriations act.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 2009-11 Omnibus Operating Budget (ESHB 1244). 09-12-062, § 388-550-7450, filed 5/28/09, effective 7/1/09.]

WAC 388-550-7500 OPPS rate. (1) The department calculates hospital-specific outpatient prospective payment system (OPPS) rates using:

- (a) A payment method model established by the department; and
- (b) The latest wage index information established and published by the centers for medicare and medicaid services (CMS) at the time the OPPS rates are set for the upcoming year. Wage index information reflects labor costs in the cost-based statistical area (CBSA) where a hospital is located.

(2) The department may adjust OPPS rates to pay for graduate medical education (GME) costs. The department

obtains the GME information from a hospital's "as filed" annual medicare cost report (Form 2552-96) and applicable patient revenue reconciliation data provided by the hospital.

(a) The hospital's "as filed" medicare cost report must cover a period of twelve consecutive months in its medicare cost report year. In the case where a delay in submission of the CMS medicare cost report to the medicare fiscal intermediary is granted by medicare, the department may adjust the hospital's OPPS rate.

(b) The department may not pay GME expenses for hospitals in specified categories, and hospitals that meet, or fail to meet, conditions specified in statute or WAC.

(3) In response to direction from the legislature, the department may change the method for calculating OPPS rates to achieve the legislature's targeted expenditure levels for outpatient hospital services. The legislative direction may take the form of express language in the Biennial Appropriations Act or may be reflected in the level of funding appropriated to the department in the Biennial Appropriations Act.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 2009-11 Omnibus Operating Budget (ESHB 1244). 09-12-062, § 388-550-7500, filed 5/28/09, effective 7/1/09. Statutory Authority: RCW 74.08.-090, 74.09.500. 07-13-100, § 388-550-7500, filed 6/20/07, effective 8/1/07; 04-20-061, § 388-550-7500, filed 10/1/04, effective 11/1/04.]

WAC 388-550-7600 OPPS payment calculation. (1)

The department follows the discounting and modifier policies of the centers for medicare and medicaid services (CMS). The department calculates the ambulatory payment classification (APC) payment as follows:

APC payment =

National payment rate x Hospital OPPS rate x

Discount factor (if applicable) x Units of service (if applicable) x

Budget target adjustor

(2) The total OPPS claim payment is the sum of the APC payments plus the sum of the lesser of the billed charge or allowed charge for each non-APC service.

(3) The department pays hospitals for claims that involve clients who have third-party liability (TPL) insurance, the lesser of either the:

(a) Billed amount minus the third-party payment amount; or

(b) Allowed amount minus the third-party payment amount.

(4) In response to direction from the legislature, the department may change the method for calculating OPPS payments to achieve the legislature's targeted expenditure levels for outpatient hospital services. The legislative direction may take the form of express language in the Biennial Appropriations Act or may be reflected in the level of funding appropriated to the department in the Biennial Appropriations Act.

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 2009-11 Omnibus Operating Budget (ESHB 1244). 09-12-062, § 388-550-7600, filed 5/28/09, effective 7/1/09. Statutory Authority: RCW 74.08.-090, 74.09.500. 07-13-100, § 388-550-7600, filed 6/20/07, effective 8/1/07; 04-20-061, § 388-550-7600, filed 10/1/04, effective 11/1/04.]

Chapter 388-554 WAC
ENTERAL NUTRITION PROGRAM

WAC

388-554-100	Enteral nutrition—General.
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388-554-500	Covered enteral nutrition products, equipment and related supplies—Orally administered—Clients twenty years of age and younger only.
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WAC 388-554-100 Enteral nutrition—General. (1)

The department covers the enteral nutrition products, equipment, and related supplies listed in this chapter, according to department rules and subject to the limitations and requirements in this chapter.

(2) The department pays for enteral nutrition products, equipment and related supplies when they are:

- (a) Covered;
- (b) Within the scope of the eligible client's medical care program;
- (c) Medically necessary as defined under WAC 388-500-0005;
- (d) Authorized, as required within this chapter, chapters 388-501 and 388-502 WAC, and the department's published billing instructions and numbered memoranda; and
- (e) Billed according to this chapter, chapters 388-501 and 388-502, and the department's published billing instructions and numbered memoranda.

(3) The department requires prior authorization for covered enteral nutrition products, equipment and related supplies when the clinical criteria set forth in this chapter are not met, including the criteria associated with the expedited prior authorization process. The department evaluates requests requiring prior authorization on a case-by-case basis to determine whether they are medically necessary, according to the process found in WAC 388-501-0165.

(4) The department evaluates a request for a service that is in a covered category, but has been determined to be experimental or investigational per WAC 388-531-0550, under the provisions of WAC 388-501-0165.

(5) The department terminates a provider's participation with the department according to chapter 388-502 WAC.

[Statutory Authority: 2009 c 564 § 1109, RCW 74.04.050, and 74.08.090. 10-01-138, § 388-554-100, filed 12/21/09, effective 1/21/10. Statutory Authority: RCW 74.08.090, 74.09.530 and chapter 74.09 RCW. 05-04-059, § 388-554-100, filed 1/28/05, effective 3/1/05.]

WAC 388-554-200 Enteral nutrition—Definitions.

The following terms and definitions and those found in WAC 388-500-0005 apply to this chapter:

"BMI" see **"body mass index."**

"Body mass index (BMI)"—A number that shows body weight relative to height, and is calculated using inches and pounds or meters and kilograms.

"Department"—The department of social and health services (DSHS).

"Enteral nutrition"—The use of medically necessary nutritional products alone, or in combination with traditional food, when a client is unable to consume enough traditional food to meet nutritional requirements. Enteral nutritional solutions can be given orally or via feeding tubes.

"Enteral nutrition equipment"—Durable medical feeding pumps and intravenous (IV) poles used in conjunction with nutrition supplies to dispense formula to a client.

"Enteral nutrition product"—Enteral nutrition formulas and/or products.

"Enteral nutrition supplies"—The supplies, such as nasogastric, gastrostomy and jejunostomy tubes, necessary to allow nutritional support via the alimentary canal or any route connected to the gastrointestinal system.

"Growth chart"—A series of percentile curves that illustrate the distribution of select body measurements (i.e., height, weight, and age) in children published by the Centers for Disease Control and Prevention, National Center for Health Statistics. CDC growth charts: United States. <http://www.cdc.gov/growthcharts/>

"Nonfunctioning digestive tract"—Caused by a condition that affects the body's alimentary organs and their ability to break down, digest, and absorb nutrients.

"Orally administered enteral nutrition products"—Enteral nutrition solutions and products that a client consumes orally for nutritional support.

"Tube-delivery"—The provision of nutritional requirements through a tube into the stomach or small intestine.

"Women, infants and children (WIC) program" (Also known as WIC program)—A special supplemental nutrition program managed by the department of health (DOH) that serves to safeguard the health of children up to age five and low-income pregnant and breastfeeding women who are at nutritional risk, by providing them with healthy, nutritious foods to supplement diets, information on healthy eating, and referral to health care.

[Statutory Authority: 2009 c 564 § 1109, RCW 74.04.050, and 74.08.090. 10-01-138, § 388-554-200, filed 12/21/09, effective 1/21/10. Statutory Authority: RCW 74.08.090, 74.09.530 and chapter 74.09 RCW. 05-04-059, § 388-554-200, filed 1/28/05, effective 3/1/05.]

WAC 388-554-300 Enteral nutrition—Client eligibility.

(1) To receive oral or tube-delivered enteral nutrition products, equipment, and related supplies, clients must be eligible for one of the following medical assistance programs:

- (a) Categorically needy program (CN or CNP);
- (b) Categorically needy program - state children's health insurance program (CNP-SCHIP);
- (c) Children's healthcare programs as defined in WAC 388-505-0210;
- (d) Limited casualty program - Medically needy program (LCP-MNP);
- (e) General assistance (GAU/ADATSA); and
- (f) Emergency medical only programs when the services are necessary to treat the client's emergency medical condition.

(2) Clients who are enrolled in a department-contracted managed care organization (MCO) must arrange for enteral nutrition products, equipment, and related supplies directly through his or her department-contracted MCO.

(3) For clients who reside in a nursing facility, adult family home, assisted living facility, boarding home, or any other residence where the provision of food is included in the daily rate, oral enteral nutrition products are the responsibility of the facility to provide in accordance with chapters 388-76, 388-97 and 388-78A WAC.

(4) For clients who reside in a state-owned facility (i.e. state school, developmental disabilities (DD) facility, mental health facility, Western State Hospital, and Eastern State Hospital) enteral nutrition products, equipment, and related supplies are the responsibility of the state-owned facility to provide.

(5) Clients who have elected and are eligible to receive the department's hospice benefit must arrange for enteral nutrition products, equipment and related supplies directly through the hospice benefit.

(6) Children who qualify for supplemental nutrition from the women, infants, and children (WIC) program must receive supplemental nutrition directly from that program unless the client meets the limited circumstances in WAC 388-554-500 (1)(d).

[Statutory Authority: 2009 c 564 § 1109, RCW 74.04.050, and 74.08.090, 10-01-138, § 388-554-300, filed 12/21/09, effective 1/21/10. Statutory Authority: RCW 74.08.090, 74.09.530 and chapter 74.09 RCW. 05-04-059, § 388-554-300, filed 1/28/05, effective 3/1/05.]

WAC 388-554-400 Enteral nutrition—Provider requirements. (1) The following providers are eligible to enroll/contract with the department to provide orally administered enteral nutrition products and tube-delivered enteral nutrition products, equipment, and related supplies:

- (a) Pharmacy provider; or
- (b) Durable medical equipment (DME) provider.

(2) To receive payment for orally administered enteral nutrition products and tube-delivered enteral nutrition products, equipment and related supplies, a provider must:

- (a) Meet the requirements in chapters 388-501 and 388-502 WAC;
- (b) Provide only those services that are within the scope of the provider's license;

(c) Obtain prior authorization from the department, if required, before delivery to the client and before billing the department;

(d) Deliver enteral nutritional products in quantities sufficient to meet the client's authorized needs, not to exceed a one-month supply;

(e) Confirm with the client or the client's caregiver that the next month's delivery of authorized orally administered enteral nutrition products is necessary and document the confirmation in the client's file. The department does not pay for automatic periodic delivery of products;

(f) Furnish clients with new or used equipment that includes full manufacturer and dealer warranties for at least one year; and

(g) Notify the client's physician if the client has indicated the enteral nutrition product is not being used as prescribed and document the notification in the client's file.

[Statutory Authority: 2009 c 564 § 1109, RCW 74.04.050, and 74.08.090, 10-01-138, § 388-554-400, filed 12/21/09, effective 1/21/10. Statutory Authority: RCW 74.08.090, 74.09.530 and chapter 74.09 RCW. 05-04-059, § 388-554-400, filed 1/28/05, effective 3/1/05.]

WAC 388-554-500 Covered enteral nutrition products, equipment and related supplies—Orally administered—Clients twenty years of age and younger only. (1) The department covers orally administered enteral nutrition products for clients twenty years of age and younger only, as follows:

(a) The client's nutritional needs cannot be met using traditional foods, baby foods, and other regular grocery products that can be pulverized or blenderized and used to meet the client's caloric and nutritional needs;

(b) The client is able to manage their feedings in one of the following ways:

- (i) Independently; or
- (ii) With a caregiver who can manage the feedings; and
- (c) The client meets one of the following clinical criteria:

(i) Acquired immune deficiency syndrome (AIDS). Providers must obtain prior authorization to receive payment. The client must:

(A) Be in a wasting state;

(B) Have a weight-for-length less than or equal to the fifth percentile if the client is three years of age or younger; or

(C) Have a body mass index (BMI) of:

(I) Less than or equal to the fifth percentile if the client is four through seventeen years of age; or

(II) Less than or equal to 18.5 if the client is eighteen through twenty years of age; or

(D) Have a BMI of:

(I) Less than or equal to twenty-five; and

(II) An unintentional or unexplained weight loss of five percent in one month, seven and a half percent in three months, or ten percent in six months.

(ii) Amino acid, fatty acid, and carbohydrate metabolic disorders.

(A) The client must require a specialized nutrition product; and

(B) Providers must follow the department's expedited prior authorization process to receive payment.

(iii) Cancer(s).

(A) The client must be receiving chemotherapy and/or radiation therapy or post-therapy treatment;

(B) The department pays for orally administered nutritional products for up to three months following the completion of chemotherapy or radiation therapy; and

(C) Providers must follow the department's expedited prior authorization process to receive payment.

(iv) Chronic renal failure.

(A) The client must be receiving dialysis and have a fluid restrictive diet in order to use nutrition bars; and

(B) Providers must follow the department's expedited prior authorization process to receive payment.

(v) Decubitus pressure ulcers.

(A) The client must have stage three or greater decubitus pressure ulcers and an albumin level of 3.2 or below; and

(B) Providers must follow the department's expedited prior authorization process to receive a maximum of three month's payment.

(vi) Failure to thrive or malnutrition/malabsorption as a result of a stated primary diagnosed disease.

(A) The provider must obtain prior authorization to receive payment; and

(B) The client must have:

(I) A disease or medical condition that is only organic in nature and not due to cognitive, emotional, or psychological impairment; and

(II) A weight-for-length less than or equal to the fifth percentile if the client is two years of age or younger; or

(III) A BMI of:

(aa) Less than or equal to the fifth percentile if the client is three through seventeen years of age; or

(bb) Less than or equal to 18.5, an albumin level of 3.5 or below, and a cholesterol level of one hundred sixty or below if the client is age eighteen through twenty years of age; or

(IV) Have a BMI of:

(aa) Less than or equal to twenty five; and

(bb) An unintentional or unexplained weight loss of five percent in one month, seven and a half percent in three months, or ten percent in six months.

(vii) Medical conditions (e.g., dysphagia) requiring a thickener.

(A) The client must:

(I) Require a thickener to aid in swallowing or currently be transitioning from tube feedings to oral feedings; and

(II) Be evaluated by a speech therapist or an occupational therapist who specializes in dysphagia. The report recommending a thickener must be in the client's chart in the prescriber's office.

(B) Providers must follow the department's expedited prior authorization process to receive payment.

(d) If four years of age or younger.

(i) The client must:

(A) Have a certified registered dietitian (RD) evaluation with recommendations which support the prescriber's order for oral enteral nutrition products or formulas; and

(B) Have a signed and dated written notification from WIC indicating one of the following:

(I) Client is not eligible for the women, infants, and children (WIC) program; or

(II) Client is eligible for WIC program, but the need for the oral enteral nutrition product or formula exceeds WIC's allowed amount; or

(III) The requested oral enteral nutrition product or formula is not available through the WIC program. Specific, detailed documentation of the tried and failed efforts of similar WIC products, or the medical need for alternative products must be in the prescriber's chart for the client; and

(C) Meet one of the following clinical criteria:

(I) Low birth weight (less than 2500 grams);

(II) A decrease across two or more percentile lines on the CDC growth chart, once a stable growth pattern has been established;

(III) Failure to gain weight on two successive measurements, despite dietary interventions; or

(IV) Documented specific, clinical factors that place the child at risk for a compromised nutrition and/or health status.

(ii) Providers must follow the department's expedited prior authorization process to receive payment.

(e) If five years of age through twenty years of age.

(i) The client must:

(A) Have a certified RD evaluation, for eligible clients, with recommendations which support the prescriber's order for oral enteral nutrition products; and

(B) Meet one of the following clinical criteria:

(I) A decrease across two or more percentile lines on the CDC growth chart, once a stable growth pattern has been established;

(II) Failure to gain weight on two successive measurements, despite dietary interventions; or

(III) Documented specific, clinical factors that place the child at risk for a compromised nutrition and/or health status.

(ii) Providers must follow the department's expedited prior authorization process to receive payment.

(2) Requests to the department for prior authorization for orally administered enteral nutrition products must include a completed Oral Enteral Nutrition Worksheet Prior Authorization Request (DSHS 13-743), available for download at: <http://www1.dshs.wa.gov/msa/forms/eforms.html>. The DSHS 13-743 form must be:

(a) Completed by the prescribing physician, advanced registered nurse practitioner (ARNP), or physician assistant-certified (PA-C), verifying all of the following:

(i) The client meets the requirements listed in this section;

(ii) The client's physical limitations and expected outcome;

(iii) The client's current clinical nutritional status, including the relationship between the client's diagnosis and nutritional need;

(iv) For a client eighteen through twenty years of age, the client's recent weight loss history and a comparison of the client's actual weight to ideal body weight and current body mass index (BMI);

(v) For a client younger than eighteen years of age, the client's growth history and a comparison to expected weight gain, and:

(A) An evaluation of the weight-for-length percentile if the client is three years of age or younger; or

(B) An evaluation of the BMI if the client is four through seventeen years of age.

(vi) The client's medical condition and the exact daily caloric amount of needed enteral nutrition product;

(vii) The reason why the client is unable to consume enough traditional food to meet nutritional requirements;

(viii) The medical reason the specific enteral nutrition product, equipment, and/or supply is prescribed;

(ix) Documentation explaining why less costly, equally effective products or traditional foods are not appropriate;

(x) The number of days or months the enteral nutrition products, equipment, and/or necessary supplies are required; and

(xi) The client's likely expected outcome if enteral nutritional support is not provided.

