WSR 11-21-020
EMERGENCY RULES
DEPARTMENT OF
SOCIAL AND HEALTH SERVICES
(Economic Services Administration)
[Filed October 11, 2011, 9:37 a.m., effective October 11, 2011, 9:37 a.m.]

Effective Date of Rule: Immediately.

Other Findings Required by Other Provisions of Law as Precondition to Adoption or Effectiveness of Rule: ESHB 2082, Laws of 2011, terminates all components of the disability lifeline (DL) program effective October 31, 2011, and establishes the aged, blind, or disabled (ABD) assistance and the pregnant women assistance (PWA) programs effective November 1, 2011.

Purpose: The department is amending, repealing, and creating new rules to eliminate reference to the DL program and to establish standards for the ABD assistance and PWA programs to comply with ESHB 2082.

Citation of Existing Rules Affected by this Order: Repealing WAC 388-400-0025, 388-404-0010, 388-408-0010, 388-418-0025, 388-424-0016, 388-448-0001, 388-448-0010, 388-448-0020, 388-448-0030, 388-448-0035, 388-448-0040, 388-448-0050, 388-448-0060, 388-448-0070, 388-448-0080, 388-448-0090, 388-448-0100, 388-448-0110, 388-448-0120, 388-448-0130, 388-448-0140, 388-448-0150, 388-448-0160, 388-448-0180, 388-448-0200, 388-448-0210, 388-448-0220, 388-448-0250, 388-450-0110, 388-450-0135, 388-450-0175, 388-462-0011 and 388-478-0030; and amending WAC 388-273-0020, 388-406-0005, 388-406-0045, 388-406-0055, 388-408-0005, 388-416-0010, 388-424-0010, 388-424-0015, 388-436-0030, 388-442-0010, 388-450-0040, 388-450-0045: 388-450-0095, 388-450-0100, 388-450-0115, 388-450-0120, 388-450-0130, 388-450-0156, 388-450-0170, 388-460-0020, 388-460-0040, 388-468-0005, 388-470-0055, 388-473-0010, 388-474-0010, 388-474-0020, 388-476-0005, 388-478-0035, and 388-486-0005.

Statutory Authority for Adoption: RCW 74.04.005, 74.04.050, 74.04.055, 74.04.057, 74.08.090, 74.08A.100, 74.04.770, 74.04.0052, 74.04.655, 74.04.770, 74.08.043, 74.08.335.

Other Authority: ESHB 2082, chapter 36, Laws of 2011.

Under RCW 34.05.350 the agency for good cause finds that state or federal law or federal rule or a federal deadline for state receipt of federal funds requires immediate adoption of a rule.

Reasons for this Finding: ESHB 2082, Laws of 2011, eliminates DL October 31, 2011, and creates ABD and PWA November 1, 2011.

Number of Sections Adopted in Order to Comply with Federal Statute: New 28, Amended 29, Repealed 33; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 0, Amended 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 28, Amended 29, Repealed 33; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.

Date Adopted: October 10, 2011.

Katherine I. Vasquez
Rules Coordinator

AMENDATORY SECTION (Amending WSR 02-18-106, filed 9/3/02, effective 10/4/02)

WAC 388-273-0020 Who may receive Washington telephone assistance program (WTAP)? (1) To receive WTAP benefits, you must:

(a) Be age eighteen or older or, if under eighteen, be the responsible head of household, and either;

(b) Be receiving one of the following programs from us:

(i) Temporary assistance for needy families (TANF);

(ii) State family assistance (SFA);

(iii) ((~~General assistance~~)) Pregnant women assistance (PWA);

(iv) Aged, blind, or disabled (ABD) cash assistance;

(v) Refugee assistance;

(((~~v~~))) (vi) Food assistance;

(((~~vi~~))) (vii) State Supplemental Security Income (SSI);

(((~~vii~~))) (viii) Medical assistance, including medicare cost sharing programs;

(((~~viii~~))) (ix) Community options program entry system (COPES);

(((~~ix~~))) (x) Chore services; or

(c) Have completed using community service voice mail services, and been identified to the department as eligible for WTAP by the community agency that provided your community service voice mail program; and

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

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

(b) **"Flat rate service"** is telephone service with a single monthly payment that allows unlimited local calling for a specified length of time. The local exchange flat rate includes any federal end user access charges and other charges necessary to obtain the service; and

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

NEW SECTION

WAC 388-400-0055 Who is eligible for the pregnant women assistance (PWA) program? Effective November 1, 2011:

(1) You can get pregnant women assistance (PWA), if you:

(a) Are pregnant as verified by a medical statement;

(b) Meet the citizenship/alien status requirements of WAC 388-424-0010;

(c) Live in the state of Washington per WAC 388-468-0005;

(d) Do not live in a public institution unless specifically allowed under RCW 74.08.025;

(e) Meet TANF/SFA:

(i) Income requirements under chapter 388-450 WAC;

(ii) Resource requirements under chapter 388-470 WAC; and

(iii) Transfer of property requirements under chapter 388-488 WAC.

(f) Tell us your social security number as required under WAC 388-476-0005;

(g) Report changes of circumstances as required under WAC 388-418-0005; and

(2) If you are an unmarried pregnant minor your living arrangements must meet the requirements of WAC 388-486-0005.

(3) You cannot get PWA if you:

(a) Are eligible for temporary assistance for needy families (TANF) benefits;

(b) Are eligible for state family assistance (SFA) benefits;

(c) Refuse or fail to meet a TANF or SFA eligibility rule;

(d) Refuse or fail to participate in drug or alcohol treatment as required in WAC 388-449-0220; or

(e) Are eligible for supplemental security income (SSI) benefits.

NEW SECTION

WAC 388-400-0060 Who is eligible for aged, blind or disabled (ABD) cash assistance? (1) Effective November 1, 2011, you are eligible for aged, blind, or disabled (ABD) cash benefits if you:

(a) Are:

(i) At least sixty-five years old;

(ii) Blind as defined by the Social Security Administration (SSA); or

(iii) Likely to be disabled as defined in WAC 388-449-0001 through 388-449-0100; and

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

(c) Are in financial need according to ABD cash income and resource rules in chapters 388-450, 388-470 and 388-488 WAC. We determine who is in your assistance unit according to WAC 388-408-0010;

(d) Meet the citizenship/alien status requirements under WAC 388-424-0015;

(e) Provide a social security number as required under WAC 388-476-0005;

(f) Reside in the state of Washington as required under WAC 388-468-0005;

(g) Sign an interim assistance reimbursement authorization to agree to repay the monetary value of general assistance, disability lifeline, or aged blind or disabled benefits subsequently duplicated by supplemental security income benefits as described under WAC 388-449-0200, 388-449-0210 and 388-474-0020;

(h) Report changes of circumstances as required under WAC 388-418-0005; and

(i) Complete a mid-certification review and provide proof of any changes as required under WAC 388-418-0011.

(2) You aren't eligible for aged, blind, or disabled cash benefits if you:

(a) Are eligible for temporary assistance for needy families (TANF) benefits;

(b) Are eligible for state family assistance (SFA) benefits;

(c) Refuse or fail to meet a TANF or SFA eligibility rule;

(d) Refuse or fail to participate in drug or alcohol treatment as required in WAC 388-449-0220;

(e) Refuse of fail to follow through with the SSI application as required in WAC 388-449-0200;

(f) Refuse or fail to participate in vocational rehabilitation services as required in WAC 388-449-0225;

(g) Are eligible for supplemental security income (SSI) benefits;

(h) Are an ineligible spouse of an SSI recipient; or

(i) Failed to follow a Social Security Administration (SSA) program rule or application requirement and SSA denied or terminated your benefits.

(3) If you reside in a public institution and meet all other requirements, your eligibility for ABD cash depends on the type of institution. A "public institution" is an institution that is supported by public funds, and a governmental unit either is responsible for it or exercises administrative control over it.

(a) You may be eligible for ABD cash if you are:

(i) A patient in a public medical institution; or

(ii) A patient in a public mental institution and:

(A) Sixty-five years of age or older; or

(B) Twenty years of age or younger.

(4) You aren't eligible for ABD cash when you are in the custody of or confined in a public institution such as a state penitentiary or county jail including placement:

(a) In a work release program; or

(b) Outside of the institution including home detention.

AMENDATORY SECTION (Amending WSR 09-19-129, filed 9/22/09, effective 11/1/09)

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~~)) ABD cash 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 Statistical 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.

AMENDATORY SECTION (Amending WSR 09-19-129, filed 9/22/09, effective 11/1/09)

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)~~)) ABD cash, 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).

AMENDATORY SECTION (Amending WSR 10-11-033, filed 5/11/10, effective 7/1/10)

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, PWA, or RCA; or

(c) No later than the forty-fifth day for ((~~general assistance (GA)~~)) aged, blind, or disabled (ABD) cash assistance 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 date you provide the required verification. 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.

(4) For long-term care, the date your services start is stated in WAC 388-106-0045.

AMENDATORY SECTION (Amending WSR 03-17-066, filed 8/18/03, effective 9/18/03)

WAC 388-408-0005 What is a cash assistance unit? (1) For all sections of this chapter:

(a) **"We"** means the department of social and health services.

(b) **"You"** means a person that is applying for or getting benefits from the department.

(c) **"Assistance unit"** or **"AU"** is the group of people who live together and whose income or resources we count to decide your eligibility for benefits and the amount of benefits you get.

(2) For ((~~GA-U~~)) ABD cash, we decide who is in the AU under WAC ((~~388-408-0010~~)) 388-408-0060.

(3) For TANF, PWA, or SFA, we decide who is in the AU by taking the following steps:

(a) We start with who must be in the AU under WAC 388-408-0015;

(b) We add those you choose to have in the AU under WAC 388-408-0025; and

(c) We remove those who are not allowed in the AU under WAC 388-408-0020.

NEW SECTION

WAC 388-408-0060 Who is in my assistance unit for aged, blind, or disabled (ABD) cash assistance? (1) If you are an adult that is aged, blind, or likely to be disabled as defined in WAC 388-400-0060, 388-449-0001, you can be in a ABD cash AU;

(2) If you are married and live with your spouse, we decide who to include in the AU based on who is aged, blind, or likely to be disabled:

(a) If you are both aged, blind, or likely to be disabled as defined in WAC 388-400-0060, 388-449-0001, we include both of you in the same AU.

(b) If only one spouse is aged, blind, or likely to be disabled, we include only the aged, blind, or likely to be disabled spouse in the AU. We count some of the income of the spouse that is not in the AU as income to the AU under WAC 388-450-0135.

AMENDATORY SECTION (Amending WSR 02-17-030, filed 8/12/02, effective 9/12/02)

WAC 388-416-0010 Medical certification periods for recipients of cash assistance programs. (1) The certification period for medical services begins on the first day of the month of application when the client is determined eligible for cash assistance for one of the following programs:

(a) Temporary assistance for needy families (TANF);

(b) Aged, blind, or disabled (ABD) cash assistance;

(c) Pregnant women assistance (PWA);

(d) Supplemental Security Income (SSI); or

(((~~(e)~~))) (e) Refugee assistance.

(2) The certification period for the medical programs associated with the cash programs in subsection (1) of this section continues as long as eligibility for these programs lasts. When a client's cash assistance is terminated, eligibility for medical assistance is continued until eligibility is redetermined as described in WAC 388-418-0025.

(3) The certification period for medical can begin up to three months prior to the month of application for clients described in subsection (1) of this section if the conditions in WAC 388-416-0015(6) apply.

((~~(4) The certification period for medical care services begins on the date eligibility begins for the following cash assistance programs:~~

~~(a) General assistance for unemployable persons (GA-U); or~~

~~(b) Alcohol and Drug Abuse Treatment and Support Act (ADATSA) programs, when the client is either receiving a grant or waiting for treatment to begin.~~

~~(5) The certification period for medical care services for clients in subsection (4) of this section runs concurrently with the period of eligibility for the client's cash assistance program.~~))

AMENDATORY SECTION (Amending WSR 11-16-056, filed 7/29/11, effective 8/29/11)

WAC 388-424-0010 Citizenship and alien status—Eligibility for TANF, medicaid, and CHIP. (1) To receive temporary assistance for needy families (TANF), medicaid, or children's health insurance program (CHIP) benefits, an individual must meet all other eligibility requirements and be one of the following as defined in WAC 388-424-0001:

(a) A United States (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; or

(f) A Hmong or Highland Lao.

(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, medicaid, and CHIP.

(3) A "qualified alien" who first physically entered the U.S. on or after August 22, 1996 cannot receive TANF, medicaid, or CHIP for five years after obtaining status as a qualified alien unless the criteria in WAC 388-424-0006 (4) or (5) are met.

(4) A lawfully present "nonqualified alien" child or pregnant woman as defined in WAC 388-424-0001 who meet residency requirements as defined in WAC 388-468-0005 may receive medicaid or CHIP.

(5) An alien who is ineligible for TANF, medicaid or CHIP 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 medical program); or

(b) State-funded cash or chemical dependency benefits as described in WAC 388-424-0015 (state family assistance (SFA), aged, blind, or disabled (ABD) cash, disability lifeline (DL) and the Alcohol and Drug Addiction Treatment and Support Act (ADATSA)), and medical benefits as described in WAC 388-424-0016; or

(c) Pregnancy medical benefits for noncitizen women as described in WAC 388-462-0015(3); or

(d) State-funded apple health for kids as described in WAC 388-505-0210(5).

AMENDATORY SECTION (Amending WSR 11-16-056, filed 7/29/11, effective 8/29/11)

WAC 388-424-0015 Immigrant eligibility restrictions for the state family assistance, ((~~general assistance~~)) ABD cash, PWA, and ADATSA programs. (1) To receive state family assistance (SFA) benefits, you must be:

(a) A "qualified alien" as defined in WAC 388-424-0001 who is ineligible for TANF due to the five-year bar as described in WAC 388-424-0006(3); or

(b) A nonqualified alien who meets the Washington state residency requirements as listed in WAC 388-468-0005, including a noncitizen American Indian who does not meet the criteria in WAC 388-424-0001.

(2) To receive ((~~general assistance (GA)~~)) aged, blind, or disabled (ABD) cash or pregnant women assistance (PWA) benefits, you must be ((~~ineligible for the TANF, SFA, or SSI program for a reason other than failure to cooperate with program requirements, and belong to one of the following groups 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" or similarly defined lawful immigrant such as victim of trafficking as defined in WAC 388-424-0001; or

(e) A nonqualified alien ((~~who meets the Washington state residency requirements as listed in WAC 388-468-0005~~)) described in WAC 388-424-0001 who:

(i) Has declared their intent to stay in the United States indefinitely; and

(ii) Provides current documentation that they have petitioned the United States Citizenship and Immigration Services (USCIS) for adjustment of status and USCIS is not taking action to enforce their departure; or

(iii) Are citizens of Micronesia, the Republic of the Marshall Islands, or the Republic of Palau who have a compact or free association with the United States.

(3) To receive ADATSA benefits, you must belong to one of the following groups 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" or similarly defined lawful immigrant such as victim of trafficking; or

(e) A nonqualified alien who meets the Washington state residency requirements as listed in WAC 388-468-0005.

AMENDATORY SECTION (Amending WSR 11-02-037, filed 12/29/10, effective 2/1/11)

WAC 388-436-0030 How does my eligibility for other possible cash benefits impact my eligibility for CEAP ((~~depends on other possible cash benefits.~~))? (1) You are ineligible for CEAP if you, or a household member, are eligible for any of the following programs:

(a) TANF or SFA, unless the family has had its case grant terminated due to WAC 388-310-1600 within the last six months;

(b) Pregnant women assistance (PWA);

(c) RCA;

(((~~c) Disability lifeline (DL)~~))) (d) Aged, blind, or disabled (ABD) cash;

(((~~d)~~))) (e) Supplemental Security Income (SSI);

(((~~e)~~))) (f) Medical assistance for those applicants requesting help for a medical need;

(((~~f)~~))) (g) Food assistance for those applicants requesting help for a food need;

(((~~g)~~))) (h) Housing assistance from any available source for those applicants requesting help for a housing need;

(((~~h)~~))) (i) Unemployment compensation, veteran's benefits, industrial insurance benefits, Social Security benefits, pension benefits, or any other source of financial benefits the applicant is potentially eligible to receive.

(2) The department may require the applicant, or anyone in the assistance unit, to apply for and take any required action to receive benefits from programs described in the above subsection (1)(a) through (h).

(3) The department may not authorize CEAP benefits to any household containing a member who is:

(a) Receiving cash benefits from any of the following programs:

(i) TANF/SFA;

(ii) PWA;

(iii) RCA;

(((~~(iii)~~))) (iv) DCA; or

(((~~(iv) DL~~))) (v) ABD cash.

(b) Receiving reduced cash benefits for failure to comply with program requirements of TANF/SFA, or RCA.((-))

(4) The department may authorize CEAP to families reapplying for TANF/SFA who are not eligible for TANF cash benefits under WAC 388-310-1600 until they complete the four week participation requirement.

AMENDATORY SECTION (Amending WSR 05-21-100, filed 10/18/05, effective 11/18/05)

WAC 388-442-0010 How does being a fleeing felon impact my eligibility for benefits? (1) You are a **fleeing felon** if you are fleeing to avoid prosecution, custody, or confinement for a crime or an attempt to commit a crime that is considered a felony in the place from which you are fleeing.

(2) If you are a fleeing felon, or violating a condition of probation or parole as determined by an administrative body or court that has the authority to make this decision, you are not eligible for TANF/SFA, ((~~GA~~)) PWA, ABD cash, or Basic Food benefits.

NEW SECTION

WAC 388-449-0001 What are the disability requirements for the aged, blind, or disabled (ABD) program? For the purposes of this chapter, "we" and "us" refer to the department of social and health services.

"You" means the applicant or recipient.

"Disabled" is defined by the Social Security Administration for supplemental security income (SSI) as the inability to engage in any substantial gainful activity (SGA) by reason of any medically determinable physical or mental impairment(s) which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve months.

"Physical impairment" means a diagnosable physical illness.

"Mental impairment" means a diagnosable mental disorder. We exclude any diagnosis of or related to alcohol or drug abuse or addiction.

(1) We determine if you are likely to be disabled when:

(a) You apply for ABD cash benefits;

(b) You become employed;

(c) You obtain work skills by completing a training program; or

(d) We receive new information that indicates you may be employable.

(2) We determine you are likely to be disabled if:

(a) The Social Security Administration (SSA) determined you are eligible for disability benefits;

(b) You are determined to meet SSA disability criteria by disability determination services (DDDS);

(c) The Social Security Administration (SSA) stops your supplemental security income (SSI) payments solely because you are not a citizen;

(d) You are eligible for long-term care services from aging and disability services administration for a medical condition that is expected to last twelve months or more or result in death; or

(e) You are approved through the sequential evaluation process (SEP) defined in WAC 388-449-0005 through 388-449-0100. The SEP is the sequence of five steps. Step 1 considers whether you are currently working. Steps 2 and 3 consider medical evidence and whether you are likely to meet a listed impairment under Social Security's rules. Steps 4 and 5 consider your residual functional capacity and vocational factors such as age, education, and work experience in order to determine your ability to do your past work or other work.

(3) If you have a physical or mental impairment and you are impaired by alcohol or drug addiction and do not meet the other disability criteria in subsection (2)(a) through (d) above, we decide if you are eligible for ABD cash by applying the sequential evaluation process described in WAC 388-449-0005 through 388-449-0100. You aren't eligible for ABD cash benefits if you are disabled primarily because of alcoholism or drug addiction.

(4) In determining disability, we consider only your ability to perform basic work-related activities. "Basic work-related activities" are activities that anyone would be required to perform in a work setting. They consist of: sitting, standing, walking, lifting, carrying, handling, and other physical functions (including manipulative or postural functions, (such as reaching, handling, stooping, or crouching) seeing, hearing, communicating, remembering, understanding and following instructions, responding appropriately to supervision and coworkers, and tolerating the pressures of a work setting.

(5) We determine you are not likely to meet SSI disability criteria if SSA denied your application for SSI or Social Security Disability Insurance (SSDI) in the last twelve months unless:

(a) You file a timely appeal with SSA;

(b) SSA decides you have good cause for a late appeal; or

(c) You give us medical evidence of a potentially disabling condition that SSA did not consider or that your condition has deteriorated; and

(i) You give us proof that SSA denied your request to reconsider your claim; or

(ii) You give us proof that you don't meet the nondisability criteria for SSI.

NEW SECTION

WAC 388-449-0005 Sequential evaluation process step 1—How does the department determine if you are performing substantial gainful employment? We deny disability if you are engaging in substantial gainful activity (SGA) when you apply for aged, blind, or disabled (ABD) benefits. "Substantial gainful activity" means you are performing, in a regular and predictable manner, an activity usually done for pay or profit.

(1) You must be earning less than the SGA standard as defined by the Social Security Administration (SSA) to be eligible for ABD cash, unless you work:

(a) Under special conditions that go beyond the employer providing reasonable accommodation, such as in a sheltered workshop; or

(b) Occasionally or part-time because your impairment limits the hours you are able to work compared to unimpaired workers in the same job as verified by your employer.

NEW SECTION

WAC 388-449-0010 What evidence do we consider to determine disability? To determine whether a medically determinable impairment exists, we consider medical evidence from "acceptable medical sources." "Acceptable medical sources" include:

(1) For a physical impairment, a health professional licensed in Washington State or where the examination was performed:

(a) A physician, which includes:

(i) Medical doctor (M.D.);

(ii) Doctor of osteopathy (D.O.);

(iii) Doctor of optometry (O.D.) for visual disorders;

(iv) Doctor of podiatry (D.P.) for foot disorders; and

(v) Qualified speech-language pathologists, for purposes of establishing speech or language impairments only.

(2) For a mental impairment, professionals licensed in Washington State or where the examination was performed:

(a) A psychiatrist; or

(b) A psychologist.

(3) We accept medical evidence of how your impairment(s) affect your ability to function from treating medical sources once a diagnosis of a medically determinable impairment has been established by an "acceptable medical source" listed in (1) and (2) above:

(a) All medical professionals listed in (1) and (2) above;

(b) A physician who is currently treating you for a mental impairment;

(c) A physician's assistant who is currently treating your for a physical impairment; and

(d) An advanced nurse practitioner who is treating you for a condition within their certification.

(4) "Other evidence" means information from other sources not listed in subsection (1), (2), or (3) of this section who can provide supporting documentation of functioning for impairments established by acceptable medical sources in subsections (1) or (2) of this section. Other sources include public and private agencies, nonmedical sources such as schools, parents and caregivers, social workers and employers, and other practitioners such as naturopaths, chiropractors, and audiologists.

NEW SECTION

WAC 388-449-0015 What medical evidence do I need to provide? You must give us medical evidence of your impairment(s) and how they affect your ability to perform regular and continuous work activity. Medical evidence must be in writing and be clear, objective, and complete.

(1) Objective evidence for physical impairments means:

(a) Laboratory test results;

(b) Pathology reports;

(c) Radiology findings including results of X rays and computer imaging scans;

(d) Clinical findings, including but not limited to ranges of joint motion, blood pressure, temperature or pulse, and documentation of a physical examination; and

(e) Hospital history and physical reports and admission and discharge summaries; or

(f) Other medical history and physical reports related to your current impairments.

(2) Objective evidence for mental impairments means:

(a) Clinical interview observations, including objective mental status exam results and interpretation.

(b) Explanation of how examination findings meet the clinical and diagnostic criteria of the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM).

(c) Hospital, outpatient and other treatment records related to your current impairments.

(d) Testing results, if any, including:

(i) Description and interpretation of tests of memory, concentration, cognition or intelligence; or

(ii) Interpretation of medical tests to identify or exclude a connection between the mental impairment and physical illness.

(3) Medical evidence sufficient for a disability determination must be from a medical professional described in WAC 388-449-0010 and must include:

(a) A diagnosis for the impairment, or impairments, based on an examination performed by an acceptable medical source defined in WAC 388-449-0010 within five years of application;

(b) A clear description of how the impairment relates to your ability to perform the work-related activities listed in WAC 388-449-0005;

(c) Documentation of how long a condition has impaired your ability to perform work related activities;

(d) A prognosis, or written statement of how long an impairment will impair your ability to perform work related activities; and

(e) A written statement from a medical professional (defined in WAC 388-449-0010) describing what you are capable of doing despite your impairment (medical source statement) based on an examination performed within ninety days of the date of application or forty-five days before the month of disability review.

(4) We will consider documentation in addition to objective evidence to support the acceptable medical source or treating provider's opinion that you are unable to perform substantial gainful employment, such as proof of hospitalization.

(5) When making a disability decision, we don't use your report of symptoms as evidence unless objective evidence shows there is an impairment that could reasonably be expected to produce those symptoms.

(6) We don't use symptoms related to substance abuse or a diagnosis of addiction or chemical dependency when determining disability if substance use is material to your impairment.

(7) We consider diagnoses that are independent of addiction or chemical dependency when determining disability.

(8) We determine you have a diagnosis that is independent of addiction or chemical dependency if the impairment

will persist at least ninety days after you stop using drugs or alcohol.

(9) If you can't obtain medical evidence sufficient for us to determine if you are likely to be disabled without cost to you, and you meet the other eligibility conditions in WAC 388-400-0060, we pay the costs to obtain objective evidence based on our published payment limits and fee schedules.

(10) We determine the likelihood of disability based solely on the objective information we receive. We are not obligated to accept another agency's or person's decision that you are disabled or unemployable.

(11) We can't use a statement from a medical professional to determine that you are disabled unless the statement is supported by objective medical evidence.

NEW SECTION

WAC 388-449-0020 How does the department evaluate functional capacity for mental health impairments? If you have a mental impairment, we evaluate ability to function in a work setting based on objective narrative clinical assessment from a medical professional as described in WAC 388-449-0010. We may also use other evidence as described in WAC 388-449-0010. Functioning means your ability to perform typical tasks that would be required in a routine job setting and your ability to interact effectively while working.

(1) We evaluate cognitive and social functioning by assessing your ability to:

(a) Understand, remember, and persist in tasks by following simple instructions of one or two steps.

(b) Understand, remember, and persist in tasks by following complex instructions of three or more steps.

(c) Perform activities within a schedule, maintain regular attendance, and be punctual within customary tolerances.

(d) Learn new tasks.

(e) Perform routine tasks without undue supervision.

(f) Adapt to changes in a routine work setting.

(g) Make simple work-related decisions.

(h) Be aware of normal hazards and take appropriate precautions.

(i) Ask simple questions or request assistance.

(j) Communicate and perform effectively in a work setting with public contact.

(k) Communicate and perform effectively in a work setting with limited public contact.

(l) Complete a normal workday and workweek without interruptions from psychologically based symptoms.

(m) Set realistic goals and plan independently.

NEW SECTION

WAC 388-449-0030 How does the department evaluate functional capacity for physical impairments? If you have a physical impairment we evaluate your ability to work based on objective medical evidence from a medical professional as described in WAC 388-449-0010. We may also use other evidence as described in WAC 388-449-0010.

(1) **"Exertion level"** means having strength, flexibility, and mobility to lift, carry, stand or walk as needed to fulfill job duties in the following work levels. For this section, "occasionally" means less than one-third of the time and "frequently" means one-third to two-thirds of the time.

The following table is used to determine your exertion level. Included in this table is a strength factor, which is your ability to perform physical activities, as defined in Appendix C of the Dictionary of Occupational Titles (DOT), Revised Edition, published by the U.S. Department of Labor as posted on the Occupational Information Network (O*NET).

If you are able to:	Then we assign this exertion level
(a) Lift ten pounds maximum and frequently lift or carry lightweight articles. Walking or standing only for brief periods.	Sedentary
(b) Lift twenty pounds maximum and frequently lift or carry objects weighing up to ten pounds. Walk six out of eight hours per day or stand during a significant portion of the workday. Sitting and using pushing or pulling arm or leg movements most of the day.	Light
(c) Lift fifty pounds maximum and frequently lift or carry up to twenty-five pounds.	Medium
(d) Lift on hundred pounds maximum and frequently lift or carry up to fifty pounds.	Heavy

(2) **"Exertional limitation"** means a restriction in mobility, agility or flexibility in the following twelve activities: Balancing, bending, climbing, crawling, crouching, handling, kneeling, pulling, pushing, reaching, sitting, and stooping. We consider any exertional limitations when we determine your ability to work.

(3) **"Functional physical capacity"** means the degree of strength, agility, flexibility, and mobility you can apply to work-related activities. We consider the effect of the physical impairment on the ability to perform work-related activities when the physical impairment is assigned an overall severity rating of three or four. We determine functional physical capacity based on your exertional and nonexertional limitations. All limitations must be substantiated by the medical evidence and directly related to the diagnosed impairment(s).

(4) **"Nonexertional physical limitation"** means a restriction on work activities that does not affect strength, mobility, agility, or flexibility. Environmental restrictions may include, among other things, your inability to work in an area where you would be exposed to chemicals.

(5) **"Functional limitations"** means a restriction on work activities caused by unrelieved pain or the effects of medication prescribed to treat an impairment. We determine your functional limitations based on objective documentation from a medical professional as described in WAC 388-449-0010. We may also use other evidence as described in WAC

388-449-0010. We evaluate functioning by assessing your ability to:

(a) Perform activities within a schedule, maintain regular attendance, and be punctual within customary tolerances.

(b) Perform routine tasks without undue supervision.

(c) Make simple work-related decisions.

(d) Be aware of normal hazards and take appropriate precautions.

(e) Ask simple questions or request assistance.

NEW SECTION

WAC 388-449-0035 How does the department assign severity ratings to my impairment? (1) "Severity rating" is a rating of the extent of your impairment and how it impacts your ability to perform the basic work activities. The following chart provides a description of limitations on work activities and the severity ratings that would be assigned to each.

Effect on Work Activities	Degree of Impairment	Numerical Value
(a) There is no effect on your performance of basic work-related activities.	None	1
(b) There is no significant effect on your performance of basic work-related activities.	Mild	2
(c) There are limits on your performance of basic work-related activities.	Moderate	3
(d) There are significant limits on your performance of basic work-related activities.	Marked	4
(e) You are unable to perform basic work-related activities.	Severe	5

(2) We use the description of how your condition impairs your ability to perform work activities given by the acceptable medical source or your treating provider, and review other evidence you provide, to establish severity ratings when the impairments are supported by, and consistent with, the objective medical evidence.

(3) A contracted doctor reviews your medical evidence and the ratings assigned to your impairment when:

(a) The medical evidence indicates functional limitations consistent with at least a moderate physical or mental health impairment;

(b) Your impairment has lasted, or is expected to last, twelve months or more with medical treatment; and

(c) You were not previously determined likely to be disabled as defined in WAC 388-449-0010 through 388-449-0100.

(4) The contracted doctor reviews your medical evidence, severity ratings, and functional assessment to determine whether:

(a) The Medical evidence is objective and sufficient to support the findings of the provider;

(b) Description of impairments is supported by the medical evidence; and

(c) Severity rating and assessment of functional limitations assigned by DSHS are consistent with the medical evidence.

(5) If the medical provider's description of your impairment(s) is not consistent with the objective evidence, we will assign a severity rating consistent with objective medical evidence, and clearly describe why we rejected the medical evidence provider's opinion.

NEW SECTION

WAC 388-449-0040 How does the department determine the severity of mental impairments? If you are diagnosed with a mental impairment by an acceptable medical source described in WAC 388-449-0010, we use information from medical sources described in WAC 388-449-0010 to determine how the impairment limits work-related activities.

(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, and other evidence, 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	None (1)
71 to 84	Moderate (3)
60 to 70	Marked (4)
59 or lower	Severe (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 an impairment diagnosed as a mood, thought, memory, or cognitive 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 most recent published edition of the Diagnostic and Statistical Manual of Mental Disorders.

(6) The Global Assessment of Functioning (GAF) is a numeric scale (0 through 100) used to rate the social, occupational, and psychological functioning of adults.

(7) 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 objective evidence and global assessment of functional score are consistent with a limitation on performing work activities.	Moderate (3)
(b) You are diagnosed with a functional disorder with psychotic features. (c) You have had two ore more hospitalizations for psychiatric reasons in the past two years. (d) You have had more than six months of continuous psychiatric inpatient or residential treatment in the past two years. (e) The objective evidence and global assessment of functioning score are consistent with significant limitations on ability to perform work activities.	Marked (4)
(f) The objective evidence and global assessment of functioning score are consistent with the absence of ability to perform work activities.	Severe (5)

(8) 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 moderate severity (3) ratings; or (b) One or more disorders rated moderate severity (3), and one rated marked severity (4).	Marked (4)
(c) Two or more disorders rated marked severity (4).	Severe (5)

NEW SECTION

WAC 388-449-0045 How does the department determine the severity of physical impairments? We must decide if your physical impairment is serious enough to significantly limit your ability to perform substantial gainful activity. "Severity of a physical impairment" means the degree that an impairment restricts you from performing basic work-related activities (see WAC 388-449-0005). Severity ratings range from none to severe. We will assign severity ratings according to the table in WAC 388-449-0035.

We assign to each physical impairment a severity rating that is supported by medical evidence.

NEW SECTION

WAC 388-449-0050 How does the department determine the severity of multiple impairments? (1) If you have more than one impairment we decide the overall severity rating by determining if your impairments have a combined effect on your ability to be gainfully employed. Each diagnosis is grouped by affected organ or function into one of thirteen "body systems." The thirteen body systems consist of:

(a) Musculo-skeletal;
(b) Special senses and speech;
(c) Respiratory;
(d) Cardiovascular;
(e) Digestive;
(f) Genito-urinary;
(g) Hematological;
(h) Skin;
(i) Endocrine;
(j) Neurological;
(k) Mental disorders;
(l) Malignant neoplastic; and
(m) Immune system.

(2) We follow these rules when there are multiple impairments:

(a) We group each diagnosis by body system.

(b) When you have two or more diagnosed impairments that limit work activities, we assign an overall severity rating as follows:

Your Condition	Severity Rating
(i) All impairments are mild and there is no cumulative effect on basic work activities.	Mild
(ii) All impairments are mild and there is a cumulative effect on basic work activities.	Moderate
(iii) Two or more impairments are of moderate severity and there is a cumulative effect on basic work activities.	Marked
(iv) Two are more impairments are of marked severity.	Severe

NEW SECTION

WAC 388-449-0060 Sequential evaluation process step II—How does the department review medical evidence to determine if I am eligible for benefits? When we receive your medical evidence, we review it to determine if it is sufficient to decide whether your circumstances meet disability requirements.

(1) We require written medical evidence to determine disability. The medical evidence must:

(a) Contain sufficient information as described under WAC 388-449-0015;

(b) Be written by an acceptable medical source or treating provider described in WAC 388-449-0010;

(c) Document the existence of a potentially disabling condition by an acceptable medical source described in WAC 388-449-0010; and

(d) Document an impairment has lasted, or is expected to last, twelve continuous months or more, or result in death;

(2) If the information received isn't clear, we may require more information before we determine your ability to perform substantial gainful activity. As examples, we may require you to get more medical tests or be examined by a medical specialist.

(3) We deny disability if:

(a) We don't have evidence that your impairment is of at least marked severity as defined in WAC 388-449-0035, 388-449-0040, 388-449-0045 388-449-0050;

(b) A reported impairment isn't expected to last twelve or more months or result in death; or

(c) Drug or alcohol abuse or addiction is material to your impairments.

NEW SECTION

WAC 388-449-0070 Sequential evaluation process step III—How does the department determine if you meet SSA listing of impairments criteria? We approve disability when we determine your impairment(s) meet the listings as described in appendix 1 to Subpart P of Part 404 within Title 20 of the Code of Federal Regulations.

NEW SECTION

WAC 388-449-0080 Sequential evaluation process step IV—How does the department evaluate if I am able to perform relevant past work? (1) If we neither deny disability at Step 1 or 2 nor approve it at Step 3, we consider our assessment of your physical and/or mental functional capacity, per WAC 388-449-0020, 388-449-0030, to determine if you can do work you have done in the past.

(2) We evaluate your work experience to determine if you have relevant past work and transferable skills. "Relevant past work" means work:

(a) Defined as substantial gainful activity per WAC 388-449-0005; and

(b) You have performed in the past fifteen years;

(c) You performed long enough to acquire the knowledge and skills to continue performing the job. You must meet the specific vocational preparation level as defined in Appendix C of the Dictionary of Occupational Titles.

(3) For each relevant past work situation, we compare:

(a) The exertional, nonexertional, and skill requirements of the job based on the Appendix C of the Dictionary of Occupational Titles.

(b) Your current cognitive, social, exertional, and nonexertional factors that significantly limit your ability to perform past work.

(4) We deny disability when we determine that you are able to perform any of your relevant past work regularly and continuously.

(5) We approve disability when you are fifty-five years of age or older and don't have the physical, cognitive, or social ability to perform past work.

NEW SECTION

WAC 388-449-0100 Sequential evaluation process step V—How does the department evaluate if I can perform other work when determining disability? If we decide you cannot do work that you have done before, we then decide if you have the residual functional capacity to perform other work.

(1) We evaluate education in terms of formal schooling or other training to acquire skills that enables you to meet job requirements. We classify education as:

If you	Then your education level is
(a) Can't read or write a simple communication, such as two sentences or a list of items.	Illiterate
(b) Have no formal schooling or vocational training beyond the sixth grade.	Marginal education
(c) Have no formal schooling or vocational training beyond the eleventh grade; or (d) Had participated in special education in basic academic classes of reading, writing or mathematics in high school.	Limited education
(e) Have received a high school diploma or general equivalency degree (GED) and don't meet the special education definition in (d) above; or (f) Have received skills training and were awarded a certificate, degree or license.	High school and above level of education

(2) We approve disability when you have a marked or severe physical health impairments and you meet the criteria below:

Exertional Level	Your age	Your education level	Other vocational factors	Environmental and Functional limitations
Less than sedentary	Any age	Any level	Does not apply	Does not apply

Exertional Level	Your age	Your education level	Other vocational factors	Environmental and Functional limitations
Sedentary	Any age	Any level	Does not apply	You have marked or severe environmental or functional impairments that preclude all sedentary work
Sedentary	Fifty and older	Any level	Does not apply	Does not apply
Sedentary	Forty-five and older	Marginal education or limited English proficiency (LEP)	No transferable skills to work level	Does not apply
Light	Any age	Any level	Does not apply	You have marked or severe environmental or functional impairments that preclude all sedentary work
Light	Fifty and older	Marginal education or limited English proficiency (LEP)	Does not apply	Does not apply

(3) We approve disability when you have mental impairments, with an overall severity of marked or severe, and we have documentation, including a mental status exam (MSE) per WAC 388-449-0040, that demonstrate social or cognitive factors, as described in WAC 388-448-0020 that interfere with working as follows:

Your age	Your education	Work history	Social limitation
Any age	Any level	Any	Markedly impaired in the ability to: (a) Understand, remember, and persist in tasks by following simple instructions of one or two steps; (b) Perform activities within a schedule, maintain regular attendance, and be punctual within customary tolerances; (c) Perform routine tasks without undue supervision; (d) Adapt to changes in a routine work setting; (e) Make simple work-related decisions; (f) Be aware of normal hazards and take appropriate precautions; (g) Ask simple questions or request assistance. Communicate and perform effectively in a work setting; or (h) Complete a normal workday and workweek without interruptions from psychologically based symptoms.
Any age	Any level	Unskilled	Markedly impaired in the ability to: (i) Understand, remember, and persist in tasks by following simple instructions of one or two steps; (j) Make simple work-related decisions; (k) Communicate and perform effectively in a work setting; or (l) Adapt to changes in a routine work setting.
Fifty and older	Any level	Skilled	Markedly impaired in the ability to: (m) Understand, remember, and persist in tasks by following complex instructions; (n) Set realistic goals and plan independently; or (o) Learn new tasks.

(4) We approve disability when you have both mental and physical impairments, with an overall severity marked or severe, and we have documentation, including a mental status exam (MSE) per WAC 388-449-0040, that demonstrate social or cognitive factors, as described in WAC 388-448-0020 that interfere with working as follows:

Your age	Your education	Skill or Work Level	Social Restrictions	Past Work
Any age	Any level	Restricted to light work level or less	You are moderately impaired in your ability to communicate and perform effectively in a work setting	No transferable skills to work level

Your age	Your education	Skill or Work Level	Social Restrictions	Past Work
Fifty or older	Limited education or LEP	Restricted to light work level or less	Does not apply	No transferable skills to work level
Any age	Marginal education or LEP	Restricted to medium work level or less	You are moderately impaired in your ability to communicate and perform effectively in a work setting with limited public contact	No transferable skills to work level

(5) If you don't meet the criteria listed above, and there are jobs you can do, we will find you are able to perform other work and we will take the following actions:

(a) Deny disability; and

(b) Give you examples of jobs you can do despite your impairments.

NEW SECTION

WAC 388-449-0150 When does my eligibility for aged, blind, or disabled (ABD) cash benefits end? (1) The maximum period of eligibility for ABD cash is twenty-four months before we must review additional medical evidence. If you remain on ABD cash at the end of the twenty-four month period, we determine your eligibility using current medical evidence.

(2) If your application for SSI is denied:

(a) We review your eligibility for the ABD cash program;

(b) We stop your benefits if you do not provide proof you have filed an appeal with SSA within sixty days of a SSI denial for not being disabled.

(3) We stop your benefits after the final decision on your application for SSI/SSA benefits or if you fail to follow through with any part of the SSI/SSA application or appeals process.

NEW SECTION

WAC 388-449-0200 Am I eligible for cash assistance for aged, blind, or disabled (ABD) while waiting for supplemental security income (SSI)? (1) You may receive ABD benefits while you are waiting to receive supplemental security income (SSI) benefits only when you:

(a) Have filed your SSI application with the Social Security Administration (SSA), follow through with SSA directions and requirements to process your application including keeping all interview and consultative examination appointments, and do not withdraw your application;

(b) Agree to assign the initial or reinstated SSI payment to us provided under WAC 388-449-0210;

(c) Are otherwise eligible according to WAC 388-400-0060; and

(d) Meet disability criteria listed in WAC 388-449-0001.

(2) To demonstrate your impairments are disabling despite medical treatment, you must participate in medical treatment for the impairments that keep you from working, unless you meet one of the following good cause reasons:

(a) The treatment provider has identified a risk that the treatment may cause further limitations or loss of a function or an organ and you are not willing to take that risk; or

(b) We determine that treatment is not available because you can't obtain it without cost to you.

(3) If you refuse or fail to participate in medical treatment without good cause, your benefits will end until you reapply and provide proof you are pursuing treatment as recommended.

NEW SECTION

WAC 388-449-0210 What is interim assistance and how do I assign it to the department? The ABD and SSI programs both provide cash assistance to meet your basic needs. You cannot receive this assistance for the same time period from both programs. When you are approved for or reinstated on SSI, you may receive a retroactive payment. When we made GA, DL, or ABD payments to you or on your behalf for the same time period, you must assign your interim assistance to repay us.

(1) **"Assign"** means that you sign a written authorization for the Social Security Administration (SSA) to send the SSI retroactive payment to us.

(2) **"Interim assistance"** means the monetary value of benefits we paid to you or on your behalf during:

(a) The time between your SSI application date and the month recurring SSI payments begin; or

(b) The period your SSI payments were suspended or terminated, and later reinstated.

NEW SECTION

WAC 388-449-0220 How does alcohol or drug dependence affect my eligibility for the ABD cash and pregnant women assistance programs? (1) You must complete a chemical dependency assessment when we have information that indicates you may be chemically dependent.

(2) You must accept an assessment referral and participate in drug or alcohol treatment if a certified chemical dependency counselor indicates a need for treatment, unless you meet one of the following good cause reasons:

(a) We determine that your physical or mental health impairment prevents you from participating in treatment.

(b) The outpatient chemical dependency treatment you need isn't available in the county you live in.

(c) You need inpatient chemical dependency treatment at a location that you can't reasonably access.

(3) If you refuse or fail to complete an assessment or treatment without good cause, your benefits will end until

you provide proof you are pursuing an assessment or treatment as required.

NEW SECTION

WAC 388-449-0225 Am I required to participate in vocational rehabilitation services if I receive ABD cash grant? You must participate in vocational rehabilitation services through the division of vocational rehabilitation (DVR) if you are determined to be eligible for DVR services.

AMENDATORY SECTION (Amending WSR 10-15-069, filed 7/16/10, effective 8/16/10)

WAC 388-450-0040 Native American benefits and payments. This section applies to TANF/SFA, RCA, ((~~GA~~)) PWA, ABD cash, medical, and food assistance programs.

(1) The following types of income are not counted when a client's benefits are computed:

(a) Up to two thousand dollars per individual per calendar year received under the Alaska Native Claims Settlement Act, P.L. 92-203 and 100-241;

(b) Income received from Indian trust funds or lands held in trust by the Secretary of the Interior for an Indian tribe or individual tribal member. Income includes:

(i) Interest; and

(ii) Investment income accrued while such funds are held in trust.

(c) Income received from Indian judgement funds or funds held in trust by the Secretary of the Interior distributed per capita under P.L. 93-134 as amended by P.L. 97-458 and 98-64. Income includes:

(i) Interest; and

(ii) Investment income accrued while such funds are held in trust.

(d) Up to two thousand dollars per individual per calendar year received from leases or other uses of individually owned trust or restricted lands, P.L. 103-66;

(e) Payments from an annuity fund established by the Puyallup Tribe of Indians Settlement Act of 1989, P.L. 101-41, made to a Puyallup Tribe member upon reaching twenty-one years of age; and

(f) Payments from the trust fund established by the P.L. 101-41 made to a Puyallup Tribe member.

(2) Other Native American payments and benefits that are excluded by federal law are not counted when determining a client's benefits. Examples include but are not limited to:

(a) White Earth Reservation Land Settlement Act of 1985, P.L. 99-264, Section 16;

(b) Payments made from submarginal land held in trust for certain Indian tribes as designated by P.L. 94-114 and P.L. 94-540;

(c) Payments under the Seneca Nation Settlement Act, P.L. 101-503; and

(d) For medical assistance, receipt of money by a member of a federally recognized tribe from exercising federally protected rights or extraction of protected resources, such as fishing, shell-fishing, or selling timber, is considered conversion of an exempt resource during the month of receipt. Any amounts remaining from the conversion of this exempt resource on the first of the month after the month of receipt will remain exempt if the funds were used to purchase another exempt resource. Any amounts remaining in the form of countable resources (such as in checking or savings accounts) on the first of the month after receipt, will be added to other countable resources for eligibility determinations.

AMENDATORY SECTION (Amending WSR 06-17-017, filed 8/4/06, effective 9/4/06)

WAC 388-450-0045 How do we count income from employment and training programs? This section applies to cash assistance, Basic Food, and medical programs for families, children, and pregnant women.

(1) We treat payments issued under the Workforce Investment Act (WIA) as follows:

(a) For cash assistance and medical programs for families, children, and pregnant women, we exclude all payments.

(b) For Basic Food:

(i) We exclude OJT earnings for children who are eighteen years of age or younger and under parental control as described in WAC 388-408-0035.

(ii) We count OJT earnings as earned income for people who are:

(A) Age nineteen and older; or

(B) Age eighteen or younger and not under parental control.

(iii) We exclude all other payments.

(2) We exclude **all** payments issued under the National and Community Service Trust Act of 1993. This includes payments made through the AmeriCorps program.

(3) We treat payments issued under Title I of the Domestic Volunteer Act of 1973, such as VISTA, AmeriCorps Vista, university year for action, and urban crime prevention program as follows:

(a) For cash assistance and medical programs for families, children, and pregnant women, we exclude all payments.

(b) For Basic Food, we count most payments as earned income. We exclude the payments if you:

(i) Received Basic Food or cash assistance at the time you joined the Title I program; or

(ii) Were participating in the Title I program and received an income disregard at the time of conversion to the Food Stamp Act of 1977. We continue to exclude the payments even if you do not get Basic Food every month.

(4) We exclude **all** payments issued under Title II of the Domestic Volunteer Act of 1973. These include:

(a) Retired senior volunteer program (RSVP);

(b) Foster grandparents program; and

(c) Senior companion program.

(5) We count training allowances from vocational and rehabilitative programs as earned income when:

(a) The program is recognized by federal, state, or local governments; and

(b) The allowance is not a reimbursement.

((~~(6) When GAU clients receive training allowances we allow:~~

~~(a) The earned income incentive and work expense deduction specified under WAC 388-450-0175, when applicable; and~~

~~(b) The actual cost of uniforms or special clothing required for the course as a deduction, if enrolled in a remedial education or vocational training course.~~

~~(7) We exclude support service payments received by or made on behalf of WorkFirst participants.~~))

AMENDATORY SECTION (Amending WSR 98-16-044, filed 7/31/98, effective 9/1/98)

WAC 388-450-0095 Allocating income—General. This section applies to TANF/SFA, RCA, ((~~and GA~~)) PWA, and ABD cash assistance programs.

(1) Allocation is the process of determining how much of a financially responsible person's income is considered available to meet the needs of legal dependents within or outside of an assistance unit.

(2) In-bound allocation means income possessed by a financially responsible person outside the assistance unit which is considered available to meet the needs of legal dependents in the assistance unit.

(3) Out-bound allocation means income possessed by a financially responsible assistance unit member which is set aside to meet the needs of a legal dependent outside the assistance unit.

AMENDATORY SECTION (Amending WSR 04-15-057, filed 7/13/04, effective 8/13/04)

WAC 388-450-0100 Allocating income—Definitions. The following definitions apply to the allocation rules for TANF/SFA, RCA, ((~~and GA~~)) PWA, and ABD cash programs:

(1) **"Dependent"** means a person who:

(a) Is or could be claimed for federal income tax purposes by the financially responsible person; or

(b) The financially responsible person is legally obligated to support.

(2) **"Financially responsible person"** means a parent, stepparent, adoptive parent, spouse or caretaker relative.

(3) A **"disqualified assistance unit member"** means a person who is:

(a) An unmarried pregnant or parenting minor under age eighteen who has not completed a high school education or general education development (GED) certification and is not participating in those educational activities which would lead to the attainment of a high school diploma or GED;

(b) An unmarried pregnant or parenting minor under age eighteen who is not living in a department-approved living situation;

(c) The financially responsible person who does not report to the department within five days of the date it becomes reasonably clear that the absence of a child will exceed ninety days;

(d) A person who has been convicted in federal or state court of having made a fraudulent statement or representation about their place of residence in order to receive assistance from two or more states at the same time as defined in WAC 388-446-0010; and

(e) A person who has been convicted of unlawfully receiving public assistance as defined under WAC 388-446-0005.

(4) **"Ineligible assistance unit member"** means an individual who is:

(a) Ineligible for cash assistance due to the citizenship/alien status requirements in WAC 388-424-0010;

(b) Ineligible to receive assistance under WAC 388-442-0010 for having been convicted after August 21, 1996, under federal or state law, of possession, use or distribution of a controlled substance;

(c) Ineligible to receive assistance under WAC 388-442-0010 for fleeing to avoid prosecution or custody or confinement after conviction for a crime or attempt to commit a crime;

(d) Ineligible to receive assistance under WAC 388-442-0010 for violating a condition of probation or parole which was imposed under a federal or state law as determined by an administrative body or court of competent jurisdiction;

(e) The spouse of a woman who receives cash benefits from the ((~~GA-S~~)) PWA program; or

(f) The adult parent of a minor parent's child.

NEW SECTION

WAC 388-450-0112 Does the department allocate the income of an ABD cash client to legal dependents? This section applies to the aged, blind, or disabled (ABD) cash assistance program.

(1) The income of an ABD cash client is reduced by the following:

(a) The ABD cash earned income disregard as specified in WAC 388-450-0177; and

(b) An amount not to exceed the department's standard of need for court or administratively ordered current or back support for legal dependents.

(2) When a ABD cash client in a medical institution, alcohol or drug treatment center, congregate care facility or adult family home has income, the income is countable to meet the client's needs after the income is reduced by the following:

(a) The payment standard amount for the nonapplying spouse and legal dependents living in the home; and

(b) The standard of assistance the client is eligible for while in an alternative care facility.

AMENDATORY SECTION (Amending WSR 98-16-044, filed 7/31/98, effective 9/1/98)

WAC 388-450-0115 ((~~Allocating~~)) Does the department allocate the income of a financially responsible person who is excluded from the assistance unit((~~,~~))? This section applies to TANF/SFA, RCA and ((~~GA-S~~)) PWA programs.

The income of a financially responsible person excluded from the assistance unit is available to meet the needs of the assistance unit after the income is reduced by the following:

(1) A ninety dollar work expense deduction from the financially responsible person(s) excluded from the assistance unit who is employed;

(2) The payment standard amount for the ineligible assistance unit members living in the home; and

(3) An amount not to exceed the department's standard of need for court or administratively ordered current or back support for legal dependents.

AMENDATORY SECTION (Amending WSR 98-16-044, filed 7/31/98, effective 9/1/98)

WAC 388-450-0120 ((~~Allocating~~)) Does the department allocate the income of financially responsible parents to a pregnant or parenting minor((~~,~~))? This section applies to TANF/SFA, RCA and ((~~GA-S~~)) PWA programs.

The income of nonapplying financially responsible parent(s) of a pregnant or parenting minor is countable to meet the needs of the minor and the child(ren) after the income is reduced by the following:

(1) A ninety dollar work expense from the financially responsible parent's gross income from employment;

(2) An amount not to exceed the department's standard of need for:

(a) The financially responsible parent and dependent living in the home who are not applying for or receiving cash benefits and not a disqualified individual; and

(b) Court or administratively ordered current or back support for legal dependents.

(3) Spousal maintenance payments made to meet the needs of individuals not living in the home.

AMENDATORY SECTION (Amending WSR 98-16-044, filed 7/31/98, effective 9/1/98)

WAC 388-450-0130 ((~~Allocating~~)) Does the department allocate the income of a nonapplying spouse to a caretaker relative((~~,~~))? This section applies to TANF/SFA, PWA, and RCA programs.

(1) The community income of the nonapplying spouse and applying spouse is combined. See WAC 388-450-0005 to determine what income is available as community income.

(2) Subtract a one person payment standard as specified in WAC 388-478-0020.

(3) The remainder is allocated to the caretaker relative.

NEW SECTION

WAC 388-450-0137 Does the department allocate income of an ineligible spouse to an ABD cash client? This section applies to the aged, blind, or disabled (ABD) cash assistance program.

(1) When an ABD cash client is married and lives with the nonapplying spouse, the following income is available to the client:

(a) The remainder of the client's wages, retirement benefits or separate property after reducing the income by:

(i) The ABD cash work incentive deduction, as specified in WAC 388-450-0177; and

(ii) An amount not to exceed the department's standard of need for court or administratively ordered current or back support for legal dependents.

(b) The remainder of the nonapplying spouse's wages, retirement benefits and separate property after reducing the income by:

(i) An amount not to exceed the department's standard of need for court or administratively ordered current or back support for legal dependents; and

(ii) The payment standard amount as specified under WAC 388-478-0033 which includes ineligible assistance unit members.

(c) One-half of all other community income, as provided in WAC 388-450-0005.

AMENDATORY SECTION (Amending WSR 11-16-056, filed 7/29/11, effective 8/29/11)

WAC 388-450-0156 When am I exempt from deeming? (1) If you meet any of the following conditions, you are **permanently** exempt from deeming and we do not count your sponsor's income or resources against your benefits:

(a) The Immigration and Nationality Act (INA) does not require you to have a sponsor. Immigrants who are not required to have a sponsor include those with the following status with United States Citizenship and Immigration Services (USCIS):

(i) Refugee;

(ii) Parolee;

(iii) Asylee;

(iv) Cuban/Haitian entrant; or

(v) Special immigrant from Iraq or Afghanistan.

(b) You were sponsored by an organization or group as opposed to an individual;

(c) You do not meet the alien status requirements to be eligible for benefits under chapter 388-424 WAC;

(d) You have worked or can get credit for forty qualifying quarters of work under Title II of the Social Security Act. We do not count a quarter of work toward this requirement if the person working received TANF, food stamps, Basic Food, SSI, CHIP, or nonemergency medicaid benefits. We count a quarter of work by the following people toward your forty qualifying quarters:

(i) Yourself;

(ii) Each of your parents for the time they worked before you turned eighteen years old (including the time they worked before you were born); and

(iii) Your spouse if you are still married or your spouse is deceased.

