WSR 16-04-023
EMERGENCY RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Developmental Disabilities Administration)

[Filed January 22, 2016, 3:04 p.m., effective January 22, 2016, 3:04 p.m.]

Effective Date of Rule: Immediately upon filing.

Purpose: This filing allows DSHS to continue the individual and family services (IFS) waiver and the community first choice (CFC) program. Both were implemented by emergency rules and need to remain active by emergency while the department continues working with the Centers for Medicare and Medicaid Services (CMS), stakeholders, advocacy groups, and other DSHS administrations to refine the semantics and structure of the text for the CR-102 filing, public comment period, and public hearing. In addition these rules clarify where the DDA assessment and reassessment are administered and define overnight planned respite services.

Citation of Existing Rules Affected by this Order: Amending WAC 388-823-0010 Definitions, 388-825-020 Definitions, 388-825-057 Am I eligible to receive paid services from DDD?, 388-825-0571 What services am I eligible to receive from DDD if I am under the age of eighteen, have been determined to meet DDD eligibility requirements, and I am in a dependency guardianship or foster care with children's administration?, 388-825-059 How will I know which paid services I will receive?, 388-825-068 What medicaid state plan services may DDD authorize?, 388-825-083 Is there a comprehensive list of waiver and state-only DDD services?, 388-825-305 What service providers are governed by the qualifications in these rules?, 388-825-310 What are the qualifications for providers?, 388-825-325 What are required skills and abilities for individuals and agencies contracted to provide respite care, personal care services through the medicaid personal care program or the DDD HCBS Basic, Basic Plus, CIIBS, or 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Statutory Authority for Adoption: SSB 6387 of the 63rd legislature, 2014 regular session for the IFS waiver, ESHB 2746 of the 63rd legislative [legislature], 2014 regular session for the CFC waiver and ESSB 6052.S.L of the 64th legislative [legislature], 2015 3rd sp. sess. for the definition of overnight planned respite services.

Other Authority: RCW 71A.12.030, 71A.12.120.

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 purpose for this filing is to allow DSHS to continue the IFS waiver and CFC program. Both of these were implemented by emergency rules and need to remain active by emergency rules while we continue working with CMS, stakeholders, advocacy groups, and other DSHS administrations to refine the semantics and structure of the text for the supplemental CR-102 filing, the comment period, and public hearing.

Related to the IFS waiver: Once SSB 6387 of the 63rd legislature 2014 regular session was passed, DDA worked on the new required IFS waiver while we concurrently identified and programmed the enhancements needed to our statewide assessment tool "CARE" that would incorporate the waiver into our daily work process. Our intent was to be ready to file the emergency rules and implement the system changes to CARE upon the waiver approval date given to us by CMS. Our advanced preparation paid off and once CMS approved our IFS waiver we were able to file the CR-103E to make those changes to rule effective by emergency on June 1, 2015, which turned out to be a short period of time from when CMS approved the waiver and when the waiver would be effective. Although we had also filed the CR-102 and held a public comment hearing for those proposed rules we find ourselves not able to make those rules effective through the regular process prior to needing the additional changes to some sections in chapter 388-845 WAC by the CMS implementation date for the new CFC program.

Related to CFC program: ESHB 2746 requires DSHS to refinance personal care services and establish a 1915(k) CFC program per §1915(k) of the Social Security Act. To that end, DSHS has been working to develop a state plan amendment for implementation after CMS approval. This new program also needed modifications to our statewide assessment tool "CARE" and updates to rules of which some sections needing updates are the same sections within chapter 388-845 WAC that have been adopted by emergency but not yet completed the regular process to be adopted permanently.

Related to where the DDA assessment and reassessment is administered: These changes are to more closely align our rules with 42 C.F.R. 441.540 (a)(3) that allows the individual to select a time and location of their convenience for assessments.

Related to the definition of overnight planned respite services: Rule changes to implement overnight planned respite services, as approved in ESSB 6052.S.L of the 64th legislative [legislature], 2015 3rd sp. sess. are being implemented by a different emergency rule filing. However, since the definitions section is already open in this filing we are adding the definition in this filing.

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 16, Amended 90, 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 16, Amended 90, Repealed 0.

Date Adopted: January 22, 2016.

Katherine I. Vasquez
Rules Coordinator

AMENDATORY SECTION (Amending WSR 14-12-046, filed 5/29/14, effective 7/1/14)

WAC 388-823-0010 Definitions. The following definitions apply to this chapter:

"ABAS-II" means adaptive behavior assessment system-second edition, which is a comprehensive, norm-referenced assessment of adaptive behavior and skills of individuals from birth through age 89.

"CAS" means the DAS-Naglieri cognitive assessment system, a clinical instrument for assessing intelligence based on a battery of cognitive tasks. The test is used for children ages five through seventeen years eleven months.

"Client" means a person with a developmental disability as defined in chapter 388-823 WAC who is currently eligible and active with the developmental disabilities administration (DDA).

"Community first choice (CFC) is a medicaid state plan program defined in chapter 388-106 WAC.

"C-TONI" means the comprehensive test of nonverbal intelligence, a battery of six subtests, designed to measure different aspects of nonverbal intellectual abilities from ages six to eighteen years eleven months.

"DAS" means differential ability scales, which is a cognitive abilities battery for children and adolescents at least age two years, six months but under age eighteen.

"DDA" means the developmental disabilities administration, an administration within department of social and health services.

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

"Documentation" means written information that provides support for certain claims, such as diagnoses, test scores, or residency for the purpose of establishing DDA eligibility.

"DSM-IV-TR" means the diagnostic and statistical manual of mental disorders, fourth edition, text revision.

"DSM-5" means the diagnostic and statistical manual of mental disorders, fifth edition.

"Eligible" means that DDA has determined that you have a condition that meets all of the requirements for a developmental disability as set forth in this chapter.

"ESIT" means early support for infants and toddlers, a program administered by the department of early learning.

"Expiration date" means a specific date that your eligibility as a client of DDA and all services paid by DDA will stop.

"FSIQ" means the full scale intelligence quotient which is a broad measure of intelligence achieved through one of the standardized intelligence tests included in these rules. Any standard error of measurement value will not be taken into consideration when making a determination for DDA eligibility.

"Functional limitation" means a reduced ability or lack of ability to perform an action or activity in the manner or within the range considered to be normal.

"ICAP" means the inventory for client and agency planning. This is a standardized assessment of functional ability. The adaptive behavior section of the ICAP assesses daily living skills and the applicant awareness of when to perform these skills. The goal is to get a snapshot of his/her ability.

"K-ABC" means Kaufman assessment battery for children, which is a clinical instrument for assessing intellectual development. It is an individually administered test of intelligence and achievement for children at least age two years, six months but under age twelve years, six months. The K-ABC comprises four global scales, each yielding standard scores. A special nonverbal scale is provided for children at least age four years but under age twelve years, six months.

"Leiter-R" means Leiter international performance scale - revised, which is an untimed, individually administered test of nonverbal cognitive ability for individuals at least age two years but under age twenty-one years.

"Medicaid personal care (MPC)" ((~~means~~)) is a medicaid ((~~personal care and is the provision of medically necessary personal care tasks~~)) state plan program as defined in chapter 388-106 WAC.

"Necessary supplemental accommodation representative" means an individual who receives copies of DDA planned action notices (PANs) and other department correspondence in order to help a client understand the documents and exercise the client's rights. A necessary supplemental accommodation representative is identified by a client of DDA when the client does not have a legal guardian and the client is requesting or receiving DDA services.

"Nonverbal" means that you do not possess sufficient verbal skills to complete a standard intellectual test.

"NSA" means necessary supplemental accommodations, which are services provided to you if you have a mental, neurological, physical, or sensory impairment or other problems that prevent you from getting program benefits in the same way that an unimpaired person would get them.

"Review" means DDA must determine that a current client of DDA still meets all of the requirements for a developmental disability as set forth in this chapter.

"RHC" means a residential habilitation center operated by the DDA.

"SIB-R" means the scale of independent behavior-revised which is an adaptive behavior assessment derived from quality standardization and norming. It can be administered as a questionnaire or as a carefully structured interview, with special materials to aid the interview process.

"SOLA" means a state operated living alternative residential service for adults operated by DDA.

"Stanford-Binet" is a battery of fifteen subtests measuring intelligence for individuals at least age two years but under age twenty-three years.

"Termination" means an action taken by DDA that stops your DDA eligibility and services paid by DDA. If your DDA eligibility is terminated your DDA authorized services will also be terminated. If you remain eligible for community first choice (CFC) or medicaid personal care (MPC) and you are under the age of eighteen DDA will continue to authorize this service. If you are eighteen or older ((~~medicaid personal care~~)) CFC or MPC services will be authorized by the aging and long-term support administration.

"VABS" means Vineland adaptive behavior scales, which is an assessment to measure adaptive behavior in children from birth but under age eighteen years, nine months and in adults with low functioning in four separate domains:

Communication, daily living skills, socialization, and motor skills.

"Wechsler" means the Wechsler intelligence scale, which is an individually administered measure of an individual's capacity for intelligent behavior. There are three Wechsler intelligence scales, dependent upon the age of the individual:

• Wechsler preschool and primary scale of intelligence for children at least age three years but under age seven years;

• Wechsler intelligence scale for children at least age six years but under age sixteen years; and

• Wechsler adult intelligence scale for individuals at least age sixteen years but under age seventy-four years.

"WJ III(r)" means the Woodcock-Johnson(r) III, a test which is designed to provide a co-normed set of tests for measuring general intellectual ability, specific cognitive abilities, scholastic aptitude, oral language, and academic achievement. The WJ III(r) is used for ages two and up.

AMENDATORY SECTION (Amending WSR 12-22-037, filed 11/1/12, effective 12/2/12)

WAC 388-825-020 Definitions. "Authorization" means DDD approval of funding for a service as identified in the individual support plan or evidence of payment for a service.

"Client or person" means a person who has a developmental disability as defined in RCW 71A.10.020(3) who also has been determined eligible to receive services by the division under chapter 71A.16 RCW.

"Community first choice (CFC)" is a medicaid state plan program defined in chapter 388-106 WAC.

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

"Director" means the director of the division of developmental disabilities.

"Division or DDD" means the division of developmental disabilities within the aging and disability services administration of the department of social and health services.

"Enhanced respite services" means respite care for DDD enrolled children and youth, who meet specific criteria, in a DDD contracted and licensed staffed residential setting.

"Family" means relatives who live in the same home with the eligible client. Relatives include spouse or registered domestic partner; natural, adoptive or step parent; grandparent; child; stepchild; sibling; stepsibling; uncle; aunt; first cousin; niece; or nephew.

"ICF/ID" means a facility certified as an intermediate care facility for intellectually disabled by Title XIX to provide diagnosis, treatment and rehabilitation services to the individuals with intellectual disabilities or individuals with related conditions.

"ICF/ID eligible" for admission to an ICF/ID means a person is determined by DDD as needing active treatment as defined in C.F.R. 483.440. Active treatment requires:

(1) Twenty-four hour supervision; and

(2) Continuous training and physical assistance in order to function on a daily basis due to deficits in the following areas: Toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication.

"Individual support plan (ISP)" is a document that authorizes and identifies the DDD paid services to meet a client's assessed needs.

"Medicaid personal care (MPC)" is ((~~the provision of medically necessary personal care tasks as~~)) a medicaid state plan program defined in chapter 388-106 WAC.

"Overnight planned respite services" means services intended to provide short-term intermittent relief for persons who live with the DDA client as the primary care provider and are either (1) a family member (paid or unpaid); or (2) a nonfamily member who is not paid. These services provide person-centered support, care and planned activities for the client in the community.

"Residential habilitation center" or **"RHC"** means a state-operated facility certified to provide ICF/ID and/or nursing facility level of care for persons with developmental disabilities.

"Residential programs" means provision of support for persons in community living situations. Residential programs include DDD certified community residential services and support, both facility-based such as licensed group homes, and nonfacility based, such as supported living and state-operated living alternatives (SOLA). Other residential programs include alternative living (as described in chapter 388-829A WAC, companion homes (as described in chapter 388-829C WAC), adult family homes, adult residential care services, children's foster homes, group care and staffed residential homes.

"Respite care" means short-term intermittent care for DDD clients in order to provide relief for persons who normally provide that care.

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

"State supplementary payment (SSP)" is the state paid cash assistance program for certain DDD eligible SSI clients.

AMENDATORY SECTION (Amending WSR 08-11-072, filed 5/19/08, effective 6/19/08)

WAC 388-825-057 Am I eligible to receive paid services from DDD? You may be eligible to receive paid services from DDD if you are currently an eligible client of DDD per chapter 388-823 WAC and:

(1) You are under the age of three and meet the eligibility requirements contained in WAC 388-823-0800 through 388-823-0850; or

(2) You are a recipient of Washington ((~~state medicaid~~)) apple health under the categorically needy program (CNP) or the alternative benefit plan and meet the eligibility requirements contained in ((~~chapters 388-474, 388-475 and 388-513~~)) chapter 182-513 WAC; or

(3) You are enrolled in a DDD home and community based services waiver and meet the eligibility requirements contained in chapter 388-845 WAC; or

(4) You have been enrolled in the individual and family services program and meet the eligibility requirements contained in chapter 388-832 WAC; or

(5) You have been approved to receive a state-only funded service.

AMENDATORY SECTION (Amending WSR 08-11-072, filed 5/19/08, effective 6/19/08)

WAC 388-825-0571 What services am I eligible to receive from DDD if I am under the age of eighteen, have been determined to meet DDD eligibility requirements, and I am in a dependency guardianship or foster care with children's administration? Your services from DDD are limited to CFC or medicaid personal care services and related case management if you meet the programmatic eligibility for ((~~medicaid personal care~~)) those programs defined in chapter 388-106 and 388-71 WAC ((~~governing medicaid personal care (MPC) using the current department approved assessment form, comprehensive assessment reporting evaluation (CARE),~~)) and:

(1) You are under the age of eighteen;

(2) You have been determined to meet DDD eligibility requirements; and

(3) You are in a dependency guardianship or foster care with children's administration.

AMENDATORY SECTION (Amending WSR 08-11-072, filed 5/19/08, effective 6/19/08)

WAC 388-825-059 How will I know which paid services I will receive? Your person-centered service plan/individual support plan (ISP) identifies the services and the amount of service you can receive.

AMENDATORY SECTION (Amending WSR 12-22-037, filed 11/1/12, effective 12/2/12)

WAC 388-825-068 What medicaid state plan services can DDD authorize? DDD may authorize the following medicaid state plan services if you meet the eligibility criteria for the program:

(1) Community first choice, per chapter 388-106 WAC;

(2) Medicaid personal care, per chapter 388-106 WAC;

((~~(2)~~)) (3) Private duty nursing for adults age eighteen and older; per chapter 388-106 WAC;

((~~(3)~~)) (4) Private duty nursing for children under the age of eighteen, per WAC 182-551-3000;

((~~(4) Adult day health for adults, per chapter 388-106 WAC; and~~))

(5) ICF/ID services, per chapters 388-835 and 388-837 WAC;

(6) Nursing facility services at residential habilitation centers (RHC) per chapter 388-97 WAC.

AMENDATORY SECTION (Amending WSR 10-02-101, filed 1/6/10, effective 2/6/10)

WAC 388-825-083 Is there a comprehensive list of waiver and state-only DDD services? For medicaid state plan services authorized by DDD, see WAC 388-825-068. The following is a list of waiver and state-only services that DDD can authorize and those services that can be either a waiver or a state-only service:

(1) **Waiver personal care services that are not available with state-only funds include:**

(a) In-home services;

(b) Adult family home; and

(c) Adult residential care.

(2) **Waiver services that can be funded as state-only services:**

(a) Assistive technology;

(b) Behavior management and consultation;

((~~(b)~~)) (c) Community engagement;

(d) Community guide;

(e) Community transition;

((~~(c)~~)) (f) Environmental accessibility adaptations;

((~~(d)~~)) (g) Medical equipment and supplies;

((~~(e)~~)) (h) Occupational therapy;

((~~(f)~~)) (i) Peer mentoring;

(j) Person-centered planning facilitation;

(k) Physical therapy;

((~~(g)~~)) (l) Respite care;

((~~(h)~~)) (m) Sexual deviancy evaluation;

((~~(i)~~)) (n) Skilled nursing;

((~~(j)~~)) (o) Specialized clothing;

(p) Specialized nutrition;

(q) Specialized medical equipment or supplies;

((~~(k)~~)) (r) Specialized psychiatric services;

((~~(l)~~)) (s) Speech, hearing and language therapy;

((~~(m)~~)) (t) Staff/family consultation and training;

((~~(n)~~)) (u) Supported parenting services;

(v) Therapeutic equipment and supplies;

(w) Transportation/mileage;

((~~(o)~~)) (x) Vehicle modification;

(y) Residential habilitation services (RHS), including:

(i) Alternative living;

(ii) Companion homes;

(iii) Supported living;

(iv) Group home;

(v) Child foster care;

(vi) Child group care;

(vii) Staffed residential; and

(viii) State operated living alternative (SOLA);

((~~(p)~~)) (z) Employment/day programs, including:

(i) Community access;

(ii) ((~~Community guide;~~))

((~~(iii)~~)) ((~~Person-to-person;~~

~~(iv)~~)) Prevocational services; and

((~~(v)~~)) (iii) Supported employment;

((~~(q)~~)) (aa) ((~~ITEIP/~~))County programs, including child development services;

((~~(r)~~)) (bb) Behavioral ((~~Mental~~)) health stabilization services, including:

(i) Behavior ((~~management~~)) support and consultation;

(ii) ((~~Mental health crisis~~)) Behavioral health crisis diversion bed services; and

(iii) ((~~Skilled nursing; and~~

~~(s)~~)) Specialized psychiatric services.

(3) **State-only services that are not available as a waiver service:**

(a) Adult day care;

(b) Architectural and vehicle modification;

(c) Attendant care;

(d) Child care for foster children;

(e) Chore services;

(f) Community services grant;

(g) Individual and family assistance;

(h) Information/education;

(i) Medical and dental services;

(j) Medical insurance copays and costs exceeding other coverage;

(k) Parent and sibling education;

(l) Parent training and counseling;

(m) Psychological counseling;

(n) Recreational opportunities;

(o) State supplementary payments;

(((~~(p) Specialized clothing;~~

~~(q) Specialized nutrition;~~

~~(r)~~))) (p) Training of the client;

(((~~(s)~~))) (q) Transportation - cost of escort service or travel time; and

(((~~(t)~~))) (r) Reimbursement to families for the purchase of approved items or services.

AMENDATORY SECTION (Amending WSR 07-23-062, filed 11/16/07, effective 12/17/07)

WAC 388-825-305 What service providers are governed by the qualifications in these rules? These rules govern individuals and agencies contracted with to provide:

(1) Respite care services;

(2) Personal care services through the ((~~medicaid personal care program or DDD HCBS Basic~~)), Basic Plus((~~, or CORE~~)) waiver((~~s~~)); ((~~or~~))

(3) Community first choice services;

(4) Medicaid personal care; or

(5) Attendant care services.

AMENDATORY SECTION (Amending WSR 05-17-135, filed 8/19/05, effective 9/19/05)

WAC 388-825-310 What are the qualifications for respite care, community first choice, medicaid personal care, and attendant care service providers? (1) ((~~Individuals and agencies providing medicaid personal care (chapters 388-71 and 388-106 WAC) and DDD HCBS waiver personal care (chapter 388-845 WAC)~~)) The providers of services in WAC 388-825-305 must meet the qualifications and training requirements in WAC 388-71-0500 through 388-71-05909.

(2) ((~~Individuals and agencies providing nonwaiver DDD home and community based services (HCBS) in the client's residence or the provider's residence or other setting must meet the requirements in WAC 388-825-300 through 388-825-400~~)) Individuals and agencies providing state only individual and family services must meet the provider qualifications in chapter 388-832 WAC for the specific service.

(3) Individuals and agencies providing HCBS waiver services must meet the provider qualifications in chapter 388-845 WAC for the specific service. In addition to meeting the provider qualifications in chapter 388-845 WAC, respite care providers must meet requirements in subsection (1) of this section.