(b) Written, signed (including the prescriber's credentials), and dated by the prescriber on the same day and before delivery of the enteral nutrition product, equipment, or related supply. This form must not be back-dated; and

(c) Be submitted within three months from the date the prescriber signs the prescription.

(3) Clients twenty years of age and younger must be evaluated by a certified RD within thirty days of initiation of enteral nutrition products and periodically (at the discretion of the certified RD) while receiving enteral nutrition prod-

ucts. The certified RD must be a current provider with the department.

[Statutory Authority: 2009 c 564 § 1109, RCW 74.04.050, and 74.08.090. 10-01-138, § 388-554-500, filed 12/21/09, effective 1/21/10. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 06-24-036, § 388-554-500, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.08.090, 74.09.530 and chapter 74.09 RCW. 05-04-059, § 388-554-500, filed 1/28/05, effective 3/1/05.]

WAC 388-554-600 Covered enteral nutrition products, equipment and related supplies—Tube-delivered.

(1) The department covers tube-delivered enteral nutrition products, equipment, and related supplies, without prior authorization, for eligible clients regardless of age, as follows:

- (a) When the client meets the following clinical criteria:
 - (i) The client has a valid prescription;
 - (A) To be valid, a prescription must:
 - (I) Be written by a physician, advanced registered nurse practitioner (ARNP), or physician's assistant certified (PA-C);
 - (II) Be written, signed (including the prescriber's credentials), and dated by the prescriber on the same day and before delivery of the supply, equipment, or device. Prescriptions must not be back-dated;
 - (III) Be submitted within three months from the date the prescriber signs the prescription; and
 - (IV) State the specific product requested, diagnosis, estimated length of need (months), and quantity.
 - (ii) The client is able to manage his or her tube feedings in one of the following ways:
 - (A) Independently; or
 - (B) With a caregiver who can manage the feedings; and
 - (iii) The client has at least one of the following medical conditions:
 - (A) A nonfunction or disease or clinical condition that impairs the client's ability to ingest sufficient calories and nutrients from products orally or does not permit sufficient calories and nutrients from food to reach the gastrointestinal tract; or
 - (B) A disease or condition of the small bowel that impairs digestion and absorption of an oral diet, either of which requires tube feedings to provide sufficient nutrients to maintain weight and strength that is properly proportioned to the client's overall health status.
 - (b) With the following limitations:
 - (i) One purchased pump, per client, in a five-year period; and
 - (ii) One purchased nondisposable intravenous pole required for enteral nutrition product delivery, per client, per lifetime.

(c) Providers must follow the department's expedited prior authorization process to receive payment.

(2) The department pays for up to twelve months of rental payments for tube-delivered enteral nutrition equipment. After twelve months of rental, the department considers the equipment purchased and it becomes the client's property.

(3) The department pays for replacement parts for tube-delivered enteral nutrition equipment, with prior authorization, when:

- (a) Owned by the client;
- (b) Less than five years old; and
- (c) No longer under warranty.

[Statutory Authority: 2009 c 564 § 1109, RCW 74.04.050, and 74.08.090. 10-01-138, § 388-554-600, filed 12/21/09, effective 1/21/10. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 06-24-036, § 388-554-600, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.08.090, 74.09.530 and chapter 74.09 RCW. 05-04-059, § 388-554-600, filed 1/28/05, effective 3/1/05.]

WAC 388-554-700 Enteral nutrition products, equipment and related supplies—Authorization.

(1) The department requires providers to obtain authorization for covered orally administered enteral nutrition products, and tube-delivered enteral equipment and related supplies as required in this chapter and in published department billing instructions and/or numbered memoranda or when the clinical criteria required in this chapter are not met.

(a) For prior authorization (PA), a provider must submit a written request to the department as specified in WAC 388-554-500(2).

(b) For expedited prior authorization (EPA), a provider must establish that the client's condition meets the clinically appropriate EPA criteria outlined in this chapter and in the department's published enteral nutrition billing instructions. The appropriate EPA number must be used when the provider bills the department.

(c) Upon request, a provider must provide documentation to the department showing how the client's condition met the criteria for PA or EPA.

(2) Authorization requirements in this chapter are not a denial of service for the client.

(3) When an oral enteral nutrition product or tube-delivered enteral nutrition equipment or related supply requires authorization, the provider must properly request authorization in accordance with the department's rules, billing instructions, and numbered memoranda.

(4) When authorization is not properly requested, the department rejects and returns the request to the provider for further action. The department does not consider the rejection of the request to be a denial of service.

(5) The department's authorization does not necessarily guarantee payment.

(6) The department evaluates requests for authorization for covered enteral nutrition products, equipment, and related supplies that exceed limitations in this chapter on a case-by-case basis in accordance with WAC 388-501-0169.

(7) The department may recoup any payment made to a provider if the department later determines that the service was not properly authorized or did not meet the EPA criteria. Refer to WAC 388-502-0100 (1)(c).

(8) If a fee-for-service client enrolls in a department-contracted MCO before the department completes the purchase or rental of prescribed enteral nutrition products, necessary equipment and supplies:

(a) The department rescinds the authorization of the purchase or rental;

(b) The department stops paying for any equipment on the last day of the month preceding the month in which the client becomes enrolled in the managed care plan; and

(c) The department-contracted MCO determines the client's continuing need for the equipment and is then responsible for the client.

(9) The department rescinds any authorization for prescribed equipment if the equipment was not delivered to the client before the client:

(a) Loses medical eligibility;

(b) Becomes covered by a hospice agency and the equipment is used in the treatment of the terminal diagnosis or related condition(s);

(c) Becomes eligible for a department-contracted managed care plan; or

(d) Dies.

[Statutory Authority: 2009 c 564 § 1109, RCW 74.04.050, and 74.08.090. 10-01-138, § 388-554-700, filed 12/21/09, effective 1/21/10. Statutory Authority: RCW 74.08.090, 74.09.530 and chapter 74.09 RCW. 05-04-059, § 388-554-700, filed 1/28/05, effective 3/1/05.]

WAC 388-554-800 Noncovered—Enteral nutrition products, equipment, and related supplies. (1) The department does not cover the following:

(a) Nonmedical equipment, supplies, and related services, including but not limited to, back-packs, pouches, bags, baskets, or other carrying containers; and

(b) Orally administered enteral nutrition products for clients twenty-one years of age and older.

(2) An exception to rule (ETR), as described in WAC 388-501-0160, may be requested for a noncovered service.

(3) When EPSDT applies, the department evaluates a noncovered service, equipment, or supply according to the process in WAC 388-501-0165 to determine if it is medically necessary, safe, effective, and not experimental (see WAC 388-534-0100 for EPSDT rules).

[Statutory Authority: 2009 c 564 § 1109, RCW 74.04.050, and 74.08.090. 10-01-138, § 388-554-800, filed 12/21/09, effective 1/21/10. Statutory Authority: RCW 74.08.090, 74.09.530 and chapter 74.09 RCW. 05-04-059, § 388-554-800, filed 1/28/05, effective 3/1/05.]

WAC 388-554-900 Reimbursement—Enteral nutrition products, equipment, and related supplies. (1) The department:

(a) Determines reimbursement for enteral nutrition products, equipment, and related-supplies according to a set fee schedule;

(b) Considers medicare's current fee schedule when determining maximum allowable fees;

(c) Considers vendor rate increases or decreases as directed by the legislature; and

(d) Evaluates and updates the maximum allowable fees for enteral nutrition products, equipment, and related supplies at least once per year.

(2) The department's payment for covered enteral nutrition products, equipment and related supplies includes all of the following:

(a) Any adjustments or modifications to the equipment 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) Instructions to the client and/or caregiver on the safe and proper use of equipment provided;

(c) Full service warranty;

(d) Delivery and pick-up; and

(e) Fitting and adjustments.

(3) If changes in circumstance occur during the rental period, such as death or ineligibility, the department discontinues payment effective on the date of the change in circumstance.

(4) The department does not pay for simultaneous rental and a purchase of any item.

(5) The department does not reimburse providers for equipment that is supplied to them at no cost through suppliers/manufacturers.

(6) The provider who furnishes enteral nutrition equipment to a client is responsible for any costs incurred to have another provider repair equipment if all of the following apply:

(a) Any equipment that the department considers purchased requires repair during the applicable warranty period;

(b) The provider refuses or is unable to fulfill the warranty; and

(c) The client still needs the equipment.

(7) If the rental equipment must be replaced during the warranty period, the department recoups fifty percent of the total amount previously paid toward rental and eventual purchase of the equipment delivered to the client if:

(a) The provider is unwilling or unable to fulfill the warranty; and

(b) The client still needs the equipment.

[Statutory Authority: 2009 c 564 § 1109, RCW 74.04.050, and 74.08.090. 10-01-138, § 388-554-900, filed 12/21/09, effective 1/21/10.]

Chapter 388-561 WAC

TRUSTS, ANNUITIES, AND LIFE ESTATES— EFFECT ON MEDICAL PROGRAMS

WAC

388-561-0200

Annuities established prior to April 1, 2009.

388-561-0201

Annuities established on or after April 1, 2009.

WAC 388-561-0200 Annuities established prior to April 1, 2009. (1) The department determines how annuities affect eligibility for medical programs.

(2) A revocable annuity is considered an available resource.

(3) An irrevocable annuity established prior to May 1, 2001 is not an available resource when issued by an individual, insurer, or other body licensed and approved to do business in the jurisdiction in which the annuity is established.

(4) 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.

(5) An annuity established on or after May 1, 2001 and before April 1, 2009 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.

(6) An irrevocable annuity established on or after May 1, 2001 and before April 1, 2009 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.

(7) 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.

(8) An irrevocable annuity, established on or after May 1, 2001 and before April 1, 2009 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 ineligible in the month of application.

(9) 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, as defined in WAC 388-475-0050 (b) and (c), of the client;

(d) A person designated to use the annuity for the sole benefit of the client, client's spouse, or a blind or disabled child, as defined in WAC 388-475-0050 (b) and (c), of the client.

(10) 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, 74.04.057, 74.08.090, 74.09.500, 74.09.530. 09-06-048, § 388-561-0200, filed 2/25/09, effective 4/1/09; 08-20-117 and 08-21-083, § 388-561-0200, filed 9/30/08 and 10/14/08, effective 4/1/09. Statutory Authority: RCW 74.04.050, 74.08.090, and 74.09.500. 01-06-043, § 388-561-0200, filed 3/5/01, effective 5/1/01.]

WAC 388-561-0201 Annuities established on or after April 1, 2009. (1) The department determines how annuities affect eligibility for medical programs. Applicants and recipients of medicaid must disclose to the state any interest the applicant or spouse has in an annuity.

(2) A revocable annuity is considered an available resource.

(3) The following annuities are not considered an available resource or a transfer of a resource as described in WAC 388-513-1363, if the annuity meets the requirements described in (4)(d), (e) and (f) of this subsection:

(a) An annuity described in subsection (b) or (q) of section 408 of the Internal Revenue Code of 1986;

(b) Purchased with proceeds from an account or trust described in subsection (a), (c), or (p) of section 408 of the Internal Revenue Code of 1986;

(c) Purchased with proceeds from a simplified employee pension (within the meaning of section 408 of the Internal Revenue Code of 1986); or

(d) Purchased with proceeds from a Roth IRA described in section 408A of the Internal Revenue Code of 1986.

(4) The purchase of an annuity not described in subsection (3) established on or after April 1, 2009, will be considered as an available resource unless it:

(a) Is immediate, irrevocable, nonassignable; and

(b) Is paid out in equal monthly amounts with no deferral and no balloon payments:

(i) Over a term equal to the actuarial life expectancy of the annuitant; or

(ii) Over a term that is not less than five years if the actuarial life expectancy of the annuitant is at least five years; or

(iii) Over a term not less than the actuarial life expectancy of the annuitant, if the actuarial life expectancy of the annuitant is less than five years.

(iv) Actuarial life expectancy shall be determined by tables that are published by the office of the chief actuary of the social security administration (<http://www.ssa.gov/OACT/STATS/table4c6.html>).

(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;

(d) Names the state as the remainder beneficiary when the purchaser of the annuity is the annuitant and is an applicant for or recipient of medicaid, or a community spouse of an applicant for or recipient of long-term care or waiver services:

(i) In the first position for the total amount of medical assistance paid for the individual, including both long-term care services and waiver services; or

(ii) In the second position for the total amount of medical assistance paid for the individual, including both long-term care services and waiver services, if there is a community spouse, or a minor or disabled child as defined in WAC 388-475-0050 (b) and (c) who is named as the beneficiary in the first position.

(e) Names the state as the beneficiary upon the death of the community spouse for the total amount of medical assistance paid on behalf of the individual at any time of any payment from the annuity if a community spouse is the annuitant;

(f) Names the state as the beneficiary in the first position for the total amount of medical assistance paid on behalf of the individual at the time of any payment from the annuity, including both long-term care services and waiver services, unless the annuitant has a community spouse or minor or disabled child, as defined in WAC 388-475-0050 (b) and (c). If the annuitant has a community spouse or minor or disabled child, such spouse or child may be named as beneficiary in the first position, and the state shall be named as beneficiary in the second position:

(i) If the community spouse, minor or disabled child, or representative for a child named as beneficiary is in the first position as described in (f) and transfers his or her right to receive payments from the annuity for less than fair market value, then the state shall become the beneficiary in the first position.

(5) If the annuity is not considered a resource, the stream of income produced by the annuity is considered available income.

(6) An irrevocable annuity established on or after April 1, 2009 that meets all of the requirements of subsection (4) except that it is not immediate or scheduled to be paid out in equal monthly amounts will not be treated as a resource if:

(a) The full pay out is within the actuarial life expectancy of the annuitant; and

(b) The annuitant:

(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 beginning with the month of eligibility. The income from the annuity remains unearned income to the annuitant.

(7) An irrevocable annuity, established on or after April 1, 2009 that is scheduled to pay out beyond the actuarial life expectancy of the annuitant, will be considered a resource.

(8) An irrevocable annuity established on or after April 1, 2009 that meets all of the requirements of subsection (4) or (5) is considered unearned income when the annuitant is:

(a) The client;

(b) The spouse of the client;

(c) The blind or disabled child, as defined in WAC 388-475-0050 (b) and (c), 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.

(10) Nothing in this section shall be construed as preventing the department from denying eligibility for medical assistance for an individual based on the income or resources derived from an annuity other than an annuity described in subsections (3), (4), and (5).

[Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 09-06-048, § 388-561-0201, filed 2/25/09, effective 4/1/09; 08-20-117 and 08-21-083, § 388-561-0201, filed 9/30/08 and 10/14/08, effective 4/1/09.]

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 and ability to pay.
388-720-0030	Modifications.
388-720-0040	Hearing.
388-720-0050	Powers of the administrative law judge.

WAC 388-720-0010 Definitions. "Department" means the department of social and health services, state of Washington.

"Dependent" means the juvenile's parent or parents, a registered domestic partner, a stepparent living in the home who has no income, any child, stepchild or adult family member on whom the parent may claim a federal income tax deduction, not including the juvenile confined to the department.

"Federal poverty guidelines" means the poverty guidelines updated periodically in the federal register by the U.S. Department of Health and Human Services (HHS) under the authority of 42 U.S.C. 9902(2).

"Gross income" means the total income, as determined by the department, from all sources, received by the legally obligated person, the legally obligated person's spouse or registered domestic partner, the juvenile, or other children or step-children of the legally obligated person remaining in the household. Child support received for the juvenile will be included as gross income; child support received for other children will not be counted as part of the legally obligated person's gross income.

"Juvenile" means a 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.

"Legally obligated person," "financially obligated person" and "responsible person" mean the parent or parents of the juvenile or other person or persons, including registered domestic partners, legally obligated to care for and support the juvenile, including a stepparent.

[Statutory Authority: RCW 13.40.220, 09-24-093, § 388-720-0010, filed 12/1/09, effective 1/1/10; 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 and ability to pay. (1) A parent or other legally obligated person shall pay a percentage of gross income to reimburse the department for the cost of support, treatment and confinement of the juvenile.

(2) Gross income, adjusted annually according to the published Federal Poverty Guidelines, shall form the basis to determine obligation to pay.

(3) Ability to pay and obligation to reimburse are determined by application of the information provided by a parent or other legally obligated person in the financial information

statement and/or by other information available to the department to the reimbursement schedule below:

Gross Income as Percentage of Dependents in Home
Federal Poverty Guideline

	1	2	3	4	5	6
150 - 174%	12%	12%	10%	10%	8%	8%
175 - 199%	13%	13%	11%	11%	9%	9%
200 - 224%	14%	14%	12%	12%	10%	10%
225 - 249%	15%	15%	13%	13%	11%	11%
250 - 274%	16%	16%	14%	14%	12%	12%
275 - 299%	17%	17%	15%	15%	13%	13%
300 - 399%	18%	18%	16%	16%	14%	14%
400%+	20%	20%	18%	18%	16%	16%

Reimbursement Obligation: Assessed Percentage of Gross Income

(4) Within fifteen days of receipt of the financial information statement, the legally obligated person shall complete, sign and mail the statement to the department.

(5) Based on the statement, if returned, and on other information available to it, the department shall determine the legally obligated person's gross income, the number of parents or registered domestic partners and dependents remaining in the household, and the reimbursement obligation, and shall serve on the legally obligated person a notice and finding of financial responsibility.