(e) You become a United States (U.S.) Citizen;

(f) Your sponsor is dead; or

(g) If USCIS or a court decides that you, your child, or your parent was a victim of domestic violence from your sponsor and:

(i) You no longer live with your sponsor; and

(ii) Leaving your sponsor caused your need for benefits.

(2) You are exempt from the deeming process while you are in the same AU as your sponsor;

(3) For children and pregnancy medical programs, you are exempt from sponsor deeming requirements.

(4) For Basic Food, you are exempt from deeming while you are under age eighteen.

(5) For state family assistance, ((~~disability lifeline (DL)~~)) aged, blind, or disabled (ABD) cash, pregnant women assistance (PWA), state-funded Basic Food benefits, and state-

funded medical assistance for legal immigrants you are exempt from the deeming process if:

(a) Your sponsor signed the affidavit of support more than five years ago;

(b) Your sponsor becomes permanently incapacitated; or

(c) You are a qualified alien according to WAC 388-424-0001 and you:

(i) Are on active duty with the U.S. armed forces or you are the spouse or unmarried dependent child of someone on active duty;

(ii) Are an honorably discharged veteran of the U.S. armed forces or you are the spouse or unmarried dependent child of an honorably discharged veteran;

(iii) Were employed by an agency of the U.S. government or served in the armed forces of an allied country during a military conflict between the U.S. and a military opponent; or

(iv) Are a victim of domestic violence and you have petitioned for legal status under the Violence Against Women Act.

(6) If you, your child, or your parent was a victim of domestic violence, you are exempt from the deeming process for twelve months if:

(a) You no longer live with the person who committed the violence; and

(b) Leaving this person caused your need for benefits.

(7) If your AU has income at or below one hundred thirty percent of the federal poverty level (FPL), you are exempt from the deeming process for twelve months. This is called the "indigence exemption." You may choose to use this exemption or not to use this exemption in full knowledge of the possible risks involved. See risks in subsection (9) below. For this rule, we count the following as income to your AU:

(a) Earned and unearned income your AU receives from any source; and

(b) Any noncash items of value such as free rent, commodities, goods, or services you receive from an individual or organization.

(8) If you use the indigence exemption, and are eligible for a federal program, we are required by law to give the United States attorney general the following information:

(a) The names of the sponsored people in your AU;

(b) That you are exempt from deeming due to your income;

(c) Your sponsor's name; and

(d) The effective date that your twelve-month exemption began.

(9) If you use the indigence exemption, and are eligible for a state program, we do not report to the United States attorney general.

(10) If you choose not to use the indigence exemption:

(a) You could be found ineligible for benefits for not verifying your sponsor's income and resources; or

(b) You will be subject to regular deeming rules under WAC 388-450-0160.

AMENDATORY SECTION (Amending WSR 04-03-051, filed 1/15/04, effective 2/15/04)

WAC 388-450-0170 ((~~TANF/SFA earned income incentive and deduction.~~)) Does the department provide an earned income deduction as an incentive for persons who receive TANF/SFA to work? This section applies to TANF/SFA, RCA, PWA, and medical programs for children, pregnant women, and families except as specified under WAC 388-450-0210.

(1) If a client works, the department only counts some of the income to determine eligibility and benefit level.

(2) We only count fifty percent of your monthly gross earned income. We do this to encourage you to work.

(3) If you pay for care before we approve your benefits, we subtract the amount you pay for those dependent children or incapacitated adults who get cash assistance with you.

(a) The amount we subtract is:

(i) Prorated according to the date you are eligible for benefits;

(ii) Cannot be more than your gross monthly income; and

(iii) Cannot exceed the following for each dependent child or incapacitated adult:

Dependent Care Maximum Deductions

Hours Worked Per Month	Child Two Years of Age & Under	Child Over Two Years of Age or Incapacitated Adult
0 - 40	$ 50.00	$ 43.75
41 - 80	$ 100.00	$ 87.50
81 - 120	$ 150.00	$ 131.25
121 or More	$ 200.00	$ 175.00

(b) In order to get this deduction:

(i) The person providing the care must be someone other than the parent or stepparent of the child or incapacitated adult; and

(ii) You must verify the expense.

NEW SECTION

WAC 388-450-0177 Does the department offer an income deduction for the ABD cash program as an incentive for clients to work? The department gives a deduction to people who receive income from work while receiving aged, blind, or disabled cash assistance. The deduction applies to aged, blind, or disabled cash benefits only. We allow the following income deduction when we determine the amount of your benefits:

We only count fifty percent of your monthly gross earned income. We do this to encourage you to work.

AMENDATORY SECTION (Amending WSR 06-10-034, filed 4/27/06, effective 6/1/06)

WAC 388-460-0020 Who is a protective payee? (1) A protective payee is a person or an employee of an agency who manages client cash benefits to provide for basic needs -

housing, utilities, clothing, child care, and food. They may also provide services such as training clients how to manage money.

(2) Clients are assigned to protective payees for the following reasons:

(a) Emergency or temporary situations where a child is left without a caretaker (TANF/SFA) per WAC 388-460-0030;

(b) Mismanagement of money (TANF/SFA, ((~~GA~~)) PWA, ABD cash, or WCCC) per WAC 388-460-0035; or

(c) Pregnant or parenting minors per WAC 388-460-0040.

AMENDATORY SECTION (Amending WSR 02-14-083, filed 6/28/02, effective 7/1/02)

WAC 388-460-0040 When ((~~is~~)) does the department assign a protective payee assigned to TANF/SFA or PWA pregnant or parenting minors? Pregnant or parenting minors who are not emancipated under court order must be assigned to protective payees if the clients are:

(1) Head of a household;

(2) Under age eighteen;

(3) Unmarried; and

(4) Pregnant or have a dependent child.

AMENDATORY SECTION (Amending WSR 03-20-060, filed 9/26/03, effective 10/27/03)

WAC 388-468-0005 Residency. Subsections (1) through (4) applies to cash, the Basic Food program, and medical programs.

(1) A resident is a person who:

(a) Currently lives in Washington and intends to continue living here permanently or for an indefinite period of time; or

(b) Entered the state looking for a job; or

(c) Entered the state with a job commitment.

(2) A person does not need to live in the state for a specific period of time to be considered a resident.

(3) A child under age eighteen is a resident of the state where the child's primary custodian lives.

(4) With the exception of subsection (5) of this section, a client can temporarily be out of the state for more than one month. If so, the client must supply the department with adequate information to demonstrate the intent to continue to reside in the state of Washington.

(5) Basic Food program assistance units who are not categorically eligible do not meet residency requirements if they stay out of the state more than one calendar month.

(6) A client may not receive comparable benefits from another state for the cash and Basic Food programs.

(7) A former resident of the state can apply for the ((~~GA-U~~)) ABD cash program while living in another state if:

(a) The person:

(i) Plans to return to this state;

(ii) Intends to maintain a residence in this state; and

(iii) Lives in the United States at the time of the application.

(b) In addition to the conditions in subsection (7)(a)(i)(ii), and (iii) being met, the absence must be:

(i) Enforced and beyond the person's control; or

(ii) Essential to the person's welfare and is due to physical or social needs.

(c) See WAC 388-406-0035, 388-406-0040, and 388-406-0045 for time limits on processing applications.

(8) Residency is not a requirement for detoxification services.

(9) A person is not a resident when the person enters Washington state only for medical care. This person is not eligible for any medical program. The only exception is described in subsection (10) of this section.

(10) It is not necessary for a person moving from another state directly to a nursing facility in Washington state to establish residency before entering the facility. The person is considered a resident if they intend to remain permanently or for an indefinite period unless placed in the nursing facility by another state.

(11) For purposes of medical programs, a client's residence is the state:

(a) Paying a state Supplemental Security Income (SSI) payment; or

(b) Paying federal payments for foster or adoption assistance; or

(c) Where the noninstitutionalized individual lives when medicaid eligibility is based on blindness or disability; or

(d) Where the parent or legal guardian, if appointed, for an institutionalized:

(i) Minor child; or

(ii) Client twenty-one years of age or older, who became incapable of determining residential intent before reaching age twenty-one.

(e) Where a client is residing if the person becomes incapable of determining residential intent after reaching twenty-one years of age; or

(f) Making a placement in an out-of-state institution; or

(g) For any other institutionalized individual, the state of residence is the state where the individual is living with the intent to remain there permanently or for an indefinite period.

(12) In a dispute between states as to which is a person's state of residence, the state of residence is the state in which the person is physically located.

AMENDATORY SECTION (Amending WSR 08-18-043, filed 8/29/08, effective 10/1/08)

WAC 388-470-0055 How do my resources count toward the resource limit for Basic Food? (1) For Basic Food, if your assistance unit (AU) is not categorically eligible (CE) under WAC 388-414-0001, we count the following resources toward your AU's resource limit to decide if you are eligible for benefits under WAC 388-470-0005:

(a) Liquid resources. 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) Stocks, bonds, annuities, or mutual funds less any early withdrawal penalty;

(v) Available trusts or trust accounts; or

(vi) Lump sum payments. A lump sum payment is money owed to you from a past period of time that you get but do not expect to get on a continuing basis.

(b) Nonliquid resources, personal property, and real property not specifically excluded in subsection (2) below.

(c) Vehicles as described in WAC 388-470-0075.

(d) The resources of a sponsor as described in WAC 388-470-0060.

(2) The following resources do not count toward your resource limit:

(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;

(iv) Is essential to the employment or self-employment of a household member. 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; or

(v) Is essential for the maintenance or use of an income-producing vehicle; or

(vi) Has an equity value equal to or less than half of the resource limit as described in WAC 388-470-0005.

(d) Household goods

(e) Personal effects;

(f) Life insurance policies, including policies with cash surrender value (CSV);

(g) One burial plot per household member;

(h) One funeral agreement per household member, up to fifteen hundred dollars;

(i) Pension plans or retirement funds not specifically counted in subsection (1) above;

(j) Sales contracts, if the contract is producing income consistent with its fair market value;

(k) Government payments issued for the restoration of a home damaged in a disaster;

(l) Indian lands held jointly with the Tribe, or land that can be sold only with the approval of the Bureau of Indian Affairs;

(m) Nonliquid resources that have a lien placed against them;

(n) Earned Income Tax Credits (EITC):

(i) For twelve months, if you were a Basic Food recipient when you got the EITC and you remain on Basic Food for all twelve months; or

(ii) The month you get it and the month after, if you were not getting Basic Food when you got the EITC.

(o) Energy assistance payments or allowances;

(p) The resources of a household member who gets SSI, TANF/SFA, PWA, or ((~~GA~~)) ABD cash benefits;

(q) Retirement funds or accounts that are tax exempt under the Internal Revenue Code;

(r) Education funds or accounts in a tuition program under section 529 or 530 of the Internal Revenue Code; and

(s) Resources specifically excluded by federal law.

(3) 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.

(4) 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.

AMENDATORY SECTION (Amending WSR 05-19-059, filed 9/16/05, effective 10/17/05)

WAC 388-473-0010 What are ongoing additional requirements and how do I qualify? "Ongoing additional requirement" means a need beyond essential food, clothing, and shelter needs and is necessary to help you continue living independently.

(1) We may authorize ongoing additional requirement benefits if you are active in one of the following programs:

(a) Temporary assistance for needy families (TANF), or tribal TANF;

(b) State family assistance (SFA);

(c) Pregnant women assistance (PWA);

(d) Refugee cash;

(((~~(d) General assistance cash~~)) (e) Aged, blind, or disabled (ABD); or

(((~~(e)~~)) (f) Supplemental Security Income (SSI).

(2) You apply for an ongoing additional requirement benefit by notifying staff who maintain your cash or medical assistance that you need additional help to live independently.

(3) We authorize ongoing additional requirement benefits only when we determine the item is essential to you. We make the decision based on proof you provide of:

(a) The circumstances that create the need; and

(b) How the need affects your health, safety and ability to continue to live independently.

(4) We authorize ongoing additional requirement benefits by increasing your monthly cash assistance benefit.

(5) We use the following review cycle table to decide when to review your need for the additional benefit(s).

REVIEW CYCLE	
Program	Frequency (Months)
TANF/RCA	6 Months
((~~GA~~)) ABD	12 Months
SSI	24 Months
All	Any time need or circumstances are expected to change
All	Any time need or circumstances are expected to change.

(6) Monthly payment standards for ongoing additional requirements are described under WAC 388-478-0050.

Reviser's note: The typographical error in the above section occurred in the copy filed by the agency and appears in the Register pursuant to the requirements of RCW 34.08.040.

AMENDATORY SECTION (Amending WSR 02-11-033, filed 5/7/02, effective 6/7/02)

WAC 388-474-0010 How does being a supplemental security income (SSI) client affect your cash assistance eligibility? (1) If you are married to an SSI recipient but do not get SSI in your own right, you are called an "ineligible spouse."

(2) If you are an ineligible spouse you cannot get the SSI state supplement when you are:

(a) The caretaker relative of a child who receives TANF or SFA; and

(b) Required to be included in the TANF or SFA assistance unit with the child (see WAC 388-408-0015); or

(c) Receiving refugee assistance.

(3) If you are an ineligible spouse and get an SSI state supplement (WAC 388-474-0012), you cannot get ((~~general assistance (GA)~~)) aged, blind, or disabled (ABD) cash assistance.

AMENDATORY SECTION (Amending WSR 02-11-033, filed 5/7/02, effective 6/7/02)

WAC 388-474-0020 What can ((~~a general assistance-unemployable (GA-U)~~)) an aged, blind, or disabled (ABD) cash assistance client expect when supplemental security income (SSI) benefits begin? You ((~~can only get~~)) may only receive assistance to meet your basic needs from one government source at a time (WAC ((~~388-448-0210~~)) 388-449-0210). If you are ((~~a GA-U~~)) an ABD cash client who begins ((~~setting~~)) getting SSI, you should know that:

(1) If you got advance, emergency or retroactive SSI cash assistance for any period where you ((~~got GA-U~~)) received general assistance (GA), disability lifeline (DL), or aged, blind, or disabled (ABD) cash assistance, you must repay the department the amount of ((~~GA-U~~)) cash assistance paid to you for the matching time period.

(2) When you apply for ((~~GA-U~~)) ABD cash you must sign DSHS 18-235(X), interim assistance reimbursement agreement (IARA) to ((~~get GA-U~~)) receive ABD cash assistance.

(3) You cannot use your ((~~GA-U~~)) ABD money to replace money deducted from your SSI check to repay an SSI overpayment.

AMENDATORY SECTION (Amending WSR 10-17-101, filed 8/17/10, effective 9/17/10)

WAC 388-476-0005 Social Security number requirements. (1) With certain exceptions, each person who applies for or receives cash, medical or food assistance benefits must provide to the department a Social Security number (SSN), or numbers if more than one has been issued. For SSN requirements for immigrants, see WAC 388-424-0009.

(2) If the person is unable to provide the SSN, either because it is not known or has not been issued, the person must:

(a) Apply for the SSN;

(b) Provide proof that the SSN has been applied for; and

(c) Provide the SSN when it is received.

(3) Assistance will not be delayed, denied or terminated pending the issuance of an SSN by the Social Security Administration. However, a person who does not comply with these requirements is not eligible for assistance.

(4) For cash, medical, and food assistance benefits, a person cannot be disqualified from receiving benefits for refusing to apply for or supply an SSN based on religious grounds.

(5) For food assistance programs:

(a) A person can receive benefits for the month of application and the following month if the person attempted to apply for the SSN and made every effort to provide the needed information to the Social Security Administration.

(b) If a person is unable to provide proof of application for a SSN for a newborn:

(i) The newborn can receive Basic Food with the household while effort is being made to get the SSN.

(ii) For the newborn to continue receiving Basic Food benefits; the household must provide proof of application for SSN or the SSN for the newborn, at the next recertification, or within six months following the month the baby is born, whichever is later.

(6) For medical programs, a newborn as described in WAC 388-505-0210(1) is eligible for categorically needy (CN) medical without meeting the SSN requirement until the baby's first birthday.

(7) There is no SSN requirement for the following programs:

(a) The consolidated emergency assistance program;

(b) The refugee cash and medical assistance program;

(c) The alien emergency medical program; and

(d) ((~~The state-funded pregnant woman program; and~~ ~~(e)~~)) Detoxification services.

NEW SECTION

WAC 388-478-0016 Need standards for aged, blind, or disabled (ABD) cash assistance. The need standards for cash assistance units are:

(1) For assistance units with obligation to pay shelter costs:

Assistance Unit Size	Need Standard
1	$339
2	$428

(2) For assistance units with shelter provided at no cost:

Assistance Unit Size	Need Standard
1	$206
2	$261

NEW SECTION

WAC 388-478-0027 What are the payment standards for pregnant women assistance (PWA)? (1) The payment standards for PWA cash assistance units with obligations to pay shelter costs are:

Assistance Unit Size	Payment Standard
1	$197

(2) The payment standards for PWA cash assistance units with shelter provided at no cost are:

Assistance Unit Size	Payment Standard
1	$120

NEW SECTION

WAC 388-478-0033 What are the payment standards for aged, blind, or disabled (ABD) cash assistance? (1) The payment standards for aged, blind, or disabled (ABD) cash assistance program assistance units with obligations to pay shelter costs are:

Assistance Unit Size	Payment standard
1	$197
2	$248

(2) The payment standards for aged, blind, or disabled (ABD) cash assistance units with shelter provided at no cost are:

Assistance Unit Size	Payment Standard
1	$120
2	$152

AMENDATORY SECTION (Amending WSR 98-16-044, filed 7/31/98, effective 9/1/98)

WAC 388-486-0005 Unmarried pregnant or parenting minors—Required living arrangement. (1) This rule affects only the minor's eligibility for cash assistance. It does not affect the eligibility of the minor parent's child for a cash grant.

(2) The following definitions apply to terms used in this section:

(a) "Unmarried" means a person who have never been married or whose marriage has been annulled. It does not include a person who has been divorced or widowed.

(b) "Minor" means a person younger than eighteen years of age.

(c) "Legal guardian" means a court-appointed legal guardian or court-appointed permanent custodian.

(d) "Relative" is a person who related to the pregnant or parenting minor as defined under RCW 74.15.020(4).

(3) An unmarried pregnant or parenting minor is not eligible for TANF, SFA or ((~~GA-S~~)) PWA unless the person:

(a) Has been emancipated by a court; or

(b) Lives in a home approved by the department and has a protective payee.

(4) The home of a minor's parent, legal guardian, or adult relative may be approved unless:

(a) The minor has no living parent, legal guardian, or adult relative that can be located or those persons do not want the minor to live with them;

(b) The minor or the minor's child is being or has been seriously harmed either physically, emotionally or sexually in the home of the parent, legal guardian, or adult relative;

(c) Substantial evidence exists of an act or failure to act by the parent, legal guardian, or adult relative that presents imminent or serious harm to the minor or the minor's child if they lived there; or

(d) The department determines that it is in the best interest of the minor or the minor's child to waive the requirement of living in the home of a parent, legal guardian, or adult relative.

(5) If the home of a minor's parent, legal guardian, or adult relative is not available or suitable, one of the following alternatives may be approved:

(a) A facility or home licensed under chapter 74.15 RCW that provides a supportive and supervised living arrangement requiring residents to learn parenting skills;

(b) A maternity home;

(c) Other adult-supervised living arrangement; or

(d) The minor's current or proposed living arrangement, if the department determines it is appropriate.

(6) A home that includes the other natural parent of the minor's child or unborn child is never approved if:

(a) The minor is under age sixteen; and

(b) The other parent is eighteen or older and meets the age criteria for rape of a child as set forth in RCW 9A.44.073, 9A.44.076, and 9A.44.079.

(7) The income of a minor parent found ineligible under this section is treated according to WAC 388-450-0100 and 388-450-0115 when determining the eligibility and benefit level of the minor parent's child.

Reviser's note: The typographical errors in the above section occurred in the copy filed by the agency and appear in the Register pursuant to the requirements of RCW 34.08.040.

REPEALER

The following sections of the Washington Administrative Code are repealed:

WAC 388-400-0025	Who is eligible for disability lifeline benefits?
WAC 388-404-0010	Age requirement for GA-U and ADATSA.
WAC 388-408-0010	Who is in my assistance unit for general assistance?
WAC 388-418-0025	Effect of changes on medical program eligibility.

WAC 388-424-0016	Citizenship and alien status—Immigrant eligibility restrictions for state medical benefits.
WAC 388-448-0001	What are the incapacity requirements for general assistance?
WAC 388-448-0010	How do we decide if you are incapacitated?
WAC 388-448-0020	Which health professionals can I go to for medical evidence?
WAC 388-448-0030	What medical evidence do I need to provide?
WAC 388-448-0035	How we assign severity ratings to your impairment.
WAC 388-448-0040	PEP step I—Review of medical evidence required for eligibility determination.
WAC 388-448-0050	PEP step II—How we determine the severity of mental impairments.
WAC 388-448-0060	PEP step III—How we determine the severity of physical impairments.
WAC 388-448-0070	PEP step IV—How we determine the severity of multiple impairments.
WAC 388-448-0080	PEP step V—How we determine your ability to function in a work environment if you have a mental impairment.
WAC 388-448-0090	PEP step V—How we determine your ability to function in a work environment if you have a physical impairment.
WAC 388-448-0100	PEP step VI—How we evaluate capacity to perform relevant past work.
WAC 388-448-0110	PEP step VII—How we evaluate your capacity to perform other work.
WAC 388-448-0120	How we decide how long you are incapacitated.
WAC 388-448-0130	Treatment and referral requirements.
WAC 388-448-0140	When does a person have good cause for refusing or failing to participate in medical treatment or referrals to other agencies?
WAC 388-448-0150	Penalty for refusing or failure to participate in medical treatment or other agency referrals.
WAC 388-448-0160	When do my disability lifeline benefits end?
WAC 388-448-0180	How do we redetermine your eligibility when we decide you are eligible for general assistance expedited medicaid (GAX)?
WAC 388-448-0200	Can I get general assistance while waiting for Supplemental Security Income (SSI)?
WAC 388-448-0210	What is interim assistance and how do I assign it to you?
WAC 388-448-0220	How does alcohol or drug dependence affect my eligibility for disability lifeline?
WAC 388-448-0250	Are there limits on the number of months I may receive disability lifeline benefits?
WAC 388-450-0110	Allocating the income of a GA-U client to legal dependents.
WAC 388-450-0135	Allocating income of an ineligible spouse to a GA-U client.
WAC 388-450-0175	Does the department offer an income deduction for the general assistance program as an incentive for clients to work?
WAC 388-462-0011	Post adoption cash benefit.

REPEALER

The following section of the Washington Administrative Code is repealed:

WAC 388-478-0030	Payment standards for disability lifeline and ADATSA.

AMENDATORY SECTION (Amending WSR 11-16-029, filed 7/27/11, effective 8/27/11)

WAC 388-478-0035 What are the maximum earned income limits for TANF, SFA, PWA and RCA((.))? To be eligible for temporary assistance for needy families (TANF), state family assistance (SFA), ((~~or~~)) refugee cash assistance (RCA), or a pregnant women assistance (PWA), a family's gross earned income must be below the following levels:

Number of Family Members	Maximum Earned Income Level	Number of Family Members	Maximum Monthly Earned Income Level
1	$610	6	$1,472
2	770	7	1,700
3	955	8	1,882
4	1,124	9	2,066
5	1,295	10 or more	2,246

WSR 11-21-049
EMERGENCY RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Economic Services Administration)

[Filed October 12, 2011, 3:54 p.m., effective November 1, 2011]

Effective Date of Rule: November 1, 2011.

Other Findings Required by Other Provisions of Law as Precondition to Adoption or Effectiveness of Rule: ESHB 2082, Laws of 2011, terminates all components of the disability lifeline (DL) program effective October 31, 2011, and establishes the aged, blind, or disabled (ABD) assistance and the pregnant women assistance (PWA) programs effective November 1, 2011.

Purpose: The department is amending, repealing, and creating new rules to eliminate reference to the DL program and to establish standards for the ABD assistance and PWA programs to comply with ESHB 2082.

Citation of Existing Rules Affected by this Order: Repealing WAC 388-400-0025, 388-404-0010, 388-408-0010, 388-418-0025, 388-424-0016, 388-448-0001, 388-448-0010, 388-448-0020, 388-448-0030, 388-448-0035, 388-448-0040, 388-448-0050, 388-448-0060, 388-448-0070, 388-448-0080, 388-448-0090, 388-448-0100, 388-448-0110, 388-448-0120, 388-448-0130, 388-448-0140, 388-448-0150, 388-448-0160, 388-448-0180, 388-448-0200, 388-448-0210, 388-448-0220, 388-448-0250, 388-450-0110, 388-450-0135, 388-450-0175, 388-462-0011 and 388-478-0030; amending WAC 388-273-0020, 388-406-0005, 388-406-0045, 388-406-0055, 388-408-0005, 388-416-0010, 388-424-0010, 388-424-0015, 388-436-0030, 388-442-0010, 388-450-0040, 388-450-0045: 388-450-0095, 388-450-0100, 388-450-0115, 388-450-0120, 388-450-0130, 388-450-0156, 388-450-0170, 388-460-0020, 388-460-0040, 388-468-0005, 388-473-0010, 388-474-0010, 388-474-0020, 388-476-0005, 388-478-0035 and 388-486-0005; and creating WAC 388-400-0055, 388-400-0060, 388-408-0060, 388-449-0001, 388-449-0005, 388-449-0010, 388-449-0015, 388-449-0020, 388-449-0030, 388-449-0035, 388-449-0040, 388-449-0045, 388-449-0050, 388-449-0060, 388-449-0070, 388-449-0080, 388-449-0100, 388-449-0150, 388-449-0200, 388-449-0210, 388-449-0220, 388-449-0225, 388-450-0112, 388-450-0137, 388-450-0177, 388-478-0027, and 388-478-0033.

Statutory Authority for Adoption: RCW 74.04.005, 74.04.050, 74.04.055, 74.04.057, 74.08.090, 74.08A.100, 74.04.770, 74.04.0052, 74.04.655, 74.04.770, 74.08.043, 74.08.335.

Other Authority: ESHB 2082, chapter 36, Laws of 2011.

Under RCW 34.05.350 the agency for good cause finds that state or federal law or federal rule or a federal deadline for state receipt of federal funds requires immediate adoption of a rule.

Reasons for this Finding: ESHB 2082, Laws of 2011, eliminates DL October 31, 2011, and creates ABD and PWA November 1, 2011.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 27, Amended 28, Repealed 33.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 0, Amended 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 27, Amended 29, Repealed 33; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.

Date Adopted: October 12, 2011.

Katherine I. Vasquez
Rules Coordinator

AMENDATORY SECTION (Amending WSR 02-18-106, filed 9/3/02, effective 10/4/02)

WAC 388-273-0020 Who may receive Washington telephone assistance program (WTAP)? (1) To receive WTAP benefits, you must:

(a) Be age eighteen or older or, if under eighteen, be the responsible head of household, and either;

(b) Be receiving one of the following programs from us:

(i) Temporary assistance for needy families (TANF);

(ii) State family assistance (SFA);

(iii) ((~~General assistance~~)) Pregnant women assistance (PWA);

(iv) Aged, blind, or disabled (ABD) cash assistance;

(v) Refugee assistance;

(((~~v~~))) (vi) Food assistance;

(((~~vi~~))) (vii) State Supplemental Security Income (SSI);

(((~~vii~~))) (viii) Medical assistance, including medicare cost sharing programs;

(((~~viii~~))) (ix) Community options program entry system (COPES);

(((~~ix~~))) (x) Chore services; or

(c) Have completed using community service voice mail services, and been identified to the department as eligible for WTAP by the community agency that provided your community service voice mail program; and

(2) Apply to a local exchange company for WTAP and request the lowest available flat rate telephone service at the WTAP rate. In exchange areas where wireline service is not

available without service extension, you may apply to a wireless carrier:

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

(b) **"Flat rate service"** is telephone service with a single monthly payment that allows unlimited local calling for a specified length of time. The local exchange flat rate includes any federal end user access charges and other charges necessary to obtain the service; and

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

NEW SECTION

WAC 388-400-0055 Who is eligible for the pregnant women assistance (PWA) program? Effective November 1, 2011:

(1) You can get pregnant women assistance (PWA), if you:

(a) Are pregnant as verified by a medical statement;

(b) Meet the citizenship/alien status requirements of WAC 388-424-0010;

(c) Live in the state of Washington per WAC 388-468-0005;

(d) Do not live in a public institution unless specifically allowed under RCW 74.08.025;

(e) Meet TANF/SFA:

(i) Income requirements under chapter 388-450 WAC;

(ii) Resource requirements under chapter 388-470 WAC; and

(iii) Transfer of property requirements under chapter 388-488 WAC.

(f) Tell us your social security number as required under WAC 388-476-0005;

(g) Report changes of circumstances as required under WAC 388-418-0005; and

(2) If you are an unmarried pregnant minor your living arrangements must meet the requirements of WAC 388-486-0005.

(3) You cannot get PWA if you:

(a) Are eligible for temporary assistance for needy families (TANF) benefits;

(b) Are eligible for state family assistance (SFA) benefits;

(c) Refuse or fail to meet a TANF or SFA eligibility rule;

(d) Refuse or fail to participate in drug or alcohol treatment as required in WAC 388-449-0220; or

(e) Are eligible for supplemental security income (SSI) benefits.

NEW SECTION

WAC 388-400-0060 Who is eligible for aged, blind or disabled (ABD) cash assistance? (1) Effective November 1, 2011, you are eligible for aged, blind, or disabled (ABD) cash benefits if you:

(a) Are:

(i) At least sixty-five years old;

(ii) Blind as defined by the Social Security Administration (SSA); or

(iii) Likely to be disabled as defined in WAC 388-449-0001 through 388-449-0100; and

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

(c) Are in financial need according to ABD cash income and resource rules in chapters 388-450, 388-470 and 388-488 WAC. We determine who is in your assistance unit according to WAC 388-408-0010;

(d) Meet the citizenship/alien status requirements under WAC 388-424-0015;

(e) Provide a social security number as required under WAC 388-476-0005;

(f) Reside in the state of Washington as required under WAC 388-468-0005;

(g) Sign an interim assistance reimbursement authorization to agree to repay the monetary value of general assistance, disability lifeline, or aged blind or disabled benefits subsequently duplicated by supplemental security income benefits as described under WAC 388-449-0200, 388-449-0210 and 388-474-0020;

(h) Report changes of circumstances as required under WAC 388-418-0005; and

(i) Complete a mid-certification review and provide proof of any changes as required under WAC 388-418-0011.

(2) You aren't eligible for aged, blind, or disabled cash benefits if you:

(a) Are eligible for temporary assistance for needy families (TANF) benefits;

(b) Are eligible for state family assistance (SFA) benefits;

(c) Refuse or fail to meet a TANF or SFA eligibility rule;

(d) Refuse or fail to participate in drug or alcohol treatment as required in WAC 388-449-0220;

(e) Refuse of fail to follow through with the SSI application as required in WAC 388-449-0200;

(f) Refuse or fail to participate in vocational rehabilitation services as required in WAC 388-449-0225;

(g) Are eligible for supplemental security income (SSI) benefits;

(h) Are an ineligible spouse of an SSI recipient; or

(i) Failed to follow a Social Security Administration (SSA) program rule or application requirement and SSA denied or terminated your benefits.

(3) If you reside in a public institution and meet all other requirements, your eligibility for ABD cash depends on the type of institution. A "public institution" is an institution that is supported by public funds, and a governmental unit either is responsible for it or exercises administrative control over it.

(a) You may be eligible for ABD cash if you are:

(i) A patient in a public medical institution; or

(ii) A patient in a public mental institution and:

(A) Sixty-five years of age or older; or

(B) Twenty years of age or younger.

(4) You aren't eligible for ABD cash when you are in the custody of or confined in a public institution such as a state penitentiary or county jail including placement:

(a) In a work release program; or

(b) Outside of the institution including home detention.

AMENDATORY SECTION (Amending WSR 09-19-129, filed 9/22/09, effective 11/1/09)

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~~)) ABD cash 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 Statistical 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.

AMENDATORY SECTION (Amending WSR 09-19-129, filed 9/22/09, effective 11/1/09)

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)~~)) ABD cash, 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).

AMENDATORY SECTION (Amending WSR 10-11-033, filed 5/11/10, effective 7/1/10)

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, PWA, or RCA; or

(c) No later than the forty-fifth day for ((~~general assistance (GA)~~)) aged, blind, or disabled (ABD) cash assistance 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 date you provide the required verification. 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.

(4) For long-term care, the date your services start is stated in WAC 388-106-0045.

AMENDATORY SECTION (Amending WSR 03-17-066, filed 8/18/03, effective 9/18/03)

WAC 388-408-0005 What is a cash assistance unit? (1) For all sections of this chapter:

(a) **"We"** means the department of social and health services.

(b) **"You"** means a person that is applying for or getting benefits from the department.

(c) **"Assistance unit"** or **"AU"** is the group of people who live together and whose income or resources we count to decide your eligibility for benefits and the amount of benefits you get.

(2) For ((~~GA-U~~)) ABD cash, we decide who is in the AU under WAC ((~~388-408-0010~~)) 388-408-0060.

(3) For TANF, PWA, or SFA, we decide who is in the AU by taking the following steps:

(a) We start with who must be in the AU under WAC 388-408-0015;

(b) We add those you choose to have in the AU under WAC 388-408-0025; and

(c) We remove those who are not allowed in the AU under WAC 388-408-0020.

NEW SECTION

WAC 388-408-0060 Who is in my assistance unit for aged, blind, or disabled (ABD) cash assistance? (1) If you are an adult that is aged, blind, or likely to be disabled as defined in WAC 388-400-0060, 388-449-0001, you can be in a ABD cash AU;

(2) If you are married and live with your spouse, we decide who to include in the AU based on who is aged, blind, or likely to be disabled:

(a) If you are both aged, blind, or likely to be disabled as defined in WAC 388-400-0060, 388-449-0001, we include both of you in the same AU.

(b) If only one spouse is aged, blind, or likely to be disabled, we include only the aged, blind, or likely to be disabled spouse in the AU. We count some of the income of the spouse that is not in the AU as income to the AU under WAC 388-450-0135.

AMENDATORY SECTION (Amending WSR 02-17-030, filed 8/12/02, effective 9/12/02)

WAC 388-416-0010 Medical certification periods for recipients of cash assistance programs. (1) The certification period for medical services begins on the first day of the month of application when the client is determined eligible for cash assistance for one of the following programs:

(a) Temporary assistance for needy families (TANF);

(b) Aged, blind, or disabled (ABD) cash assistance;

(c) Pregnant women assistance (PWA);

(d) Supplemental Security Income (SSI); or

((~~(e)~~)) (e) Refugee assistance.

(2) The certification period for the medical programs associated with the cash programs in subsection (1) of this section continues as long as eligibility for these programs lasts. When a client's cash assistance is terminated, eligibility for medical assistance is continued until eligibility is redetermined as described in WAC 388-418-0025.

(3) The certification period for medical can begin up to three months prior to the month of application for clients described in subsection (1) of this section if the conditions in WAC 388-416-0015(6) apply.

((~~(4) The certification period for medical care services begins on the date eligibility begins for the following cash assistance programs:~~

~~(a) General assistance for unemployable persons (GA-U); or~~

~~(b) Alcohol and Drug Abuse Treatment and Support Act (ADATSA) programs, when the client is either receiving a grant or waiting for treatment to begin.~~

~~(5) The certification period for medical care services for clients in subsection (4) of this section runs concurrently with the period of eligibility for the client's cash assistance program.~~))

AMENDATORY SECTION (Amending WSR 11-16-056, filed 7/29/11, effective 8/29/11)

WAC 388-424-0010 Citizenship and alien status—Eligibility for TANF, medicaid, and CHIP. (1) To receive temporary assistance for needy families (TANF), medicaid, or children's health insurance program (CHIP) benefits, an individual must meet all other eligibility requirements and be one of the following as defined in WAC 388-424-0001:

(a) A United States (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; or

(f) A Hmong or Highland Lao.

(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, medicaid, and CHIP.

(3) A "qualified alien" who first physically entered the U.S. on or after August 22, 1996 cannot receive TANF, medicaid, or CHIP for five years after obtaining status as a qualified alien unless the criteria in WAC 388-424-0006 (4) or (5) are met.

(4) A lawfully present "nonqualified alien" child or pregnant woman as defined in WAC 388-424-0001 who meet residency requirements as defined in WAC 388-468-0005 may receive medicaid or CHIP.

(5) An alien who is ineligible for TANF, medicaid or CHIP 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 medical program); or

(b) State-funded cash or chemical dependency benefits as described in WAC 388-424-0015 (state family assistance (SFA), aged, blind, or disabled (ABD) cash, disability lifeline (DL) and the Alcohol and Drug Addiction Treatment and Support Act (ADATSA)), and medical benefits as described in WAC 388-424-0016; or

(c) Pregnancy medical benefits for noncitizen women as described in WAC 388-462-0015(3); or

(d) State-funded apple health for kids as described in WAC 388-505-0210(5).

AMENDATORY SECTION (Amending WSR 11-16-056, filed 7/29/11, effective 8/29/11)

WAC 388-424-0015 Immigrant eligibility restrictions for the state family assistance, ((~~general assistance~~)) ABD cash, PWA, and ADATSA programs. (1) To receive state family assistance (SFA) benefits, you must be:

(a) A "qualified alien" as defined in WAC 388-424-0001 who is ineligible for TANF due to the five-year bar as described in WAC 388-424-0006(3); or

(b) A nonqualified alien who meets the Washington state residency requirements as listed in WAC 388-468-0005, including a noncitizen American Indian who does not meet the criteria in WAC 388-424-0001.

(2) To receive ((~~general assistance (GA)~~)) aged, blind, or disabled (ABD) cash or pregnant women assistance (PWA) benefits, you must be ((~~ineligible for the TANF, SFA, or SSI program for a reason other than failure to cooperate with program requirements, and belong to one of the following groups 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" or similarly defined lawful immigrant such as victim of trafficking as defined in WAC 388-424-0001; or

(e) A nonqualified alien ((~~who meets the Washington state residency requirements as listed in WAC 388-468-0005~~)) described in WAC 388-424-0001 who:

(i) Has declared their intent to stay in the United States indefinitely; and

(ii) Provides current documentation that they have petitioned the United States Citizenship and Immigration Services (USCIS) for adjustment of status and USCIS is not taking action to enforce their departure; or

(iii) Are citizens of Micronesia, the Republic of the Marshall Islands, or the Republic of Palau who have a compact or free association with the United States.

(3) To receive ADATSA benefits, you must belong to one of the following groups 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" or similarly defined lawful immigrant such as victim of trafficking; or

(e) A nonqualified alien who meets the Washington state residency requirements as listed in WAC 388-468-0005.

AMENDATORY SECTION (Amending WSR 11-02-037, filed 12/29/10, effective 2/1/11)

WAC 388-436-0030 How does my eligibility for other possible cash benefits impact my eligibility for CEAP ((~~depends on other possible cash benefits.~~))? (1) You are ineligible for CEAP if you, or a household member, are eligible for any of the following programs:

(a) TANF or SFA, unless the family has had its case grant terminated due to WAC 388-310-1600 within the last six months;

(b) Pregnant women assistance (PWA);

(c) RCA;

(((~~c) Disability lifeline (DL)~~))) (d) Aged, blind, or disabled (ABD) cash;

(((~~d)~~))) (e) Supplemental Security Income (SSI);

(((~~e)~~))) (f) Medical assistance for those applicants requesting help for a medical need;

(((~~f~~))) (g) Food assistance for those applicants requesting help for a food need;

(((~~g~~))) (h) Housing assistance from any available source for those applicants requesting help for a housing need;

(((~~h~~))) (i) Unemployment compensation, veteran's benefits, industrial insurance benefits, Social Security benefits, pension benefits, or any other source of financial benefits the applicant is potentially eligible to receive.

(2) The department may require the applicant, or anyone in the assistance unit, to apply for and take any required action to receive benefits from programs described in the above subsection (1)(a) through (h).

(3) The department may not authorize CEAP benefits to any household containing a member who is:

(a) Receiving cash benefits from any of the following programs:

(i) TANF/SFA;

(ii) PWA;

(iii) RCA;

(((~~iii~~))) (iv) DCA; or

(((~~iv) DL~~))) (v) ABD cash.

(b) Receiving reduced cash benefits for failure to comply with program requirements of TANF/SFA, or RCA.((~~-~~))

(4) The department may authorize CEAP to families reapplying for TANF/SFA who are not eligible for TANF cash benefits under WAC 388-310-1600 until they complete the four week participation requirement.

AMENDATORY SECTION (Amending WSR 05-21-100, filed 10/18/05, effective 11/18/05)

WAC 388-442-0010 How does being a fleeing felon impact my eligibility for benefits? (1) You are a **fleeing felon** if you are fleeing to avoid prosecution, custody, or confinement for a crime or an attempt to commit a crime that is considered a felony in the place from which you are fleeing.

(2) If you are a fleeing felon, or violating a condition of probation or parole as determined by an administrative body or court that has the authority to make this decision, you are not eligible for TANF/SFA, (((~~GA~~))) PWA, ABD cash, or Basic Food benefits.

NEW SECTION

WAC 388-449-0001 What are the disability requirements for the aged, blind, or disabled (ABD) program? For the purposes of this chapter, "we" and "us" refer to the department of social and health services.

"You" means the applicant or recipient.

"Disabled" is defined by the Social Security Administration for supplemental security income (SSI) as the inability to engage in any substantial gainful activity (SGA) by reason of any medically determinable physical or mental impairment(s) which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve months.

"Physical impairment" means a diagnosable physical illness.

"Mental impairment" means a diagnosable mental disorder. We exclude any diagnosis of or related to alcohol or drug abuse or addiction.

(1) We determine if you are likely to be disabled when:

(a) You apply for ABD cash benefits;

(b) You become employed;

(c) You obtain work skills by completing a training program; or

(d) We receive new information that indicates you may be employable.

(2) We determine you are likely to be disabled if:

(a) The Social Security Administration (SSA) determined you are eligible for disability benefits;

(b) You are determined to meet SSA disability criteria by disability determination services (DDDS);

(c) The Social Security Administration (SSA) stops your supplemental security income (SSI) payments solely because you are not a citizen;

(d) You are eligible for long-term care services from aging and disability services administration for a medical condition that is expected to last twelve months or more or result in death; or

(e) You are approved through the sequential evaluation process (SEP) defined in WAC 388-449-0005 through 388-449-0100. The SEP is the sequence of five steps. Step 1 considers whether you are currently working. Steps 2 and 3 consider medical evidence and whether you are likely to meet a listed impairment under Social Security's rules. Steps 4 and 5 consider your residual functional capacity and vocational factors such as age, education, and work experience in order to determine your ability to do your past work or other work.

(3) If you have a physical or mental impairment and you are impaired by alcohol or drug addiction and do not meet the other disability criteria in subsection (2)(a) through (d) above, we decide if you are eligible for ABD cash by applying the sequential evaluation process described in WAC 388-449-0005 through 388-449-0100. You aren't eligible for ABD cash benefits if you are disabled primarily because of alcoholism or drug addiction.

(4) In determining disability, we consider only your ability to perform basic work-related activities. "Basic work-related activities" are activities that anyone would be required to perform in a work setting. They consist of: sitting, standing, walking, lifting, carrying, handling, and other physical functions (including manipulative or postural functions, (such as reaching, handling, stooping, or crouching) seeing, hearing, communicating, remembering, understanding and following instructions, responding appropriately to supervision and coworkers, and tolerating the pressures of a work setting.

(5) We determine you are not likely to meet SSI disability criteria if SSA denied your application for SSI or Social Security Disability Insurance (SSDI) in the last twelve months unless:

(a) You file a timely appeal with SSA;

(b) SSA decides you have good cause for a late appeal; or

(c) You give us medical evidence of a potentially disabling condition that SSA did not consider or that your condition has deteriorated; and

(i) You give us proof that SSA denied your request to reconsider your claim; or

(ii) You give us proof that you don't meet the nondisability criteria for SSI.

NEW SECTION

WAC 388-449-0005 Sequential evaluation process step 1—How does the department determine if you are performing substantial gainful employment? We deny disability if you are engaging in substantial gainful activity (SGA) when you apply for aged, blind, or disabled (ABD) benefits. "Substantial gainful activity" means you are performing, in a regular and predictable manner, an activity usually done for pay or profit.

(1) You must be earning less than the SGA standard as defined by the Social Security Administration (SSA) to be eligible for ABD cash, unless you work:

(a) Under special conditions that go beyond the employer providing reasonable accommodation, such as in a sheltered workshop; or

(b) Occasionally or part-time because your impairment limits the hours you are able to work compared to unimpaired workers in the same job as verified by your employer.

NEW SECTION

WAC 388-449-0010 What evidence do we consider to determine disability? To determine whether a medically determinable impairment exists, we consider medical evidence from "acceptable medical sources." "Acceptable medical sources" include:

(1) For a physical impairment, a health professional licensed in Washington State or where the examination was performed:

(a) A physician, which includes:

(i) Medical doctor (M.D.);

(ii) Doctor of osteopathy (D.O.);

(iii) Doctor of optometry (O.D.) for visual disorders;

(iv) Doctor of podiatry (D.P.) for foot disorders; and

(v) Qualified speech-language pathologists, for purposes of establishing speech or language impairments only.

(2) For a mental impairment, professionals licensed in Washington State or where the examination was performed:

(a) A psychiatrist; or

(b) A psychologist.

(3) We accept medical evidence of how your impairment(s) affect your ability to function from treating medical sources once a diagnosis of a medically determinable impairment has been established by an "acceptable medical source" listed in (1) and (2) above:

(a) All medical professionals listed in (1) and (2) above;

(b) A physician who is currently treating you for a mental impairment;

(c) A physician's assistant who is currently treating your for a physical impairment; and

(d) An advanced nurse practitioner who is treating you for a condition within their certification.

(4) "Other evidence" means information from other sources not listed in subsection (1), (2), or (3) of this section who can provide supporting documentation of functioning for impairments established by acceptable medical sources in subsections (1) or (2) of this section. Other sources include public and private agencies, nonmedical sources such as schools, parents and caregivers, social workers and employers, and other practitioners such as naturopaths, chiropractors, and audiologists.

NEW SECTION

WAC 388-449-0015 What medical evidence do I need to provide? You must give us medical evidence of your impairment(s) and how they affect your ability to perform regular and continuous work activity. Medical evidence must be in writing and be clear, objective, and complete.

(1) Objective evidence for physical impairments means:

(a) Laboratory test results;

(b) Pathology reports;

(c) Radiology findings including results of X rays and computer imaging scans;

(d) Clinical findings, including but not limited to ranges of joint motion, blood pressure, temperature or pulse, and documentation of a physical examination; and

(e) Hospital history and physical reports and admission and discharge summaries; or

(f) Other medical history and physical reports related to your current impairments.

(2) Objective evidence for mental impairments means:

(a) Clinical interview observations, including objective mental status exam results and interpretation.

(b) Explanation of how examination findings meet the clinical and diagnostic criteria of the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM).

(c) Hospital, outpatient and other treatment records related to your current impairments.

(d) Testing results, if any, including:

(i) Description and interpretation of tests of memory, concentration, cognition or intelligence; or

(ii) Interpretation of medical tests to identify or exclude a connection between the mental impairment and physical illness.

(3) Medical evidence sufficient for a disability determination must be from a medical professional described in WAC 388-449-0010 and must include:

(a) A diagnosis for the impairment, or impairments, based on an examination performed by an acceptable medical source defined in WAC 388-449-0010 within five years of application;

(b) A clear description of how the impairment relates to your ability to perform the work-related activities listed in WAC 388-449-0005;

(c) Documentation of how long a condition has impaired your ability to perform work related activities;

(d) A prognosis, or written statement of how long an impairment will impair your ability to perform work related activities; and

(e) A written statement from a medical professional (defined in WAC 388-449-0010) describing what you are capable of doing despite your impairment (medical source statement) based on an examination performed within ninety days of the date of application or forty-five days before the month of disability review.

(4) We will consider documentation in addition to objective evidence to support the acceptable medical source or treating provider's opinion that you are unable to perform substantial gainful employment, such as proof of hospitalization.

(5) When making a disability decision, we don't use your report of symptoms as evidence unless objective evidence shows there is an impairment that could reasonably be expected to produce those symptoms.

(6) We don't use symptoms related to substance abuse or a diagnosis of addiction or chemical dependency when determining disability if substance use is material to your impairment.

(7) We consider diagnoses that are independent of addiction or chemical dependency when determining disability.

(8) We determine you have a diagnosis that is independent of addiction or chemical dependency if the impairment will persist at least ninety days after you stop using drugs or alcohol.

(9) If you can't obtain medical evidence sufficient for us to determine if you are likely to be disabled without cost to you, and you meet the other eligibility conditions in WAC 388-400-0060, we pay the costs to obtain objective evidence based on our published payment limits and fee schedules.

(10) We determine the likelihood of disability based solely on the objective information we receive. We are not obligated to accept another agency's or person's decision that you are disabled or unemployable.

(11) We can't use a statement from a medical professional to determine that you are disabled unless the statement is supported by objective medical evidence.

NEW SECTION

WAC 388-449-0020 How does the department evaluate functional capacity for mental health impairments? If you have a mental impairment, we evaluate ability to function in a work setting based on objective narrative clinical assessment from a medical professional as described in WAC 388-449-0010. We may also use other evidence as described in WAC 388-449-0010. Functioning means your ability to perform typical tasks that would be required in a routine job setting and your ability to interact effectively while working.

(1) We evaluate cognitive and social functioning by assessing your ability to:

(a) Understand, remember, and persist in tasks by following simple instructions of one or two steps.

(b) Understand, remember, and persist in tasks by following complex instructions of three or more steps.

(c) Perform activities within a schedule, maintain regular attendance, and be punctual within customary tolerances.

(d) Learn new tasks.

(e) Perform routine tasks without undue supervision.

(f) Adapt to changes in a routine work setting.

(g) Make simple work-related decisions.

(h) Be aware of normal hazards and take appropriate precautions.

(i) Ask simple questions or request assistance.

(j) Communicate and perform effectively in a work setting with public contact.

(k) Communicate and perform effectively in a work setting with limited public contact.

(l) Complete a normal workday and workweek without interruptions from psychologically based symptoms.

(m) Set realistic goals and plan independently.

NEW SECTION

WAC 388-449-0030 How does the department evaluate functional capacity for physical impairments? If you have a physical impairment we evaluate your ability to work based on objective medical evidence from a medical professional as described in WAC 388-449-0010. We may also use other evidence as described in WAC 388-449-0010.

(1) **"Exertion level"** means having strength, flexibility, and mobility to lift, carry, stand or walk as needed to fulfill job duties in the following work levels. For this section, "occasionally" means less than one-third of the time and "frequently" means one-third to two-thirds of the time.

The following table is used to determine your exertion level. Included in this table is a strength factor, which is your ability to perform physical activities, as defined in Appendix C of the Dictionary of Occupational Titles (DOT), Revised Edition, published by the U.S. Department of Labor as posted on the Occupational Information Network (O*NET).

If you are able to:	Then we assign this exertion level
(a) Lift ten pounds maximum and frequently lift or carry lightweight articles. Walking or standing only for brief periods.	Sedentary
(b) Lift twenty pounds maximum and frequently lift or carry objects weighing up to ten pounds. Walk six out of eight hours per day or stand during a significant portion of the workday. Sitting and using pushing or pulling arm or leg movements most of the day.	Light
(c) Lift fifty pounds maximum and frequently lift or carry up to twenty-five pounds.	Medium
(d) Lift on hundred pounds maximum and frequently lift or carry up to fifty pounds.	Heavy

(2) **"Exertional limitation"** means a restriction in mobility, agility or flexibility in the following twelve activities: Balancing, bending, climbing, crawling, crouching, handling, kneeling, pulling, pushing, reaching, sitting, and stooping. We consider any exertional limitations when we determine your ability to work.

(3) **"Functional physical capacity"** means the degree of strength, agility, flexibility, and mobility you can apply to work-related activities. We consider the effect of the physical impairment on the ability to perform work-related activities when the physical impairment is assigned an overall severity rating of three or four. We determine functional

physical capacity based on your exertional and nonexertional limitations. All limitations must be substantiated by the medical evidence and directly related to the diagnosed impairment(s).

(4) **"Nonexertional physical limitation"** means a restriction on work activities that does not affect strength, mobility, agility, or flexibility. Environmental restrictions may include, among other things, your inability to work in an area where you would be exposed to chemicals.

(5) **"Functional limitations"** means a restriction on work activities caused by unrelieved pain or the effects of medication prescribed to treat an impairment. We determine your functional limitations based on objective documentation from a medical professional as described in WAC 388-449-0010. We may also use other evidence as described in WAC 388-449-0010. We evaluate functioning by assessing your ability to:

(a) Perform activities within a schedule, maintain regular attendance, and be punctual within customary tolerances.

(b) Perform routine tasks without undue supervision.

(c) Make simple work-related decisions.

(d) Be aware of normal hazards and take appropriate precautions.

(e) Ask simple questions or request assistance.

NEW SECTION

WAC 388-449-0035 How does the department assign severity ratings to my impairment? (1) "Severity rating" is a rating of the extent of your impairment and how it impacts your ability to perform the basic work activities. The following chart provides a description of limitations on work activities and the severity ratings that would be assigned to each.

Effect on Work Activities	Degree of Impairment	Numerical Value
(a) There is no effect on your performance of basic work-related activities.	None	1
(b) There is no significant effect on your performance of basic work-related activities.	Mild	2
(c) There are limits on your performance of basic work-related activities.	Moderate	3
(d) There are significant limits on your performance of basic work-related activities.	Marked	4
(e) You are unable to perform basic work-related activities.	Severe	5

(2) We use the description of how your condition impairs your ability to perform work activities given by the acceptable medical source or your treating provider, and review other evidence you provide, to establish severity ratings when the impairments are supported by, and consistent with, the objective medical evidence.

(3) A contracted doctor reviews your medical evidence and the ratings assigned to your impairment when:

(a) The medical evidence indicates functional limitations consistent with at least a moderate physical or mental health impairment;

(b) Your impairment has lasted, or is expected to last, twelve months or more with medical treatment; and

(c) You were not previously determined likely to be disabled as defined in WAC 388-449-0010 through 388-449-0100.

(4) The contracted doctor reviews your medical evidence, severity ratings, and functional assessment to determine whether:

(a) The Medical evidence is objective and sufficient to support the findings of the provider;

(b) Description of impairments is supported by the medical evidence; and

(c) Severity rating and assessment of functional limitations assigned by DSHS are consistent with the medical evidence.

(5) If the medical provider's description of your impairment(s) is not consistent with the objective evidence, we will assign a severity rating consistent with objective medical evidence, and clearly describe why we rejected the medical evidence provider's opinion.

NEW SECTION

WAC 388-449-0040 How does the department determine the severity of mental impairments? If you are diagnosed with a mental impairment by an acceptable medical source described in WAC 388-449-0010, we use information from medical sources described in WAC 388-449-0010 to determine how the impairment limits work-related activities.

(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, and other evidence, 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	None (1)
71 to 84	Moderate (3)
60 to 70	Marked (4)
59 or lower	Severe (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 an impairment diagnosed as a mood, thought, memory, or cognitive 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 most recent published edition of the Diagnostic and Statistical Manual of Mental Disorders.

(6) The Global Assessment of Functioning (GAF) is a numeric scale (0 through 100) used to rate the social, occupational, and psychological functioning of adults.

(7) 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 objective evidence and global assessment of functional score are consistent with a limitation on performing work activities.	Moderate (3)
(b) You are diagnosed with a functional disorder with psychotic features. (c) You have had two ore more hospitalizations for psychiatric reasons in the past two years. (d) You have had more than six months of continuous psychiatric inpatient or residential treatment in the past two years. (e) The objective evidence and global assessment of functioning score are consistent with significant limitations on ability to perform work activities.	Marked (4)
(f) The objective evidence and global assessment of functioning score are consistent with the absence of ability to perform work activities.	Severe (5)

(8) 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 moderate severity (3) ratings; or (b) One or more disorders rated moderate severity (3), and one rated marked severity (4).	Marked (4)
(c) Two or more disorders rated marked severity (4).	Severe (5)

NEW SECTION

WAC 388-449-0045 How does the department determine the severity of physical impairments? We must decide if your physical impairment is serious enough to significantly limit your ability to perform substantial gainful activity. "Severity of a physical impairment" means the degree that an impairment restricts you from performing basic work-related activities (see WAC 388-449-0005). Severity ratings range from none to severe. We will assign severity ratings according to the table in WAC 388-449-0035.