AMENDATORY SECTION (Amending WSR 10-02-101, filed 1/6/10, effective 2/6/10)

WAC 388-825-325 What are required skills and abilities for individuals and agencies contracted to provide community first choice services, medicaid personal care, respite care, ((~~personal care services through the medicaid personal care program or the DDD HCBS Basic, Basic Plus, CHBS, or Core waivers,~~)) or attendant care services? (1) As a provider of community first choice services, medicaid personal care, respite care, ((~~personal care services through the medicaid personal care program or the DDD HCBS Basic, Basic Plus, CHBS, or Core waivers,~~)) or attendant care services, you must be able to:

(a) Adequately maintain records of services performed and payments received;

(b) Read and understand the person's service plan. Translation services may be used if needed;

(c) Be kind and caring to the DSHS client for whom services are authorized;

(d) Identify problem situations and take the necessary action;

(e) Respond to emergencies without direct supervision;

(f) Understand the way your employer wants you to do things and carry out instructions;

(g) Work independently;

(h) Be dependable and responsible;

(i) Know when and how to contact the client's representative and the client's case resource manager;

(j) Participate in any quality assurance reviews required by DSHS;

(2) If you are working with an adult client of DSHS as a provider of attendant care, you must also:

(a) Be knowledgeable about the person's preferences regarding the care provided;

(b) Know the resources in the community the person prefers to use and enable the person to use them;

(c) Know who the person's friends are and enable the person to see those friends; and

(d) Enable the person to keep in touch with his/her family as preferred by the person.

AMENDATORY SECTION (Amending WSR 10-02-101, filed 1/6/10, effective 2/6/10)

WAC 388-825-330 What is required for agencies ((~~wanting~~)) to provide care in the home of a person with developmental disabilities? (1) Agencies providing community first choice services, medicaid personal care or respite services must be licensed as a home care agency or a home health agency through the department of health per chapter 246-335 WAC.

(2) If a residential agency certified per chapter 388-101 WAC ((~~wishes~~)) wants to provide medicaid personal care or respite care in the client's home((~~,~~)) the agency must have a home care agency ((~~certification~~)) or ((~~a~~)) home health license.

(3) If a residential agency certified per chapter 388-101 WAC only wants to provide skills acquisition under the community first choice program the agency must be contracted with the department to provide the service.

AMENDATORY SECTION (Amending WSR 07-23-062, filed 11/16/07, effective 12/17/07)

WAC 388-825-355 ((~~Are there any educational~~)) What are the training requirements for individuals providing respite care, attendant care, community first choice, or personal care services? (((~~(1) If you are an~~)) The training and certification requirements for individuals who ((~~providing~~)) provide personal care or community first choice services ((~~for adults, you must meet the training requirements~~)) are listed in chapter 388-71 WAC ((~~388-71-05665 through 388-71-05909.~~))

~~(2) If you provide personal care for children, or provide respite care, there is no required training but DDD retains the authority to require training of any provider~~)).

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 07-10-029, filed 4/23/07, effective 6/1/07)

WAC 388-828-1020 What definitions apply to this chapter? The following definitions apply to this chapter:

"AAIDD" means the American Association on Intellectual and Developmental Disabilities.

"Acuity Scale" refers to an assessment tool that is intended to provide a framework for documenting important assessment elements and for standardizing the key questions that should be asked as part of a professional assessment. The design helps provide consistency from client to client by minimizing subjective bias and assists in promoting objective assessment of a person's support needs.

"ADSA" means the aging and disability services administration (ADSA), an administration within the department of social and health services, which includes the following divisions: Home and community services, residential care services, management services and division of developmental disabilities.

"ADSA contracted provider" means an individual or agency who is licensed, certified, and/or contracted by ADSA to provide services to DDD clients.

"Adult family home" or "AFH" means a residential home in which a person or persons provide personal care, special care, room and board to more than one but not more than six adults who are not related by blood or marriage to the person or persons providing the services (see RCW 70.12.-010).

"Agency provider" means a licensed and/or ADSA certified business who is contracted with ADSA or a county to provide DDD services (e.g., personal care, respite care, residential services, therapy, nursing, employment, etc.).

"Algorithm" means a numerical formula used by the DDD assessment for one or more of the following:

(1) Calculation of assessed information to identify a client's relative level of need;

(2) Determination regarding which assessment modules a client receives as part of his/her DDD assessment; and

(3) Assignment of a service level to support a client's assessed need.

"Authorization" means DDD approval of funding for a service as identified in the individual support plan or evidence of payment for a service.

"CARE" refers to the comprehensive assessment reporting evaluation assessment per chapter 388-106 WAC.

"Client" means a person who has a developmental disability as defined in RCW 71A.10.020(3) who also has been determined eligible to receive services by the division under chapter 71A.16 RCW.

"Collateral contact" means a person or agency that is involved in the client's life (e.g., legal guardian, family member, care provider, friend, etc.).

"Companion home" is a DDD contracted residential service that provides twenty-four hour training, support, and supervision, to one adult living with a paid provider.

"DDD" means the division of developmental disabilities, a division with the aging and disability services administration (ADSA), department of social and health services (DSHS).

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

"Group home" or "GH" means an ADSA licensed adult family home or boarding home contracted and certified by ADSA to provide residential services and support to adults with developmental disabilities.

"ICF/MR" means a facility certified as an intermediate care facility for the mentally retarded to provide habilitation services to DDD clients.

"ICF/MR level of care" is a standardized assessment of a client's need for ICF/MR level of care per 42 C.F.R. 440 and 42 C.F.R. 483. In addition, ICF/MR level of care refers to one of the standards used by DDD to determine whether a client meets minimum eligibility criteria for one of the DDD HCBS waivers.

"Person-centered service plan/individual support plan" or "ISP" is a document that ((~~authorizes and~~)) identifies ((~~the DDD paid services to meet a client's assessed needs~~)) your goals and assessed health and welfare needs. Your person-centered service plan also indicates the paid services and natural supports that will assist you to achieve your goals and address your assessed needs.

"Legal guardian" means a person/agency, appointed by a court, who is authorized to make some or all decisions for a person determined by the court to be incapacitated. In the absence of court intervention, parents remain the legal guardians for their child until the child reaches the age of eighteen.

"LOC score" means a score for answers to questions in the support needs assessment for children that are used in determining if a client meets eligibility requirements for ICF/MR level of care.

"Modules" refers to three sections of the DDD assessment. They are: The support assessment, the service level assessment, and the person-centered service plan/individual support plan (ISP).

"Panel" refers to the visual user-interface in the DDD assessment computer application where assessment questions are typically organized by topic and you and your respondents' answers are recorded.

"Plan of care" or "POC" refers to the paper-based assessment and service plan for clients receiving services on one of the DDD HCBS waivers prior to June 1, 2007.

"Raw score" means the numerical value when adding a person's "Frequency of support," "Daily support time," and "Type of support" scores for each activity in the support needs and supplemental protection and advocacy scales of the supports intensity scale (SIS) assessment.

"Residential habilitation center" or "RHC" is a state-operated facility certified to provide ICF/MR and/or nursing facility level of care for persons with developmental disabilities per chapter 71A.20 RCW.

"Respondent" means the adult client and/or another person familiar with the client who participates in the client's DDD assessment by answering questions and providing information. Respondents may include ADSA contracted providers.

"SIS" means the supports intensity scale developed by the American Association of Intellectual and Developmental Disabilities (AAIDD). The SIS is in the support assessment module of the DDD assessment.

"Service provider" refers to an ADSA contracted agency or person who provides services to DDD clients. Also refers to state operated living alternative programs (SOLA).

"SOLA" means a state operated living alternative program for adults that is operated by DDD.

"State supplementary payment" or "SSP" is the state paid cash assistance program for certain DDD eligible Social Security income clients per chapter 388-827 WAC.

"Supported living" or "SL" refers to residential services provided by ADSA certified residential agencies to clients living in homes that are owned, rented, or leased by the clients or their legal representatives.

"Waiver personal care" means physical or verbal assistance with activities of daily living (ADL) and instrumental activities of daily living (IADL) due to your functional limitations per chapter 388-106 WAC to individuals who are authorized to receive services available in the ((~~Basic,~~)) Basic Plus((~~, and Core~~)) waiver((~~s~~)) per chapter 388-845 WAC.

"Waiver respite care" means short-term intermittent relief for persons normally providing care to individuals who are authorized to receive services available in the individual and family services (IFS), children's intensive in-home behavioral support (CIIBS) ((~~Basic~~)), Basic Plus, and Core waivers per chapter 388-845 WAC.

"You/Your" means the client.

AMENDATORY SECTION (Amending WSR 08-12-037, filed 5/30/08, effective 7/1/08)

WAC 388-828-1060 What is the purpose of the DDD assessment? The purpose of the DDD assessment is to provide a comprehensive assessment process that:

(1) Collects a common set of assessment information for reporting purposes to the legislature and the department.

(2) Promotes consistency in evaluating client support needs for purposes of planning, budgeting, and resource management.

(3) Identifies a level of service and/or number of hours that is used to support the assessed needs of clients who have been authorized by DDD to receive:

(a) Medicaid personal care services or ((~~DDD HCBS waiver personal care~~)) community first choice services per chapter 388-106 WAC;

(b) Waiver respite care services per chapter 388-845 WAC;

(c) Services in the voluntary placement program (VPP) per chapter 388-826 WAC;

(d) Supported living residential services per chapter 388-101 WAC;

(e) Group home residential services per chapter 388-101 WAC;

(f) Group training home residential services per chapter 388-101 WAC;

(g) Companion home residential services per chapter 388-829C WAC; ((~~or~~))

(h) Individual and family services per chapter 388-832 WAC;

(i) Individual and family services waiver per chapter 388-845 WAC;

(j) State supplementary program per chapter 388-827 WAC.

(4) Records your service requests.

AMENDATORY SECTION (Amending WSR 07-10-029, filed 4/23/07, effective 6/1/07)

WAC 388-828-1500 When does DD((~~D~~))A conduct a reassessment? (1) A reassessment must occur:

(((~~1~~))) (a) On an annual basis if you are receiving a paid service or SSP; ((~~or~~)) and

(((~~2~~))) (b) When a significant change is reported that may affect your need for support((~~,~~)) (E.g., changes in your medical condition, caregiver status, behavior, living situation, employment status((~~,~~))); and

(c) Before the next ISP date of your current assessment.

(2) DDA will provide you with notice in advance of your next ISP date so you may schedule the assessment at a time that is convenient to you.

AMENDATORY SECTION (Amending WSR 07-10-029, filed 4/23/07, effective 6/1/07)

WAC 388-828-1520 Where is the DD((~~D~~))A assessment and reassessment administered? ((~~The DDD assessment and reassessment are administered in your place of residence~~)) (1) DDA assessments and reassessments are administered in your home or place of residence or at another location that is convenient to you.

(2) If the DDA assessment is not administered in your home or place of residence and if you receive a DDA paid service in your home, a follow up home visit will be conducted to ensure your person-centered service plan can be implemented in your living environment.

AMENDATORY SECTION (Amending WSR 08-12-037, filed 5/30/08, effective 7/1/08)

WAC 388-828-1540 Who participates in your DDD assessment? (1) ((~~All relevant persons who are involved in your life may participate in your DDD assessment, including your parent(s), legal representative/guardian, advocate(s), and service provider(s)~~)) You choose the people who participate in your assessment and person-centered service planning meeting.

(2) DDD requires that at a minimum: You, one of your respondents, and a DDD employee participate in your DDD assessment interview. In addition:

(a) If you are under the age of eighteen, your parent(s) or legal guardian(s) must participate in your DDD assessment interview.

(b) If you are age eighteen or older, your court appointed legal representative/guardian must be consulted if he/she does not attend your DDD assessment interview.

(c) If you are age eighteen and older and have no legal representative/guardian, DDD will assist you to identify a respondent.

(d) DDD may ((~~require additional respondents to participate in~~)) consult with other people who were not present at your DDD assessment interview, if needed, to obtain complete and accurate information.

AMENDATORY SECTION (Amending WSR 07-10-029, filed 4/23/07, effective 6/1/07)

WAC 388-828-8000 What is the purpose of the person-centered service plan/individual support plan (ISP) module? The purpose of the person-centered service plan/individual support plan module is to create a written plan that includes:

(1) Your goals and desired outcomes;

(2) The services and supports, both paid and unpaid, that will assist you to achieve your identified goals.

(3) Your acuity scores generated from the support assessment;

(((~~2~~))) (4) Referral information;

(((~~3~~))) (5) The SSP, if any, you are approved to receive in lieu of a DDD paid service; and

(((~~4~~))) (6) DDD paid services you are authorized to receive:

(a) If you are enrolled in a DDD waiver, the ISP must address all the health and welfare needs identified in your ICF/MR level of care assessment and the supports used to meet your assessed needs; or

(b) If you are not enrolled in a DDD waiver, DDD is only required to address the DDD paid services you are approved to receive.

AMENDATORY SECTION (Amending WSR 08-20-118, filed 9/30/08, effective 10/31/08)

WAC 388-831-0065 What if I refuse to participate in the risk assessment? (1) If you refuse to participate in the risk assessment, the division cannot determine what your health and safety needs are, or whether you can be supported successfully in the community with reasonable safeguards. You will not be eligible for any division services except for case management and community first choice (CFC) or medicaid personal care (MPC) services (if eligible under chapter 388-106 WAC).

(2) Your name will be placed on the specialized client database. This database identifies individuals who may present a danger to their communities.

(3) If DDD determines it can provide only case management and ((~~personal care~~)) CFC or MPC services, you and your legal representative will receive a notice of the determination that explains the decision and your right to appeal that decision.

AMENDATORY SECTION (Amending WSR 08-20-118, filed 9/30/08, effective 10/31/08)

WAC 388-831-0160 What services may I receive if I refuse placement in the community protection program? If you are offered and refuse community protection program residential services, you may only receive case management services and community first choice or medicaid personal care services (if eligible under chapter 388-106 WAC).

AMENDATORY SECTION (Amending WSR 13-24-045, filed 11/26/13, effective 1/1/14)

WAC 388-845-0001 Definitions. "Aggregate services" means a combination of services subject to the dollar limitations in the Basic Plus waivers.

"Allocation" means the amount of IFS waiver funding available to the client for a maximum of twelve months.

"CARE" means comprehensive assessment and reporting evaluation.

"CIIBS" means children's intensive in-home behavioral support waiver.

"Client or person" means a person who has a developmental disability as defined in RCW ((~~71A.10.020(3)~~)) 71A.10.020(5) and has been determined eligible to receive services by the administration under chapter 71A.16 RCW.

"Community crisis stabilization services" or "CCSS" means a state operated program that provides short term supports to participants who meet specific criteria and who are in crisis and/or who are at risk of hospitalization or institutional placement.

"DDA" means the developmental disabilities administration, of the department of social and health services.

"DDA assessment" refers to the standardized assessment tool as defined in chapter 388-828 WAC, used by DDA to measure the support needs of persons with developmental disabilities.

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

"EPSDT" means early and periodic screening, diagnosis, and treatment, medicaid's child health component providing a mandatory and comprehensive set of benefits and services for children up to age twenty one as defined in WAC 182-534-0100.

"Enhanced respite services" means respite care for DDA enrolled children and youth, who meet specific criteria, in a DDA contracted and licensed staffed residential setting.

"Evidence based treatment" means the use of physical, mental and behavioral health interventions for which systematic, empirical research has provided evidence of statistically significant effectiveness as treatments for specific conditions. Alternate terms with the same meaning are evidence-based practice (EBP) and empirically supported treatment (EST).

"Family" means the following relatives: ((~~who live in the same home with the eligible client. Relatives include~~)) spouse or registered domestic partner; natural, adoptive or step parent; grandparent; child; stepchild; sibling; stepsibling; uncle; aunt; first cousin; niece; or nephew.

"Family home" means the residence where you and your relative(s) live.

"Gainful employment" means employment that reflects achievement of or progress towards a living wage.

"HCBS waivers" means home and community based services waivers.

"Home" means present or intended place of residence.

"ICF/ID" means an intermediate care facility for individuals with intellectual disabilities.

"IFS waiver" means the individual and family services waiver.

((~~"Individual support plan (ISP)" is a document that authorizes and identifies the DDA paid services and unpaid supports to meet a client's assessed needs.~~))

"Integrated business settings" means a setting that enables participants to either work alongside or interact with individuals who do not have disabilities, or both.

"Integrated settings" mean typical community settings not designed specifically for individuals with disabilities in which the majority of persons employed and participating are individuals without disabilities.

"Legal representative" means a parent of a person who is under eighteen years of age, a person's legal guardian, a person's limited guardian when the subject matter is within the scope of limited guardianship, a person's attorney at law, a person's attorney in fact, or any other person who is authorized by law to act for another person.

"Living wage" means the amount of earned wages needed to enable an individual to meet or exceed his/her living expenses.

"Necessary supplemental accommodation representative" means an individual who receives copies of DDA planned action notices (PANs) and other department correspondence in order to help a client understand the documents and exercise the client's rights. A necessary supplemental accommodation representative is identified by a client of DDA when the client does not have a legal guardian and the client is requesting or receiving DDA services.

"Participant" means a client who is enrolled in a home and community based services waiver program.

"Person-centered service plan/individual support plan (ISP)" is a document that identifies your goals and assessed health and welfare needs. Your person-centered service plan also indicates the paid services and natural supports that will assist you to achieve your goals and address your assessed needs.

"Primary caregiver" means the person who provides the majority of your care and supervision.

"Provider" means an individual or agency who meets the provider qualifications and is contracted with DSHS to provide services to you.

"Respite assessment" means an algorithm within the DDA assessment that determines the number of hours of respite care you may receive per year if you are enrolled in the Basic Plus, children's intensive in-home behavioral support, or Core waiver.

"SSI" means supplemental security income, an assistance program administered by the federal Social Security Administration for blind, disabled and aged individuals.

"SSP" means state supplementary payment program, a state-paid cash assistance program for certain clients of the developmental disabilities administration.

"State funded services" means services that are funded entirely with state dollars.

"You/your" means the client.

AMENDATORY SECTION (Amending WSR 13-24-045, filed 11/26/13, effective 1/1/14)

WAC 388-845-0015 What HCBS waivers are provided by the developmental disabilities administration (DDA)? DDA provides services through ((~~four~~)) five HCBS waivers:

(1) Basic Plus waiver;

(2) Core waiver;

(3) Community protection (CP) waiver; ((~~and~~))

(4) Children's intensive in-home behavioral support waiver (CIIBS); and

(5) Individual and family services (IFS) waiver.

AMENDATORY SECTION (Amending WSR 13-24-045, filed 11/26/13, effective 1/1/14)

WAC 388-845-0020 When were the HCBS waivers effective? Basic Plus, children's intensive in-home behavioral support, Core and community protection waivers were effective September 1, 2012.

Individual and family services waiver was effective June 1, 2015.

AMENDATORY SECTION (Amending WSR 13-24-045, filed 11/26/13, effective 1/1/14)

WAC 388-845-0030 Do I meet criteria for HCBS waiver-funded services? (1) You meet criteria for DDA HCBS waiver-funded services if you meet all of the following:

(((~~1~~))) (a) You have been determined eligible for DDA services per RCW 71A.10.020.

(((~~2~~))) (b) You have been determined to meet ICF/ID level of care per WAC 388-845-0070, 388-828-3060 and 388-828-3080.

(((~~3~~))) (c) You meet disability criteria established in the Social Security Act.

(((~~4~~))) (d) You meet financial eligibility requirements as defined in WAC ((~~388-515-1510~~)) 182-515-1510.

(((~~5~~))) (e) You choose to receive services in the community rather than in an ICF/ID facility.

(((~~(6)~~))) (f) You have a need for monthly waiver services or monthly monitoring as identified in your person-centered service plan/individual support plan.

(((~~(7)~~))) (g) You are not residing in hospital, jail, prison, nursing facility, ICF/ID, or other institution.