(6) If a legally obligated person fails to timely provide a financial statement and insufficient information is available to the department to determine ability to pay, the reimbursement obligation shall be the current monthly average (marginal) institutional cost of care as determined by the department.

(7) Assessed obligation for reimbursement may not exceed the institutional average daily rate (full cost of care) as determined by the department.

(8) 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. The 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.

(9) If the juvenile's parents or other legally obligated persons reside in separate households, each shall be liable for reimbursement.

(10) The gross income of a legally obligated person shall be reduced by the amount the person pays in spousal maintenance to the juvenile's parent, which is gross income to the receiving parent.

(11) The gross income of a legally obligated person 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 legally obligated person did not claim as a dependent under the reimbursement schedule.

(12) The legally obligated person of the juvenile shall be exempt from the payment of the cost of the juvenile's care in the state facility if:

(a) The legally obligated person receives adoption support or is eligible to receive adoption support for the juvenile offender; or

(b) The legally obligated person, or such person's child, spouse, registered domestic partner, or spouse's child or a dependent person in the household was the victim of the offense for which the juvenile was committed to the department.

(13) As provided for in RCW 13.40.220, the office of financial recovery, on behalf of the department, may negotiate with legally obligated persons the payment schedules and methods used to satisfy costs of support, treatment and confinement.

[Statutory Authority: RCW 13.40.220. 09-24-093, § 388-720-0020, filed 12/1/09, effective 1/1/10; 04-05-080, § 388-720-0020, filed 2/17/04, effective 3/19/04; 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 Modifications. (1) A legally obligated person may submit a modified 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 legally obligated person 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 from the date of the change in income.

(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 of information available to it if the conditions of subsection (1) or (2) of this section are met.

[Statutory Authority: RCW 13.40.220. 09-24-093, § 388-720-0030, filed 12/1/09, effective 1/1/10; 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 Hearing. (1) A legally obligated person may request a hearing pursuant to RCW 13.40.220(6) and chapter 34.05 RCW to contest a notice and finding of financial responsibility issued by the department.

(2) The sole issues which may be considered at the hearing are whether the:

(a) Person receiving the notice and finding of financial responsibility is a person financially obligated for the care and support of the juvenile; and

(b) Department, as described under WAC 388-720-0020 correctly:

(i) Determined the legally obligated person's gross income and determined the number of parents in the household, including registered domestic partners, and dependents;

(ii) Determined exemptions; and

(iii) Calculated the reimbursement obligation in accordance with the reimbursement schedule as described under WAC 388-720-0020.

[Statutory Authority: RCW 13.40.220. 09-24-093, § 388-720-0040, filed 12/1/09, effective 1/1/10; 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 after the hearing conducted in accordance with WAC 388-720-0040, in the final order rendered shall:

(1) Include the name and age of the juvenile.

(2) Include the legally obligated person's monthly obligation amount for the period of the juvenile's confinement beginning with the date the child enters the custody of the department.

(3) Not establish any amount constituting a repayment figure of any accrued obligation of the legally obligated person.

(4) State that any accrued obligation shall be paid by the legally obligated person 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.

(5) Include a statement that the responsible person's financial obligation is collectible by OFR and that should the legally obligated person fail to comply with any payment plan entered into by OFR and the legally obligated person, or the legally obligated person 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 legally obligated person. Legal collection action can include, but is not limited to:

(a) The filing of liens against the real and personal property of the responsible person; or

(b) The issuance of a garnishment order against the wages, bank accounts, or other property of the responsible persons.

[Statutory Authority: RCW 13.40.220. 09-24-093, § 388-720-0050, filed 12/1/09, effective 1/1/10. 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 388-826 WAC

VOLUNTARY PLACEMENT PROGRAM

WAC

388-826-0077 Are there limits to the respite care I can receive if I receive voluntary placement services?

WAC 388-826-0077 Are there limits to the respite care I can receive if I receive voluntary placement services? The following limitations apply to the respite care you can receive when approved for voluntary placement services:

(1) The DDD assessment will determine how much respite you can receive per chapter 388-828 WAC.

(2) Prior approval by the DDD regional administrator or designee is required:

(a) To exceed fourteen days in a calendar per month for out-of-home respite; or

(b) To pay for more than eight hours in a twenty-four hour period of time for respite care in any setting other than your place of residence.

(3) Respite providers have the following limitations and requirements:

(a) If respite is provided in a private home, the home must be licensed;

(b) The respite provider cannot be the spouse of the foster parent receiving respite if the spouse and the foster parent reside in the same residence;

(c) If you receive respite from a provider who requires licensure, the respite services are limited to those age-specific services contained in the provider's license.

(4) DDD cannot pay for any fees associated with the respite care; for example, membership fees at a recreational facility, or insurance fees.

(5) If you require respite from a licensed practical nurse (LPN) or a registered nurse (RN), services may be authorized as skilled nursing services per WAC 388-845-1700 using an LPN or RN.

(6) Respite cannot replace daycare while your foster parent is at work.

(7) Respite cannot replace natural supports available to the child while in foster care. Family members will not be paid to provide respite.

(8) If you reside in a licensed staffed residential home or group care facility, you are not eligible to receive respite care.

[Statutory Authority: RCW 71A.12.010, 71A.12.030, and Title 71A RCW. 09-24-063, § 388-826-0077, filed 11/25/09, effective 12/26/09.]

Chapter 388-827 WAC

STATE SUPPLEMENTARY PAYMENT PROGRAM

WAC

388-827-0115 What are the programmatic eligibility requirements for DDD/SSP?

WAC 388-827-0115 What are the programmatic eligibility requirements for DDD/SSP? Following are the programmatic eligibility requirements to receive DDD/SSP:

(1) You received one or more of the following services from DDD with state-only funding between March 1, 2001 and June 30, 2003 and continue to demonstrate a need for and meet the DDD program eligibility requirements for these services. Additionally, you must have been eligible for or

received SSI prior to July 1, 2006; or you received Social Security Title II benefits as a disabled adult child prior to July 1, 2006 and would have been eligible for SSI if you did not receive these benefits.

(a) Certain voluntary placement program services, which include:

- (i) Foster care basic maintenance,
- (ii) Foster care specialized support,
- (iii) Agency specialized support,
- (iv) Staffed residential home,
- (v) Out-of-home respite care,
- (vi) Agency in-home specialized support,
- (vii) Group care basic maintenance,
- (viii) Group care specialized support,
- (ix) Transportation,
- (x) Agency attendant care,
- (xi) Child care,
- (xii) Professional services,
- (xiii) Nursing services,
- (xiv) Interpreter services,

(b) Family support;

(c) One or more of the following residential services:

- (i) Adult family home,
- (ii) Adult residential care facility,
- (iii) Alternative living,
- (iv) Group home,
- (v) Supported living,
- (vi) Agency attendant care,
- (vii) Supported living or other residential service allow-

ance,

(viii) Intensive individual supported living support (companion homes).

(2) For individuals with community protection issues as defined in WAC 388-820-020, the department will determine eligibility for SSP on a case-by-case basis.

(3) For new authorizations of family support opportunity:

(a) You were on the family support opportunity waiting list prior to January 1, 2003; and

(b) You are on the home and community based services (HCBS) waiver administered by DDD; and

(c) You continue to meet the eligibility requirements for the family support opportunity program contained in WAC 388-825-200 through 388-825-242; and

(d) You must have been eligible for or received SSI prior to July 1, 2003; or you received Social Security Title II benefits as a disabled adult child prior to July 1, 2003 and would have been eligible for SSI if you did not receive these benefits.

(4) For individuals on one of the HCBS waivers administered by DDD (Basic, Basic Plus, Core or community protection):

(a) You must have been eligible for or received SSI prior to April 1, 2004; and

(b) You were determined eligible for SSP prior to April 1, 2004.

(5) You received medicaid personal care (MPC) between September 2003 and August 2004; and

(a) You are under age eighteen at the time of your initial comprehensive assessment and reporting evaluation (CARE) assessment;

(b) You received or were eligible to receive SSI at the time of your initial CARE assessment;

(c) You are not on a home and community based services waiver administered by DDD; and

(d) You live with your family, as defined in WAC 388-825-020.

(6) If you meet all of the requirements listed in (5) above, your SSP will continue.

(7) You received one or more of the following state-only funded residential services between July 1, 2003 and June 30, 2006 and continue to demonstrate a need for and meet the DDD program eligibility requirements for these services:

(a) Adult residential care facility;

(b) Alternative living;

(c) Group home;

(d) Supported living;

(e) Agency attendant care;

(f) Supported living or other residential allowance.

(8) You received one or more of the following residential services between July 1, 2003 and June 30, 2009 and demonstrate an ongoing need for a residential allowance request on a periodic, or routine basis of at least once a quarter. You must also receive SSI or would receive SSI if it were not for the receipt of DAC as well as continue to meet the program eligibility requirements for these services:

(a) Alternative living;

(b) Supported living; or

(c) Companion homes.

[Statutory Authority: RCW 71A.12.030, 71A.10.020, 74.04.057, and Title 71A RCW, 20 C.F.R. Part 416. 09-19-107, § 388-827-0115, filed 9/21/09, effective 10/1/09. Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 07-24-030, § 388-827-0115, filed 11/28/07, effective 12/29/07. Statutory Authority: RCW 71A.12.030, 74.04.057 and 20 C.F.R. 416.2099. 06-24-074, § 388-827-0115, filed 12/4/06, effective 1/4/07. Statutory Authority: RCW 71A.12.030, 71A.12.120, and chapter 71A.12 RCW. 05-10-039, § 388-827-0115, filed 4/28/05, effective 5/29/05. Statutory Authority: RCW 71A.12.030 and 71A.12.120. 04-15-094, § 388-827-0115, filed 7/16/04, effective 8/16/04. Statutory Authority: RCW 71A.12.030, 71A.10.020, 2002 c 371. 04-02-015, § 388-827-0115, filed 12/29/03, effective 1/29/04.]

Chapter 388-828 WAC

THE DIVISION OF DEVELOPMENTAL DISABILITIES (DDD) ASSESSMENT

WAC

388-828-5020	How is information in the protective supervision acuity scale used by DDD?
388-828-5520	How is information in the DDD behavioral acuity scale used by DDD?
388-828-5985	How does DDD determine your unadjusted respite assessment level if DDD has authorized you to receive voluntary placement services per chapter 388-826 WAC?
388-828-5990	How does DDD determine your unadjusted respite assessment level if DDD has authorized you to receive companion home services per chapter 388-829C WAC?
388-828-6005	How does DDD determine your voluntary placement services support score per chapter 388-826 WAC?
388-828-6006	How does DDD determine the number to use in the adjustment of your voluntary placement services score?
388-828-6007	How does DDD determine the number of respite hours you may receive annually if you are receiving voluntary placement services?
388-828-6010	How does DDD determine your companion home services support score per chapter 388-829C WAC?

388-828-6011	How does DDD determine the number to use in the adjustment of your companion home services support score?
388-828-6012	How does DDD determine the number of respite hours you may receive annually if you are receiving companion home services?
388-828-8020	What components contained in the individual support plan module determine a service level and/or number of hours?
388-828-9040	How does DDD determine your individual and family services level?
388-828-9060	How does DDD determine your individual and family services rating?
388-828-9520	Where does the residential algorithm obtain your support needs information?
388-828-9530	How does the residential algorithm identify your residential support needs score?
388-828-9540	What residential service levels of support does DDD use?
388-828-9700	How does the residential algorithm use your assessed support needs scores to determine your residential service level of support?

WAC 388-828-5020 How is information in the protective supervision acuity scale used by DDD? (1) Information obtained in the protective supervision acuity scale is one of the factors used by DDD to determine:

(a) The amount of waiver respite, if any, that you are authorized to receive;

(b) Your individual and family services level, if you are authorized to receive individual and family services per chapter 388-832 WAC; and

(c) Your residential service level of support, if you are authorized to receive a residential service listed in WAC 388-828-9510.

(2) The protective supervision acuity scale is not used when determining your medicaid personal care or waiver personal care; and

(3) The information is used for reporting purposes to the legislature and the department.

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 09-06-047, § 388-828-5020, filed 2/25/09, effective 3/28/09; 08-12-037, § 388-828-5020, filed 5/30/08, effective 7/1/08; 07-10-029, § 388-828-5020, filed 4/23/07, effective 6/1/07.]

WAC 388-828-5520 How is information in the DDD behavioral acuity scale used by DDD? (1) Information obtained in the DDD behavioral acuity scale is one of the factors used by DDD to determine:

(a) The amount of waiver respite, if any, that you are authorized to receive;

(b) Your individual and family services level, if you are authorized to receive individual and family services per chapter 388-832 WAC; and

(c) Your residential service level of support, if you are authorized to receive a residential service listed in WAC 388-828-9510.

(2) The DDD behavioral acuity scale does not affect service determination for the medicaid personal care or waiver personal care assessment.

(3) The information is used for reporting purposes to the legislature and the department.

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 09-06-047, § 388-828-5520, filed 2/25/09, effective 3/28/09; 08-12-037, § 388-828-5520, filed 5/30/08, effective 7/1/08; 07-10-029, § 388-828-5520, filed 4/23/07, effective 6/1/07.]

WAC 388-828-5985 How does DDD determine your unadjusted respite assessment level if DDD has authorized you to receive voluntary placement services per chapter 388-826 WAC? DDD determines your unadjusted respite assessment level for voluntary placement services using the following table:

If your Protective Supervision Support Level is:	And your behavioral acuity level is:	Then your unadjusted respite assessment level is:
0	None	1
0	Low	1
0	Medium	2
0	High	2
1	None	1
1	Low	1
1	Medium	2
1	High	3
2 or 3	None	2
2 or 3	Low	2
2 or 3	Medium	2
2 or 3	High	4
4	None	2
4	Low	2
4	Medium	3
4	High	4
5	None	3
5	Low	3
5	Medium	4
5	High	5
6	None	3
6	Low	3
6	Medium	4
6	High	5

[Statutory Authority: RCW 71A.12.010, 71A.12.030, and Title 71A RCW. 09-24-063, § 388-828-5985, filed 11/25/09, effective 12/26/09.]

WAC 388-828-5990 How does DDD determine your unadjusted respite assessment level if DDD has authorized you to receive companion home services per chapter 388-829C WAC? DDD determines your unadjusted respite assessment level for companion home services using the following table:

If your Protective Supervision Support Level is:	And your behavioral acuity level is:	Then your unadjusted respite assessment level is:
0	None	1
0	Low	1
0	Medium	2
0	High	2
1	None	1
1	Low	1
1	Medium	2
1	High	3
2 or 3	None	2
2 or 3	Low	2
2 or 3	Medium	2
2 or 3	High	4
4	None	2
4	Low	2

If your Protective Supervision Support Level is:	And your behavioral acuity level is:	Then your unadjusted respite assessment level is:
4	Medium	3
4	High	4
5	None	3
5	Low	3
5	Medium	4
5	High	5
6	None	3
6	Low	3
6	Medium	4
6	High	5

[Statutory Authority: RCW 71A.12.010, 71A.12.030, and Title 71A RCW. 09-20-004, § 388-828-5990, filed 9/24/09, effective 10/25/09.]

WAC 388-828-6005 How does DDD determine your voluntary placement services support score per chapter 388-826 WAC?

If you are authorized to receive voluntary placement services per chapter 388-826 WAC and		Your ADL support needs level for the SIS per WAC 388-828-5480			
		None	Low	Medium	High
Your medical acuity level per WAC 388-828-5700	None	288	288	321	337
	Low	288	288	321	337
	Medium	288	343	402	443
	High	288	443	619	693

Example: If your ADL support needs level is "medium" and your medical acuity level is "low," the amount of your adjustment is 321.

[Statutory Authority: RCW 71A.12.010, 71A.12.030, and Title 71A RCW. 09-24-063, § 388-828-6006, filed 11/25/09, effective 12/26/09.]

WAC 388-828-6007 How does DDD determine the number of respite hours you may receive annually if you are receiving voluntary placement services? DDD determines the number of respite hours you may receive annually by adding your voluntary services support score in WAC 388-828-6005 to your adjusted voluntary services support rating score in WAC 388-828-6006.

Example: If your voluntary placement services support score is 240 and your adjusted voluntary placement services score is 321, the number of respite hours you may receive annually is 561.

[Statutory Authority: RCW 71A.12.010, 71A.12.030, and Title 71A RCW. 09-24-063, § 388-828-6007, filed 11/25/09, effective 12/26/09.]

WAC 388-828-6010 How does DDD determine your companion home services support score per chapter 388-829C WAC?

If you are authorized to receive companion home services per chapter 388-829C and		Your ADL support needs level for the SIS per WAC 388-828-5480			
		None	Low	Medium	High
Your medical acuity level per WAC 388-828-5700	None	288	288	321	337
	Low	288	288	321	337
	Medium	288	343	402	443
	High	288	443	619	693

Example: If your ADL support needs level is "medium" and your medical acuity level is "medium," the amount of your adjustment is 402.

[Statutory Authority: RCW 71A.12.010, 71A.12.030, and Title 71A RCW. 09-20-004, § 388-828-6011, filed 9/24/09, effective 10/25/09.]