We assign to each physical impairment a severity rating that is supported by medical evidence.

NEW SECTION

WAC 388-449-0050 How does the department determine the severity of multiple impairments? (1) If you have more than one impairment we decide the overall severity rating by determining if your impairments have a combined effect on your ability to be gainfully employed. Each diagnosis is grouped by affected organ or function into one of thirteen "body systems." The thirteen body systems consist of:

(a) Musculo-skeletal;

(b) Special senses and speech;

(c) Respiratory;

(d) Cardiovascular;

(e) Digestive;

(f) Genito-urinary;

(g) Hematological;

(h) Skin;

(i) Endocrine;

(j) Neurological;

(k) Mental disorders;

(l) Malignant neoplastic; and

(m) Immune system.

(2) We follow these rules when there are multiple impairments:

(a) We group each diagnosis by body system.

(b) When you have two or more diagnosed impairments that limit work activities, we assign an overall severity rating as follows:

Your Condition	Severity Rating
(i) All impairments are mild and there is no cumulative effect on basic work activities.	Mild
(ii) All impairments are mild and there is a cumulative effect on basic work activities.	Moderate
(iii) Two or more impairments are of moderate severity and there is a cumulative effect on basic work activities.	Marked
(iv) Two are more impairments are of marked severity.	Severe

NEW SECTION

WAC 388-449-0060 Sequential evaluation process step II—How does the department review medical evidence to determine if I am eligible for benefits? When we receive your medical evidence, we review it to determine if it is sufficient to decide whether your circumstances meet disability requirements.

(1) We require written medical evidence to determine disability. The medical evidence must:

(a) Contain sufficient information as described under WAC 388-449-0015;

(b) Be written by an acceptable medical source or treating provider described in WAC 388-449-0010;

(c) Document the existence of a potentially disabling condition by an acceptable medical source described in WAC 388-449-0010; and

(d) Document an impairment has lasted, or is expected to last, twelve continuous months or more, or result in death;

(2) If the information received isn't clear, we may require more information before we determine your ability to perform substantial gainful activity. As examples, we may require you to get more medical tests or be examined by a medical specialist.

(3) We deny disability if:

(a) We don't have evidence that your impairment is of at least marked severity as defined in WAC 388-449-0035, 388-449-0040, 388-449-0045 388-449-0050;

(b) A reported impairment isn't expected to last twelve or more months or result in death; or

(c) Drug or alcohol abuse or addiction is material to your impairments.

NEW SECTION

WAC 388-449-0070 Sequential evaluation process step III—How does the department determine if you meet SSA listing of impairments criteria? We approve disability when we determine your impairment(s) meet the listings as described in appendix 1 to Subpart P of Part 404 within Title 20 of the Code of Federal Regulations.

NEW SECTION

WAC 388-449-0080 Sequential evaluation process step IV—How does the department evaluate if I am able to perform relevant past work? (1) If we neither deny disability at Step 1 or 2 nor approve it at Step 3, we consider our assessment of your physical and/or mental functional capacity, per WAC 388-449-0020, 388-449-0030, to determine if you can do work you have done in the past.

(2) We evaluate your work experience to determine if you have relevant past work and transferable skills. "Relevant past work" means work:

(a) Defined as substantial gainful activity per WAC 388-449-0005; and

(b) You have performed in the past fifteen years;

(c) You performed long enough to acquire the knowledge and skills to continue performing the job. You must meet the specific vocational preparation level as defined in Appendix C of the Dictionary of Occupational Titles.

(3) For each relevant past work situation, we compare:

(a) The exertional, nonexertional, and skill requirements of the job based on the Appendix C of the Dictionary of Occupational Titles.

(b) Your current cognitive, social, exertional, and nonexertional factors that significantly limit your ability to perform past work.

(4) We deny disability when we determine that you are able to perform any of your relevant past work regularly and continuously.

(5) We approve disability when you are fifty-five years of age or older and don't have the physical, cognitive, or social ability to perform past work.

NEW SECTION

WAC 388-449-0100 Sequential evaluation process step V—How does the department evaluate if I can perform other work when determining disability? If we decide you cannot do work that you have done before, we then decide if you have the residual functional capacity to perform other work.

(1) We evaluate education in terms of formal schooling or other training to acquire skills that enables you to meet job requirements. We classify education as:

If you	Then your education level is
(a) Can't read or write a simple communication, such as two sentences or a list of items.	Illiterate
(b) Have no formal schooling or vocational training beyond the sixth grade.	Marginal education
(c) Have no formal schooling or vocational training beyond the eleventh grade; or (d) Had participated in special education in basic academic classes of reading, writing or mathematics in high school.	Limited education
(e) Have received a high school diploma or general equivalency degree (GED) and don't meet the special education definition in (d) above; or (f) Have received skills training and were awarded a certificate, degree or license.	High school and above level of education

(2) We approve disability when you have a marked or severe physical health impairments and you meet the criteria below:

Exertional Level	Your age	Your education level	Other vocational factors	Environmental and Functional limitations
Less than sedentary	Any age	Any level	Does not apply	Does not apply
Sedentary	Any age	Any level	Does not apply	You have marked or severe environmental or functional impairments that preclude all sedentary work
Sedentary	Fifty and older	Any level	Does not apply	Does not apply
Sedentary	Forty-five and older	Marginal education or limited English proficiency (LEP)	No transferable skills to work level	Does not apply
Light	Any age	Any level	Does not apply	You have marked or severe environmental or functional impairments that preclude all sedentary work
Light	Fifty and older	Marginal education or limited English proficiency (LEP)	Does not apply	Does not apply

(3) We approve disability when you have mental impairments, with an overall severity of marked or severe, and we have documentation, including a mental status exam (MSE) per WAC 388-449-0040, that demonstrate social or cognitive factors, as described in WAC 388-448-0020 that interfere with working as follows:

Your age	Your education	Work history	Social limitation
Any age	Any level	Any	Markedly impaired in the ability to: (a) Understand, remember, and persist in tasks by following simple instructions of one or two steps; (b) Perform activities within a schedule, maintain regular attendance, and be punctual within customary tolerances; (c) Perform routine tasks without undue supervision; (d) Adapt to changes in a routine work setting; (e) Make simple work-related decisions; (f) Be aware of normal hazards and take appropriate precautions; (g) Ask simple questions or request assistance. Communicate and perform effectively in a work setting; or (h) Complete a normal workday and workweek without interruptions from psychologically based symptoms.
Any age	Any level	Unskilled	Markedly impaired in the ability to: (i) Understand, remember, and persist in tasks by following simple instructions of one or two steps; (j) Make simple work-related decisions; (k) Communicate and perform effectively in a work setting; or (l) Adapt to changes in a routine work setting.
Fifty and older	Any level	Skilled	Markedly impaired in the ability to: (m) Understand, remember, and persist in tasks by following complex instructions; (n) Set realistic goals and plan independently; or (o) Learn new tasks.

(4) We approve disability when you have both mental and physical impairments, with an overall severity marked or severe, and we have documentation, including a mental status exam (MSE) per WAC 388-449-0040, that demonstrate social or cognitive factors, as described in WAC 388-448-0020 that interfere with working as follows:

Your age	Your education	Skill or Work Level	Social Restrictions	Past Work
Any age	Any level	Restricted to light work level or less	You are moderately impaired in your ability to communicate and perform effectively in a work setting	No transferable skills to work level
Fifty or older	Limited education or LEP	Restricted to light work level or less	Does not apply	No transferable skills to work level
Any age	Marginal education or LEP	Restricted to medium work level or less	You are moderately impaired in your ability to communicate and perform effectively in a work setting with limited public contact	No transferable skills to work level

(5) If you don't meet the criteria listed above, and there are jobs you can do, we will find you are able to perform other work and we will take the following actions:

(a) Deny disability; and

(b) Give you examples of jobs you can do despite your impairments.

NEW SECTION

WAC 388-449-0150 When does my eligibility for aged, blind, or disabled (ABD) cash benefits end? (1) The maximum period of eligibility for ABD cash is twenty-four months before we must review additional medical evidence. If you remain on ABD cash at the end of the twenty-four month period, we determine your eligibility using current medical evidence.

(2) If your application for SSI is denied:

(a) We review your eligibility for the ABD cash program;

(b) We stop your benefits if you do not provide proof you have filed an appeal with SSA within sixty days of a SSI denial for not being disabled.

(3) We stop your benefits after the final decision on your application for SSI/SSA benefits or if you fail to follow through with any part of the SSI/SSA application or appeals process.

NEW SECTION

WAC 388-449-0200 Am I eligible for cash assistance for aged, blind, or disabled (ABD) while waiting for supplemental security income (SSI)? (1) You may receive ABD benefits while you are waiting to receive supplemental security income (SSI) benefits only when you:

(a) Have filed your SSI application with the Social Security Administration (SSA), follow through with SSA directions and requirements to process your application including keeping all interview and consultative examination appointments, and do not withdraw your application;

(b) Agree to assign the initial or reinstated SSI payment to us provided under WAC 388-449-0210;

(c) Are otherwise eligible according to WAC 388-400-0060; and

(d) Meet disability criteria listed in WAC 388-449-0001.

(2) To demonstrate your impairments are disabling despite medical treatment, you must participate in medical treatment for the impairments that keep you from working, unless you meet one of the following good cause reasons:

(a) The treatment provider has identified a risk that the treatment may cause further limitations or loss of a function or an organ and you are not willing to take that risk; or

(b) We determine that treatment is not available because you can't obtain it without cost to you.

(3) If you refuse or fail to participate in medical treatment without good cause, your benefits will end until you reapply and provide proof you are pursuing treatment as recommended.

NEW SECTION

WAC 388-449-0210 What is interim assistance and how do I assign it to the department? The ABD and SSI programs both provide cash assistance to meet your basic needs. You cannot receive this assistance for the same time period from both programs. When you are approved for or reinstated on SSI, you may receive a retroactive payment. When we made GA, DL, or ABD payments to you or on your behalf for the same time period, you must assign your interim assistance to repay us.

(1) **"Assign"** means that you sign a written authorization for the Social Security Administration (SSA) to send the SSI retroactive payment to us.

(2) **"Interim assistance"** means the monetary value of benefits we paid to you or on your behalf during:

(a) The time between your SSI application date and the month recurring SSI payments begin; or

(b) The period your SSI payments were suspended or terminated, and later reinstated.

NEW SECTION

WAC 388-449-0220 How does alcohol or drug dependence affect my eligibility for the ABD cash and pregnant women assistance programs? (1) You must complete a chemical dependency assessment when we have information that indicates you may be chemically dependent.

(2) You must accept an assessment referral and participate in drug or alcohol treatment if a certified chemical dependency counselor indicates a need for treatment, unless you meet one of the following good cause reasons:

(a) We determine that your physical or mental health impairment prevents you from participating in treatment.

(b) The outpatient chemical dependency treatment you need isn't available in the county you live in.

(c) You need inpatient chemical dependency treatment at a location that you can't reasonably access.

(3) If you refuse or fail to complete an assessment or treatment without good cause, your benefits will end until you provide proof you are pursuing an assessment or treatment as required.

NEW SECTION

WAC 388-449-0225 Am I required to participate in vocational rehabilitation services if I receive ABD cash grant? You must participate in vocational rehabilitation services through the division of vocational rehabilitation (DVR) if you are determined to be eligible for DVR services.

AMENDATORY SECTION (Amending WSR 10-15-069, filed 7/16/10, effective 8/16/10)

WAC 388-450-0040 Native American benefits and payments. This section applies to TANF/SFA, RCA, ((~~GA~~)) PWA, ABD cash, medical, and food assistance programs.

(1) The following types of income are not counted when a client's benefits are computed:

(a) Up to two thousand dollars per individual per calendar year received under the Alaska Native Claims Settlement Act, P.L. 92-203 and 100-241;

(b) Income received from Indian trust funds or lands held in trust by the Secretary of the Interior for an Indian tribe or individual tribal member. Income includes:

(i) Interest; and

(ii) Investment income accrued while such funds are held in trust.

(c) Income received from Indian judgement funds or funds held in trust by the Secretary of the Interior distributed per capita under P.L. 93-134 as amended by P.L. 97-458 and 98-64. Income includes:

(i) Interest; and

(ii) Investment income accrued while such funds are held in trust.

(d) Up to two thousand dollars per individual per calendar year received from leases or other uses of individually owned trust or restricted lands, P.L. 103-66;

(e) Payments from an annuity fund established by the Puyallup Tribe of Indians Settlement Act of 1989, P.L. 101-41, made to a Puyallup Tribe member upon reaching twenty-one years of age; and

(f) Payments from the trust fund established by the P.L. 101-41 made to a Puyallup Tribe member.

(2) Other Native American payments and benefits that are excluded by federal law are not counted when determining a client's benefits. Examples include but are not limited to:

(a) White Earth Reservation Land Settlement Act of 1985, P.L. 99-264, Section 16;

(b) Payments made from submarginal land held in trust for certain Indian tribes as designated by P.L. 94-114 and P.L. 94-540;

(c) Payments under the Seneca Nation Settlement Act, P.L. 101-503; and

(d) For medical assistance, receipt of money by a member of a federally recognized tribe from exercising federally protected rights or extraction of protected resources, such as fishing, shell-fishing, or selling timber, is considered conversion of an exempt resource during the month of receipt. Any amounts remaining from the conversion of this exempt resource on the first of the month after the month of receipt will remain exempt if the funds were used to purchase another exempt resource. Any amounts remaining in the form of countable resources (such as in checking or savings accounts) on the first of the month after receipt, will be added to other countable resources for eligibility determinations.

AMENDATORY SECTION (Amending WSR 06-17-017, filed 8/4/06, effective 9/4/06)

WAC 388-450-0045 How do we count income from employment and training programs? This section applies to cash assistance, Basic Food, and medical programs for families, children, and pregnant women.

(1) We treat payments issued under the Workforce Investment Act (WIA) as follows:

(a) For cash assistance and medical programs for families, children, and pregnant women, we exclude all payments.

(b) For Basic Food:

(i) We exclude OJT earnings for children who are eighteen years of age or younger and under parental control as described in WAC 388-408-0035.

(ii) We count OJT earnings as earned income for people who are:

(A) Age nineteen and older; or

(B) Age eighteen or younger and not under parental control.

(iii) We exclude all other payments.

(2) We exclude **all** payments issued under the National and Community Service Trust Act of 1993. This includes payments made through the AmeriCorps program.

(3) We treat payments issued under Title I of the Domestic Volunteer Act of 1973, such as VISTA, AmeriCorps Vista, university year for action, and urban crime prevention program as follows:

(a) For cash assistance and medical programs for families, children, and pregnant women, we exclude all payments.

(b) For Basic Food, we count most payments as earned income. We exclude the payments if you:

(i) Received Basic Food or cash assistance at the time you joined the Title I program; or

(ii) Were participating in the Title I program and received an income disregard at the time of conversion to the Food Stamp Act of 1977. We continue to exclude the payments even if you do not get Basic Food every month.

(4) We exclude **all** payments issued under Title II of the Domestic Volunteer Act of 1973. These include:

(a) Retired senior volunteer program (RSVP);

(b) Foster grandparents program; and

(c) Senior companion program.

(5) We count training allowances from vocational and rehabilitative programs as earned income when:

(a) The program is recognized by federal, state, or local governments; and

(b) The allowance is not a reimbursement.

(((~~(6) When GAU clients receive training allowances we allow:~~

~~(a) The earned income incentive and work expense deduction specified under WAC 388-450-0175, when applicable; and~~

~~(b) The actual cost of uniforms or special clothing required for the course as a deduction, if enrolled in a remedial education or vocational training course.~~

~~(7) We exclude support service payments received by or made on behalf of WorkFirst participants.~~))

AMENDATORY SECTION (Amending WSR 98-16-044, filed 7/31/98, effective 9/1/98)

WAC 388-450-0095 Allocating income—General. This section applies to TANF/SFA, RCA, ((~~and GA~~)) PWA, and ABD cash assistance programs.

(1) Allocation is the process of determining how much of a financially responsible person's income is considered available to meet the needs of legal dependents within or outside of an assistance unit.

(2) In-bound allocation means income possessed by a financially responsible person outside the assistance unit which is considered available to meet the needs of legal dependents in the assistance unit.

(3) Out-bound allocation means income possessed by a financially responsible assistance unit member which is set aside to meet the needs of a legal dependent outside the assistance unit.

AMENDATORY SECTION (Amending WSR 04-15-057, filed 7/13/04, effective 8/13/04)

WAC 388-450-0100 Allocating income—Definitions. The following definitions apply to the allocation rules for TANF/SFA, RCA, ((~~and GA~~)) PWA, and ABD cash programs:

(1) **"Dependent"** means a person who:

(a) Is or could be claimed for federal income tax purposes by the financially responsible person; or

(b) The financially responsible person is legally obligated to support.

(2) **"Financially responsible person"** means a parent, stepparent, adoptive parent, spouse or caretaker relative.

(3) A **"disqualified assistance unit member"** means a person who is:

(a) An unmarried pregnant or parenting minor under age eighteen who has not completed a high school education or general education development (GED) certification and is not participating in those educational activities which would lead to the attainment of a high school diploma or GED;

(b) An unmarried pregnant or parenting minor under age eighteen who is not living in a department-approved living situation;

(c) The financially responsible person who does not report to the department within five days of the date it becomes reasonably clear that the absence of a child will exceed ninety days;

(d) A person who has been convicted in federal or state court of having made a fraudulent statement or representation about their place of residence in order to receive assistance from two or more states at the same time as defined in WAC 388-446-0010; and

(e) A person who has been convicted of unlawfully receiving public assistance as defined under WAC 388-446-0005.

(4) **"Ineligible assistance unit member"** means an individual who is:

(a) Ineligible for cash assistance due to the citizenship/alien status requirements in WAC 388-424-0010;

(b) Ineligible to receive assistance under WAC 388-442-0010 for having been convicted after August 21, 1996, under federal or state law, of possession, use or distribution of a controlled substance;

(c) Ineligible to receive assistance under WAC 388-442-0010 for fleeing to avoid prosecution or custody or confinement after conviction for a crime or attempt to commit a crime;

(d) Ineligible to receive assistance under WAC 388-442-0010 for violating a condition of probation or parole which was imposed under a federal or state law as determined by an administrative body or court of competent jurisdiction;

(e) The spouse of a woman who receives cash benefits from the ((~~GA-S~~)) PWA program; or

(f) The adult parent of a minor parent's child.

NEW SECTION

WAC 388-450-0112 Does the department allocate the income of an ABD cash client to legal dependents? This section applies to the aged, blind, or disabled (ABD) cash assistance program.

(1) The income of an ABD cash client is reduced by the following:

(a) The ABD cash earned income disregard as specified in WAC 388-450-0177; and

(b) An amount not to exceed the department's standard of need for court or administratively ordered current or back support for legal dependents.

(2) When a ABD cash client in a medical institution, alcohol or drug treatment center, congregate care facility or adult family home has income, the income is countable to meet the client's needs after the income is reduced by the following:

(a) The payment standard amount for the nonapplying spouse and legal dependents living in the home; and

(b) The standard of assistance the client is eligible for while in an alternative care facility.

AMENDATORY SECTION (Amending WSR 98-16-044, filed 7/31/98, effective 9/1/98)

WAC 388-450-0115 ((~~Allocating~~)) Does the department allocate the income of a financially responsible person who is excluded from the assistance unit((~~,~~))? This section applies to TANF/SFA, RCA and ((~~GA-S~~)) PWA programs.

The income of a financially responsible person excluded from the assistance unit is available to meet the needs of the assistance unit after the income is reduced by the following:

(1) A ninety dollar work expense deduction from the financially responsible person(s) excluded from the assistance unit who is employed;

(2) The payment standard amount for the ineligible assistance unit members living in the home; and

(3) An amount not to exceed the department's standard of need for court or administratively ordered current or back support for legal dependents.

AMENDATORY SECTION (Amending WSR 98-16-044, filed 7/31/98, effective 9/1/98)

WAC 388-450-0120 ((~~Allocating~~)) Does the department allocate the income of financially responsible parents to a pregnant or parenting minor((~~,~~))? This section applies to TANF/SFA, RCA and ((~~GA-S~~)) PWA programs.

The income of nonapplying financially responsible parent(s) of a pregnant or parenting minor is countable to meet the needs of the minor and the child(ren) after the income is reduced by the following:

(1) A ninety dollar work expense from the financially responsible parent's gross income from employment;

(2) An amount not to exceed the department's standard of need for:

(a) The financially responsible parent and dependent living in the home who are not applying for or receiving cash benefits and not a disqualified individual; and

(b) Court or administratively ordered current or back support for legal dependents.

(3) Spousal maintenance payments made to meet the needs of individuals not living in the home.

AMENDATORY SECTION (Amending WSR 98-16-044, filed 7/31/98, effective 9/1/98)

WAC 388-450-0130 ((~~Allocating~~)) Does the department allocate the income of a nonapplying spouse to a caretaker relative((~~,~~))? This section applies to TANF/SFA, PWA, and RCA programs.

(1) The community income of the nonapplying spouse and applying spouse is combined. See WAC 388-450-0005 to determine what income is available as community income.

(2) Subtract a one person payment standard as specified in WAC 388-478-0020.

(3) The remainder is allocated to the caretaker relative.

NEW SECTION

WAC 388-450-0137 Does the department allocate income of an ineligible spouse to an ABD cash client? This section applies to the aged, blind, or disabled (ABD) cash assistance program.

(1) When an ABD cash client is married and lives with the nonapplying spouse, the following income is available to the client:

(a) The remainder of the client's wages, retirement benefits or separate property after reducing the income by:

(i) The ABD cash work incentive deduction, as specified in WAC 388-450-0177; and

(ii) An amount not to exceed the department's standard of need for court or administratively ordered current or back support for legal dependents.

(b) The remainder of the nonapplying spouse's wages, retirement benefits and separate property after reducing the income by:

(i) An amount not to exceed the department's standard of need for court or administratively ordered current or back support for legal dependents; and

(ii) The payment standard amount as specified under WAC 388-478-0033 which includes ineligible assistance unit members.

(c) One-half of all other community income, as provided in WAC 388-450-0005.

AMENDATORY SECTION (Amending WSR 11-16-056, filed 7/29/11, effective 8/29/11)

WAC 388-450-0156 When am I exempt from deeming? (1) If you meet any of the following conditions, you are **permanently** exempt from deeming and we do not count your sponsor's income or resources against your benefits:

(a) The Immigration and Nationality Act (INA) does not require you to have a sponsor. Immigrants who are not required to have a sponsor include those with the following status with United States Citizenship and Immigration Services (USCIS):

(i) Refugee;

(ii) Parolee;

(iii) Asylee;

(iv) Cuban/Haitian entrant; or

(v) Special immigrant from Iraq or Afghanistan.

(b) You were sponsored by an organization or group as opposed to an individual;

(c) You do not meet the alien status requirements to be eligible for benefits under chapter 388-424 WAC;

(d) You have worked or can get credit for forty qualifying quarters of work under Title II of the Social Security Act. We do not count a quarter of work toward this requirement if the person working received TANF, food stamps, Basic Food, SSI, CHIP, or nonemergency medicaid benefits. We count a quarter of work by the following people toward your forty qualifying quarters:

(i) Yourself;

(ii) Each of your parents for the time they worked before you turned eighteen years old (including the time they worked before you were born); and

(iii) Your spouse if you are still married or your spouse is deceased.

(e) You become a United States (U.S.) Citizen;

(f) Your sponsor is dead; or

(g) If USCIS or a court decides that you, your child, or your parent was a victim of domestic violence from your sponsor and:

(i) You no longer live with your sponsor; and

(ii) Leaving your sponsor caused your need for benefits.

(2) You are exempt from the deeming process while you are in the same AU as your sponsor;

(3) For children and pregnancy medical programs, you are exempt from sponsor deeming requirements.

(4) For Basic Food, you are exempt from deeming while you are under age eighteen.

(5) For state family assistance, ((~~disability lifeline (DL)~~)) aged, blind, or disabled (ABD) cash, pregnant women assistance (PWA), state-funded Basic Food benefits, and state-funded medical assistance for legal immigrants you are exempt from the deeming process if:

(a) Your sponsor signed the affidavit of support more than five years ago;

(b) Your sponsor becomes permanently incapacitated; or

(c) You are a qualified alien according to WAC 388-424-0001 and you:

(i) Are on active duty with the U.S. armed forces or you are the spouse or unmarried dependent child of someone on active duty;

(ii) Are an honorably discharged veteran of the U.S. armed forces or you are the spouse or unmarried dependent child of an honorably discharged veteran;

(iii) Were employed by an agency of the U.S. government or served in the armed forces of an allied country during a military conflict between the U.S. and a military opponent; or

(iv) Are a victim of domestic violence and you have petitioned for legal status under the Violence Against Women Act.

(6) If you, your child, or your parent was a victim of domestic violence, you are exempt from the deeming process for twelve months if:

(a) You no longer live with the person who committed the violence; and

(b) Leaving this person caused your need for benefits.

(7) If your AU has income at or below one hundred thirty percent of the federal poverty level (FPL), you are exempt from the deeming process for twelve months. This is called the "indigence exemption." You may choose to use this exemption or not to use this exemption in full knowledge of the possible risks involved. See risks in subsection (9) below. For this rule, we count the following as income to your AU:

(a) Earned and unearned income your AU receives from any source; and

(b) Any noncash items of value such as free rent, commodities, goods, or services you receive from an individual or organization.

(8) If you use the indigence exemption, and are eligible for a federal program, we are required by law to give the United States attorney general the following information:

(a) The names of the sponsored people in your AU;

(b) That you are exempt from deeming due to your income;

(c) Your sponsor's name; and

(d) The effective date that your twelve-month exemption began.

(9) If you use the indigence exemption, and are eligible for a state program, we do not report to the United States attorney general.

(10) If you choose not to use the indigence exemption:

(a) You could be found ineligible for benefits for not verifying your sponsor's income and resources; or

(b) You will be subject to regular deeming rules under WAC 388-450-0160.

AMENDATORY SECTION (Amending WSR 04-03-051, filed 1/15/04, effective 2/15/04)

WAC 388-450-0170 ((~~TANF/SFA earned income incentive and deduction.~~)) Does the department provide an earned income deduction as an incentive for persons who receive TANF/SFA to work? This section applies to TANF/SFA, RCA, PWA, and medical programs for children, pregnant women, and families except as specified under WAC 388-450-0210.

(1) If a client works, the department only counts some of the income to determine eligibility and benefit level.

(2) We only count fifty percent of your monthly gross earned income. We do this to encourage you to work.

(3) If you pay for care before we approve your benefits, we subtract the amount you pay for those dependent children or incapacitated adults who get cash assistance with you.

(a) The amount we subtract is:

(i) Prorated according to the date you are eligible for benefits;

(ii) Cannot be more than your gross monthly income; and

(iii) Cannot exceed the following for each dependent child or incapacitated adult:

Dependent Care Maximum Deductions

Hours Worked Per Month	Child Two Years of Age & Under	Child Over Two Years of Age or Incapacitated Adult
0 - 40	$ 50.00	$ 43.75
41 - 80	$ 100.00	$ 87.50
81 - 120	$ 150.00	$ 131.25
121 or More	$ 200.00	$ 175.00

(b) In order to get this deduction:

(i) The person providing the care must be someone other than the parent or stepparent of the child or incapacitated adult; and

(ii) You must verify the expense.

NEW SECTION

WAC 388-450-0177 Does the department offer an income deduction for the ABD cash program as an incentive for clients to work? The department gives a deduction to people who receive income from work while receiving aged, blind, or disabled cash assistance. The deduction applies to aged, blind, or disabled cash benefits only. We allow the following income deduction when we determine the amount of your benefits:

We only count fifty percent of your monthly gross earned income. We do this to encourage you to work.

AMENDATORY SECTION (Amending WSR 06-10-034, filed 4/27/06, effective 6/1/06)

WAC 388-460-0020 Who is a protective payee? (1) A protective payee is a person or an employee of an agency who manages client cash benefits to provide for basic needs -

housing, utilities, clothing, child care, and food. They may also provide services such as training clients how to manage money.

(2) Clients are assigned to protective payees for the following reasons:

(a) Emergency or temporary situations where a child is left without a caretaker (TANF/SFA) per WAC 388-460-0030;

(b) Mismanagement of money (TANF/SFA, ((~~GA~~)) PWA, ABD cash, or WCCC) per WAC 388-460-0035; or

(c) Pregnant or parenting minors per WAC 388-460-0040.

AMENDATORY SECTION (Amending WSR 02-14-083, filed 6/28/02, effective 7/1/02)

WAC 388-460-0040 When ((~~is~~)) does the department assign a protective payee assigned to TANF/SFA or PWA pregnant or parenting minors? Pregnant or parenting minors who are not emancipated under court order must be assigned to protective payees if the clients are:

(1) Head of a household;

(2) Under age eighteen;

(3) Unmarried; and

(4) Pregnant or have a dependent child.

AMENDATORY SECTION (Amending WSR 03-20-060, filed 9/26/03, effective 10/27/03)

WAC 388-468-0005 Residency. Subsections (1) through (4) applies to cash, the Basic Food program, and medical programs.

(1) A resident is a person who:

(a) Currently lives in Washington and intends to continue living here permanently or for an indefinite period of time; or

(b) Entered the state looking for a job; or

(c) Entered the state with a job commitment.

(2) A person does not need to live in the state for a specific period of time to be considered a resident.

(3) A child under age eighteen is a resident of the state where the child's primary custodian lives.

(4) With the exception of subsection (5) of this section, a client can temporarily be out of the state for more than one month. If so, the client must supply the department with adequate information to demonstrate the intent to continue to reside in the state of Washington.

(5) Basic Food program assistance units who are not categorically eligible do not meet residency requirements if they stay out of the state more than one calendar month.

(6) A client may not receive comparable benefits from another state for the cash and Basic Food programs.

(7) A former resident of the state can apply for the ((~~GA-U~~)) ABD cash program while living in another state if:

(a) The person:

(i) Plans to return to this state;

(ii) Intends to maintain a residence in this state; and

(iii) Lives in the United States at the time of the application.

(b) In addition to the conditions in subsection (7)(a)(i)(ii), and (iii) being met, the absence must be:

(i) Enforced and beyond the person's control; or

(ii) Essential to the person's welfare and is due to physical or social needs.

(c) See WAC 388-406-0035, 388-406-0040, and 388-406-0045 for time limits on processing applications.

(8) Residency is not a requirement for detoxification services.

(9) A person is not a resident when the person enters Washington state only for medical care. This person is not eligible for any medical program. The only exception is described in subsection (10) of this section.

(10) It is not necessary for a person moving from another state directly to a nursing facility in Washington state to establish residency before entering the facility. The person is considered a resident if they intend to remain permanently or for an indefinite period unless placed in the nursing facility by another state.

(11) For purposes of medical programs, a client's residence is the state:

(a) Paying a state Supplemental Security Income (SSI) payment; or

(b) Paying federal payments for foster or adoption assistance; or

(c) Where the noninstitutionalized individual lives when medicaid eligibility is based on blindness or disability; or

(d) Where the parent or legal guardian, if appointed, for an institutionalized:

(i) Minor child; or

(ii) Client twenty-one years of age or older, who became incapable of determining residential intent before reaching age twenty-one.

(e) Where a client is residing if the person becomes incapable of determining residential intent after reaching twenty-one years of age; or

(f) Making a placement in an out-of-state institution; or

(g) For any other institutionalized individual, the state of residence is the state where the individual is living with the intent to remain there permanently or for an indefinite period.

(12) In a dispute between states as to which is a person's state of residence, the state of residence is the state in which the person is physically located.

AMENDATORY SECTION (Amending WSR 05-19-059, filed 9/16/05, effective 10/17/05)

WAC 388-473-0010 What are ongoing additional requirements and how do I qualify? "Ongoing additional requirement" means a need beyond essential food, clothing, and shelter needs and is necessary to help you continue living independently.

(1) We may authorize ongoing additional requirement benefits if you are active in one of the following programs:

(a) Temporary assistance for needy families (TANF), or tribal TANF;

(b) State family assistance (SFA);

(c) Pregnant women assistance (PWA);

(d) Refugee cash;

((~~(d) General assistance cash~~)) (e) Aged, blind, or disabled (ABD); or

((~~(e)~~)) (f) Supplemental Security Income (SSI).

(2) You apply for an ongoing additional requirement benefit by notifying staff who maintain your cash or medical assistance that you need additional help to live independently.

(3) We authorize ongoing additional requirement benefits only when we determine the item is essential to you. We make the decision based on proof you provide of:

(a) The circumstances that create the need; and

(b) How the need affects your health, safety and ability to continue to live independently.

(4) We authorize ongoing additional requirement benefits by increasing your monthly cash assistance benefit.

(5) We use the following review cycle table to decide when to review your need for the additional benefit(s).

REVIEW CYCLE	
Program	Frequency (Months)
TANF/RCA	6 Months
((~~GA~~)) ABD	12 Months
SSI	24 Months
All	Any time need or circumstances are expected to change
All	Any time need or circumstances are expected to change.

(6) Monthly payment standards for ongoing additional requirements are described under WAC 388-478-0050.

Reviser's note: The typographical error in the above section occurred in the copy filed by the agency and appears in the Register pursuant to the requirements of RCW 34.08.040.

AMENDATORY SECTION (Amending WSR 02-11-033, filed 5/7/02, effective 6/7/02)

WAC 388-474-0010 How does being a supplemental security income (SSI) client affect your cash assistance eligibility? (1) If you are married to an SSI recipient but do not get SSI in your own right, you are called an "ineligible spouse."

(2) If you are an ineligible spouse you cannot get the SSI state supplement when you are:

(a) The caretaker relative of a child who receives TANF or SFA; and

(b) Required to be included in the TANF or SFA assistance unit with the child (see WAC 388-408-0015); or

(c) Receiving refugee assistance.

(3) If you are an ineligible spouse and get an SSI state supplement (WAC 388-474-0012), you cannot get ((~~general assistance (GA)~~)) aged, blind, or disabled (ABD) cash assistance.

AMENDATORY SECTION (Amending WSR 02-11-033, filed 5/7/02, effective 6/7/02)

WAC 388-474-0020 What can ((~~a general assistance-unemployable (GA-U)~~)) an aged, blind, or disabled (ABD) cash assistance client expect when supplemental security income (SSI) benefits begin? You ((~~can only get~~)) may only receive assistance to meet your basic needs from one government source at a time (WAC ((~~388-448-0210~~)) 388-449-0210). If you are ((~~a GA-U~~)) an ABD cash client who begins ((~~setting~~)) getting SSI, you should know that:

(1) If you got advance, emergency or retroactive SSI cash assistance for any period where you ((~~got GA-U~~)) received general assistance (GA), disability lifeline (DL), or aged, blind, or disabled (ABD) cash assistance, you must repay the department the amount of ((~~GA-U~~)) cash assistance paid to you for the matching time period.

(2) When you apply for ((~~GA-U~~)) ABD cash you must sign DSHS 18-235(X), interim assistance reimbursement agreement (IARA) to ((~~get GA-U~~)) receive ABD cash assistance.

(3) You cannot use your ((~~GA-U~~)) ABD money to replace money deducted from your SSI check to repay an SSI overpayment.

AMENDATORY SECTION (Amending WSR 10-17-101, filed 8/17/10, effective 9/17/10)

WAC 388-476-0005 Social Security number requirements. (1) With certain exceptions, each person who applies for or receives cash, medical or food assistance benefits must provide to the department a Social Security number (SSN), or numbers if more than one has been issued. For SSN requirements for immigrants, see WAC 388-424-0009.

(2) If the person is unable to provide the SSN, either because it is not known or has not been issued, the person must:

(a) Apply for the SSN;

(b) Provide proof that the SSN has been applied for; and

(c) Provide the SSN when it is received.

(3) Assistance will not be delayed, denied or terminated pending the issuance of an SSN by the Social Security Administration. However, a person who does not comply with these requirements is not eligible for assistance.

(4) For cash, medical, and food assistance benefits, a person cannot be disqualified from receiving benefits for refusing to apply for or supply an SSN based on religious grounds.

(5) For food assistance programs:

(a) A person can receive benefits for the month of application and the following month if the person attempted to apply for the SSN and made every effort to provide the needed information to the Social Security Administration.

(b) If a person is unable to provide proof of application for a SSN for a newborn:

(i) The newborn can receive Basic Food with the household while effort is being made to get the SSN.

(ii) For the newborn to continue receiving Basic Food benefits; the household must provide proof of application for SSN or the SSN for the newborn, at the next recertification, or within six months following the month the baby is born, whichever is later.

(6) For medical programs, a newborn as described in WAC 388-505-0210(1) is eligible for categorically needy (CN) medical without meeting the SSN requirement until the baby's first birthday.

(7) There is no SSN requirement for the following programs:

(a) The consolidated emergency assistance program;

(b) The refugee cash and medical assistance program;

(c) The alien emergency medical program; and

(d) ((~~The state-funded pregnant woman program; and~~ ~~(e)~~)) Detoxification services.

NEW SECTION

WAC 388-478-0027 What are the payment standards for pregnant women assistance (PWA)? (1) The payment standards for PWA cash assistance units with obligations to pay shelter costs are:

Assistance Unit Size	Payment Standard
1	$197

(2) The payment standards for PWA cash assistance units with shelter provided at no cost are:

Assistance Unit Size	Payment Standard
1	$120

NEW SECTION

WAC 388-478-0033 What are the payment standards for aged, blind, or disabled (ABD) cash assistance? (1) The payment standards for aged, blind, or disabled (ABD) cash assistance program assistance units with obligations to pay shelter costs are:

Assistance Unit Size	Payment standard
1	$197
2	$248

(2) The payment standards for aged, blind, or disabled (ABD) cash assistance units with shelter provided at no cost are:

Assistance Unit Size	Payment Standard
1	$120
2	$152

AMENDATORY SECTION (Amending WSR 98-16-044, filed 7/31/98, effective 9/1/98)

WAC 388-486-0005 Unmarried pregnant or parenting minors—Required living arrangement. (1) This rule affects only the minor's eligibility for cash assistance. It does not affect the eligibility of the minor parent's child for a cash grant.

(2) The following definitions apply to terms used in this section:

(a) "Unmarried" means a person who have never been married or whose marriage has been annulled. It does not include a person who has been divorced or widowed.

(b) "Minor" means a person younger than eighteen years of age.

(c) "Legal guardian" means a court-appointed legal guardian or court-appointed permanent custodian.

(d) "Relative" is a person who related to the pregnant or parenting minor as defined under RCW 74.15.020(4).

(3) An unmarried pregnant or parenting minor is not eligible for TANF, SFA or ((~~GA-S~~)) PWA unless the person:

(a) Has been emancipated by a court; or

(b) Lives in a home approved by the department and has a protective payee.

(4) The home of a minor's parent, legal guardian, or adult relative may be approved unless:

(a) The minor has no living parent, legal guardian, or adult relative that can be located or those persons do not want the minor to live with them;

(b) The minor or the minor's child is being or has been seriously harmed either physically, emotionally or sexually in the home of the parent, legal guardian, or adult relative;

(c) Substantial evidence exists of an act or failure to act by the parent, legal guardian, or adult relative that presents imminent or serious harm to the minor or the minor's child if they lived there; or

(d) The department determines that it is in the best interest of the minor or the minor's child to waive the requirement of living in the home of a parent, legal guardian, or adult relative.

(5) If the home of a minor's parent, legal guardian, or adult relative is not available or suitable, one of the following alternatives may be approved:

(a) A facility or home licensed under chapter 74.15 RCW that provides a supportive and supervised living arrangement requiring residents to learn parenting skills;

(b) A maternity home;

(c) Other adult-supervised living arrangement; or

(d) The minor's current or proposed living arrangement, if the department determines it is appropriate.

(6) A home that includes the other natural parent of the minor's child or unborn child is never approved if:

(a) The minor is under age sixteen; and

(b) The other parent is eighteen or older and meets the age criteria for rape of a child as set forth in RCW 9A.44.073, 9A.44.076, and 9A.44.079.

(7) The income of a minor parent found ineligible under this section is treated according to WAC 388-450-0100 and 388-450-0115 when determining the eligibility and benefit level of the minor parent's child.

Reviser's note: The typographical errors in the above section occurred in the copy filed by the agency and appear in the Register pursuant to the requirements of RCW 34.08.040.

REPEALER

The following sections of the Washington Administrative Code are repealed:

WAC 388-400-0025	Who is eligible for disability lifeline benefits?
WAC 388-404-0010	Age requirement for GA-U and ADATSA.
WAC 388-408-0010	Who is in my assistance unit for general assistance?
WAC 388-418-0025	Effect of changes on medical program eligibility.
WAC 388-424-0016	Citizenship and alien status—Immigrant eligibility

	restrictions for state medical benefits.
WAC 388-448-0001	What are the incapacity requirements for general assistance?
WAC 388-448-0010	How do we decide if you are incapacitated?
WAC 388-448-0020	Which health professionals can I go to for medical evidence?
WAC 388-448-0030	What medical evidence do I need to provide?
WAC 388-448-0035	How we assign severity ratings to your impairment.
WAC 388-448-0040	PEP step I—Review of medical evidence required for eligibility determination.
WAC 388-448-0050	PEP step II—How we determine the severity of mental impairments.
WAC 388-448-0060	PEP step III—How we determine the severity of physical impairments.
WAC 388-448-0070	PEP step IV—How we determine the severity of multiple impairments.
WAC 388-448-0080	PEP step V—How we determine your ability to function in a work environment if you have a mental impairment.
WAC 388-448-0090	PEP step V—How we determine your ability to function in a work environment if you have a physical impairment.
WAC 388-448-0100	PEP step VI—How we evaluate capacity to perform relevant past work.
WAC 388-448-0110	PEP step VII—How we evaluate your capacity to perform other work.
WAC 388-448-0120	How we decide how long you are incapacitated.
WAC 388-448-0130	Treatment and referral requirements.
WAC 388-448-0140	When does a person have good cause for refusing or failing to participate in medical treatment or referrals to other agencies?
WAC 388-448-0150	Penalty for refusing or failure to participate in medical treatment or other agency referrals.
WAC 388-448-0160	When do my disability lifeline benefits end?
WAC 388-448-0180	How do we redetermine your eligibility when we decide you are eligible for general assistance expedited medicaid (GAX)?
WAC 388-448-0200	Can I get general assistance while waiting for Supplemental Security Income (SSI)?
WAC 388-448-0210	What is interim assistance and how do I assign it to you?
WAC 388-448-0220	How does alcohol or drug dependence affect my eligibility for disability lifeline?
WAC 388-448-0250	Are there limits on the number of months I may receive disability lifeline benefits?
WAC 388-450-0110	Allocating the income of a GA-U client to legal dependents.
WAC 388-450-0135	Allocating income of an ineligible spouse to a GA-U client.
WAC 388-450-0175	Does the department offer an income deduction for the general assistance program as an incentive for clients to work?
WAC 388-462-0011	Post adoption cash benefit.

REPEALER

The following section of the Washington Administrative Code is repealed:

WAC 388-478-0030	Payment standards for disability lifeline and ADATSA.

AMENDATORY SECTION (Amending WSR 11-16-029, filed 7/27/11, effective 8/27/11)

WAC 388-478-0035 What are the maximum earned income limits for TANF, SFA, PWA and RCA((.))? To be eligible for temporary assistance for needy families (TANF), state family assistance (SFA), ((~~or~~)) refugee cash assistance (RCA), or a pregnant women assistance (PWA), a family's gross earned income must be below the following levels:

Number of Family Members	Maximum Earned Income Level	Number of Family Members	Maximum Monthly Earned Income Level
1	$610	6	$1,472
2	770	7	1,700
3	955	8	1,882
4	1,124	9	2,066
5	1,295	10 or more	2,246

WSR 11-22-028
EMERGENCY RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Medicaid Program)

[Filed October 25, 2011, 11:07 a.m., effective October 27, 2011]

Effective Date of Rule: October 27, 2011.

Purpose: To establish hearing rules related to medicaid funded services to implement the requirements of 2E2SBH [2E2SHB] 1738, section 53, effective July 1, 2011, for the transition of the single state medicaid agency to the Washington health care authority.

Citation of Existing Rules Affected by this Order: Repealing WAC 388-526-2610.

Statutory Authority for Adoption: RCW 41.05.021.

Other Authority: 2E2SHB 1738, section 53.

Under RCW 34.05.350 the agency for good cause finds that immediate adoption, amendment, or repeal of a rule is necessary for the preservation of the public health, safety, or general welfare, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the public interest; that state or federal law or federal rule or a federal deadline for state receipt of federal funds requires immediate adoption of a rule; and that in order to implement the requirements or reductions in appropriations enacted in any budget for fiscal year 2009, 2010, 2011, 2012 or 2013, which necessitates the need for the immediate adoption, amendment, or repeal of a rule, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the fiscal needs or requirements of the agency.

Reasons for this Finding: 2E2SHB 1738, section 53(10) states that the authority "shall adopt any rules it deems necessary to implement this section" dealing with hearing rights. Further, in section 130, the bill states that "this act is necessary for the *immediate* preservation of the public peace, health, or safety of the state government and its existing public institution, and takes effect July 1, 2011." Delaying this adoption could jeopardize the agency's ability to provide general hearing rules and procedures that apply to the resolution of disputes between medical assistance clients and the various medical services programs established under chapter 74.09 RCW. This emergency rule is necessary to continue the current emergency rule adopted under WSR 11-14-040 while the permanent rule-making process is completed. The agency filed CR-101 preproposal statement of inquiry under WSR 11-19-004 on September 7, 2011, and is currently following the permanent rules process with internal drafting of the rules, conducting meetings in-house, and scheduling a discussion meeting with interested stakeholders.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 0, Amended 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 137, Amended 0, Repealed 1.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 137, Amended 0, Repealed 1.

Date Adopted: October 20, 2011.

Katherine I. Vasquez
Rules Coordinator

Chapter 388-526 WAC

((~~MEDICAL FAIR HEARINGS~~)) ADMINISTRATIVE HEARING RULES FOR MEDICAL SERVICES PROGRAMS

NEW SECTION

WAC 388-526-0005 What is the purpose and scope of this chapter? This chapter describes the general hearing rules and procedures that apply to the resolution of disputes between you and the various medical services programs established under chapter 74.09 RCW. The rules of this chapter are intended to supplement both the administrative procedure act (APA), chapter 34.05 RCW, and the model rules, chapter 10-08 WAC, adopted by the office of administrative hearings (OAH).

(1) This chapter:

(a) Establishes rules encouraging informal dispute resolution between the health care authority (HCA) or its authorized agents, and persons or entities who disagree with its actions; and

(b) Regulates all hearings involving medical services programs established under chapter 74.09 RCW.

(2) Nothing in this chapter is intended to affect the constitutional rights of any person or to limit or change additional requirements imposed by statute or other rule. Other laws or rules determine if you have a hearing right, including the APA and program rules or laws.

(3) Specific program hearing rules prevail over the rules in this chapter.

(4) The hearing rules in this chapter do not apply to the following programs:

(a) Public employees benefits program (see chapter 182-16 WAC);

(b) Basic health plan program (see chapter 182-22 WAC); and

(c) The Washington health program (see chapter 182-25 WAC).

NEW SECTION

WAC 388-526-0010 What definitions apply to this chapter? The following definitions apply to this chapter:

"Administrative law judge (ALJ)" means an impartial decision-maker who is an attorney and presides at an administrative hearing. The office of administrative hearings (OAH), which is a state agency, employs the ALJs. ALJs are not department or health care authority employees or representatives.

"Authorized agent" means a person or agency which may act on behalf of HCA pursuant to the agreement authorized by RCW 41.05.021. The authorized agent(s) may include employees of the department or its contractors.

"BOA" means the board of appeals which is physically located within the department of social and health services.

"Business days" means all days except Saturdays, Sundays, and legal holidays.

"Calendar days" means all days including Saturdays, Sundays, and legal holidays.

"Deliver" means giving a document to someone in person.

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

"Documents" means papers, letters, writings, or other printed or written items.

"Final order" means an order that is the final agency decision.

"HCA" means the health care authority.

"Health care authority (HCA) hearing representative" means an employee of HCA, an authorized agent of HCA, HCA contractor or a contractor of HCA's authorized agent, or an assistant attorney general authorized to represent HCA in an administrative hearing.

"Hearing" means a proceeding before an ALJ or review judge that gives a party an opportunity to be heard in disputes about medical services programs set forth in RCW 74.09. For purposes of this chapter, hearings include administrative hearings, adjudicative proceedings, and any other similar term referenced under chapter 34.05 RCW, the administrative procedure act, Title 182 WAC except as specifically excluded by WAC 388-526-0005(4), and Title 388 WAC, chapter 10-08 WAC, or other law.

"Initial order" is a hearing decision made by an ALJ that may be reviewed by a BOA review judge at either party's request.

"Judicial review" means a superior court's review of a final order.

"Mail" means placing a document in the mail with the proper postage.

"OAH" means the office of administrative hearings, a separate state agency from HCA or the department.

"Party" means:

(1) The health care authority (HCA); or

(2) A person or entity:

(a) Named in the action;

(b) To whom the action is directed; or

(c) Allowed to participate in a hearing to protect an interest as authorized by law or rule.

"Prehearing conference" means a proceeding scheduled and conducted by an ALJ or review judge in preparation for a hearing.

"Prehearing meeting" means an informal voluntary meeting that may be held before any prehearing conference or hearing.

"Program" means an organizational unit and the services that it provides, including services provided by HCA staff, its authorized agents, and through contracts with providers.

"Record" means the official documentation of the hearing process. The record includes recordings or transcripts, admitted exhibits, decisions, briefs, notices, orders, and other filed documents.

"Review" means a review judge evaluating initial orders entered by an ALJ and making the final agency decision as provided by RCW 34.05.464, or issuing final orders.

"Review judge" means a decision-maker with expertise in program rules who is an attorney and serves as the reviewing officer under RCW 34.05.464. In some cases, review judges conduct hearings and enter final orders. In other cases, they review initial orders and may make changes to correct any errors in an ALJ's initial order. After reviewing initial orders or conducting hearings, review judges enter final orders. Review judges are physically located at the DSHS board of appeals (BOA) and are not part of the program involved in the initial agency action.

"Rule" means a state regulation. Rules are found in the Washington Administrative Code (WAC).

"Should" means that an action is recommended but not required.

"Stay" means an order temporarily halting the HCA decision or action.

"You" means any individual or entity that has a right to be involved with the hearing process, which includes a party or a party's representative. "You" does not include HCA or HCA's representatives, or HCA's authorized agents.

NEW SECTION

WAC 388-526-0015 How do the terms in the administrative procedure act compare to this chapter? To improve clarity and understanding, the rules in this chapter may use different words than the administrative procedures act (APA) or the model rules. Following is a list of terms used in those laws and the terms as used in these rules:

Chapter 34.05 RCW Chapter 10-08 WAC	Chapter 388-526 WAC
Adjudicative proceeding	Different terms are used to refer to different stages of the hearing process and may include prehearing meeting, prehearing conference, hearing, review, reconsideration, and the entire hearing process
Application for adjudicative proceeding	Request a hearing
Enter	Make, send
Presiding officer	Administrative law judge or review judge
Reviewing officer	Review judge

NEW SECTION

WAC 388-526-0020 What does good cause mean? (1) Good cause is a substantial reason or legal justification for failing to appear, to act, or respond to an action. To show good cause, the administrative law judge must find that a party had a good reason for what they did or did not do, using the provisions of Superior Court Civil Rule 60 as a guideline.

(2) Good cause may include, but is not limited to, the following examples.

(a) You ignored a notice because you were in the hospital or were otherwise prevented from responding; or

(b) You could not respond to the notice because it was written in a language that you did not understand.

NEW SECTION

WAC 388-526-0025 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
PO Box 42488
Olympia, WA 98504-2488
(360) 664-8717
(360) 664-8721 (fax)

(b) The headquarters office is open from 8:00 a.m. 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
P.O. Box 42489
Olympia, WA 98504-2489
(360) 407-2768
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) 249-6090
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.

NEW SECTION

WAC 388-526-0030 How do I contact the board of appeals? The information included in this section is current at this time of rule adoption, but may change. Current information and additional contact information are available on the department's internet site, in person at the board of appeals (BOA) office, or by a telephone call to the BOA's main public number.

Department of Social and Health Services Board of Appeals	
Location	Office Building 2 (OB-2) 2nd Floor 1115 Washington Street Olympia, Washington

Mailing address	P.O. Box 45803 Olympia, WA 98504-5803
Telephone	(360) 664-6100
Fax	(360) 664-6187
Toll free	1-877-351-0002
Internet web site	www.dshs.wa.gov/boa

NEW SECTION

WAC 388-526-0035 How are days counted when calculating deadlines for the hearing process? (1) When counting days to find out when a hearing deadline ends under program rules or statutes:

(a) Do not include the day of the action, notice, or order. For example, if a hearing decision is mailed on Tuesday and you have twenty-one days to request a review, start counting the days with Wednesday.

(b) If the last day of the period ends on a Saturday, Sunday, or legal holiday, the deadline is the next business day.

(c) For periods of seven days or less, count only business days. For example, if you have seven days to respond to a review request that was mailed to you on Friday, May 10, the response period ends on Tuesday, May 21.

(d) For periods over seven days, count every day, including Saturdays, Sundays, and legal holidays.

(2) The deadline ends at 5:00 p.m. on the last day.

(3) If you miss a deadline, you may lose your right to a hearing or appeal of a decision.

NEW SECTION

WAC 388-526-0037 When must the office of administrative hearings reschedule a proceeding based on the amount of notice required? Any party may request that the proceeding be rescheduled and the office of administrative hearings (OAH) must reschedule if:

(1) A rule requires the OAH to provide notice of a proceeding; and

(2) The OAH does not provide the amount of notice required.

NEW SECTION

WAC 388-526-0038 When may the office of administrative hearings shorten the amount of notice required to the parties of a proceeding? The administrative law judge and the parties may agree to shorten the amount of notice required by any rule.

NEW SECTION

WAC 388-526-0040 How do parties send documents? (1) When the rules in this chapter or in other law ask a party to send copies of documents to other parties, the party must mail or deliver copies to the health care authority (HCA) hearing representative and to all other parties or their representatives.

(2) When sending documents to the office of administrative hearings (OAH) or the board of appeals (BOA), you must mail or deliver the documents to one of the locations listed in WAC 388-526-0025(2) for OAH or in WAC 388-526-0030 for BOA.

(3) When sending documents to your assigned field office, you may use the address listed at the top of your notice of hearing. If a field office has not been assigned, all written communication about your hearing must be sent to the OAH Olympia field office which sends the communication to the correct office.

(4) Documents may be sent by giving them to someone in person, placing them in the mail with proper postage, or by fax or e-mail if the party mails a copy on the same day.

NEW SECTION

WAC 388-526-0045 What is service? Service gives the party notice. When a document is given to the party, the party is considered served with official notice of the contents of the document.

NEW SECTION

WAC 388-526-0050 How does a party serve someone? Unless otherwise stated in law, a party may serve someone by:

(1) Personal service (hand delivery);

(2) First class, registered, or certified mail;

(3) Fax if the party mails a copy of the document the same day;

(4) Commercial delivery service; or

(5) Legal messenger service.

NEW SECTION

WAC 388-526-0055 When must a party serve someone? A party must serve all other parties and their representatives whenever the party files a pleading, brief or other document with the office of administrative hearings or the board of appeals, or when required by law.

NEW SECTION

WAC 388-526-0060 When is service complete? Service is complete when:

(1) Personal service is made;

(2) Mail is properly stamped, addressed, and deposited in the United States mail;

(3) Fax produces proof of transmission;

(4) A parcel is delivered to a commercial delivery service with charges prepaid; or

(5) A parcel is delivered to a legal messenger service with charges prepaid.