(((~~(8)~~))) (h) Additionally, for the children's intensive in-home behavioral support (CIIBS) waiver-funded services:

(((~~(a)~~))) (i) You are age eight or older and under the age of eighteen for initial enrollment and under age twenty-one for continued enrollment;

(((~~(b)~~))) (ii) You have been determined to meet CIIBS program eligibility per chapter 388-828 WAC prior to initial enrollment only;

(((~~(c)~~))) (iii) You live with your family; and

(((~~(d)~~))) (iv) Your parent/guardian(s) and primary caregiver(s), if other than parent/guardian(s), have signed the participation agreement.

(2) For individual and family services waiver funded services, you must meet the criteria in subsection (1) of this section and also:

(a) Live in your family home; and

(b) Are age three or older.

Reviser's note: RCW 34.05.395 requires the use of underlining and deletion marks to indicate amendments to existing rules. The rule published above varies from its predecessor in certain respects not indicated by the use of these markings.

AMENDATORY SECTION (Amending WSR 13-24-045, filed 11/26/13, effective 1/1/14)

WAC 388-845-0041 What is DDA's responsibility to provide my services under the DDA HCBS waivers administered by DDA? If you are enrolled in an HCBS waiver administered by ((~~DDD~~)) DDA.

(1) DDA will provide an annual comprehensive assessment to evaluate your health and welfare needs. Your person-centered service plan/individual support plan, as specified in WAC 388-845-3055, will document:

(a) Your identified health and welfare needs; and

(b) Your HCBS waiver services and nonwaiver services authorized to meet your assessed need.

(2) You have access to DDA paid services that are provided within the scope of your waiver, subject to the limitations in WAC 388-845-0110 and 388-845-0115.

(3) DDA will provide waiver services you need and qualify for within your waiver.

(4) DDA will not deny or limit, based on lack of funding, the number of waiver services for which you are eligible.

AMENDATORY SECTION (Amending WSR 13-24-045, filed 11/26/13, effective 1/1/14)

WAC 388-845-0045 When there is capacity to add people to a waiver, how does DDA determine who will be enrolled? When there is capacity on a waiver and available funding for new waiver participants, DDA may enroll people from the statewide data base in a waiver based on the following priority considerations:

(1) First priority will be given to current waiver participants assessed to require a different waiver because their identified health and welfare needs have increased and these needs cannot be met within the scope of their current waiver.

(2) DDA may also consider any of the following populations in any order:

(a) Priority populations as identified and funded by the legislature.

(b) Persons DDA has determined to be in immediate risk of ICF/ID admission due to unmet health and welfare needs.

(c) Persons identified as a risk to the safety of the community.

(d) Persons currently receiving services through state-only funds.

(e) Persons on an HCBS waiver that provides services in excess of what is needed to meet their identified health and welfare needs.

(f) Persons who were previously on an HCBS waiver since April 2004 and lost waiver eligibility per WAC 388-845-0060 (1)(i).

(3) ((~~For the Basic Plus waiver only,~~)) DDA may consider persons who need the waiver services available in the Basic Plus or IFS waivers to maintain them in their family's home or in their own home.

AMENDATORY SECTION (Amending WSR 13-24-045, filed 11/26/13, effective 1/1/14)

WAC 388-845-0052 What is the process if I am already on a DDA HCBS waiver and request enrollment onto a different ((~~waiver~~)) DDA HCBS waiver? (1) If you are already enrolled in a DDA HCBS waiver and you request to be enrolled in a different waiver DDA will do the following:

(a) Assess your needs to determine whether your health and welfare needs can be met with services available on your current waiver or whether those needs can only be met through services offered on a different waiver.

(b) If DDA determines your health and welfare needs can be met by services available on your current waiver your enrollment request will be denied.

(c) If DDA determines your health and welfare needs can only be met by services available on a different waiver your service need will be reflected in your person-centered service plan/ISP.

(d) If DDA determines there is capacity on the waiver that is determined to meet your needs, DDA will place you on that waiver.

(2) You will be notified in writing of DDA's decision under subsection (1)(a) of this section and if your health and welfare needs cannot be met on your current waiver, DDA will notify you in writing whether there is capacity on the waiver that will meet your health and welfare needs and whether you will be enrolled on that waiver. If current capacity on that waiver does not exist, your eligibility for enrollment onto that different waiver will be tracked on a statewide data base.

AMENDATORY SECTION (Amending WSR 13-24-045, filed 11/26/13, effective 1/1/14)

WAC 388-845-0055 How do I remain eligible for the waiver? (1) Once you are enrolled in a DDA HCBS waiver,

you can remain eligible if you continue to meet eligibility criteria in WAC 388-845-0030, and:

(((~~(1)~~))) (a) You complete a reassessment with DDA at least once every twelve months to determine if you continue to meet all of these eligibility requirements; and

(((~~(2)~~))) (b) You must either receive a waiver service at least once in every thirty consecutive days, as specified in WAC 182-513-1320 (3)(((~~(b)~~))), or your health and welfare needs require monthly monitoring, which will be documented in your client record; and

(((~~(3)~~))) (c) You complete an in-person DDA assessment/reassessment interview ((~~administered in your home~~)) per WAC 388-828-1520.

(((~~(4) In addition, for~~))) (2) For the children's intensive in-home behavioral supports waiver, you must meet the criteria in subsection (1) of this section and also:

(a) Be under age twenty-one;

(b) Live with your family; and

(c) Have an annual participation agreement signed by your parent/guardian(s) and primary caregiver(s), if other than parent/guardian(s).

(3) For the individual and family services waiver, you must meet the criteria in subsection (1) of this section and:

(a) Live in the family home; and

(b) Be age three or over.

AMENDATORY SECTION (Amending WSR 13-24-045, filed 11/26/13, effective 1/1/14)

WAC 388-845-0060 Can my waiver enrollment be terminated? DDA may terminate your waiver enrollment if DDA determines that:

(1) Your health and welfare needs cannot be met in your current waiver or for one of the following reasons:

(a) You no longer meet one or more of the requirements listed in WAC 388-845-0030;

(b) You do not have an identified need for a waiver service at the time of your annual person-centered service plan/individual support plan;

(c) You do not use a waiver service at least once in every thirty consecutive days and your health and welfare do not require monthly monitoring;

(d) You are on the community protection waiver and:

(i) You choose not to be served by a certified residential community protection provider-intensive supported living services (CP-ISLS);

(ii) You engage in any behaviors identified in WAC 388-831-0240 (1) through (4); and

(iii) DDA determines that your health and safety needs or the health and safety needs of the community cannot be met in the community protection program.

(e) You choose to disenroll from the waiver;

(f) You reside out-of-state;

(g) You cannot be located or do not make yourself available for the annual waiver reassessment of eligibility;

(h) You refuse to participate with DDA in:

(i) Service planning;

(ii) Required quality assurance and program monitoring activities; or

(iii) Accepting services agreed to in your person-centered service plan/individual support plan as necessary to meet your health and welfare needs.

(i) You are residing in a hospital, jail, prison, nursing facility, ICF/ID, or other institution and remain in residence at least one full calendar month, and are still in residence:

(i) At the end of that full calendar month, there is no immediate plan for you to return to the community; or

(ii) At the end of the twelfth month following the effective date of your current person-centered service plan/individual support plan, as described in WAC 388-845-3060; or

(iii) The end of the waiver fiscal year, whichever date occurs first.

(j) Your needs exceed the maximum funding level or scope of services under the Basic Plus waiver as specified in WAC 388-845-3080; or

(k) Your needs exceed what can be provided under WAC 388-845-3085; or

(2) Services offered on a different waiver can meet your health and welfare needs and DDA enrolls you on a different waiver.

AMENDATORY SECTION (Amending WSR 13-24-045, filed 11/26/13, effective 1/1/14)

WAC 388-845-0100 What determines which waiver I am assigned to? DDA will assign you to the waiver with the minimum service package necessary to meet your health and welfare needs, based on its evaluation of your DDA assessment as described in chapter 388-828 WAC and the following criteria:

(1) For the individual and family services waiver, you:

(a) Are age three or older;

(b) Live in your family home; and

(c) Are assessed to need a waiver service to remain in the family home.

(2) For the Basic Plus waiver your health and welfare needs require a waiver service to remain in the community.

(((~~(2)~~))) (3) For the Core waiver:

(a) You are at immediate risk of out-of-home placement; and/or

(b) You have an identified health and welfare need for residential services that cannot be met by the Basic Plus waiver.

(((~~(3)~~))) (4) For the community protection waiver, refer to WAC 388-845-0105 and chapter 388-831 WAC.

(((~~(4)~~))) (5) For the children's intensive in-home behavioral support waiver, you:

(a) Are age eight or older and under age eighteen;

(b) Live with your family;

(c) Are assessed at high or severe risk of out of home placement due to challenging behavior per chapter 388-828 WAC; and

(d) You have a signed participation agreement from your parent/guardian(s) and primary caregiver(s), if other than parent/guardian(s).

AMENDATORY SECTION (Amending WSR 13-24-045, filed 11/26/13, effective 1/1/14)

WAC 388-845-0105 What criteria determine assignment to the community protection waiver? DDA may assign you to the community protection waiver only if you are at least eighteen years of age, not currently residing in a hospital, jail or other institution, and meet the following criteria:

(1) You have been identified by DDA as a person who meets one or more of the following:

(a) You have been convicted of or charged with a crime of sexual violence as defined in chapter 71.09 RCW;

(b) You have been convicted of or charged with acts directed towards strangers or individuals with whom a relationship has been established or promoted for the primary purpose of victimization, or persons of casual acquaintance with whom no substantial personal relationship exists;

(c) You have been convicted of or charged with a sexually violent offense and/or predatory act, and may constitute a future danger as determined by a qualified professional;

(d) You have not been convicted and/or charged, but you have a history of stalking, violent, sexually violent, predatory and/or opportunistic behavior which demonstrates a likelihood to commit a sexually violent and/or predatory act based on current behaviors that may escalate to violence, as determined by a qualified professional; or

(e) You have committed one or more violent offense, as defined in RCW 9.94A.030.

(2) You receive or agree to receive residential services from certified residential community protection provider-intensive supported living services (CP-ISLS); and

(3) You comply with the specialized supports and restrictions in your:

(a) Person-centered service plan/individual support plan;

(b) Individual instruction and support plan (IISP); and/or

(c) Treatment plan provided by DDA approved certified individuals and agencies.

AMENDATORY SECTION (Amending WSR 13-24-045, filed 11/26/13, effective 1/1/14)

WAC 388-845-0110 Are there limitations to the waiver services I can receive? There are limitations to waiver services. ((~~In addition to the limitations to your access to nonwaiver services cited for specific services in WAC 388-845-0115, the following limitations apply~~)) Those are:

(1) A service must be ((~~offered~~)) available in your waiver.

(2) The need for a service must be identified and authorized in your person-centered service plan/individual support plan.

(((~~(2)~~))) (3) Behavioral health stabilization services may be added to your person-centered service plan/individual support plan after the services are provided.

(((~~(3)~~))) (4) Waiver services are limited to services required to prevent ICF/ID placement.

(((~~(4)~~))) (5) The cost of your waiver services cannot exceed the average daily cost of care in an ICF/ID.

(((~~(5)~~))) (6) Waiver services cannot replace or duplicate other available paid or unpaid supports or services. Participants must first pursue benefits available to them through private insurance and the medicaid state plan.

(((~~(6)~~))) (7) Waiver funding cannot be authorized for treatments determined by DSHS to be experimental.

(((~~(7) The~~))) (8) For IFS and Basic Plus waivers, ((~~has~~)) services must not exceed the yearly limits ((~~on some~~)) specified in these programs for specific services and/or combinations of services. ((~~The combination of services is referred to as aggregate services.~~))

(((~~(8)~~))) (9) Your choice of qualified providers and services is limited to the most cost effective option that meets your health and welfare needs.

(((~~(9)~~))) (10) Services provided out-of-state, other than in recognized bordering cities, are limited to respite care and personal care during vacations of not more than thirty consecutive days.

(a) You may receive services in a recognized out-of-state bordering city on the same basis as in-state services.

(b) The only recognized bordering cities per WAC 182-501-0175 are:

(i) Coeur d'Alene, Moscow, Sandpoint, Priest River and Lewiston, Idaho; and

(ii) Portland, The Dalles, Hermiston, Hood River, Rainier, Milton-Freewater and Astoria, Oregon.

(((~~(10)~~))) (11) Other out-of-state waiver services require an approved exception to rule before DDA can authorize payment.

(((~~(11)~~))) (12) Waiver services do not cover co-pays, deductibles, dues, membership fees or subscriptions.

AMENDATORY SECTION (Amending WSR 10-22-088, filed 11/1/10, effective 12/2/10)

WAC 388-845-0111 Are there limitations regarding who can provide services? The following limitations apply to providers for waiver services:

(1) Your spouse must not be your paid provider for any waiver service.

(2) If you are under age eighteen, your natural, step, or adoptive parent must not be your paid provider for any waiver service.

(3) If you are age eighteen or older, your natural, step, or adoptive parent must not be your paid provider for any waiver service with the exception of:

(a) Personal care;

(b) Transportation to and from a waiver service;

(c) Residential habilitation services per WAC 388-845-1510 if your parent is certified as a residential agency per chapter 388-101 WAC; or

(d) Respite care if you and the parent who provides the respite care live in separate homes.

(4) If you receive CIIBS waiver services, your legal representative or family member per WAC 388-845-0001 must not be your paid provider for any waiver service with the exception of:

(a) ((~~Personal care;~~

~~(b)~~)) Transportation to and from a waiver service; and

(((~~(c)~~))) (b) Respite per WAC 388-845-1605 through 388-845-1620.

AMENDATORY SECTION (Amending WSR 13-24-045, filed 11/26/13, effective 1/1/14)

WAC 388-845-0115 Does my waiver eligibility limit my access to DDA nonwaiver services? If you are enrolled in a DDA HCBS waiver:

(1) You are not eligible for state-only funding for DDA services; and

(2) You ((~~are not~~)) may be eligible for medicaid personal care or community first choice services.

AMENDATORY SECTION (Amending WSR 13-24-045, filed 11/26/13, effective 1/1/14)

WAC 388-845-0200 What waiver services are available to me? Each of the DDA HCBS waivers has a different scope of service and your person-centered service plan/individual support plan defines the waiver services available to you.

AMENDATORY SECTION (Amending WSR 13-24-045, filed 11/26/13, effective 1/1/14)

WAC 388-845-0210 What is the scope of services for the Basic Plus waiver? ((~~services.~~))

BASIC PLUS WAIVER	SERVICES	YEARLY LIMIT
	AGGREGATE SERVICES: Behavior support and consultation Community guide Environmental ((~~accessibility~~)) adaptations Occupational therapy Physical therapy Skilled nursing Specialized medical equipment/supplies Specialized psychiatric services Speech, hearing and language services Staff/family consultation and training Transportation	May not exceed $6192 per year on any combination of these services
	Wellness Education EMPLOYMENT SERVICES: Prevocational services Supported employment Individual technical assistance	Limits are determined by DDA assessment and employment status; No new enrollment in prevocational services after September 1, 2015
	Community access ((~~Adult foster care (adult family home)~~)) ((~~Adult residential care (assisted living facility)~~))	Limits are determined by DDA assessment ((~~Determined per department rate structure~~))
	BEHAVIORAL HEALTH STABILIZATION SERVICES: Behavior support and consultation Behavioral health crisis diversion bed services Specialized psychiatric services	Limits determined by a behavioral health professional or DDA
	Personal care	Limits determined by the CARE tool used as part of the DDA assessment
	Respite care	Limits are determined by the DDA assessment
	Sexual deviancy evaluation	Limits are determined by DDA
	Emergency assistance is only for Basic Plus waiver aggregate services	$6000 per year; preauthorization required

AMENDATORY SECTION (Amending WSR 13-24-045, filed 11/26/13, effective 1/1/14)

WAC 388-845-0215 What is the scope of services for the CORE waiver? ((~~services.~~))

CORE WAIVER	SERVICES	YEARLY LIMIT
	Behavior support and consultation Community guide Community transition Environmental ((~~accessibility~~)) adaptations	Determined by the person-centered service plan/individual support plan, not to exceed the average cost of

CORE WAIVER	SERVICES	YEARLY LIMIT
		an ICF/ID for any combination of services
	Occupational therapy	
	Physical therapy	
	Sexual deviancy evaluation	
	Skilled nursing	
	Specialized medical equipment/supplies	
	Specialized psychiatric services	
	Speech, hearing and language services	
	Staff/family consultation and training	
	Transportation Wellness education	
	Residential habilitation	
	Community access	Limits are determined by DDA assessment
	Employment services	Limits are determined by DDA assessment and employment status; No new enrollment in prevocational services after September 1, 2015
	Prevocational services	
	Supported employment	
	Individualized technical assistance	
	BEHAVIORAL HEALTH STABILIZATION SERVICES: Behavior support and consultation Behavioral health crisis diversion bed services Specialized psychiatric services	Limits determined by a behavioral health professional or DDA
	((~~Personal care~~))	((~~Limits determined by the CARE tool used as part of the DDA assessment~~))
	Respite care	Limits are determined by the DDA assessment

AMENDATORY SECTION (Amending WSR 13-24-045, filed 11/26/13, effective 1/1/14)

WAC 388-845-0220 What is the scope of services for the community protection waiver? ((~~services.~~))

COMMUNITY PROTECTION WAIVER	SERVICES	YEARLY LIMIT
	Behavior support and consultation	Determined by the person-centered service plan/individual support plan, not to exceed the average cost of an ICF/ID for any combination of services
	Community transition	
	Environmental ((~~accessibility~~)) adaptations	
	Occupational therapy	
	Physical therapy	
	Sexual deviancy evaluation	
	Skilled nursing	
	Specialized medical equipment and supplies	
	Specialized psychiatric services	
	Speech, hearing and language services	
	Staff/family consultation and training	
	Transportation	
	Residential habilitation	
	Employment Services:	Limits determined by DDA assessment and employment status; No new enrollment in prevocational

COMMUNITY PROTECTION WAIVER	SERVICES	YEARLY LIMIT
		services after September 1, 2015
	Prevocational services Supported employment Individual technical assistance	
	BEHAVIORAL HEALTH STABILIZATION SERVICES: Behavioral support and consultation Behavioral health crisis diversion bed services Specialized psychiatric services	Limits determined by a behavioral health professional or DDA

AMENDATORY SECTION (Amending WSR 13-24-045, filed 11/26/13, effective 1/1/14)

WAC 388-845-0225 What is the scope of services for the children's intensive in-home behavioral support (CIIBS) waiver? ((~~services.~~))

CIIBS Waiver	Services	Yearly Limit
	• Behavior support and consultation • Staff/family consultation and training • Environmental ((~~accessibility~~)) adaptations • Occupational therapy • Physical therapy • Sexual deviancy evaluation • Nurse delegation • Specialized medical equipment/supplies • Specialized psychiatric services • Speech, hearing and language services • Transportation • Assistive technology • Therapeutic equipment and supplies • Specialized nutrition and clothing • Vehicle modifications	Determined by the person-centered service plan/individual support plan. Total cost of waiver services cannot exceed the average cost of $4,000 per month per participant.
	((~~Personal care~~))	((~~Limits determined by the DDA assessment. Costs are included in the total average cost of $4000 per month per participant for all waiver services.~~))
	Respite care	Limits determined by the DDA assessment. Costs are included in the total average cost of $4000 per month per participant for all waiver services.
	Behavioral health Stabilization services: Behavioral support and consultation Crisis diversion bed services Specialized psychiatric services	Limits determined by behavioral health specialist

NEW SECTION

WAC 388-845-0230 What is the scope of services for the individual and family services (IFS) waiver? (1) IFS waiver services include:

(a) Assistive technology;

(b) Behavioral health stabilization services (paid for outside of annual allocation):

(i) Behavioral support and consultation; and

(ii) Specialized psychiatric service.

(c) Behavioral support and consultation;

(d) Community engagement;

(e) Environmental adaptations;

(f) Nurse delegation;

(g) Occupational therapy;

(h) Person-centered plan facilitation;

(i) Peer mentoring;

(j) Physical therapy;

(k) Speech, hearing and language services;

(l) Respite care;

(m) Psychosexual evaluation (paid for outside of annual allocation);

(n) Skilled nursing;

(o) Specialized clothing;

(p) Specialized medical equipment and supplies;

(q) Specialized nutrition;

(r) Supported parenting services;

(s) Staff/Family consultation and training;

(t) Therapeutic equipment and supplies;

(u) Transportation; and

(v) Vehicle modification.