If your unadjusted respite assessment level for voluntary placement services in WAC 388-828-5985 is:	Then your voluntary placement services support score is:
1	240
2	240
3	409
4	578
5	747

[Statutory Authority: RCW 71A.12.010, 71A.12.030, and Title 71A RCW. 09-24-063, § 388-828-6005, filed 11/25/09, effective 12/26/09.]

WAC 388-828-6006 How does DDD determine the number to use in the adjustment of your voluntary placement services score? DDD determines the amount of the adjustment for your voluntary placement services support score using the following tables:

If your unadjusted respite assessment level for companion home services in WAC 388-828-5990 is:	Then your companion home services support score is:
1	98
2	98
3	267
4	436
5	605

[Statutory Authority: RCW 71A.12.010, 71A.12.030, and Title 71A RCW. 09-20-004, § 388-828-6010, filed 9/24/09, effective 10/25/09.]

WAC 388-828-6011 How does DDD determine the number to use in the adjustment of your companion home services support score? DDD determines the amount of the adjustment for your companion home services support score using the following table:

WAC 388-828-6012 How does DDD determine the number of respite hours you may receive annually if you are receiving companion home services? DDD determines the number of respite hours you may receive annually by adding your companion home services support score in WAC 388-828-6010 to your adjusted companion home services support score in WAC 388-828-6011.

Example: If your companion home services support score is 267 and adjusted companion home services support rating is 343, the number of respite hours you may receive annually is 610.

[Statutory Authority: RCW 71A.12.010, 71A.12.030, and Title 71A RCW. 09-20-004, § 388-828-6012, filed 9/24/09, effective 10/25/09.]

WAC 388-828-8020 What components contained in the individual support plan module determine a service level and/or number of hours? The following components

of the individual support plan module determine a service level and/or number of hours:

(1) The foster care rate assessment, as defined in chapter 388-826 WAC;

(2) The individual and family services algorithm, as defined in WAC 388-828-9000 through 388-828-9140; and

(3) The residential algorithm, as defined in WAC 388-828-9500 through 388-828-9700.

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 09-06-047, § 388-828-8020, filed 2/25/09, effective 3/28/09; 08-12-037, § 388-828-8020, filed 5/30/08, effective 7/1/08; 07-10-029, § 388-828-8020, filed 4/23/07, effective 6/1/07.]

WAC 388-828-9040 How does DDD determine your individual and family services level? (1) DDD determines your individual and family services level using the following table:

If your protective supervision support level is:	And your primary caregiver risk level is:	And your backup caregiver risk score is:	And your behavioral acuity level is:	Then your unadjusted individual and family services level is:
0	None	1	None	1
0	None	1	Low	1
0	None	1	Medium	1
0	None	1	High	2
0	None	2 or 3	None	1
0	None	2 or 3	Low	1
0	None	2 or 3	Medium	2
0	None	2 or 3	High	2
0	Low	1	None	1
0	Low	1	Low	1
0	Low	1	Medium	1
0	Low	1	High	2
0	Low	2 or 3	None	1
0	Low	2 or 3	Low	1
0	Low	2 or 3	Medium	2
0	Low	2 or 3	High	2
0	Medium	1	None	1
0	Medium	1	Low	1
0	Medium	1	Medium	1
0	Medium	1	High	2
0	Medium	2 or 3	None	1
0	Medium	2 or 3	Low	1
0	Medium	2 or 3	Medium	2
0	Medium	2 or 3	High	2
0	High	1	None	1
0	High	1	Low	1
0	High	1	Medium	2
0	High	1	High	2
0	High	2 or 3	None	2
0	High	2 or 3	Low	2
0	High	2 or 3	Medium	2
0	High	2 or 3	High	3
0	Immediate	1	None	1
0	Immediate	1	Low	1
0	Immediate	1	Medium	2
0	Immediate	1	High	2
0	Immediate	2 or 3	None	2
0	Immediate	2 or 3	Low	2
0	Immediate	2 or 3	Medium	2
0	Immediate	2 or 3	High	3

If your protective supervision support level is:	And your primary caregiver risk level is:	And your backup caregiver risk score is:	And your behavioral acuity level is:	Then your unadjusted individual and family services level is:
1	None	1	None	1
1	None	1	Low	1
1	None	1	Medium	1
1	None	1	High	2
1	None	2 or 3	None	1
1	None	2 or 3	Low	1
1	None	2 or 3	Medium	2
1	None	2 or 3	High	3
1	Low	1	None	1
1	Low	1	Low	1
1	Low	1	Medium	1
1	Low	1	High	2
1	Low	2 or 3	None	1
1	Low	2 or 3	Low	1
1	Low	2 or 3	Medium	2
1	Low	2 or 3	High	3
1	Medium	1	None	1
1	Medium	1	Low	1
1	Medium	1	Medium	2
1	Medium	1	High	3
1	Medium	2 or 3	None	1
1	Medium	2 or 3	Low	2
1	Medium	2 or 3	Medium	2
1	Medium	2 or 3	High	3
1	High	1	None	2
1	High	1	Low	2
1	High	1	Medium	2
1	High	1	High	3
1	High	2 or 3	None	2
1	High	2 or 3	Low	2
1	High	2 or 3	Medium	3
1	High	2 or 3	High	4
1	Immediate	1	None	2
1	Immediate	1	Low	2
1	Immediate	1	Medium	2
1	Immediate	1	High	3
1	Immediate	2 or 3	None	2
1	Immediate	2 or 3	Low	2
1	Immediate	2 or 3	Medium	3
1	Immediate	2 or 3	High	4
2 or 3	None	1	None	1
2 or 3	None	1	Low	1
2 or 3	None	1	Medium	2
2 or 3	None	1	High	3
2 or 3	None	2 or 3	None	2
2 or 3	None	2 or 3	Low	2
2 or 3	None	2 or 3	Medium	2
2 or 3	None	2 or 3	High	4
2 or 3	Low	1	None	1
2 or 3	Low	1	Low	1
2 or 3	Low	1	Medium	2
2 or 3	Low	1	High	3
2 or 3	Low	2 or 3	None	2
2 or 3	Low	2 or 3	Low	2
2 or 3	Low	2 or 3	Medium	2
2 or 3	Low	2 or 3	High	4
2 or 3	Medium	1	None	2
2 or 3	Medium	1	Low	2

If your protective supervision support level is:	And your primary caregiver risk level is:	And your backup caregiver risk score is:	And your behavioral acuity level is:	Then your unadjusted individual and family services level is:
2 or 3	Medium	1	Medium	2
2 or 3	Medium	1	High	3
2 or 3	Medium	2 or 3	None	2
2 or 3	Medium	2 or 3	Low	2
2 or 3	Medium	2 or 3	Medium	3
2 or 3	Medium	2 or 3	High	4
2 or 3	High	1	None	2
2 or 3	High	1	Low	2
2 or 3	High	1	Medium	2
2 or 3	High	1	High	3
2 or 3	High	2 or 3	None	2
2 or 3	High	2 or 3	Low	2
2 or 3	High	2 or 3	Medium	3
2 or 3	High	2 or 3	High	4
2 or 3	Immediate	1	None	2
2 or 3	Immediate	1	Low	2
2 or 3	Immediate	1	Medium	2
2 or 3	Immediate	1	High	3
2 or 3	Immediate	2 or 3	None	2
2 or 3	Immediate	2 or 3	Low	2
2 or 3	Immediate	2 or 3	Medium	3
2 or 3	Immediate	2 or 3	High	4
4	None	1	None	2
4	None	1	Low	2
4	None	1	Medium	2
4	None	1	High	3
4	None	2 or 3	None	2
4	None	2 or 3	Low	2
4	None	2 or 3	Medium	3
4	None	2 or 3	High	4
4	Low	1	None	2
4	Low	1	Low	2
4	Low	1	Medium	2
4	Low	1	High	3
4	Low	2 or 3	None	2
4	Low	2 or 3	Low	2
4	Low	2 or 3	Medium	3
4	Low	2 or 3	High	4
4	Medium	1	None	2
4	Medium	1	Low	2
4	Medium	1	Medium	3
4	Medium	1	High	3
4	Medium	2 or 3	None	2
4	Medium	2 or 3	Low	3
4	Medium	2 or 3	Medium	3
4	Medium	2 or 3	High	4
4	High	1	None	2
4	High	1	Low	2
4	High	1	Medium	3
4	High	1	High	3
4	High	2 or 3	None	2
4	High	2 or 3	Low	3
4	High	2 or 3	Medium	4
4	High	2 or 3	High	4
4	Immediate	1	None	2
4	Immediate	1	Low	2
4	Immediate	1	Medium	3
4	Immediate	1	High	3

If your protective supervision support level is:	And your primary caregiver risk level is:	And your backup caregiver risk score is:	And your behavioral acuity level is:	Then your unadjusted individual and family services level is:
4	Immediate	2 or 3	None	2
4	Immediate	2 or 3	Low	3
4	Immediate	2 or 3	Medium	4
4	Immediate	2 or 3	High	4
5	None	1	None	2
5	None	1	Low	2
5	None	1	Medium	3
5	None	1	High	4
5	None	2 or 3	None	3
5	None	2 or 3	Low	3
5	None	2 or 3	Medium	4
5	None	2 or 3	High	5
5	Low	1	None	2
5	Low	1	Low	2
5	Low	1	Medium	3
5	Low	1	High	4
5	Low	2 or 3	None	3
5	Low	2 or 3	Low	3
5	Low	2 or 3	Medium	4
5	Low	2 or 3	High	5
5	Medium	1	None	2
5	Medium	1	Low	2
5	Medium	1	Medium	3
5	Medium	1	High	4
5	Medium	2 or 3	None	3
5	Medium	2 or 3	Low	3
5	Medium	2 or 3	Medium	4
5	Medium	2 or 3	High	5
5	High	1	None	2
5	High	1	Low	2
5	High	1	Medium	3
5	High	1	High	4
5	High	2 or 3	None	3
5	High	2 or 3	Low	3
5	High	2 or 3	Medium	4
5	High	2 or 3	High	5
5	Immediate	1	None	2
5	Immediate	1	Low	2
5	Immediate	1	Medium	3
5	Immediate	1	High	4
5	Immediate	2 or 3	None	3
5	Immediate	2 or 3	Low	3
5	Immediate	2 or 3	Medium	4
5	Immediate	2 or 3	High	5
6	None	1	None	2
6	None	1	Low	3
6	None	1	Medium	3
6	None	1	High	4
6	None	2 or 3	None	3
6	None	2 or 3	Low	3
6	None	2 or 3	Medium	4
6	None	2 or 3	High	5
6	Low	1	None	2
6	Low	1	Low	3
6	Low	1	Medium	3
6	Low	1	High	4
6	Low	2 or 3	None	3
6	Low	2 or 3	Low	3

If your protective supervision support level is:	And your primary caregiver risk level is:	And your backup caregiver risk score is:	And your behavioral acuity level is:	Then your unadjusted individual and family services level is:
6	Low	2 or 3	Medium	4
6	Low	2 or 3	High	5
6	Medium	1	None	3
6	Medium	1	Low	3
6	Medium	1	Medium	3
6	Medium	1	High	4
6	Medium	2 or 3	None	3
6	Medium	2 or 3	Low	4
6	Medium	2 or 3	Medium	4
6	Medium	2 or 3	High	5
6	High	1	None	3
6	High	1	Low	3
6	High	1	Medium	4
6	High	1	High	4
6	High	2 or 3	None	4
6	High	2 or 3	Low	4
6	High	2 or 3	Medium	5
6	High	2 or 3	High	5
6	Immediate	1	None	3
6	Immediate	1	Low	3
6	Immediate	1	Medium	4
6	Immediate	1	High	4
6	Immediate	2 or 3	None	4
6	Immediate	2 or 3	Low	4
6	Immediate	2 or 3	Medium	5
6	Immediate	2 or 3	High	5

(2) DDD adds one level to your individual and family services level when your individual and family services level is determined to be:

(a) Level one, two, three, or four; and

(b) You have a score of four for question two "Other caregiving for persons who are disabled, seriously ill, or under five" in the DDD caregiver status acuity scale. See WAC 388-828-5260.

[Statutory Authority: RCW 71A.12.010, 71A.12.030, and Title 71A RCW. 09-21-033, § 388-828-9040, filed 10/13/09, effective 11/13/09. Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-828-9040, filed 8/5/08, effective 9/5/08.]

WAC 388-828-9060 How does DDD determine your individual and family services rating? (1) Your individual and family services rating is determined by using the following table:

If your unadjusted individual and family services level is:	Then your individual and family services support rating is:
1	0
2	240
3	336
4	432
5	528

[Statutory Authority: RCW 71A.12.010, 71A.12.030, and Title 71A RCW. 09-21-033, § 388-828-9060, filed 10/13/09, effective 11/13/09. Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-828-9060, filed 8/5/08, effective 9/5/08.]

WAC 388-828-9520 Where does the residential algorithm obtain your support needs information? The residential algorithm obtains your support needs information from the following components of your current DDD assessment:

(1) The supports intensity scale assessment (SIS) per WAC 388-828-4000 through 388-828-4320;

(2) The DDD protective supervision acuity scale per WAC 388-828-5000 through 388-828-5100;

(3) The DDD behavioral acuity scale per WAC 388-828-5500 through 388-828-5640;

(4) The DDD medical acuity scale per WAC 388-828-5660 through 388-828-5700;

(5) The program and services panel per WAC 388-828-6020;

(6) The DDD seizure acuity scale per WAC 388-828-7040 through 388-828-7080; and

(7) The DDD sleep panel per WAC 388-828-9640.

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 09-06-047, § 388-828-9520, filed 2/25/09, effective 3/28/09. 08-15-091, recodified as § 388-828-9520, filed 7/17/08, effective 7/17/08; 08-12-037, § 388-828-10040, filed 5/30/08, effective 7/1/08.]

WAC 388-828-9530 How does the residential algorithm identify your residential support needs score? The residential algorithm uses the support needs information from your current DDD assessment to identify the following residential support needs scores:

(1) Community protection program enrollment as defined in WAC 388-828-9590;

(2) Daily support needs score as defined in WAC 388-828-9560;

(3) Mid-frequency support needs score as defined in WAC 388-828-9580;

(4) Behavior support needs score as defined in WAC 388-828-9590;

(5) Medical support needs score as defined in WAC 388-828-9600;

(6) Seizure support needs score as defined in WAC 388-828-9610;

(7) Protective supervision support needs score as defined in WAC 388-828-9620;

(8) Ability to seek help score as defined in WAC 388-828-9630;

(9) Nighttime support needs score as defined in WAC 388-828-9640;

(10) Toileting support needs score as defined in WAC 388-828-9650; and

(11) Total critical support time as defined in WAC 388-828-9660 through 388-828-9690.

[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 09-06-047, § 388-828-9530, filed 2/25/09, effective 3/28/09. 08-15-091, recodified as § 388-828-9530, filed 7/17/08, effective 7/17/08; 08-12-037, § 388-828-10060, filed 5/30/08, effective 7/1/08.]

WAC 388-828-9540 What residential service levels of support does DDD use? DDD uses the following residential service levels of support which correspond with your assessed support needs (see WAC 388-828-9530):

Support Need Level	Typical Support Need Characteristics from the DDD Assessment	Expected Level of Support*
Weekly or less Support Level 1	Client requires supervision, training, or physical assistance in areas that typically occur weekly or less often, such as shopping, paying bills, or medical appointments. Client is generally independent in support areas that typically occur daily or every couple of days.	Clients assessed to need this level receive support on a weekly basis or less frequently.
Multiple times per week Support Level 2	Client is able to maintain health and safety for a full day or more at a time AND needs supervision, training, or physical assistance with tasks that typically occur every few days, such as light housekeeping, menu planning, or guidance and support with relationships. Client is generally independent in support areas that must occur daily.	Clients assessed to need this level receive support multiple times per week.
Intermittent daily -Low Support Level 3A	Client is able to maintain health and safety for short periods of time (i.e., hours, but not days) OR needs supervision, training, or physical assistance with activities that typically occur daily, such as bathing, dressing, or taking medications.	Clients assessed to need this level receive daily support.
Intermittent daily - Moderate Support Level 3B	Client requires supervision, training, or physical assistance with multiple tasks that typically occur daily OR requires frequent checks for health and safety or due to disruptions in routines.	Clients assessed to need this level receive daily support and may receive checks during nighttime hours as needed.
Close proximity Support Level 4	Client requires support with a large number of activities that typically occur daily OR is able to maintain health and safety for very short periods of time (i.e., less than 2 hours, if at all) AND requires occasional health and safety checks or support during overnight hours.	Clients assessed to need this level receive supports in close proximity 24 hours per day. Support hours may be shared with neighboring households.
Continuous day and continuous night Support Level 5	Client is generally unable to maintain health and safety OR requires support with a large number of activities that occur daily or almost every day AND requires nighttime staff typically within the household.	Clients assessed to need this level receive support 24 hours per day.
Community Protection Support Level 6	Client is enrolled in the community protection program.	Clients assessed to need this level of support will receive 24 hour per day supervision per community protection program policy.
*Emergency access to residential staff is available to all clients, 24-hours per day, regardless of the residential service level of support the assessment indicates.		