NEW SECTION

WAC 388-526-0065 How does a party prove service? A party may prove service by providing any of the following:

(1) A sworn statement;

(2) The certified mail receipt signed by the recipient;

(3) An affidavit or certificate of mailing;

(4) A signed receipt from the person who accepted the commercial delivery service or legal messenger service package; or

(5) Proof of fax transmission.

NEW SECTION

WAC 388-526-0070 What is filing? (1) Filing is the act of delivering documents to the office of administrative hearings (OAH) or the board of appeals (BOA).

(2) The date of filing is the date documents are received by OAH or BOA.

(3) Filing is complete when the documents are received by OAH or BOA during office hours.

NEW SECTION

WAC 388-526-0075 How does a party file documents? (1) A party may file documents by delivering them to the office of administrative hearings or the board of appeals by:

(a) Personal service (hand delivery);

(b) First class, registered, or certified mail;

(c) Fax transmission if the party mails a copy of the document the same day;

(d) Commercial delivery service; or

(e) Legal messenger service.

(2) A party cannot file documents by e-mail.

NEW SECTION

WAC 388-526-0080 What are your options for resolving a dispute with the health care authority? (1) If you disagree with a decision or action of the health care authority, or one of its authorized agents, you have several options for resolving your dispute, which may include the following:

(a) Any special prehearing alternative or administrative process offered by the program;

(b) Prehearing meeting;

(c) Prehearing conference; and

(d) Hearing.

(2) Because you have a limited time to request a hearing, you must request a hearing within the deadline on the notice of the agency action to preserve your hearing right.

NEW SECTION

WAC 388-526-0085 Do you have a right to a hearing? (1) You have a right to a hearing only if a law or program rule gives you that right. If you are not sure, you should request a hearing to protect your right.

(2) Some programs may require you to go through an informal administrative process before you can request or have a hearing. The notice of the action sent to you should include information about this requirement if it applies.

(3) You have a limited time to request a hearing. The deadline for your request varies by the program involved. You should submit your request right away to protect your right to a hearing, even if you are also trying to resolve your dispute informally.

(4) If you request a hearing, one is scheduled.

(5) If the health care authority hearing representative or the administrative law judge (ALJ) questions your right to a hearing, the ALJ decides whether you have that right.

(6) If the ALJ decides you do not have a right to a hearing, your request is dismissed.

(7) If the ALJ decides you do have a right to a hearing, the hearing proceeds.

NEW SECTION

WAC 388-526-0090 Who may request a hearing? Either you or your representative may request a hearing.

NEW SECTION

WAC 388-526-0095 What if you have questions about requesting a hearing? If you have questions about how, when, and where to request a hearing, you should:

(1) Contact the specific program involved, the office of administrative hearings, or the board of appeals;

(2) Review the notice sent to you of the action or decision; or

(3) Review the applicable law or program rule.

NEW SECTION

WAC 388-526-0100 How do you request a hearing? (1) You may request a hearing in writing or orally, depending upon which program is involved. The notice and applicable laws and rules should tell you whether the request must be in writing or may be made orally.

(2) If you are allowed to make an oral request, you may do so to a health care authority (HCA) employee, HCA's authorized agent, or to an office of administrative hearings (OAH) employee in person, by telephone, or by voice mail.

(3) You may send a written request by mail, delivery service, personal service, or by fax if you mail a copy the same day. You should send written requests to the location on the notice or to OAH at the location specified in WAC 388-526-0025(2).

NEW SECTION

WAC 388-526-0105 What information do you give when requesting a hearing? (1) Your hearing request must contain enough information to identify you and the agency action. You should include:

(a) Your name, address, and telephone number;

(b) A brief explanation of why you disagree with the agency action;

(c) Your client identification or case number, contract number, or any other information that identifies your case or the program involved; and

(d) Any assistance you need, including a foreign or sign language interpreter or any other accommodation for a disability.

(2) You should also refer to a program's specific rules or the notice to see if additional information is required in your request.

(3) The office of administrative hearings (OAH) may not be able to process your hearing request if it cannot identify or locate you and determine the agency action involved.

NEW SECTION

WAC 388-526-0110 What happens after you request a hearing? (1) After you request a hearing, the office of administrative hearings sends the parties a notice containing the hearing date, time, and place. This document is called the notice of hearing. The parties may also receive a written notice of a prehearing conference. You may receive a notice of a prehearing conference either before or after receiving the notice of the hearing.

(2) Before your hearing is held:

(a) The health care authority (HCA) hearing representative may contact you and try to resolve your dispute; and

(b) You are encouraged to contact the HCA hearing representative and try to resolve your dispute.

(3) If you do not appear for your hearing, an administrative law judge may enter an order of default or an order dismissing your hearing according to WAC 388-526-0285.

NEW SECTION

WAC 388-526-0115 May you withdraw your hearing request? (1) You may withdraw your hearing request for any reason and at any time by contacting the health care authority hearing representative or the office of administrative hearings (OAH) in writing or orally with the administrative law judge and the other parties. After your request for withdrawal is received, your hearing is cancelled and OAH sends an order dismissing the hearing. If you withdraw your request you may not be able to request another hearing on the same action.

(2) If you withdraw your hearing request, you may only set aside the dismissal according to WAC 388-526-0290.

NEW SECTION

WAC 388-526-0120 Do you have the right to an interpreter in the hearing process? If you need an interpreter because you or any of your witnesses are a person with limited English proficiency, the office of administrative hearings will provide an interpreter at no cost to you.

NEW SECTION

WAC 388-526-0125 What definitions apply to limited English proficient parties? The following definitions apply to LEP parties:

"Hearing impaired person" means a person who, because of a hearing or speech impairment, cannot readily speak, understand, or communicate in spoken language.

"Intermediary interpreter" means an interpreter who:

(1) Is a certified deaf interpreter (CDI); and

(2) Is able to assist in providing an accurate interpretation between spoken and sign language or between types of sign language by acting as an intermediary between a hearing impaired person and a qualified interpreter.

"Limited English proficient (LEP)" includes limited English speaking persons or other persons unable to communicate in spoken English because of a hearing impairment.

"Limited English-speaking (LES) person" means a person who, because of non-English speaking cultural background or disability, cannot readily speak or understand the English language.

"Qualified interpreter" includes qualified interpreters for a limited English-speaking person or a person with a hearing impairment.

"Qualified interpreter for a limited English-speaking person" means a person who is readily able to interpret or translate spoken and written English communications to and from a limited English-speaking person. If an interpreter is court certified, the interpreter is considered qualified.

"Qualified interpreter for a person with a hearing impairment" means a visual language interpreter who is certified by the registry of interpreters for the deaf or National Association of the Deaf and is readily able to interpret or translate spoken communications to and from a hearing impaired person.

NEW SECTION

WAC 388-526-0130 What requirements apply to notices for limited English-speaking parties? If the office of administrative hearings is notified that you are a limited English-speaking person, all hearing notices, decisions and orders for you must:

(1) Be written in your primary language; or

(2) Include a statement in your primary language:

(a) Indicating the importance of the notice; and

(b) Telling you how to get help in understanding the notice and responding to it.

NEW SECTION

WAC 388-526-0135 What requirements apply to interpreters? (1) The office of administrative hearings (OAH) must provide a qualified interpreter to assist any person who:

(a) Has limited English proficiency; and

(b) Is a party or witness in a hearing.

(2) OAH may hire or contract with persons to interpret at hearings.

(3) The following persons may not be used as interpreters:

(a) A relative of any party;

(b) Health care authority (HCA) employees; or

(c) HCA authorized agents.

(4) The administrative law judge (ALJ) must determine, at the beginning of the hearing, if an interpreter can accurately interpret all communication for the person requesting the service. To do so, the ALJ considers the interpreter's:

(a) Ability to meet the needs of the hearing impaired person or limited English speaking person;

(b) Education, certification, and experience;

(c) Understanding of the basic vocabulary and procedures involved in the hearing; and

(d) Ability to be impartial.

(5) The parties or their representatives may question the interpreter's qualifications and ability to be impartial.

(6) If at any time before or during the hearing the interpreter does not provide accurate and effective communication, the ALJ must provide another interpreter.

NEW SECTION

WAC 388-526-0140 May you waive interpreter services? (1) If you are limited English proficient, you may ask to waive interpreter services.

(2) You must make your request in writing or through a qualified interpreter on the record.

(3) The administrative law judge must determine if your waiver has been knowingly and voluntarily made.

(4) You may withdraw your waiver at any time before or during the hearing.

NEW SECTION

WAC 388-526-0145 What requirements apply to the use of interpreters? (1) Interpreters must:

(a) Use the interpretive mode that the parties, the hearing impaired person, the interpreter, and the administrative law judge (ALJ) consider the most accurate and effective;

(b) Interpret statements made by the parties and the ALJ;

(c) Not disclose information about the hearing without the written consent of the parties; and

(d) Not comment on the hearing or give legal advice.

(2) The ALJ must allow enough time for all interpretations to be made and understood.

(3) The ALJ may video tape a hearing and use it as the official transcript for hearings involving a hearing impaired person.

NEW SECTION

WAC 388-526-0150 What requirements apply to hearing decisions involving limited English-speaking parties? (1) When an interpreter is used at a hearing, the administrative law judge must explain that the decision is written in English but that a party using an interpreter may contact the interpreter for an oral translation of the decision at no cost to you.

(2) Interpreters must provide a telephone number where they can be reached. This number must be attached to any decision or order mailed to the parties.

(3) The office of administrative hearings or the board of appeals must mail a copy of a decision or order to the interpreter for use in oral translation.

NEW SECTION

WAC 388-526-0155 Who represents you during the hearing process? (1) You may represent yourself or have anyone represent you, except health care authority (HCA) employees, HCA's authorized agents, and DSHS employees.

(2) Your representative may be a friend, relative, community advocate, attorney, or paralegal.

(3) You should inform the HCA hearing representative or the office of administrative hearings of your representative's name, address, and telephone number.

NEW SECTION

WAC 388-526-0157 How does a party appear? (1) If you are going to represent yourself, you should provide the administrative law judge (ALJ) and other parties with your name, address, and telephone number.

(2) If you are represented, your representative should provide the ALJ and other parties with the representative's name, address, and telephone number.

(3) The presiding officer may require your representative to file a written notice of appearance or to provide documentation that you have authorized the representative to appear on your behalf. In cases involving confidential information, your representative must file a legally sufficient signed written consent or release of information document.

(4) If your representative is an attorney admitted to practice in Washington state, your attorney must file a written notice of appearance, and must file a notice of withdrawal upon withdrawal of representation.

(5) If you or your representative put in a written notice of appearance, the ALJ should call the telephone number on the notice of appearance if you, or your representative, do not appear by calling in with a telephone number before a hearing (including a prehearing).

NEW SECTION

WAC 388-526-0160 If a health care authority employee, a health care authority's authorized agent, and DSHS employee cannot represent you, can they assist you during the hearing process? Although a health care authority (HCA) employee, HCA authorized agent, and DSHS employee cannot represent you during the hearing process, they may assist you by:

(1) Acting as a witness;

(2) Referring you to community legal resources;

(3) Helping you get nonconfidential information; or

(4) Informing you about or providing copies of the relevant laws or rules.

NEW SECTION

WAC 388-526-0165 What if you would like to be represented by an attorney but you cannot afford one? (1) Neither the health care authority (HCA), HCA's authorized agents, or the office of administrative hearings (OAH) will pay for an attorney for you.

(2) If you want an attorney to represent you and cannot afford one, community resources may be available to assist you. These legal services may be free or available at a reduced cost. HCA, HCA's authorized agent, or OAH can tell you who to contact for legal assistance.

(3) Information about legal assistance can also be found at www.oah.wa.gov.

NEW SECTION

WAC 388-526-0170 Who represents the health care authority during the hearing? (1) The health care authority (HCA) hearing representative as defined in WAC 388-526-0010 represents HCA during the hearing. The HCA hearing representative may or may not be an attorney.

(2) An administrative law judge (ALJ) is independent and does not represent HCA or any other party.

NEW SECTION

WAC 388-526-0175 What is a prehearing meeting? (1) A prehearing meeting is an informal meeting with a health care authority (HCA) hearing representative that may be held before any prehearing conference or hearing.

(2) An HCA hearing representative may contact you before the scheduled hearing to arrange a prehearing meeting. You may also contact the HCA hearing representative to request a prehearing meeting.

(3) A prehearing meeting is voluntary. You are not required to request one, and you are not required to participate in one.

(4) The prehearing meeting includes you and/or your representative, the HCA hearing representative, and any other party. An administrative law judge (ALJ) does not attend a prehearing meeting.

(5) The prehearing meeting gives the parties an opportunity to:

(a) Clarify issues;

(b) Exchange documents and witness statements;

(c) Resolve issues through agreement or withdrawal; and

(d) Ask questions about the hearing process and the laws and rules that apply.

(6) A prehearing meeting may be held or information exchanged:

(a) In person;

(b) By telephone conference call;

(c) Through correspondence; or

(d) Any combination of the above that is agreeable to the parties.

(7) If a prehearing conference is required by the program or rule, a prehearing meeting may not be an option available to you.

NEW SECTION

WAC 388-526-0180 What happens during a prehearing meeting? During a prehearing meeting:

(1) A health care authority (HCA) hearing representative:

(a) Explains the role of the HCA hearing representative in the hearing process;

(b) Explains how a hearing is conducted and the relevant laws and rules that apply;

(c) Explains your right to representation during the hearing;

(d) Responds to your questions about the hearing process;

(e) Identifies accommodation and safety issues;

(f) Distributes copies of the documents to be presented during the hearing;

(g) Provides, upon request, copies of relevant laws and rules;

(h) Identifies additional documents or evidence you may want or be required to present during the hearing;

(i) Tells you how to obtain documents from your file;

(j) Clarifies the issues; and

(k) Attempts to settle the dispute, if possible.

(2) You should explain your position and provide documents that relate to your case. You also have the right to consult legal resources.

(3) You and the HCA hearing representative may enter into written agreements or stipulations, including agreements that settle your dispute.

NEW SECTION

WAC 388-526-0185 What happens after a prehearing meeting? (1) If you and the health care authority (HCA) hearing representative resolve the dispute during the prehearing meeting and put it in writing or present the agreement to an administrative law judge (ALJ), your agreement may be legally enforceable.

(2) Any agreements or stipulations made at the prehearing meeting must be presented to an ALJ before or during the hearing, if you want the ALJ to consider the agreement.

(3) If all of your issues are not resolved in the prehearing meeting, you may request a prehearing conference before an ALJ or go to your scheduled hearing. The ALJ may also order a prehearing conference.

(4) You may withdraw your hearing request at any time if the HCA hearing representative agrees to some action that resolves your dispute, or for any other reason. If you withdraw your hearing request, the hearing is not held and the ALJ sends a written order of dismissal.

NEW SECTION

WAC 388-526-0190 What happens if you do not participate in a prehearing meeting? You are not required to participate in a prehearing meeting. If you do not participate, it does not affect your right to a hearing.

NEW SECTION

WAC 388-526-0195 What is a prehearing conference? (1) A prehearing conference is a formal proceeding conducted on the record by an administrative law judge (ALJ) to prepare for a hearing. The ALJ must record the prehearing conference using audio recording equipment (such as a digital recorder or tape recorder).

(2) An ALJ may conduct the prehearing conference in person, by telephone conference call, or in any other manner acceptable to the parties. Your attendance is mandatory.

(3) You may lose the right to participate during the hearing if you do not attend the prehearing conference.

NEW SECTION

WAC 388-526-0197 When is a prehearing conference scheduled? (1) The administrative law judge (ALJ) may require a prehearing conference. Any party may request a prehearing conference.

(2) The ALJ must grant the first request for a prehearing conference if it is received by the office of administrative hearings (OAH) at least seven business days before the scheduled hearing date.

(3) The ALJ may grant untimely or additional requests for prehearing conferences.

(4) If the parties do not agree to a continuance, the OAH and/or the ALJ must set a prehearing conference to decide whether there is good cause to grant or deny the continuance.

(5) The OAH must schedule prehearing conferences for all cases which concern:

(a) The department's division of residential care services under Title XIX of the federal social security act; and

(b) Provider and vendor overpayment hearings.

NEW SECTION

WAC 388-526-0200 What happens during a prehearing conference? During a prehearing conference the parties and the administrative law judge may:

(1) Simplify or clarify the issues to be decided during the hearing;

(2) Agree to the date, time, and place of the hearing;

(3) Identify accommodation and safety issues;

(4) Agree to postpone the hearing;

(5) Allow the parties to make changes in their own documents, including the notice or the hearing request;

(6) Agree to facts and documents to be entered during the hearing;

(7) Set a deadline to exchange names and phone numbers of witnesses and documents before the hearing;

(8) Schedule additional prehearing conferences;

(9) Resolve the dispute;

(10) Consider granting a stay if authorized by law or program rule; or

(11) Determine any other procedural issues raised by the parties.

NEW SECTION

WAC 388-526-0205 What happens after a prehearing conference? (1) After the prehearing conference ends, the administrative law judge (ALJ) must enter a written prehearing order describing:

(a) The actions taken;

(b) Any changes to the documents;

(c) Any agreements reached; and

(d) Any ruling of the ALJ.

(2) The ALJ must send the prehearing order to the parties at least fourteen calendar days before the scheduled hearing, except a hearing may still occur as allowed under WAC 388-526-0280(5). The parties and the ALJ may agree to a shorter time period.

(3) A party may object to the prehearing order by notifying the ALJ in writing within ten days after the mailing date of the order. The ALJ must issue a ruling on the objection.

(4) If no objection is made to the prehearing order, the order determines how the hearing is conducted, including whether the hearing will be in person or held by telephone conference or other means, unless the ALJ changes the order for good cause.

(5) The ALJ may take further appropriate actions to address other concerns.

NEW SECTION

WAC 388-526-0210 What happens if a party does not attend a prehearing conference? (1) All parties are required to attend a prehearing conference.

(2) If you do not attend, you may not be allowed to participate in the hearing. The administrative law judge may dismiss your hearing request or enter an order of default against you.

NEW SECTION

WAC 388-526-0215 What is the authority of the administrative law judge? (1) The administrative law judge (ALJ) must hear and decide the issues de novo (anew) based on what is presented during the hearing.

(2) As needed, the ALJ may:

(a) Determine the order for presenting evidence;

(b) Issue subpoenas or orders directing witnesses to appear or bring documents;

(c) Rule on objections, motions, and other procedural matters;

(d) Rule on an offer of proof made to admit evidence;

(e) Admit relevant evidence;

(f) Impartially question witnesses to develop the record;

(g) Call additional witnesses and request exhibits to complete the record;

(h) Give the parties an opportunity to cross-examine witnesses or present more evidence against the witnesses or exhibits;

(i) Keep order during the hearing;

(j) Allow or require oral or written argument and set the deadlines for the parties to submit argument or evidence;

(k) Permit others to attend, photograph, or electronically record hearings, but may place conditions to preserve confidentiality or prevent disruption;

(l) Allow a party to waive rights given by chapters 34.05 RCW or 388-526 WAC, unless another law prevents it;

(m) Decide whether a party has a right to a hearing;

(n) Issue protective orders;

(o) Consider granting a stay if authorized by law or agency rule; and

(p) Take any other action necessary and authorized under these or other rules.

(3) The ALJ administers oaths or affirmations and takes testimony.

(4) The ALJ enters initial orders. Initial orders may become final orders pursuant to WAC 388-526-0525.

NEW SECTION

WAC 388-526-0216 Is the authority of the administrative law judge and the review judge limited? The authority of the administrative law judge and the review judge is limited to those powers conferred (granted) by statute or rule. The ALJ and the review judge do not have any inherent or common law powers.

NEW SECTION

WAC 388-526-0218 When do review judges conduct the hearing and enter final orders? (1) Review judges conduct the hearing and enter the final order in cases where a contractor for the delivery of nursing facility services requests an administrative hearing under WAC 388-96-904(5). Any party dissatisfied with a decision or an order of dismissal of a review judge may request reconsideration from the review judge as provided by this chapter and WAC 388-96-904(12).

(2) The review judge enters final agency decisions on all cases in the form of a final order.

(3) Following a review judge's decision, you, but not the health care authority or any of its authorized agents, may file a petition for judicial review as provided by this chapter.

(4) A review judge has the same authority as an administrative law judge, as described in WAC 388-526-0215, when conducting a hearing.

NEW SECTION

WAC 388-526-0220 What rules and laws must an administrative law judge and review judge apply when conducting a hearing or making a decision? (1) Administrative law judges (ALJs) and review judges must first apply the applicable program rules adopted in the Washington Administrative Code (WAC).

(2) If no program rule applies, the ALJ or review judge must decide the issue according to the best legal authority and reasoning available, including federal and Washington state constitutions, statutes, regulations, and court decisions.

(3) When applying program rules regarding the substantive rights and responsibilities of the parties (such as eligibility for services, benefits, or a license), the ALJ and review judge must apply the program rules that were in effect on the date the agency notice was sent, unless otherwise required by other rule or law. If the health care authority (HCA) or HCA's authorized agents amends the notice, the ALJ and review judge must apply the rules that were in effect on the date the initial notice was sent, unless otherwise required by other rule or law.

(4) When applying program rules regarding the procedural rights and responsibilities of the parties, the ALJ and review judge must apply the rules that are in effect on the date the procedure is followed.

(5) Program rules determine the amount of time HCA or HCA's authorized agent has to process your application for services, benefits, or a license.

(6) The ALJ and review judge must apply the rules in this chapter beginning on the date each rule is effective.

NEW SECTION

WAC 388-526-0221 How is the index of significant decisions used? (1) A final order may be relied on, used, or cited as precedent by a party if the final order has been indexed in the index of significant decisions.

(2) The index of significant decisions is available to the public at www.dshs.wa.gov/boa. For information on how to obtain a copy of the index, see WAC 388-01-190.

(3) If a precedential published decision entered by the Court of Appeals or the Supreme Court reverses an indexed board of appeals final order, that order will be removed from the index of significant decisions.

NEW SECTION

WAC 388-526-0225 May an administrative law judge or review judge decide that a rule is invalid? (1) Neither an administrative law judge or a review judge may decide that a rule is invalid or unenforceable. Only a court may decide this issue.

(2) If the validity of a rule is raised during the hearing, the ALJ or review judge may allow argument for court review.

NEW SECTION

WAC 388-526-0230 When is the administrative law judge assigned to the hearing? The office of administrative hearings (OAH) assigns an administrative law judge (ALJ) at least five business days before the hearing. A party may ask which ALJ is assigned to the hearing by calling or writing the OAH field office listed on the notice of hearing. If requested by a party, the OAH must send the name of the assigned ALJ to the party by e-mail or in writing at least five business days before the party's scheduled hearing date.

NEW SECTION

WAC 388-526-0235 May a party request a different judge? A party may file a motion of prejudice against an administrative law judge (ALJ) under RCW 34.12.050. A party may also request that an ALJ or review judge be disqualified under RCW 34.05.425.

NEW SECTION

WAC 388-526-0240 How does a party file a motion of prejudice? (1) A party may request a different administrative law judge (ALJ) by sending a written motion of prejudice to the office of administrative hearings (OAH) before the ALJ rules on a discretionary issue in the case, admits evidence, or takes testimony. A motion of prejudice must include an affidavit or statement that a party does not believe that the ALJ can hear the case fairly.

(2) Rulings that are not considered discretionary rulings for purposes of this section include but are not limited to those:

(a) Granting or denying a request for a continuance; and

(b) Granting or denying a request for a prehearing conference.

(3) A party must send the written motion of prejudice to the chief ALJ at the OAH headquarters identified in WAC 388-526-0025(1) and must send a copy to the OAH field office where the ALJ is assigned.

(4) A party may make an oral motion of prejudice at the beginning of the hearing before the ALJ rules on a discretionary issue in the case, admits evidence, or takes testimony if:

(a) The OAH did not assign an ALJ at least five business days before the date of the hearing; or

(b) The OAH changed the assigned ALJ within five business days of the date of the hearing.

(5) The first request for a different ALJ is automatically granted. The chief ALJ or a designee grants or denies any later requests.

NEW SECTION

WAC 388-526-0245 May an administrative law judge or review judge be disqualified? (1) An administrative law judge (ALJ) or review judge may be disqualified for bias, prejudice, or conflict of interest, or if one of the parties or a party's representative has an ex parte contact with the ALJ or review judge.

(2) Ex parte contact means a written or oral communication with the ALJ or review judge about something related to the hearing when the other parties are not present. Procedural questions are not considered an ex parte contact. Examples of procedural questions include clarifying the hearing date, time, or location or asking for directions to the hearing location.

(3) To ask to disqualify an ALJ or review judge, a party must send a written petition for disqualification. A petition for disqualification is a written explanation to request assignment of a different ALJ or review judge. A party must promptly make the petition upon discovery of possible bias, conflict of interest, or an ex parte contact.

(4) A party must send or deliver the petition to the ALJ or review judge assigned to the case. That ALJ or review judge must decide whether to grant or deny the petition and must state the facts and reasons for the decision.

NEW SECTION

WAC 388-526-0250 What happens after you request a hearing, and when must the office of administrative hearings provide notice of the hearing and prehearing conferences? (1) The office of administrative hearings (OAH) must send a copy of your hearing request to the health care authority (HCA) or HCA's authorized agent who made the decision on HCA's behalf, unless OAH received your hearing request from HCA or HCA's authorized agent. The OAH should send it to HCA or HCA's authorized agent within four business days of the OAH receiving your request.

(2) The OAH must send a notice of hearing to all parties and their representatives at least fourteen calendar days before the hearing date.

(3) If the OAH schedules a prehearing conference, the OAH must send a notice of prehearing conference to the parties and their representatives at least seven business days before the date of the prehearing conference except:

(a) The OAH and/or an administrative law judge (ALJ) may convert a scheduled hearing into a prehearing conference and provide less than seven business days notice of the prehearing conference; and

(b) The OAH may give less than seven business days notice if the only purpose of the prehearing conference is to consider whether there is good cause to grant a continuance under WAC 388-526-0280 (3)(b).

(4) The OAH and/or the ALJ must reschedule the hearing if necessary to comply with the notice requirements in this section.

(5) If the ALJ denies a continuance after a prehearing conference, the hearing may proceed on the scheduled hearing date, but the ALJ must still issue a written order regarding the denial of the continuance.

(6) You may ask for a prehearing meeting even after you have requested a hearing.

NEW SECTION

WAC 388-526-0255 What information must the office of administrative hearings include in the notice of hearing? (1) A notice of hearing is a written notice that must include:

(a) The names of all parties who receive the notice and, if known, the names and addresses of their representatives;

(b) The name, mailing address, and telephone number of the administrative law judge (ALJ), if known;

(c) The date, time, place, and nature of the hearing;

(d) The legal authority and jurisdiction for the hearing; and

(e) The date of the hearing request.

(2) The office of administrative hearings (OAH) also sends you information with your notice of hearing telling you the following:

(a) If you fail to attend or participate in a prehearing conference or a hearing, you may lose your right to a hearing. Then the ALJ may send:

(i) An order of default against you; or

(ii) An order dismissing the hearing.

(b) If you need a qualified interpreter because you or any of your witnesses are persons with limited English proficiency, OAH will provide an interpreter at no cost to you.

(c) If the hearing is to be held by telephone or in person, and how to request a change in the way it is held.

(d) How to indicate any special needs for yourself or your witnesses, including the need for an interpreter in a primary language or for sensory impairments.

(e) How to contact OAH if a party has a safety concern.

NEW SECTION

WAC 388-526-0260 May the health care authority or the health care authority's authorized agent amend a notice? (1) The administrative law judge (ALJ) must allow the health care authority (HCA) or HCA's authorized agent to amend (change) the notice of an action before or during the hearing to match the evidence and facts.

(2) HCA or HCA's authorized agent must put the change in writing and give a copy to the ALJ and all parties.

(3) The ALJ must offer to continue (postpone) the hearing to give the parties more time to prepare or present evidence or argument if there is a significant change from the earlier agency notice.

(4) If the ALJ grants a continuance, the office of administrative hearings must send a new hearing notice at least fourteen calendar days before the hearing date.

NEW SECTION

WAC 388-526-0265 May you amend your hearing request? (1) The administrative law judge (ALJ) may allow you to amend your hearing request before or during the hearing.

(2) The ALJ must offer to continue (postpone) the hearing to give the other parties more time to prepare or present evidence or argument if there is a significant change in the hearing request.

(3) If the ALJ grants a continuance, the office of administrative hearings must send a new hearing notice at least fourteen calendar days before the hearing date.

NEW SECTION

WAC 388-526-0270 Must you tell the health care authority hearing representative and the office of administrative hearings when your mailing address changes? (1) You must tell the health care authority (HCA) hearing representative and the office of administrative hearings (OAH), as soon as possible, when your mailing address changes.

(2) If you do not notify the HCA hearing representative and OAH of a change in your mailing address and they continue to send notices and other important papers to your last known mailing address, the administrative law judge (ALJ) may assume that you received the documents.

NEW SECTION

WAC 388-526-0275 What is a continuance? A continuance is a change in the date or time of a prehearing conference, hearing or the deadline for other action.

NEW SECTION

WAC 388-526-0280 Who may request a continuance? (1) Any party may request a continuance either orally or in writing.

(2) Before contacting the administrative law judge (ALJ) to request a continuance, a party should contact the other parties, if possible, to find out if they will agree to a continuance. If you are unable to contact the parties, the office of administrative hearings (OAH) or the health care authority hearing representative must assist you in contacting them.

(3) The party making the request for a continuance must let the ALJ know whether the other parties agreed to the continuance.

(a) If the parties agree to a continuance, the ALJ must grant it unless the ALJ finds that good cause for a continuance does not exist.

(b) If the parties do not agree to a continuance, the ALJ must set a prehearing conference to decide whether there is good cause to grant or deny the continuance. The prehearing conference will be scheduled as required by WAC 388-526-0197 and 388-526-0250.

(4) If the ALJ grants a continuance, the OAH must send a new hearing notice at least fourteen calendar days before the new hearing date.

(5) If the ALJ denies the continuance, the ALJ will proceed with the hearing on the date the hearing is scheduled, but must still issue a written order regarding the denial of the continuance.

NEW SECTION

WAC 388-526-0285 What is an order of dismissal? (1) An order of dismissal is an order sent by the administrative law judge to end the hearing. The order is made because the party who requested the hearing withdrew the request, failed to appear, or refused to participate, resulting in a default.

(2) If your hearing is dismissed because you did not appear or refused to participate, the agency action stands.

(3) If the hearing is dismissed due to a written agreement between the parties, the parties must follow the agreement.

NEW SECTION

WAC 388-526-0290 If your hearing is dismissed, may you request another hearing? (1) If the administrative law judge (ALJ) sends an order dismissing your hearing, you may ask that the ALJ vacate (set aside) the order of dismissal.

(2) If the order of dismissal is vacated, your hearing is reinstated, which means you get another opportunity to have a hearing on your initial request for hearing.

NEW SECTION

WAC 388-526-0295 Where do you send a request to vacate an order of dismissal? You must send your request to vacate an order of dismissal to the board of appeals (BOA) or the office of administrative hearings (OAH). You should specify in your request why the order of dismissal should be vacated. BOA forwards any request received to OAH to schedule a hearing. OAH sends you a notice of the hearing on the request to vacate the order of dismissal.

NEW SECTION

WAC 388-526-0300 What is the deadline for vacating an order of dismissal? (1) You must send your request to vacate an order of dismissal to the office of administrative hearings (OAH) or the board of appeals (BOA) within twenty-one calendar days after the date the order of dismissal was mailed to you. If no request is received within that deadline, the dismissal order becomes a final order.

(2) You may make a late request to vacate the order of dismissal for up to one year after it was mailed but you must show good cause according to WAC 388-526-0020 for the late request to be accepted and the dismissal to be vacated.

(3) If you ask to vacate more than one year after the order was mailed, the administrative law judge may vacate the order of dismissal if the health care authority hearing representative and any other party agrees to waive (excuse) the deadline.

NEW SECTION

WAC 388-526-0305 How does an administrative law judge vacate an order of dismissal? (1) If your request was received more than twenty-one days, but less than one year after the dismissal order was mailed, the administrative law judge (ALJ) first must decide if you have good cause according to WAC 388-526-0020.

(2) If your request was timely or you show good cause for missing the deadline, the ALJ will receive evidence and argument at a hearing from the parties on whether the order of dismissal should be vacated.

(3) The ALJ vacates an order of dismissal and reinstates the hearing if you show good cause or if the health care authority hearing representative agrees to waive the deadline. You will then be allowed to present your case about your original request for hearing, either at the same time or at a later date if a continuance is granted.

NEW SECTION

WAC 388-526-0310 May a party request a stay of the agency action? A party may request that an administrative law judge (ALJ) or review judge stay (stop) an agency action until there is a decision entered by the ALJ or review judge. An ALJ or review judge decides whether to grant the stay.

NEW SECTION

WAC 388-526-0315 May a party require witnesses to testify or provide documents? A party may require witnesses to testify or provide documents by issuing a subpoena. A subpoena is an order to appear at a certain time and place to give testimony, or to provide books, documents, or other items.

NEW SECTION

WAC 388-526-0320 Who may prepare a subpoena? (1) Administrative law judges (ALJs), the health care authority hearing representative, and attorneys for the parties may prepare subpoenas. If an attorney does not represent you, you may ask the ALJ to prepare a subpoena on your behalf. The ALJ may schedule a hearing to decide whether to issue a subpoena.

(2) An ALJ may deny a request for a subpoena. For example, an ALJ may deny a request for a subpoena when the ALJ determines that a witness has no actual knowledge regarding the facts or that the documents are not relevant.

NEW SECTION

WAC 388-526-0325 How is a subpoena served? (1) Any person who is at least eighteen years old and not a party to the hearing may serve a subpoena.

(2) Service of a subpoena is complete when the server:

(a) Gives the witness a copy of the subpoena; or

(b) Leaves a copy at the residence of the witness with a person over the age of eighteen.

(3) To prove that a subpoena was served on a witness, the person serving the subpoena must sign a written, dated statement including:

(a) Who was served with the subpoena;

(b) When the subpoena was served;

(c) Where the subpoena was served; and

(d) The name, age, and address of the person who served the subpoena.

NEW SECTION

WAC 388-526-0330 May the administrative law judge quash a subpoena? (1) A party may request that an administrative law judge (ALJ) quash (set aside) or change the subpoena request at any time before the deadline given in the subpoena.

(2) An ALJ may set aside or change a subpoena if it is unreasonable.

(3) Witnesses with safety or accommodation concerns should contact the office of administrative hearings (OAH).

NEW SECTION

WAC 388-526-0335 Do you have to pay for a subpoena? There is no cost to prepare a subpoena, but you may have to pay for:

(1) Serving a subpoena;

(2) Complying with a subpoena; and

(3) Witness fees according to RCW 34.05.446(7).

NEW SECTION

WAC 388-526-0340 How is your hearing held? (1) Hearings may be held in person or by telephone conference.

(2) A telephone conference hearing is where all parties appear by telephone.

(3) An in-person hearing is where you appear face-to-face with the administrative law judge (ALJ) and the other parties appear either in person or by telephone.

(4) Whether a hearing is held in person or by telephone conference, the parties have the right to see all documents, hear all testimony and question all witnesses.

(5) If a hearing is originally scheduled as an in-person hearing, you may request that the ALJ convert it to a telephone hearing. Once a telephone conference hearing begins, the ALJ may stop, reschedule, and convert the hearing to an in-person hearing if any party makes such a request.

NEW SECTION

WAC 388-526-0345 Is an administrative law judge present at your hearing? (1) If your hearing is scheduled as an in-person hearing, an administrative law judge (ALJ) is physically or visually present.

(2) If your hearing is scheduled as a telephone conference, an ALJ is present by telephone.

NEW SECTION

WAC 388-526-0350 Is your hearing recorded? The administrative law judge must record the entire hearing using audio recording equipment (such as a digital recorder or a tape recorder).

NEW SECTION

WAC 388-526-0355 Who may attend your hearing? (1) All parties and their representatives may attend the hearing.

(2) Witnesses may be excluded from the hearing if the administrative law judge (ALJ) finds good cause.

(3) The ALJ may also exclude other persons from all or part of the hearing.

NEW SECTION

WAC 388-526-0360 May a party convert how a hearing is held or how a witness appears at a hearing? (1) The parties have the right to request that:

(a) A hearing format be converted (changed) from an in-person hearing to a telephone conference or from a telephone conference to an in-person hearing; or

(b) A witness appear in person or by telephone conference. The office of administrative hearings (OAH) must advise you of the right to request a change in how a witness appears.

(2) A party must show a compelling reason to change the way a witness appears (in-person or by telephone conference). Some examples of compelling reasons are:

(a) A party does not speak or understand English well.

(b) A party wants to present a significant number of documents during the hearing.

(c) A party does not believe that one of the witnesses or another party is credible, and wants the administrative law judge (ALJ) to have the opportunity to see the testimony.

(d) A party has a disability or communication barrier that affects their ability to present their case.

(e) A party believes that the personal safety of someone involved in the hearing process is at risk.

(3) A compelling reason to convert the way a witness appears at a hearing can be overcome by a compelling reason not to convert how a witness appears for a hearing.

NEW SECTION

WAC 388-526-0365 How does a party convert how a hearing is held or how the witnesses or parties appear? (1) If a party wants to convert the hearing or change how their witnesses or other parties appear, the party must contact the office of administrative hearings (OAH) to request the change.

(2) The administrative law judge (ALJ) may schedule a prehearing conference to determine if the request should be granted.

(3) If the ALJ grants the request, the ALJ reschedules the hearing or changes how the witness or party appears.

(4) If the ALJ denies the request, the ALJ must issue a written order that includes findings of fact supporting why the request was denied.

NEW SECTION

WAC 388-526-0370 How are documents submitted for a telephone conference? (1) When a hearing is conducted by telephone, an administrative law judge (ALJ) may order the parties to provide the hearing documents at least five days before the hearing, so all parties have an opportunity to view them during the hearing.

(2) The health care authority hearing representative may be able to help you copy and send your documents to the ALJ and any other parties.

NEW SECTION

WAC 388-526-0375 What happens at your hearing? At your hearing:

(1) The administrative law judge (ALJ):

(a) Explains your rights;

(b) Marks and admits or rejects exhibits;

(c) Ensures that a record is made;

(d) Explains that a decision is mailed after the hearing;

(e) Notifies the parties of appeal rights;

(f) May keep the record open for a time after the hearing if needed to receive more evidence or argument; and

(g) May take actions as authorized according to WAC 388-526-0215.

(2) The parties may:

(a) Make opening statements to explain the issues;

(b) Offer evidence to prove their positions, including oral or written statements of witnesses;

(c) Question the witnesses presented by the other parties; and

(d) Give closing arguments about what the evidence shows and what laws apply.

(3) At the end of the hearing if the ALJ does not allow more time to send in evidence, the record is closed.

NEW SECTION

WAC 388-526-0380 What is a group hearing? (1) A group hearing may be held when two or more parties request a hearing about similar issues.

(2) Hearings may be combined at the request of the parties or the administrative law judge.

(3) All parties participating in a group hearing may have their own representative.

NEW SECTION

WAC 388-526-0385 May a party withdraw from a group hearing? (1) A party may withdraw from a group hearing by asking the administrative law judge (ALJ) for a separate hearing.

(2) If a party asks to withdraw from a group hearing before the ALJ makes a discretionary ruling or the hearing begins, the ALJ must give the party a separate hearing.

(3) If a party later shows good cause, the ALJ may give the party a separate hearing at any time during the hearing process.

NEW SECTION

WAC 388-526-0387 How may you request that a hearing be consolidated or severed when multiple agencies are parties to the proceeding? The following requirements apply only to adjudicative proceedings in which an applicant or recipient of medical services programs set forth in chapter 74.09 RCW seeks review of decisions made by more than one agency.

(1) When you file a single application for an adjudicative proceeding seeking review of decisions by more than one agency, this review shall be conducted initially in one adjudicative proceeding. The administrative law judge (ALJ) may sever the proceeding into multiple proceedings on the motion of any of the parties, when:

(a) All parties consent to the severance; or

(b) Either party requests severance without another party's consent, and the ALJ finds there is good cause for severing the matter and that the proposed severance is not likely to prejudice the rights of an appellant who is a party to any of the severed proceedings.

(2) If there are multiple adjudicative proceedings involving common issues or parties where there is one appellant and both the health care authority and the department are parties, upon motion of any party or upon his or her own motion, the ALJ may consolidate the proceedings if he or she finds that the consolidation is not likely to prejudice the rights of the appellant who is a party to any of the consolidated proceedings.

(3) If the ALJ grants the motion to sever the hearing into multiple proceedings or consolidate multiple proceedings into a single proceeding, the ALJ will send out an order and a new notice of hearing to the appropriate parties in accordance with WAC 388-526-0250.

NEW SECTION

WAC 388-526-0390 What is evidence? (1) Evidence includes documents, objects, and testimony of witnesses that parties give during the hearing to help prove their positions.

(2) Evidence may be all or parts of original documents or copies of the originals.

(3) Parties may offer statements signed by a witness under oath or affirmation as evidence, if the witness cannot appear.

(4) Testimony given with the opportunity for cross-examination by the other parties may be given more weight by the administrative law judge.

NEW SECTION

WAC 388-526-0395 When may the parties bring in evidence? (1) The parties may bring evidence to any prehearing meeting, prehearing conference, or hearing, or may send in evidence before these events.

(2) The administrative law judge (ALJ) may set a deadline before the hearing for the parties to provide proposed exhibits and names of witnesses. If the parties miss the deadline, the ALJ may refuse to admit the evidence unless the parties show:

(a) They have good cause for missing the deadline; or

(b) That the other parties agree.

(3) If the ALJ gives the parties more time to submit evidence, the parties may send it in after the hearing. The ALJ may allow more time for the other parties to respond to the new evidence.

NEW SECTION

WAC 388-526-0400 What evidence may the parties present during the hearing? The parties may bring any documents and witnesses to the hearing to support their position. However, the following provisions apply:

(1) The other parties may object to the evidence and question the witnesses;

(2) The administrative law judge (ALJ) determines whether the evidence is admitted and what weight (importance) to give it;

(3) If the ALJ does not admit the evidence the parties may make an offer of proof to show why the ALJ should admit it;

(4) To make an offer of proof a party presents evidence and argument on the record to show why the ALJ should consider the evidence; and

(5) The offer of proof preserves the argument for appeal.

NEW SECTION

WAC 388-526-0405 What is a stipulation? (1) A stipulation is an agreement among two or more parties that certain facts or evidence is correct or authentic.

(2) If an administrative law judge (ALJ) accepts a stipulation, the ALJ must enter it into the record.

(3) A stipulation may be made before or during the hearing.

NEW SECTION

WAC 388-526-0410 After the parties agree to a stipulation, may they change or reject it? (1) A party may change or reject a stipulation after it has been made.

(2) To change or reject a stipulation, a party must show the administrative law judge that:

(a) The party did not intend to make the stipulation or was mistaken when making it; and

(b) Changing or rejecting the stipulation does not harm the other parties.

NEW SECTION

WAC 388-526-0415 What are proposed exhibits? Proposed exhibits are documents or other objects that a party wants the administrative law judge (ALJ) to consider when reaching a decision. After the document or object is accepted by the ALJ, it is admitted and becomes an exhibit.

NEW SECTION

WAC 388-526-0420 Do the parties mark and number their proposed exhibits? (1) The health care authority (HCA) hearing representatives must mark and number their proposed exhibits and provide copies to the other parties as far ahead of the hearing as possible.

(2) The administrative law judge (ALJ) may request that you mark and number your proposed exhibits before the hearing. You should bring enough copies of your proposed exhibits for all parties. If you do not bring enough copies, you must make your proposed exhibits available for copying.

(3) If you cannot afford to pay for copies of proposed exhibits, either the HCA hearing representative or the office of administrative hearings must make the copies for you.

(4) The ALJ may require proof that you are unable to pay.

NEW SECTION

WAC 388-526-0425 Who decides whether to admit proposed exhibits into the record? (1) The administrative law judge (ALJ) decides whether or not to admit a proposed exhibit into the record and also determines the weight (importance) of the evidence.

(2) The ALJ admits proposed exhibits into the record by marking, listing, identifying, and admitting the proposed exhibits.

(3) The ALJ may also exclude proposed exhibits from the record.

(4) The ALJ must make rulings on the record to admit or exclude exhibits.

NEW SECTION

WAC 388-526-0430 What may a party do if they disagree with an exhibit? (1) A party may object to the authenticity or admissibility of any exhibit, or offer argument about how much weight the ALJ should give the exhibit.

(2) Even if a party agrees that a proposed exhibit is a true and authentic copy of a document, the agreement does not mean that a party agrees with:

(a) Everything in the exhibit or agrees that it should apply to the hearing;

(b) What the exhibit says; or

(c) How the administrative law judge should use the exhibit to make a decision.

NEW SECTION

WAC 388-526-0435 When should an administrative law judge receive proposed exhibits for a telephone hearing? (1) Parties should send their proposed exhibits to the administrative law judge (ALJ) and the other parties at least five days before the telephone hearing. In some cases, the ALJ may require that the parties send them earlier.

(2) Sending the proposed exhibits to the ALJ before the telephone hearing allows all parties to use them during the hearing.

(3) For a telephone hearing, the health care authority hearing representative may help you send copies of your proposed exhibits to the ALJ and the other parties if you cannot afford to do so.

NEW SECTION

WAC 388-526-0440 What is judicial notice? (1) Judicial notice is evidence that includes facts or standards that are generally recognized and accepted by judges, government agencies, or national associations.

(2) For example, an administrative law judge may take judicial notice of a calendar, a building code or a standard or practice.

NEW SECTION

WAC 388-526-0445 How does the administrative law judge respond to requests to take judicial notice? (1) The administrative law judge (ALJ) may consider and admit evidence by taking judicial notice.

(2) If a party requests judicial notice, or if the ALJ intends to take judicial notice, the ALJ may ask the party to provide a copy of the document that contains the information.

(3) If judicial notice has been requested, or if the ALJ intends to take judicial notice, the ALJ must tell the parties before or during the hearing.

(4) The ALJ must give the parties time to object to judicial notice evidence.

NEW SECTION

WAC 388-526-0450 What is a witness? (1) A witness is any person who makes statements or gives testimony that becomes evidence in a hearing.

(2) One type of witness is an expert witness. An expert witness is qualified by knowledge, experience, and education to give opinions or evidence in a specialized area.

NEW SECTION

WAC 388-526-0455 Who may be a witness? (1) A witness may be:

(a) You or the health care authority (HCA) hearing representative; or

(b) Anyone you, the administrative law judge (ALJ), or the HCA hearing representative asks to be a witness.

(2) The ALJ decides who may testify as a witness.

(3) An expert witness may not be a former HCA employee, a former HCA authorized agent, or a former employee of the department in the proceeding against HCA or the department if that employee was actively involved in the agency action while working for HCA or the department, unless the HCA hearing representative agrees.

NEW SECTION

WAC 388-526-0460 How do witnesses testify? All witnesses:

(1) Must affirm or take an oath to testify truthfully during the hearing.

(2) May testify in person or by telephone.

(3) May request interpreters from OAH at no cost to you.

(4) May be subpoenaed and ordered to appear according to WAC 388-526-0315.

NEW SECTION

WAC 388-526-0465 May the parties cross-examine a witness? (1) The parties have the right to cross-examine (question) each witness.

(2) If a party has a representative, only the representative, and not the party, may question the witness.

(3) The administrative law judge may also question witnesses.

NEW SECTION

WAC 388-526-0470 May witnesses refuse to answer questions? Witnesses may refuse to answer questions. However, if a witness refuses to answer, the administrative law judge may reject all of the related testimony of that witness.

NEW SECTION

WAC 388-526-0475 What evidence does an administrative law judge consider? (1) The administrative law judge (ALJ) may only consider admitted evidence to decide the case.

(2) Admission of evidence is based upon the reasonable person standard. This standard means evidence that a reasonable person would rely on in making a decision.

(3) The ALJ may admit and consider hearsay evidence. Hearsay is a statement made outside of the hearing used to prove the truth of what is in the statement. The ALJ may only base a finding on hearsay evidence if the ALJ finds that the parties had the opportunity to question or contradict it.

(4) The ALJ may reject evidence, if it:

(a) Is not relevant;

(b) Repeats evidence already admitted; or

(c) Is from a privileged communication protected by law.

(5) The ALJ must reject evidence if required by law.

(6) The ALJ decides:

(a) What evidence is more credible if evidence conflicts; and

(b) The weight given to the evidence.

NEW SECTION

WAC 388-526-0480 What does burden of proof mean? (1) Burden of proof is a party's responsibility to:

(a) Provide evidence regarding disputed facts; and

(b) Persuade the administrative law judge (ALJ) that a position is correct.

(2) To persuade the ALJ, the party who has the burden of proof must provide the amount of evidence required by WAC 388-526-0485.

NEW SECTION

WAC 388-526-0485 What is the standard of proof? Standard of proof refers to the amount of evidence needed to prove a party's position. Unless the rules or law states otherwise, the standard of proof in a hearing is a preponderance of the evidence. This standard means that it is more likely than not that something happened or exists.

NEW SECTION

WAC 388-526-0490 How is a position proven at hearing? The administrative law judge (ALJ) decides if a party has met the burden of proof. The ALJ writes a decision based on the evidence presented during the hearing and consistent with the law.

NEW SECTION

WAC 388-526-0495 What is equitable estoppel? (1) Equitable estoppel is a legal doctrine defined in case law that may only be used as a defense to prevent the agency from taking some action against you, such as collecting an overpayment. Equitable estoppel may not be used to require the agency to continue to provide something, such as benefits, or to require the agency to take action contrary to a statute.

(2) There are five elements of equitable estoppel. The standard of proof is clear and convincing evidence. You must prove all of the following:

(a) The agency made a statement or took an action or failed to take an action, which is inconsistent with a later claim or position by the agency. For example, the agency or one of its authorized agents gave you money based on your application, then later tells you that you received an overpayment and wants you to pay the money back based on the same information.

(b) You reasonably relied on the agency's original statement, action or failure to act. For example, you believed the agency acted correctly when you received money.

(c) You will be injured to your detriment if the agency is allowed to contradict the original statement, action or failure to act. For example, you did not seek nongovernmental assistance because you were receiving benefits from the agency, and you would have been eligible for these other benefits.

(d) Equitable estoppel is needed to prevent a manifest injustice. Factors to be considered in determining whether a manifest injustice would occur include, but are not limited to, whether:

(i) You cannot afford to repay the money to the agency;

(ii) You gave the agency timely and accurate information when required;

(iii) You did not know that the agency made a mistake;

(iv) You are free from fault; and

(v) The overpayment was caused solely by an agency mistake.

(e) The exercise of government functions is not impaired. For example, the use of equitable estoppel in your case will not result in circumstances that will impair agency functions.

(3) If the ALJ concludes that you have proven all of the elements of equitable estoppel in subsection (2) of this section with clear and convincing evidence, the agency is stopped or prevented from taking action or enforcing a claim against you.

NEW SECTION

WAC 388-526-0500 What may an administrative law judge do before the record is closed? Before the record is closed, the administrative law judge may:

(1) Set another hearing date;

(2) Enter orders to address limited issues if needed before writing and mailing a hearing decision to resolve all issues in the proceeding; or

(3) Give the parties more time to send in exhibits or written argument.

NEW SECTION

WAC 388-526-0505 When is the record closed? The record is closed:

(1) At the end of the hearing if the administrative law judge does not allow more time to send in evidence or argument; or

(2) After the deadline for sending in evidence or argument is over.

NEW SECTION

WAC 388-526-0510 What happens when the record is closed? No more evidence may be taken without good cause after the record is closed.

NEW SECTION

WAC 388-526-0512 What is included in the hearing record? (1) The administrative law judge must produce a complete official record of the proceedings.

(2) The official record must include, if applicable:

(a) Notice of all proceedings;

(b) Any prehearing order;

(c) Any motions, pleadings, briefs, petitions requests, and intermediate rulings;

(d) Evidence received or considered;

(e) A statement of matters officially noticed;

(f) Offers of proof, objections, and any resulting rulings;

(g) Proposed findings, requested orders and exceptions;

(h) A complete audio recording of the entire hearing, together with any transcript of the hearing;

(i) Any final order, initial order, or order on reconsideration; and

(j) Matters placed on the record after an ex parte communication.

NEW SECTION

WAC 388-526-0515 What happens after the record is closed? (1) After the record is closed, the administrative law judge (ALJ) must enter an initial or final order and send copies to the parties.

(2) The maximum time an ALJ has to send a decision is ninety calendar days after the record is closed, but many programs have earlier deadlines. Specific program rules may set the deadlines.

(3) The office of administrative hearings must send the official record of the proceedings to the board of appeals. The record must be complete when it is sent, and include all parts required by WAC 388-526-0512.

NEW SECTION

WAC 388-526-0520 What information must the administrative law judge include in the decision? The administrative law judge (ALJ) must include the following information in the decision:

(1) Identify the hearing decision as a health care authority case;

(2) List the name and docket number of the case and the names of all parties and representatives;

(3) Find the facts used to resolve the dispute based on the hearing record;

(4) Explain why evidence is credible when the facts or conduct of a witness is in question;

(5) State the law that applies to the dispute;

(6) Apply the law to the facts of the case in the conclusions of law;

(7) Discuss the reasons for the decision based on the facts and the law;

(8) State the result and remedy ordered;

(9) Explain how to request changes in the decision and the deadlines for requesting them;

(10) State the date the decision becomes final according to WAC 388-526-0525; and

(11) Include any other information required by law or program rules.

NEW SECTION

WAC 388-526-0525 When do initial orders become final? If no one requests review of the initial order or if a review request is dismissed, the initial order is final twenty-one calendar days after it is mailed.

NEW SECTION

WAC 388-526-0530 What if a party disagrees with the administrative law judge's decision? (1) If a party disagrees with an administrative law judge's (ALJ) initial or final order because of a clerical error, the party may ask for a corrected decision from the ALJ as provided in WAC 388-526-0540 through 388-526-0555.

(2) If a party disagrees with an initial order and wants it changed, the party must request review by a review judge as provided in WAC 388-526-0560 through 388-526-0595.
If a party wants to stay the agency action until review of the initial order is completed, the party must request a stay from a review judge.

(3) Final orders entered by ALJs may not be reviewed by a review judge.

(4) If a party disagrees with an ALJ's final order, the party may request reconsideration as provided in WAC 388-526-0605 through 388-526-0635. You may also petition for judicial review of the final order as stated in WAC 388-526-0640 through 388-526-0650. You do not need to file a request for reconsideration of the final order before petitioning for judicial review. The health care authority may not

request judicial review of an ALJ's or review judge's final order.

NEW SECTION

WAC 388-526-0540 How are clerical errors in the administrative law judge's decision corrected? (1) A clerical error is a mistake that does not change the intent of the decision.

(2) The administrative law judge corrects clerical errors in hearing decisions by issuing a second decision referred to as a corrected decision or corrected order. Corrections may be made to initial orders and final orders.

(3) Some examples of clerical error are:

(a) Missing or incorrect words or numbers;

(b) Dates inconsistent with the decision or evidence in the record such as using May 3, 1989, instead of May 3, 1998; or

(c) Math errors when adding the total of an overpayment.

NEW SECTION

WAC 388-526-0545 How does a party ask for a corrected administrative law judge decision? (1) A party may ask for a corrected administrative law judge (ALJ) decision by calling or writing the office of administrative hearings office that held the hearing.

(2) When asking for a corrected decision, please identify the clerical error you found.

NEW SECTION

WAC 388-526-0550 How much time do the parties have to ask for a corrected administrative law judge decision? (1) The parties must ask the administrative law judge (ALJ) for a corrected decision on or before the tenth calendar day after the order was mailed.

(2) If you ask the ALJ to correct a decision, the time period provided by this section for requesting a corrected decision of an initial order, and the time it takes the ALJ to deny the request or make a decision regarding the request for a corrected initial order, do not count against any deadline, if any, for a review judge to enter a final order.