(2) Your IFS waiver services annual allocation is based upon the DDA assessment described in chapter 388-828 WAC. The DDA assessment determines your service level & annual allocation based on your assessed need. Annual allocations are:

(a) Level 1 = one thousand two hundred dollars;

(b) Level 2 = one thousand eight hundred dollars;

(c) Level 3 = two thousand four hundred dollars;

(d) Level 4 = three thousand six hundred dollars.

AMENDATORY SECTION (Amending WSR 10-22-088, filed 11/1/10, effective 12/2/10)

WAC 388-845-0415 What is assistive technology? Assistive technology consists of items, equipment, or product systems used to increase, maintain, or improve functional capabilities of waiver participants, as well as services to directly assist the participant and caregivers to select, acquire, and use the technology. Assistive technology is available in the CIIBS and IFS waivers, and includes the following:

(1) The evaluation of the needs of the waiver participant, including a functional evaluation of the ((~~child~~)) participant in the ((~~child's~~)) participant's customary environment;

(2) Purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices;

(3) Selecting, designing, fitting, customizing, adapting, applying, retaining, repairing, or replacing assistive technology devices;

(4) Coordinating and using other therapies, interventions, or services with assistive technology devices, such as those associated with existing education and rehabilitation plans and programs;

(5) Training or technical assistance for the participant and/or if appropriate, the ((~~child's~~)) participant's family; and

(6) Training or technical assistance for professionals, including individuals providing education and rehabilitation services, employers, or other individuals who provide services to, employ, or are otherwise involved in the assistive technology related life functions of ((~~children~~)) individuals with disabilities.

AMENDATORY SECTION (Amending WSR 13-24-045, filed 11/26/13, effective 1/1/14)

WAC 388-845-0420 Who is a qualified provider of assistive technology? The provider of assistive technology must be an ((~~assistive technology vendor~~)) entity contracted with DDA to provide assistive technology, or one of the following professionals contracted with DDA and duly licensed, registered or certified to provide this service:

(1) Occupational therapist;

(2) Physical therapist;

(3) Speech and language pathologist;

(4) Certified music therapist;

(5) ((~~Certified recreation therapist~~)) Recreation therapist registered in Washington and certified by the National Council for Therapeutic Recreation;

(6) Audiologist; ((~~or~~))

(7) Behavior specialist((~~.~~)); or

(8) Rehabilitation counselor.

AMENDATORY SECTION (Amending WSR 13-24-045, filed 11/26/13, effective 1/1/14)

WAC 388-845-0425 Are there limits to the assistive technology I can receive? (1) ((~~Providers of assistive technology services must be certified, registered or licensed therapists as required by law and contracted with DDA for the therapy they are providing.~~)) Clinical and support needs for assistive technology are identified in the waiver participant's DDA assessment and documented in the person-centered service plan/individual support plan.

(2) ((~~Vendors of assistive technology must maintain a business license required by law and be contracted with DDA to provide this service.~~

~~(3)~~)) Assistive technology may be authorized as a waiver service by obtaining an initial denial of funding or information showing that the technology is not covered by medicaid or private insurance.

(((~~(4)~~))) (3) The department does not pay for experimental technology.

(((~~(5)~~))) (4) The department requires your treating professional's written recommendation regarding your need for the technology. This recommendation must take into account that:

(a) The treating professional has personal knowledge of and experience with the requested and ((~~alternative~~)) assistive technology; and

(b) The treating professional has recently examined you, reviewed your medical records, and conducted a functional evaluation.

(((~~(6)~~))) (5) Assistive technology requires prior approval by the DDA regional administrator or designee;

(6) The department may require a written second opinion from a department selected professional that meets the same criteria in subsection ((~~(5) above~~)) (4) of this section.

(7) The dollar amounts for the waiver participant's IFS waiver annual allocation limit the amount of assistive technology you are authorized to receive.

AMENDATORY SECTION (Amending WSR 13-24-045, filed 11/26/13, effective 1/1/14)

WAC 388-845-0505 Who is a qualified provider of behavior support and consultation? Under the Basic Plus, Core, ((~~and community protection~~)) CP and IFS waivers, the provider of behavior support and consultation must be one of the following professionals contracted with DDA and duly licensed, registered or certified to provide this service:

(1) Marriage and family therapist;

(2) Mental health counselor;

(3) Psychologist;

(4) Sex offender treatment provider;

(5) Social worker;

(6) Registered nurse (RN) or licensed practical nurse (LPN);

(7) Psychiatrist;

(8) Psychiatric advanced registered nurse practitioner (ARNP);

(9) Physician assistant working under the supervision of a psychiatrist;

(10) Counselors registered or certified in accordance with the requirements of chapter 18.19 RCW;

(11) Polygrapher; or

(12) State operated behavior support agency limited to behavioral health stabilization services.

AMENDATORY SECTION (Amending WSR 13-24-045, filed 11/26/13, effective 1/1/14)

WAC 388-845-0510 Are there limits to the behavior support and consultation I can receive? ((~~The following limits apply to your receipt of~~)) (1) Clinical and support needs for behavior support and consultation((~~:~~)) are identified in the waiver participant's DDA assessment and documented in the person-centered service plan/individual support plan.

(((~~(1)~~))) (2) DDA and the treating professional will determine the need and amount of service you will receive, subject to the limitations in subsection (((~~(2)~~))) (3) ((~~below~~)) of this section.

(((~~(2)~~))) (3) The dollar ((~~limitations~~)) amounts for aggregate services in your Basic Plus waiver or the dollar amounts in the annual allocation for the IFS waiver limit the amount of service unless provided as a behavioral health stabilization service.

(((~~(3)~~))) (4) DDA reserves the right to require a second opinion from a department-selected provider.

(((~~4~~))) (5) Behavior support and consultation not provided as a behavioral health stabilization service requires prior approval by the DDA regional administrator or designee.

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 388-845-0650 What are community engagement services? (1) Community engagement services are services designed to increase a waiver participant's connection to and engagement in formal and informal community supports.

(2) Services are designed to develop creative, flexible and supportive community resources and relationships for individuals with developmental disabilities.

(3) Waiver participants are introduced to the community resources and supports that are available in their area.

(4) Participants are supported to develop skills that will facilitate integration into their community.

(5) Outcomes for this service include skill development, ((~~positive relationships~~)) opportunities for socialization, valued community roles and involvement in community activities/organizations/groups/projects/other resources.

(6) This service is available in IFS waiver.

Reviser's note: The unnecessary underscoring and strikethrough 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 388-845-0655 Who is a qualified provider of community engagement service? Any individual or agency contracted with DDA as a "community engagement service provider" is qualified to provide this service as evidenced by:

(1) Two years of community engagement experience with the community in which the participant lives; and

(2) Organizations that provide peer support to individuals with developmental disabilities or families that have a member with a developmental disability and are contracted with DDA to provide this service.

NEW SECTION

WAC 388-845-0660 Are there limitations to the community engagement services I can receive? (1) Support needs for community engagement services are identified in the waiver participant's DDA assessment and documented in the person-centered service plan/individual support plan.

(2) The dollar amounts in the annual allocation for the IFS waiver limit the amount of service you can receive.

(3) Community engagement services do not pay for the following costs:

(a) Membership fees or dues; and/or

(b) Equipment related to activities; and/or

(c) The cost of any activities;

(4) Community engagement services are provided in the community where the participant lives.

AMENDATORY SECTION (Amending WSR 13-24-045, filed 11/26/13, effective 1/1/14)

WAC 388-845-0820 Are there limits to my use of emergency assistance? All of the following limitations apply to your use of emergency assistance:

(1) Prior approval by the DDA regional administrator or designee is required based on a reassessment of your person-centered service plan/individual support plan to determine the need for emergency services;

(2) Payment authorizations are reviewed every thirty days and cannot exceed six thousand dollars per twelve months based on the effective date of your current ((~~plan of care or~~)) person-centered service plan/individual support plan;

(3) Emergency assistance services are limited to the Basic Plus waiver aggregate services;

(4) Emergency assistance may be used for interim services until:

(a) The emergency situation has been resolved; or

(b) You are transferred to alternative supports that meet your assessed needs; or

(c) You are transferred to an alternate waiver that provides the service you need.

AMENDATORY SECTION (Amending WSR 13-24-045, filed 11/26/13, effective 1/1/14)

WAC 388-845-0900 What are environmental ((~~accessibility~~)) adaptations? (1) Environmental ((~~accessibility~~)) adaptations are available in all of the DDA HCBS waivers. Environmental adaptations ((~~and~~)) provide ((~~the~~)) physical adaptations within the physical structure of the home, or outside the home to provide access to the home. The need must be identified by the DDA assessment and the participant's person-centered service plan/ ((~~required by the individual's~~)) individual support plan. ((~~needed to~~)) The following criteria must be met:

(a) Ensure the health, welfare and safety of the individual or caregiver or both; or

(b) Enable the individual who would otherwise require institutionalization to function with greater independence in the home.

(2) Environmental ((~~accessibility~~)) adaptations may include the purchase and installation of ((~~ramps and grab bars, widening of doorways, modification of bathroom facilities, or installing specialized electrical and/or plumbing systems necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the individual.~~)) the following:

(a) Portable and fixed ramps;

(b) Grab bars and handrails;

(c) Widening of doorways, addition of pocket doors, or removal of nonweight bearing walls for accessibility;

(d) Prefabricated roll-in showers and bathtubs;

(e) Automatic touchless or other adaptive faucets and switches;

(f) Automatic turn-on and shut-off adaptations for appliances in the home;

(g) Adaptive toilets, bidets, and sinks;

(h) Specialized electrical and/or plumbing systems necessary for the approved modification or medical equipment and supplies that are necessary for the welfare of the individual and/or safety of the caregiver;

(i) Repairs to environmental adaptations due to wear and tear if necessary for client safety and more cost-effective than replacement of the adaptation;

(j) Debris removal necessary due to hoarding behavior addressed in the participant's positive behavior support plan (PBSP);

(k) Lowering or raising of counters, sinks, cabinets, or other modifications for accessibility;

(l) Reinforcement of walls and replacement of hollow doors with solid core doors;

(m) Replacement of windows with non-breakable glass;

(n) Adaptive hardware and switches;

(o) Ceiling mounted lift systems or portable lift systems; and

(p) Other adaptations that meet identified needs.

(3) For the CIIBS and IFS waivers only, adaptations ((~~include repairs~~)) to the home necessary ((~~due to~~)) to prevent property destruction caused by the participant's behavior, as addressed in the participant's positive behavior support plan.

AMENDATORY SECTION (Amending WSR 13-24-045, filed 11/26/13, effective 1/1/14)

WAC 388-845-0905 Who is a qualified provider for ((~~building these~~)) environmental ((~~accessibility~~)) adaptations? ((~~The provider making these environmental accessibility adaptations~~))

(1) For adaptations that do not require installation, qualified providers are retail vendors with a valid business license contracted with DDA to provide this service.

(2) For adaptations requiring installation, qualified providers must be a registered contractor per chapter 18.27 RCW and contracted with DDA. The contractor or subcontractor must be licensed and bonded to perform the specific type of work they are providing.

(3) For debris removal, qualified providers must be contracted with DDA.

AMENDATORY SECTION (Amending WSR 13-24-045, filed 11/26/13, effective 1/1/14)

WAC 388-845-0910 What limitations apply to environmental ((~~accessibility~~)) adaptations? The following service limitations apply to environmental ((~~accessibility~~)) adaptations:

(1) Clinical and support needs for environmental adaptations are identified in the waiver participant's DDA assessment and documented in the person-centered service plan/individual support plan;

(2) Environmental ((~~accessibility~~)) adaptations require prior approval by the DDA regional administrator or designee((~~.~~)) supported by written bids from licensed contractors:

(a) One bid is required for adaptations costing one thousand five hundred dollars or less;

(b) Two bids are required for adaptations costing more than one thousand five hundred dollars and equal to or less than five thousand dollars;

(c) Three bids are required for adaptations costing more than five thousand dollars;

(d) All bids must include the cost of all required permits and sales tax;

(e) Bids must be itemized and clearly outline the scope of work.

(3) DDA may require an occupational therapist, physical therapist, or construction consultant to review and recommend an appropriate environmental adaptation statement of work prior to the waiver participant soliciting bids or purchasing adaptive equipment.

(((~~(2) With the exception of damage repairs under the CIIBS waiver, e~~))) (4) Environmental ((~~accessibility~~)) adaptations or improvements to the home are excluded if they are of general utility without direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc.

(5) Environmental adaptations must meet all local and state building codes. Evidence of any required completed inspections must be submitted to DDA prior to authorizing payment for work.

(6) Deteriorated condition of the dwelling or other remodeling projects in progress in the dwelling may prevent

or limit some or all environmental adaptations at the discretion of DDA.

(7) Location of the dwelling in a flood plain, landslide zone or other hazardous area may limit or prevent any environmental adaptations at the discretion of DDA.

(8) Written consent from the dwelling landlord is required prior to starting any environmental adaptations for a rental property. The landlord must not require removal of the environmental adaptations at the end of the waiver participant's tenancy as a condition of the landlord approving the environmental adaptation to the waiver participant's dwelling.

(((~~(3)~~))) (9) Environmental ((~~accessibility~~)) adaptations cannot add to the total square footage of the home.

(((~~(4)~~))) (10) The dollar ((~~limitations~~)) amounts for aggregate services in your Basic Plus waiver or the dollar amount of your annual IFS allocation limit the amount of service you may receive.

(((~~(5)~~))) (11) Damage repairs under the CIIBS and IFS waivers are subject to the following restrictions:

(a) Limited to the cost of restoration to the original condition((~~.~~));

(b) Limited to the dollar amounts of the IFS waiver participant's annual allocation;

(c) Behaviors of waiver participants that resulted in damage to the dwelling must be addressed in a positive behavior support plan prior to the repair of damages;

(((~~(b)~~))) (d) Repairs to personal property such as furniture and appliances and normal wear and tear are excluded.

(12) The following adaptations are not included in this service:

(a) Building fences and fence repairs;

(b) Carpet or carpet replacement.

AMENDATORY SECTION (Amending WSR 13-24-045, filed 11/26/13, effective 1/1/14)

WAC 388-845-1015 Are there limits to the extended state plan services I can receive? (1) Clinical and support needs for extended state plan services are identified in the waiver participant's DDA assessment and documented in the person-centered service plan/individual support plan.

(2) Additional therapy may be authorized as a waiver service only after you have accessed what is available to you under medicaid and any other private health insurance plan;

(((~~(2)~~))) (3) The department does not pay for treatment determined by DSHS to be experimental;

(((~~(3)~~))) (4) The department and the treating professional determine the need for and amount of service you can receive:

(a) The department may require a second opinion from a department selected provider.

(b) The department will require evidence that you have accessed your full benefits through medicaid before authorizing this waiver service.

(((~~(4)~~))) (5) The dollar ((~~limitations~~)) amount for Basic Plus waiver aggregate services limit the amount of service you may receive.

(6) The dollar amount for your annual allocation on the IFS waiver limit the amount of service you may receive.

AMENDATORY SECTION (Amending WSR 13-24-045, filed 11/26/13, effective 1/1/14)

WAC 388-845-1040 Are there limits to the individualized technical assistance services I can receive? (1) Individualized technical assistance service cannot exceed three months in an individual's plan year.

(2) These services are available on the Basic Plus, Core and ((~~community protection~~)) CP waivers.

(3) Individual must be receiving supported employment or prevocational services.

(4) Services are limited to additional hours per WAC 388-828-9355 and 388-828-9360.

AMENDATORY SECTION (Amending WSR 13-24-045, filed 11/26/13, effective 1/1/14)

WAC 388-845-1110 What are the limits of behavioral health crisis diversion bed services? (1) Clinical and support needs for behavioral health crisis diversion bed services are identified in the waiver participant's DDA assessment and documented in the person-centered service plan/individual support plan.

(2) Behavioral health crisis diversion bed services are intermittent and temporary. The duration and amount of services you need to stabilize your crisis is determined by a behavioral health professional and/or DDA.

(((~~(2)~~))) (3) These services are available in the CIIBS, Basic Plus, Core((~~,~~)) and community protection waivers administered by DDA as behavioral health stabilization services in accordance with WAC 388-845-1150 through 388-845-1160.

(((~~(3)~~))) (4) The costs of behavioral health crisis diversion bed services do not count toward the dollar ((~~limits~~)) amounts for aggregate services in the Basic Plus waiver.

AMENDATORY SECTION (Amending WSR 13-24-045, filed 11/26/13, effective 1/1/14)

WAC 388-845-1150 What are behavioral health stabilization services? Behavioral health stabilization services assist persons who are experiencing a behavioral health crisis or meet criteria for enhanced respite or community crisis stabilization services. These services are available in the Basic Plus, Core, CIIBS, IFS and community protection waivers to individuals determined by behavioral health professionals or DDA to be at risk of institutionalization or hospitalization who need one or more of the following services:

(1) Behavior support and consultation;

(2) Specialized psychiatric services; or

(3) Behavioral health crisis diversion bed services (not available to participants on the IFS waiver).

AMENDATORY SECTION (Amending WSR 13-24-045, filed 11/26/13, effective 1/1/14)

WAC 388-845-1160 Are there limitations to the behavioral health stabilization services that I can receive? (1) Clinical and support needs for behavioral health stabilization services are identified in the waiver participant's DDA

assessment and documented in the person-centered service plan/individual support plan.

(2) Behavioral health stabilization services are intermittent and temporary. The duration and amount of services you need to stabilize your crisis is determined by a behavioral health professional and/or DDA.

(((~~(2)~~))) (3) The costs of behavioral health stabilization services do not count toward the dollar ((~~limitations~~)) amounts for aggregate services in the Basic Plus waiver or the annual allocation in the IFS waiver.

(((~~(3)~~))) (4) Behavioral health stabilization services require prior approval by DDA or its designee.

AMENDATORY SECTION (Amending WSR 10-22-088, filed 11/1/10, effective 12/2/10)

WAC 388-845-1170 What is nurse delegation? (1) Nurse delegation services are services in compliance with WAC 246-840-910 through 246-840-970 by a registered nurse to provide training and nursing management for nursing assistants who perform delegated nursing tasks.

(2) Delegated nursing tasks include, but are not limited to, administration of noninjectable medications except for insulin, blood glucose testing, and tube feedings.

(3) Services include the initial visit, care planning, competency testing of the nursing assistant, consent of the client, additional instruction and supervisory visits.

(4) Clients who receive nurse delegation services must be considered "stable and predictable" by the delegated nurse.

(5) Nurse delegation services are available on all DDA HCBS waivers.

AMENDATORY SECTION (Amending WSR 10-22-088, filed 11/1/10, effective 12/2/10)

WAC 388-845-1180 Are there limitations to the nurse delegation services that I receive? The following limitations apply to receipt of nurse delegation services:

(1) Clinical and support needs for nurse delegation are identified in the waiver participant's DDA assessment and documented in the person-centered service plan/individual support plan.

(2) The department requires the delegating nurse's written recommendation regarding your need for the service. This recommendation must take into account that the nurse has recently examined you, reviewed your medical records, and conducted a nursing assessment.

(((~~(2)~~))) (3) The department may require a written second opinion from a department selected nurse delegator that meets the same criteria in subsection (((~~(1)~~))) (2) of this section.

(((~~(3)~~))) (4) The following tasks must not be delegated:

(a) Injections, other than insulin;

(b) Central lines;

(c) Sterile procedures; and

(d) Tasks that require nursing judgment.

(5) The dollar amounts for aggregate services in your basic plus waiver or the dollar amounts for your annual allocation in your IFS waiver limit the amount of nurse delegation service you are authorized to receive.

NEW SECTION

WAC 388-845-1190 What is peer mentoring? (1) Peer mentoring is a form of mentorship that takes place between a person who is living through the experience of having a developmental disability or being the family member of a person who has a developmental disability (peer mentor) and a person who is new to that experience (the peer mentee).