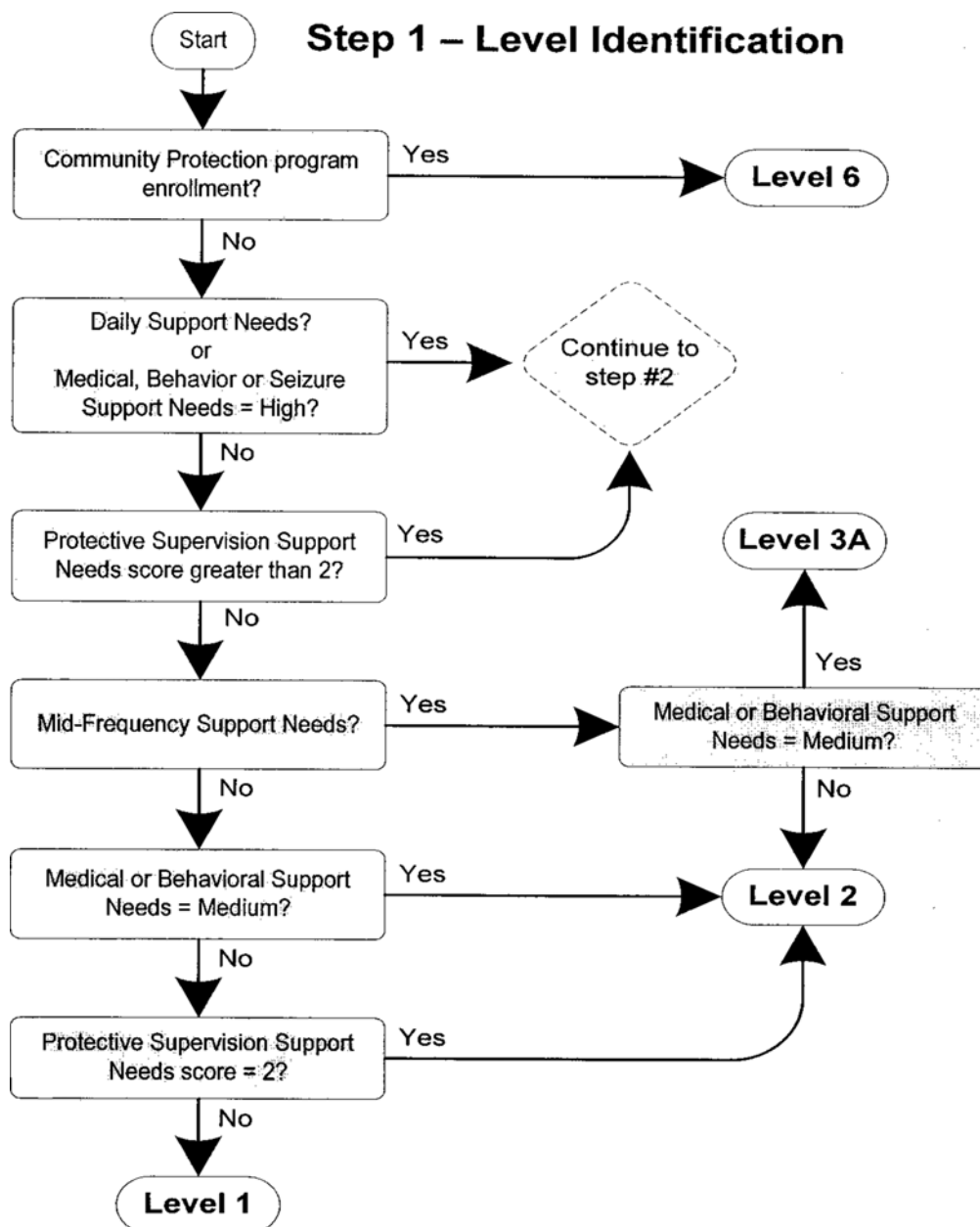
[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 09-06-047, § 388-828-9540, filed 2/25/09, effective 3/28/09. 08-15-091, recodified as § 388-828-9540, filed 7/17/08, effective 7/17/08; 08-12-037, § 388-828-10080, filed 5/30/08, effective 7/1/08.]

WAC 388-828-9700 How does the residential algorithm use your assessed support needs scores to determine your residential service level of support? (1) The residential algorithm uses your assessed support needs scores (as defined in WAC 388-828-9550 through 388-828-9690) to answer questions in a decision tree.

(2) The decision tree path determines your residential service level of support (WAC 388-828-9540).

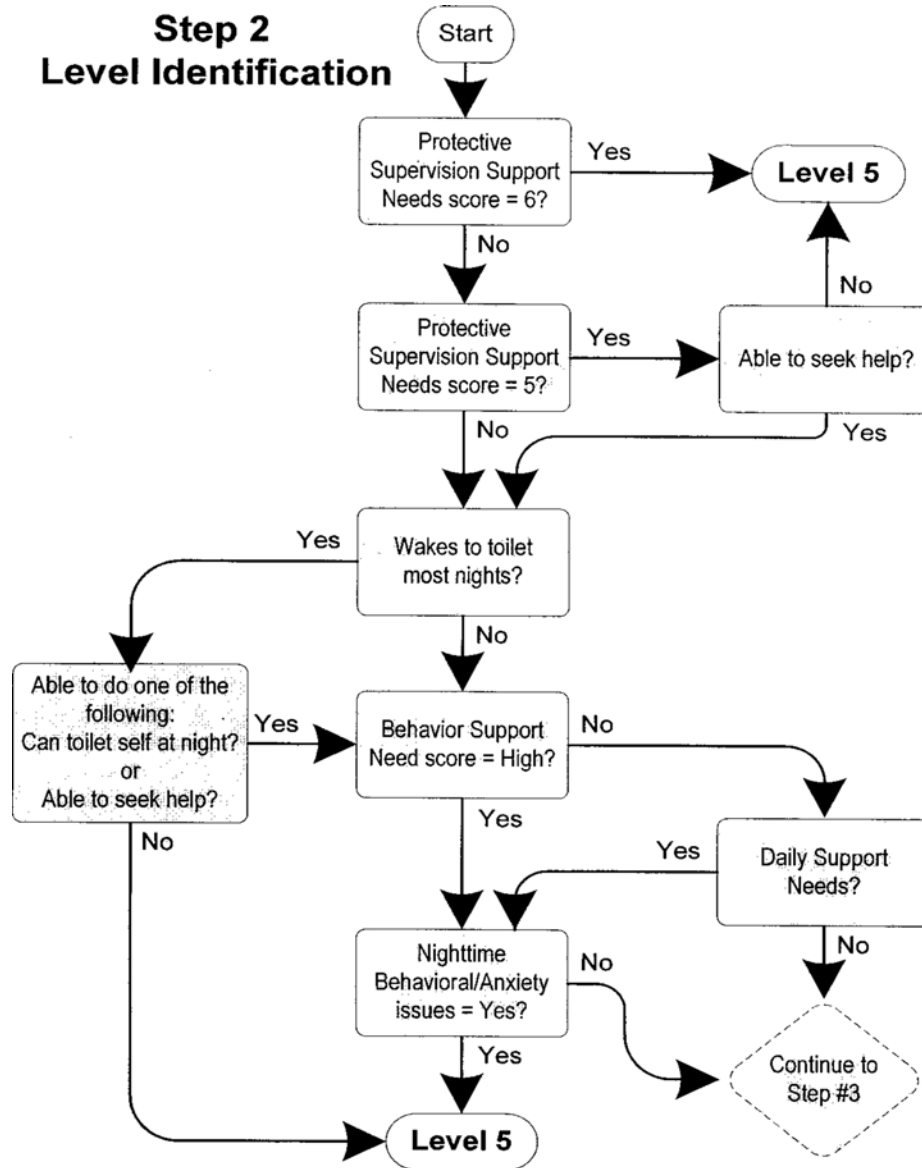
(3) The decision tree is separated into the following three steps:

(a) Step 1 determines whether your residential support needs scores meet the criteria for less than daily support or the criteria for community protection.

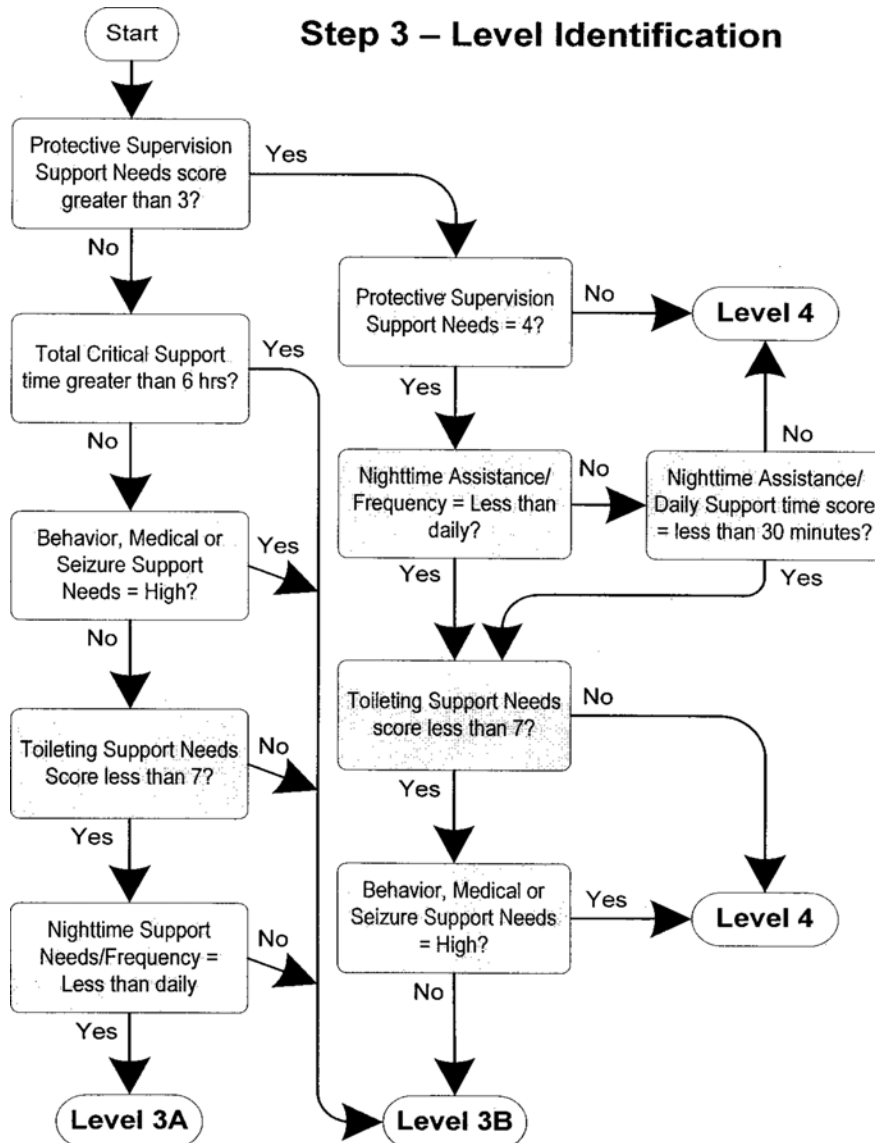


(b) Step 2 determines whether your residential support needs scores meet the criteria for continuous day and night support.

Step 2 Level Identification



(c) Step 3 determines whether your residential support needs scores meet the criteria for intermittent support.



[Statutory Authority: RCW 71A.12.030 and Title 71A RCW. 09-06-047, § 388-828-9700, filed 2/25/09, effective 3/28/09. 08-15-091, recodified as § 388-828-9700, filed 7/17/08, effective 7/17/08; 08-12-037, § 388-828-10380, filed 5/30/08, effective 7/1/08.]

Chapter 388-829C WAC COMPANION HOMES

WAC

388-829C-230 Are companion home clients eligible to receive respite?

WAC 388-829C-230 Are companion home clients eligible to receive respite? Companion home clients are eligible to receive respite care to provide intermittent relief to the companion home provider. The DDD assessment will determine how much respite you can receive per chapter 388-828 WAC.

[Statutory Authority: RCW 71A.12.010, 71A.12.030, and Title 71A RCW. 09-20-004, § 388-829C-230, filed 9/24/09, effective 10/25/09. Statutory Authority: RCW 71A.12.30 [71A.12.030] and Title 71A RCW. 07-16-102, § 388-829C-230, filed 7/31/07, effective 9/1/07.]

Chapter 388-832 WAC INDIVIDUAL AND FAMILY SERVICES PROGRAM

WAC

388-832-0001 What definitions apply to this chapter?
 388-832-0005 What is the individual and family services program?
 388-832-0007 What is the purpose of the individual and family services (IFS) program?
 388-832-0015 Am I eligible for the IFS program?
 388-832-0020 Will I be authorized to receive IFS services if I meet the eligibility criteria in WAC 388-832-0015?
 388-832-0022 What determines the allocation of funds available to me to purchase IFS services?
 388-832-0023 If I qualify for another DDD service, will my IFS program be reduced or terminated?
 388-832-0024 If I participate in the IFS program, will I be eligible for services through the DDD home and community based services (HCBS) waiver?
 388-832-0025 Am I eligible for the IFS program if I currently receive other DDD paid services?
 388-832-0060 May DDD terminate my eligibility for the IFS program?
 388-832-0065 If I go into a temporary out of home placement, will I be eligible for IFS upon my return home?

388-832-0067	Are my children eligible for IFS program services, if I am a client of DDD?
388-832-0070	What is the IFS program request list?
388-832-0072	Who is eligible to be on the IFS program request list?
388-832-0075	Do I have to have a DDD assessment before I can be added to the IFS request list?
388-832-0080	How or when am I taken off the IFS request list?
388-832-0082	If the DDD assessment determines I am not eligible for the IFS program, may I remain on the IFS request list?
388-832-0085	When there is state funding available to enroll additional clients in the IFS program, how will DDD select from the clients on the IFS program request list?
388-832-0087	What happens next if I am selected from the IFS program request list?
388-832-0090	If I currently receive funding from the traditional family support program, the family support opportunity program or the family support pilot program, will I qualify for the IFS program?
388-832-0091	If I currently receive funding from the traditional family support program, the family support opportunity program or the family support pilot program, will that funding continue until my next assessment?
388-832-0113	Will my IFS allocation be impacted by my income?
388-832-0120	Will my IFS allocation be impacted if I am eligible for medicaid personal care services?
388-832-0123	Will my IFS allocation be impacted if I am eligible for private duty nursing or the medically intensive children's program?
388-832-0125	Will my IFS allocation be impacted if I am eligible for the community options programs entry system (COPEs)?
388-832-0127	What if I have assessed needs that cannot be met by the IFS program?
388-832-0128	When is the individual support plan effective?
388-832-0135	How may my family use its IFS program allocation?
388-832-0136	If I have a family support reimbursement contract, may DDD ask me to verify my purchases through reviewing receipts?
388-832-0137	May I use my allocation over a two-year period for large costly expenditures?
388-832-0160	Are there limits to the respite care I receive?
388-832-0165	What are considered excess medical costs not covered by another source?
388-832-0166	How are excess medical costs paid?
388-832-0168	Are there limits to excess medical costs?
388-832-0170	What therapies may I receive?
388-832-0175	Who is a qualified therapist?
388-832-0180	Are there limits to the therapy I may receive?
388-832-0185	What are architectural and vehicular modifications?
388-832-0195	What limits apply to architectural and vehicular modifications?
388-832-0200	What are equipment and supplies?
388-832-0205	Who are qualified providers of equipment and supplies?
388-832-0210	Are there limitations to my receipt of equipment and supplies?
388-832-0215	What are specialized nutrition and specialized clothing?
388-832-0220	How do I pay for specialized nutrition and specialized clothing?
388-832-0225	Are there limits for specialized nutrition and specialized clothing?
388-832-0235	What are copays for medical and therapeutic services?
388-832-0240	How do I pay for medical and therapeutic copays?
388-832-0245	Are there limits to medical and therapeutic copays?
388-832-0255	Who is a qualified provider for transportation services?
388-832-0260	Are there limitations to the transportation services I can receive?
388-832-0275	Are there limitations to the training and counseling?
388-832-0285	Who is a qualified provider of behavior management?
388-832-0290	Are there limits to behavior management?
388-832-0308	How is parent/sibling education paid?
388-832-0310	Are there limitations to parent/sibling education?
388-832-0315	What are recreational opportunities?
388-832-0320	How are recreational opportunities paid for?
388-832-0325	Are there limitations to recreation opportunities?
388-832-0330	Do I have a choice of IFS program services?
388-832-0332	May I choose my provider?
388-832-0333	What restrictions apply to the IFS program services?
388-832-0335	What is a one-time award?
388-832-0340	Who is eligible for a one-time award?
388-832-0345	Are there limitations to one-time awards?
388-832-0350	How do I request a one-time award?
388-832-0353	Do I need to have a DDD assessment before I receive a one-time award?

388-832-0366	What limitations apply to emergency services?
388-832-0367	What if the client or family situation requires more than ninety days of emergency service?
388-832-0369	Do I need to have a DDD assessment before I receive an emergency service?
388-832-0460	How will DDD notify me of their decisions?

WAC 388-832-0001 What definitions apply to this chapter? The following definitions apply to this chapter:

"Agency provider" means a licensed and/or ADSA certified business that is contracted with ADSA or a county to provide DDD services (e.g., personal care, respite care, residential services, therapy, nursing, employment, etc.).