NEW SECTION

WAC 388-526-0555 What happens when a party requests a corrected administrative law judge decision? (1) When a party requests a corrected initial or final order, the administrative law judge (ALJ) must either:

(a) Send all parties a corrected order; or

(b) Deny the request within three business days of receiving it.

(2) If the ALJ corrects an initial order and a party does not request review, the corrected initial order becomes final twenty-one calendar days after the original initial order was mailed.

(3) If the ALJ denies a request for a corrected initial order and the party still wants the hearing decision changed, the party must request review by a review judge.

(4) Requesting an ALJ to correct the initial order does not automatically extend the deadline to request review of the initial order by a review judge. When a party needs more time to request review of an initial order, the party must ask for more time to request review as permitted by WAC 388-526-0580(2).

(5) If the ALJ denies a request for a corrected final order and you still want the hearing decision changed, you must request judicial review.

NEW SECTION

WAC 388-526-0560 What is review of an initial order by a review judge? (1) Review by a review judge is available to a party who disagrees with the administrative law judge's (ALJ) initial order.

(2) If a party wants the initial order changed, the party must request that a review judge review the initial order.

(3) If a request is made for a review judge to review an initial order, it does not mean there is another hearing conducted by a review judge.

(4) The review judge considers the request, the initial order, and the record, and may hear oral argument, before deciding if the initial order should be changed.

(5) Review judges may not review ALJ final orders.

NEW SECTION

WAC 388-526-0565 What evidence does the review judge consider in reviewing an initial order? (1) The review judge, in most cases, only considers evidence given at the original hearing before the administrative law judge.

(2) The review judge may allow the parties to make oral argument when reviewing initial orders.

NEW SECTION

WAC 388-526-0570 Who may request review of an initial order? (1) Any party may request a review judge to review the initial order.

(2) If more than one party requests review, each request must meet the deadlines in WAC 388-526-0580.

NEW SECTION

WAC 388-526-0575 What must a party include in the review request? A party must make the review request in writing and send it to the board of appeals. The party should identify the:

(1) Parts of the initial order with which the party disagrees; and

(2) Evidence supporting the party's position.

NEW SECTION

WAC 388-526-0580 What is the deadline for requesting review by a review judge? (1) The board of appeals (BOA) must receive the written review request on or before 5:00 p.m. on the twenty-first calendar day after the initial order was mailed.

(2) A review judge may extend the deadline if a party:

(a) Asks for more time before the deadline expires; and

(b) Gives a good reason for more time.

(3) A review judge may accept a review request after the twenty-one calendar day deadline only if:

(a) The BOA receives the review request on or before the thirtieth calendar day after the deadline; and

(b) A party shows good cause for missing the deadline.

(4) If you ask a review judge to review an administrative law judge decision, the time period provided by this section for requesting review of an initial order, including any extensions, does not count against any deadline, if any, for a review judge to enter the final order.

NEW SECTION

WAC 388-526-0585 Where does a party send the request for review by a review judge? (1) A party must send the request for review of the initial order to the board of appeals (BOA) at the address given in WAC 388-526-0030. A party should also send a copy of the review request to the other parties.

(2) After receiving a party's review request, BOA sends a copy to the other parties, their representatives, and the office of administrative hearings. The other parties and their representatives may respond as described in WAC 388-526-0590.

NEW SECTION

WAC 388-526-0590 How does the party that is not requesting review respond to the review request? (1) A party does not have to respond to the review request. A response is optional.

(2) If a party decides to respond, that party must send the response so that the board of appeals (BOA) receives it on or before the seventh business day after the date the other party's review request was mailed to the party by the BOA.

(3) The party should send a copy of the response to all other parties or their representatives.

(4) A review judge may extend the deadline in subsection (2) of this section if a party asks for more time before the deadline to respond expires and gives a good reason.

(5) If you ask for more time to respond, the time period provided by this section for responding to the review request, including any extensions, does not count against any deadline, if any, for a review judge to enter the final order. A review judge may accept and consider a party's response even if it is received after the deadline.

NEW SECTION

WAC 388-526-0595 What happens after the review response deadline? (1) After the response deadline, the record on review is closed unless there is a good reason to keep it open.

(2) A review judge is assigned to review the initial order after the record is closed. To find out which judge is assigned, call the board of appeals.

(3) After the record is closed, the assigned review judge:

(a) Reviews the initial order; and

(b) Enters a final order that affirms, changes, dismisses or reverses the initial order; or

(c) Returns the case to the office of administrative hearings for further action.

NEW SECTION

WAC 388-526-0600 What is the authority of the review judge? (1) Review judges review initial orders and enter final orders. The review judge has the same decision-making authority as the administrative law judge (ALJ). The review judge considers the entire record and decides the case de novo (anew). In reviewing findings of fact, the review judge must give due regard to the ALJ's opportunity to observe witnesses.

(2) Review judges may return (remand) cases to the office of administrative hearings for further action.

(3) In cases where there is a consolidated hearing pursuant to WAC 388-526-0387, any party may request review of the initial order in accordance with the requirements contained in this chapter.

(4) A review judge conducts the hearing and enters the final order in cases covered by WAC 388-526-0218.

NEW SECTION

WAC 388-526-0605 What if a party does not agree with a final order entered by the office of administrative hearings or the board of appeals? (1) If a party does not agree with the final order and wants it reconsidered, the party must:

(a) Ask the administrative law judge (ALJ) to reconsider the decision, if the final order was entered by an ALJ; or

(b) Ask the review judge to reconsider the decision, if the final order was entered by a review judge.

(2) The final order or the reconsideration decision is the final agency decision. If you disagree with that decision, you must petition for judicial review to change it.

(3) You may ask the court to stay or stop the agency action after filing the petition for judicial review.

NEW SECTION

WAC 388-526-0610 What is reconsideration? (1) Reconsideration is:

(a) Asking an administrative law judge (ALJ) to reconsider a final order entered by the ALJ because the party believes the ALJ made a mistake; or

(b) Asking a review judge to reconsider a final order entered by a review judge because the party believes the review judge made a mistake.

(2) If a party asks for reconsideration of the final order, the reconsideration process must be completed before you request judicial review. However, you do not need to request reconsideration of a final order before you request judicial review.

NEW SECTION

WAC 388-526-0615 What must a party include in the reconsideration request? The party must make the request

in writing and clearly state why the party wants the final order reconsidered.

NEW SECTION

WAC 388-526-0620 What is the deadline for requesting reconsideration? (1) If the office of administrative hearings (OAH) entered the final order, OAH must receive a written reconsideration request on or before the tenth calendar day after the final order was mailed.

(2) If the board of appeals (BOA) entered the final order, BOA must receive a written reconsideration request on or before the tenth calendar day after the final order was mailed.

(3) If a reconsideration request is received after the deadline, the final order will not be reconsidered and the deadline to ask for superior court review continues to run.

(4) OAH or BOA may extend its deadline if a party:

(a) Asks for more time before the deadline expires; and

(b) Gives a good reason for the extension.

(5) If a party does not request reconsideration or ask for an extension within the deadline, the final order may not be reconsidered and it becomes the final agency decision.

NEW SECTION

WAC 388-526-0625 Where does a party send a reconsideration request? (1) A party must send a written reconsideration request to the office of administrative hearings (OAH) if OAH entered the final order, or to the board of appeals (BOA) if BOA entered the final order.

(2) After receiving a reconsideration request, OAH or BOA sends a copy to the other parties and representatives and gives them time to respond.

NEW SECTION

WAC 388-526-0630 How does a party respond to a reconsideration request? (1) A party does not have to respond to a request. A response is optional.

(2) If a party responds, that party must send a response to the office of administrative hearings (OAH) if OAH entered the final order, or to the board of appeals (BOA) if BOA entered the final order, by or before the seventh business day after the date OAH or BOA mailed the request to the party.

(3) A party must send a copy of the response to any other party or representative.

(4) If a party needs more time to respond, OAH or BOA may extend its deadline if the party gives a good reason within the deadline in subsection (2) of this section.

NEW SECTION

WAC 388-526-0635 What happens after a party requests reconsideration? (1) After the office of administrative hearings (OAH) or the board of appeals (BOA) receives a reconsideration request, an administrative law judge (ALJ) or review judge has twenty calendar days to send a reconsideration decision unless OAH or BOA sends notice allowing more time.

(2) After OAH or BOA receives a reconsideration request, the ALJ or review judge must either:

(a) Write a reconsideration decision; or

(b) Send all parties an order denying the request.

(3) If the ALJ or review judge does not send an order or notice granting more time within twenty days of receipt of the reconsideration request, the request is denied.

NEW SECTION

WAC 388-526-0640 What is judicial review? (1) Judicial review is the process of appealing a final order to a court.

(2) You may appeal a final order by filing a written petition for judicial review that meets the requirements of RCW 34.05.546. HCA may not request judicial review.

(3) You must consult RCW 34.05.510 to 34.05.598 for further details of the judicial review process.

NEW SECTION

WAC 388-526-0645 When must you ask for judicial review? (1) You must file your petition for judicial review with the superior court within thirty calendar days after the office of administrative hearings or the board of appeals mails its final order.

(2) Generally, you may file a petition for judicial review only after you have completed the administrative hearing process. However, you do not need to file a request for reconsideration of a final order before requesting judicial review.

NEW SECTION

WAC 388-526-0650 How do you serve your petition for judicial review? (1) You must file and serve the petition for judicial review of a final order within thirty days after the date it was mailed. You must file your petition for judicial review with the court. You must serve copies of your petition on health care authority (HCA), the office of the attorney general, and all other parties.

(2) To serve HCA, you must deliver a copy of the petition to the director of HCA or to the board of appeals (BOA). You may hand deliver the petition or send it by mail that gives proof of receipt. The physical location of the director is:

Director
Health Care Authority
626 8th Avenue SE
Olympia, WA 98501

The mailing address of the director is:

Director
Health Care Authority
P.O. Box 45502
Olympia, WA 98504-5502

The physical and mailing addresses for BOA are in WAC 388-526-0030.

(3) To serve the office of the attorney general and other parties, you may send a copy of the petition for judicial review by regular mail. You may send a petition to the address for the attorney of record to serve a party. You may serve the office of the attorney general by hand delivery to:

Office of the Attorney General
7141 Cleanwater Drive S.W.
Tumwater, Washington 98501

The mailing address of the attorney general is:

Office of the Attorney General
P.O. Box 40124
Olympia, WA 98504-0124

REPEALER

The following section of the Washington Administrative Code is repealed:

WAC 388-526-2610	Prehearing reviews for clients who request a fair hearing.

WSR 11-22-072
EMERGENCY RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Aging and Disability Services Administration)

[Filed November 1, 2011, 9:15 a.m., effective November 1, 2011, 9:15 a.m.]

Effective Date of Rule: Immediately.

Purpose: This emergency WAC filing replaces and supersedes WSR 11-17-145 filed August 24, 2011. Under section 6014 of the Deficit Reduction Act of 2005 (DRA), medicaid will not pay for long-term care services for individuals whose equity interest in their home exceeds $500,000. Effective January 1, 2011, these limits are to be increased each year by the percentage increase in the consumer price index urban (CPIU). Effective January 1, 2011, the excess home equity limits is $506,000. The standard utility allowance (SUA) reference has changed effective October 1, 2011, this emergency adoption corrects the reference.

Eliminating reference to general assistance and/or disability lifeline and referencing to the correct aged, blind or disabled (ABD) cash program or medical care services (MCS) program. This emergency adoption is coordinated with community services division's (CSD) emergency adoption in eliminating disability lifeline, this is to ensure that expenditures do not exceed funds appropriated under the 2011-2013 operating budget (2ESHB 1087) signed by Governor Gregoire on June 15, 2011.

Citation of Existing Rules Affected by this Order: Amending WAC 388-513-1305, 388-513-1315, 388-513-1350, 388-513-1380, 388-515-1505, 388-515-1506, 388-515-1507, 388-515-1509, 388-515-1512, and 388-515-1514.

Statutory Authority for Adoption: RCW 74.04.050, 74.04.057, 74.09.500, and 74.09.530.

Other Authority: Deficit Reduction Act (DRA) of 2005.

Under RCW 34.05.350 the agency for good cause finds that state or federal law or federal rule or a federal deadline for state receipt of federal funds requires immediate adoption of a rule.

Reasons for this Finding: Federal standard change of the excess home equity provisions effective January 1, 2011, based on the CPIU. This CR-103E continues emergency rules filed under WSR 11-10-038 while the department completes the process for permanent adoption. The initial public notice (CR-101) was filed December 29, 2010, under WSR 11-02-032. The SUA changed effective October 1, 2011. The department is coordinating with the health care authority (HCA) regarding current recodifying and emergency WACs HCA and CSD has filed which affect WAC references in chapters 388-513 and 388-515 WAC regarding changes to aged, blind or disabled cash, and medical care services.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 10, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 0, Amended 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 10, Repealed 0.

Date Adopted: October 27, 2011.

Katherine I. Vasquez
Rules Coordinator

AMENDATORY SECTION (Amending WSR 06-07-077, filed 3/13/06, effective 4/13/06)

WAC 388-513-1305 Determining eligibility for noninstitutional medical assistance in an alternate living facility (ALF). This section describes how the department defines the monthly income standard and uses it to determine eligibility for noninstitutional medical assistance for a client who lives in a department-contracted ALF. Refer to WAC 388-478-0045 for the personal needs allowance (PNA) amount that applies in this rule.

(1) Alternate living facilities include the following:

(a) An adult family home (AFH);

(b) An adult residential care facility (ARC);

(c) An adult residential rehabilitation center (ARRC);

(d) An adult residential treatment facility (ARTF);

(e) An assisted living facility (AL);

(f) A division of developmental disabilities (DDD) group home (GH); and

(g) An enhanced adult residential care facility (EARC).

(2) The monthly income standard for noninstitutional medical assistance under the categorically needy (CN) program that cannot exceed the special income level (SIL) equals the following amounts. For a client who lives in:

(a) An ARC, an ARRC, an ARTF, an AL, a DDD GH, or an EARC, the department-contracted rate based on a thirty-one day month plus the PNA; or

(b) An AFH, the department-contracted rate based on a thirty-one day month plus the PNA plus the cost of any add-on hours authorized by the department.

(3) The monthly income standard for noninstitutional medical assistance under the medically needy (MN) program equals the private facility rate based on a thirty-one-day month plus the PNA.

(4) ((~~The monthly income standard for noninstitutional medical assistance under the general assistance (GA) program equals the GA grant standard described in WAC 388-478-0045.~~

~~(5)~~)) The department determines a client's nonexcluded resources for noninstitutional medical assistance under the((~~:~~

~~(a) General assistance (GA) and temporary assistance for needy families (TANF) programs as described in chapter 388-470 WAC; and~~

~~(b) SSI-related medical program as described in chapter 388-475 WAC.~~

~~(6)~~)) SSI related program as described in chapter 388-475 WAC.

(5) The department determines a client's nonexcluded income for noninstitutional medical assistance under the SSI related program as described in((~~:~~

~~(a) Chapter 388-450 WAC for GA and TANF programs; and~~

~~(b) Chapter 388-475 WAC and WAC 388-506-0620 for SSI-related medical programs~~)) chapter 388-475 WAC.

(((~~(7)~~))) (6) The department approves CN noninstitutional medical assistance for a period of up to twelve months for a client who receives Supplemental Security Income (SSI) or who is SSI-related as described in WAC 388-475-0050, if:

(a) The client's nonexcluded resources described in subsection (5) do not exceed the standard described in WAC 388-513-1350(1); and

(b) The client's nonexcluded income described in subsection (6) does not exceed the CN standard described in subsection (2).

(((~~(8)~~))) (7) The department approves MN noninstitutional medical assistance for a period of months described in chapter 388-416 WAC for an SSI-related client, if:

(a) The client's nonexcluded resources described in subsection (5) do not exceed the standard described in WAC 388-513-1350(1); and

(b) The client satisfies any spenddown liability as described in chapter 388-519 WAC.

(9) ((~~The department approves GA and TANF noninstitutional medical assistance for a period of months described in chapter 388-416 WAC.~~

~~(10)~~)) The client described in subsections (7) and (9) keeps the PNA amount and pays remaining income to the facility for board and room.

Reviser's note: The typographical error in the above section occurred in the copy filed by the agency and appears in the Register pursuant to the requirements of RCW 34.08.040.

AMENDATORY SECTION (Amending WSR 10-01-158, filed 12/22/09, effective 1/22/10)

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)~~)) aged, blind, or disabled (ABD) cash assistance, medical care services (MCS) and the state funded ((~~nursing facility~~)) long-term care services 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)~~)) aged, blind, or disabled cash assistance described in WAC 388-400-0060 and meet citizenship requirements for federally funded medicaid described in WAC 388-424-0010; 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 pre-approved 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)~~)) programs under the following rules:

(a) A client who is eligible for ABD cash assistance program described in WAC 388-400-0060 but is not eligible for federally funded medicaid due to citizenship requirements receives MCS medical described in WAC 182-508-0005. A client who is eligible for MCS may receive institutional services but is not eligible for hospice or HCB waiver services.

(b) A client who is not eligible for ABD cash assistance but is eligible for MCS coverage only described in WAC 182-508-0005 may receive institutional services but is not eligible for hospice or HCB waiver services.

(c) A noncitizen client who is not eligible under subsections (11)(a) or (b) and needs long-term care services may be eligible under WAC 388-438-0110 and WAC 388-438-0125. This program must be pre-approved by aging and disability services administration (ADSA).

(12) 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)~~))) (13) 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)~~))) (14) 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)~~)) ABD cash assistance described in WAC 388-400-0060 or MCS described in 182-508-0005, consider eligibility under WAC 388-505-0255 or 388-505-0260.

(((~~(16)~~))) (15) 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.

(16) Noncitizen clients not eligible under subsection (15) of this section can be considered for LTC services under WAC 388-438-0125. These clients must be pre-approved by ADSA.

(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.

AMENDATORY SECTION (Amending WSR 09-12-058, filed 5/28/09, effective 7/1/09)

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. Effective January 1, 2011, the excess home equity limits increase to five hundred six thousand dollars. On January 1, 2012 and on January 1 of each year thereafter, this standard may be increased or decreased by the percentage increased or decreased in the consumer price index-urban (CPIU). For current excess home equity standard starting January 1, 2011 and each year thereafter, see http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml.

(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/LTCstandardspna.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.

AMENDATORY SECTION (Amending WSR 09-07-037, filed 3/10/09, effective 4/10/09)

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~~)) ABD cash 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~~)) described in WAC 388-450-0195, 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.

AMENDATORY SECTION (Amending WSR 08-22-052, filed 11/3/08, effective 12/4/08)

WAC 388-515-1505 Long-term care home and community based services and hospice. (1) This chapter describes the general and financial eligibility requirements for categorically needy (CN) home and community based (HCB) services administered by home and community services (HCS) and hospice services administered by ((~~health and recovery services administration (HRSA)~~)) the health care authority (HCA).

(2) The HCB service programs are:

(a) Community options program entry system (COPES);

(b) Program of all-inclusive care for the elderly (PACE);

(c) Washington medicaid integration partnership (WMIP); or

(d) New Freedom consumer directed services (New Freedom).

(3) Roads to community living (RCL) services. For RCL services this chapter is used only to determine your cost of care. Medicaid eligibility is guaranteed for three hundred sixty-five days upon discharge from a medical institution.

(4) Hospice services if you don't reside in a medical institution and:

(a) Have gross income at or below the special income level (SIL); and

(b) Aren't eligible for another CN or medically needy (MN) medicaid program.

(5) WAC 388-515-1506 describes the general eligibility requirements for HCS CN waivers.

(6) WAC 388-515-1507 describes eligibility for waiver services when you are eligible for medicaid using noninstitutional CN rules.

(7) WAC 388-515-1508 describes the initial financial eligibility requirements for waiver services when you are not eligible for noninstitutional CN medicaid described in WAC 388-515-1507(1).

(8) WAC 388-515-1509 describes the rules used to determine your responsibility in the cost of care for waiver services if you are not eligible for medicaid under a CN program listed in WAC 388-515-1507(1). This is also called client participation or post eligibility.

AMENDATORY SECTION (Amending WSR 08-22-052, filed 11/3/08, effective 12/4/08)

WAC 388-515-1506 What are the general eligibility requirements for home and community based (HCB) services and hospice? (1) To be eligible for home and community based (HCB) services and hospice you must:

(a) Meet the program and age requirements for the specific program:

(i) COPES, per WAC 388-106-0310;

(ii) PACE, per WAC 388-106-0705;

(iii) WMIP waiver services, per WAC 388-106-0750;

(iv) New Freedom, per WAC 388-106-1410;

(v) Hospice, per chapter ((~~388-551~~)) 182-551 WAC; or

(vi) Roads to community living (RCL), per WAC 388-106-0250, 388-106-0255 and 388-106-0260.

(b) Meet the disability criteria for the Supplemental Security Income (SSI) program as described in WAC 388-475-0050;

(c) Require the level of care provided in a nursing facility described in WAC 388-106-0355;

(d) Be residing in a medical institution as defined in WAC ((~~388-500-0005~~)) 182-500-0050, or likely to be placed in one within the next thirty days without HCB services provided under one of the programs listed in subsection (1)(a);

(e) Have attained institutional status as described in WAC 388-513-1320;

(f) Be determined in need of services and be approved for a plan of care as described in subsection (1)(a);

(g) Be able to live at home with community support services and choose to remain at home, or live in a department-contracted:

(i) Enhanced adult residential care (EARC) facility;

(ii) Licensed adult family home (AFH); or

(iii) Assisted living (AL) facility.

(h) Not be subject to a penalty period of ineligibility for the transfer of an asset as described in WAC 388-513-1363 through 388-513-1366;

(i) Not have a home with equity in excess of the requirements described in WAC 388-513-1350.

(2) Refer to WAC 388-513-1315 for rules used to determine countable resources, income, and eligibility standards for long-term care services.

(3) Current income and resource standard charts are located at: http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.html.

AMENDATORY SECTION (Amending WSR 09-14-043, filed 6/24/09, effective 7/25/09)

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~~)) Aged, blind, or disabled (ABD) cash assistance described in WAC ((~~388-505-0110(6)~~)) 388-400-0060 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),~~)) aged, blind or disabled (ABD) cash assistance program described in WAC 388-400-0060 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~~)) WAC 388-478-0033;

(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~~)) ABD cash 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 ABD 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/ltcstandardsPNAchartsubfile.shtml.

AMENDATORY SECTION (Amending WSR 08-22-052, filed 11/3/08, effective 12/4/08)

WAC 388-515-1509 How does the department determine how much of my income I must pay towards the cost of my care if I am only eligible for home and community based (HCB) services under WAC 388-515-1508? If you are only eligible for medicaid under WAC 388-515-1508, the department determines how much you must pay based upon the following:

(1) If you are single and living at home as defined in WAC 388-106-0010, you keep all your income up to the federal poverty level (FPL) for your personal needs allowance (PNA).

(2) If you are married living at home as defined in WAC 388-106-0010, you keep all your income up to the medically needy income level (MNIL) for your PNA.

(3) If you live in an assisted living (AL) facility, enhanced adult residential center (EARC), or adult family home (AFH), you:

(a) Keep a PNA from your gross nonexluded income. The PNA is sixty-two dollars and seventy-nine cents effective July 1, 2008; and

(b) Pay for your room and board up to the ADSA room and board standard.

(4) In addition to paying room and board, you may also have to pay toward the cost of personal care. This is called your participation. Income that remains after the PNA and any room and board deduction is reduced by allowable deductions in the following order:

(a) If you are working, the department allows an earned income deduction of the first sixty-five dollars plus one-half of the remaining earned income.

(b) Guardianship fees and administrative costs including any attorney fees paid by the guardian only as allowed by chapter 388-79 WAC;

(c) Current or back child support garnished or withheld from your income according to a child support order in the month of the garnishment if it is for the current month. If the department allows this as deduction from your income, the department will not count it as your child's income when determining the family allocation amount;

(d) A monthly maintenance needs allowance for your community spouse not to exceed that in WAC 388-513-1380 (5)(b) unless a greater amount is allocated as described in subsection (e) of this section. This amount:

(i) Is allowed only to the extent that you make your income available to your community spouse; and

(ii) 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 1 (http://aspe.os.dhhs.gov/poverty/); and

(B) Excess shelter expenses. For the purposes of this section, excess shelter expenses are the actual required maintenance expenses for your community spouse's principal residence. These expenses are determined in the following manner:

(I) Rent, including space rent for mobile homes, plus;

(II) Mortgage, plus;

(III) Taxes and insurance, plus;

(IV) Any required payments for maintenance care for a condominium or cooperative, minus;

(V) The food assistance standard utility allowance (SUA) ((~~(for long-term care services this is set at the standard utility allowance for a four-person household),~~)) described in WAC 388-450-0195 provided the utilities are not included in the maintenance charges for a condominium or cooperative, minus;

(VI) The standard shelter allocation. This standard is based on thirty percent of one hundred fifty percent of the two person federal poverty level. This standard increases annually on July 1 (http://aspe.os.dhhs.gov/poverty).

(e) Is reduced by your community spouse's gross countable income.

(f) The amount allocated to the community spouse may be greater than the amount in subsection (d)(ii) only when:

(i) There is a court order approving the higher amount for the support of your community spouse; or

(ii) A hearings officer determines a greater amount is needed because of exceptional circumstances resulting in extreme financial duress.

(g) A monthly maintenance needs amount for each minor or dependent child, dependent parent, or dependent sibling of your community or institutional spouse. The amount the department allows is based on the living arrangement of the dependent. If the dependent:

(i) Resides with your community spouse, the amount is equal to one-third of the community spouse allocation as described in WAC 388-513-1380 (5)(b)(i)(A) that exceeds the dependent family member's income (child support received from a noncustodial parent is considered the child's income);

(ii) Does not reside with the community spouse, the amount is equal to the MNIL based on the number of dependent family members in the home less their separate income (child support received from a noncustodial parent is considered the child's income).

(h) Your unpaid medical expenses which have not been used to reduce excess resources. Allowable medical expenses are described in WAC 388-513-1350.

(i) The total of the following deductions cannot exceed the SIL (three hundred percent of the FBR):

(i) Personal needs allowance in subsections (1), (2) and (3)(a) and (b); and

(ii) Earned income deduction of the first sixty-five dollars plus one-half of the remaining earned income in subsection (4)(a); and

(iii) Guardianship fees and administrative costs in subsection (4)(b).

(5) You must pay your provider the combination of the room and board amount and the cost of personal care services after all allowable deductions.

(6) You may have to pay third party resources described in WAC 388-501-0200 in addition to the room and board and participation. The combination of room and board, participation, and third party resources is the total amount you must pay.

(7) Current income and resource standards for long-term care (including SIL, MNIL, FPL, FBR) are located at:

http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml.

(8) If you are in multiple living arrangements in a month (an example is a move from an adult family home to a home setting on HCB services), the department allows you the highest PNA available based on all the living arrangements and services you have in a month.

(9) Current PNA and ADSA room and board standards are located at: http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/ltcstandardsPNAchartsubfile.shtml.

AMENDATORY SECTION (Amending WSR 08-24-069, filed 12/1/08, effective 1/1/09)

WAC 388-515-1512 What are the financial requirements if I am eligible for medicaid under the noninstitutional categorically needy program (CN-P)? (1) You automatically meet income and resource eligibility for DDD waiver services if you are eligible for medicaid under a categorically needy program (CN-P) 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. These clients have medicaid eligibility determined and maintained by the Social Security Administration;

(b) Healthcare for workers with disabilities (HWD) described in WAC 388-475-1000 through 388-475-1250;

(c) SSI-related CN-P medicaid described in WAC 388-475-0100 (2)(a) and (b) or meets the requirements in WAC 388-475-0880 and is CN-P eligible after the income disregards have been applied;

(d) CN-P medicaid for a child as described in WAC 388-505-0210 (1), (2), (7) or (8); or

(e) ((~~General assistance expedited medicaid disability (GA-X) or general assistance based on aged/blind/disabled criteria described in WAC 388-505-0110(6)~~)) Aged, blind or disabled (ABD) cash assistance described in WAC 388-400-0060.

(2) If you are eligible for a CN-P medicaid program listed in subsection (1) above, you do not have to pay (participate) toward the cost of your personal care and/or habilitation services.

(3) If you are eligible for a CN-P medicaid program listed in subsection (1) above, you do not need to meet the initial eligibility income test of gross income at or below the special income level (SIL), which is three hundred percent of the federal benefit rate (FBR).

(4) If you are eligible for a CN-P medicaid program listed in subsection (1), you pay up to the ADSA room and board standard described in WAC 388-515-1505. Room and board and long-term care standards are located at http://www1.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml.

(a) If you live in an ARC, AFH or DDD group home, you keep a personal needs allowance (PNA) and use your income to pay up to the ADSA room and board standard. Effective January 1, 2009 the PNA is sixty-two dollars and seventy-nine cents.

(5) If you are eligible for a premium based medicaid program such as healthcare for workers with disabilities (HWD), you must continue to pay the medicaid premium to remain eligible for that CN-P program.

AMENDATORY SECTION (Amending WSR 08-24-069, filed 12/1/08, effective 1/1/09)

WAC 388-515-1514 How does the department determine how much of my income I must pay towards the cost of my care if I am not eligible for medicaid under a categorically needy program (CN-P) listed in WAC 388-515-1512(1)? If you are not eligible for medicaid under a categorically needy program (CN-P) listed in WAC 388-515-1512(1), the department determines how much you must pay based upon the following:

(1) If you are an SSI-related client living at home as defined in WAC 388-106-0010, you keep all your income up to the SIL (three hundred percent of the FBR) for your personal needs allowance (PNA).

(2) If you are an SSI-related client and you live in an ARC, AFH or DDD group home, you:

(a) Keep a personal needs allowance (PNA) from your gross nonexcluded income. Effective January 1, 2009 the PNA is sixty-two dollars and seventy-nine cents; and

(b) Pay for your room and board up to the ADSA room and board rate described in http://www1.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml.

(3) Income that remains after the allocation described in (2) above, is reduced by allowable deductions in the following order:

(a) If you are working, we allow an earned income deduction of the first sixty-five dollars plus one-half of the remaining earned income;

(b) Guardianship fees and administrative costs including any attorney fees paid by the guardian only as allowed by chapter 388-79 WAC;

(c) Current or back child support garnished from your income or withheld according to a child support order in the month of the garnishment if it is for the current month. If we allow this as deduction from your income, we will not count it as your child's income when determining the family allocation amount;

(d) A monthly maintenance needs allowance for your community spouse not to exceed that in WAC 388-513-1380 (5)(b) unless a greater amount is allocated as described in subsection (e) of this section. This amount:

(i) Is allowed only to the extent that your income is made available to your community spouse; and

(ii) 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. For the purposes of this section, excess shelter expenses are the actual required maintenance expenses for your community spouse's principal residence. These expenses are determined in the following manner:

(I) Rent, including space rent for mobile homes, plus;

(II) Mortgage, plus;

(III) Taxes and insurance, plus;

(IV) Any required payments for maintenance care for a condominium or cooperative minus;

(V) The food assistance standard utility allowance ((~~(for long term care services this is set at the standard utility allowance (SUA) for a four-person household),~~)) provided the utilities are not included in the maintenance charges for a condominium or cooperative, minus;

(VI) The standard shelter allocation. This standard 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

(VII) Is reduced by your community spouse's gross countable income.

(iii) May be greater than the amount in subsection (d)(ii) only when:

(A) There is a court order approving a higher amount for the support of your community spouse; or

(B) A hearings officer determines a greater amount is needed because of exceptional circumstances resulting in extreme financial duress.

(e) A monthly maintenance needs amount for each minor or dependent child, dependent parent or dependent sibling of your community or institutionalized spouse. The amount we allow is based on the living arrangement of the dependent. If the dependent:

(i) Resides with your community spouse, the amount is equal to one-third of the community spouse allocation as described in WAC 388-513-1380 (5)(b)(i)(A) that exceeds the dependent family member's income (child support received from a noncustodial parent is considered the child's income);

(ii) Does not reside with the community spouse, the amount is equal to the MNIL based on the number of dependent family members in the home less their separate income (child support received from a noncustodial parent is considered the child's income).

(f) Your unpaid medical expenses which have not been used to reduce excess resources. Allowable medical expenses are described in WAC 388-513-1350.

(g) The total of the following deductions cannot exceed the SIL (three hundred percent of the FBR):

(i) Personal needs allowances in subsection (1) for in home or subsection (2)(a) in a residential setting; and

(ii) Earned income deduction of the first sixty-five dollars plus one-half of the remaining earned income in subsection (3)(a); and

(iii) Guardianship fees and administrative costs in subsection (3)(b).

(4) If you are eligible for ((~~general assistance expedited medicaid disability (GA-X) or general assistance based on aged/blind/disabled criteria described in WAC 388-505-0110(6),~~)) aged, blind or disabled (ABD) cash assistance described in WAC 388-400-0060 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~~)) ABD cash 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~~)) ABD cash grant to the facility for the cost of room and board up to the ADSA room and board standard described in http://www1.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml; or

(c) When you live in an ARC or DDD group home, you are only eligible to receive a cash grant of thirty-eight dollars and eighty-four cents which you keep for your PNA.

(5) The combination of the room and board amount and the cost of personal care and/or habilitation services (participation) after all allowable deductions have been considered is called your total responsibility. You pay this amount to the ARC, AFH or DDD group home provider.

WSR 11-23-001

EMERGENCY RULES

DEPARTMENT OF FISH AND WILDLIFE

[Order 11-292—Filed November 2, 2011, 2:39 p.m., effective November 5, 2011, 7:00 p.m.]

Effective Date of Rule: November 5, 2011, 7:00 p.m.

Purpose: Amend commercial fishing rules.

Citation of Existing Rules Affected by this Order: Repealing WAC 220-52-04000H and 220-52-04600L; and amending WAC 220-52-046.

Statutory Authority for Adoption: RCW 77.12.047 and 77.04.020.

Under RCW 34.05.350 the agency for good cause finds that immediate adoption, amendment, or repeal of a rule is necessary for the preservation of the public health, safety, or general welfare, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the public interest.

Reasons for this Finding: The provisions of this rule are in conformity with agreed plans with applicable tribes, which have been entered as required by court order. The Puget Sound commercial season is structured to meet harvest allocation objectives. There is insufficient time to adopt permanent rules.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 1, Amended 0, Repealed 2.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.

Date Adopted: November 2, 2011.

James B. Scott, Jr.
for Philip Anderson
Director

NEW SECTION

WAC 220-52-04600M Puget Sound crab fishery—Seasons and areas. Notwithstanding the provisions of WAC 220-52-046, effective 7:00 p.m. November 5, 2011, until further notice, all Puget Sound Crab Management Regions are closed to commercial crab fishing. The Puget Sound Crab Management Regions include Marine Fish-Shellfish Management and Catch Reporting Areas 20A, 20B, 21A, 21B, 22A, 22B, 23A, 23B, 23C, 23D, 24A, 24B, 24C, 24D, 25A, 25B, 25D, 26AW, 26AE, and 29.

REPEALER

The following sections of the Washington Administrative Code are repealed effective 7:00 p.m. November 5, 2011:

WAC 220-52-04000H	Commercial crab fishery—Lawful and unlawful gear, methods, and other unlawful acts. (11-288)
WAC 220-52-04600L	Puget Sound crab fishery—Seasons and areas. (11-288)

WSR 11-23-005
EMERGENCY RULES
SUPERINTENDENT OF PUBLIC INSTRUCTION

[Filed November 3, 2011, 12:10 p.m., effective November 3, 2011, 12:10 p.m.]

Effective Date of Rule: Immediately.

Purpose: Updating the WAC to address the 1.20 FTE limitation for running start students after the passing of HB 1087.

Citation of Existing Rules Affected by this Order: Amending WAC 392-121-136.

Statutory Authority for Adoption: RCW 28A.150.290.

Under RCW 34.05.350 the agency for good cause finds that in order to implement the requirements or reductions in appropriations enacted in any budget for fiscal year 2009, 2010, 2011, 2012 or 2013, which necessitates the need for the immediate adoption, amendment, or repeal of a rule, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the fiscal needs or requirements of the agency.

Reasons for this Finding: The need to update the requirements of HB 1087 and address the 1.20 FTE limitations for running start students and the financial impact of passing HB 1087.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 1, Repealed 0.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 0, Amended 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.

Date Adopted: September 28, 2011.

Randy Dorn
State Superintendent

AMENDATORY SECTION (Amending WSR 10-13-020, filed 6/4/10, effective 7/5/10)

WAC 392-121-136 Limitation on enrollment counts. Enrollment counts pursuant to WAC 392-121-106 through 392-121-133 are subject to the following limitations:

(1) Except as provided in (a), (b) and (c) of this subsection, no student, including a student enrolled in more than one school district, shall be counted as more than one full-time equivalent student on any count date or more than one annual average full-time equivalent student in any school year.

(a) School districts operating approved vocational skills center programs during the summer vacation months may claim additional full-time equivalent students based upon actual enrollment in such vocational skills centers on the aggregate of enrolled hours based upon the fourth day of each summer session. Each district operating an approved vocational skills center program shall be entitled to claim one annual average full-time equivalent student for each 900 hours of planned student enrollment for the summer term(s) subject to the limitation in (c) of this subsection.

(b) Enrollment count limitations apply separately to a student's running start, skills center and high school enrollments and is limited to an overall maximum ((~~2.0~~)) 1.8 FTE.

(c) Subject to (b) of this subsection, a student enrolled in a skill center program during the regular school year may be claimed for up to a combined 1.6 full-time equivalent student. A student enrolled in running start may be claimed for up to a combined 1.2 full-time equivalent student including school district and college or university. A student enrolled in high school and skills center for more than a 1.0 FTE, can be claimed for a 0.2 running start FTE.

Each student may be claimed for a maximum of a 1.0 full-time equivalent for the skills center enrollment, a maximum of a 1.0 full-time equivalent for running start and a maximum of a 1.0 full-time equivalent for the student's high school enrollment subject to the overall ((~~1.6~~)) combined FTE ((~~maximum~~)) limitation in (b) of this subsection.

(2) Running start enrollment counts are limited as provided in chapter 392-169 WAC and specifically as provided in WAC 392-169-060.

(3) The full-time equivalent reported for a five year old preschool student with a disability is limited as provided in WAC 392-121-137.

(4) No kindergarten student, including a student enrolled in more than one school district, shall be counted as more than one-half of an annual average full-time equivalent student in any school year.

(5) A student reported as part-time on Form SPI E-672 shall not be reported by a school district for more than part-time basic education funding on that enrollment count date and the total enrollment reported by one or more school districts for basic education and on Form SPI E-672 must not exceed one full-time equivalent.

(6) Districts providing an approved state-funded full-day kindergarten program as provided in chapter 28A.150 RCW (from E2SSB 5841) may claim up to an additional 0.50 FTE based upon student enrolled hours in excess of the 0.50 FTE provided under subsection (4) of this section.

WSR 11-23-007
EMERGENCY RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 11-293—Filed November 4, 2011, 12:02 p.m., effective November 11, 2011, 12:01 p.m.]

Effective Date of Rule: November 11, 2011, 12:01 p.m.

Purpose: Amend recreational fishing rules.

Citation of Existing Rules Affected by this Order: Repealing WAC 220-56-36000W; and amending WAC 220-56-360.

Statutory Authority for Adoption: RCW 77.12.047 and 77.04.020.

Under RCW 34.05.350 the agency for good cause finds that immediate adoption, amendment, or repeal of a rule is necessary for the preservation of the public health, safety, or general welfare, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the public interest.

Reasons for this Finding: Survey results show that adequate clams are available for harvest in Razor Clam Areas 1, 2 and those portions of Razor Clam Area 3 opened for harvest. Washington department of health has certified clams from these beaches to be safe for human consumption. There is insufficient time to adopt permanent rules.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 1, Amended 0, Repealed 1.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.

Date Adopted: November 4, 2011.

James B. Scott, Jr.
for Philip Anderson
Director

NEW SECTION

WAC 220-56-36000W Razor clams—Areas and seasons. Notwithstanding the provisions of WAC 220-56-360, it is unlawful to dig for or possess razor clams taken for personal use from any beach in Razor Clam Areas 1, 2, or 3, except as provided for in this section:

1. Effective 12:01 p.m. November 11 through 11:59 p.m. November 12, 2011, razor clam digging is allowed in Razor Clam Area 1. Digging is allowed from 12:01 p.m. to 11:59 p.m. each day only.

2. Effective 12:01 p.m. November 11 through 11:59 p.m. November 12, 2011, razor clam digging is allowed in Razor Clam Area 2. Digging is allowed from 12:01 p.m. to 11:59 p.m. each day only.

3. Effective 12:01 p.m. November 11 through 11:59 p.m. November 12, 2011, razor clam digging is allowed in that portion of Razor Clam Area 3 that is between the Copalis River and the southern boundary of the Quinault Indian Nation (Grays Harbor County). Digging is allowed from 12:01 p.m. to 11:59 p.m. each day only.

4. It is unlawful to dig for razor clams at any time in Long Beach, Twin Harbors Beach or Copalis Beach Clam sanctuaries defined in WAC 220-56-372.

REPEALER

The following section of the Washington Administrative Code is repealed effective 12:01 a.m. November 13, 2011:

WAC 220-56-36000W	Razor clams—Areas and seasons.

WSR 11-23-009
EMERGENCY RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 11-294—Filed November 4, 2011, 2:55 p.m., effective November 4, 2011, 2:55 p.m.]

Effective Date of Rule: Immediately.

Purpose: Amend commercial fishing rules.

Citation of Existing Rules Affected by this Order: Repealing WAC 220-47-31100N; and amending WAC 220-47-311.

Statutory Authority for Adoption: RCW 77.12.047 and 77.04.020.

Under RCW 34.05.350 the agency for good cause finds that immediate adoption, amendment, or repeal of a rule is necessary for the preservation of the public health, safety, or general welfare, and that observing the time requirements of

notice and opportunity to comment upon adoption of a permanent rule would be contrary to the public interest.

Reasons for this Finding: In-season update models suggest that the run-size is larger than the previously agreed-to run-size level, and that additional fish are available for harvest in Salmon Management and Catch Reporting Areas 12 and 12B. There is insufficient time to adopt permanent rules.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 1, Amended 0, Repealed 1.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.

Date Adopted: November 4, 2011.

James B. Scott, Jr.
for Philip Anderson
Director

NEW SECTION

WAC 220-47-31100P Purse seines—Open periods. Notwithstanding the provisions of WAC 220-47-311, effective immediately until further notice, it is unlawful to take, fish for, or possess salmon taken for commercial purposes with purse seine gear in waters of Puget Sound Salmon Management and Catch Reporting Area 12C.

REPEALER

The following section of the Washington Administrative Code is repealed:

WAC 220-47-31100N	Purse seines—Open periods. (11-290)

WSR 11-23-041
RESCISSION OF EMERGENCY RULES
HEALTH CARE AUTHORITY

[Filed November 8, 2011, 2:49 p.m.]

Please rescind the emergency repeal of WAC 182-538-063 filed under WSR 11-22-052 on October 31, 2011.

November 8, 2011
Kevin M. Sullivan
Rules Coordinator

WSR 11-23-043
EMERGENCY RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 11-295—Filed November 8, 2011, 4:16 p.m.]

Effective Date of Rule: Immediately.

Purpose: Amend commercial fishing rules.

Citation of Existing Rules Affected by this Order: Repealing WAC 220-47-31100P; and amending WAC 220-47-311 and 220-47-411.

Statutory Authority for Adoption: RCW 77.12.047 and 77.04.020.

Under RCW 34.05.350 the agency for good cause finds that immediate adoption, amendment, or repeal of a rule is necessary for the preservation of the public health, safety, or general welfare, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the public interest.

Reasons for this Finding: Nontreaty catches were high yesterday in Puget Sound Salmon Management and Catch Reporting Area 12, and share may have been attained. Purse seine hours in Puget Sound Salmon Management and Catch Reporting Areas 10 and 11 are reduced to offset the closure of Area 12. Gill net effort has been low during the season, and harvestable fish remain. There is insufficient time to adopt permanent rules.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 2, Amended 0, Repealed 1.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.

Date Adopted: November 8, 2011.

Lori Preuss
for Philip Anderson
Director

NEW SECTION

WAC 220-47-31100Q Purse seine—Open periods. Notwithstanding the provisions of WAC 220-47-311:

(1) It is unlawful to take, fish for, or possess salmon taken for commercial purposes with purse seine gear in waters of Puget Sound Salmon Management and Catch Reporting Areas 12, 12B and 12C.

(2) It is unlawful to take, fish for, or possess salmon taken for commercial purposes with purse seine gear in waters of Puget Sound Salmon Management and Catch Reporting Areas 10 and 11, except open from 10:00 a.m. to 3:00 p.m., Wednesday, November 9, 2011.

NEW SECTION

WAC 220-47-41100Y Gill net—Open periods. Notwithstanding the provisions of WAC 220-47-411:

(1) It is unlawful to take, fish for, or possess salmon taken for commercial purposes with gill net gear in waters of Puget Sound Salmon Management and Catch Reporting Areas 12, 12B, and 12C.

(2) It is unlawful to take, fish for, or possess salmon taken for commercial purposes with gill net gear in waters of Puget Sound Salmon Management and Catch Reporting Areas 10 and 11, except open from 4:00 p.m. Tuesday, November 8, through 8:00 a.m. Wednesday, November 9; 4:00 p.m. Wednesday, November 9, through 8:00 a.m. Thursday, November 10; and 4:00 p.m. Thursday, November 10, through 8:00 a.m. Friday, November 11.

REPEALER

The following section of the Washington Administrative code is repealed:

WAC 220-47-31100P	Purse seine—Open periods. (11-294)

WSR 11-23-049
EMERGENCY RULES
BUILDING CODE COUNCIL

[Filed November 9, 2011, 10:43 a.m., effective November 9, 2011]

Effective Date of Rule: Immediately.

Purpose: To reserve Chapter 12 of the Washington State Energy Code, WAC 51-11-1200, to suspend requirements for energy metering. This is an extension of the emergency rule filed under WSR 11-15-031 on July 12, 2011.

Citation of Existing Rules Affected by this Order: Suspending WAC 51-11-1200.

Statutory Authority for Adoption: RCW 19.27A.020, 19.27A.025, and 19.27A.045.

Other Authority: Chapters 19.27 and 34.05 RCW.

Under RCW 34.05.350 the agency for good cause finds that immediate adoption, amendment, or repeal of a rule is necessary for the preservation of the public health, safety, or general welfare, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the public interest.

Reasons for this Finding: The council finds that the rule causes potential economic hardship on building owners. Further, the rule has unintended and unanticipated consequences on the required installation of standby power for emergency systems. To preserve safety and public health in newly constructed and renovated buildings, the rule must be suspended to assure properly installed standby power for emergency systems, and to allow the council to examine the costs of installing the energy metering systems. The council is currently in the process of developing the proposed permanent rule, along with the necessary cost-benefit analysis and small business economic impact statement.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 0, Amended 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.

Date Adopted: October 14, 2011.

Kristyn Clayton
Council Chair

WSR 11-23-050
EMERGENCY RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 11-296—Filed November 9, 2011, 2:16 p.m., effective November 10, 2011, 12:01 p.m.]

Effective Date of Rule: November 10, 2011, 12:01 p.m.

Purpose: Amend commercial fishing rules.

Citation of Existing Rules Affected by this Order: Repealing WAC 220-40-02700P; and amending WAC 220-40-027.

Statutory Authority for Adoption: RCW 77.12.047 and 77.04.020.

Under RCW 34.05.350 the agency for good cause finds that immediate adoption, amendment, or repeal of a rule is necessary for the preservation of the public health, safety, or general welfare, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the public interest.

Reasons for this Finding: Based on catch information to date, harvest guidelines will be exceeded if retention of white sturgeon in the Willapa Bay commercial gillnet fishery is allowed beyond 12:01 p.m. on Thursday, November 10, 2011. There is insufficient time to adopt permanent rules.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 1, Amended 0, Repealed 1.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.

Date Adopted: November 9, 2011.

Philip Anderson
Director

NEW SECTION

WAC 220-40-02700P Salmon—Willapa Bay fall fishery. Notwithstanding the provisions of WAC 220-40-027, effective 12:01 p.m. November 10 through December 31, 2011, it is unlawful to fish for salmon in Willapa Bay for commercial purposes or to possess salmon taken from those waters for commercial purposes, except that:

Fishing Periods:

1. Gillnet gear may be used to fish for salmon only as shown below:

6:00 p.m. November 11 through 6:00 p.m. November 19, 2011	Areas 2M, 2N, 2R, 2T, and 2U

Gear:

2. Gillnet gear restrictions - All Areas:

a. Drift gill net gear only. It is unlawful to use set net gear. It is permissible to have on board a commercial vessel more than one net, provided the nets are of a mesh size that is legal for the fishery, and the length of any one net does not exceed one thousand five hundred feet in length.

b. Nets with a mesh size different from that being actively fished must be properly stored. A properly stored net is defined as a net on a drum that is fully covered by a tarp (canvas or plastic) and bound with a minimum of ten revolutions of rope that is 3/8 (0.375) inches or greater.

c. It is unlawful to use a gill net to fish for salmon if the lead line weighs more than two pounds per fathom of net as measured on the cork line, provided that it is lawful to have a gill net with a lead line weighing more than two pounds per fathom aboard a vessel when the vessel is fishing in or transiting through Willapa Bay.

3. From November 11 through November 19, 2011: Mesh size must not exceed six and one-half inch maximum mesh.

a. Only one net of six and one-half inch configuration, not exceeding fifteen hundred feet, may be used when in the act of fishing.

b. Only one net may be fishing at a time; other nets must be properly stored.

c. From November 11 through November 19, 2011, all white sturgeon, all steelhead, and all green sturgeon must be handled with care to minimize injury to the fish and must be released immediately to the river/bay when fishing in Willapa Bay Areas 2K, 2M, 2N, 2R, 2T, and 2U.

Other:

4. Quick reporting is required for wholesale dealers and fishers retailing their catch under a "direct retail endorsement." According to WAC 220-69-240(12), reports must be made by 10:00 a.m. the day following landing.

5. Effective 12:01 p.m. November 10 through December 31, 2011, it is unlawful to retain white sturgeon.

6. The retention of green sturgeon and steelhead is prohibited.

7. It is unlawful to fish with gillnet gear in Areas 2K, 2M, 2N, 2R, 2T, and 2U unless the vessel operator has attended a "Fish Friendly" best fishing practices workshop and has in their possession a department-issued certification card.

REPEALER

The following section of the Washington Administrative Code is repealed effective January 1, 2012:

WAC 220-40-02700P	Salmon Willapa Bay fall fishery.

WSR 11-23-058
EMERGENCY RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 11-297—Filed November 10, 2011, 4:16 p.m., effective November 11, 2011, 8:01 a.m.]

Effective Date of Rule: November 11, 2011, 8:01 a.m.

Purpose: Amend commercial fishing rules.

Citation of Existing Rules Affected by this Order: Repealing WAC 220-47-31100Q and 220-47-41100Y; and amending WAC 220-47-311 and 220-47-411.

Statutory Authority for Adoption: RCW 77.12.047 and 77.04.020.

Under RCW 34.05.350 the agency for good cause finds that immediate adoption, amendment, or repeal of a rule is necessary for the preservation of the public health, safety, or general welfare, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the public interest.

Reasons for this Finding: This emergency rule is needed to adjust fishing schedules based on comanager agreement. There is insufficient time to adopt permanent rules.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 2, Amended 0, Repealed 2.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.

Date Adopted: November 10, 2011.

Joe Stohr
for Philip Anderson
Director

NEW SECTION

WAC 220-47-31100R Purse seine—Open periods. Notwithstanding the provisions of WAC 220-47-311:

(1) It is unlawful to take, fish for, or possess salmon taken for commercial purposes with purse seine gear in waters of Puget Sound Salmon Management and Catch Reporting Areas 12, 12B and 12C.

(2) It is unlawful to take, fish for, or possess salmon taken for commercial purposes with purse seine gear in waters of Puget Sound Salmon Management and Catch Reporting Areas 10 and 11.

NEW SECTION

WAC 220-47-41100Z Gill net—Open periods. Notwithstanding the provisions of WAC 220-47-411, it is unlawful to take, fish for, or possess salmon taken for commercial purposes with gill net gear in waters of Puget Sound Salmon Management and Catch Reporting Areas 12, 12B, and 12C.

REPEALER

The following sections of the Washington Administrative code are repealed effective 8:01 a.m. November 11, 2011:

WAC 220-47-31100Q	Purse seine—Open periods. (11-295)
WAC 220-47-41100Y	Gill net—Open periods. (11-295)

WSR 11-23-059
EMERGENCY RULES
HEALTH CARE AUTHORITY
(Medicaid Program)

[Filed November 13, 2011, 2:53 p.m., effective November 13, 2011, 2:53 p.m.]

Effective Date of Rule: Immediately.

Purpose: During the reorganization of chapter 182-543 WAC, long-standing policy language regarding reimbursement was unintentionally deleted. This rule-making action reinstates the language that was deleted. This rule revision also clarifies in WAC 182-543-5500 that prior authorization is required for the purchase of replacement batteries for wheelchairs.

Citation of Existing Rules Affected by this Order: Amending WAC 182-543-5500, 182-543-9100, 182-543-9200, 182-543-9300, and 182-543-9400.

Statutory Authority for Adoption: RCW 41.05.021.

Under RCW 34.05.350 the agency for good cause finds that immediate adoption, amendment, or repeal of a rule is necessary for the preservation of the public health, safety, or general welfare, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the public interest; that state or federal law or federal rule or a federal deadline for state receipt of federal funds requires immediate adoption of a rule; and that in order to implement the requirements or reductions in appropriations enacted in any budget for fiscal year 2009, 2010, 2011, 2012 or 2013, which necessitates the need for the immediate adoption, amendment, or repeal of a rule, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the fiscal needs or requirements of the agency.

Reasons for this Finding: The unintentional deletion could cause the agency to not be able to maintain prudent and consistent pricing for durable medical equipment. In order to implement the budgetary requirements for fiscal year 2012-13, this crucial missing language must be reinstated.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 0, Amended 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 5, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 5, Repealed 0.

Date Adopted: November 13, 2011.

Kevin M. Sullivan
Rules Coordinator

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-543-5500 Covered—Medical supplies and related services. The ((~~department~~)) agency covers, without prior authorization unless otherwise specified, the following medical supplies and related services:

(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;

(2) Bandages, dressings, and tapes;

(3) Batteries - Replacement batteries:

(a) The ((~~department~~)) agency pays for the purchase of replacement batteries for wheelchairs with prior authorization.

(b) The ((~~department~~)) agency does not pay for wheelchair replacement batteries that are used for speech generating devices (SGDs) or ventilators. See WAC ((~~388-543-3400~~)) 182-543-3400 for speech generating devices and chapter ((~~388-548~~)) 182-548 WAC for ventilators.

(4) 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) Diabetic test strips as follows:

(i) For clients, twenty years of age and younger, as follows:

(A) Insulin dependent, three hundred test strips and three hundred lancets per client, per month.

(B) For noninsulin dependent, one hundred test strips and one hundred lancets per client, per month.

(ii) For clients, twenty-one years of age and older:

(A) Insulin dependent, one hundred test strips and one hundred lancets per client, per month.

(B) For noninsulin dependent, one hundred test strips and one hundred lancets per client, every three months.

(iii) For pregnant women with gestational diabetes, the ((~~department~~)) agency pays for the quantity necessary to support testing as directed by the client's physician, up to sixty days postpartum.

(d) See WAC ((~~388-543-5500~~)) 182-543-5500(12) for blood glucose monitors.

(5) 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.

(6) Decubitus care products:

(a) Cushion (gel, sacroiliac, or accuback) and cushion cover (any size) - One per twelve-month period;

(b) Synthetic or lamb's wool sheepskin pad - One per twelve-month period;

(c) Heel or elbow protectors - Four per twelve-month period.

(7) 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~~)) agency does not pay for either of the following when billed in combination with an ostomy faceplate:

(i) Drainable pouches with plastic face plate attached; or

(ii) Drainable pouches with rubber face plate.