(2) Peer mentors utilize their personal experiences to provide support and guidance to a waiver participant and family members of a waiver participant.

(3) Peer mentors may orient a waiver participant to local community services, programs and resources and provide answers to participants' questions or suggest other sources of support.

(4) Peer mentoring is available in the IFS waiver.

NEW SECTION

WAC 388-845-1191 Who are qualified providers of peer mentoring? Qualified providers include organizations who:

(1) Provide peer mentoring support and training to individuals with developmental disabilities or to families with a member with a developmental disability; and

(2) Are contracted with DDA to provide this service.

NEW SECTION

WAC 388-845-1192 What limitations are there for peer mentoring? (1) Support needs for peer mentoring are identified in the waiver participant's DDA assessment and documented in the person-centered service plan/individual support plan.

(2) Peer mentors cannot mentor their own family members.

(3) The dollar amounts for the waiver participant's annual allocation in the IFS waiver limit the amount of peer mentoring service that the participant is authorized to receive.

NEW SECTION

WAC 388-845-1195 What is person-centered plan facilitation? (1) Person-centered plan facilitation is an approach to forming life plans that is centered on the individual. It is used as a life planning process to enable individuals with disabilities to increase personal self-determination. Person-centered plan facilitation is available in the IFS waiver.

(2) Person-centered plan facilitation typically includes:

(a) Identifying and developing a potential circle of people who know and care about the individual;

(b) Exploring what matters to the waiver participant by listening to and learning from the person;

(c) Developing a vision for a meaningful life, as defined by the waiver participant, which may include goals for education, employment, housing, relationships and recreation;

(d) Discovering capacities and assets of the waiver participant and her or his family, neighborhood, and support network;

(e) Generating an action plan; and

(f) Facilitating follow-up meetings to track progress towards goals.

NEW SECTION

WAC 388-845-1196 Who are qualified providers of person-centered plan facilitation? Qualified providers include organizations and individuals who:

(1) Provide person-centered plan facilitation to individuals with developmental disabilities; and

(2) Are contracted with DDA to provide this service.

NEW SECTION

WAC 388-845-1197 What limitations are there for person-centered plan facilitation? (1) Support needs for person-centered planning facilitation are identified in the waiver participant's DDA assessment and documented in the person-centered service plan/individual support plan.

(2) Person-centered plan facilitation may include follow up contacts with the waiver participant and his or her family to consult on plan implementation.

(3) The dollar amounts for the waiver participants' annual allocation in the IFS waiver limit the amount of person-centered plan facilitation service the individual is authorized to receive.

AMENDATORY SECTION (Amending WSR 13-24-045, filed 11/26/13, effective 1/1/14)

WAC 388-845-1300 What are personal care services? Personal care services as defined in WAC 388-106-0010 are the provision of assistance with personal care tasks. These services are available in the Basic Plus((~~, CIIBS and Core~~)) waiver((~~s~~)) if:

(1) You do not meet the programmatic eligibility requirements for community first choice services in chapter 388-106 WAC; and

(2) You meet the programmatic eligibility requirements for medicaid personal care in chapter 388-106 WAC.

AMENDATORY SECTION (Amending WSR 13-24-045, filed 11/26/13, effective 1/1/14)

WAC 388-845-1310 Are there limits to the personal care services I can receive? (1) Clinical and support needs for personal care services are identified in the waiver participant's DDA assessment and documented in the person-centered service plan/individual support plan.

(2) You must meet the programmatic eligibility for medicaid personal care in chapter 388-106 WAC governing medicaid personal care (MPC) using the current department approved assessment form: Comprehensive assessment reporting evaluation (CARE).

(((~~2~~))) (3) The maximum hours of personal care you may receive are determined by the CARE tool used as part of the DDA assessment.

(a) Provider rates are limited to the department established hourly rates for in-home medicaid personal care.

(b) Homecare agencies must be licensed through the department of health and contracted with DSHS.

AMENDATORY SECTION (Amending WSR 13-24-045, filed 11/26/13, effective 1/1/14)

WAC 388-845-1410 Are there limits to the prevocational services I can receive? The following limitations apply to your receipt of prevocational services:

(1) Clinical and support needs for prevocational services are identified in the waiver participant's DDA assessment and documented in the person-centered service plan/individual support plan.

(2) You must be age twenty and graduating from high school prior to your July or August twenty-first birthday, age twenty-one and graduated from high school, or age twenty-two or older to receive prevocational services.

(((~~2~~))) (3) New referrals for prevocational services require prior approval by the DDA regional administrator and county coordinator or their designees.

(((~~3~~))) (4) Prevocational services are a time limited step on the pathway toward individual employment and are dependent on your demonstrating steady progress toward gainful employment over time. Your annual employment plan will include exploration of integrated settings within your next service year. Criteria that would trigger a review of your need for these services include, but are not limited to:

(a) Compensation at more than fifty percent of the prevailing wage;

(b) Significant progress made toward your defined goals;

(c) Recommendation by your individual support plan team.

(((~~4~~))) (5) You will not be authorized to receive prevocational services in addition to community access services or supported employment services.

(((~~5~~))) (6) Your service hours are determined by the assistance you need to reach your employment outcomes as described in WAC 388-828-9325.

AMENDATORY SECTION (Amending WSR 13-24-045, filed 11/26/13, effective 1/1/14)

WAC 388-845-1600 What is respite care? Respite care is short-term intermittent care in order to provide relief for persons who: ((~~normally provide care for and l~~))

(1) Live with you and are your primary care providers; and

(a) Your family members (paid or unpaid care providers); or

(b) Nonfamily members who are not paid to provide care for you; or

(c) Contracted companion home providers paid by DDA to provide support to you; or

(d) Licensed children's foster home providers paid by DDA to provide support to you.

(2) This service is available in the Basic Plus, CIIBS, ((~~and~~)) Core and IFS waivers.

AMENDATORY SECTION (Amending WSR 13-24-045, filed 11/26/13, effective 1/1/14)

WAC 388-845-1605 Who is eligible to receive respite care? You are eligible to receive respite care if you are in the

Basic Plus, CIIBS, ((~~or~~)) Core or IFS waiver and((~~:~~)) meet the criteria in WAC 388-845-1600.

(((~~(1) You live in a private home and no person living with you is contracted by [DSHS] to provide you with a service; or~~

~~(2) You are age eighteen or older and:~~

~~(a) You live with your natural, step or adoptive parent(s) who is also contracted by [DSHS] to provide you with a service; and~~

~~(b) No one else living with you is contracted by DSHS to provide you with a service; or~~

~~(3) You are under the age of eighteen and:~~

~~(a) You live with your natural, step or adoptive parent(s); and~~

~~(b) There is a person living with you who is contracted by DSHS to provide you with a service; or~~

~~(4) You live with a caregiver who is paid by DDA to provide supports as:~~

~~(a) A contracted companion home provider; or~~

~~(b) A licensed children's foster home provider.~~))

AMENDATORY SECTION (Amending WSR 13-24-045, filed 11/26/13, effective 1/1/14)

WAC 388-845-1607 Can someone who lives with me be my respite provider? Someone who lives with you may be your respite provider as long as he or she is not ((~~the person who normally provides care for you~~)) your primary care provider and is not contracted to provide any other DSHS paid service to you. The limitations listed in WAC 388-845-0111 also apply.

AMENDATORY SECTION (Amending WSR 13-24-045, filed 11/26/13, effective 1/1/14)

WAC 388-845-1620 Are there limits to the respite care I can receive? The following limitations apply to the respite care you can receive:

(1) For basic plus, core and CIIBS waivers, the DDA assessment will determine how much respite you can receive per chapter 388-828 WAC.

(2) For the IFS waiver, the dollar amount for your annual allocation in your IFS waiver limits the amount of respite care you may receive.

(3) Respite cannot replace:

(a) Day care while your parent or guardian is at work; and/or

(b) Personal care hours available to you. When determining your unmet need, DDA will first consider the personal care hours available to you.

(((~~(3)~~))) (4) Respite providers have the following limitations and requirements:

(a) If respite is provided in a private home, the home must be licensed unless it is the client's home or the home of a relative of specified degree per WAC 388-825-345;

(b) The respite provider cannot be the spouse of the caregiver receiving respite if the spouse and the caregiver reside in the same residence; and

(c) If you receive respite from a provider who requires licensure, the respite services are limited to those age-specific services contained in the provider's license.

(((~~(4)~~))) (5) Your ((~~caregiver~~)) individual respite provider may not provide:

(a) Other DDA services for you ((~~or other persons~~)) during your respite care hours((~~:~~)); or

(b) DDA paid services to other persons during your respite care hours.

(((~~(5) If your personal care provider is your parent, your parent provider will not be paid to provide respite services to any client in the same month that you receive respite services.~~))

(6) Your primary caregivers may not provide other DDA services for you during your respite care hours.

(7) If your personal care provider is your parent and you live in your parent's adult family home you may not receive respite.

(((~~(7)~~))) (8) DDA may not pay for any fees associated with the respite care; for example, membership fees at a recreational facility, or insurance fees.

(((~~(8)~~))) (9) If you require respite from a licensed practical nurse (LPN) or a registered nurse (RN), services may be authorized as skilled nursing services per WAC 388-845-1700 using an LPN or RN. Respite care from a LPN or RN requires prior approval per WAC 388-845-1700(2). If you are in the IFS or Basic Plus waiver, skilled nursing services are limited to the dollar ((~~limits~~)) amounts of your basic plus aggregate services or IFS annual allocation per WAC 388-845-0210 and 388-845-0230.

AMENDATORY SECTION (Amending WSR 13-24-045, filed 11/26/13, effective 1/1/14)

WAC 388-845-1660 Are there limitations to the sexual deviancy evaluations I can receive? (1) Clinical and support needs for sexual deviancy evaluations are identified in the waiver participant's DDA assessment and documented in the person-centered service plan/individual support plan. Sexual deviancy evaluations must meet the standards contained in WAC 246-930-320.

(2) Sexual deviancy evaluations require prior approval by the DDA regional administrator or designee.

(3) The costs of sexual deviancy evaluations do not count toward the dollar limits for aggregate services in the Basic Plus waivers or the annual allocation in the IFS waiver.

AMENDATORY SECTION (Amending WSR 10-22-088, filed 11/1/10, effective 12/2/10)

WAC 388-845-1700 What is skilled nursing? (1) Skilled nursing is continuous, intermittent, or part time nursing services. These services are available in the Basic Plus, Core, IFS and ((~~Community Protection~~)) CP waivers.

(2) Services include nurse delegation services, per WAC 388-845-1170, provided by a registered nurse, including the initial visit, follow-up instruction, and/or supervisory visits.

AMENDATORY SECTION (Amending WSR 13-24-045, filed 11/26/13, effective 1/1/14)

WAC 388-845-1710 Are there limitations to the skilled nursing services I can receive? The following limitations apply to your receipt of skilled nursing services:

(1) Clinical and support needs for skilled nursing services are identified in the waiver participant's DDA assessment and documented in the person-centered service plan/individual support plan.

(((1))) (2) Skilled nursing services with the exception of nurse delegation and nursing evaluations require prior approval by the DDA regional administrator or designee.

(((2))) (3) DDA and the treating professional determine the need for and amount of service.

(((3))) (4) DDA reserves the right to require a second opinion by a department-selected provider.

(((4))) (5) The dollar ((limitation)) amount for aggregate services in your Basic Plus waiver or the dollar amount of your annual allocation in your IFS waiver limits the amount of skilled nursing services you may receive.

Reviser's note: RCW 34.05.395 requires the use of underlining and deletion marks to indicate amendments to existing rules. The rule published above varies from its predecessor in certain respects not indicated by the use of these markings.

AMENDATORY SECTION (Amending WSR 13-24-045, filed 11/26/13, effective 1/1/14)

WAC 388-845-1800 What are specialized medical equipment and supplies? (1) Specialized medical equipment and supplies are durable and nondurable medical equipment not available through medicaid or the state plan (or are in excess of what is available through your medicaid state plan benefit) which enables individuals to:

(a) Increase their abilities to perform their activities of daily living; or

(b) Perceive, control or communicate with the environment in which they live.

(2) Durable medical equipment and medical supplies are defined in WAC 182-543-1000 and 182-543-5500 respectively.

(3) Also included are items necessary for life support; and ancillary supplies and equipment necessary to the proper functioning of the equipment and supplies described in subsection (1) above.

(4) Specialized medical equipment and supplies include the maintenance and repair of specialized medical equipment not covered through the medicaid state plan.

(5) Specialized medical equipment and supplies are available in all DDA HCBS waivers.

AMENDATORY SECTION (Amending WSR 13-24-045, filed 11/26/13, effective 1/1/14)

WAC 388-845-1810 Are there limitations to my receipt of specialized medical equipment and supplies? The following limitations apply to your receipt of specialized medical equipment and supplies:

(1) Clinical and support needs for specialized medical equipment and supplies are identified in the waiver participant's DDA assessment and documented in the person-centered service plan/individual support plan.

(((1))) (2) Specialized medical equipment and supplies require prior approval by the DDA regional administrator or designee for each authorization.

(((2))) (3) DDA ((reserves the right to)) may require a second opinion by a department-selected provider.

(((3))) (4) Items ((reimbursed)) purchased with waiver funds shall be in addition to any medical equipment and supplies furnished under the medicaid state plan.

(((4))) (5) Items must be of direct medical or remedial benefit to the individual and necessary as a result of the individual's disability.

(((5))) (6) Medications, prescribed or nonprescribed, and vitamins are excluded.

(((6))) (7) The dollar ((limitations)) amounts for aggregate services in your Basic Plus waiver limit the amount of service you may receive.

(8) The dollar amounts for your annual allocation in your IFS waiver limit the amount of service you may receive.

AMENDATORY SECTION (Amending WSR 10-22-088, filed 11/1/10, effective 12/2/10)

WAC 388-845-1840 What is specialized nutrition ((and specialized clothing))? (((1))) Specialized nutrition is available to you in the CIIBS and IFS waivers and is defined as:

(((a))) (1) Assessment, intervention, and monitoring services from a certified dietitian; and/or

(((b))) (2) Specially prepared food, or purchase of particular types of food, needed to sustain you in the family home. Specialized nutrition is in addition to meals a parent would provide and specific to your medical condition or diagnosis.

(((2) Specialized clothing is available to you in the CIIBS waiver and defined as nonrestrictive clothing adapted to the participant's individual needs and related to his/her disability. Specialized clothing can include weighted clothing, clothing designed for tactile defensiveness, specialized footwear, or reinforced clothing.))

AMENDATORY SECTION (Amending WSR 13-24-045, filed 11/26/13, effective 1/1/14)

WAC 388-845-1845 Who are qualified providers of specialized nutrition ((and specialized clothing))? (((1))) Providers of specialized nutrition are:

(((a))) (1) Certified dietitians contracted with DDA to provide this service or employed by an agency contracted with DDA to provide this service; and

(((b))) (2) Specialized nutrition vendors contracted with DDA to provide this service.

(((2) Providers of specialized clothing are specialized clothing vendors contracted with DDA to provide this service.))

AMENDATORY SECTION (Amending WSR 13-24-045, filed 11/26/13, effective 1/1/14)

WAC 388-845-1850 Are there limitations to my receipt of specialized nutrition ((and specialized clothing))? (1) The following limitations apply to your receipt of specialized nutrition services:

(a) Clinical and support needs for specialized nutrition are identified in the waiver participant's DDA assessment and

documented in the person-centered service plan/individual support plan.

(b) Specialized nutrition may be authorized as a waiver service if the service is not covered by medicaid or private insurance. You must assist the department in determining whether third party payments are available;

(((~~(b)~~))) (c) Services must be safe, effective, and individualized;

(((~~(c)~~))) (d) Services must be ordered by a physician licensed to practice in the state of Washington;

(((~~(d)~~))) (e) Specialized diets must be periodically monitored by a certified dietitian;

(((~~(e)~~))) (f) Specialized nutrition products will not constitute a full nutritional regime unless an enteral diet is the primary source of nutrition;

(((~~(f)~~))) (g) Department coverage of specialized nutrition products is limited to costs that are over and above inherent family food costs;

(((~~(g)~~))) (h) DDA ((~~reserves the right to~~)) may require a second opinion by a department selected provider; and

(((~~(h)~~))) (i) Prior approval by regional administrator or designee is required for participants on the CIIBS waiver.

(2) The ((~~following limitations apply to your receipt of specialized clothing:~~)) dollar amounts for your annual allocation in your IFS waiver limit the amount of service you may receive.

(((~~(a) Specialized clothing may be authorized as a waiver service if the service is not covered by medicaid or private insurance. You must assist the department in determining whether third party payments are available.~~

~~(b) The department requires written documentation from an appropriate health professional regarding your need for the service. This recommendation must take into account that the health professional has recently examined you, reviewed your medical records, and conducted an assessment.~~

~~(c) The department may require a second opinion from a department selected provider that meets the same criteria as subsection (b) of this section.~~

~~(d) Prior approval by regional administrator or designee is required.~~))

NEW SECTION

WAC 388-845-1855 What is specialized clothing? Specialized clothing is available to you in the CIIBS and IFS waivers and is defined as nonrestrictive clothing adapted to your individual needs and related to your disability, such as weighted clothing, clothing designed for tactile defensiveness, specialized footwear, or reinforced clothing.

NEW SECTION

WAC 388-845-1860 Who are qualified providers of specialized clothing? Providers of specialized clothing are specialized clothing vendors contracted with DDA to provide this service.

NEW SECTION

WAC 388-845-1865 Are there limitations to my receipt of specialized clothing? (1) The following limitations apply to your receipt of specialized clothing:

(a) Clinical and support needs for specialized clothing are identified in the waiver participant's DDA assessment and documented in the person-centered service plan/individual support plan.

(b) Specialized clothing may be authorized as a waiver service if the service is not covered by medicaid or private insurance. You must assist the department in determining whether third party payments are available.

(c) The department requires written documentation from an appropriate health professional regarding your need for the service. This recommendation must take into account that the health professional has recently examined you, reviewed your medical records, and conducted an assessment.

(d) The department may require a second opinion from a department selected provider that meets the criteria in subsection (1)(c) of this section.

(2) For IFS waiver participants, the dollar amounts for your annual allocation in your IFS waiver limit the amount of service you may receive.

AMENDATORY SECTION (Amending WSR 13-24-045, filed 11/26/13, effective 1/1/14)

WAC 388-845-1910 Are there limitations to the specialized psychiatric services I can receive? (1) Clinical and support needs for specialized psychiatric services are identified in the waiver participant's DDA assessment and documented in the person-centered service plan/individual support plan.

(2) Specialized psychiatric services are excluded if they are available through other medicaid programs.

(3) DDA and the treating professional will determine the need and amount of service you will receive in the IFS, basic plus, core, CIIBS, and CP waivers, subject to the limitations in subsection (4) of this section.

(((~~(2)~~))) (4) The dollar ((~~limitations~~)) amounts for aggregate service in your Basic Plus waiver or the dollar amount of your annual allocation in your IFS waiver limit the amount of specialized psychiatric services you are authorized to receive, unless provided as a behavioral health stabilization service.

(((~~(3)~~))) (5) Specialized psychiatric services require prior approval by the DDA regional administrator or designee.

AMENDATORY SECTION (Amending WSR 13-24-045, filed 11/26/13, effective 1/1/14)

WAC 388-845-2000 What is staff/family consultation and training? (1) Staff/family consultation and training is professional assistance to families or direct service providers to help them better meet the needs of the waiver person. This service is available in all DDA HCBS waivers.

(2) Consultation and training is provided to families, direct staff, or personal care providers to meet the specific needs of the waiver participant as outlined in the ((~~individual's~~)) person-centered service plan/individual support plan, including:

(a) Health and medication monitoring;
(b) Positioning and transfer;
(c) Basic and advanced instructional techniques;
(d) Positive behavior support;
(e) Augmentative communication systems;
(f) Diet and nutritional guidance;
(g) Disability information and education;
(h) Strategies for effectively and therapeutically interacting with the participant;
(i) Environmental consultation; and
(j) For the IFS and CIIBS waivers only, individual and family counseling.