"Allocation" means an amount of funding available to the client and family for a maximum of twelve months, based upon assessed need.

"Authorization" means DDD approval of funding for a service as identified in the individual support plan or evidence of payment of a service.

"Back-up caregiver" is a person who has been identified as an informal caregiver and is available to provide assistance as an informal caregiver when other caregivers are unavailable.

"Client" means a person who has a developmental disability as defined in RCW 71A.10.020(3) who also has been determined eligible to receive services by the division under chapter 71A.16 RCW.

"DDD" means the division of developmental disabilities, a division within the aging and disability services administration (ADSA), department of social and health services (DSHS).

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

"Emergency" means the client's health or safety is in jeopardy.

"Family" means relatives who live in the same home with the eligible client. Relatives include spouse or registered domestic partner; natural, adoptive or step parent; grandparent; child; stepchild; sibling; stepsibling; uncle; aunt; first cousin; niece; or nephew.

"Family home" means the residence where you and your relatives live.

"Formal caregiver" is a person/agency who receives payment from DDD to provide a service.

"Individual and family services contract" means a contract between DDD and the family to reimburse the family for the purchase of goods and services.

"Individual provider" means an individual who is contracted with DDD to provide medicaid or waiver personal care, respite care, or attendant care services.

"Individual support plan" or "ISP" is a document that authorizes the DDD paid services to meet a client's needs identified in the DDD assessment.

"Informal caregiver" is a person who provides supports without payment from DDD for a service.

"Legal guardian" means a person/agency, appointed by a court, which is authorized to make some or all decisions for a person determined by the court to be incapacitated. In the absence of court intervention, parents remain the legal guardian for their child until the child reaches the age of eighteen.

"Pass through contract" means a contract between DDD and a third party to reimburse the third party for the purchase of goods and services.

"Primary caregiver" is the formal or informal caregiver who provides the most support.

"Residential habilitation center" or **"RHC"** is a state operated facility certified to provide ICF/MR and/or nursing facility level of care for persons with developmental disabilities per chapter 71A.20 RCW.

"Significant change" means changes in your medical condition, caregiver status, behavior, living situation or employment status.

"State funded services" means services that are funded entirely with state dollars.

"State supplementary payment" or **"SSP"** means a state paid cash assistance program for certain DDD clients eligible for supplemental security income per chapter 388-827 WAC.

"You" means the client.

[Statutory Authority: RCW 71A.12.30 [71A.12.030], 71A.12.040, and Title 71A RCW. 09-11-054, § 388-832-0001, filed 5/13/09, effective 6/13/09. Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0001, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0005 What is the individual and family services program? The "individual and family services program" (IFS program) is a state-only funded program that:

- (1) Provides an array of services to families to help maintain and stabilize the family unit; and
- (2) Replaces:
 - (a) The family support opportunity program (WAC 388-825-200 through 388-825-242);
 - (b) The traditional family support program (WAC 388-825-252 through 388-825-256);
 - (c) The family support pilot program (WAC 388-825-500 through 388-825-595); and
 - (d) Other family support rules (WAC 388-825-244 through 388-825-250).

[Statutory Authority: RCW 71A.12.30 [71A.12.030], 71A.12.040, and Title 71A RCW. 09-11-054, § 388-832-0005, filed 5/13/09, effective 6/13/09. Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0005, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0007 What is the purpose of the individual and family services (IFS) program? The purpose of the IFS program is to:

- (1) Form a partnership between the state and families to help support families who have a DDD eligible family member living in the family home; and
- (2) Provide families with a choice of services and allow families more control over the resources allocated to them.

[Statutory Authority: RCW 71A.12.30 [71A.12.030], 71A.12.040, and Title 71A RCW. 09-11-054, § 388-832-0007, filed 5/13/09, effective 6/13/09. Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0007, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0015 Am I eligible for the IFS program? (1) You are eligible to be considered for the IFS program if you meet the following criteria:

- (a) You are currently an eligible client of DDD;
- (b) You live in your family home;

(c) You are not enrolled in a DDD home and community based services waiver defined in chapter 388-845 WAC;

(d) You are currently enrolled in traditional family support, family support opportunity or the family support pilot or funding has been approved for you to receive IFS program services;

(e) You are age three or older;

(f) You have been assessed as having a need for IFS program services as listed in WAC 388-832-0140; and

(g) You are not receiving a DDD adult or child residential service or licensed foster care.

(2) If you are a parent who is a client of DDD, you are eligible to receive IFS program services in order to promote the integrity of the family unit, provided:

(a) You meet the criteria in subsections (1)(a) through (f) above; and

(b) Your minor child who lives in your home is at risk of being placed up for adoption or into foster care.

[Statutory Authority: RCW 71A.12.30 [71A.12.030], 71A.12.040, and Title 71A RCW. 09-11-054, § 388-832-0015, filed 5/13/09, effective 6/13/09. Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0015, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0020 Will I be authorized to receive IFS services if I meet the eligibility criteria in WAC 388-832-0015? Meeting eligibility criteria per WAC 388-832-0015 for the IFS program does not ensure access to or receipt of the IFS program services.

(1) Receipt of IFS services is limited by availability of funding and your assessed need.

(2) WAC 388-832-0085 through 388-832-0090 describes how DDD will determine who will be approved to receive funding.

[Statutory Authority: RCW 71A.12.30 [71A.12.030], 71A.12.040, and Title 71A RCW. 09-11-054, § 388-832-0020, filed 5/13/09, effective 6/13/09. Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0020, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0022 What determines the allocation of funds available to me to purchase IFS services? The allocation of funds is based upon the DDD assessment described in chapter 388-828 WAC. The DDD assessment will determine your service level based on your assessed need.

[Statutory Authority: RCW 71A.12.30 [71A.12.030], 71A.12.040, and Title 71A RCW. 09-11-054, § 388-832-0022, filed 5/13/09, effective 6/13/09. Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0022, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0023 If I qualify for another DDD service, will my IFS program be reduced or terminated? Since your IFS amount is based on the assessed need, if your needs change, the dollar amount may be impacted. However, if you are qualified for another DDD service, you can still receive IFS as long as you continue to have an assessed need and have met the eligibility criteria per WAC 388-832-0015 for the IFS program with the exception of WAC 388-832-0024.

[Statutory Authority: RCW 71A.12.30 [71A.12.030], 71A.12.040, and Title 71A RCW. 09-11-054, § 388-832-0023, filed 5/13/09, effective 6/13/09. Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0023, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0024 If I participate in the IFS program, will I be eligible for services through the DDD home and community based services (HCBS) waiver? (1) If you participate in the IFS program you may not participate in the DDD HCBS waiver.

(2) You may request enrollment in a DDD HCBS waiver at any time per WAC 388-845-0050.

(3) Participation in the IFS program will not affect your potential waiver eligibility.

[Statutory Authority: RCW 71A.12.30 [71A.12.030], 71A.12.040, and Title 71A RCW. 09-11-054, § 388-832-0024, filed 5/13/09, effective 6/13/09. Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0024, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0025 Am I eligible for the IFS program if I currently receive other DDD paid services? (1) If you receive other nonwaiver DDD funded services, you may be eligible for the IFS program.

(2) If you receive SSP in lieu of traditional family support or family support opportunity, you are not eligible to receive IFS program funding.

[Statutory Authority: RCW 71A.12.30 [71A.12.030], 71A.12.040, and Title 71A RCW. 09-11-054, § 388-832-0025, filed 5/13/09, effective 6/13/09. Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0025, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0060 May DDD terminate my eligibility for the IFS program? You may be terminated from the IFS program for any of the following reasons:

(1) You no longer meet DDD eligibility per WAC 388-823-0010 through 388-823-0170;

(2) You no longer meet the eligibility criteria for the IFS program per WAC 388-832-0015;

(3) You have not used an IFS program service during the last twelve calendar months;

(4) You cannot be located or do not make yourself available for the annual DDD assessment;

(5) You refuse to participate with DDD in service planning; and/or

(6) You begin to receive a DDD residential service.

[Statutory Authority: RCW 71A.12.30 [71A.12.030], 71A.12.040, and Title 71A RCW. 09-11-054, § 388-832-0060, filed 5/13/09, effective 6/13/09. Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0060, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0065 If I go into a temporary out of home placement, will I be eligible for IFS upon my return home? (1) If you are disenrolled in the IFS program due to out of home placement, you may request reinstatement in the IFS program once you return to your family home.

(2) You may make this request by contacting your DDD case manager.

(3) Your case manager will schedule an assessment with you and, if you meet all the eligibility criteria described in WAC 388-832-0015, have an assessed need, and funding is available, you may receive an IFS program allocation.

[Statutory Authority: RCW 71A.12.30 [71A.12.030], 71A.12.040, and Title 71A RCW. 09-11-054, § 388-832-0065, filed 5/13/09, effective 6/13/09. Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0065, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0067 Are my children eligible for IFS program services, if I am a client of DDD? If you are a parent with a developmental disability and a client of DDD, your children may be eligible for IFS program services if funding is available and your children:

(1) Are ages birth through seventeen years of age;

(2) Are at risk of out of home placement; and

(3) Live with you.

[Statutory Authority: RCW 71A.12.30 [71A.12.030], 71A.12.040, and Title 71A RCW. 09-11-054, § 388-832-0067, filed 5/13/09, effective 6/13/09. Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0067, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0070 What is the IFS program request list? The IFS request list is a list of clients who live with their family and the family has requested family support services. At the time of the family's request for IFS program services, funding was not available; therefore these clients were placed on the IFS program request list effective on the date of their request.

[Statutory Authority: RCW 71A.12.30 [71A.12.030], 71A.12.040, and Title 71A RCW. 09-11-054, § 388-832-0070, filed 5/13/09, effective 6/13/09. Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0070, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0072 Who is eligible to be on the IFS program request list? (1) To be on the IFS request list you must live in your family home and remain eligible for DDD services.

(2) If you are in temporary placement and the plan is to return home you may remain on the IFS request list.

[Statutory Authority: RCW 71A.12.30 [71A.12.030], 71A.12.040, and Title 71A RCW. 09-11-054, § 388-832-0072, filed 5/13/09, effective 6/13/09. Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0072, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0075 Do I have to have a DDD assessment before I can be added to the IFS request list? You do not have to have a DDD assessment prior to your name being added to the IFS request list.

(1) Your name and request date will be added to the request list.

(2) A notice will be sent to you to let you know your name has been added to the IFS request list.

[Statutory Authority: RCW 71A.12.30 [71A.12.030], 71A.12.040, and Title 71A RCW. 09-11-054, § 388-832-0075, filed 5/13/09, effective 6/13/09. Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0075, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0080 How or when am I taken off the IFS request list? You are taken off the IFS request list if:

(1) You no longer live in your family home;

(2) You are no longer eligible for DDD services;

(3) You request your name to be removed from the IFS request list;

(4) You do not respond by the date outlined on the IFS notification to schedule the DDD assessment;

(5) You are offered IFS services and refuse services; or

(6) You are on the HCBS waiver.

[Statutory Authority: RCW 71A.12.30 [71A.12.030], 71A.12.040, and Title 71A RCW. 09-11-054, § 388-832-0080, filed 5/13/09, effective 6/13/09. Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0080, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0082 If the DDD assessment determines I am not eligible for the IFS program, may I remain on the IFS request list? If the DDD assessment determines you are not eligible for the IFS program, you may request to remain on the request list. The date you ask to remain on the list becomes your new request date.

[Statutory Authority: RCW 71A.12.30 [71A.12.030], 71A.12.040, and Title 71A RCW. 09-11-054, § 388-832-0082, filed 5/13/09, effective 6/13/09. Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0082, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0085 When there is state funding available to enroll additional clients in the IFS program, how will DDD select from the clients on the IFS program request list? When there is state funding available for additional IFS participants, DDD may enroll participants based on the following considerations:

(1) Clients who have requested residential habilitation center (RHC) respite, emergency services, or residential placement, prior to June 30, 2007.

(2) Clients with the highest scores in caregiver and behavior status on the mini assessment.

(3) Clients who have been on the IFS program request list the longest.

[Statutory Authority: RCW 71A.12.30 [71A.12.030], 71A.12.040, and Title 71A RCW. 09-11-054, § 388-832-0085, filed 5/13/09, effective 6/13/09. Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0085, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0087 What happens next if I am selected from the IFS program request list? If you are selected from the IFS program request list:

(1) Your DDD case/resource manager will contact you, and determine if you meet the eligibility criteria for IFS program per WAC 388-832-0015.

(2) If you meet the criteria per (1) above, your case/resource manager will schedule an appointment to complete your DDD assessment or reassessment.

(3) If you have not been receiving any DDD paid services, your DDD eligibility may need to be reviewed per WAC 388-823-1010(3).

(4) Your DDD eligibility review must be finalized prior to the completion of the DDD assessment for the IFS program.

[Statutory Authority: RCW 71A.12.30 [71A.12.030], 71A.12.040, and Title 71A RCW. 09-11-054, § 388-832-0087, filed 5/13/09, effective 6/13/09. Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0087, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0090 If I currently receive funding from the traditional family support program, the family support opportunity program or the family support pilot program, will I qualify for the IFS program? If you currently receive funding from the traditional family support program, the family support opportunity program or the family support pilot program, you may qualify for the IFS program if you meet the eligibility criteria in WAC 388-832-0015.

[Statutory Authority: RCW 71A.12.30 [71A.12.030], 71A.12.040, and Title 71A RCW. 09-11-054, § 388-832-0090, filed 5/13/09, effective 6/13/09. Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0090, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0091 If I currently receive funding from the traditional family support program, the family support opportunity program or the family support pilot program, will that funding continue until my next assessment? If you currently receive funding from the traditional family support (TFS) program, the family support opportunity (FSO) program or the family support pilot (FSP) program, you may continue to receive funding under the TFS, FSO, or the FSP program until your next DDD assessment.

[Statutory Authority: RCW 71A.12.30 [71A.12.030], 71A.12.040, and Title 71A RCW. 09-11-054, § 388-832-0091, filed 5/13/09, effective 6/13/09. Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0091, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0113 Will my IFS allocation be impacted by my income? The amount of your allocation will be solely based on your assessed needs. Your income will not affect your IFS allocation.

[Statutory Authority: RCW 71A.12.30 [71A.12.030], 71A.12.040, and Title 71A RCW. 09-11-054, § 388-832-0113, filed 5/13/09, effective 6/13/09. Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0113, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0120 Will my IFS allocation be impacted if I am eligible for medicaid personal care services? If you meet financial and functional eligibility for medicaid personal care services, your IFS allocation will be adjusted according to WAC 388-828-9100 through 388-828-9140.

[Statutory Authority: RCW 71A.12.30 [71A.12.030], 71A.12.040, and Title 71A RCW. 09-11-054, § 388-832-0120, filed 5/13/09, effective 6/13/09. Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0120, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0123 Will my IFS allocation be impacted if I am eligible for private duty nursing or the medically intensive children's program? If you meet eligibility for private duty nursing described in WAC 388-106-1000, or the medically intensive children's program described in WAC 388-551-3000, your IFS allocation will be adjusted according to WAC 388-828-9100 through 388-828-9140.

[Statutory Authority: RCW 71A.12.30 [71A.12.030], 71A.12.040, and Title 71A RCW. 09-11-054, § 388-832-0123, filed 5/13/09, effective 6/13/09. Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0123, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0125 Will my IFS allocation be impacted if I am eligible for the community options programs entry system (COPES)? If you are eligible for the community options programs entry system (COPES), your IFS allocation will not be adjusted.

[Statutory Authority: RCW 71A.12.30 [71A.12.030], 71A.12.040, and Title 71A RCW. 09-11-054, § 388-832-0125, filed 5/13/09, effective 6/13/09. Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0125, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0127 What if I have assessed needs that cannot be met by the IFS program? If you complete the DDD assessment and are assessed to have an unmet need and there is no approved funding to support that need, DDD will offer you referral information for ICF/MR services. In addition, DDD may:

(1) Provide information and referral for non-DDD community-based supports; and

(2) Add your name to the waiver data base, if you have requested enrollment in a DDD HCBS waiver per chapter 388-845 WAC.

[Statutory Authority: RCW 71A.12.30 [71A.12.030], 71A.12.040, and Title 71A RCW. 09-11-054, § 388-832-0127, filed 5/13/09, effective 6/13/09. Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0127, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0128 When is the individual support plan effective? (1) For an initial individual support plan, the plan is effective the date DDD signs and approves the plan based on a signature or verbal consent.

(2) For a reassessment, amendment or review of the individual support plan, the plan is effective the date DDD signs and approves it after a signature or verbal consent is obtained.

[Statutory Authority: RCW 71A.12.30 [71A.12.030], 71A.12.040, and Title 71A RCW. 09-11-054, § 388-832-0128, filed 5/13/09, effective 6/13/09. Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0128, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0135 How may my family use its IFS program allocation? Your IFS program allocation is available to pay for any of the services listed in WAC 388-832-0140 if:

(1) The service need relates to your disability, and

(2) The need is identified in your DDD assessment and identified on your ISP.

[Statutory Authority: RCW 71A.12.30 [71A.12.030], 71A.12.040, and Title 71A RCW. 09-11-054, § 388-832-0135, filed 5/13/09, effective 6/13/09. Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0135, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0136 If I have a family support reimbursement contract, may DDD ask me to verify my purchases through reviewing receipts? (1) If you have a family support reimbursement contract, you must first need prior approval from your DDD case manager and then DDD will ask you to verify your purchases through reviewing receipts.