(8) Syringes and needles;

(9) 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 back sheet that is moisture impervious and is at least 1.00 mm thick, designed to protect clothing and linens;

(vi) Have a top sheet 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 back sheet 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 back sheet 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 nonwoven, porous materials that have a high degree of permeability, allowing fluids to pass through and into the absorbent filler. The patient contact surface must be soft and durable;

(v) Have filler material that is highly absorbent. It must be heavy weight fluff filler or the equivalent; and

(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~~)) agency pays for urological products when they are used alone. The following are examples of products which the ((~~department~~)) agency does not pay for when used in combination with each other:

(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) The ((~~department~~)) agency approves a client's use of a combination of products only when the client uses different products for daytime and nighttime use. Example: pull-up pants for daytime use and disposable diapers for nighttime use. The total quantity of all products in this section used in combination cannot exceed the monthly limitation for the product with the highest limit.

(h) Purchased disposable diapers (any size) are limited to two hundred per month for clients three years of age and older.

(i) Reusable cloth diapers (any size) are limited to:

(i) Purchased - Thirty-six per year; and

(ii) Rented - Two hundred per month.

(j) Disposable briefs and pull-up pants (any size) are limited to:

(i) Two hundred per month for a client age three to eighteen years of age; and

(ii) One hundred fifty per month for a client nineteen years of age and older.

(k) 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.

(l) Disposable pant liners, shields, guards, pads, and undergarments are limited to two hundred per month.

(m) Underpads for beds are limited to:

(i) Disposable (any size) - One hundred eighty per month.

(ii) Purchased, reusable (large) - Forty-two per year.

(iii) Rented, reusable (large) - Ninety per month.

(10) Urological supplies - Urinary retention:

(a) Bedside drainage bag, day or night, with or without anti-reflux device, with or without tube - Two per month. The ((~~department~~)) agency does not pay for these when billed in combination with any of the following:

(i) With extension drainage tubing for use with urinary leg bag or urostomy pouch (any type, any length), with connector/adapter; and/or

(ii) With an insertion tray with drainage bag, and with or without catheter.

(b) Bedside drainage bottle, with or without tubing - Two per six month period.

(c) Extension drainage tubing (any type, any length), with connector/adapter, for use with urinary leg bag or urostomy pouch. The ((~~department~~)) agency does not pay for these when 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. The ((~~department~~)) agency does not pay for these when billed in combination with other insertion trays that include drainage bag, catheters, and/or individual lubricant packets.

(ii) With indwelling catheters - Three per month. The ((~~department~~)) agency does not pay for these when 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. The ((~~department~~)) agency does not pay for these when 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). The ((~~department~~)) agency does not pay for these when billed in combination with irrigation tray or tubing.

(i) Irrigation tray with syringe (bulb or piston) - Thirty per month. The ((~~department~~)) agency does not pay for these when billed in combination with irrigation syringe (bulb or piston), or irrigation tubing set.

(j) Irrigation tubing set - Thirty per month. The ((~~department~~)) agency does not pay for these when billed in combination with an irrigation tray or irrigation syringe (bulb or piston).

(k) Leg straps (latex foam and fabric), 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. The ((~~department~~)) agency does not pay for these when 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. The ((~~department~~)) agency does not pay for these when billed in combination with drainage bag and without catheter.

(p) Urinary leg bag, latex - One per month. The ((~~department~~)) agency does not pay for these when billed in combination with or without catheter.

(11) Miscellaneous supplies:

(a) Bilirubin light therapy supplies when provided with a bilirubin light which the ((~~department~~)) agency prior authorized - Five days supply.

(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., LiceOff TM) for use with lice combs - One bottle per twelve-month period.

(f) Nonsterile gloves - Two hundred, per client, per month.

(i) For clients residing in an assisted living facility, the ((~~department~~)) agency pays, with prior authorization, for additional nonsterile gloves up to the quantity necessary as directed by the client's physician, not to exceed a total of four hundred per client, per month.

(ii) Prior authorization requests must include a completed:

(A) General Information for Authorization form (((~~DSHS~~)) HCA 13-835). The ((~~department's~~)) agency's electronic forms are available online (see WAC ((~~388-543-7000~~)) 182-543-7000 Authorization); and

(B) Limitation Extension Request Incontinent Supplies and Gloves form (((~~DSHS~~)) HCA 13-870).

(g) Sterile gloves - Thirty pair, per client, per month.

(12) Miscellaneous DME:

(a) Bilirubin light or light pad - Five days rental per twelve-month period for at-home newborns with jaundice.

(b) Blood glucose monitor (specialized or home) - One in a three-year period. See WAC ((~~388-543-5500~~)) 182-543-5500(4) for blood monitoring/testing supplies. The ((~~department~~)) agency does not pay for continuous glucose monitoring systems including related equipment and supplies under the durable medical equipment benefit. See WAC ((~~388-553-500~~)) 182-553-500 home infusion therapy/parenteral nutrition program.

(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 with 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.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-543-9100 Reimbursement method—Other DME. (1) The ((~~department~~)) agency sets, evaluates and updates the maximum allowable fees for purchased other durable medical equipment (DME) at least once yearly using one or more of the following:

(a) The current medicare rate, as established by the federal centers for medicare and medicaid services (CMS), for a new purchase if a medicare rate is available;

(b) A pricing cluster; or

(c) On a by-report basis.

(2) Establishing reimbursement rates for purchased other DME based on pricing clusters.

(a) A pricing cluster is based on a specific healthcare common procedure coding system (HCPCS) code.

(b) The ((~~department's~~)) agency's pricing cluster is made up of all the brands/models for which the ((~~department~~)) agency obtains pricing information. However, the ((~~department~~)) agency may limit the number of brands/models included in the pricing cluster. The ((~~department~~)) agency considers all of the following when establishing the pricing cluster:

(i) A client's medical needs;

(ii) Product quality;

(iii) Introduction, substitution or discontinuation of certain brands/models; and/or

(iv) Cost.

(c) When establishing the fee for other DME items in a pricing cluster, the maximum allowable fee is the median amount of available manufacturers' list prices for all brands/models as noted in subsection (2)(b) of this section.

(3) The ((~~department~~)) agency evaluates a by report (BR) item, procedure, or service for medical necessity, appropriateness and reimbursement value on a case-by-case basis. The ((~~department~~)) agency calculates the reimbursement rate for these items at eighty-five percent of the manufacturer's ((~~list~~)) suggested retail price (MSRP) as of July 31st of the base year or one hundred twenty-five percent of the wholesale acquisition cost from the manufacturer's invoice.

(4) Monthly rental reimbursement rates for other DME. The ((~~department's~~)) agency's maximum allowable fee for monthly rental is established using one of the following:

(a) For items with a monthly rental rate on the current medicare fee schedule as established by the federal centers for medicare and medicaid services (CMS), the ((~~department~~)) agency equates its maximum allowable fee for monthly rental to the current medicare monthly rental rate;

(b) For items that have a new purchase rate but no monthly rental rate on the current medicare fee schedule as established by the federal centers for medicare and medicaid services (CMS), the ((~~department~~)) agency sets the maximum allowable fee for monthly rental at one-tenth of the new purchase price of the current medicare rate;

(c) For items not included in the current medicare fee schedule as established by the federal centers for medicare and medicaid services (CMS), the ((~~department~~)) agency considers the maximum allowable monthly reimbursement rate as by-report. The ((~~department~~)) agency calculates the monthly reimbursement rate for these items at one-tenth of eighty-five percent of the manufacturer's list price.

(5) Daily rental reimbursement rates for other DME. The ((~~department's~~)) agency's maximum allowable fee for daily rental is established using one of the following:

(a) For items with a daily rental rate on the current medicare fee schedule as established by the centers for medicare and medicaid services (CMS), the ((~~department~~)) agency equates its maximum allowable fee for daily rental to the current medicare daily rental rate;

(b) For items that have a new purchase rate but no daily rental rate on the current medicare fee schedule as established by CMS, the ((~~department~~)) agency sets the maximum allowable fee for daily rental at one-three-hundredth of the new purchase price of the current medicare rate;

(c) For items not included in the current medicare fee schedule as established by CMS, the ((~~department~~)) agency considers the maximum allowable daily reimbursement rate as by-report. The ((~~department~~)) agency calculates the daily reimbursement rate at one-three-hundredth of eighty-five percent of the manufacturer's ((~~list~~)) suggested retail price (MSRP) as of July 31st of the base year or one hundred twenty-five percent of the wholesale acquisition cost from the manufacturer's invoice.

(6) The ((~~department~~)) agency does not reimburse for DME and related supplies, prosthetics, orthotics, medical supplies, related services, and related repairs and labor charges under fee-for-service (FFS) when the client is any of the following:

(a) An inpatient hospital client;

(b) Eligible for both medicare and medicaid, and is staying in a skilled nursing facility in lieu of hospitalization;

(c) Terminally ill and receiving hospice care; or

(d) Enrolled in a risk-based managed care plan that includes coverage for such items and/or services.

(7) The ((~~department~~)) agency rescinds any purchase order for a prescribed item if the equipment was not delivered to the client before the client:

(a) Dies;

(b) Loses medical eligibility;

(c) Becomes covered by a hospice agency; or

(d) Becomes covered by a managed care organization.

(8) A provider may incur extra costs for customized equipment that may not be easily resold. In these cases, for purchase orders rescinded in subsection (7) of this section, the ((~~department~~)) agency may pay the provider an amount it considers appropriate to help defray these extra costs. The ((~~department~~)) agency requires the provider to submit justification sufficient to support such a claim.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-543-9200 Reimbursement method—Wheelchairs. (1) The ((~~department~~)) agency reimburses a DME provider for purchased wheelchairs based on the specific brand and model of wheelchair dispensed. The ((~~department~~)) agency decides which brands and/or models of wheelchairs are eligible for reimbursement based on all of the following:

(a) A client's medical needs;

(b) Product quality;

(c) Cost; and

(d) Available alternatives.

(2) The ((~~department~~)) agency sets, evaluates and updates the maximum allowable fees at least once yearly for wheelchair purchases, wheelchair rentals, and wheelchair accessories (e.g., cushions and backs) using the lesser of the following:

(a) The current medicare fees;

(b) The actual invoice for the specific item; or

(c) A percentage of the manufacturer's ((~~list~~)) suggested retail price (MSRP) as of January 31st of the base year, or a

percentage of the wholesale acquisition cost (AC). The ((~~department~~)) agency uses the following percentages:

(i) For basic standard wheelchairs, sixty-five percent of MSRP or one hundred forty percent of AC;

(ii) For add-on accessories and parts, eighty-four percent of MSRP or one hundred forty percent of AC;

(iii) For up-charge modifications and cushions, eighty percent of MSRP or one hundred forty percent of AC;

(iv) For all other manual wheelchairs, eighty percent of MSRP or one hundred forty percent of AC; and

(v) For all other power-drive wheelchairs, eighty-five percent of MSRP or one hundred forty percent of AC.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-543-9300 Reimbursement method—Prosthetics and orthotics. (1) The ((~~department~~)) agency sets, evaluates and updates the maximum allowable fees for prosthetics and orthotics at least once yearly as follows:

(a) For items with a rate on the current medicare fee schedule, as established by the federal centers for medicare and medicaid services (CMS), the ((~~department~~)) agency equates its maximum allowable fee to the current medicare rate; and

(b) For those items not included in the medicare fee schedule, as established by CMS, the rate is considered by-report. The ((~~department~~)) agency evaluates a by-report item, procedure, or service based upon medical necessity criteria, appropriateness, and reimbursement value on a case-by-case basis. The ((~~department~~)) agency calculates the reimbursement for these items at eighty-five percent of the manufacturer's ((~~list~~)) suggested retail price as of July 31st of the base year or one hundred twenty-five percent of the wholesale acquisition cost from the manufacturer's invoice.

(2) The ((~~department~~)) agency follows healthcare common procedure coding system (HCPCS) guidelines for product classification and code assignation.

(3) The ((~~department's~~)) agency's reimbursement for a prosthetic or orthotic includes the cost of any necessary molds, fitting, shipping, handling or any other administrative expenses related to provision of the prosthetic or orthotic to the client.

(4) The ((~~department's~~)) agency's hospital reimbursement rate includes any prosthetics and/or orthotics required for surgery and/or placed during the hospital stay.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-543-9400 Reimbursement method—Medical supplies and related services. (1) The ((~~department~~)) agency sets, evaluates and updates the maximum allowable fees for medical supplies and nondurable medical equipment (DME) items at least once yearly using one or more of the following:

(a) The current medicare rate, as established by the federal centers for medicare and medicaid services (CMS), if a medicare rate is available;

(b) A pricing cluster;

(c) Based on input from stakeholders or other relevant sources that the ((~~department~~)) agency determines to be reliable and appropriate; or

(d) On a by-report basis.

(2) Establishing reimbursement rates for medical supplies and non-DME items based on pricing clusters.

(a) A pricing cluster is based on a specific healthcare common procedure coding system (HCPCS) code.

(b) The ((~~department's~~)) agency's pricing cluster is made up of all the brands for which the ((~~department~~)) agency obtains pricing information. However, the ((~~department~~)) agency 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~~)) agency. The ((~~department~~)) agency considers all of the following when establishing the pricing cluster:

(i) A client's medical needs;

(ii) Product quality;

(iii) Cost; and

(iv) Available alternatives.

(c) When establishing the fee for medical supplies or other nonDME items in a pricing cluster, the maximum allowable fee is the median amount of available manufacturers' list prices.

(3) The ((~~department~~)) agency evaluates a by-report (BR) item, procedure, or service for its medical necessity, appropriateness and reimbursement value on a case-by-case basis. The ((~~department~~)) agency calculates the reimbursement rate at eighty-five percent of the manufacturer's ((~~list~~)) suggested retail price as of July 31st of the base year or one hundred twenty-five percent of the wholesale acquisition cost from the manufacturer's invoice.

(4) For clients residing in skilled nursing facilities, see WAC ((~~388-543-5700~~)) 182-543-5700.

WSR 11-23-067
EMERGENCY RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 11-298—Filed November 14, 2011, 3:20 p.m., effective November 21, 2011, 12:01 a.m.]

Effective Date of Rule: November 21, 2011, 12:01 a.m.

Purpose: Amend recreational fishing rules.

Citation of Existing Rules Affected by this Order: Repealing WAC 232-28-61900I; and amending WAC 232-28-619.

Statutory Authority for Adoption: RCW 77.12.047 and 77.04.020.

Under RCW 34.05.350 the agency for good cause finds that immediate adoption, amendment, or repeal of a rule is necessary for the preservation of the public health, safety, or general welfare, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the public interest.

Reasons for this Finding: These fish were grown as an opportunity to provide quality family trout fishing during the Thanksgiving weekend. The opener allows anglers to plan their trip to these lakes and equal access to these fish on the

day of the opener. There is insufficient time to adopt permanent rules.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 1, Amended 0, Repealed 1.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.

Date Adopted: November 14, 2011.

Joe Stohr
for Philip Anderson
Director

NEW SECTION

WAC 232-28-61900I Exceptions to statewide rules. Notwithstanding the provisions of WAC 232-28-619, effective November 21 through November 24, 2011, it is unlawful to fish in the following waters:

(1) Fort Borst Park Pond (Lewis Co.)
(2) South Lewis County Park Pond (Lewis Co.)
(3) Kress Lake (Cowlitz Co.)
(4) Battleground Lake (Clark Co.)
(5) Rowland Lake (Klickitat Co.)

REPEALER

The following section of the Washington Administrative Code is repealed effective November 25, 2011:

WAC 232-28-61900I	Exceptions to statewide rules.

WSR 11-23-072
EMERGENCY RULES
HEALTH CARE AUTHORITY
(Medicaid Program)

[Filed November 15, 2011, 10:25 a.m., effective November 15, 2011, 10:25 a.m.]

Effective Date of Rule: Immediately.

Purpose: In meeting the requirements of E2SHB 2082, the agency is amending WAC 182-538-063 to replace General assistance—Unemployable with medical care services program. The new incapacity-based medical care services program became effective November 1, 2011, under WSR 11-22-052.

Citation of Existing Rules Affected by this Order: Amending WAC 182-538-063.

Statutory Authority for Adoption: RCW 41.05.021, 74.09.035.

Other Authority: Chapter 36, Laws of 2011 (ESSHB [E2SHB] 2082).

Under RCW 34.05.350 the agency for good cause finds that state or federal law or federal rule or a federal deadline for state receipt of federal funds requires immediate adoption of a rule.

Reasons for this Finding: See Purpose statement above.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 1, Repealed 0.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 0, Amended 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 1, Repealed 0.

Date Adopted: November 14, 2011.

Kevin M. Sullivan
Rules Coordinator

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-538-063 ((~~GAU~~)) MCS clients residing in a designated mandatory managed care plan county. (1) In Laws of 2007, chapter 522, section 209 (13) and (14), the legislature authorized the department to provide coverage of certain medical and mental health benefits to clients who:

(a) ((~~Receive~~)) Are eligible for medical care services (MCS) under ((~~the general assistance unemployable (GAU) program~~)) WAC 182-508-0005; and

(b) Reside in a county designated by the ((~~department~~)) agency as a mandatory managed care plan county.

(2) The only sections of chapter ((~~388-538~~)) 182-538 WAC that apply to ((~~GAU~~)) MCS clients described in this section are incorporated by reference into this section.

(3) ((~~GAU~~)) MCS clients who reside in a county designated by the department as a mandatory managed care plan county must enroll in a managed care plan as required by WAC ((~~388-505-0110(7)~~)) 182-508-0001 to receive ((~~department-paid~~)) agency-paid medical care. ((~~A GAU~~)) An MCS client enrolled in an MCO plan under this section is defined as ((~~a GAU~~)) an MCS enrollee.

(4) ((~~GAU~~)) MCS clients are exempt from mandatory enrollment in managed care if they are American Indian or Alaska Native (AI/AN) and meet the provisions of 25 U.S.C. 1603 (c)-(d) for federally recognized tribal members and their descendants.

(5) The ((~~department~~)) agency exempts ((~~a GAU~~)) an MCS client from mandatory enrollment in managed care:

(a) If the ((~~GAU~~)) MCS client resides in a county that is not designated by the ((~~department~~)) agency as a mandatory MCO plan county; or

(b) In accordance with WAC ((~~388-538-130~~)) 182-538-130(3).

(6) The ((~~department~~)) agency ends ((~~a GAU~~)) an MCS enrollee's enrollment in managed care in accordance with WAC ((~~388-538-130~~)) 182-538-130(4).

(7) On a case-by-case basis, the ((~~department~~)) agency may grant ((~~a GAU~~)) an MCS client's request for exemption from managed care or ((~~a GAU~~)) an MCS enrollee's request to end enrollment when, in the ((~~department's~~)) agency's judgment:

(a) The client or enrollee has a documented and verifiable medical condition; and

(b) Enrollment in managed care could cause an interruption of treatment that could jeopardize the client's or enrollee's life or health or ability to attain, maintain, or regain maximum function.

(8) The ((~~department~~)) agency enrolls ((~~GAU~~)) MCS clients in managed care effective on the earliest possible date, given the requirements of the enrollment system. The ((~~department~~)) agency does not enroll clients in managed care on a retroactive basis.

(9) Managed care organizations (MCOs) that contract with the ((~~department~~)) agency to provide services to ((~~GAU~~)) MCS clients must meet the qualifications and requirements in WAC ((~~388-538-067~~)) 182-538-067 and ((~~388-538-095~~)) 182-538-095 (3)(a), (b), (c), and (d).

(10) The ((~~department~~)) agency pays MCOs capitated premiums for ((~~GAU~~)) MCS enrollees based on legislative allocations for the ((~~GAU~~)) MCS program.

(11) ((~~GAU~~)) MCS enrollees are eligible for the scope of care as described in WAC ((~~388-501-0060~~)) 182-501-0060 for medical care services (MCS) programs.

(a) ((~~A GAU~~)) An MCS enrollee is entitled to timely access to medically necessary services as defined in WAC ((~~388-500-0005~~)) 182-500-0070;

(b) MCOs cover the services included in the managed care contract for ((~~GAU~~)) MCS enrollees. MCOs may, at their discretion, cover services not required under the MCO's contract for ((~~GAU~~)) MCS enrollees;

(c) The ((~~department~~)) agency pays providers on a fee-for-service basis for the medically necessary, covered medical care services not covered under the MCO's contract for ((~~GAU~~)) MCS enrollees;

(d) ((~~A GAU~~)) An MCS enrollee may obtain:

(i) Emergency services in accordance with WAC ((~~388-538-100~~)) 182-538-100; and

(ii) Mental health services in accordance with this section.

(12) The ((~~department~~)) agency does not pay providers on a fee-for-service basis for services covered under the MCO's contract for ((~~GAU~~)) MCS enrollees, even if the MCO has not paid for the service, regardless of the reason. The MCO is solely responsible for payment of MCO-contracted healthcare services that are:

(a) Provided by an MCO-contracted provider; or

(b) Authorized by the MCO and provided by nonparticipating providers.

(13) The following services are not covered for ((~~GAU~~)) MCS enrollees unless the MCO chooses to cover these services at no additional cost to the ((~~department~~)) agency:

(a) Services that are not medically necessary;

(b) Services not included in the medical care services scope of care, unless otherwise specified in this section;

(c) Services, other than a screening exam as described in WAC ((~~388-538-100~~)) 182-538-100(3), received in a hospital emergency department for nonemergency medical conditions; and

(d) Services received from a nonparticipating provider requiring prior authorization from the MCO that were not authorized by the MCO.

(14) A provider may bill ((~~a GAU~~)) an MCS enrollee for noncovered services described in subsection (12) of this section, if the requirements of WAC ((~~388-502-0160~~)) 182-502-0160 and ((~~388-538-095~~)) 182-538-095(5) are met.

(15) Mental health services and care coordination are available to ((~~GAU~~)) MCS enrollees on a limited basis, subject to available funding from the legislature and an appropriate delivery system.

(16) A care coordinator (a person employed by the MCO or one of the MCO's subcontractors) provides care coordination to ((~~a GAU~~)) an MCS enrollee in order to improve access to mental health services. Care coordination may include brief, evidenced-based mental health services.

(17) To ensure ((~~a GAU~~)) an MCS enrollee receives appropriate mental health services and care coordination, the ((~~department~~)) agency requires the enrollee to complete at least one of the following assessments:

(a) A physical evaluation;

(b) A psychological evaluation;

(c) A mental health assessment completed through the client's local community mental health agency (CMHA) and/or other mental health agencies;

(d) A brief evaluation completed through the appropriate care coordinator located at a participating community health center (CHC);

(e) An evaluation by the client's primary care provider (PCP); or

(f) An evaluation completed by medical staff during an emergency room visit.

(18) ((~~A GAU~~)) An MCS enrollee who is screened positive for a mental health condition after completing one or more of the assessments described in subsection (17) of this section may receive one of the following levels of care:

(a) **Level 1.** Care provided by a care coordinator when it is determined that the ((~~GAU~~)) MCS enrollee does not require Level 2 services. The care coordinator will provide the following, as determined appropriate and available:

(i) Evidenced-based behavioral health services and care coordination to facilitate receipt of other needed services.

(ii) Coordination with the PCP to provide medication management.

(iii) Referrals to other services as needed.

(iv) Coordination with consulting psychiatrist as necessary.

(b) **Level 2.** Care provided by a contracted provider when it is determined that the ((~~GAU~~)) MCS enrollee requires services beyond Level 1 services. A care coordinator

refers the ((~~GAU~~)) MCS enrollee to the appropriate provider for services:

(i) A regional support network (RSN) contracted provider; or

(ii) A contractor-designated entity.

(19) Billing and reporting requirements and payment amounts for mental health services and care coordination provided to ((~~GAU~~)) MCS enrollees are described in the contract between the MCO and the ((~~department~~)) agency.

(20) The total amount the ((~~department~~)) agency pays in any biennium for services provided pursuant to this section cannot exceed the amount appropriated by the legislature for that biennium. The ((~~department~~)) agency has the authority to take whatever actions necessary to ensure the ((~~department~~)) agency stays within the appropriation.

(21) Nothing in this section shall be construed as creating a legal entitlement to any ((~~GAU~~)) MCS client for the receipt of any medical or mental health service by or through the ((~~department~~)) agency.

(22) An MCO may refer enrollees to the ((~~department's~~)) agency's patient review and coordination (PRC) program according to WAC ((~~388-501-0135~~)) 182-501-0135.

(23) The grievance and appeal process found in WAC ((~~388-538-110~~)) 182-538-110 applies to ((~~GAU~~)) MCS enrollees described in this section.

(24) The hearing process found in chapter ((~~388-02~~)) 182-526 WAC and WAC ((~~388-538-112~~)) 182-538-112 applies to ((~~GAU~~)) MCS enrollees described in this section.

WSR 11-23-074
EMERGENCY RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Economic Services Administration)

[Filed November 15, 2011, 12:37 p.m., effective November 15, 2011, 12:37 p.m.]

Effective Date of Rule: Immediately.

Purpose: The DSHS division of child support (DCS) is adopting these third emergency rules to implement changes in the federal regulations concerning establishing and enforcing intergovernmental child support obligations. The federal rules being implemented in this rule-making order are 45 C.F.R. Parts 301.1, 302.35, 302.36, 303.3, 303.7, 303.11, 303.20, 305.63, 307.13, and 308.2.

The public rule-making hearing on these rules was first set for August 9, 2011, under WSR 11-13-108. DCS filed a supplemental CR-102 Notice of proposed rule making, because we made significant changes to the text of the rules prior to the hearing date. The supplemental CR-102, published as WSR 11-18-098, set the rule-making hearing for October 25, 2011. The CR-103P Rule-making order, was filed with rules and policies assistance unit on October 26, 2011, and it was published as WSR 11-22-116 on November 2, 2011, under RCW 34.05.380(2), the effective date of the final rules will be December 3, 2011.

This rule-making project is necessary to implement federal regulations concerning intergovernmental child support cases. DCS filed emergency rules with an effective date of March 31, 2011, under WSR 11-08-020, under RCW 34.05.350(2), those rules expired one hundred twenty days after filing, on July 29, 2011. On July 21, 2011, DCS filed a second set of emergency rules with an effective date of July 30, 2011, under WSR 11-16-006, under RCW 34.05.350(2), those rules will expire one hundred twenty days after filing, on November 18, 2011, which means that they will expire before the final rules take effect on December 3, 2011.

DCS is filing this third emergency rule package in order to keep the rules in effect until after the CR-103P is filed and the thirty-day period required under RCW 34.05.380(2) has run.

THE RULES ADOPTED IN THIS THIRD EMERGENCY FILING ARE IDENTICAL TO THE PRIOR EMERGENCY RULES.

Citation of Existing Rules Affected by this Order: Amending WAC 388-14A-2080 Once DCS opens a support enforcement case, under what circumstances can it be closed?, 388-14A-2085 Under what circumstances may DCS ((~~deny~~)) keep a support enforcement case open despite a request to close ((~~a support enforcement case~~)) it?, 388-14A-2090 Who ((~~is mailed~~)) receives notice ((~~of DCS' intent to close~~)) when DCS closes a case?, 388-14A-2097 What happens to payments that come in after a case is closed?, 388-14A-2160 ((~~If my information is confidential, can~~)) On what authority does DCS ((~~report me to~~)) share my confidential information with a credit bureau?, 388-14A-3130 What happens if a ((~~parent~~)) party makes a timely request for hearing on a support establishment notice?, 388-14A-3304 The division of child support may serve a notice of support debt and demand for payment when it is enforcing a support order issued in Washington state, a foreign court order or a foreign administrative order for support, 388-14A-3305 What can I do if I disagree with a notice of support debt and demand for payment?, 388-14A-3306 Does a notice of support debt and demand for payment result in a final determination of support arrears?, 388-14A-3307 How does the division of child support proceed when there are multiple child support orders for the same obligor and children?, 388-14A-7100 The division of child support may register an order from another state for enforcement or modification, 388-14A-7305 How ((~~do I~~)) does a party, IV-D agency or jurisdiction ask ((~~DCS to do~~)) for a determination of controlling order?, 388-14A-7325 How does DCS notify the parties ((~~of its~~)) that a determination of the controlling order ((~~has been~~)) is going to be made? and 388-14A-7335 What happens if someone objects to ((~~DCS' proposed~~)) a notice of support debt and registration which contains a determination of the presumed controlling order?; and new WAC 388-14A-2081 Under what circumstances can DCS close a case when the application for services was made directly to DCS? and 388-14A-2083 Under what circumstances can DCS close an intergovernmental case, otherwise known as a case where the application for services was originally made to another state, tribe, territory or country?

Statutory Authority for Adoption: RCW 26.23.120, 34.05.350 (1)(b), 43.20A.550, 74.04.055, 74.08.090, 74.20.040(9), 74.20A.310.

Other Authority: 45 C.F.R. Parts 301.1, 302.35, 302.36, 303.3, 303.7, 303.11, 303.20, 305.63, 307.13, and 308.2.

Under RCW 34.05.350 the agency for good cause finds that state or federal law or federal rule or a federal deadline for state receipt of federal funds requires immediate adoption of a rule.

Reasons for this Finding: 45 C.F.R. Parts 301.1, 302.35, 302.36, 303.3, 303.7, 303.11, 303.20, 305.63, 307.13, and 308.2.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 3, Amended 13, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 0, Amended 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 3, Amended 13, Repealed 0.

Date Adopted: November 9, 2011.

Katherine I. Vasquez
Rules Coordinator

AMENDATORY SECTION (Amending WSR 01-03-089, filed 1/17/01, effective 2/17/01)

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

(1) ((~~There is no current support order, and the support debt owed by the noncustodial parent (NCP) is less than five hundred dollars, or cannot be enforced under Washington law;~~)) The circumstances under which the division of child support (DCS) may close a case depend on whether the application for services was made directly to DCS or to another governmental entity.

(2) ((~~The NCP or putative (alleged) father is dead with no assets, income or estate available for collection;~~)) WAC 388-14A-2081 discusses closure of a case when one of the parties submitted an application for support enforcement services directly to DCS, which includes when DCS opened the case as the result of an application for public assistance in the state of Washington.

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

~~(a) Institutionalized in a psychiatric facility;~~

~~(b) Incarcerated without possibility of parole; or~~

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

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

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

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

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

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

~~(9) DCS cannot obtain a paternity order because:~~

~~(a) The putative father is dead;~~

~~(b) Genetic testing has excluded all putative fathers;~~

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

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

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

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

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

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

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

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

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

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

~~(15) Any other circumstances exist which would allow closure under 45 C.F.R. 303.11 or any other federal statute or regulation~~)) WAC 388-14A-2083 discusses closure of an intergovernmental case, which is what we call a case where the application for services was made to the child support enforcement agency of another state, tribe, territory, country or political subdivision thereof, which then requested support enforcement services from DCS.

NEW SECTION

WAC 388-14A-2081 Under what circumstances can DCS close a case when the application for services was made directly to DCS? When the application for services was made directly to the division of child support (DCS) by one of the parties, including when DCS opened the case as the result of an application for public assistance in the state of Washington, the case must remain open unless DCS determines that:

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

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

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

(a) Institutionalized in a psychiatric facility;

(b) Incarcerated without possibility of parole; or

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

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

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

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

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

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

(9) DCS cannot obtain a paternity order because:

(a) The putative father is dead;

(b) Genetic testing has excluded all putative fathers;

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

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

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

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

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

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

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

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

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

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

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

NEW SECTION

WAC 388-14A-2083 Under what circumstances can DCS close an intergovernmental case, otherwise known as a case where the application for services was originally made to another state, tribe, territory or country? (1) When the application for services was originally made by a party to the child support enforcement agency of another state, tribe, territory, country or political subdivision thereof, which then requested support enforcement services from the division of child support (DCS), DCS keeps the case open until:

(a) The state, tribe, territory, country or political subdivision that received the application for services tells DCS that its case is closed.

(b) The state, tribe, territory, country or political subdivision that received the application for services tells DCS that it no longer wants DCS to provide services.

(c) DCS documents failure to cooperate by the initiating jurisdiction, and that cooperation is essential for the next step in enforcement.

(2) DCS calls this type of case an "intergovernmental case."

(a) The state, tribe, territory, country or political subdivision thereof which referred the case to DCS is called the "initiating jurisdiction."

(b) In these cases, DCS is the "responding jurisdiction."

AMENDATORY SECTION (Amending WSR 01-03-089, filed 1/17/01, effective 2/17/01)

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

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

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

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

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

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

(2) If DCS is the responding jurisdiction in an intergovernmental case DCS cannot deny a request from the initiating jurisdiction to close the intergovernmental portion of a DCS case.

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

(((~~(3)~~)) (4) If a superior court order specifies that the noncustodial parent (NCP) must make payments to the WSSR, but the CP does not want support enforcement services, DCS ((~~keeps the case open as~~)) changes the case status to a payment services only (PSO) case, which means that:

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

(b) DCS does not provide enforcement services.

AMENDATORY SECTION (Amending WSR 01-03-089, filed 1/17/01, effective 2/17/01)

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

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

~~(b) DCS does not provide sixty days' prior notice when closing a case under WAC 388-14A-2080(4)~~)) The reason for case closure determines whether the division of child support (DCS):

(a) Sends a notice of intent to close;

(b) Sends a notice of case closure; or

(c) Notifies the other jurisdiction.

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

(3) ((~~In an interstate case, DCS mails the notice to the CP by regular mail in care of the other state's child support agency~~)) If DCS is closing a case under WAC 388-14A-2081, DCS sends a notice of intent to close, advising the parties why DCS is closing the case. DCS sends the notice sixty days before closing the case, except:

(a) DCS sends a notice of case closure but does not send a notice of intent to close when the applicant or recipient of nonassistance services submits a written request for closure, and there is no current assignment of medical or support rights;

(b) DCS notifies the initiating jurisdiction in an intergovernmental case that DCS has closed the case after the initiating jurisdiction requests case closure; and

(c) DCS does not send a notice of intent to close or a notice of case closure when:

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

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

(4) If DCS is the responding jurisdiction and is closing an ((~~interstate~~)) intergovernmental case because of noncooperation by the initiating jurisdiction, DCS ((~~also mails the notice to~~)) notifies the other state's child support agency sixty days before closing the case.

(5) When DCS is the initiating jurisdiction in an intergovernmental case and DCS closes its case, DCS notifies the responding jurisdiction that DCS has closed its case and provides the reason for closure.

AMENDATORY SECTION (Amending WSR 01-03-089, filed 1/17/01, effective 2/17/01)

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

(2) If DCS, as the initiating jurisdiction in an intergovernmental case, closed a case without notifying the responding jurisdiction, DCS must attempt to locate the custodial parent (CP) and disburse any payments the CP is entitled to receive.

Reviser's note: The typographical error in the above section occurred in the copy filed by the agency and appears in the Register pursuant to the requirements of RCW 34.08.040.

AMENDATORY SECTION (Amending WSR 06-06-076, filed 2/28/06, effective 3/31/06)

WAC 388-14A-2160 ((~~If my information is confidential, can~~)) On what authority does DCS ((~~report me to~~)) share my confidential information with a credit bureau? (1) ((~~When a consumer reporting agency, sometimes called a credit bureau, requests information regarding the amount of overdue support owed by a noncustodial parent (NCP), the division of child support (DCS) provides this information~~)) Under 42 USC §666(7), the division of child support (DCS) may report to consumer reporting agencies the name of any noncustodial parent (NCP) who is delinquent in support and the amount of overdue support owed by that parent. Consumer reporting agencies are sometimes also called credit bureaus.

(2) ((~~In addition to responding to requests for information by consumer reporting agencies~~)) Once DCS has reported an NCP to the credit bureaus, DCS ((~~reports to those agencies information regarding overdue support owed by an NCP. DCS then~~)) updates the information on a regular basis as long as DCS continues to enforce the support order, even after the NCP brings the account current.

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

(4) The notice gives the NCP ten days from the date of the notice to request a conference board under WAC 388-14A-6400 to contest the accuracy of the information. If the NCP requests a conference board, DCS does not release the information until a conference board decision has been issued.

(5) ((~~A noncustodial parent (NCP)~~)) An NCP who disagrees with the information supplied by DCS to a consumer reporting agency or credit bureau may file a notice of dispute under the federal Fair Credit Reporting Act, 15 USC 1681.

(6) For interstate or intergovernmental cases, either the initiating jurisdiction or the responding jurisdiction, or both, may report the NCP's debt to the credit bureaus.

AMENDATORY SECTION (Amending WSR 02-06-098, filed 3/4/02, effective 4/4/02)

WAC 388-14A-3130 What happens if a ((~~parent~~)) party makes a timely request for hearing on a support establishment notice? (1) A timely request for hearing is an objection made within the time limits of WAC 388-14A-3110. For late (or untimely) hearing requests, see WAC 388-14A-3135.

(2) If either parent makes a timely request for hearing, the division of child support (DCS) submits the hearing request to the office of administrative hearings (OAH) for scheduling.

(3) OAH sends a notice of hearing by first class mail to all parties at their address last known to DCS, notifying each party of the date, time and place of the hearing. DCS, the noncustodial parent (NCP), and the custodial parent are all parties to the hearing.

(4) A timely request for hearing stops the support establishment notice from becoming a final order, so DCS cannot collect on the notice. However, in appropriate circumstances, the administrative law judge (ALJ) may enter a temporary support order under WAC 388-14A-3850.

(5) A hearing on an objection to a support establishment notice is for the limited purpose of resolving the NCP's accrued support debt and current support obligation. The NCP has the burden of proving any defenses to liability.

AMENDATORY SECTION (Amending WSR 07-08-055, filed 3/29/07, effective 4/29/07)

WAC 388-14A-3304 The division of child support may serve a notice of support debt and demand for payment when it is enforcing a support order issued in Washington state, a foreign court order or a foreign administrative order for support. (1) The division of child support (DCS) may serve a notice of support debt and demand for payment on a noncustodial parent (NCP) under RCW 74.20A.040 to provide notice that DCS is enforcing a support order entered in Washington state, a foreign court order or a foreign administrative order for support.

(a) A "foreign" order is one entered in a jurisdiction other than a Washington state court or administrative forum.

(b) DCS uses the notice of support debt and demand for payment when there is only one current child support order for the NCP and the children in the case.

(c) When there are multiple current support orders for the same obligor and children, DCS determines which order to enforce as provided under WAC 388-14A-3307.

(2) DCS serves a notice of support debt and demand for payment like a summons in a civil action or by certified mail, return receipt requested.

(3) In a notice of support debt and demand for payment, DCS includes the information required by RCW 74.20A.040, the amount of current and future support, accrued support debt, interest (if interest is being assessed under WAC 388-14A-7110), any health insurance coverage obligation, and any day care costs under the court or administrative order.

(4) After service of a notice of support debt and demand for payment, the NCP must make all support payments to the Washington state support registry. DCS does not credit payments made to any other party after service of a notice of support debt and demand for payment except as provided in WAC 388-14A-3375.

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

(a) Files a request with DCS for a conference board under WAC 388-14A-6400. The effective date of a conference board request is the date DCS receives the request;

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

(c) Objects to either the validity of the foreign support order or the administrative enforcement of the foreign support order, in which case DCS proceeds with registration of the foreign support order under WAC 388-14A-7100.

(6) ((~~A notice of support debt and demand for payment served in another state becomes final according to WAC 388-14A-7200~~)) RCW 26.21A.515 controls the calculation of the debt on a notice of support debt and demand for payment.

(7) Enforcement of the following are not stayed by a request for a conference board or hearing under this section or WAC 388-14A-6400:

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

(b) Any portion of the support debt that the NCP and custodial parent (CP) fail to claim is not owed.

(8) Following service of the notice of support debt and demand for payment on the NCP, DCS mails to the last known address of the CP and/or the payee under the order:

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

(b) A notice to payee under WAC 388-14A-3315 regarding the payee's rights to contest the notice of support debt. The CP who is not the payee under the order has the same rights to contest the notice of support debt and demand for payment.

(9) If the NCP requests a conference board under subsection (5)(a) of this section, DCS mails a copy of the notice of conference board to the CP informing the CP of the CP's right to:

(a) Participate in the conference board; or

(b) Request a hearing under WAC 388-14A-3321 within twenty days of the date of a notice of conference board that was mailed to a Washington address. If the notice of conference board was mailed to an out-of-state address, the CP may request a hearing within sixty days of the date of the notice of conference board. The effective date of a hearing request is the date DCS receives the request.

(10) If the CP requests a hearing under subsection ((~~(9)~~)) (8)(b) of this section, DCS must:

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

(b) Notify the NCP of the hearing.

(11) If a CP requests a late hearing under subsection ((~~(8)~~)) (7) of this section, the CP must show good cause for filing the late request.

(12) The NCP is limited to a conference board to contest the notice and may not request a hearing on a notice of support debt and demand for payment. However, if the CP requests a hearing, the NCP may participate in the hearing.

(13) A notice of support debt and demand for payment must fully and fairly inform the NCP of the rights and responsibilities in this section.

AMENDATORY SECTION (Amending WSR 07-08-055, filed 3/29/07, effective 4/29/07)

WAC 388-14A-3305 What can I do if I disagree with a notice of support debt and demand for payment? Once the division of child support has served a notice of support debt and demand for payment, either party may disagree with the notice.

(1) If either party objects to the enforcement of a non-Washington support order, that party may request that DCS register that order under chapter 26.21A RCW. DCS then serves a notice of support debt and registration as provided in WAC ((~~388-14A-7110~~)) 388-14A-7100.

(2) If the noncustodial parent (NCP) objects to the amount of current support or the amount of support debt stated in the notice, the NCP may request a conference board under WAC 388-14A-6400.

(a) The custodial parent (CP) may participate in the conference board under this section.

(b) The CP may choose to convert the proceeding to an administrative hearing. The NCP may participate in a hearing held under this section.

(3) If the custodial parent objects to the amount of current support or the amount of support debt stated in the notice, the CP may request an administrative hearing. The NCP may participate in a hearing held under this section.

(4) See WAC 388-14A-3304 for a more full description of the hearing process on the notice of support debt and demand for payment.

AMENDATORY SECTION (Amending 07-08-055, filed 3/29/07, effective 4/29/07)

WAC 388-14A-3306 Does a notice of support debt and demand for payment result in a final determination of support arrears? (1) After service of a notice of support debt and demand for payment as provided in WAC 388-14A-3304, the final administrative order determines the support debt as of the date of the order, and:

(a) The debt determination is not a final determination under the Uniform Interstate Family Support Act (UIFSA), chapter 26.21A RCW.

(b) ((~~Any party may request that a tribunal determine any amounts owed as interest on the support debt~~)) RCW 26.21A.515 controls in any computation and/or determination of accrued interest on arrearages under the support order.

(2) The final administrative order comes about by:

(a) Operation of law if nobody objects to the notice;

(b) Agreed settlement or consent order under WAC 388-14A-3600;

(c) Final conference board decision under WAC 388-14A-6400;

(d) Final administrative order entered after hearing or a party's failure to appear for hearing.

AMENDATORY SECTION (Amending WSR 07-08-055, filed 3/29/07, effective 4/29/07)

WAC 388-14A-3307 How does the division of child support proceed when there are multiple child support orders for the same obligor and children? When more than one current child support order exists for the same obligor and children, the division of child support (DCS) may proceed as follows:

(1) When not acting as a responding jurisdiction, DCS decides whether or not a determination of controlling order is necessary, and which state has the authority to make a determination of controlling order (DCO) under UIFSA.

(2) Using the criteria listed in RCW 26.21A.130, DCS ((~~decides~~)) may decide which child support order it should enforce and ((~~serves~~)) may serve a notice of support debt and demand for payment under WAC 388-14A-3304.

(2) ((~~If DCS decides that a determination of controlling order under chapter 26.21A RCW is required~~)) When a party objects to enforcement of the order selected for enforcement under subsection (1) of this section, or when the order that DCS decides to enforce is not the order presented by a party or another jurisdiction for enforcement of current support, DCS ((~~serves~~)) may serve a notice of support debt and registration as provided in WAC 388-14A-7100.

(3) ((~~Upon request, DCS may do a determination of controlling order (DCO).~~

~~(a) See~~)) WAC 388-14A-7305 ((~~for~~)) describes how ((~~you~~)) either party or the initiating jurisdiction can ask for a DCO.

((~~(b) See~~)) (4) WAC 388-14A-7315 ((~~for~~)) describes how DCS decides whether ((~~or not~~)) to ((~~do~~)) deny a request for a DCO.

((~~(4)~~)) (5) If DCS ((~~does~~)) reviews the orders in response to a request for a DCO and decides that a Washington order is the presumed controlling order, DCS refers the case to superior court.

((~~(5)~~)) (6) If DCS ((~~does~~)) reviews the orders in response to a request for a DCO and decides that a non-Washington order is the presumed controlling order, DCS serves a notice of support debt and registration as provided in WAC 388-14A-7325.

Reviser's note: The typographical error in the above section occurred in the copy filed by the agency and appears in the Register pursuant to the requirements of RCW 34.08.040.

AMENDATORY SECTION (Amending WSR 07-08-055, filed 3/29/07, effective 4/29/07)

WAC 388-14A-7100 The division of child support may register an order from another state for enforcement or modification. (1) A support enforcement agency, or a party to a child support order or an income-withholding order for support issued by a tribunal of another state or jurisdiction, may register the order in this state for enforcement pursuant to chapter 26.21A RCW.

(a) At the option of the division of child support (DCS), the support order or income-withholding order may be regis-

tered with the superior court pursuant to RCW 26.21A.505 or it may be registered with the administrative tribunal according to subsection (2) of this section. Either method of registration is valid.

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

(c) DCS may enforce a registered order issued in another state or jurisdiction in the same manner and subject to the same procedures as an order issued by a tribunal of this state.

(d) DCS may assess and collect interest on amounts owed under support orders entered or established in a jurisdiction other than the state of Washington as provided in WAC 388-14A-7110.

(e) DCS may notify the parties that it is enforcing a non-Washington support order using the notice of support debt and demand for payment under WAC 388-14A-3304 or using the notice of support debt and registration as provided in this section and in WAC 388-14A-7110. Either method of notice is valid.

(2) DCS must give notice to the nonregistering party when it administratively registers a support order or income-withholding order issued in another state or jurisdiction. DCS gives this notice with the Notice of Support Debt and Registration (NOSDR).

(a) The notice must inform the nonregistering party:

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

(ii) That if a party wants a hearing to contest the validity or enforcement of the registered order, the party must request a hearing within twenty days after service of the notice on the nonregistering party within Washington state. If the nonregistering party was served with the notice outside of Washington state, the party has sixty days after service of the notice to request a hearing to contest the validity or enforcement of the registered order;

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

(iv) Of the amount of any alleged arrearages, including interest, if interest is being assessed under WAC 388-14A-7110; and

(v) Whether DCS has made a determination of controlling order under chapter 26.21A RCW, as described in WAC 388-14A-7325.

(b) The notice must be:

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

(ii) Served on the registering party by first class mail at the last known address; and

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

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

(3) A party or support enforcement agency seeking to modify, or to modify and enforce, a child support order issued in another state or jurisdiction may register the order in this state according to RCW 26.21A.540 through 26.21A.550.

(a) The order must be registered as provided in subsection (1)(a) if the order has not yet been registered.

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

(c) DCS may enforce a child support order of another state or jurisdiction registered for purposes of modification, as if a tribunal of this state had issued the order, but the registered order may be modified only if the requirements of RCW 26.21A.550 are met.

(4) Interpretation of the registered order is governed by RCW 26.21A.515.

AMENDATORY SECTION (Amending WSR 07-08-055, filed 3/29/07, effective 4/29/07)

WAC 388-14A-7305 How ((~~do I~~)) does a party, IV-D agency or jurisdiction ask ((~~DCS to do~~)) for a determination of controlling order? (1) When there are multiple current support orders covering the same obligor and the same children, a party to a support order may request that the division of child support (DCS) make a determination of controlling order under the Uniform Interstate Family Support Act, chapter 26.21A RCW.

(2) When another state's IV-D agency or another jurisdiction has identified that there are multiple support orders in existence and DCS has personal jurisdiction over both of the parties to the orders, the IV-D agency or jurisdiction may request a determination of controlling order from DCS.

(3) A request for a determination of controlling order may be made at any time, unless there has already been a determination of controlling order for the same obligor and children.

((~~(3)~~)) (4) DCS can provide a form which contains all the required elements for a request for determination of controlling order. A request for a determination of controlling order:

(a) Must be in writing;

(b) Must contain copies of any child support orders known to the requesting party. DCS waives this requirement if DCS has a true copy of the order on file; and

(c) ((~~State the reason the requesting party thinks DCS is enforcing the wrong~~)) Must identify the order that the requesting party believes should be the controlling order.

((~~(4)~~)) (5) A request for determination of controlling order does not constitute a petition for modification of a support order.

AMENDATORY SECTION (Amending WSR 07-08-055, filed 3/29/07, effective 4/29/07)

WAC 388-14A-7325 How does DCS notify the parties ((~~of its~~)) that a determination of the controlling order is going to be made? (1) When the division of child support (DCS) decides that a determination of controlling order is required, or when a party, IV-D agency or jurisdiction asks for a determination of controlling order, DCS reviews the

multiple child support orders for the same obligor and children to determine which order should be enforced.

(a) If DCS decides that the order that should be enforced is a Washington order, ((~~we immediately~~)) DCS refers the matter to the superior court for a determination of controlling order proceeding under chapter 26.21A RCW.

(b) If ((~~we~~)) DCS decides that the order that should be enforced is an order which was not entered in the state of Washington, DCS follows the procedures set out in subsections (2) through (4) of this section.

(2) DCS serves a notice of support debt and registration (((~~NOSDR~~))) as provided in WAC 388-14A-7100. DCS serves the ((~~NOSDR~~)) notice of support debt and registration on the obligor, the obligee, and on all identified interested parties. The ((~~NOSDR~~)) notice of support debt and registration includes a determination of controlling order.

(3) DCS serves the notice of support debt and registration on ((~~the nonrequesting~~)) a party who did not request the determination of controlling order by certified mail, return receipt requested, or by personal service.

(4) DCS serves the notice on the ((~~requesting~~)) party who requested the determination of controlling order and on any other identified interested parties by first class mail to the last known address.

AMENDATORY SECTION (Amending WSR 07-08-055, filed 3/29/07, effective 4/29/07)

WAC 388-14A-7335 What happens if someone objects to ((~~DCS' proposed~~)) a notice of support debt and registration which contains a determination of the presumed controlling order? (1) If any party, IV-D agency or jurisdiction objects to the ((~~proposed~~)) determination of presumed controlling order issued under WAC 388-14A-7325, that objection must be in writing and signed under penalty of perjury. The division of child support (DCS) provides an objection form with the notice of support debt and registration.

(2) ((~~The~~)) An objection to the determination of presumed controlling order must contain:

(a) The reason the party, IV-D agency or jurisdiction objects ((~~to the determination of controlling order~~)). Examples of reasons to object include, but are not limited to:

(i) There is another order that was not considered in making the determination;

(ii) The alleged controlling order has been vacated, suspended or modified by a later order, which is attached to the objection;

(iii) The issuing tribunal lacked personal jurisdiction over the nonpetitioning party;

(iv) The order was obtained by fraud; or

(v) Any other legal defense available under chapter 26.21A RCW.

(b) A copy of the order which the party, IV-D agency or jurisdiction believes should be the controlling order, if that order was not included with the notice.

(c) A statement of facts in support of the ((~~party's~~)) objection.

(((~~2~~))) (3) When DCS receives an objection to the proposed determination of controlling order, DCS refers the objection to the prosecuting attorney or attorney general to bring an action for determination of controlling order under RCW 26.21A.130 in the superior court.

WSR 11-23-075
EMERGENCY RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Economic Services Administration)

[Filed November 15, 2011, 12:38 p.m., effective November 15, 2011, 12:38 p.m.]

Effective Date of Rule: Immediately.

Purpose: The DSHS division of child support (DCS) is filing this second emergency rule to maintain the status quo as we complete the regular rule adoption process amending various sections in chapter 388-14A WAC to implement E2SHB 1267, chapter 283, Laws of 2011, which makes changes to the Uniform Parentage Act, contained in chapter 26.26 RCW. THESE RULES ARE EXACTLY THE SAME AS THE PRIOR EMERGENCY RULES.

The statutory changes took effect on July 22, 2011. DCS adopted emergency rules under WSR 11-16-007 in order to have our rule changes effective by July first. At the same time we filed this emergency rule-making order, DCS filed a CR-101 Preproposal statement of inquiry, to start the regular rule-making process. DCS filed the CR-102 Notice of proposed rule making, as WSR 11-20-099, the public rule-making hearing for adoption of permanent rules is set for November 8, 2011.

Citation of Existing Rules Affected by this Order: Amending WAC 388-14A-1020, 388-14A-3100, 388-14A-3102, and 388-14A-3115.

Statutory Authority for Adoption: E2SHB 1267 (chapter 283, Laws of 2011); RCW 34.05.220, 34.05.350 (1)(b), 43.20A.550, 74.04.055, 74.08.090, and 74.20A.310.

Under RCW 34.05.350 the agency for good cause finds that state or federal law or federal rule or a federal deadline for state receipt of federal funds requires immediate adoption of a rule.

Reasons for this Finding: These rules are adopted to implement E2SHB 1267, chapter 283, Laws of 2011, which makes changes to the Uniform Parentage Act, contained in chapter 26.26 RCW. E2SHB 1267's effective date is July 22, 2011, and DCS must adopt emergency rules in order to have rules effective by that date.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 4, Repealed 0.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 0, Amended 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 4, Repealed 0.

Date Adopted: November 10, 2011.

Katherine I. Vasquez
Rules Coordinator

AMENDATORY SECTION (Amending WSR 11-12-006, filed 5/19/11, effective 6/19/11)

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.

"Acknowledged father" means a man who has established a father-child relationship under RCW 26.26.300 through 26.26.375.

"Adjudicated parent" means a person who has been adjudicated by a court of competent jurisdiction to be the parent of a child.

"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 the division of child support (DCS) within the department of social and health services (DSHS).

"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.

"Cash medical support" is a term used in RCW 26.09.105 and certain federal regulations to refer to amounts paid by an obligated parent to the other parent or to the state in order to comply with the medical support obligation stated in a child support order.

"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.

"Determination of parentage" means the establishment of the parent-child relationship by the signing of a valid acknowledgment of paternity under RCW 26.26.300 through 26.26.375 or adjudication by the court.

"Differentiated support amount" means an amount of child support that represents a parent's support obligation for more than one child and may justifiably be divided into "per child" amounts for each child covered by the support order, based on information contained in the support order.

"Differentiated support order" means a child support order which provides a monthly amount of child support for two or more children, and either provides a specific support obligation for each child or provides enough information in the order so that the monthly amount may justifiably be divided into a "per child" amount for each child covered by the support order.

"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.

"Domestic partner" means a state registered domestic partner as defined in chapter 26.60 RCW.

"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 care costs" means medical expenses. Certain statutes in chapter 26.19 RCW refer to medical expenses as health care costs.

"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, med-

ical equipment (crutches, wheel chairs, prosthesis, etc.), pharmacy products, optometric care, dental care, orthodontic care, preventive care, mental health care, and physical therapy. Health insurance coverage does not include medical assistance provided under chapter 74.09 RCW.

"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 26.09.105, 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 any combination of the following:

(1) Health insurance coverage for a dependent child;

(2) Amounts owed by one parent to the other parent as a monthly payment toward the premium paid by the other parent for health insurance coverage for a dependent child;

(3) Amounts owed by a noncustodial parent to the state as a monthly payment toward the cost of managed care coverage for the child by the state, if the child receives state-financed medical coverage through the department under chapter 74.09 RCW for which there is an assignment; and

(4) Amounts owed by one parent to the other parent as his or her proportionate share of uninsured medical expenses for a dependent child.

"Monthly payment toward the premium" means a parent's contribution toward:

• Premiums paid by the other parent for insurance coverage for the child; or

• Amounts paid for managed care coverage for the child by the state, if the child receives state-financed medical coverage through the department under chapter 74.09 RCW for which there is an assignment.

This contribution is based on the obligated parent's proportionate share of the premium paid, but may not exceed twenty-five percent of the obligated parent's basic support obligation.

"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 or biological parent, adoptive parent, adjudicated parent, presumed 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.