AMENDATORY SECTION (Amending WSR 13-24-045, filed 11/26/13, effective 1/1/14)

WAC 388-845-2005 Who is a qualified provider of staff/family consultation and training? To provide staff/family consultation and training, a provider must be one of the following licensed, registered or certified professionals and be contracted with DDA:
(1) Audiologist;
(2) Licensed practical nurse;
(3) Marriage and family therapist;
(4) Mental health counselor;
(5) Occupational therapist;
(6) Physical therapist;
(7) Registered nurse;
(8) Sex offender treatment provider;
(9) Speech/language pathologist;
(10) Social worker;
(11) Psychologist;
(12) Certified American sign language instructor;
(13) Nutritionist;
(14) Counselors registered or certified in accordance with the requirements of chapter 18.19 RCW;
(15) Certified dietician;
(16) Recreation therapist registered in Washington and certified by the National Council for Therapeutic Recreation;
(17) Providers listed in WAC 388-845-0506 and contracted with DDA to provide CIIBS intensive services;
(18) Certified music therapist (for CIIBS only); ((~~or~~))
(19) Psychiatrist; or
(20) Professional advocacy organization.

AMENDATORY SECTION (Amending WSR 13-24-045, filed 11/26/13, effective 1/1/14)

WAC 388-845-2010 Are there limitations to the staff/family consultation and training I can receive? (1) Clinical and support needs for staff/family consultation and training are identified in the waiver participant's DDA assessment and documented in the person-centered service plan/individual support plan.
(2) Expenses to the family or provider for room and board or attendance, including registration, at conferences are excluded as a service under staff/family consultation and training.
((~~(2)~~)) (3) ((~~Staff/family consultation and training require prior approval by the DDA regional administrator or designee.~~)) The dollar amounts for aggregate service in your basic plus waiver or the dollar amount of the annual allocation in your IFS waiver limit the amount of staff/family consultation and training you may receive.
((~~(3) The dollar limitations for aggregate services in your Basic Plus waiver limit the amount of service you may receive.~~))

NEW SECTION

WAC 388-845-2130 What are supported parenting services? (1) Supported parenting services are professional services offered to participants who are parents or expectant parents.
(2) Services may include teaching, parent coaching, and other supportive strategies in areas critical to parenting, including child development, nutrition and health, safety, childcare, money management, time and household management, and housing.
(3) Supported parenting services are designed to build parental skills around the child's developmental domains of cognition, language, motor, social-emotional, and self-help.
(4) Supported parenting services are offered in the IFS waiver.

NEW SECTION

WAC 388-845-2135 Who are qualified providers of supported parenting services? Qualified providers of supported parenting services must:
(1) Have an understanding of the manner in which persons with intellectual/developmental disabilities best learn;
(2) Have skills in child development and family dynamics;
(3) Have a supported parenting contract with DDA; and
(4) Be one or more of the following licensed, registered or certified professionals:
(a) Audiologist;
(b) Licensed practical nurse;
(c) Marriage and family therapist;
(d) Mental health counselor;
(e) Occupational therapist;
(f) Physical therapist;
(g) Registered nurse or licensed practical nurse;
(h) Speech/language pathologist;
(i) Social worker;
(j) Psychologist;
(k) Certified american sign language instructor;
(l) Nutritionist;
(m) Counselors registered or certified in accordance with the requirements of chapter 18.19 RCW;
(n) Certified dietician;
(o) Recreation therapist registered in Washington and certified by the National Council for Therapeutic Recreation;
(p) Psychiatrist;
(q) Professional advocacy organization.

NEW SECTION

WAC 388-845-2140 Are there any limitations on my receipt of supported parenting services? The following

limitations apply to your receipt of supported parenting services:

(1) Clinical and support needs for supported parenting services are identified in your DDA assessment and documented in your person-centered service plan/individual support plan;

(2) The dollar amount of your annual allocation in your IFS waiver limit the amount of supported parenting service you are authorized to receive.

AMENDATORY SECTION (Amending WSR 13-24-045, filed 11/26/13, effective 1/1/14)

WAC 388-845-2160 What is therapeutic equipment and supplies? (1) Therapeutic equipment and supplies are only available in the CIIBS and IFS waivers.

(2) Therapeutic equipment and supplies are equipment and supplies that are necessary to implement a behavioral support plan or other therapeutic plan, designed by an appropriate professional, such as a sensory integration or communication therapy plan, and necessary in order to fully implement the therapy or intervention.

(3) Included are items such as a weighted blanket, supplies that assist to calm or redirect the ((~~child~~)) individual to a constructive activity, or a vestibular swing.

AMENDATORY SECTION (Amending WSR 12-16-095, filed 8/1/12, effective 9/1/12)

WAC 388-845-2170 Are there limitations on my receipt of therapeutic equipment and supplies? The following limitations apply to your receipt of therapeutic equipment and supplies under the CIIBS and IFS waivers:

(1) Therapeutic equipment and supplies may be authorized as a waiver service if the service is not covered by medicaid or private insurance. You must assist the department in determining whether third party payments are available.

(2) The department does not pay for experimental equipment and supplies.

(3) The department requires your treating professional's written recommendation regarding your need for the service. This recommendation must take into account that the treating professional has recently examined you, reviewed your medical records, and conducted a functional evaluation.

(4) The department may require a written second opinion from a department selected professional that meets the same criteria in subsection (3) of this section.

(5) The dollar amount of your annual allocation in your IFS waiver limits the amount of therapeutic equipment and supplies you are authorized to receive.

(6) Therapeutic equipment and supplies requires a prior approval by the DDA regional administrator or designee.

AMENDATORY SECTION (Amending WSR 13-24-045, filed 11/26/13, effective 1/1/14)

WAC 388-845-2210 Are there limitations to the transportation services I can receive? The following limitations apply to transportation services:

(1) ((~~Transportation to/from medical or medically related appointments is a medicaid transportation service and is to be considered and used first.~~

~~(2) Support needs for transportation services are identified in your DDA assessment and documented in your person-centered service plan/individual support plan.~~

~~(3) Transportation is offered in addition to medical transportation but cannot replace medicaid transportation services.~~

~~(4)~~)) Support needs for transportation services are identified in your DDA assessment and documented in your person-centered service plan/individual support plan.

(2) Transportation is limited to travel to and from a waiver service. When the waiver service is supported employment, transportation is limited to days when the participant receives employment support services.

(((~~4~~))) (3) Transportation does not include the purchase of a bus pass.

(((~~5~~))) (4) Reimbursement for provider mileage requires prior ((~~approval~~)) authorization by DDA and is paid according to contract.

(((~~6~~))) (5) This service does not cover the purchase or lease of vehicles.

(((~~7~~))) (6) Reimbursement for provider travel time is not included in this service.

(((~~8~~))) (7) Reimbursement to the provider is limited to transportation that occurs when you are with the provider.

(((~~9~~))) (8) You are not eligible for transportation services if the cost and responsibility for transportation is already included in your provider's contract and payment.

(((~~10~~))) (9) The dollar limitations for aggregate services in your Basic Plus waiver or the dollar amount of your annual allocation in the IFS waiver limit the amount of service you may receive.

(((~~11) Transportation services require prior approval by the DDA regional administrator or designee.~~)))

(((~~12~~))) (10) If your individual waiver personal care provider uses his/her own vehicle to provide transportation to you for essential shopping and medical appointments as a part of your personal care service, your provider may receive up to ((~~sixty~~)) one hundred miles per month in mileage reimbursement. If you work with more than one individual personal care provider, your limit is still a total of ((~~sixty~~)) one hundred miles per month. This cost is not counted toward the dollar limitation for aggregate services in the Basic Plus waiver.

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.

AMENDATORY SECTION (Amending WSR 10-22-088, filed 11/1/10, effective 12/2/10)

WAC 388-845-2260 What are vehicle modifications? ((~~This service is only available in the CIIBS waiver.~~)) (1) Vehicle modifications are adaptations or alterations to a vehicle required in order to accommodate the unique needs of the individual, enable full integration into the community, and ensure the health, welfare, and safety of the ((~~individual~~)) participant and/or ((~~family members~~)) caregivers.

(2) Vehicle modifications require prior approval from the DDA regional administrator or designee.

(3) Examples of vehicle modifications include:

(a) Manual hitch-mounted carrier and hitch for all wheelchair types;

(b) Wheelchair cover;

(c) Wheelchair strap-downs;

(d) Portable wheelchair ramp;

(e) Accessible running boards and steps;

(f) Assist poles and/or grab handles.

(j) Power activated carrier for all wheelchair types;

(h) Permanently installed wheelchair ramps;

(i) Repairs and maintenance to vehicular modifications as needed for client safety; and

(j) Other access modifications.

AMENDATORY SECTION (Amending WSR 13-24-045, filed 11/26/13, effective 1/1/14)

WAC 388-845-2270 Are there limitations to my receipt of vehicle modification services? Vehicle modification services are only available on the CIIBS or IFS waiver. The following limitations apply ((~~to your receipt of vehicle modifications under the CIIBS waiver~~)):

(1) ((~~Prior approval by the regional administrator or designee is required.~~)) Clinical and support needs for vehicle modification services are identified in the participant's DDA assessment and documented in the person-centered service plan/individual support plan.

(2) Vehicle modifications are excluded if they are of general utility without direct medical or remedial benefit to the ((~~individual~~)) participant or caregiver.

(3) Participants who are enrolled with division of vocational rehabilitation (DVR) must pursue this benefit through DVR first.

(4) Vehicle modifications must be the most cost effective modification based upon a comparison of contractor bids as determined by DDA.

(((~~(4)~~))) (5) Modifications will only be approved for a vehicle that serves as the participant's primary means of transportation and is owned by the participant and/or family.

(((~~(5 The department)~~))) (6) DDA requires your treating professional's written recommendation regarding your need for the service. This recommendation must take into account that the treating professional has recently examined you, reviewed your medical records, and conducted a functional evaluation.

(((~~(6)~~))) (7) The department may require a second opinion from a department selected provider that meets the same criteria as subsection (((~~(5)~~))) (6) of this section.

(8) The dollar amount for your annual allocation in your IFS waiver limits the amount of vehicle modification service you are authorized 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 13-24-045, filed 11/26/13, effective 1/1/14)

WAC 388-845-3000 What is the process for determining the services I need? Your service needs are determined through the DDA assessment and the service planning process as defined in chapter 388-828 WAC. Only identified health and welfare needs will be authorized for payment in the ((~~ISP~~)) person-centered service plan/individual support plan.

(1) You receive an initial and annual assessment of your needs using a department-approved form.

(a) You meet the eligibility requirements for ICF/ID level of care.

(b) The "comprehensive assessment reporting evaluation (CARE)" tool will determine your eligibility and amount of personal care services.

(c) If you are in the Basic Plus, CIIBS, or Core waiver, the DDA assessment will determine the amount of respite care available to you.

(2) From the assessment, DDA develops your waiver person-centered service plan/individual support plan (ISP) with you and/or your legal representative and others who are involved in your life such as your parent or guardian, advocate and service providers.

AMENDATORY SECTION (Amending WSR 13-24-045, filed 11/26/13, effective 1/1/14)

WAC 388-845-3055 What is a waiver person-centered service plan/individual support plan (ISP)? (1) The person-centered service plan/individual support plan (ISP) is the primary tool DDA uses to determine and document your needs and to identify the services to meet those needs.

(2) Your person-centered service plan/ISP must include:

(a) Your identified health and welfare needs;

(b) Both paid and unpaid services and supports approved to meet your identified health and welfare needs as identified in WAC 388-828-8040 and 388-828-8060; and

(c) How often you will receive each waiver service; how long you will need it; and who will provide it.

(3) For ((~~an initial~~)) any person-centered service plan/ISP, you or your legal representative must sign ((~~or give verbal consent to~~)) the plan indicating your agreement to the receipt of services.

(4) ((~~For a reassessment or review of your ISP, you or your legal representative must sign or give verbal consent to the plan indicating your agreement to the receipt of services.~~

~~(5)~~)) You may choose any qualified provider for the service, who meets all of the following:

(a) Is able to meet your needs within the scope of their contract, licensure and certification;

(b) Is reasonably available;

(c) Meets provider qualifications in chapters 388-845 and 388-825 WAC for contracting; and

(d) Agrees to provide the service at department rates.

AMENDATORY SECTION (Amending WSR 13-24-045, filed 11/26/13, effective 1/1/14)

WAC 388-845-3056 What if I need assistance to understand my person-centered service plan/individual support plan? If you are unable to understand your person-centered service plan/individual support plan and the individual who has agreed to provide assistance to you as your necessary supplemental accommodation representative is unable to assist you with understanding your individual support plan, DDA will take the following steps:

(1) Consult with the office of the attorney general to determine if you require a legal representative or guardian to assist you with your individual support plan.

(2) Continue your current waiver services.

(3) If the office of the attorney general or a court determines that you do not need a legal representative, DDA will continue to try to provide necessary supplemental accommodations in order to help you understand your person-centered service plan/individual support plan.

AMENDATORY SECTION (Amending WSR 13-24-045, filed 11/26/13, effective 1/1/14)

WAC 388-845-3060 When is my person-centered service plan/individual support plan effective? Your person-centered service plan/individual support plan is effective the last day of the month in which DDA signs and dates it. ((~~after a signature or consent is obtained.~~))

AMENDATORY SECTION (Amending WSR 13-24-045, filed 11/26/13, effective 1/1/14)

WAC 388-845-3061 Can a change in my person-centered service plan/individual support plan be effective before I sign it? If you verbally request a change in service to occur immediately, DDA can sign the person-centered service plan/individual support plan and approve it prior to receiving your signature.

(1) Your person-centered service plan/individual support plan will be mailed to you for signature.

(2) You retain the same appeal rights as if you had signed the person-centered service plan/individual support plan.

AMENDATORY SECTION (Amending WSR 13-24-045, filed 11/26/13, effective 1/1/14)

WAC 388-845-3062 Who is required to sign ((~~or give verbal consent to~~)) the person-centered service plan/individual support plan? (1) If you do not have a legal representative, you must sign ((~~or give verbal consent to~~)) the person-centered service plan/individual support plan.

(2) If you have a legal representative, your legal representative must sign ((~~or give verbal consent to~~)) the person-centered service plan/individual support plan.

(3) If you need assistance to understand your person-centered service plan/individual support plan, DDA will follow the steps outlined in WAC 388-845-3056 (1) and (3).

AMENDATORY SECTION (Amending WSR 13-24-045, filed 11/26/13, effective 1/1/14)

WAC 388-845-3063 Can my person-centered service plan/individual support plan be effective before the end of the month? You may request to DDA to have your person-centered service plan/individual support plan effective prior to the end of the month. The effective date will be the date DDA signs and dates it. ((~~after receiving your signature or verbal consent.~~))

AMENDATORY SECTION (Amending WSR 13-04-005, filed 1/24/13, effective 2/24/13)

WAC 388-845-3065 How long is my plan effective? Your person-centered service plan/individual support plan is effective through the last day of the twelfth month following the effective date or until another ISP is completed, whichever occurs sooner.

AMENDATORY SECTION (Amending WSR 13-24-045, filed 11/26/13, effective 1/1/14)

WAC 388-845-3070 What happens if I do not sign ((~~or verbally consent to~~)) my person-centered service plan/individual support plan (ISP)? If DDA is unable to obtain the necessary signature ((~~or verbal consent~~)) for an initial, reassessment or review of your person-centered service plan/individual support plan (ISP), DDA will take one or more of the following actions:

(1) If this person-centered service plan/individual support plan is an initial plan, DDA will be unable to provide waiver services. DDA will not assume consent for an initial plan and will follow the steps described in WAC 388-845-3056 (1) and (3).

(2) If this person-centered service plan/individual support plan is a reassessment or review ((~~and you are able to understand your ISP~~)):

(a) DDA will continue providing services as identified in your most current ISP until the end of the ten-day advance notice period as stated in WAC 388-825-105.

(b) ((~~At the end of the ten-day advance notice period, unless you file an appeal, DDA will assume consent and implement the new ISP without the required signature or verbal consent as defined in WAC 388-845-3062 above~~)) Your complete person-centered service plan/individual support plan is sent to you for signature after DDA signs and dates it. If your signed ISP is not returned to DDA within two months of your assessment completion, DDA will terminate your services.

(3) If this person-centered service plan/individual support plan is a reassessment or review and you are not able to understand your ISP, DDA will continue your existing services and take the steps described in WAC 388-845-3056.

(4) You will be provided written notification and appeal rights to this action to implement the new ISP.

(5) Your appeal rights are in WAC 388-845-4000 and 388-825-120 through 388-825-165.

AMENDATORY SECTION (Amending WSR 13-24-045, filed 11/26/13, effective 1/1/14)

WAC 388-845-3075 What if my needs change? You may request a review of your person-centered service plan/individual support plan at any time by calling your case manager. If there is a significant change in your condition or circumstances, DDA must reassess your person-centered service plan/individual support plan with you and amend the plan to reflect any significant changes. This reassessment does not affect the end date of your annual person-centered service plan/individual support plan.

AMENDATORY SECTION (Amending WSR 13-24-045, filed 11/26/13, effective 1/1/14)

WAC 388-845-3085 What if my needs exceed what can be provided under the IFS, CIIBS, Core or Community Protection waiver? (1) If you are on the IFS, CIIBS, Core or Community Protection waiver and your assessed need for services exceeds the scope of services provided under your waiver, DDA will make the following efforts to meet your health and welfare needs:

(a) Identify more available natural supports;

(b) Initiate an exception to rule to access available nonwaiver services not included in the IFS, CIIBS, Core or Community Protection waiver other than natural supports;

(c) Offer you the opportunity to apply for an alternate waiver that has the services you need, subject to WAC 388-845-0045;

(d) Offer you placement in an ICF/ID.

(2) If none of the above options is successful in meeting your health and welfare needs, DDA may terminate your waiver eligibility.

(3) If you are terminated from a waiver, you will remain eligible for nonwaiver DDA services but access to state-only funded DDA services is limited by availability of funding.

WSR 16-06-016
EMERGENCY RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 16-29—Filed February 19, 2016, 10:31 a.m., effective February 19, 2016, 10:31 a.m.]

Effective Date of Rule: Immediately upon filing.

Purpose: The purpose of this rule making is to provide for treaty Indian fishing opportunity in the Columbia River while protecting salmon listed as threatened or endangered under the Endangered Species Act (ESA). This rule making implements federal court orders governing Washington's relationship with treaty Indian tribes and federal law governing Washington's relationship with Oregon.

Citation of Existing Rules Affected by this Order: Repealing WAC 220-32-05100Q; and amending WAC 220-32-051.

Statutory Authority for Adoption: RCW 77.04.012, 77.04.020, 77.04.130, 77.12.045, and 77.12.047.

Other Authority: *United States v. Oregon,* Civil No. 68-513-KI (D. Or.), Order Adopting 2008-2017 *United States v. Oregon* Management Agreement (Aug. 12, 2008) (Doc. No. 2546); *Northwest Gillnetters Ass'n v. Sandison*, 95 Wn.2d 638, 628 P.2d 800 (1981); Washington fish and wildlife commission policies concerning Columbia River fisheries; 40 Stat. 515 (Columbia River Compact).

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: Extends the ongoing seasons in SMCRA 1G and 1F (The Dalles and John Day pools). Harvest to date has been low and sturgeon remain available under the current harvest guidelines for each pool. The regulation continues to allow the sale of fish as outlined in Section 2. The season is consistent with the 2008-2017 Management Agreement and the associated biological opinion. Rule is consistent with action of the Columbia River Compact on January 27, February 11 and 18, 2016. Conforms state rules with tribal rules. There is insufficient time to promulgate permanent regulations.