(2) You must submit receipts to your case manager whenever you are asking for reimbursement.

(3) Your request for reimbursement must be received within ninety days of the date that the service was received and no later than thirty days after the end of your allocation year.

[Statutory Authority: RCW 71A.12.30 [71A.12.030], 71A.12.040, and Title 71A RCW. 09-11-054, § 388-832-0136, filed 5/13/09, effective 6/13/09. Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0136, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0137 May I use my allocation over a two-year period for large costly expenditures? (1) You may not use your allocation over a two-year period for a large costly expenditure.

(2) Your annual allocation can only be used during the twelve-month period your assessed needs were determined.

(3) If you do not use all of your allocation, your remaining dollars do not carry over to next year.

(4) You must use a portion of your IFS program allocation within your twelve month assessment period or you may be terminated from the IFS program.

[Statutory Authority: RCW 71A.12.30 [71A.12.030], 71A.12.040, and Title 71A RCW. 09-11-054, § 388-832-0137, filed 5/13/09, effective 6/13/09. Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0137, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0160 Are there limits to the respite care I receive? The following limitations apply to the respite care you can receive:

(1) Respite cannot replace:

(a) Daycare, childcare or preschool while a parent is at work; and/or

(b) Personal care hours available to you. When determining your unmet need, DDD will first consider the personal care hours available to you.

(2) Respite providers have the following limitations and requirements:

(a) If respite is provided in a private home, the home must be licensed unless it is the client's home or the home of a relative of specified degree per WAC 388-825-345;

(b) The respite provider cannot be the spouse of the caregiver receiving respite if the spouse and the caregiver reside in the same residence; and

(c) If you receive respite from a provider who requires licensure, the respite services are limited to those age-specific services contained in the provider's license.

(d) The respite care provider cannot be your natural, step or adoptive parent living with you.

(3) Your caregiver will not be paid to provide DDD services for you or other persons at the same time you receive respite services.

(4) The need for respite must be identified in your ISP and, in combination with other IFS services, may not exceed your IFS allocation.

(5) If your personal care provider is your parent, your parent provider may not be paid to provide respite services to any client in the same month that you receive respite services.

[Statutory Authority: RCW 71A.12.30 [71A.12.030], 71A.12.040, and Title 71A RCW. 09-11-054, § 388-832-0160, filed 5/13/09, effective 6/13/09. Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0160, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0165 What are considered excess medical costs not covered by another source? Excess medical costs are medical expenses incurred by you after medical aid or private insurance have been accessed or when you do not have medical insurance. This may include the following:

(1) Skilled nursing services (e.g., ventilation, catheterization, and insulin shots);

(2) Psychiatric services;

(3) Medical and dental services deemed medically necessary by your health care professional and an allowable medicaid covered expense;

(4) Prescriptions for medications; and/or

(5) Medical and dental premiums.

[Statutory Authority: RCW 71A.12.30 [71A.12.030], 71A.12.040, and Title 71A RCW. 09-11-054, § 388-832-0165, filed 5/13/09, effective 6/13/09. Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0165, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0166 How are excess medical costs paid? (1) Excess medical costs may be paid directly to a DDD contracted provider or reimbursed to a family member

who has an individual and family services contract with the division of developmental disabilities if receipts are received within ninety days from the date of service.

(2) Skilled nursing services are paid to the DSHS contracted nurse directly.

[Statutory Authority: RCW 71A.12.30 [71A.12.030], 71A.12.040, and Title 71A RCW. 09-11-054, § 388-832-0166, filed 5/13/09, effective 6/13/09. Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0166, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0168 Are there limits to excess medical costs? There are limits to excess medical costs.

(1) The service must be of direct medical or remedial benefit to you and deemed medically necessary by your health care professional.

(2) Therapies included under WAC 388-832-0170 may not be paid under excess medical costs.

(3) Medical and dental premiums are excluded for family members other than the DDD eligible clients.

(4) The need for excess medical costs must be identified in your ISP and, in combination with other IFS services, may not exceed your IFS allocation.

(5) Other restriction per WAC 388-832-0333 also apply.

(6) Prior approval by regional administrator or designee is required.

[Statutory Authority: RCW 71A.12.30 [71A.12.030], 71A.12.040, and Title 71A RCW. 09-11-054, § 388-832-0168, filed 5/13/09, effective 6/13/09. Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0168, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0170 What therapies may I receive?

The therapies you may receive are:

(1) Physical therapy;

(2) Occupational therapy; and/or

(3) Speech, hearing and language therapy.

[Statutory Authority: RCW 71A.12.30 [71A.12.030], 71A.12.040, and Title 71A RCW. 09-11-054, § 388-832-0170, filed 5/13/09, effective 6/13/09. Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0170, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0175 Who is a qualified therapist?

Providers must be certified, registered or licensed therapists as required by law and contracted with DDD for the therapy they are providing. DDD will pay the contracted therapist directly for the therapy services they provide.

[Statutory Authority: RCW 71A.12.30 [71A.12.030], 71A.12.040, and Title 71A RCW. 09-11-054, § 388-832-0175, filed 5/13/09, effective 6/13/09. Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0175, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0180 Are there limits to the therapy I may receive? The following limitations apply to therapy you may receive:

(1) Additional therapy may be authorized as a service only after you have accessed what is available to you under medicaid and any other private health insurance plan or school;

(2) DDD does not pay for treatment determined by DSHS to be experimental;

(3) DDD determines the need and amount of services you will receive based upon information received from the therapist;

(a) DDD may require a second opinion from a DDD selected provider.

(b) DDD requires you to provide evidence that you have accessed your full benefits through medicaid, private insurance and the school before authorizing this service.

(4) The need for therapies must be identified in your ISP and, in combination with other IFS services, may not exceed your IFS allocations.

(5) Other restrictions per WAC 388-832-0333 also apply.

[Statutory Authority: RCW 71A.12.30 [71A.12.030], 71A.12.040, and Title 71A RCW. 09-11-054, § 388-832-0180, filed 5/13/09, effective 6/13/09. Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0180, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0185 What are architectural and vehicular modifications? (1) Architectural and vehicular modifications are physical adaptations to the home and vehicle of the individual to:

(a) Ensure the health, welfare and safety of the client and or caregiver; or

(b) Enable a client who would otherwise require a more restrictive environment to function with greater independence in the home or in the community.

(2) Architectural modifications include the following:

(a) Installation of ramps and grab bars;

(b) Widening of doorways;

(c) Modification of bathroom facilities;

(d) Installing specialized electrical and/or plumbing systems necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the individual;

(e) Repairs for damages to the client's residence as a result of the client's disability up to the balance of the client's allocation; or

(f) Repairs to architectural modifications if necessary for client safety.

(3) Vehicular modifications include the following:

(a) Wheel chair lifts;

(b) Strap downs;

(c) Other access modifications; or

(d) Repairs and maintenance to vehicular modifications if necessary for client safety.

[Statutory Authority: RCW 71A.12.30 [71A.12.030], 71A.12.040, and Title 71A RCW. 09-11-054, § 388-832-0185, filed 5/13/09, effective 6/13/09. Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0185, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0195 What limits apply to architectural and vehicular modifications? The following service limitations apply to architectural and vehicular modifications are in addition to any limitations in other rules governing this service:

(1) Prior approval by the regional administrator or designee is required.

(2) Architectural and vehicular modifications to the home and vehicle are excluded if they are of general utility without direct medical or remedial benefit to the individual, such as floor covering (e.g., carpeting, linoleum, tile, hard wood flooring, decking), roof repair, central air conditioning, fencing for the yard, etc.

(3) Architectural modifications may not add to the square footage of the home.

(4) DDD requires evidence that you accessed your full benefits through medicaid, private insurance and the division of vocational rehabilitation (DVR) before authorizing this service.

(5) Architectural and vehicular modifications must be the most cost effective modification based upon a comparison of contractor bids as determined by DDD.

(6) Architectural and vehicular modifications are prorated by the number of other members in the household who use these modifications.

(7) The need for architectural and vehicular modifications must be identified in your ISP and, in combination with other IFS services, may not exceed your IFS allocation.

[Statutory Authority: RCW 71A.12.30 [71A.12.030], 71A.12.040, and Title 71A RCW. 09-11-054, § 388-832-0195, filed 5/13/09, effective 6/13/09. Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0195, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0200 What are equipment and supplies? (1) Equipment and supplies are designed to assist clients to:

(a) Increase or maintain their abilities to perform their activities of daily living; or

(b) Perceive, control or communicate with the environment in which they live.

(2) Equipment and supplies may include durable and nondurable equipment that are specialized or adapted, and generally not useful to a person in the absence of illness, injury or disability.

(3) Also included are items and services necessary to the proper functioning of the equipment and supplies.

[Statutory Authority: RCW 71A.12.30 [71A.12.030], 71A.12.040, and Title 71A RCW. 09-11-054, § 388-832-0200, filed 5/13/09, effective 6/13/09. Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0200, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0205 Who are qualified providers of equipment and supplies? The provider of equipment and supplies must be an equipment supplier contracted with DDD, a parent who has an individual and family services contract, or a provider who purchases goods and services through the pass through contract.

[Statutory Authority: RCW 71A.12.30 [71A.12.030], 71A.12.040, and Title 71A RCW. 09-11-054, § 388-832-0205, filed 5/13/09, effective 6/13/09. Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0205, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0210 Are there limitations to my receipt of equipment and supplies? The following limitations apply to your receipt of equipment and supplies:

(1) Equipment and supplies with the exception of supplies for incontinence (e.g., diapers, disposable underpads, and wipes) require prior approval by the DDD regional administrator or designee for each authorization.

(2) DDD reserves the right to require a second opinion by a department-selected provider.

(3) Items reimbursed with state funds must be in addition to any medical equipment and supplies furnished under medicaid or private insurance.

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(4) Items must be of direct medical or remedial benefit to the individual and necessary as a result of the individual's disability.

(5) Medications, prescribed or nonprescribed, and vitamins are excluded.

(6) The need for equipment and supplies must be identified in your ISP and, in combination with other IFS services, may not exceed your IFS allocation.

[Statutory Authority: RCW 71A.12.30 [71A.12.030], 71A.12.040, and Title 71A RCW. 09-11-054, § 388-832-0210, filed 5/13/09, effective 6/13/09. Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0210, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0215 What are specialized nutrition and specialized clothing? (1) Specialized nutrition is specialized formulas or specially prepared foods for which a written recommendation has been provided by a qualified and appropriate professional and when it constitutes fifty percent or more of the person's caloric intake (e.g., licensed physician or registered dietitian).

(2) Specialized clothing is nonrestrictive clothing adapted for a physical disability, excessive wear clothing, or specialized footwear for which a written recommendation has been provided by a qualified and appropriate professional (e.g., a podiatrist, physical therapist, or behavior specialist).

[Statutory Authority: RCW 71A.12.30 [71A.12.030], 71A.12.040, and Title 71A RCW. 09-11-054, § 388-832-0215, filed 5/13/09, effective 6/13/09. Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0215, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0220 How do I pay for specialized nutrition and specialized clothing? Specialized nutrition and specialized clothing can be a reimbursable expense through the individual and family services contract and the pass through contract.

[Statutory Authority: RCW 71A.12.30 [71A.12.030], 71A.12.040, and Title 71A RCW. 09-11-054, § 388-832-0220, filed 5/13/09, effective 6/13/09. Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0220, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0225 Are there limits for specialized nutrition and specialized clothing? (1) The need for specialized nutrition and specialized clothing must be identified in your ISP and, in combination with other IFS services, may not exceed your IFS allocation.

(2) Prior approval by regional administrator or designee is required.

[Statutory Authority: RCW 71A.12.30 [71A.12.030], 71A.12.040, and Title 71A RCW. 09-11-054, § 388-832-0225, filed 5/13/09, effective 6/13/09. Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0225, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0235 What are copays for medical and therapeutic services? Copays are fixed fees that subscribers to a medical plan must pay to use specific medical or therapeutic services covered by the plan. These services must have been deemed medically necessary by your health care professional.

[Statutory Authority: RCW 71A.12.30 [71A.12.030], 71A.12.040, and Title 71A RCW. 09-11-054, § 388-832-0235, filed 5/13/09, effective 6/13/09. Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0235, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0240 How do I pay for medical and therapeutic copays? Medical and therapeutic copays can be a reimbursable expense through the individual and family services contract and the pass through contract.

[Statutory Authority: RCW 71A.12.30 [71A.12.030], 71A.12.040, and Title 71A RCW. 09-11-054, § 388-832-0240, filed 5/13/09, effective 6/13/09. Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0240, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0245 Are there limits to medical and therapeutic copays? (1) Medical and therapeutic copays must be identified in your ISP and, in combination with other IFS services, may not exceed your IFS allocation.

(2) The copays must be for your medical or therapeutic needs.

(3) Prescribed or nonprescribed vitamins and supplements are excluded.

[Statutory Authority: RCW 71A.12.30 [71A.12.030], 71A.12.040, and Title 71A RCW. 09-11-054, § 388-832-0245, filed 5/13/09, effective 6/13/09. Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0245, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0255 Who is a qualified provider for transportation services? (1) The provider of transportation services can be an individual or agency contracted with DDD.

(2) Transportation services can be a reimbursable expense through the individual and family services contract.

[Statutory Authority: RCW 71A.12.30 [71A.12.030], 71A.12.040, and Title 71A RCW. 09-11-054, § 388-832-0255, filed 5/13/09, effective 6/13/09. Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0255, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0260 Are there limitations to the transportation services I can receive? The following limitations apply to transportation services:

(1) Transportation to/from medical or medically related appointments is a medicaid transportation service and is to be considered and used first.

(2) Transportation is offered in addition to medical transportation but cannot replace medicaid transportation services.

(3) Transportation is limited to travel to and from an IFS program service.

(4) This service does not cover the purchase or lease of vehicles.

(5) Reimbursement to the provider is limited to transportation that occurs when you are with the provider.

(6) You are not eligible for transportation services if the cost and responsibility for transportation is already included in your provider's contract and payment.

(7) Per diem costs may be reimbursed utilizing the state rate to access medical services if the DDD client and one family member must travel over one hundred fifty miles one way.

(8) Air ambulance costs due to an emergency may be reimbursed after insurance, deductibles, medicaid and other resources have been exhausted not to exceed your annual IFS allocation.

(9) The need for transportation services must be identified in your ISP and, in combination with other IFS services, may not exceed your IFS allocation.

[Statutory Authority: RCW 71A.12.30 [71A.12.030], 71A.12.040, and Title 71A RCW. 09-11-054, § 388-832-0260, filed 5/13/09, effective 6/13/09. Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0260, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0275 Are there limitations to the training and counseling? There are limitations to training and counseling that your family may receive.

(1) Expenses to the family for room and board or attendance, including registration fees for conferences are excluded as a service under family counseling and training.

(2) The need for training and counseling must be identified in your ISP and, in combination with other IFS services, may not exceed your IFS allocation.

[Statutory Authority: RCW 71A.12.30 [71A.12.030], 71A.12.040, and Title 71A RCW. 09-11-054, § 388-832-0275, filed 5/13/09, effective 6/13/09. Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0275, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0285 Who is a qualified provider of behavior management? The provider of behavior management and consultation must be one of the following professionals contracted with DDD and must adhere to and follow DDD's positive behavior support policy and be duly licensed, registered or certified to provide this service:

- (1) Marriage and family therapist;
- (2) Mental health counselor;
- (3) Psychologist;
- (4) Sex offender treatment provider;
- (5) Social worker;
- (6) Registered nurse (RN) or licensed practical nurse (LPN);
- (7) Psychiatrist;
- (8) Psychiatric advanced registered nurse practitioner (ARNP);
- (9) Physician assistant working under the supervision of a psychiatrist;
- (10) Registered counselor; or
- (11) Polygrapher.

[Statutory Authority: RCW 71A.12.30 [71A.12.030], 71A.12.040, and Title 71A RCW. 09-11-054, § 388-832-0285, filed 5/13/09, effective 6/13/09. Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0285, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0290 Are there limits to behavior management? The following limits apply to your receipt of behavior management:

(1) DDD will determine the need and amount of service you may receive based upon information from the treating professional.

(2) DDD may require a second opinion from a DDD-selected provider.

(3) Only scientifically proven, nonexperimental methods may be utilized.

(4) Providers may not use methods that cause pain, threats, isolation or locked settings.

(5) The need for behavior management must be identified in your ISP and, in combination with other IFS services, may not exceed your IFS allocation.

(6) Psychological testing is not allowed.

(7) Behavior management services require prior approval by the regional administrator or designee.

[Statutory Authority: RCW 71A.12.30 [71A.12.030], 71A.12.040, and Title 71A RCW. 09-11-054, § 388-832-0290, filed 5/13/09, effective 6/13/09. Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0290, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0308 How is parent/sibling education paid? Parent/sibling education may be a reimbursable expense through the individual and family services contract, the pass through contract or paid directly to the contracted provider.

[Statutory Authority: RCW 71A.12.30 [71A.12.030], 71A.12.040, and Title 71A RCW. 09-11-054, § 388-832-0308, filed 5/13/09, effective 6/13/09. Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0308, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0310 Are there limitations to parent/sibling education? There are limitations to parent/sibling education that your family may receive.

(1) Parent/sibling education does not include conference fees or lodging.