"Nonmedical expenses" means amounts incurred on behalf of a child which are not medical expenses as defined in this chapter. Nonmedical expenses include, but are not limited to, day care or other special childrearing expenses such as tuition and long-distance transportation costs to and from the parents for visitation purposes.

"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.

"Parent" means an individual who has established a parent-child relationship under RCW 26.26.101.

"Parent-child relationship" means the legal relationship between a child and a parent of the child. The term

includes the mother-child relationship and the father-child relationship.

"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.

"Presumed parent" means a person who, by operation of law under RCW 26.26.116, is recognized as the parent of a child until that status is rebutted or confirmed in a judicial proceeding.

"Private insurance" means accessible health insurance for a child provided by a parent without the need for service of a national medical support notice, and does not include health insurance provided by the state without a contribution from either parent.

"Proportionate share" or **"proportional share"** means an amount equal to a parent's percentage share of the combined monthly net income of both parents as computed on the worksheets when determining a parent's child support obligation under chapter 26.19 RCW.

"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.

"Self-support reserve" or **"self support reserve"** means an amount equal to one hundred twenty-five percent of the federal poverty guideline for a one-person family.

"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.

"Support order" means a court order, administrative order or tribal court order which contains a determination, finding, decree or order that sets a child support obligation (including medical support) and orders either the payment of a set or determinable amount of money for current support and/or a support debt, or the provision of medical support, or both.

"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.

"Underlying order" means an existing child support order for which DCS serves a notice of support owed under RCW 26.23.110 to determine a sum certain support obligation.

"Undifferentiated support amount" means an amount of child support that represents a parent's support obligation for more than one child which cannot justifiably be divided into "per child" amounts for each child covered by the support order.

"Undifferentiated support order" means a child support order which provides a monthly amount of child support for two or more children, but does not provide a specific support obligation for each child or does not contain enough information in either the order or the worksheets associated with the order to justify dividing the monthly amount into "per child" amounts for each child covered by the support order.

"Uninsured medical expenses":

For the purpose of establishing or enforcing support obligations means:

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

(2) Premiums, copayments, or deductibles incurred on behalf of a child.

"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.

AMENDATORY SECTION (Amending WSR 11-12-006, filed 5/19/11, effective 6/19/11)

WAC 388-14A-3100 How does the division of child support establish a child support obligation when there is no child support order? (1) When there is no order setting the amount of child support a noncustodial parent (NCP) should pay, the division of child support (DCS) serves a support establishment notice on the NCP and the custodial parent (CP). A support establishment notice is an administrative notice that can become an enforceable order for support if nobody requests a hearing on the notice.

(2) DCS may serve a support establishment notice when there is no order that:

(a) Establishes the NCP's support obligation for the child(ren) named in the notice; or

(b) Specifically relieves the NCP of a support obligation for the child(ren) named in the notice.

(3) Whether support is based upon an administrative order or a court order, DCS may serve a support establishment notice when the parties to a paternity order subsequently marry each other and then separate, or parties to a decree of dissolution remarry each other and then separate. The remaining provisions of the paternity order or the decree of dissolution, including provisions establishing paternity, remain in effect.

(4) Depending on the legal relationship between the NCP and the child for whom support is being set and on the type of child support obligation which is being established, DCS serves one of the ((~~following~~)) support establishment notices((~~:~~)) listed in subsections (5), (6) or (7). WAC 388-14A-3102 describes which notice DCS uses to set the support obligation of a father who has signed a paternity acknowledgment or an affidavit of paternity.

(((~~(a) Notice~~)) (5) DCS may serve a notice and finding of financial responsibility (NFFR)((~~, see~~)) under WAC 388-14A-3115. ((~~This notice is used~~)) DCS uses this notice when the ((~~NCP is either the mother or the legal father of~~)) NCP's parentage of the child is based on:

(a) The presumption arising from the existence of a marriage or a registered domestic partnership;

(b) The entry of a court order adjudicating the parent-child relationship;

(c) The entry of an adoption order;

(d) The man's having signed and filed a paternity acknowledgment under RCW 26.26.300 through 26.26.375, unless the acknowledgment has been rescinded or successfully challenged; or

(e) The woman's being the biological mother of, and having given birth to, the child. ((~~WAC 388-14A-3102 describes when DCS uses a NFFR to set the support obligation of a father who has signed an acknowledgment or affidavit of paternity.~~

~~(b)~~)) (6) DCS may serve a notice and finding of parental responsibility (NFPR)((~~, see~~)) under WAC 388-14A-3120. ((~~This notice is used~~)) DCS uses this notice when the NCP was not married to the mother but has filed an affidavit or acknowledgment of paternity which did not become a conclusive presumption of paternity. ((~~WAC 388-14A-3102 describes when DCS uses a NFPR to set the support obligation of a father who has signed an acknowledgment or affidavit of paternity.~~

~~(c)~~)) (7) DCS may serve a "Medical support only" NFFR or NFPR((~~, which as of October 1, 2009, replaced the notice and finding of medical responsibility (NFMR), see~~)) under WAC 388-14A-3125. Until October 1, 2009, DCS used the notice and finding of medical responsibility (NRMR) for this purpose. A medical support only NFFR or NFPR, whichever is appropriate, is used when DCS seeks to set only a medical support obligation instead of a monetary child support obligation.

AMENDATORY SECTION (Amending WSR 05-12-136, filed 6/1/05, effective 7/2/05)

WAC 388-14A-3102 When the parents have signed an acknowledgment or affidavit of paternity, which support establishment notice does the division of child support serve on the noncustodial parent? (1) When the parents of a child are not married, they may sign an affidavit of paternity, also called an acknowledgment of paternity or a paternity acknowledgment. The legal effect of the affidavit or acknowledgment depends on when it is filed, in what state it is filed, and whether both parents were over age eighteen when the affidavit was signed.

(2) For affidavits or acknowledgments filed on or before July 1, 1997 with the center for health statistics in the state of Washington, the division of child support (DCS) serves a notice and finding of parental responsibility (NFPR)((~~. See~~)) under WAC 388-14A-3120.

(3) For affidavits or acknowledgments filed after July 1, 1997 with the center for health statistics in the state of Washington, DCS serves a notice and finding of financial responsibility (NFFR) under WAC 388-14A-3115, because the affidavit or acknowledgment has become a conclusive presumption of paternity under RCW 26.26.320.

(4) For acknowledgments or affidavits filed with the vital records agency of another state, DCS determines whether to serve a NFFR or NFPR depending on the laws of the state where the affidavit is filed.

(5) DCS relies on the acknowledgment or affidavit, even if the mother or father were not yet eighteen years of age at the time they signed or filed the acknowledgment or affidavit, as provided in RCW 26.26.315(4).

(6) If the mother was married at the time of the child's birth, but not to the man acknowledging paternity, the man to whom she was married must also have signed and filed a denial of paternity within ten days of the child's birth.

(7) If the acknowledgment or affidavit is legally deficient in any way, DCS may refer the case for paternity establishment in the superior court.

(8) If the mother is the noncustodial parent, DCS serves a NFFR.

AMENDATORY SECTION (Amending WSR 11-12-006, filed 5/19/11, effective 6/19/11)

WAC 388-14A-3115 The notice and finding of financial responsibility is used to set child support when paternity is not an issue. (1) A notice and finding of financial responsibility (NFFR) is an administrative notice served by the division of child support (DCS) that can become an enforceable order for support, pursuant to RCW 74.20A.055.

(2) DCS may serve a NFFR when the noncustodial parent (NCP) is a legal parent of the child, based on:

(a) The presumption arising from the existence of a marriage or registered domestic partnership;

(b) The entry of a court order adjudicating the parent-child relationship;

(c) The entry of an adoption order;

(d) The man's having signed and filed a paternity acknowledgment under RCW 26.26.300 through 26.26.375,

unless the acknowledgment has been rescinded or successfully challenged; or

(e) The woman's being the biological mother of, and having given birth to, the child.

(3) DCS serves a NFFR in the situations listed in this section and in WAC 388-14A-3100. There may be other bases on which a court can determine parentage and/or establish a child support obligation.

(4) The NFFR:

(a) Advises the noncustodial parent and the custodial parent (who can be either a parent or the physical custodian of the child) of the support obligation for the child or children named in the notice. The NFFR fully and fairly advises the parents of their rights and responsibilities under the NFFR.

(b) Includes the information required by RCW 26.23.050 and 74.20A.055.

(c) Includes a provision that both parents are obligated to provide medical support, as required by RCW 26.09.105, 26.18.170 and 26.23.050. This requirement does not apply to the custodial parent when the custodial parent is not one of the parents of the child covered by the order.

(d) Includes a provision that apportions the share of uninsured medical expenses to both the mother and the father, pursuant to RCW 26.09.105, 26.18.170 and 26.23.050.

(e) May include an obligation for the noncustodial parent to contribute his or her proportionate share of the cost of day care or childcare, which may be stated either as a sum certain amount per month, or as a proportion of the expenses incurred by the custodial parent.

(f) Warns the noncustodial parent (NCP) and the custodial parent (CP) that at an administrative hearing, the administrative law judge (ALJ) may set the support obligation in an amount higher or lower than, or different from, the amount stated in the NFFR, if necessary for an accurate support order.

(((~~3~~))) (5) As provided in WAC 388-14A-3125, DCS may serve a notice and finding of financial responsibility that can become an enforceable order for support to establish and enforce a health insurance obligation. This type of NFFR is called "medical support only" NFFR.

(((~~4~~))) (6) DCS uses a medical support only NFFR when the custodial parent has requested medical support enforcement services only and has asked DCS in writing not to collect monetary child support.

(((~~5~~))) (7) A medical support only NFFR does not include a monthly financial support obligation, but may include:

(a) An obligation to pay a monthly payment toward the premium paid by the CP or the state for health insurance coverage for the child(ren); and

(b) An obligation to pay a proportionate share of the child(ren)'s uninsured medical expenses.

(((~~6~~))) (8) An administrative order resulting from a medical support only NFFR may later be modified to include a monthly financial support obligation, as provided in WAC 388-14A-3925(2).

(((~~7~~))) (9) After service of the NFFR, the NCP and the CP must notify DCS of any change of address, or of any changes that may affect the support obligation.

(((~~8~~))) (10) The NCP must make all support payments to the Washington state support registry after service of the NFFR. DCS does not give the NCP credit for payments made to any other party after service of a NFFR, except as provided by WAC 388-14A-3375.

(((~~9~~))) (11) DCS may take immediate wage withholding action and enforcement action without further notice under chapters 26.18, 26.23, and 74.20A RCW when the NFFR is a final order. WAC 388-14A-3110 describes when the notice becomes a final order.

(((~~10~~))) (12) In most cases, a child support obligation continues until the child reaches the age of eighteen. WAC 388-14A-3810 describes when the obligation under the NFFR can end sooner or later than age eighteen.

(((~~11~~))) (13) If paternity has been established by an affidavit or acknowledgment of paternity, or paternity acknowledgment, DCS attaches a copy of the acknowledgment, affidavit, or certificate of birth record information to the notice. A party wishing to challenge the acknowledgment or denial of paternity may only bring an action in court to rescind or challenge the acknowledgment or denial of paternity under RCW 26.26.330 and 26.26.335.

(((~~12~~))) (14) If the parents filed a paternity affidavit ((~~or~~)) acknowledgment of paternity, or by a paternity acknowledgment in another state, and by that state's law paternity is therefore conclusively established, DCS may serve a NFFR to establish a support obligation.

(((~~13~~))) (15) A hearing on a NFFR is for the limited purpose of resolving the NCP's accrued support debt and current support obligation. The hearing is not for the purpose of setting a payment schedule on the support debt. The NCP has the burden of proving any defenses to liability.

WSR 11-23-081
RESCISSION OF EMERGENCY RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Aging and Disability Services Administration)

[Filed November 16, 2011, 2:24 p.m.]

Effective immediately upon filing, the department of social and health services, aging and disability services administration, rescinds emergency rules filed as WSR 11-22-073 on November 1, 2011. That filing amended rules under chapter 388-106 WAC.

Katherine I. Vasquez
Rules Coordinator

WSR 11-23-082
EMERGENCY RULES
DEPARTMENT OF
SOCIAL AND HEALTH SERVICES
(Aging and Disability Services Administration)
[Filed November 16, 2011, 3:07 p.m., effective November 16, 2011, 3:07 p.m.]

Effective Date of Rule: Immediately.

Purpose: The department is amending chapter 388-106 WAC, Long-term care services, to revise the assessment process for allocating personal care hours to disabled children as a result of the Washington state supreme court decision regarding the *Samantha A. v. Department of Social and Health Services*.

Citation of Existing Rules Affected by this Order: Repealing WAC 388-106-0126 and 388-106-0213; and amending WAC 388-106-0075 and 388-106-0130.

Statutory Authority for Adoption: RCW 74.08.090, 74.09.520.

Under RCW 34.05.350 the agency for good cause finds that immediate adoption, amendment, or repeal of a rule is necessary for the preservation of the public health, safety, or general welfare, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the public interest; and that state or federal law or federal rule or a federal deadline for state receipt of federal funds requires immediate adoption of a rule.

Reasons for this Finding: The department must revise its assessment process as soon as possible in order to allocate personal care services for children on a more individualized basis. The emergency rule is necessary in order to implement as soon as possible the state supreme court decision in *Samantha A. v. DSHS*. The department is proceeding with the permanent adoption as the CR-101 was filed as WSR 11-22-074 on November 1, 2011.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 2, Repealed 2; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 0, Amended 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 2, Repealed 2.

Date Adopted: November 16, 2011.

Katherine I. Vasquez
Rules Coordinator

AMENDATORY SECTION (Amending WSR 05-11-082, filed 5/17/05, effective 6/17/05)

WAC 388-106-0075 How is my need for personal care services assessed in CARE? ((~~To assess your need for personal care services,~~)) The department gathers information from you, your caregivers, family members((~~,~~)) and other sources to assess your abilities to perform personal care tasks. The department will also consider developmental milestones for children as defined in WAC 388-106-0130 when individually assessing your abilities and needs for assistance. The department will assess your ability to perform:

(1) Activities of daily living (ADL) using self performance((~~,~~)) support provided, status and assistance available, as defined in WAC 388-106-0010. Also, the department determines your need for "assistance with body care" and "assistance with medication management," as defined in WAC 388-106-0010; and

(2) Instrumental activities of daily living (IADL) using self performance((~~,~~)) difficulty, status and assistance available, as defined in WAC 388-106-0010.

AMENDATORY SECTION (Amending WSR 11-11-024, filed 5/10/11, effective 6/10/11)

WAC 388-106-0130 How does the department determine the number of hours I may receive for in-home care? (1) The department assigns a base number of hours to each classification group as described in WAC 388-106-0125.

(2) The department will ((~~deduct from the~~)) adjust base hours to account for informal supports, shared benefit, and age appropriate functioning (as those terms are defined in WAC 388-106-0010), ((~~or~~)) and other paid services that meet some of an individual's need for personal care services, including adult day health, as follows:

(a) The CARE tool determines the adjustment for informal supports ((~~by determining~~)), shared benefit, and age appropriate functioning; determines the amount of assistance available ((~~to meet your needs,~~)); assigns ((~~it~~)) a numeric ((~~percentage,~~)) value to those assessed indicators; and ((~~reduces~~)) adjusts the base hours assigned to the classification group by the numeric ((~~percentage~~)) value. The department has assigned the following numeric values for the amount of assistance available for each ADL and IADL:

Meds	Self Performance	Status	Assistance Available	Value ((~~Percentage~~))
Self administration of medications	Rules for all codes apply except independent is not counted	Unmet	N/A	1
		Met	N/A	0
		Decline	N/A	0

		Age appropriate functioning	N/A	0
		Partially met	<1/4 time	.9
			1/4 to 1/2 time	.7
			1/2 to 3/4 time	.5
			>3/4 time	.3
Unscheduled ADLs	**Self Performance**	**Status**	**Assistance Available**	**Value ((~~Percentage~~))**
Bed mobility, transfer, walk in room, eating, toilet use	Rules apply for all codes except: Did not occur/client not able and Did not occur/no provider = 1; Did not occur/client declined and independent are not counted.	Unmet	N/A	1
		Met	N/A	0
		Decline	N/A	0
		Age appropriate functioning	N/A	0
		Partially met	<1/4 time	.9
			1/4 to 1/2 time	.7
			1/2 to 3/4 time	.5
			>3/4 time	.3
Scheduled ADLs	**Self Performance**	**Status**	**Assistance Available**	**Value ((~~Percentage~~))**
Dressing, personal hygiene, bathing	Rules apply for all codes except: Did not occur/client not able and Did not occur/no provider = 1; Did not occur/client declined and independent are not counted.	Unmet	N/A	1
		Met	N/A	0
		Decline	N/A	0
		Age appropriate functioning	N/A	0
		Partially met	<1/4 time	.75
			1/4 to 1/2 time	.55
			1/2 to 3/4 time	.35
			>3/4 time	.15
IADLs	**Self Performance**	**Status**	**Assistance Available**	**Value ((~~Percentage~~))**
Meal preparation, Ordinary housework, Essential shopping	Rules for all codes apply except independent is not counted.	Unmet	N/A	1
		Met	N/A	0
		Decline	N/A	0
		Age appropriate functioning	N/A	0
		Partially met or shared benefit	<1/4 time	.3
			1/4 to 1/2 time	.2
			1/2 to 3/4 time	.1
			>3/4 time	.05
IADLs	**Self Performance**	**Status**	**Assistance Available**	**Value ((~~Percentage~~))**
Travel to medical	Rules for all codes apply except independent is not counted.	Unmet	N/A	1
		Met	N/A	0
		Decline	N/A	0
		Age appropriate functioning	N/A	0

		Partially met	<1/4 time	.9
			1/4 to 1/2 time	.7
			1/2 to 3/4 time	.5
			>3/4 time	.3
Key: > means greater than < means less than				

(b) To determine the amount of ((~~reduction~~)) adjustments for informal support, shared benefit and/or age appropriate functioning, the ((~~value percentages~~)) numeric values are totaled and divided by the number of qualifying ADLs and IADLs needs. The result is value A. Value A is then subtracted from one. This is value B. Value B is divided by three. This is value C. Value A and Value C are summed. This is value D. Value D is multiplied by the "base hours" assigned to your classification group and the result is the number of adjusted in-home hours ((~~reduced for informal supports~~)).

(3) ((~~Also, the department will adjust in-home base hours when:~~

~~(a) There is more than one client receiving ADSA-paid personal care services living in the same household, the status under subsection (2)(a) of this section must be met or partially met for the following IADLs:~~

~~(i) Meal preparation;~~

~~(ii) Housekeeping;~~

~~(iii) Shopping; and~~

~~(iv) Wood supply.~~

~~(b) You are under the age of eighteen, your assessment will be coded according to age guidelines codified in WAC 388-106-0213.~~

~~(4)~~)) After ((~~deductions~~)) adjustments are made to your base hours, as described in ((~~subsections (2) and (3)~~)) subsection (2), the department may add on hours based on your living environment:

Condition	Status	Assistance Available	Add On Hours
Offsite laundry facilities, which means the client does not have facilities in own home and the caregiver is not available to perform any other personal or household tasks while laundry is done.	N/A	N/A	8
Client is >45 minutes from essential services (which means he/she lives more than 45 minutes one-way from a full-service market).	Unmet	N/A	5
	Met	N/A	0
	Age appropriate	N/A	0
	Partially met or shared benefit	<1/4 time	5
		between 1/4 to 1/2 time	4
		between 1/2 to 3/4 time	2
		>3/4 time	2
Wood supply used as sole source of heat.	Unmet	N/A	8
	Met	N/A	0
	Declines	N/A	0
	Age appropriate	N/A	0
	Partially met or shared benefit	<1/4 time	8
		between 1/4 to 1/2 time	6
		between 1/2 to 3/4 time	4
		>3/4 time	2

(((~~(5)~~))) (4) In the case of New Freedom consumer directed services (NFCDS), the department determines hours as described in WAC 388-106-1445.

(((~~(6)~~))) (5) The result of actions under subsections (2), (3), and (4) is the maximum number of hours that can be used to develop your plan of care. The department must take into account cost effectiveness, client health and safety, and program limits in determining how hours can be used to ((~~meet~~)) address your identified needs. In the case of New Freedom consumer directed services (NFCDS), a New Freedom spending plan (NFSP) is developed in place of a plan of care.

(((~~(7)~~))) (6) You and your case manager will work to determine what services you choose to receive if you are eligible. The hours may be used to authorize:

(a) Personal care services from a home care agency provider and/or an individual provider.

(b) Home delivered meals (i.e. a half hour from the available hours for each meal authorized).

(c) Adult day care (i.e. a half hour from the available hours for each hour of day care authorized).

(d) A home health aide if you are eligible per WAC 388-106-0300 or 388-106-0500.

(e) A private duty nurse (PDN) if you are eligible per WAC 388-71-0910 and 388-71-0915 or WAC 388-551-3000 (i.e. one hour from the available hours for each hour of PDN authorized).

(f) The purchase of New Freedom consumer directed services (NFCDS).

(7) If you are a child applying for personal care services:

(a) The department will complete a CARE assessment and use the developmental milestones table below when assessing your ability to perform personal care tasks.

(b) Your status will be coded as age appropriate when your self performance is at a level expected for persons in your assessed age range, as indicated by the developmental milestones table, unless the circumstances in subpart (c) apply.

(c) The department may code status as other than age appropriate for an ADL or IADL, despite your self performance falling within the expected developmental milestones for your age, if the department determines during your assessment that your level of functioning is not primarily due to your age.

Developmental Milestones for Activities of Daily Living (ADLS)		
ADL	**Self-Performance**	**Assessed Age Range**
Medication Management	Independent Self-Directed Assistance Required Must Be Administered	Birth through the 17th year
Locomotion in Room	Independent Supervision Limited Extensive	Birth through the 3rd year
	Total	Birth through the 1st year
Locomotion Outside Room	Independent Supervision	Birth through the 5th year
	Limited Extensive	Birth through the 3rd year
	Total	Birth through the 1st year
Walk in Room	Independent Supervision Limited Extensive	Birth through the 3rd year
	Total	Birth through the 1st year
Bed Mobility	Independent Supervision Limited Extensive	Birth through the 2nd year
	Total	Birth through the 1st year
Transfers	Independent Supervision Limited Extensive Total	Birth through the 2nd year
Toilet Use	Independent Supervision Limited Extensive	Birth through the 7th year
	Total	Birth through the 3rd year
Eating	Independent Supervision Limited Extensive Total	Birth through the 2nd year

Developmental Milestones for Activities of Daily Living (ADLS)		
ADL	**Self-Performance**	**Assessed Age Range**
Bathing	Independent Supervision	Birth through the 11th year
	Physical help/Transfer only Physical help/part of bathing	Birth through the 7th year
	Total	Birth through the 4th year
Dressing	Independent Supervision	Birth through the 11th year
	Limited Extensive	Birth through the 7th year
	Total	Birth through the 4th year
Personal Hygiene	Independent Supervision	Birth through the 11th year
	Limited or extensive	Birth through the 7th year
	Total	Birth through the 4th year

Developmental Milestones for Instrumental Activities of Daily Living		
IADL	**Self Performance**	**Assessed Age**
Telephone Transportation Essential Shopping Wood Supply Housework Finances Meal Preparation	Independent Supervision Limited Extensive Total	Birth through the 17th year

Additional Developmental Milestones coding		
CARE panel	**Selection**	**Assessed Age**
Speech/Hearing: Comprehension	By others client is = Age Appropriate	Birth through the 2nd year
Psych Social: MMSE	Can MMSE be administereed? = No	Birth through the 17th year
Psych Social: Memory/Short Term	Recent memory = Age appropriate	Birth through the 11th year
Psych Social: Memory/Long Term	Long Term memory = Age appropriate	Birth through the 11th year
Psych Social: Depression	Interview = unable to obtain	Birth through the 11th year
Psych Social: Decision Making	Rate how client makes decision =Age appropriate	Birth through the 11th year
Bladder/Bowel:	Bladder/Bowel Control: Continent Usually Continent Occasionally Incontinent Frequently Incontinent	Birth through the 11th year
Bladder/Bowel:	Bladder/Bowel Control: Incontinent all or most of the time	Birth through the 5th year
Bladder/Bowel:	Appliance and programs = Potty Training	Birth through the 3rd year

(8) If you are a child applying for personal care services and your self performance is not age appropriate as determined under subsection (7), the department will assess for any informal supports or shared benefit available to assist you with each ADL and IADL.

(a) When you are living with your legally responsible parent(s), the department will take into account their legal obligation to care for you when determining the availability of informal supports. Legally responsible parents include natural parents, step-parents, and adoptive parents. Legally responsible parents generally do not include other relative caregivers or foster parents. A legally responsible parent will not be considered unavailable to meet your needs due to other obligations such as work or additional children because such obligations do not decrease the parent's legal responsibility to care for you regardless of your disabilities.

(b) Informal supports for school-age children include supports actually available through a school district, regardless of whether you take advantage of those available supports.

(c) The department will presume that you have informal supports available to assist you with your ADLs and IADLs over three-fourths but not all of the time. The department will code your informal support as greater or less than the presumed amount if your assessment shows that your need for assistance with personal care tasks is fully met by informal supports or shared benefit, or if you provide specific information during your assessment to indicate why you do not have support available three-fourths or more of the time to assist you with a particular ADL or IADL.

Reviser's note: The spelling error in the above section occurred in the copy filed by the agency and appears in the Register pursuant to the requirements of RCW 34.08.040.

REPEALER

The following section of the Washington Administrative Code is repealed:

WAC 388-106-0126	If I am under age twenty-one, how does CARE use criteria to place me in a classification group for in-home care?
WAC 388-106-0213	How are my needs assessed if I am a child applying for MPC services?

WSR 11-23-084
RESCISSION OF EMERGENCY RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Aging and Adult Services Administration)

[Filed November 16, 2011, 3:25 p.m.]

Effective immediately upon filing, the department of social and health services, aging and disability services administration, rescinds emergency rules filed as WSR 11-22-075 on November 1, 2011. That filing amended rules under WAC 388-106-0125.

Katherine I. Vasquez
Rules Coordinator

WSR 11-23-085
EMERGENCY RULES
DEPARTMENT OF EARLY LEARNING

[Filed November 17, 2011, 8:35 a.m., effective November 17, 2011, 8:35 a.m.]

Effective Date of Rule: Immediately.

Purpose: The department of early learning (DEL) is extending adoption of new WAC 170-151-994, 170-295-0065, and 170-296-0172 to implement section 4 of 2SHB 1903 (chapter 295, Laws of 2011), requiring current DEL child care licensees to pay a one-time $45 fee to be used only to fund DEL costs of creating, developing and administering an individual-based/portable background check clearance registry established in the bill. The registry is necessary for DEL to administer a portable background check process as directed by 2SHB 1903 by July 1, 2012. The registry would allow individual child care workers to change licensed child care employers or work in multiple child care facilities without having to undergo a new DEL background check for each employer or facility as required now. This filing replaces and supersedes emergency rules filed as WSR 11-15-090 on July 20, 2011.

Statutory Authority for Adoption: RCW 43.215.060, 43.215.070 (2)(c), and 43.43.832(6); chapter 43.215 RCW.

Other Authority: 2SHB 1903 (chapter 295, Laws of 2011); RCW 43.215.200 and 43.215.215.

Under RCW 34.05.350 the agency for good cause finds that immediate adoption, amendment, or repeal of a rule is necessary for the preservation of the public health, safety, or general welfare, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the public interest; and that in order to implement the requirements or reductions in appropriations enacted in any budget for fiscal year 2009, 2010, 2011, 2012 or 2013, which necessitates the need for the immediate adoption, amendment, or repeal of a rule, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the fiscal needs or requirements of the agency.

Reasons for this Finding: Conducting a background check is integral to determining an individual's character and suitability to provide child care, and for protecting the safety and health of children in child care. RCW 43.215.200, 43.215.215, and 43.43.832(6) provide DEL authority to investigate the criminal background history and other relevant information of individuals: Seeking a DEL child care license; wishing to work in child care; or who reside on the premises of a licensed child care center or home.

In adopting 2SHB 1903, the legislature established a new account in the state treasury specifically for the purpose

of funding an individual-based/portable background check clearance registry. Section 4 of the bill states:

"*Effective July 1, 2011, all agency licensees shall pay the department* (DEL) *a one-time fee established by the department. When establishing the fee, the department must consider the cost of developing and administering the (individual-based/portable background check clearance) registry, and shall not set a fee which is estimated to generate revenue beyond the estimated costs for the development and administration of the registry. Fee revenues must be deposited in the individual-based/portable background check clearance account created in section 5 of this act, and may be expended only for the costs of developing and administering the individual-based/portable background check clearance registry created in section 1 of this act.*"

Section 5 of the bill states, in part, "*...Expenditures from the account may be made only for development, administration, and implementation of the individual-based/portable background check registry established in section 1 of this act. Only the director of the department of early learning or the director's designee may authorize expenditures from the account. The account is subject to allotment procedures under chapter 43.88 RCW, but an appropriation is not required for expenditures.*"

The legislature determined that costs of developing, administering and implementing the individual-based/portable background check clearance registry must be funded through user fees. As provided in section 4 of the bill, DEL has estimated that the initial SFY 2012 cost to create, develop, administer and implement the registry and related systems is approximately $326,250. Divided by an estimated 7,250 current child care facilities licensed by DEL as of July 2011, the one-time fee amount would be $45 per licensee - the amount provided in these rules ($326,250/7,250 = $45). See the DEL fiscal note for 2SHB 1903 as enacted filed with the state office of financial management. DEL must generate the one-time fee revenues early in fiscal year 2012 to develop the initial technology, administration, and fund management capacities of the registry.

The registry must be operational by July 1, 2012, when section 2 of 2SHB 1903 directs an estimated 41,500 current licensees, child care staff, and others associated with DEL-licensed child care facilities to renew their DEL background check utilizing the individual-based/portable background check clearance registry. Background check clearances of an estimated 6,500 new licensees, staff and others who enter the child care industry in the state each year will also be entered on the new registry.

DEL plans to develop permanent rules to implement 2SHB 1903, and the department has filed a preproposal statement of inquiry, filing number WSR 11-12-076, to initiate regular rule making, and the department is pursuing permanent rule making.

Filing this rule is consistent with state office of financial management guidance regarding Executive Order 10-06 (extended under Executive Order 11-03) suspending noncritical rule making, but allowing rules to proceed that are: "*Required by federal and state law or required to maintain federally delegated or authorized programs...*" *or* "*Necessary to manage budget shortfalls, maintain fund solvency, or for revenue generating activities.*"

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 3, Amended 0, Repealed 0.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 0, Amended 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 3, Amended 0, Repealed 0.

Date Adopted: November 17, 2011.

Elizabeth M. Hyde
Director

NEW SECTION

WAC 170-151-994 School-age child care centers—Individual-based/portable background check clearance registry—One-time fee. (1) As required by section 4, chapter 295, Laws of 2011 (2SHB 1903), beginning July 22, 2011, all agency licensees who are licensed with the department as of July 1, 2011, shall pay a one-time fee of forty-five dollars in addition to any other fees imposed by this chapter.

(2) Fee payments made under this section shall be:

(a) By check, draft, or money order;

(b) Sent by mail; and

(c) Postmarked before September 1, 2011.

(3) Pursuant to RCW 43.215.300, the department may suspend the license of any agency licensee:

(a) Who fails to pay the fee required in subsection (2) of this section until the fee is paid; or

(b) Whose check, draft, or money order is reported as having nonsufficient funds (NSF) or is otherwise dishonored by nonacceptance or nonpayment.

(4) All fees collected under this section shall be deposited in the individual-based/portable background check clearance account created in section 5, chapter 295, Laws of 2011 (2SHB 1903) and may be expended only for the costs of developing and administering the individual-based/portable background check clearance registry created in section 1 of that act.

NEW SECTION

WAC 170-295-0065 Child care centers—Individual-based/portable background check clearance registry—One-time fee. (1) As required by section 4, chapter 295, Laws of 2011 (2SHB 1903), beginning July 22, 2011, all agency licensees who are licensed with the department as of July 1, 2011, shall pay a one-time fee of forty-five dollars in addition to any other fees imposed by this chapter.

(2) Fee payments made under this section shall be:

(a) By check, draft, or money order;

(b) Sent by mail; and

(c) Postmarked before September 1, 2011.

(3) Pursuant to RCW 43.215.300, the department may suspend the license of any agency licensee:

(a) Who fails to pay the fee required in subsection (2) of this section until the fee is paid; or

(b) Whose check, draft, or money order is reported as having nonsufficient funds (NSF) or is otherwise dishonored by nonacceptance or nonpayment.

(4) All fees collected under this section shall be deposited in the individual-based/portable background check clearance account created in section 5, chapter 295, Laws of 2011 (2SHB 1903) and may be expended only for the costs of developing and administering the individual-based/portable background check clearance registry created in section 1 of that act.

NEW SECTION

WAC 170-296-0172 Family home child care providers—Individual-based/portable background check clearance registry—One-time fee. (1) As required by section 4, chapter 295, Laws of 2011 (2SHB 1903), beginning July 22, 2011, all agency licensees who are licensed with the department as of July 1, 2011, shall pay a one-time fee of forty-five dollars in addition to any other fees imposed by this chapter.

(2) Fee payments made under this section shall be:

(a) By check, draft, or money order;

(b) Sent by mail; and

(c) Postmarked before September 1, 2011.

(3) Pursuant to RCW 43.215.300, the department may suspend the license of any agency licensee:

(a) Who fails to pay the fee required in subsection (2) of this section until the fee is paid; or

(b) Whose check, draft, or money order is reported as having nonsufficient funds (NSF) or is otherwise dishonored by nonacceptance or nonpayment.

(4) All fees collected under this section shall be deposited in the individual-based/portable background check clearance account created in section 5, chapter 295, Laws of 2011 (2SHB 1903) and may be expended only for the costs of developing and administering the individual-based/portable background check clearance registry created in section 1 of that act.

WSR 11-23-086
EMERGENCY RULES
OFFICE OF INSURANCE COMMISSIONER

[Insurance Commissioner Matter No. 2011-27—Filed November 17, 2011, 8:38 a.m., effective November 17, 2011, 8:38 a.m.]

Effective Date of Rule: Immediately.

Purpose: Chapter 31, Laws of 2011 (HB 1694) amended RCW 48.15.040 and 48.15.090. The commissioner no longer requires an affidavit of due diligence to be filed by surplus line brokers, and instead receives a certification. Unauthorized insurers must meet the minimum financial requirements before business can be placed with the insurer. These emergency rules will amend the existing rules to conform to these statutory changes. The permanent rule is in the process of completion and adoption.

Citation of Existing Rules Affected by this Order: Repealing WAC 284-15-090; and amending WAC 284-15-020, 284-15-030, and 284-15-050.

Statutory Authority for Adoption: RCW 48.02.060 and 48.15.015.

Other Authority: Chapter 31, Laws of 2011.

Under RCW 34.05.350 the agency for good cause finds that state or federal law or federal rule or a federal deadline for state receipt of federal funds requires immediate adoption of a rule.

Reasons for this Finding: The Nonadmitted and Reinsurance Reform Act (NRRA) was enacted by congress as part of the Dodd-Frank Wall Street Reform and Consumer Protection Act in 2010. The NRRA included sections on surplus lines insurance which preempt state laws. The provisions became effective July 21, 2011. Chapter 31, Laws of 2011 (HB 1694) was enacted to conform state law to the NRRA and made certain provisions effective on July 21, 2011, to coincide with the effective date of the NRRA. These emergency rules amend the existing rules to comply with these changes until the permanent rule is adopted.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 1, Repealed 1; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 3, Repealed 1.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 1, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 0, Amended 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 1, Amended 3, Repealed 1.

Date Adopted: November 17, 2011.

Mike Kreidler
Insurance Commissioner

AMENDATORY SECTION (Amending Matter No. R 2008-04, filed 7/2/08, effective 8/2/08)

WAC 284-15-020 Surplus line broker—Solvent insurer required. (1) A surplus line broker must not knowingly place surplus line insurance with financially unsound insurers. Foreign ((~~and alien~~)) insurers must meet or exceed the minimum financial and other conditions required by RCW 48.15.090 ((~~and WAC 284-15-090~~)).

(2) A surplus line broker must substantiate the financial condition of ((~~an~~)) a foreign unauthorized insurer before placing insurance with the insurer. The broker must also maintain evidence of the financial condition of the insurer for at least five years.

(((~~(a) If~~)) (3) A surplus line broker may place((~~s~~)) insurance with an alien unauthorized insurer shown on the National Association of Insurance Commissioners (NAIC) Quarterly Listing of Alien Insurers ((~~dated within three months after placement of the risk, it will be deemed that the insurer meets the financial requirements of RCW 48.15.090 and WAC 284-15-090 and that the financial condition of the insurer is~~)). The financial condition of an insurer named on the listing is deemed to be adequately documented.

(((~~(b) If a surplus line broker places insurance with an alien unauthorized insurer that is not shown on the NAIC Quarterly Listing of Alien Insurers, the broker must maintain information for at least five years adequate to show that the requirements of subsection (1) of this section have been met or exceeded. This documentation shall include at least the following:~~

~~(i) A copy of the unauthorized insurer's most recent available annual financial statement, in English with United States dollar equivalents;~~

~~(ii) Any other information obtained by the broker that verifies the financial condition of the alien unauthorized insurer; and~~

~~(iii) The current NAIC annual statement or its equivalent on file for any alien unauthorized insurer used.~~))

AMENDATORY SECTION (Amending Matter No. R 2006-04, filed 6/6/06, effective 7/7/06)

WAC 284-15-030 Surplus line brokers' form to be filed—Contract ((~~stamp~~)) statement to be used. (1) ((~~RCW 48.15.040 requires that a surplus line broker execute an affidavit at the time of procuring insurance from an unauthorized insurer, and to file such affidavit with the commissioner within thirty days after the insurance is procured.~~)) For the purpose of complying with the requirements of section 5, chapter 31 (HB 1694), Laws of 2011, and RCW 48.15.040, the date insurance is procured is the date coverage is bound or the date coverage is effective, whichever is later. The ((~~form for filing such affidavit shall~~)) certification required by RCW 48.15.040 must be in substantially the following form, and may include additional information to satisfy requirements of the Surplus Line Association of Washington:

Policy or Certificate No:	Premium, including any policy fee:

1. Name and license number of filing Surplus Line Broker:
2. Name and address of ((~~producing agent or broker~~)) referring insurance producer (if any):
3. Name(s) of unauthorized insurer(s):
4. Name and address of insured:
5. Binding or effective date, whichever is later:
6. Brief statement of coverages (common trade terms may be used, e.g. "furrier's block"):

((~~STATE OF WASHINGTON~~ } ~~SS.~~ ~~SURPLUS LINE BROKER'S AFFIDAVIT~~))
COUNTY }

7. Certification:

I have procured insurance from an unauthorized insurer or insurers, in accordance with the laws and regulations of the state of Washington under my surplus line broker's license. Details of such transaction are set forth above.

((~~Such~~)) The insurance could not be procured, after diligent effort was made to do so from among a majority of the insurers authorized to transact that kind of insurance in this state, and placing the insurance in such unauthorized insurer(s) was not done for the purpose of securing a lower premium rate than would be accepted by any authorized insurer.

I certify that I am duly authorized to place this coverage on behalf of the insured, that the risk has been duly accepted by the insurer(s), and that ((~~I ascertained~~)) the financial condition of the unauthorized insurer(s) before placing the insurance therewith meets or exceeds the financial requirements provided by law.

I certify that under the penalty of the suspension or revocation of my surplus line broker's license that the facts contained in this certification are true and correct.

. . . . . .
(Signature of Surplus Line Broker)

((~~Subscribed and sworn to before me this . . . . . day of . . . . . , 20. . .~~

. . . . . .
~~Notary Public in and for the State of Washington, residing at~~)) . . . . . (Date)

(2) Every insurance contract, including those evidenced by a binder, procured and delivered on or after January 1, 2012, as a surplus line coverage ((~~pursuant to~~)) under chapter 48.15 RCW ((~~shall~~)) must have a conspicuous statement ((~~stamped~~)) upon its face, which ((~~shall~~)) must be initialed by or bear the name of the surplus line broker who procured it, as follows:

"This contract is registered and delivered as a surplus line coverage under the insurance code of the state of Washington, enacted in 1947. It is not ((~~issued by a company regulated by the Washington state insurance commissioner and is not~~)) protected by any Washington state guaranty ((~~fund~~)) association law."

(3) Every insurance contract, including those evidenced by a binder, procured and delivered on or before December 31, 2011, as a surplus line coverage under chapter 48.15 RCW must have a conspicuous statement upon its face, which must be initialed by or bear the name of the surplus line broker who procured it, either as set forth in subsection (2) of this section, or as follows:

"This contract is registered and delivered as a surplus line coverage under the insurance code of the state of Washington, enacted in 1947. It is not issued by a company regulated by the Washington state insurance commissioner and is not protected by any Washington state guaranty fund law."

NEW SECTION

WAC 284-15-035 Exempt commercial purchasers. A surplus line broker who has procured insurance with an unauthorized insurer for an exempt commercial purchaser must file with the commissioner within sixty days of the procurement (binding or effective date, whichever is later) of the insurance a report of the insurance. The report must be in a format acceptable to the commissioner. The report must include the following information:

(1) Policy or certificate number;

(2) Premium, including any policy fee;

(3) Name and license number of the filing surplus line broker;

(4) Name(s) of unauthorized insurer(s);

(5) Name and address of insured;

(6) Binding or effective date, whichever is later;

(7) Brief statement of coverages (common terms may be used); and

(8) Other information as required by the commissioner.

AMENDATORY SECTION (Amending Matter No. R 2008-04, filed 7/2/08, effective 8/2/08)

WAC 284-15-050 Surplus line—Waiver of financial requirements. (1) The commissioner may waive the financial requirements specified in RCW 48.15.090 ((~~and WAC 284-15-090~~)) in circumstances where insurance cannot be otherwise procured on risks located in this state. Except as set forth in (e) of this subsection ((~~(5) of this section~~)), at least the following information must be submitted when a surplus line broker requests the commissioner to waive the financial requirements:

(((~~(1)~~))) (a) A detailed letter explaining the need to waive the financial requirements;

(((~~(2)~~))) (b) Documentation of the financial condition of the proposed insurer as reported in its annual statement as of the end of the preceding calendar year;

(((~~(3)~~))) (c) Summary information showing the number of years the company has been writing the specific line of insurance;

(((~~(4)~~))) (d) A written ((~~acknowledgement~~)) acknowledgment signed by the proposed insured confirming all of the following:

(((~~(a)~~))) (i) The insured has been informed that the coverage will be issued by an insurer (or insurers) that is not an authorized insurer in the state of Washington;

(((~~(b)~~))) (ii) The insured understands that financial requirements for surplus line insurers must be waived by all parties concerned to enable this coverage to be obtained; and

(((~~(c)~~))) (iii) The insured understands that there is no protection for the insured under the Washington Insurance Guaranty Association because the coverage will be issued by an unauthorized insurer;

(((~~(5)~~))) (e) For accounts requiring a multiplicity of insurers, in lieu of the requirements in ((~~subsections (2)~~))) (b) and (((~~(3)~~))) (c) of this ((~~section~~)) subsection, the commissioner may accept certification from a surplus line broker that the broker has investigated the financial condition of the prospective insurers and is satisfied that they are capable of underwriting the specified risks. Records and documents supporting the broker's certification must be maintained by the broker for the term of the policies and as long thereafter as a claim may be litigated, but in no case less than five years after completion of the transaction.

(2) In no event will the commissioner waive the financial requirements when the insurer's capital and surplus is less than four million five hundred thousand dollars.

REPEALER

The following section of the Washington Administrative Code is repealed:

WAC 284-15-090	Financial requirements for unauthorized foreign and alien insurers increased.

WSR 11-23-092
EMERGENCY RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Aging and Disability Services Administration)

[Filed November 17, 2011, 2:08 p.m., effective November 17, 2011, 2:08 p.m.]

Effective Date of Rule: Immediately.

Purpose: The department is amending chapter 388-106 WAC, Long-term care services, to revise the assessment process for allocating personal care hours to disabled children.

Citation of Existing Rules Affected by this Order: Amending WAC 388-106-0125.

Statutory Authority for Adoption: RCW 74.08.090, 74.09.520.

Under RCW 34.05.350 the agency for good cause finds that immediate adoption, amendment, or repeal of a rule is necessary for the preservation of the public health, safety, or general welfare, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the public interest; and that state or federal law or federal rule or a federal deadline for state receipt of federal funds requires immediate adoption of a rule.

Reasons for this Finding: The department must revise its assessment process as soon as possible in order to allocate personal care services for children on a more individualized basis to comply with a supreme court order. The department is proceeding with the permanent adoption as a CR-101 was filed as WSR 11-22-074 on November 1, 2011. This filing replaces and supersedes the CR-103E filed as WSR 11-17-133 on August 24, 2011.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 0, Amended 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 1, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 1, Repealed 0.

Date Adopted: November 16, 2011.

Katherine I. Vasquez
Rules Coordinator

AMENDATORY SECTION (Amending WSR 10-11-050, filed 5/12/10, effective 6/12/10)

WAC 388-106-0125 ((~~If I am age twenty-one or older,~~)) How does CARE use criteria to place me in a classification group for in-home care? CARE uses the criteria of cognitive performance score as determined under WAC 388-106-0090, clinical complexity as determined under WAC 388-106-0095, mood/behavior and behavior point score as determined under WAC 388-106-0100, ADLS as determined under WAC 388-106-0105, and exceptional care as determined under WAC 388-106-0110 to place you into one of the following seventeen in-home groups. CARE classification is determined first by meeting criteria to be placed into a group, then you are further classified based on ADL score or behavior point score into a classification sub-group following a classification path of highest possible base hours to lowest qualifying base hours. Each classification group is assigned a number of base hours as described below based upon the level of funding provided by the legislature for personal care services, and based upon the related level of functional disability of persons in each classification group as compared to persons in other classification groups.

(1) If you meet the criteria for exceptional care, then CARE will place you in **Group E.** CARE then further classifies you into:

(a) **Group E High** with ((~~416~~)) 393 base hours if you have an ADL score of 26-28; or

(b) **Group E Medium** with ((~~346~~)) 327 base hours if you have an ADL score of 22-25.

(2) If you meet the criteria for clinical complexity and have cognitive performance score of 4-6 or you have cognitive performance score of 5-6, then you are classified in **Group D** regardless of your mood and behavior qualification or behavior points. CARE then further classifies you into:

(a) **Group D High** with ((~~277~~)) 260 base hours if you have an ADL score of 25-28; or

(b) **Group D Medium-High** with ((~~234~~)) 215 base hours if you have an ADL score of 18-24; or

(c) **Group D Medium** with ((~~185~~)) 168 base hours if you have an ADL score of 13-17; or

(d) **Group D Low** with ((~~138~~)) 120 base hours if you have an ADL score of 2-12.

(3) If you meet the criteria for clinical complexity and have a CPS score of less than 4, then you are classified in **Group C** regardless of your mood and behavior qualification or behavior points. CARE then further classifies you into:

(a) **Group C High** with ((~~194~~)) 176 base hours if you have an ADL score of 25-28; or

(b) **Group C Medium-High** with ((~~174~~)) 158 base hours if you have an ADL score of 18-24; or

(c) **Group C Medium** with ((~~132~~)) 115 base hours if you have an ADL score of 9-17; or

(d) **Group C Low** with ((~~87~~)) 73 base hours if you have an ADL score of 2-8.

(4) If you meet the criteria for mood and behavior qualification and do not meet the classification for C, D, or E groups, then you are classified into **Group B.** CARE further classifies you into:

(a) **Group B High** with ((~~147~~)) 129 base hours if you have an ADL score of 15-28; or

(b) **Group B Medium** with ((~~82~~)) 69 base hours if you have an ADL score of 5-14; or

(c) **Group B Low** with ((~~47~~)) 39 base hours if you have an ADL score of 0-4; or

(5) If you meet the criteria for behavior points and have a CPS score of greater than 2 and your ADL score is greater than 1, and do not meet the classification for C, D, or E groups, then you are classified in **Group B.** CARE further classifies you into:

(a) **Group B High** with ((~~147~~)) 129 base hours if you have a behavior point score 12 or greater; or

(b) **Group B Medium-High** with ((~~101~~)) 84 base hours if you have a behavior point score greater than 6; or

(c) **Group B Medium** with ((~~82~~)) 69 base hours if you have a behavior point score greater than 4; or

(d) **Group B Low** with ((~~47~~)) 39 base hours if you have a behavior point score greater than 1.

(6) If you are not clinically complex and your CPS score is less than 5 and you do not qualify under either mood and behavior criteria, then you are classified in **Group A.** CARE further classifies you into:

(a) **Group A High** with ((~~71~~)) 59 base hours if you have an ADL score of 10-28; or

(b) **Group A Medium** with ((~~56~~)) 47 base hours if you have an ADL score of 5-9; or

(c) **Group A Low** with ((~~26~~)) 22 base hours if you have an ADL score of 0-4.

Reviser's note: The typographical error in the above section occurred in the copy filed by the agency and appears in the Register pursuant to the requirements of RCW 34.08.040.

WSR 11-23-096
EMERGENCY RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 11-301—Filed November 17, 2011, 2:37 p.m., effective November 17, 2011, 2:37 p.m.]

Effective Date of Rule: Immediately.

Purpose: Amend commercial fishing rules.

Citation of Existing Rules Affected by this Order: Repealing WAC 220-47-31100R and 220-47-41100Z; and amending WAC 220-47-311 and 220-47-411.

Statutory Authority for Adoption: RCW 77.12.047 and 77.04.020.

Under RCW 34.05.350 the agency for good cause finds that immediate adoption, amendment, or repeal of a rule is

necessary for the preservation of the public health, safety, or general welfare, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the public interest.

Reasons for this Finding: This emergency rule is needed to adjust fishing schedules based on comanager agreement. There is insufficient time to adopt permanent rules.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 2, Amended 0, Repealed 2.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.

Date Adopted: November 17, 2011.

Lori Preuss
for Philip Anderson
Director

NEW SECTION

WAC 220-47-31100S Purse seine—Open periods. Notwithstanding the provisions of WAC 220-47-311:

(1) It is unlawful to take, fish for, or possess salmon taken for commercial purposes with purse seine gear in waters of Puget Sound Salmon Management and Catch Reporting Areas 12, 12B and 12C.

(2) It is unlawful to take, fish for, or possess salmon taken for commercial purposes with purse seine gear in waters of Puget Sound Salmon Management and Catch Reporting Areas 10 and 11.

NEW SECTION

WAC 220-47-41100A Gill net—Open periods. Notwithstanding the provisions of WAC 220-47-411:

(1) It is unlawful to take, fish for, or possess salmon taken for commercial purposes with gill net gear in waters of Puget Sound Salmon Management and Catch Reporting Areas 12, 12B, and 12C.

(2) It is unlawful to take, fish for, or possess salmon taken for commercial purposes with gill net gear in waters of Puget Sound Salmon Management and Catch Reporting Areas 10 and 11, except from 3:00 p.m. November 20 through 8:00 a.m. November 21, and 3:00 p.m. November 22 through 8:00 a.m. November 23.

REPEALER

The following sections of the Washington Administrative code are repealed:

WAC 220-47-31100R	Purse seine—Open periods. (11-297)
WAC 220-47-41100Z	Gill net—Open periods. (11-297)

WSR 11-23-097
EMERGENCY RULES
SUPERINTENDENT OF PUBLIC INSTRUCTION

[Filed November 17, 2011, 3:10 p.m., effective November 17, 2011, 3:10 p.m.]

Effective Date of Rule: Immediately.

Purpose: To provide rules for the vocational indirect cost limit for middle school career and technical education programs.

To limit middle school and secondary carry over to the ensuing year to no more than the vocational enhancement allocation less the recovery.

Citation of Existing Rules Affected by this Order: Amending WAC 392-121-570 and 392-121-578.

Statutory Authority for Adoption: RCW 28A.150.290 (1).

Under RCW 34.05.350 the agency for good cause finds that in order to implement the requirements or reductions in appropriations enacted in any budget for fiscal year 2009, 2010, 2011, 2012 or 2013, which necessitates the need for the immediate adoption, amendment, or repeal of a rule, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the fiscal needs or requirements of the agency.

Reasons for this Finding: Rule revisions are needed to implement legislative changes that add middle school career and technical programs to the vocational indirect cost limit.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 1, Repealed 0.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 0, Amended 1, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.

Date Adopted: November 17, 2011.

Randy Dorn
State Superintendent

AMENDATORY SECTION (Amending WSR 04-01-058, filed 12/11/03, effective 1/11/04)

WAC 392-121-570 Vocational indirect cost limit—Applicable code provisions—Purpose—Effective date. (1) WAC 392-121-570 through 392-121-578 define the fifteen percent limit on indirect cost charges to school district state-funded vocational-secondary programs as required by the Biennial Operating Appropriations Act. These rules do not apply to federal vocational funding which is governed by federal policies.

(2) The purpose of these sections is to assure that state allocations for vocational education are expended by school districts to support state vocational programs. The minimum levels defined here are not to be construed as recommended expenditure levels.

(3) These sections are effective for the 2002-03 school year and thereafter.

(4) WAC 392-121-570 through 392-121-578 also apply to program 34, with program 34 substituted wherever program 31 appears. Running start does not apply to program 34.

AMENDATORY SECTION (Amending WSR 04-01-058, filed 12/11/03, effective 1/11/04)

WAC 392-121-578 Vocational indirect cost limit—Recovery of state allocations. (1) At the time of the January apportionment calculations after the close of the school year, the superintendent of public instruction shall recalculate each school district's minimum direct expenditures.

(2) If the district's program 31 expenditures are below the minimum program 31 expenditure amount, the district shall be allowed to carry over into the ensuing school year an amount equal to up to ten percent of the minimum expenditure amount excluding any carryover from the prior school year. The actual amount carried over to the ensuing year shall be no more than the vocational enhancement less the recovery.

(3) The superintendent of public instruction shall recover from the district's general apportionment allocation as a prior year adjustment an amount equal to the lesser of the district's enhancement allocation for vocational students or the following amount:

(a) The district's minimum program 31 expenditures; minus

(b) The district's program 31 expenditures plus any allowable carryover.

(((~~(2)~~))) (4) Recoveries made pursuant to this section shall be adjusted after the January apportionment calculation if revised enrollment, staff mix, or expenditure data submitted by the district and accepted by the superintendent of public instruction materially affects the district's recovery amount.

WSR 11-23-102
EMERGENCY RULES
HEALTH CARE AUTHORITY
(Medicaid Program)

[Filed November 18, 2011, 10:57 a.m., effective November 18, 2011, 10:57 a.m.]

Effective Date of Rule: Immediately.

Purpose: In meeting the requirements of E2SHB [ESHB] 2082, the agency is creating WAC 182-504-0125 Effect of changes on medical program eligibility, to medical care services program. The new incapacity-based medical care services program became effective November 1, 2011, under WSR 11-22-052.

Statutory Authority for Adoption: RCW 41.05.021, 74.09.035.

Other Authority: Chapter 36, Laws of 2011 (E2SHB [ESHB] 2082).

Under RCW 34.05.350 the agency for good cause finds that state or federal law or federal rule or a federal deadline for state receipt of federal funds requires immediate adoption of a rule.

Reasons for this Finding: See Purpose statement above.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 1, Amended 0, Repealed 0.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 0, Amended 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 1, Amended 0, Repealed 0.

Date Adopted: November 16, 2011.

Kevin M. Sullivan
Rules Coordinator

NEW SECTION

WAC 182-504-0125 Effect of changes on medical program eligibility. (1) An individual continues to be eligible for medical assistance until the agency or the agency's designee completes a review of the individual's case record and determines the individual is ineligible for medical assistance or is eligible for another medical program. This applies to all individuals who, during a certification period, become ineligible for, or are terminated from, or request termination from:

(a) A categorically needy (CN) medicaid program;

(b) A program included in apple health for kids; or

(c) Any of the following cash grants:

(i) Temporary assistance for needy families (TANF);

(ii) Supplemental Security Income (SSI); or

(iii) Aged, blind, disabled (ABD) cash assistance. See WAC 388-434-0005 for changes reported during eligibility review.