The Yakama, Warm Springs, Umatilla, and Nez Perce Indian tribes have treaty fishing rights in the Columbia River and inherent sovereign authority to regulate their fisheries. Washington and Oregon also have some authority to regulate fishing by treaty Indians in the Columbia River, authority that the states exercise jointly under the congressionally ratified Columbia River Compact. *Sohappy v. Smith*, 302 F. Supp. 899 (D. Or. 1969). The tribes and the states adopt parallel regulations for treaty Indian fisheries under the supervision of the federal courts. A court order sets the current parameters. *United States v. Oregon*, Civil No. 68-513-KI (D. Or.), Order Adopting 2008-2017 *United States v. Oregon* Management Agreement (Aug. 12, 2008) (Doc. No. 2546). Some salmon and steelhead stocks in the Columbia River are listed as threatened or endangered under the federal ESA. On May 5, 2008, the National Marine Fisheries Service issued a biological opinion under 16 U.S.C. § 1536 that allows for some incidental take of these species in the fisheries as described in the 2008-2017 *U.S. v. Oregon* Management Agreement.

Columbia River fisheries are monitored very closely to ensure consistency with court orders and ESA guidelines. Because conditions change rapidly, the fisheries are managed almost exclusively by emergency rule. As required by court order, the Washington (WDFW) and Oregon (ODFW) departments of fish and wildlife convene public hearings and invite tribal participation when considering proposals for new emergency rules affecting treaty fishing rights. *Sohappy*, 302 F. Supp. at 912. WDFW and ODFW then adopt regulations reflecting agreements reached.

Number of Sections Adopted in Order to Comply with Federal Statute: New 1, Amended 0, Repealed 1; Federal Rules or Standards: New 1, Amended 0, Repealed 1; 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: February 19, 2016.

J. W. Unsworth
Director

NEW SECTION

WAC 220-32-05100R Columbia River salmon seasons above Bonneville Dam. Notwithstanding the provisions of WAC 220-32-050, WAC 220-32-051, WAC 220-32-052 and WAC 220-32-058, effective immediately until further notice, it is unlawful for a person to take or possess salmon, steelhead, sturgeon, shad, carp, catfish, walleye, bass, or yellow perch taken for commercial purposes in Columbia River Salmon Management and Catch Reporting Areas 1F, 1G, and 1H. However, those individuals possessing treaty fishing rights under the Yakima, Warm Springs, Umatilla, and Nez Perce treaties may fish for salmon, steelhead, sturgeon, shad, carp, catfish, walleye, bass, or yellow perch under the following provisions:

(1) Open Areas: SMCRA 1G and 1H (The Dalles Pool and John Day Pool):

(a) Season: Immediately through 6:00 p.m. February 27, 2016.

(b) Gear: Gill nets, hoop nets, dip bag nets, and rod and reel with hook and line. No mesh restriction on gillnets.

(c) Allowable sale: Salmon, steelhead, shad, carp, catfish, walleye, bass, or yellow perch. Sturgeon between 43-54 inches in fork length may be sold or kept for subsistence. Live release of all oversize and under-size sturgeon is required.

(2) Open Areas: SMCRA 1F, 1G, and 1H (Zone 6):

(d) Season: Immediately through 6:00 p.m. March 21, 2016.

(e) Gear: Hoop nets, dip bag nets, and rod and reel with hook and line.

(f) Allowable sale: Salmon, steelhead, shad, carp, catfish, walleye, bass, or yellow perch. Sturgeon from 43-54 inches caught in the John Day and Dalles pools may be sold only if caught during open commercial gillnet periods for that pool. Sturgeon between 38-54 inches in fork length in SMCRA 1F may only be kept for subsistence. Live release of all oversize and under-size sturgeon is required.

(3) 24-hour quick reporting is required for Washington wholesale dealers for all areas as provided in WAC 220-69-240, except that all landings from treaty fisheries described above must be reported within 24-hours of completing the fish ticket (not 24-hours after the period concludes).

(4) Fish caught during the open period may be sold after the period concludes.

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.

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 section of the Washington Administrative Code is repealed:

WAC 220-32-05100Q Columbia River salmon seasons above Bonneville Dam. (16-25)

WSR 16-06-017
EMERGENCY RULES
BUILDING CODE COUNCIL

[Filed February 19, 2016, 2:42 p.m., effective February 19, 2016, 2:42 p.m.]

Effective Date of Rule: Immediately upon filing.

Purpose: This rule is being filed for renewal of WSR 15-14-064, originally filed on June 26, 2015, and renewed as WSR 15-22-015 on October 23, 2015. The rule was established to provide regulatory guidance to marijuana processing or extraction facilities. This new industry in Washington state produces marijuana for sale in specially licensed retail stores throughout the state. At this time there are no specific regulations in place to ensure safety in the processing plants or extraction facilities. This rule establishes specific requirements for handling hazardous materials, establishes inspection standards, and provides construction and permit requirements to ensure the life/safety of occupants, first responders, and the general public.

Citation of Existing Rules Affected by this Order: Amending WAC 51-54A-105 and new section WAC 51-54A-3800.

Statutory Authority for Adoption: RCW 19.27.031, 19.27.074.

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 emergency rules provide operational and construction permit requirements for marijuana extraction. Marijuana extraction can involve explosive materials and dangerous process[es] that pose serious risks to public health, safety and welfare, as illustrated by the 2013 explosion, fire and fatality in Bellevue. These rules provide administrative direction, establish definitions, create requirements for engineering reports and inspections, identify construction requirements and electrical systems, and direct other administrative oversight to protect public safety. The state liquor and cannabis board's WAC 314-55-104 looks to state fire safety and building codes implemented by local fire officials to provide these protections. Given the serious risks posed by activities regulated by this rule, observing perma-

nent rule timing requirements would be contrary to the public interest. The council has established a special technical advisory group to develop language for permanent rule making.

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 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: June 12, 2015.

David F. Kokot
Chair

AMENDATORY SECTION (Amending WSR 13-04-063, filed 2/1/13, effective 7/1/13)

WAC 51-54A-0105 Permits.

SECTION 105 SCOPE AND GENERAL REQUIREMENTS

105.1.1 Permits required. Any property owner or authorized agent who intends to conduct an operation or business, or install or modify systems and equipment, which is regulated by this code, or to cause any such work to be done shall first make application to the fire code official and obtain the required permit.

105.6.49 Marijuana extraction systems. An operational permit is required to use a marijuana/cannabis extraction system regulated under WAC 314-55-104.

105.7.19 Marijuana extraction systems. A construction permit is required to install a marijuana/cannabis extraction system regulated under WAC 314-55-104.

NEW SECTION

WAC 51-54A-3800 Marijuana processing or extraction facilities.

SECTION 3801—ADMINISTRATION

3801.1 Scope. Marijuana processing or extraction facilities shall comply with this chapter and the International Building Code. The extraction process includes the act of extraction of the oils and fats by use of a solvent, desolventizing of the raw material and production of the miscella, distillation of the solvent from the miscella and solvent recovery. The use, storage, transfilling, and handling of hazardous materials in these facilities shall comply with this chapter, other applicable provisions of this code and the International Building Code.

3801.2 Application. The requirements set forth in this chapter are requirements specific only to marijuana processing and extraction facilities and shall be applied as exceptions or additions to applicable requirements set forth elsewhere in this code.

3801.3 Multiple hazards. Where a material, its use or the process it is associated with poses multiple hazards, all hazards shall be addressed in accordance with Section 5001.1 and other material specific chapters.

3801.4 Existing building or facilities. Existing buildings or facilities used for the processing of marijuana shall comply with this chapter. Existing buildings or facilities used for marijuana extraction shall comply with the requirements of this chapter by July 1, 2016.

3801.5 Permits. Permits shall be required as set forth in Section 105.6 and 105.7.

SECTION 3802—DEFINITIONS

Marijuana extraction facility (MEF): A building used for the solvent-based extraction process of marijuana.

Marijuana extraction equipment (MEE): Equipment or appliances used for the extraction of botanical material such as essential oils, from marijuana.

Marijuana extraction room (MER): The room or space in which the solvent-based extractions occur.

Finding: The results of an inspection, examination, analysis or review.

Observation: A practice or condition not technically noncompliant with other regulations or requirements, but could lead to noncompliance if left unaddressed.

Desolventizing: The act of removing a solvent from a material.

Miscella: A mixture, in any proportion, of the extracted oil or fat and the extracting solvent.

Transfilling: The process of taking a gas source, either compressed or in liquid form (usually in bulk containers), and transferring it into a different container (usually a smaller compressed cylinder).

SECTION 3802—PROCESSING OR EXTRACTION OF MARIJUANA

3802.1 Location. Marijuana processing shall be located in a building complying with the International Building Code and this code. The marijuana extraction process shall be located in a room dedicated to the extraction process. The extraction room shall not be used for any other purpose including storage.

3802.2 Staffing. The extraction process shall be continuously staffed by personnel trained in the extraction process, the transfer of LP-gas where applicable, and all emergency procedures. All staff training records shall be maintained on-site by the owner and made available upon request from the fire code official.

3802.3 Systems, equipment and processes. Systems, equipment, and processes shall be in accordance with Sections 3802.3.1 through 3802.3.3.7.

3802.3.1 Application. Systems, equipment and processes shall include, but are not limited to, vessels, chambers, containers, cylinders, tanks, piping, tubing, valves, fittings, and pumps.

3802.3.2 General requirements. In addition to the requirements in Section 3802, systems, equipment and processes shall also comply with Section 5003.2, other applicable provisions of this code, the International Building Code, and the International Mechanical Code.

3802.3.3 Additional requirements for marijuana extraction. In addition to the requirements of Section 3802.3, marijuana extraction systems, equipment and process shall comply with this section.

3802.3.3.1 General requirements. The requirements set forth in Section 5003.2 shall apply to vessels, chambers, containers, cylinders, tanks, piping, tubing, valves, fittings, and pumps used in the extraction process. The use of ovens in post-process purification or winterization shall comply with Section 3802.3.3.7.

3802.3.3.2 Systems and equipment. Systems or equipment used for the extraction of marijuana/cannabis oils from plant material shall be listed for the specific use. If the system used for extraction of marijuana/cannabis oils and products from plant material is not listed, then the system shall have a designer of record. If the designer of record is not a licensed Washington professional engineer, then the system shall be peer reviewed by a licensed Washington professional engineer. In reviewing the system, the licensed professional engineer shall review and consider any information provided by the system's designer or manufacturer. For systems and equipment not listed for the specific use, a technical report documenting the design or peer review as outlined in Section 3802.3.3.4.2 shall be prepared and submitted to the fire code official for review and approval for systems and equipment used for the extraction of marijuana/cannabis oils and products from plant material. The firm or individual performing the engineering analysis for the technical report shall be approved by the fire code official prior to performing the analysis.

3802.3.3.3 Change of extraction medium. Where the medium of extraction or solvent is changed from the material indicated in the technical report or as required by the manufacturer, the technical report shall be revised at the cost of the facility owner, submitted for review and approval by the fire code official prior to the use of the equipment with the new medium or solvent. If the original engineer of record is not available, then new engineer of record shall comply with Section 3802.3.3.4.1.

3802.3.3.4 Required technical report. The technical report documenting the design or peer review shall be submitted for review and approval by the fire code official prior to the equipment being located or installed at the facility.

3802.3.3.4.1 Approval of the engineer of record. Where a technical report is required to be submitted for review and approval by the fire code official to meet the requirements of 3802.3.3.2, the following actions shall occur:

1. Prior to submittal of the technical report, the engineer shall submit educational background and professional experience specific to the review and approval of system, equipment and processes with like hazards of those associated with the marijuana extraction system to the fire code official.

2. Once the proof of qualifications are found acceptable by the fire code official, the engineer of record shall produce the technical report and the report shall be signed and sealed in accordance with Washington state requirements.

The proof of qualifications shall include documentation indicating the person is a professional engineer licensed in Washington state.

3802.3.3.4.2 Content of technical report and engineering analysis. All, but not limited to, the items listed below shall be included in the technical report.

1. Manufacturer information.
2. Engineer of record information.
3. Date of review and report revision history.
4. Signature page shall include:

a. Author of the report;

b. Date of report;

c. Seal, date and signature of engineer of record performing the design or peer review; and

d. Date, signature, and stamp of the professional engineer performing the engineering document review of the report. The engineering document review cannot be performed by the authoring engineer.

5. Model number of the item evaluated. If the equipment is provided with a serial number, the serial number shall be included for verification at time of site inspection.

6. Methodology of the design or peer review process used to determine minimum safety requirements. Methodology shall consider the basis of design, and shall include a code analysis and code path to demonstrate the reason as to why specific code or standards are applicable or not.

7. Equipment description. A list of every component and subassembly (clamp, fittings, hose, quick disconnects, gauges, site glass, gaskets, valves, pumps, vessels, containers, switches, etc.) of the system or equipment, indicating the manufacturer, model number, material, and solvent compatibility. Vendor cut sheets shall be provided.

8. A general flow schematic or general process flow diagram (PFD) of the process. Post-processing or winterization may be included in this diagram. All primary components of the process equipment shall be identified and match the aforementioned list. Operating temperatures, pressures, and solvent state of matter shall be identified in each primary step or component. A piping and instrumentation diagram (PID or PI&D) may be provided but is not required.

9. Analysis of the vessel(s) if pressurized beyond standard atmospheric pressure. Analysis shall include purchased and fabricated components.

10. Structural analysis for the frame system supporting the equipment.

11. Process safety analysis of the extraction system, from the introduction of raw product to the end of the extraction process.

12. Comprehensive process hazard analysis considering failure modes and points of failure throughout the process. This portion of the review should include review of emer-

gency procedure information provided by the manufacturer of the equipment or process and not that of the facility, building or room.

13. Review of the assembly instructions, operational and maintenance manuals provided by the manufacturer.

14. Report shall include findings and observations of the analysis.

15. List of references used in the analysis.

3802.3.3.5 Building analysis. If the technical report, or manufacturers literature indicate specific requirements for the location, room, space or building, where the extraction process is to occur, the engineer of record, as approved in 3802.3.3.4.1 shall review the construction documents of such location, room, space or building and provide a report of their findings and observations to the fire code official.

Analysis shall include:

1. Process safety analysis of the entire process from raw material to finished product.

2. Comprehensive process hazard analysis considering failure modes and points throughout the process. Should include review of emergency procedures as related to the equipment or process, and the facility.

3802.3.3.6 Site inspection. Prior to operation of the extraction equipment, if required by the fire code official, the engineer of record, as approved in 3802.3.3.4.1 shall inspect the site of the extraction process once equipment has been installed for compliance with the technical report and the building analysis. The engineer of record shall provide a report of findings and observations of the site inspection to the fire code official prior to the approval of the extraction process. The field inspection report authored by engineer of record shall include the serial number of the equipment used in the process and shall confirm the equipment installed is the same model and type of equipment identified in the technical report.

3802.3.3.7 Post-process purification and winterization. Post-processing and winterization involving the heating or pressurizing of the miscella to other than normal pressure or temperature shall be approved and performed in an appliance listed for such use. Domestic or commercial cooking appliances shall not be used. The use of industrial ovens shall comply with Chapter 30.

EXCEPTION: An automatic fire extinguishing system shall not be required for batch-type Class A ovens having less than 3.0 cubic feet of work space.

3802.4 Construction requirements.

3802.4.1 Location. Marijuana extraction shall not be located in any building containing a Group A, E, I or R occupancy.

3802.4.1.1 Extraction room. The extraction equipment and extraction process shall be located in a room dedicated to extraction.

3802.4.2 Egress. Each marijuana extraction room shall be provided with at least one exit, swinging in the direction of travel provided with an automatic closer and panic hardware.

3802.4.2.1 Facility egress. The marijuana extraction room shall not enter directly into an exit, exit passageway, horizontal exit or along the sole egress path from another portion of the building.

3802.4.3 Ventilation. Each marijuana extraction room shall be provided with a dedicated hazardous exhaust system complying with Section 5004.3 for all solvents other than water. The operation of the hazardous exhaust system shall be continuous.

3802.4.4 Control area. Each marijuana extraction room shall be considered a single control area and comply with Section 5003.8.3.

3802.4.5 Ignition source control. Extraction equipment and extraction processes using a hydrocarbon-based liquid or gas solvent shall be provided with ventilation rates for the room to maintain the concentration of flammable constituents in air below 25% of the lower flammability limit of the respective solvent. If not provided with the required ventilation rate, then Class I Division II electrical requirements shall apply to the entire room.

3802.4.6 Interlocks. All electrical components within the extraction room shall be interlocked with the hazardous exhaust system and when provided, the gas detection system. When the hazardous exhaust system is not operational, then light switches and electrical outlets shall be disabled. Activation of the gas detection system shall disable all light switches and electrical outlets.

3802.4.7 Emergency power.

3802.4.7.1 Emergency power for extraction process. Where power is required for the operation of the extraction process, an automatic emergency power source shall be provided. The emergency power source shall have sufficient capacity to allow safe shutdown of the extraction process plus an additional 2 hours of capacity beyond the shutdown process.

3802.4.7.2 Emergency power for other than extraction process. An automatic emergency power system shall be provided for the following items when installed.

3802.4.7.2.1 Required electrical systems.

1. Extraction room lighting;
2. Extraction room ventilation system;
3. Solvent gas detection system;
4. Emergency alarm systems;
5. Automatic fire extinguishing systems.

3802.4.8 Continuous gas detection system. For extraction processes utilizing gaseous hydrocarbon-based solvents, a continuous gas detection system shall be provided. The gas detection threshold shall be no greater than 25% of the LEL/LFL limit of the materials.

3802.4.9 Liquefied-petroleum gases shall not be released to the atmosphere.

3802.5 Carbon dioxide enrichment or extraction. Extraction processes using carbon dioxide shall comply with the section.

3802.5.1 Scope. Carbon dioxide systems with more than 100 pounds of carbon dioxide shall comply with Sections 3802.5

through 3802.5.8. This section is applicable to carbon dioxide systems utilizing compressed gas systems, liquefied-gas system, dry ice, or on-site carbon dioxide generation.

3802.5.2 Permits. Permits shall be required as set forth in Section 105.6 and 105.7.

3802.5.3 Equipment. The storage, use, and handling of liquid carbon dioxide shall be in accordance with Chapter 54 and the applicable requirements of NFPA 55, Chapter 13. Insulated liquid carbon dioxide system shall have pressure relief devices in accordance with NFPA 55.

3802.5.5 Protection from damage. Carbon dioxide systems shall be installed so the storage tanks, cylinders, piping and fittings are protected from damage by occupants or equipment during normal facility operations.

3802.5.7 Signage. At the entrance to each area using or storing carbon dioxide, signage shall be posted indicating the hazard. Signs shall be durable and permanent in nature and not less than 7 inches wide by 10 inches tall. Signs shall bear the "skull and crossbones" emblem with the warning "DANGER! POTENTIAL OXYGEN DEFICIENT ATMOSPHERE." NFPA 704 signage shall be provided at the building main entry and the rooms where the carbon dioxide is used and stored.

3802.5.8 Ventilation. Mechanical ventilation shall be in accordance with the International Mechanical Code and shall comply with all of the following:

1. Mechanical ventilation in the room or area shall be at a rate of not less than 1 cubic foot per minute per square foot.

2. The exhaust system intake shall be taken from a point within 12 inches of the floor.

3. The ventilation system shall be designed to operate at a negative pressure in relation to the surrounding area.

3802.6 Flammable or combustible liquid. The use of a flammable or combustible liquid for the extraction of oils and fats from marijuana shall comply with this section.

3802.6.1 Scope. The use of flammable and combustible liquids for liquid extraction process where the liquid is boiled, distilled, or evaporated shall comply with this section and NFPA 30.

3802.6.2 Location. The process using a flammable or combustible liquid shall be located within a hazardous exhaust fume hood, rated for exhausting flammable vapors. Electrical equipment used within the hazardous exhaust fume hood shall be rated for use in flammable atmospheres. Heating of flammable or combustible liquids over an open flame is prohibited.

Exception: The use of a heating element not rated for flammable atmospheres may be approved where documentation from the manufacturer or an approved testing laboratory indicates is it rated for heating of flammable liquids.

WSR 16-06-018
EMERGENCY RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 16-28—Filed February 19, 2016, 3:59 p.m., effective February 19, 2016, 3:59 p.m.]

Effective Date of Rule: Immediately upon filing.

Purpose: Amend commercial fishing rules for sea urchins.

Citation of Existing Rules Affected by this Order: Repealing WAC 220-52-07300V; and amending WAC 220-52-073.