(2) Viewing of VHS or DVD at home by your parent or sibling does not meet the definition of parent or sibling education.

(3) The need for parent/sibling education must be identified in your ISP and, in combination with other IFS services, may not exceed your IFS allocation.

[Statutory Authority: RCW 71A.12.30 [71A.12.030], 71A.12.040, and Title 71A RCW. 09-11-054, § 388-832-0310, filed 5/13/09, effective 6/13/09. Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0310, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0315 What are recreational opportunities? (1) Recreational opportunities are leisure activities that may be available to children and adults with a developmental disability such as summer camps, YMCA activities, day trips or typical activities available in your community.

(2) Recreational opportunities may include memberships in civic groups, clubs, crafting classes, or classes outside of K-12 school curriculum or sport activities.

[Statutory Authority: RCW 71A.12.30 [71A.12.030], 71A.12.040, and Title 71A RCW. 09-11-054, § 388-832-0315, filed 5/13/09, effective 6/13/09. Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0315, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0320 How are recreational opportunities paid for? Recreational opportunities may be a reimbursable expense through the individual and family services contract, the pass through contract or the recreational opportunity contract.

[Statutory Authority: RCW 71A.12.30 [71A.12.030], 71A.12.040, and Title 71A RCW. 09-11-054, § 388-832-0320, filed 5/13/09, effective 6/13/09. Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0320, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0325 Are there limitations to recreation opportunities? The following limitations apply to recreation opportunities:

(1) Recreational opportunities must occur in your community or the bordering states addressed in WAC 388-832-0331.

(2) The need for recreation opportunities must be identified in your ISP and, in combination with other IFS services, may not exceed your IFS allocation.

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(3) DDD does not pay for recreational opportunities that may pose a risk to individuals with disabilities or the community at large.

[Statutory Authority: RCW 71A.12.30 [71A.12.030], 71A.12.040, and Title 71A RCW. 09-11-054, § 388-832-0325, filed 5/13/09, effective 6/13/09. Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0325, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0330 Do I have a choice of IFS program services? In collaboration with your case manager and based upon your assessed need, you may choose the services available with this program.

[Statutory Authority: RCW 71A.12.30 [71A.12.030], 71A.12.040, and Title 71A RCW. 09-11-054, § 388-832-0330, filed 5/13/09, effective 6/13/09. Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0330, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0332 May I choose my provider? You may choose a qualified individual, agency or licensed provider within the guidelines described in WAC 388-825-300 through 388-825-400. These WACs describe:

(1) Qualifications for individuals and agencies providing DDD services in the client's residence or the provider's residence or other settings; and

(2) Conditions under which DDD will pay for the services of an individual provider or a home care agency provider or other provider.

[Statutory Authority: RCW 71A.12.30 [71A.12.030], 71A.12.040, and Title 71A RCW. 09-11-054, § 388-832-0332, filed 5/13/09, effective 6/13/09. Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0332, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0333 What restrictions apply to the IFS program services? The following restrictions apply to the IFS program services:

(1) IFS program services are authorized only after you have accessed what is available to you under medicaid, including medicaid personal care, and any other private health insurance plan, school, division of vocational rehabilitation or child development services.

(2) All IFS program service payments must be agreed to by DDD and you in your ISP.

(3) DDD may contract directly with a service provider or parent for the reimbursement of goods or services purchased by the family member.

(4) DDD may not pay for treatment determined by DSHS/MAA or private insurance to be experimental.

(5) Your choice of qualified providers and services may be limited to the most cost effective option that meets your assessed need.

(6) The IFS program must not pay for services provided after the death of the eligible client. Payment may occur after the date of death, but not the service.

(7) DDD's authorization period begins when you agree to be in the IFS program and have given written or verbal approval for your ISP. The period will last up to one year and may be renewed if you continue to need and utilize services. If you have not utilized the services within one year period you will be terminated from this program.

(8) IFS program must not pay for psychological evaluations or testing, or DNA testing.

(9) Supplies/materials related to recreation opportunities are the responsibility of the family.

[Statutory Authority: RCW 71A.12.30 [71A.12.030], 71A.12.040, and Title 71A RCW. 09-11-054, § 388-832-0333, filed 5/13/09, effective 6/13/09. Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0333, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0335 What is a one-time award? (1) One-time awards are payments to individuals and families who meet the IFS program eligibility requirements and have a one time unmet need not covered by any other sources for which they are eligible.

(2) One-time awards can only be used for architectural/vehicular modifications, or specialized equipment.

[Statutory Authority: RCW 71A.12.30 [71A.12.030], 71A.12.040, and Title 71A RCW. 09-11-054, § 388-832-0335, filed 5/13/09, effective 6/13/09. Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0335, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0340 Who is eligible for a one-time award? You are eligible to be considered for a one-time award if:

- (1) You are not currently authorized for IFS program services in your ISP;
- (2) You meet the eligibility for the IFS program;
- (3) The need is critical to the health or safety of you or your caregiver; and
- (4) You and your family have no other resource to meet the need or your resources do not cover all of the expense.

[Statutory Authority: RCW 71A.12.30 [71A.12.030], 71A.12.040, and Title 71A RCW. 09-11-054, § 388-832-0340, filed 5/13/09, effective 6/13/09. Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0340, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0345 Are there limitations to one-time awards? (1) One-time awards are limited to architectural/vehicular modifications or specialized equipment.

(2) One-time awards cannot exceed six thousand dollars in a twenty-four month period.

(3) One-time awards must be approved by the DDD regional administrator or designee.

(4) Eligibility for a one-time award does not guarantee approval and authorization of the service by DDD. Services are based on availability of funding.

(5) One-time awards will be prorated by the number of other members in the household who use these modifications or specialized equipment.

[Statutory Authority: RCW 71A.12.30 [71A.12.030], 71A.12.040, and Title 71A RCW. 09-11-054, § 388-832-0345, filed 5/13/09, effective 6/13/09. Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0345, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0350 How do I request a one-time award? If you have a need for a one-time award, you may make the request to your case manager.

[Statutory Authority: RCW 71A.12.30 [71A.12.030], 71A.12.040, and Title 71A RCW. 09-11-054, § 388-832-0350, filed 5/13/09, effective 6/13/09. Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0350, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0353 Do I need to have a DDD assessment before I receive a one-time award? You need to have a DDD assessment before receiving a one-time award.

[Statutory Authority: RCW 71A.12.30 [71A.12.030], 71A.12.040, and Title 71A RCW. 09-11-054, § 388-832-0353, filed 5/13/09, effective 6/13/09. Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0353, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0366 What limitations apply to emergency services? (1) Emergency services may be granted to individuals and families who are on the IFS wait list and have an emergent need.

(2) Funds are provided for a limited period not to exceed ninety days.

(3) All requests are reviewed and approved or denied by the regional administrator or designee.

[Statutory Authority: RCW 71A.12.30 [71A.12.030], 71A.12.040, and Title 71A RCW. 09-11-054, § 388-832-0366, filed 5/13/09, effective 6/13/09. Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0366, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0367 What if the client or family situation requires more than ninety days of emergency service? If the client or family situation requires more than ninety days of emergency services, DDD will conduct an administrative review of DDD services to determine if the need can be met through other services.

[Statutory Authority: RCW 71A.12.30 [71A.12.030], 71A.12.040, and Title 71A RCW. 09-11-054, § 388-832-0367, filed 5/13/09, effective 6/13/09. Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0367, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0369 Do I need to have a DDD assessment before I receive an emergency service? You do not need to have a DDD assessment before receiving an emergency service; however the regional manager/designee may request a DDD assessment for a client at any time.

[Statutory Authority: RCW 71A.12.30 [71A.12.030], 71A.12.040, and Title 71A RCW. 09-11-054, § 388-832-0369, filed 5/13/09, effective 6/13/09. Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0369, filed 8/5/08, effective 9/5/08.]

WAC 388-832-0460 How will DDD notify me of their decisions? Your DDD case resource manager will call you and send a written planned action notice per WAC 388-825-100 to notify you of their decision.

[Statutory Authority: RCW 71A.12.30 [71A.12.030], 71A.12.040, and Title 71A RCW. 09-11-054, § 388-832-0460, filed 5/13/09, effective 6/13/09. Statutory Authority: RCW 71A.12.030, 71A.12.040, and 2007 c 283. 08-16-121, § 388-832-0460, filed 8/5/08, effective 9/5/08.]

Chapter 388-845 WAC

DDD HOME AND COMMUNITY BASED SERVICES WAIVERS

WAC

388-845-0060 Can my waiver enrollment be terminated?

WAC 388-845-0060 Can my waiver enrollment be terminated? DDD may terminate your waiver enrollment if DDD determines that:

- (1) Your health and welfare needs cannot be met in your current waiver or for one of the following reasons:

(a) You no longer meet one or more of the requirements listed in WAC 388-845-0030;

(b) You do not have an identified need for a waiver service at the time of your annual plan of care or individual support plan;

(c) You do not use a waiver service at least once in every thirty consecutive days and your health and welfare do not require monthly monitoring;

(d) You are on the community protection waiver and:

(i) You choose not to be served by a certified residential community protection provider-intensive supported living services (CP-ISLS);

(ii) You engage in any behaviors identified in WAC 388-831-0240 (1) through (4); and

(iii) DDD determines that your health and safety needs or the health and safety needs of the community cannot be met in the community protection program.

(e) You choose to disenroll from the waiver;

(f) You reside out-of-state;

(g) You cannot be located or do not make yourself available for the annual waiver reassessment of eligibility;

(h) You refuse to participate with DDD in:

(i) Service planning;

(ii) Required quality assurance and program monitoring activities; or

(iii) Accepting services agreed to in your plan of care or individual support plan as necessary to meet your health and welfare needs.

(i) You are residing in a hospital, jail, prison, nursing facility, ICF/MR, or other institution and remain in residence at least one full calendar month, and are still in residence:

(i) At the end of the twelfth month following the effective date of your current plan of care or individual support plan, as described in WAC 388-845-3060; or

(ii) The end of the waiver fiscal year, whichever date occurs first.

(j) Your needs exceed the maximum funding level or scope of services under the Basic or Basic Plus waiver as specified in WAC 388-845-3080; or

(k) Your needs exceed what can be provided under WAC 388-845-3085; or

(2) Services offered on a different waiver can meet your health and welfare needs and DDD enrolls you on a different waiver.

[Statutory Authority: RCW 71A.12.030, 71A.12.120, and Title 71A RCW. 09-10-021, § 388-845-0060, filed 4/28/09, effective 5/29/09; 07-20-050, § 388-845-0060, filed 9/26/07, effective 10/27/07. Statutory Authority: RCW 71A.12.030, 71A.12.12 [71A.12.120] and chapter 71A.12 RCW. 06-01-024, § 388-845-0060, filed 12/13/05, effective 1/13/06.]

Chapter 388-865 WAC

COMMUNITY MENTAL HEALTH AND INVOLUNTARY TREATMENT PROGRAMS

WAC

388-865-0245	Administration of the Involuntary Treatment Act.
388-865-0275	Management information system.
388-865-0405	Competency requirements for staff.
388-865-0440	Availability of consumer information.
388-865-0452	Emergency crisis intervention services—Additional standards.
388-865-0456	Case management services—Additional standards.
388-865-0466	Community support outpatient certification—Additional standards.

388-865-0468

Emergency crisis intervention services certification—Additional standards.

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 chapters 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 chapters 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 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 designated mental health professional escorts a consumer to a facility, the 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.

(4) Ensuring that the requirements of RCW 71.05.700 through 71.05.715 are met.

[Statutory Authority: RCW 71.05.560, 71.05.700, 71.05.705, 71.05.710, 71.05.715, 71.05.720, and 71.24.035. 09-19-012, § 388-865-0245, filed 9/3/09, effective 10/4/09. Statutory Authority: RCW 71.24.035, 71.05.560, and chapters 71.24 and 71.05 RCW. 06-17-114, § 388-865-0245, filed 8/18/06, effective 9/18/06. 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 388-865-0275 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 chapters 70.02, 71.05, and 71.34 RCW) and this chapter. Information about consumers and their individualized crisis plans must:

(a) Be available twenty-four hours a day, seven days a week to designated mental health professionals and inpatient evaluation and treatment facilities, as consistent with confidentiality statutes;

(b) Be available to the state and regional support network staff as required for management information and program review; and

(c) Comply with the requirements of RCW 71.05.715.

(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, 71.05.700, 71.05.705, 71.05.710, 71.05.715, 71.05.720, and 71.24.035. 09-19-012, § 388-865-0275, filed 9/3/09, effective 10/4/09. Statutory Authority: RCW 71.24.035, 71.05.560, and chapters 71.24 and 71.05 RCW. 06-17-114, § 388-865-0275, filed 8/18/06, effective 9/18/06. 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 388-865-0405 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 388-865-0150;

(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 388-865-0105 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, to include at a minimum:

(a) The skills he or she needs for his/her job description and the population served; and

(b) The requirements of RCW 71.05.720.

[Statutory Authority: RCW 71.05.560, 71.05.700, 71.05.705, 71.05.710, 71.05.715, 71.05.720, and 71.24.035. 09-19-012, § 388-865-0405, filed 9/3/09, effective 10/4/09. 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 388-865-0440 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 the following, as consistent with confidentiality statutes and without unduly delaying a crisis response:

(a) Designated mental health professionals;

(b) Crisis teams; and

(c) Voluntary and involuntary inpatient evaluation and treatment facilities.

(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, 71.05.700, 71.05.705, 71.05.710, 71.05.715, 71.05.720, and 71.24.035. 09-19-012, § 388-865-0440, filed 9/3/09, effective 10/4/09. Statutory Authority: RCW 71.24.035, 71.05.560, and chapters 71.24 and 71.05 RCW. 06-17-114, § 388-865-0440, filed 8/18/06, effective 9/18/06. 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 388-865-0452 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.

(2) Written procedures for managing assaultive and/or self-injurious patient behavior.

(3) Written procedures for visits to homes and other private locations in accordance with the requirements of RCW 71.05.700 through 71.05.715.

(4) Crisis telephone screening;

(5) 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.

(6) 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 designated mental health professional.

(7) 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.

(8) 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 designated mental health professional and transporting consumers.

[Statutory Authority: RCW 71.05.560, 71.05.700, 71.05.705, 71.05.710, 71.05.715, 71.05.720, and 71.24.035. 09-19-012, § 388-865-0452, filed 9/3/09, effective 10/4/09. Statutory Authority: RCW 71.24.035, 71.05.560, and chapters 71.24 and 71.05 RCW. 06-17-114, § 388-865-0452, filed 8/18/06, effective 9/18/06. 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 388-865-0456 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;

(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; and

(7) Maintain written procedures for home visits in accordance with the requirements of RCW 71.05.700 through 71.05.715.

[Statutory Authority: RCW 71.05.560, 71.05.700, 71.05.705, 71.05.710, 71.05.715, 71.05.720, and 71.24.035. 09-19-012, § 388-865-0456, filed 9/3/09, effective 10/4/09. 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 388-865-0466 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 chapters 71.05 and 71.34 RCW.

(b) A copy of the less restrictive alternative court order and any subsequent modifications are included in the clinical record;

(c) Development and implementation of an individual service plan which addresses the conditions of the less restrictive alternative court order and a plan for transition to voluntary treatment;

(d) That the consumer receives psychiatric treatment including medication management for the assessment and

prescription of psychotropic medications appropriate to the needs of the consumer. Such services must be provided:

- (i) At least weekly during the fourteen-day period;
- (ii) Monthly during the ninety-day and one-hundred eighty day periods of involuntary treatment unless the attending physician determines another schedule is more appropriate, and they record the new schedule and the reasons for it in the consumer's clinical record.

(2) Maintain written procedures for managing assaultive and/or self-destructive patient behavior, and provide training to staff in these interventions;

(3) Have a written protocol for referring consumers to an inpatient evaluation and treatment facility for admission on a seven-day-a-week, twenty-four-hour-a-day basis;

(4) For consumers who require involuntary detention the protocol must also include procedures for:

- (a) Contacting the designated mental health professional regarding revocations and extension of less restrictive alternatives, and

- (b) Transporting consumers.

(5) Maintain written procedures for home visits in accordance with the requirements of RCW 71.05.700 through 71.05.715

[Statutory Authority: RCW 71.05.560, 71.05.700, 71.05.705, 71.05.710, 71.05.715, 71.05.720, and 71.24.035. 09-19-012, § 388-865-0466, filed 9/3/09, effective 10/4/09. Statutory Authority: RCW 71.24.035, 71.05.560, and chapters 71.24 and 71.05 RCW. 06-17-114, § 388-865-0466, filed 8/18/06, effective 9/18/06. 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 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;

(5) Follow a written protocol for transporting individuals to inpatient evaluation and treatment facilities; and

(6) Maintain written procedures for home visits in accordance with the requirements of RCW 71.05.700 through 71.05.715.

[Statutory Authority: RCW 71.05.560, 71.05.700, 71.05.705, 71.05.710, 71.05.715, 71.05.720, and 71.24.035. 09-19-012, § 388-865-0468, filed 9/3/09, effective 10/4/09. Statutory Authority: RCW 71.24.035, 71.05.560, and chapters 71.24 and 71.05 RCW. 06-17-114, § 388-865-0468, filed 8/18/06, effective 9/18/06. 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.]