(2) If CN medical coverage ends under one program and the individual meets all the eligibility requirements to be eligible under a different CN medical program, coverage is approved under the new program. If the individual's income exceeds the standard for CN medical coverage, the agency or the agency's designee considers eligibility under the medically needy (MN) program where appropriate.

(3) If CN medical coverage ends and the individual does not meet the eligibility requirements to be eligible under a different medical program, the redetermination process is complete and medical assistance is terminated giving advance and adequate notice with the following exception:

(a) An individual who claims to have a disability is referred to the division of disability determination services for a disability determination if that is the only basis under which the individual is potentially eligible for medical assistance. Pending the outcome of the disability determination, medical eligibility is considered under the SSI-related medical program described in chapter 388-475 WAC.

(b) An individual with countable income in excess of the SSI-related CN medical standard is considered for medically needy (MN) coverage or medically needy (MN) with spenddown pending the final outcome of the disability determination.

(4) An individual who becomes ineligible for refugee cash assistance is eligible for continued refugee medical assistance through the eight-month limit, as described in WAC 388-400-0035(4).

(5) An individual who receives a TANF cash grant or family medical is eligible for a medical extension, as described under WAC 388-523-0100, when the cash grant or family medical program is terminated as a result of:

(a) An increase in earned income; or

(b) Collection of child or spousal support.

(6) Changes in income during a certification period affects eligibility for all medical programs except:

(a) Pregnant women's CN medical programs;

(b) A program included in apple health for kids, except as specified in subsection (5) of this section; or

(c) The first six months of the medical extension benefits described under chapter 388-523 WAC.

(7) A child who receives premium-based coverage under a program included in apple health for kids described in WAC 388-505-0210 and chapter 388-542 WAC must be redetermined for a 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.

(8) An individual who receives SSI-related CN medical coverage and reports a change in earned income which exceeds the substantial gainful activity (SGA) limit set by Social Security Administration no longer meets the definition of a disabled individual as described in WAC 388-475-0050, unless the individual continues to receive a Title 2 cash benefit, e.g., SSDI, DAC, or DWB. The agency or the agency's designee redetermines eligibility for such an individual under the health care for workers with disabilities (HWD) program which waives the SGA income test. The HWD program is a premium-based program and the individual must approve the premium amount before the agency or the agency's designee can authorize ongoing CN medical benefits under this program.

WSR 11-23-110
EMERGENCY RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 11-300—Filed November 18, 2011, 4:18 p.m., effective November 25, 2011, 12:01 p.m.]

Effective Date of Rule: November 25, 2011, 12:01 p.m.

Purpose: Amend recreational fishing rules.

Citation of Existing Rules Affected by this Order: Repealing WAC 220-56-36000X; and amending WAC 220-56-360.

Statutory Authority for Adoption: RCW 77.12.047 and 77.04.020.

Under RCW 34.05.350 the agency for good cause finds that immediate adoption, amendment, or repeal of a rule is necessary for the preservation of the public health, safety, or general welfare, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the public interest.

Reasons for this Finding: Survey results show that adequate clams are available for harvest in Razor Clam Areas 1, 2 and those portions of Razor Clam Area 3 opened for harvest. Washington department of health has certified clams from these beaches to be safe for human consumption. There is insufficient time to adopt permanent rules.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 1, Amended 0, Repealed 1.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.

Date Adopted: November 18, 2011.

Philip Anderson
Director

NEW SECTION

WAC 220-56-36000X Razor clams—Areas and seasons. Notwithstanding the provisions of WAC 220-56-360, it

is unlawful to dig for or possess razor clams taken for personal use from any beach in Razor Clam Areas 1, 2, or 3, except as provided for in this section:

1. Effective 12:01 p.m. November 25 through 11:59 p.m. November 26, 2011, razor clam digging is allowed in Razor Clam Area 1. Digging is allowed from 12:01 p.m. to 11:59 p.m. each day only.

2. Effective 12:01 p.m. November 25 through 11:59 p.m. November 26, 2011, razor clam digging is allowed in Razor Clam Area 2. Digging is allowed from 12:01 p.m. to 11:59 p.m. each day only.

3. Effective 12:01 p.m. November 25 through 11:59 p.m. November 25, 2011, razor clam digging is allowed in that portion Razor Clam Area 3 that is between the Grays Harbor North Jetty and the Copalis River (Grays Harbor County). Digging is allowed from 12:01 p.m. to 11:59 p.m. only.

4. Effective 12:01 p.m. November 25 through 11:59 p.m. November 26, 2011, razor clam digging is allowed in that portion Razor Clam Area 3 that is between the Copalis River and the southern boundary of the Quinault Indian Nation (Grays Harbor County). Digging is allowed from 12:01 p.m. to 11:59 p.m. each day only.

5. It is unlawful to dig for razor clams at any time in Long Beach, Twin Harbors Beach or Copalis Beach Clam sanctuaries defined in WAC 220-56-372.

Reviser's note: The typographical errors in the above section occurred in the copy filed by the agency and appear in the Register pursuant to the requirements of RCW 34.08.040.

REPEALER

The following section of the Washington Administrative Code is repealed effective 12:01 a.m. November 27, 2011:

WAC 220-56-36000X	Razor clams—Areas and seasons.

WSR 11-23-111
EMERGENCY RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 11-302—Filed November 18, 2011, 4:18 p.m., effective November 18, 2011, 4:18 p.m.]

Effective Date of Rule: Immediately.

Purpose: Amend commercial fishing rules.

Citation of Existing Rules Affected by this Order: Repealing WAC 220-47-31100S and 220-47-41100A; and amending WAC 220-47-311 and 220-47-411.

Statutory Authority for Adoption: RCW 77.12.047 and 77.04.020.

Under RCW 34.05.350 the agency for good cause finds that immediate adoption, amendment, or repeal of a rule is necessary for the preservation of the public health, safety, or general welfare, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the public interest.

Reasons for this Finding: Harvestable numbers of chum salmon are available in Salmon Management and Catch Reporting Area 12C for commercial harvest. There is insufficient time to adopt permanent rules.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 2, Amended 0, Repealed 2.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.

Date Adopted: November 18, 2011.

Philip Anderson
Director

NEW SECTION

WAC 220-47-31100T Purse seine—Open periods. Notwithstanding the provisions of WAC 220-47-311:

(1) It is unlawful to take, fish for, or possess salmon taken for commercial purposes with purse seine gear in waters of Puget Sound Salmon Management and Catch Reporting Areas 12, 12B and 12C, except open in Area 12C from 7 a.m. through 4 p.m. November 22.

(2) It is unlawful to take, fish for, or possess salmon taken for commercial purposes with purse seine gear in waters of Puget Sound Salmon Management and Catch Reporting Areas 10 and 11.

NEW SECTION

WAC 220-47-41100B Gill net—Open periods. Notwithstanding the provisions of WAC 220-47-411:

(1) It is unlawful to take, fish for, or possess salmon taken for commercial purposes with gill net gear in waters of Puget Sound Salmon Management and Catch Reporting Areas 12, 12B, and 12C, except open in Area 12C from 7 a.m. through 6 p.m. daily on November 20, 21, and 23.

(2) It is unlawful to take, fish for, or possess salmon taken for commercial purposes with gill net gear in waters of Puget Sound Salmon Management and Catch Reporting Areas 10 and 11, except open from 3:00 p.m. November 20 through 8:00 a.m. November 21, and 3:00 p.m. November 22 through 8:00 a.m. November 23.

REPEALER

The following sections of the Washington Administrative code are repealed:

WAC 220-47-31100S	Purse seine—Open periods. (11-301)

WAC 220-47-41100A	Gill net—Open periods. (11-301)

WSR 11-23-128
EMERGENCY RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 11-303—Filed November 21, 2011, 3:43 p.m., effective November 21, 2011, 3:43 p.m.]

Effective Date of Rule: Immediately.

Purpose: Amend Salmon—Willapa Bay fall fishery.

Citation of Existing Rules Affected by this Order: Repealing WAC 220-40-02700P and 220-40-02700Q; and amending WAC 220-40-027.

Statutory Authority for Adoption: RCW 77.12.047 and 77.04.020.

Under RCW 34.05.350 the agency for good cause finds that immediate adoption, amendment, or repeal of a rule is necessary for the preservation of the public health, safety, or general welfare, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the public interest.

Reasons for this Finding: Based on catch information to date, there are sufficient numbers of white sturgeon remaining within the harvest guidelines in the 2011 Willapa Bay commercial gillnet fishery. There is insufficient time to adopt permanent rules.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 1, Amended 0, Repealed 2.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.

Date Adopted: November 21, 2011.

Lori Preuss
for Philip Anderson
Director

NEW SECTION

WAC 220-40-02700Q Salmon—Willapa Bay fall fishery. Notwithstanding the provisions of WAC 220-40-027, effective 6:00 p.m. November 21 through December 31, 2011, it is unlawful to fish for salmon in Willapa Bay for commercial purposes or to possess salmon taken from those waters for commercial purposes, except that:

Fishing Periods:

1. Gillnet gear may be used to fish for salmon only as shown below:

6:00 p.m. November 21 through 6:00 p.m. November 23, 2011	Areas 2M, 2N, 2R, 2T, and 2U

Gear:

2. Gillnet gear restrictions - All Areas:

a. Drift gill net gear only. It is unlawful to use set net gear. It is permissible to have on board a commercial vessel more than one net, provided the nets are of a mesh size that is legal for the fishery, and the length of any one net does not exceed one thousand five hundred feet in length.

b. Nets with a mesh size different from that being actively fished must be properly stored. A properly stored net is defined as a net on a drum that is fully covered by a tarp (canvas or plastic) and bound with a minimum of ten revolutions of rope that is 3/8 (0.375) inches or greater.

c. It is unlawful to use a gill net to fish for salmon if the lead line weighs more than two pounds per fathom of net as measured on the cork line, provided that it is permissible to have a gill net with a lead line weighing more than two pounds per fathom aboard a vessel when the vessel is fishing in or transiting through Willapa Bay.

3. From November 21 through November 23, 2011: Mesh size must not exceed nine-inch maximum mesh.

a. Only one net configuration, not exceeding fifteen hundred feet, may be used when in the act of fishing; other nets must be properly stored.

b. From November 21 through November 23, 2011, all steelhead and all green sturgeon must be handled with care to minimize injury to the fish and must be released immediately to the river/bay when fishing in Willapa Bay Areas 2M, 2N, 2R, 2T, and 2U.

c. White sturgeon may be retained.

Other:

4. Quick reporting is required for wholesale dealers and fishers retailing their catch under a "direct retail endorsement". According to WAC 220-69-240(12), reports must be made by 10:00 a.m. the day following landing.

5. The retention of green sturgeon is prohibited.

6. It is unlawful to fish with gillnet gear in Areas 2M, 2N, 2R, 2T, and 2U unless the vessel operator has attended a "Fish Friendly" best fishing practices workshop and has in their possession a department-issued certification card.

REPEALER

The following section of the Washington Administrative Code is repealed:

WAC 220-40-02700P	Salmon—Willapa Bay fall fishery.

The following section of the Washington Administrative Code is repealed effective January 1, 2012:

WAC 220-40-02700Q	Salmon—Willapa Bay fall fishery.

WSR 11-23-129
EMERGENCY RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 11-304—Filed November 21, 2011, 3:49 p.m., effective November 21, 2011, 3:49 p.m.]

Effective Date of Rule: Immediately.

Purpose: Amend commercial fishing rules.

Citation of Existing Rules Affected by this Order: Amending WAC 220-47-311 and 220-47-411.

Statutory Authority for Adoption: RCW 77.12.047 and 77.04.020.

Under RCW 34.05.350 the agency for good cause finds that immediate adoption, amendment, or repeal of a rule is necessary for the preservation of the public health, safety, or general welfare, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the public interest.

Reasons for this Finding: Closure is necessary to fulfill broodstock needs at the Tulalip Hatchery. There is insufficient time to adopt permanent rules.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 0, Amended 2, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.

Date Adopted: November 21, 2011.

Lori Preuss
for Philip Anderson
Director

NEW SECTION

WAC 220-47-31100U Purse seine—Open periods. Notwithstanding the provisions of WAC 220-47-311; effective immediately, it is unlawful to take, fish for, or possess salmon taken for commercial purposes with purse seine gear in waters of Puget Sound Salmon Management and Catch Reporting Areas 8D.

Reviser's note: The typographical error in the above section occurred in the copy filed by the agency and appears in the Register pursuant to the requirements of RCW 34.08.040.

NEW SECTION

WAC 220-47-41100C Gill net—Open periods. Notwithstanding the provisions of WAC 220-47-411; effective immediately, it is unlawful to take, fish for, or possess salmon taken for commercial purposes with gill net gear in waters of Puget Sound Salmon Management and Catch Reporting Areas 8D.

Reviser's note: The typographical error in the above section occurred in the copy filed by the agency and appears in the Register pursuant to the requirements of RCW 34.08.040.

WSR 11-23-169
EMERGENCY RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 11-305—Filed November 22, 2011, 4:30 p.m., effective November 22, 2011, 4:30 p.m.]

Effective Date of Rule: Immediately.

Purpose: Amend commercial use rules.

Citation of Existing Rules Affected by this Order: Repealing WAC 220-52-04600M and 220-69-24000X; and amending WAC 220-52-040, 220-52-046, and 220-69-240.

Statutory Authority for Adoption: RCW 77.12.047 and 77.04.020.

Under RCW 34.05.350 the agency for good cause finds that immediate adoption, amendment, or repeal of a rule is necessary for the preservation of the public health, safety, or general welfare, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the public interest.

Reasons for this Finding: The provisions of this rule are in conformity with agreed plans with applicable tribes, which have been entered as required by court order. The Puget Sound commercial season is structured to meet harvest allocation objectives. There is allocation available in all areas to justify the reopening. There is insufficient time to adopt permanent rules.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 1, Amended 0, Repealed 2.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.

Date Adopted: November 22, 2011.

Lori Preuss
for Philip Anderson
Director

NEW SECTION

WAC 220-52-04000H Commercial crab fishery—Lawful and unlawful gear, methods, and other unlawful acts. Notwithstanding the provisions of WAC 220-52-040:

(1) Additional area gear limits. The following Marine Fish-Shellfish Management and Catch Reporting Areas are restricted in the number of pots fished, operated, or used by a person or vessel, and it is unlawful for any person to use, maintain, operate, or control pots in excess of the following limits:

a. No commercial gear is allowed in that portion of Marine Fish-Shellfish Management and Catch Reporting Area 25A west of the 123° 7.0' longitude line projected from the new Dungeness light due south to the shore of Dungeness Bay.

(2) Effective 8:00 a.m. November 28th, 2011, it is unlawful for any person to fish for crabs for commercial purposes with more than 50 pots per license per buoy tag number in Crab Management Regions 1 (Marine Fish-Shellfish Management and Catch Reporting Areas 20A, 20B, 21A, 21B, 22A, 22B), 2 East (Marine Fish-Shellfish Management and Catch Reporting Areas 24A, 24B, 24C, 24D, 26A-East), 2 West (Marine Fish-Shellfish Management and Catch Reporting Areas 26A-West, 25B, 25D), sub-area 3-1 (Marine Fish-Shellfish Management and Catch Reporting Areas 23A and 23B), and sub-area 3-2 (Marine Fish-Shellfish Management and Catch Reporting Areas 25A, 25E, 23D).

(3) The remaining buoy tags per license per region must be onboard the designated vessel and available for inspection.

NEW SECTION

WAC 220-52-04600N Puget Sound crab fishery—Seasons and areas. Notwithstanding the provisions of WAC 220-52-046:

(1) Effective 8:00 a.m. November 28th, 2011, it is permissible to fish for Dungeness crab for commercial purposes in the following areas:

(a) Those waters of Marine Fish-Shellfish Management and Catch Reporting Area 20A between a line from the boat ramp at the western boundary of Birch Bay State Park to the western point of the entrance of the Birch Bay Marina and a line from the same boat ramp to Birch Point.

(b) Those waters of Marine Fish-Shellfish Management and Catch Reporting Area 22B in Fidalgo Bay south of a line projected from the red number 4 entrance buoy at Cape Sante Marina to the northern end of the eastern-most oil dock.

(c) Those waters of Marine Fish-Shellfish Management and Catch Reporting Area 22A in Deer Harbor north of a line projected from Steep Point to Pole Pass.

(d) Those waters of Marine Fish-Shellfish Management and Catch Reporting Area 26A-W in Useless Bay north and east of a line from the south end of the Double Bluff State Park seawall (47°58.782'N, 122°30.840'W) projected 110 degrees true to the boulder on shore (47°57.690'N, 122°26.742'W).

(e) Port Gardner: Those waters of Marine Fish-Shellfish Management and Catch Reporting Area 26A, west of a line that extends from the spiral staircase at Howarth Park due north to the south end of Gedney Island and intersecting a line projected from the outermost tip of the ferry dock at Mukilteo projected to the green #3 buoy at the mouth of the Snohomish River.

(f) Possession Point to Glendale: That portion of Marine Fish-Shellfish Management and Catch Reporting Area 26A east of a line that extends true north from the green #1 buoy at Possession Point to Possession Point, and west of a line from the green #1 buoy at Possession Point extending northward along the 200-foot depth contour to the Glendale dock.

(g) Langley: That portion of Marine Fish-Shellfish Management and Catch Reporting Area 24C shoreward of the 400-foot depth contour within an area described by two lines projected northeasterly from Sandy Point and the entrance to the marina at Langley.

(2) Effective 8:00 a.m. November 28th, 2011, until further notice, the following areas are closed to commercial crab fishing:

(a) That portion of Marine Fish-Shellfish Management and Catch Reporting Area 25A west of the 123° 7.0' longitude line projected from the new Dungeness light due south to the shore of Dungeness Bay.

(b) That portion of Marine Fish-Shellfish Management and Catch Reporting Area 23D west of a line from the eastern tip of Ediz Hook to the ITT Rayonier Dock.

(c) Those waters of Marine Fish-Shellfish Management and Catch Reporting Area 24A, east of a line projected due north from the most westerly tip of Skagit Island and extending south to the most westerly tip of Hope Island, thence southeast to Seal Rocks, thence southeast to the green can buoy at the mouth of Swinomish Channel, thence easterly to the west side of Goat Island.

(d) Those waters of Marine Fish-Shellfish Management and Catch Reporting Area 26A within the area east of a line from the spiral staircase at Howarth Park due north to the south end of Gedney Island and that portion of 24B east of a line from the north end of Gedney Island to Camano Head and south of a line drawn from Camano Head to Hermosa Point (north end of Tulalip Bay).

NEW SECTION

WAC 220-69-24000Y Duties of commercial purchasers and receivers. Notwithstanding the provisions of WAC 220-69-240, effective November 28th, 2011, until further notice, it is unlawful for any wholesale dealer acting in the capacity of an original receiver of Dungeness crab taken by non-treaty fishers from Puget Sound, to fail to report to the department the previous day's purchases by 10:00 a.m. the following business day. Reports must be made by fax to (425) 338-1066, or by e-mail at crabreport@dfw.wa.gov, and must specify the dealer name, dealer phone number, date of delivery of crab to the original receiver, and the total number of pounds of crab caught by non-treaty fishers, by Crab Management Region or by Marine Fish-Shellfish Management and Catch Reporting Area.

Reviser's note: The unnecessary underscoring in the above section occurred in the copy filed by the agency and appears in the Register pursuant to the requirements of RCW 34.08.040.

REPEALER

The following sections of the Washington Administrative Code are repealed, effective 8:00 a.m. November 28, 2011:

WAC 220-52-04600M	Puget Sound crab fishery—Seasons and areas (11-292)
WAC 220-69-24000X	Duties of commercial purchasers and receivers (11-256)

NEW SECTION

WAC 232-28-61900K Exceptions to statewide rules—Samish River. Notwithstanding the provisions of WAC 232-28-619:

- Effective December 1, 2011, until further notice, it is unlawful to fish in waters of the Samish River from the I-5 Bridge to the Hickson Bridge.
- Effective January 1, 2012, until further notice, it is unlawful to fish in waters of the Samish River from the mouth to I-5 Bridge.

WSR 11-23-170
EMERGENCY RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 11-306—Filed November 22, 2011, 4:33 p.m., effective December 1, 2011]

Effective Date of Rule: December 1, 2011.

Purpose: Amend personal use rules.

Citation of Existing Rules Affected by this Order: Amending WAC 232-28-619.

Statutory Authority for Adoption: RCW 77.12.047 and 77.04.020.

Under RCW 34.05.350 the agency for good cause finds that immediate adoption, amendment, or repeal of a rule is necessary for the preservation of the public health, safety, or general welfare, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the public interest.

Reasons for this Finding: These changes will reduce incidental hooking mortality on wild steelhead, which are expected to return in numbers below escapement goals.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 1, Amended 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.

Date Adopted: November 22, 2011.

Lori Preuss
for Philip Anderson
Director

WSR 11-23-171
EMERGENCY RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 11-307—Filed November 22, 2011, 4:34 p.m., effective December 1, 2011]

Effective Date of Rule: December 1, 2011.

Purpose: Amend personal use rules.

Citation of Existing Rules Affected by this Order: Amending WAC 232-28-619.

Statutory Authority for Adoption: RCW 77.12.047 and 77.04.020.

Under RCW 34.05.350 the agency for good cause finds that immediate adoption, amendment, or repeal of a rule is necessary for the preservation of the public health, safety, or general welfare, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the public interest.

Reasons for this Finding: The Kendall Creek Hatchery and Whatcom Creek Hatchery winter steelhead programs have had difficulty in securing sufficient numbers of broodstock fish to meet egg-take goals. Closure of the fisheries will allow the collection of sufficient numbers of fish to meet production needs. There is insufficient time to adopt permanent rules.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 1, Amended 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.

Date Adopted: November 22, 2011.

Lori Preuss
for Philip Anderson
Director

NEW SECTION

WAC 232-28-61900M Exceptions to statewide rules—North Fork Nooksack River and Whatcom Creek. Notwithstanding the provisions of WAC 232-28-619:

(1) Effective December 1, 2011, until further notice, it is unlawful to fish in those waters of the North Fork Nooksack River from the yellow post located at the upstream-most corner of the hatchery grounds approximately 1,000 feet upstream of the mouth of Kendall Creek, downstream to the Mosquito Lake Road Bridge.

(2) Effective December 1, 2011, until further notice, it is unlawful to fish in waters of Whatcom Creek from the mouth to the Woburn Street Bridge.

WSR 11-23-185
EMERGENCY RULES
OFFICE OF INSURANCE COMMISSIONER

[Insurance Commissioner Matter No. R 2011-28—Filed November 23, 2011, 11:52 a.m., effective November 23, 2011, 11:52 a.m.]

Effective Date of Rule: Immediately.

Purpose: To bring Washington state's requirements for nongrandfathered health plans into compliance with the Affordable Care Act (ACA) requirements for review of adverse benefit determinations, and to provide that all plans, both grandfathered and nongrandfathered, must continue to address grievances.

Citation of Existing Rules Affected by this Order: Amending WAC 284-43-410 [284-43-130], 284-43-615, and 284-43-620.

Statutory Authority for Adoption: RCW 48.02.060, 48.43.530.

Other Authority: P.L. 111-148 (2010, as amended) and implement regulations.

Under RCW 34.05.350 the agency for good cause finds that immediate adoption, amendment, or repeal of a rule is necessary for the preservation of the public health, safety, or general welfare, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the public interest.

Reasons for this Finding: The United States Department of Health and Human Services (HHS) deemed our state to be in compliance with the ACA requirements for review of adverse benefit determinations, based on the adoption of WSR 11-16-061, Commissioner's docket number R 2011-14. That emergency rule expires on November 26, 2011. The purpose of this emergency rule is to maintain continuity of law so that the HHS determination is not jeopardized. If HHS were to withdraw its determination due to a lapse of these rules, as of January 1, 2012, all appeals of adverse benefit determination would be subject to the federal process, creating confusion for consumers, issuers and independent review organizations. The stability of the individual and small group markets is best served by continuing to be deemed compliant with federal law, and therefore, adoption of these rules on an emergency basis pending adoption of the permanent rules is justified.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 12, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 2, Amended 2, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.

Date Adopted: November 23, 2011.

Mike Kreidler
Insurance Commissioner

AMENDATORY SECTION (Amending Matter No. R 2000-02, filed 1/9/01, effective 7/1/01)

WAC 284-43-130 Definitions. Except as defined in other subchapters and unless the context requires otherwise, the following definitions shall apply throughout this chapter.

(1) "Adverse determination and noncertification" means a decision by a health carrier to deny, modify, reduce, or terminate payment, coverage, authorization, or provision of health care services or benefits including the admission to or continued stay in a facility.

(2) "Certification" means a determination by the carrier that an admission, extension of stay, or other health care service has been reviewed and, based on the information provided, meets the clinical requirements for medical necessity, appropriateness, level of care, or effectiveness in relation to the applicable health plan.

(3) "Clinical review criteria" means the written screens, decision rules, medical protocols, or guidelines used by the carrier as an element in the evaluation of medical necessity and appropriateness of requested admissions, procedures, and services under the auspices of the applicable health plan.

(4) "Covered health condition" means any disease, illness, injury or condition of health risk covered according to the terms of any health plan.

(5) "Covered person" means an individual covered by a health plan including an enrollee, subscriber, policyholder, or beneficiary of a group plan.

(6) "Emergency medical condition" means the emergent and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent layperson acting reasonably to believe that a health condition exists that requires immediate medical attention, if failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.

(7) "Emergency services" means otherwise covered health care services medically necessary to evaluate and treat an emergency medical condition, provided in a hospital emergency department.

(8) "Enrollee point-of-service cost-sharing" or "cost-sharing" means amounts paid to health carriers directly providing services, health care providers, or health care facilities by enrollees and may include copayments, coinsurance, or deductibles.

(9) "Facility" means an institution providing health care services, including but not limited to hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory, and imaging centers, and rehabilitation and other therapeutic settings.

(10) "Formulary" means a listing of drugs used within a health plan.

(11) "Grievance" means a written or an oral complaint submitted by or on behalf of a covered person regarding((:

~~(a) Denial of health care services or payment for health care services; or~~

~~(b)~~)) issues other than health care services or payment for health care services including dissatisfaction with health care services, delays in obtaining health care services, conflicts with carrier staff or providers, and dissatisfaction with carrier practices or actions unrelated to health care services.

(12) "Health care provider" or "provider" means:

(a) A person regulated under Title 18 RCW or chapter 70.127 RCW, to practice health or health-related services or otherwise practicing health care services in this state consistent with state law; or

(b) An employee or agent of a person described in (a) of this subsection, acting in the course and scope of his or her employment.

(13) "Health care service" or "health service" means that service offered or provided by health care facilities and health care providers relating to the prevention, cure, or treatment of illness, injury, or disease.

(14) "Health carrier" or "carrier" means a disability insurance company regulated under chapter 48.20 or 48.21 RCW, a health care service contractor as defined in RCW 48.44.010, and a health maintenance organization as defined in RCW 48.46.020.

(15) "Health plan" or "plan" means any individual or group policy, contract, or agreement offered by a health carrier to provide, arrange, reimburse, or pay for health care service except the following:

(a) Long-term care insurance governed by chapter 48.84 RCW;

(b) Medicare supplemental health insurance governed by chapter 48.66 RCW;

(c) Limited health care service offered by limited health care service contractors in accordance with RCW 48.44.035;

(d) Disability income;

(e) Coverage incidental to a property/casualty liability insurance policy such as automobile personal injury protection coverage and homeowner guest medical;

(f) Workers' compensation coverage;

(g) Accident only coverage;

(h) Specified disease and hospital confinement indemnity when marketed solely as a supplement to a health plan;

(i) Employer-sponsored self-funded health plans;

(j) Dental only and vision only coverage; and

(k) Plans deemed by the insurance commissioner to have a short-term limited purpose or duration, or to be a student-only plan that is guaranteed renewable while the covered person is enrolled as a regular full-time undergraduate or graduate student at an accredited higher education institution, after a written request for such classification by the carrier and subsequent written approval by the insurance commissioner.

(16) "Managed care plan" means a health plan that coordinates the provision of covered health care services to a covered person through the use of a primary care provider and a network.

(17) "Medically necessary" or "medical necessity" in regard to mental health services and pharmacy services is a carrier determination as to whether a health service is a covered benefit if the service is consistent with generally recognized standards within a relevant health profession.

(18) "Mental health provider" means a health care provider or a health care facility authorized by state law to provide mental health services.

(19) "Mental health services" means in-patient or out-patient treatment, partial hospitalization or out-patient treatment to manage or ameliorate the effects of a mental disorder listed in the *Diagnostic and Statistical Manual (DSM) IV* published by the American Psychiatric Association, excluding diagnoses and treatments for substance abuse, 291.0 through 292.9 and 303.0 through 305.9.

(20) "Network" means the group of participating providers and facilities providing health care services to a particular health plan. A health plan network for carriers offering more than one health plan may be smaller in number than the total number of participating providers and facilities for all plans offered by the carrier.

(21) "Out-patient therapeutic visit" or "out-patient visit" means a clinical treatment session with a mental health provider of a duration consistent with relevant professional standards used by the carrier to determine medical necessity for the particular service being rendered, as defined in *Physicians Current Procedural Terminology,* published by the American Medical Association.

(22) "Participating provider" and "participating facility" means a facility or provider who, under a contract with the health carrier or with the carrier's contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payment, other than coinsurance, copayments, or deductibles, from the health carrier rather than from the covered person.

(23) "Person" means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity, or any combination of the foregoing.

(24) "Pharmacy services" means the practice of pharmacy as defined in chapter 18.64 RCW and includes any drugs or devices as defined in chapter 18.64 RCW.

(25) "Primary care provider" means a participating provider who supervises, coordinates, or provides initial care or continuing care to a covered person, and who may be required by the health carrier to initiate a referral for specialty care and maintain supervision of health care services rendered to the covered person.

(26) "Preexisting condition" means any medical condition, illness, or injury that existed any time prior to the effective date of coverage.

(27) "Premium" means all sums charged, received, or deposited by a health carrier as consideration for a health plan or the continuance of a health plan. Any assessment or any "membership," "policy," "contract," "service," or similar fee or charge made by a health carrier in consideration for a health plan is deemed part of the premium. "Premium" shall not include amounts paid as enrollee point-of-service cost-sharing.

(28) "Small group" means a health plan issued to a small employer as defined under RCW 48.43.005(24) comprising from one to fifty eligible employees.

(29) "Substitute drug" means a therapeutically equivalent substance as defined in chapter 69.41 RCW.

(30) "Supplementary pharmacy services" or "other pharmacy services" means pharmacy services involving the provision of drug therapy management and other services not required under state and federal law but that may be rendered in connection with dispensing, or that may be used in disease prevention or disease management.

SUBCHAPTER E
ADVERSE BENEFIT DETERMINATION PROCESS REQUIREMENTS FOR NONGRANDFATHERED PLANS

NEW SECTION

WAC 284-43-500 Scope and intent. This subchapter sets forth the requirements that carriers and nongrandfathered health plans must implement when establishing the adverse benefit determination process required by RCW 48.43.530 and 48.43.535. A health plan is nongrandfathered if it does not meet the definition and standards for a grandfathered health plan contained in the Affordable Care Act (2010), P.L. 111-148, as amended, and the Affordable Care Act's implementing federal regulations. These rules apply to any health plan issued, renewed, or in effect on or after January 1, 2012, and any review of an adverse benefit determination initiated after that date.

NEW SECTION

WAC 284-43-505 Definitions. These definitions apply to the sections in subchapter E, WAC 284-43-500 through 284-43-550:

"Adverse benefit determination" refers to the definition found in RCW 48.43.005. An adverse benefit determination includes a carrier or health plan's denial of enrollment status.

"Appellant" means an applicant or a person enrolled as an enrollee, subscriber, policy holder, participant, or beneficiary of an individual or group health plan, and when designated, their representative. Providers seeking expedited review of an adverse benefit determination on behalf of an appellant may act as the appellant's representative even if the appellant has not formally notified the health plan or carrier of the designation.

"External appeal or review" means the request by an appellant for an independent review organization to determine whether the carrier or health plan's internal appeal decisions are correct.

"Internal appeal or review" means the request by an appellant to a carrier or health plan to review and reconsider an adverse benefit determination.

NEW SECTION

WAC 284-43-510 Review of adverse benefit determinations—Generally. (1) Each carrier and health plan must establish and implement a comprehensive process for the review of adverse benefit determinations. The process must offer an appellant the opportunity for both internal review and external review of an adverse benefit determination. The process must meet accepted national certification standards such as those used by the National Committee for Quality Assurance, except as otherwise required by this chapter.

(2) Neither a carrier nor a health plan may take or threaten to take any punitive action against a provider acting on behalf or in support of an appellant.

(3) Unless the request for review is made by an applicant, coverage must be continued while an adverse benefit determination is reviewed. Appellants must be notified that they may be responsible for the cost of services if the adverse benefit determination is upheld.

(4)(a) A carrier must accept a request for internal review of an adverse benefit determination if it is submitted within at least sixty days of the appellant's receipt of a determination applicable to a group health plan.

(b) Within seventy-two hours of receiving a request for review, each carrier and health plan must notify the appellant of its receipt of the request.

(5)(a) The right of review and to appeal an adverse benefit determination must be clearly communicated in writing by the carrier. At a minimum, the notice must be sent at the following times:

(i) Upon request;

(ii) As part of the notice of adverse benefit determination;

(iii) To new enrollees at the time of enrollment;

(iv) Annually thereafter to enrollees, group administrators and subcontractors of the carrier; and

(v) The notice requirement under (a)(iii) and (iv) of this subsection is satisfied if the description of the internal and external review process is included in or attached to the summary health plan descriptions, policy, certificate, membership booklet, outline of coverage or other evidence of coverage provided to participants, beneficiaries, or enrollees.

(b) Each carrier and health plan must ensure that its network providers receive a written explanation of the manner in which adverse benefit determinations may be reviewed on both an expedited and nonexpedited basis.

(c) The written explanation of the review process must include information about the availability of Washington's designated ombudsman's office as that term is referenced in the Affordable Care Act (2010) P.L. 111-148, as amended. A carrier and health plan must also specifically direct appellants

to the office of the insurance commissioner's consumer protection division for assistance with questions and complaints.

(6) The review process must be accessible to persons who are limited-English speakers, who have literacy problems, or who have physical or mental disabilities that impede their ability to request review or participate in the review process.

(a) Carriers and health plans must conform to federal requirements to provide notice of the process in a culturally and linguistically appropriate manner to those seeking review.

(b) Carriers and health plans in counties where ten percent or more of the population is literate in a specific non-English language must include in notices a statement prominently displayed in the relevant language or languages, stating that oral assistance and a written notice in the non-English language are available upon request.

(7) Each carrier and health plan must consistently assist appellants with understanding the review process. Carriers and health plans may not use procedures or practices that the commissioner determines discourages an appellant from seeking expedited internal or independent external review, or concurrent expedited review.

(8) If a carrier or health plan reverses its initial adverse benefit determination, which it may at any time during the review process, the carrier or health plan must provide appellant with written or electronic notification of the decision within two business days of making the decision.

(9) Each carrier and health plan must maintain a log of each review, its resolution, and the dates of receipt, notification and determination.

(a) The carrier must make its review log available to the commissioner upon request in a form accessible by the commissioner. The log must be maintained by the carrier for a six-year period.

(b) Each carrier must identify, evaluate and make available to the commissioner data and reports on trends in reviews for at least a six-year time frame, including the data on the number of appeals, the subject matter of the appeals and their outcome.

NEW SECTION

WAC 284-43-515 Notice and explanation of adverse benefit determination—General requirements. (1) A carrier and health plan must notify enrollees of an adverse benefit determination either electronically or by U.S. mail. The notification must be provided to:

(a) An appellant or their authorized representative; and

(b) To the provider if the adverse benefit determination involves the denial of treatment or procedure prescribed by the provider.

(2) A carrier or health plan's notice must include the following information, worded in plain language:

(a) The specific reasons for the adverse benefit determination;

(b) The specific health plan policy or contract sections on which the determination is based, including references to the provisions;

(c) The plan's review procedures, including the appellant's right to a copy of the carrier and health plan's records related to the adverse benefit determination;

(d) The time limits applicable to the review; and

(e) The right of appellants and their providers to present evidence as part of a review of an adverse benefit determination.

(3) If an adverse benefit determination is based on medical necessity, decisions related to experimental treatment, or a similar exclusion or limit involving the exercise of professional judgment, the notification must contain either an explanation of the scientific or clinical basis for the determination, the manner in which the terms of the health plan were applied to the appellant's medical circumstances, or a statement that such explanation is available free of charge upon request.

(4) If an internal rule, guideline, protocol, or other similar criterion was relied on in making the adverse benefit determination, the notice must contain either the specific rule, guideline, protocol, or other similar criterion; or a statement that a copy of the rule, guideline, protocol, or other criterion is available free of charge upon request.

(5) The notice of an adverse benefit determination must include an explanation of the right to review the records of relevant information, including evidence used by the carrier or the carrier's representative that influenced or supported the decision to make the adverse benefit determination.

(a) For purposes of this subsection, "relevant information" means information relied on in making the determination, or that was submitted, considered or generated in the course of making the determination, regardless of whether the document, record or information was relied on in making the determination.

(b) Relevant information includes a statement of policy, procedure or administrative process concerning the denied treatment or benefit, regardless of whether it was relied on in making the determination.

(6) If the carrier and health plan determine that additional information is necessary to perfect the denied claim, the carrier and health plan must provide a description of the additional material or information that they require, with an explanation of why it is necessary, as soon as the need is identified.

(7) An enrollee or covered person may request that a carrier and health plan identify the medical, vocational or other experts whose advice was obtained in connection with the adverse benefit determination, even if the advice was not relied on in making the determination.

(8) The notice must include language substantially similar to the following:

"If you request a review of this adverse benefit determination, (Company name) will continue to provide coverage for the disputed benefit pending outcome of the review. If (Company name) prevails in the appeal, **you may be responsible for the cost of coverage received during the review period.** Even if you or the Company decide to pursue other remedies available under state or federal law, (Company name) must provide benefits, including making payment on a claim, if the final external review determination reverses the Company's decision. If (Company name) intends to seek judicial review

of the external review decision, the payment and/or benefits must continue until there is a judicial decision changing the final determination."

NEW SECTION

WAC 284-43-520 Electronic disclosure and communication by carriers. (1) Except as otherwise provided by applicable law, rule, or regulation, a carrier or health plan furnishing documents through electronic media is deemed to satisfy the notice and disclosure requirements regarding adverse benefit determinations with respect to applicants, covered persons, and appellants or their representative, if the carrier takes appropriate and necessary measures reasonably calculated to ensure that the system for furnishing documents:

(a) Results in actual receipt of transmitted information (e.g., using return-receipt or notice of undelivered electronic mail features, conducting periodic reviews or surveys to confirm receipt of the transmitted information);

(b) Protects the confidentiality of personal information relating to the individual's accounts and benefits (e.g., incorporating into the system measures designed to preclude unauthorized receipt of or access to such information by individuals other than the individual for whom the information is intended);

(c) Notice is provided in electronic or nonelectronic form, at the time a document is furnished electronically, that apprises the recipient of the significance of the document when it is not otherwise reasonably evident as transmitted (e.g., the attached document describes the internal review process used by your plan) and of the right to request and obtain a paper version of such document; and

(d) Upon request, the appellant or their representative is furnished a paper version of the electronically furnished documents.

(2) Subsection (1) of this section only applies to the following individuals:

(a) An appellant who affirmatively consents, in electronic or nonelectronic form, to receiving documents through electronic media and has not withdrawn such consent.

(b) In the case of documents to be furnished through the internet or other electronic communication network, has affirmatively consented or confirmed consent electronically, in a manner that reasonably demonstrates the individual's ability to access information in the electronic form that will be used to provide the information that is the subject of the consent, and has provided an address for the receipt of electronically furnished documents;

(c) Prior to consenting is provided, in electronic or nonelectronic form, a clear and conspicuous statement indicating:

(i) The types of documents to which the consent would apply;

(ii) That consent can be withdrawn at any time without charge;

(iii) The procedures for withdrawing consent and for updating the individual's electronic address for receipt of electronically furnished documents or other information;

(iv) The right to request and obtain a paper version of an electronically furnished document, including whether the paper version will be provided free of charge; and

(v) Any hardware and software requirements for accessing and retaining the documents.

(d) Following consent, if a change in hardware or software requirements needed to access or retain electronic documents creates a material risk that the individual will be unable to access or retain electronically furnished documents, the carrier must provide a statement of the revised hardware or software requirements for access to and retention of electronically furnished documents, and provide the individual receiving electronic communications with the right to withdraw consent without charge and without the imposition of any condition or consequence that was not disclosed at the time of the initial consent. The carrier or health plan must request and receive a new consent to the receipt of documents through electronic media, following a hardware or software requirement change as described in this subsection.

NEW SECTION

WAC 284-43-525 Internal review of adverse benefit determinations. An appellant seeking review of an adverse benefit determination must use the carrier and health plan's review process. Each carrier and health plan must include the opportunity for internal review of an adverse benefit determination in its review process. Treating providers may seek expedited review on a patient's behalf, regardless of whether the provider is affiliated with the carrier on a contracted basis.

(1) When a carrier and health plan receive a written request for review, the carrier must reconsider the adverse benefit review determination. The carrier and health plan must notify the appellant of the review decision within fourteen days of receipt of the request for review.

(2) For good cause, a carrier and health plan may extend the time to make a review determination by up to sixteen additional days. This thirty-day response time may be waived by the appellant only if such consent is reduced to writing, and if the parties agree in writing to a specific, agreed-upon date for determination.

(3) The carrier and health plan must provide the appellant with any new or additional evidence, or rationale considered, whether relied upon, generated by, or at the direction of, the carrier or health plan in connection with the claim. The evidence or rationale must be provided free of charge to the appellant, and sufficiently in advance of the date the notice of final internal review must be provided. The purpose of this requirement is to ensure the appellant has a reasonable opportunity to respond prior to that date. If the appellant requests an extension in order to respond to any new or additional rationale or evidence, the carrier and health plan must extend the determination date for a reasonable amount of time.

(4) A carrier and health plan's review process must provide the appellant with the opportunity to submit information, documents, written comments, records, evidence, and testimony, including information and records obtained through a second opinion. An appellant has the right to review the carrier and health plan's file and obtain a free copy

of all documents, records and information relevant to any claim that is the subject of the determination being appealed.

(5) A carrier and health plan's internal review process must include the requirement that the carrier and health plan affirmatively review and investigate the determination, and consider all information submitted by the appellant prior to issuing a determination.

(6) Review of adverse determinations must be performed by health care providers or staff who were not involved in the initial decision, and who are not subordinates of the persons involved in the initial decision. If the determination involves, even in part, medical judgment, the reviewer must be or must consult with a health care professional who has appropriate training and experience in the field of medicine encompassing the appellant's condition or disease and make a determination within the clinical standard of care for an appellant's disease or condition.

(7) The internal review process for group health plans must not contain any provision or be administered so that an appellant must file more than two requests for review prior to bringing a civil action. For individual health plans, carriers must provide for only one level of internal review before issuing a final determination, and may not require two levels of internal review.

(8) A carrier or health plan's rescission of coverage is an adverse benefit determination for which review may be requested.

NEW SECTION

WAC 284-43-530 Exhaustion of internal review remedies. (1) If a carrier or health plan fails to strictly adhere to its requirements with respect to the internal review, the internal review process is deemed exhausted, and the appellant may request external review without receiving an internal review determination from the carrier or the health plan.

(2) A carrier may challenge external review requested under this section either in court, or to the independent review organization to which the external review is assigned.

(a) The challenge must be based on a showing that the carrier violation is de minimis, and did not cause, and is not likely to cause, prejudice or harm to the appellant.

(i) This exception applies only if the external reviewer or court determines that the carrier has demonstrated that the violation was for good cause or was due to matters beyond the control of the carrier, and that the violation occurred in the context of an ongoing, good faith exchange of information between the carrier or health plan and the appellant.

(ii) This exception is not available, and the challenge may not be sustained, if the violation is part of a pattern or practice of violations by the carrier or health plan.

(b) Before filing a request for external review under this section, the appellant must request a written explanation for the violation from the carrier, and the carrier must provide such explanation within ten calendar days. The explanation must include a specific description of the carrier or health plan's basis, if any, for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted.

(c) If the independent review organization or court determines that the internal review process is not exhausted, based on a carrier or health plan's challenge under this section, the carrier or health plan must provide the appellant with notice that they may resubmit and pursue the internal appeal within a reasonable time, not to exceed ten days, of receiving the independent review organization's determination, or of the entry of the court's final order.

NEW SECTION

WAC 284-43-535 Notice of internal review determination. Each carrier and health plan's review process must require delivery to the appellant of written notification of the internal review determination. In addition to the requirements of WAC 284-43-515, the written determination must include:

(1) The actual reasons for the determination;

(2) Instructions for obtaining further review of the determination, either through a second level of internal review, if applicable, or using the external review process;

(3) The clinical rationale for the decision, which may be in summary form; and

(4) Instructions on obtaining the clinical review criteria used to make the determination.

NEW SECTION

WAC 284-43-540 Expedited review. (1) A carrier and health plan's internal and external review processes must permit an expedited review of an adverse benefit determination at any time in the review process, or concurrently, if:

(a) The appellant is currently receiving or is prescribed treatment for a medical condition related to the adverse benefit determination; and

(b) Any treating provider for the appellant, regardless of their affiliation with the carrier and health plan, believes that a delay in treatment based on the standard review time may seriously jeopardize the appellant's life, overall health or ability to regain maximum function, or would subject the appellant to severe and intolerable pain; or

(c) The determination is related to an issue related to admission, availability of care, continued stay or emergency health care services where the appellant has not been discharged from the emergency room or transport service.

(2) An appellant is not entitled to expedited review if the treatment has already been delivered and the review involves payment for the delivered treatment, if the situation is not urgent, or if the situation does not involve the delivery of services for an existing condition, illness or disease.

(3) An expedited review may be filed by appellant or the appellant's provider verbally, or in writing.

(4) The carrier or health plan must respond as expeditiously as possible to an expedited review, preferably within twenty-four hours, but in no case longer than seventy-two hours.

(a) The carrier's response to an expedited review may be delivered verbally, and must be reduced to and issued in writing not later than seventy-two hours after the date of the decision. Regardless of who makes the carrier and health plan's determination, the time frame for providing a response to an

expedited review request begins when the carrier or health plan first receives the request.

(b) If the carrier or health plan requires additional information to determine whether the service or treatment determination being reviewed is covered under the health plan, or eligible for benefits, they must request such information as soon as possible after receiving the request for expedited review.

(5) If a treating health care provider determines that a delay could jeopardize the covered person's health or ability to regain maximum function, the carrier or health plan must presume the need for expedited review, and treat the review request as such, including the need for an expedited determination of an external review under RCW 48.43.535.

(6) Neither a carrier nor a health plan may require exhaustion of the internal appeal process before an appellant may request an external review in urgent care situations that justify expedited review.

NEW SECTION

WAC 284-43-545 Concurrent expedited review of adverse benefit determinations. A carrier and health plan must offer the right to request concurrent expedited internal and external review of adverse benefit determinations. A carrier and health plan may not extend the timelines when concurrent expedited reviews are requested by making the determinations consecutively. The requisite timelines must be applied concurrently. A carrier and health plan may not deny a request for concurrent review unless the conditions for expedited review in WAC 284-43-540 are not met. Neither a carrier nor a health plan may require exhaustion of internal review if an appellant requests concurrent expedited review.

NEW SECTION

WAC 284-43-550 External review of adverse benefit determinations. When the internal review of an adverse benefit determination is final, or is deemed exhausted, the appellant may request an external review of the final internal adverse benefit determination. If the appellant requests an external review of a final internal adverse determination, the carrier or health plan must cooperatively participate in that review. Carriers and health plans must inform appellants of their right to external review, and explain the process that they must use to exercise that right.

(1) Appellants must be provided the right to external review of adverse benefit determinations based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit. The carrier and health plan may not establish a minimum dollar amount restriction as a predicate for an appellant to seek external review.

(2) Carriers must use the rotational registry system of certified independent review organizations (IRO) established by the commissioner, and must select reviewing IROs in the rotational manner described in the rotational registry system. A carrier may not make an assignment to an IRO out of sequence for any reason other than the existence of a conflict of interest, as set forth in WAC 246-305-030.

(3) The rotational registry system, a current list of certified IROs, IRO assignment instructions, and an IRO assignment form to be used by carriers are available on the insurance commissioner's web site (www.insurance.wa.gov).

(4) In addition to the requirements set forth in RCW 48.43.535, the carrier and health plan must:

(a) Make available to the appellant and to any provider acting on behalf of the appellant all materials provided to an IRO reviewing the carrier's determination;

(b) Provide IRO review without imposing any cost to the appellant or their provider; and

(c) Provide IROs with:

(i) All relevant clinical review criteria used by the carrier and other relevant medical, scientific, and cost-effectiveness evidence;

(ii) The attending or ordering provider's recommendations; and

(iii) A copy of the terms and conditions of coverage under the relevant health plan.

(d) Within one day of selecting the IRO, notify the appellant the name of the IRO and its contact information. This requirement is intended to comply with the federal standard that appellants receive notice of the IRO's identity and contact information within one day of assignment. The notice from the carrier must explain that the appellant is permitted five business days from receipt of the notice to submit additional information in writing to the IRO. The IRO must consider this information when conducting its review.

(5) A carrier may waive a requirement that internal appeals must be exhausted before an appellant may proceed to an independent review of an adverse determination.

(6) Upon receipt of the information provided by the appellant to the IRO pursuant to RCW 48.43.535 and this section, a carrier may reverse its final internal adverse determination. If it does so, it must immediately notify the IRO and the appellant.

(7) Carriers must report to the commissioner each assignment made to an IRO not later than one business day after an assignment is made. Information regarding the enrollee's personal health may not be provided with the report.

(8) The requirements of this section are in addition to the requirements set forth in RCW 48.43.535 and 43.70.235, and rules adopted by the department of health in chapter 246-305 WAC.

SUBCHAPTER F
((~~GRIEVANCE AND COMPLAINT~~)) GRANDFATHERED HEALTH PLAN APPEAL PROCEDURES

NEW SECTION

WAC 284-43-605 Application of subchapter F. For any grandfathered health plan, a carrier may comply with RCW 48.43.530 and 48.43.535 by using a grievance and complaint process that conforms to the procedures and standards set forth in WAC 284-43-615 through 284-43-630. A health plan is grandfathered if the carrier correctly designates it as such based on the federal definition standards for grandfathered health plans as set forth in the Affordable Care Act (2010), P.L. 111-148, as amended, and its implementing federal regulations.

AMENDATORY SECTION (Amending Matter No. R 2000-02, filed 1/9/01, effective 7/1/01)

WAC 284-43-615 Grievance and complaint procedures—Generally. (1) Each carrier must adopt and implement a comprehensive process for the resolution of covered persons' ((~~grievances and~~)) appeals of adverse determinations. This process shall meet accepted national certification standards such as those used by the National Committee for Quality Assurance except as otherwise required by this chapter.

(2) This process must conform to the provisions of this chapter and each carrier must:

(a) Provide a clear explanation of the ((~~grievance~~)) appeal process upon request, upon enrollment to new covered persons, and annually to covered persons and subcontractors of the carrier.

(b) Ensure that the ((~~grievance~~)) appeal process is accessible to enrollees who are limited-English speakers, who have literacy problems, or who have physical or mental disabilities that impede their ability to file ((~~a grievance.~~

~~(c) Process as a grievance a covered person's expression of dissatisfaction about customer service or the quality or availability of a health service.~~

~~(d)~~)) an appeal.

(c) Implement procedures for registering and responding to oral and written ((~~grievances~~)) appeals in a timely and thorough manner including the notification of a covered person that a grievance or appeal has been received.

(((~~e~~))) (d) Assist the covered person with all ((~~grievance and~~)) appeal processes.

(((~~f~~))) (e) Cooperate with any representative authorized in writing by the covered person.

(((~~g~~))) (f) Consider all information submitted by the covered person or representative.

(((~~h~~))) (g) Investigate and resolve all ((~~grievances and~~)) appeals.

(((~~i~~))) (h) Provide information on the covered person's right to obtain second opinions.

(((~~j~~))) (i) Track each appeal until final resolution; maintain, and make accessible to the commissioner for a period of three years, a log of all appeals; and identify and evaluate trends in appeals.

AMENDATORY SECTION (Amending Matter No. R 2000-02, filed 1/9/01, effective 7/1/01)

WAC 284-43-620 Procedures for review and appeal of adverse determinations. (1) A covered person or the covered person's representative, including the treating provider (regardless of whether the provider is affiliated with the carrier) acting on behalf of the covered person may appeal an adverse determination in writing. The carrier must reconsider the adverse determination and notify the covered person of its decision within fourteen days of receipt of the appeal unless the carrier notifies the covered person that an extension is necessary to complete the appeal; however, the extension cannot delay the decision beyond thirty days of the request for appeal, without the informed, written consent of the ((~~coverage~~)) covered person.

(2) Whenever a health carrier makes an adverse determination and delay would jeopardize the covered person's life or materially jeopardize the covered person's health, the carrier shall expedite and process either a written or an oral appeal and issue a decision no later than seventy-two hours after receipt of the appeal. If the treating health care provider determines that delay could jeopardize the covered person's health or ability to regain maximum function, the carrier shall presume the need for expeditious review, including the need for an expeditious determination in any independent review under WAC 284-43-630.

(3) A carrier may not take or threaten to take any punitive action against a provider acting on behalf or in support of a covered person appealing an adverse determination.

(4) Appeals of adverse determinations shall be evaluated by health care providers who were not involved in the initial decision and who have appropriate expertise in the field of medicine that encompasses the covered person's condition or disease.

(5) All appeals must include a review of all relevant information submitted by the covered person or a provider acting on behalf of the covered person.

(6) The carrier shall issue to affected parties and to any provider acting on behalf of the covered person a written notification of the adverse determination that includes the actual reasons for the determination, the instructions for obtaining an appeal of the carrier's decision, a written statement of the clinical rationale for the decision, and instructions for obtaining the clinical review criteria used to make the determination.

SUBCHAPTER G
GRIEVANCES

NEW SECTION

WAC 284-43-705 Definition. This definition applies to subchapter G. "Grievant" means a person filing a grievance as defined in WAC 284-43-130, and who is not an appellant under either subchapter E or F of this chapter.

NEW SECTION

WAC 284-43-715 Grievance process—Generally. This section applies to grandfathered and nongrandfathered plans.

(1) Each carrier and health plan must offer applicants, covered persons, and providers a way to resolve grievances. If the grievance is received verbally, a carrier must promptly provide information regarding the use of its grievance process to an applicant or enrollee who wants to submit a grievance. The carrier must assist the grievant in putting the complaint into writing, if requested to do so.

(2) Each carrier must maintain a log or otherwise register verbal and written grievances, and retain the log or record for six years. It must be available for review by the commissioner upon request. The log must identify the health plan, if any, under which the person was enrolled, the name of the grievant, the resolution of each grievance, the date of receipt, the date of resolution, and if different than the resolution date,

the date notice was provided to the person registering the grievance. If a health plan is administered by a third party under contract to the carrier, the third party may keep the log and make it available through the carrier to the commissioner, or the third party may forward the information for the log to the carrier.

(3) Each carrier and health plan must send notice of receipt of a grievance to the grievant within two business days of receiving the grievance.

(4) When resolving a grievance, a carrier must consider all information submitted by the person registering the grievance and perform a reasonable investigation or review of the facts, policies, procedures or practices related to the grievance. A carrier and health plan must determine a resolution in response to the grievance within forty-five business days, and must notify the grievant of the determination within five business days of making it.

(5) Grievance determinations are not adverse benefit determinations and do not establish the right to internal or external review of a carrier or health plan's resolution of the grievance.

(6) Nothing in this section prohibits a carrier from creating or using its own system to categorize the nature of grievances in order to collect data if the system permits reporting of the data specified in subsection (2) of this section.

(7) This section is effective as of November 26, 2011.