Statutory Authority for Adoption: RCW 77.04.012, 77.04.020, and 77.12.047.

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: An emergency rule is needed to close the commercial harvest of green sea urchins in Districts 1 and 2 as the quota limit is approaching. Harvestable surpluses of green sea urchin exist in the districts specified to allow 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 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: February 19, 2016.

J. W. Unsworth
Director

NEW SECTION

WAC 220-52-07300W Sea urchins Notwithstanding the provisions of WAC 220-52-073, effective immediately until further notice, it is unlawful to take or possess sea urchins taken for commercial purposes except as provided for in this section:

(1) The following areas are open for green sea urchin harvest seven days-per-week: Sea Urchin District 6 and District 7. It is unlawful to harvest green sea urchins smaller than 2.25 inches (size is largest test diameter exclusive of spines).

(2) The maximum cumulative landing of green sea urchins for each weekly fishery opening period is 3,000

pounds per valid designated sea urchin harvest license. It is permissible for all or any fraction of the maximum 3,000 pound total to be harvested during any legal harvest date within any legal harvest area so long as the cumulative total for the fishery week does not exceed the maximum. Each fishery week begins Monday and ends Sunday.

REPEALER

The following section of the Washington Administrative Code is repealed:

WAC 220-52-07300V Sea urchins. (16-22)

WSR 16-06-032
EMERGENCY RULES
UNIVERSITY OF WASHINGTON

[Filed February 23, 2016, 8:45 a.m., effective February 23, 2016, 8:45 a.m.]

Effective Date of Rule: Immediately upon filing.

Other Findings Required by Other Provisions of Law as Precondition to Adoption or Effectiveness of Rule: The University of Washington (UW) is adopting a third emergency rule making per RCW 34.05.350(2), while actively completing adoption of a permanent rule as evidenced by the proposed rule making CR-102 filed on December 22, 2015, as WSR 16-01-180, and the rule-making order CR-103P filed on February 17, 2016, as WSR 16-05-097. UW intends to rescind this emergency rule when the permanent rules take effect on March 28, 2016.

Purpose: Continuing UW's emergency section, WAC 478-120-137 Supplementary provisions regarding sexual misconduct, to comply with amendments to the student assistance general provisions issued under the Higher Education Act of 1965 (HEA), as amended, and to implement the changes made to the Clery Act by the Violence Against Women Reauthorization Act of 2013 (VAWA) (Pub. L. 113-4), until such time as the permanent amendments to chapter 478-120 WAC take effect on March 28, 2016. These provisions are also necessary to comply with the state legislature's recent adoption of statutes and amendments related to campus sexual violence, chapter 28B.112 RCW.

Statutory Authority for Adoption: RCW 28B.20.130 and chapter 28B.112 RCW.

Other Authority: UW Board of Regents Governance, Standing Orders, Chapter 8.

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 amendments (34 C.F.R. Part 668.46) apply to UW as a recipient of federal funds. This emergency section to chapter 478-120 WAC, Student conduct code for the University of Washington, confirms that UW prohibits sexual misconduct (sexual assault, sexual harassment, sexual exploitation, stalking, relationship or dating violence, and domestic violence); clearly defines sexual misconduct and "consent"; clarifies the steps under UW's disciplinary process that apply in cases involving an allegation of sexual misconduct; and makes clear that protective interim measures can be implemented following an allegation of sexual misconduct.

Number of Sections Adopted in Order to Comply with Federal Statute: New 1, 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 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: February 18, 2016.

Rebecca Goodwin Deardorff
Director of Rules Coordination

NEW SECTION

WAC 478-120-137 Supplementary provisions regarding sexual misconduct. (1) By way of clarification only, it is hereby affirmed that sexual assault, sexual harassment, indecent exposure, sexual exploitation, stalking, domestic violence, and relationship violence all as defined herein (collectively "sexual misconduct") are prohibited conduct and any student who has engaged in sexual misconduct may be subject to the imposition of disciplinary sanctions as described in WAC 478-120-040.

(2) Notwithstanding any other provision of this conduct code, a student may be subject to disciplinary proceedings in connection with any allegation of sexual misconduct that occurs off campus if the university reasonably determines that a significant university interest is affected.

(3) Notwithstanding any other provision of this conduct code, "exceptional circumstances" shall be deemed to exist in all cases involving an allegation of sexual misconduct, and such cases shall be subject to the following supplementary provisions:

(a) The initiating officer will concurrently serve both the accused student and any complainant(s) with a copy of the initiating officer's initial order. For the purposes of this section, "complainant" means a student or another member of the university community who believes that an act of sexual misconduct has been committed against him or her in violation of this conduct code.

(b) Either a complainant or the accused student may appeal such initial order in accordance with WAC 478-120-075, and both the accused student and any complainant shall receive notice of any appeal and notice of any hearing before the faculty appeal board.

(c) If a timely appeal of an initial order issued by the initiating officer is submitted and a request for a formal hearing is made, the faculty appeal board shall conduct a formal hear-

ing in accordance with WAC 478-120-100 and 478-120-115 and the following supplementary provisions shall apply:

(i) Both the accused student and any complainant will have the right to participate as a party in the hearing, including to be represented by counsel and/or be accompanied by an advisor, to call witnesses, to cross-examine witnesses, and to submit documentary evidence. A complainant (with or without counsel and/or an advisor) may attend the formal hearing in its entirety, regardless of whether the complainant decides to participate as a party.

(ii) An accused student and the complainant may not ask questions of each other directly, but may submit written questions to the chair, who will ask any relevant and appropriate questions submitted by these parties. The chair has discretion to accept, reject, or rephrase any question submitted by the accused student or a complainant.

(iii) At the discretion of the chair, and where the rights of the parties will not be prejudiced thereby, all or part of any formal hearing, including the testimony of witnesses, may be conducted by telephone, video, or other electronic means.

(iv) Both the accused student and any complainant shall be concurrently served with all orders issued by the faculty appeal board.

(d) In any matter involving an allegation of sexual misconduct, any complainant shall have the same rights as the accused student to participate as a party in any administrative review under WAC 478-120-105, to appeal a faculty appeal board's initial order to the president of the university under WAC 478-120-125, to participate as a party in any appeal to the president, and to seek reconsideration of a final order under WAC 478-120-135. In the event that a complainant appeals in a timely manner an initial order, such order shall not become final until that appeal is resolved. Any notices or orders issued by the president shall be concurrently served on the accused student and any complainant(s).

(e) Except as otherwise provided in this section, matters involving allegations of sexual misconduct will be subject to all the other applicable provisions of this conduct code.

(4) For the purposes of this section, "sexual misconduct" includes sexual assault, sexual harassment, indecent exposure, sexual exploitation, stalking, domestic violence, and relationship violence, all as defined in subsections (5) through (11) of this section.

(5) For the purposes of this student conduct code "sexual assault" means any sexual contact with another person without (or that exceeds) that person's consent.

(a) For the purposes of this definition, "sexual contact" includes:

(i) Any touching of another person for the purpose of sexual gratification; or

(ii) Any penetration, no matter how slight, of the vagina or anus with any body part or object, or oral penetration by a sex organ, of another person.

(b) For the purposes of this definition, "consent" means that at the time of and throughout the sexual contact, there are actual words or conduct indicating freely given agreement between the parties to engage in the sexual contact. A determination of whether consent had been given in connection with an incident of sexual contact shall take into account the following:

(i) Past consent does not imply future consent;

(ii) Consent given to one person does not imply consent given to another person;

(iii) Consent to one sexual act does not imply consent to other sexual acts;

(iv) Lack of resistance to sexual contact does not imply consent;

(v) Consent can be withdrawn at any time.

(c) Consent cannot be given by a person who, at the relevant time, cannot understand the facts, nature, extent, or implications of the sexual contact for any reason including, but not limited to, being asleep, unconscious, mentally or physically impaired due to an intellectual or other disability, or mentally or physically incapacitated due to the effects of drugs or alcohol. Indications that a person may be incapacitated by alcohol or drugs and therefore cannot grant consent include, but are not limited to, stumbling, falling down, an inability to stand or walk on their own, slurred speech or incoherent communication, an inability to focus their eyes or confusion about what is happening around them, blacking out, or vomiting. A failure to exhibit any of these behaviors does not necessarily mean that a person is capable of giving consent or is not incapacitated.

(d) Sexual contact is not consensual when force or coercion is threatened or used to gain acquiescence. Force includes the use of physical violence, physical force, threats, or intimidation to overcome resistance or gain agreement to sexual contact. Coercion includes using pressure, deception, or manipulation to cause someone to agree to sexual contact against his or her will, without the use of physical force. Pressure can mean verbal or emotional pressure.

(e) Sexual assault also includes sexual contact with a person who is under the statutory age of consent in accordance with chapter 9A.44 RCW.

(f) Use of alcohol or other drugs is not a valid defense to an allegation of sexual assault.

(6) For the purposes of this conduct code, "sexual harassment" means unwelcome language or conduct of a sexual nature that is sufficiently severe, persistent, or pervasive such that it could reasonably be expected to create an intimidating, hostile, or offensive environment, or has the purpose or effect of unreasonably interfering with a person's academic or work performance or a person's ability to participate in or benefit from the university's programs, services, opportunities, or activities.

(7) For purposes of this conduct code, "indecent exposure" means the exposure of a person's genitals or other private body parts when done in a place or manner in which such exposure is likely to cause affront or alarm, or is against generally accepted standards of decency. Breast feeding or expressing breast milk is not indecent exposure.

(8) For the purposes of this conduct code, "sexual exploitation" includes:

(a) Taking nonconsensual or abusive advantage of another for one's own sexual benefit, or for the sexual benefit of anyone other than the one being exploited;

(b) Compelling another by threat or force to engage in sexual conduct or activity;

(c) Transmitting, distributing, publishing, or threatening to transmit, distribute, or publish photos, video, or other

recordings of a private and sexual nature where such transmission, publication, or distribution is without the consent of the subject(s) and is likely to cause emotional distress to the subject(s);

(d) Taking or making photographs, films, or digital images of the private body parts of another person without that person's consent;

(e) Causing or attempting to cause the impairment of another person to gain nonconsensual sexual advantage over that person;

(f) Prostituting another person;

(g) Knowingly allowing another to surreptitiously watch otherwise consensual sexual activity; or

(h) Taking, making, or directly transmitting nonconsensual video or audio recordings of sexual activity.

(9) For purposes of this conduct code, "stalking" means engaging in a course of conduct that would cause a reasonable person to fear for his or her safety or the safety of others or to suffer substantial emotional distress. "Course of conduct" means two or more acts including, but not limited to, acts in which the stalker directly, indirectly, or through third parties, by any action, method, device, or means (including electronic), follows, monitors, observes, surveils, threatens, or communicates to or about a person, or interferes with a person's property. "Substantial emotional distress" means significant mental suffering or anguish that may, but does not necessarily require medical or other professional treatment or counseling.

(10) For purposes of this conduct code, "domestic violence" means the infliction of physical harm, bodily injury, assault, or the fear of imminent physical harm, bodily injury or assault committed against a family or household member, including:

(a) A current or former spouse or intimate partner;

(b) A person with whom the person shares a child in common;

(c) A person with whom one is cohabitating or has cohabitated; or

(d) A person with whom one resides including a roommate, suitemate or housemate.

Domestic violence also includes sexual assault or stalking as defined herein of one family or household member by another family or household member.

(11) For the purposes of this conduct code, "relationship violence," also referred to as "dating violence," means violence, other than domestic violence as defined in subsection (10) of this section, committed by a person who is or has been in a social relationship of a romantic or intimate nature with the victim. The existence of such a relationship shall be determined based on the reporting party's statement and with consideration of the length of the relationship, the type of relationship, and the frequency of interaction between the persons involved in the relationship. For the purposes of this definition, relationship or dating violence includes, but is not limited to, sexual or physical abuse or the threat of such abuse.

(12) As in all proceedings under this conduct code, the applicable standard of proof in cases involving sexual misconduct shall be the "preponderance of evidence" standard. This means that, in order for a student to be held responsible for a violation, it must be shown, based on all of the evidence in the record, that it is more likely than not that the student engaged in an act or acts of misconduct. The burden of proof in any hearing rests with the party seeking to establish that the violation occurred.

(13) Following receipt of a report of alleged sexual misconduct, the university may implement interim protective measures including, but not limited to:

(a) A "no-contact directive" prohibiting direct or indirect contact, by any means, with a complainant, an accused student, a reporting student, other specified persons, and/or a specific student organization;

(b) Reassignment of or removal from on-campus housing; or

(c) Changes to class schedules, assignments, or tests.

Interim protective measures will remain in place until an initial order becomes final or a final order is issued. Implementation of any interim measure does not assume any determination of, or create any presumption regarding responsibility for a violation under the student conduct code.

WSR 16-06-047
EMERGENCY RULES
DEPARTMENT OF HEALTH

[Filed February 24, 2016, 10:10 a.m., effective February 24, 2016, 10:10 a.m.]

Effective Date of Rule: Immediately upon filing.

Purpose: WAC 246-980-140, home care aide (HCA), amending rules to add skills acquisition training to HCA's scope of practice to align with DSHS' rule that implements the Centers for Medicaid and Medicare Services' (CMS) community first choice option (CFCO) program. The CFCO program provides person-centered services at an enhanced medicaid match rate for participating states. Rules must be effective by July 1, 2015, for Washington state to receive the enhanced medicaid match rate.

Citation of Existing Rules Affected by this Order: Amending WAC 246-980-140.

Statutory Authority for Adoption: Chapter 18.88B RCW.

Other Authority: 42 C.F.R. 441.510, ESHB 2746 (2014), SSB 6387 (2014), DSHS state work plan.

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: Under RCW 34.05.350, an agency must find good cause for implementing an emergency rule or amendment. The statutory criteria this rule amendment meets is found under RCW 34.05.350 (1)(b) that states, "That state or federal law or federal rule or a federal deadline for state receipt of federal funds requires immediate adoption of [a] rule." This emergency rule amendment meets the criteria per the following:

This emergency rule amendment is in response to a federal deadline for state receipt of federal funds from CMS for Washington state to receive an enhanced medicaid match rate of fifty-six percent beginning July 1, 2015, for state implementation of its CFCO program.

Federal deadline for state receipt of federal funds - The CFCO program is a medicaid Title XIX entitlement program that is a part of the Affordable Care Act. The federal program provides person-centered services within in-home and community-based settings. Services provided - including the skills acquisition services - must be provided in a manner that is prescribed by 42 C.F.R. 441.510 for states choosing to participate in this federal program. The CFCO program allows the state to receive a higher federal medicaid match rate of fifty-six percent versus fifty percent, and based on state legislation passed in 2014 requiring the department of social and health services (DSHS) to participate in the CFCO program, DSHS submitted a formal state plan to CMS outlining all federal objectives that will be met starting July 1, 2015. DSHS' state plan under Title XIX of the Social Security Act for CFCO services goes into effect July 1, 2015, at which time the medicaid match enhancement rate to Washington state begins.

The department of health (DOH) and DSHS jointly administer the home care aide program, also known as long-term care workers in both statute and rules, under chapters 18.88B and 74.39A RCW. DOH must amend WAC 246-980-140 to allow home care aides, also known as long-term care workers, to provide skills acquisition training to elderly and vulnerable clients to align with DSHS rule amendments to meet the federal objectives in Washington's formal state plan. Both DOH and DSHS must revise their home care aide rules by July 1, 2015, for Washington state to qualify for the enhanced federal match.

State laws for state receipt of federal funds requiring immediate adoption of rule - In addition, SSB 6387 (chapter 139, Laws of 2014) requires DSHS to increase the number of people served on the CFCO medicaid program by replacing the individual and family services program through an expansion of client caseload beginning June 30, 2015. To implement SSB 6387, DSHS must administer the federal CFCO program, which expands HCAs' scope of practice to include skills acquisition training. Amending the DOH home care aide rules supports DSHS' efforts to implement SSB 6387 and the CFCO program.

In addition, ESHB 2746 (chapter 166, Laws of 2014) directed DSHS to refinance its medicaid personal care services for individuals with developmental disabilities and individuals with long-term care needs through the CFCO program by August 30, 2015. DSHS also cites this bill as authorizing their agency to implement the CFCO program, which is to begin by July 1, 2015.

This filing extends emergency rules filed as WSR 15-22-029 on October 27, 2015. DOH has initiated formal rule making by filing a preproposal statement of inquiry on January 19, 2016, WSR 16-03-063. DSHS is close to adopting final rule language, which will help DOH move forward with its proposed rule.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 1, 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 1, Repealed 0.

Date Adopted: February 24, 2016.

Dennis E. Worsham
Deputy Secretary
for John Wiesman, DrPH, MPH
Secretary

AMENDATORY SECTION (Amending WSR 13-19-087, filed 9/18/13, effective 10/19/13)

WAC 246-980-140 Scope of practice for long-term care workers. (1) A long-term care worker performs activities of daily living or activities of daily living and instrumental activities of daily living. A person performing only instrumental activities of daily living is not acting under the long-term care worker scope of practice.

(a) "Activities of daily living" means self-care abilities related to personal care such as bathing, eating, using the toilet, dressing, and transfer. This may include fall prevention, skin and body care.

(b) "Instrumental activities of daily living" means activities in the home and community including cooking, shopping, house cleaning, doing laundry, working, and managing personal finances.

(2) A long-term care worker documents observations and tasks completed, as well as communicates observations on the day they were performed to clients, family, supervisors, and, if appropriate, health care providers.

(3) A long-term care worker may perform medication assistance as described in chapter 246-888 WAC.

(4) A long-term care worker may perform nurse delegated tasks, to include medication administration, if he or she meets and follows the requirements in WAC 246-980-130.

(5) A long-term care worker may also provide skills acquisition training that allows individuals in their homes, or residential facilities that are licensed and contracted as an adult family home as defined in RCW 70.128.010, or an assisted living facility as defined in RCW 18.20.020, to acquire, maintain, and enhance skills necessary to accomplish ADLs and IADLs more independently.

WSR 16-06-063
EMERGENCY RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 16-31—Filed February 25, 2016, 1:08 p.m., effective February 29, 2016, 8:00 a.m.]

Effective Date of Rule: February 29, 2016, 8:00 a.m.

Purpose: Amend Puget Sound commercial crab fishing rules.

Citation of Existing Rules Affected by this Order: Repealing WAC 220-52-04500N; and amending WAC 220-52-045.

Statutory Authority for Adoption: RCW 77.04.012, 77.04.020, and 77.12.047.

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: Provisions in state/tribal management agreements will be achieved by the opening dates contained herein. The special management areas are listed in accordance with state/tribal management agreements. Because the specific timing of the reduction in the size in the Quinault Special Management Area was dependent on the outcome of inseason state and tribal discussions 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: February 25, 2016.

J. W. Unsworth
Director

NEW SECTION

WAC 220-52-04500P Commercial crab fishery—Seasons and areas—Coastal. Notwithstanding the provisions of WAC 220-52-045, effective immediately until further notice, it is unlawful to fish for Dungeness crab in Washington coastal waters, the Pacific Ocean, Grays Harbor, Willapa Bay, or the Columbia River, except as provided for in this section.

(1) The area from and the U.S./Canada border to the WA/OR border (46°15.00) and Willapa Bay is open.

(2) For the purposes of this section, the waters of Willapa Bay are defined to include the marine waters east of a line connecting 46°44.76 N, 124°05.76 W and 46°38.93 N, 124°04.33 W.

(3) Licenses and vessels designated to those licenses that participate (as defined by WAC 220-52-036) in the coastal commercial Dungeness crab fishery in the waters of the Pacific Ocean between Point Arena, California and the U.S. Canada border, are prohibited from fishing in any area where the season opening is delayed for the first 30 days following the opening of the delayed area if the vessel was employed in the coastal crab fishery during the previous 45 days.

(4) The Quinault Secondary Special Management Area (SSMA) is closed to fishing for Dungeness crab starting at 8:00 A.M., February 29, 2016, from the area shoreward of a line approximating the 27-fathom depth curve between the mouth of the Copalis River (47º08.00) and Split Rock (47º24.50). This area will be closed until further notice. This SSMA is described by the following coordinates:

• Northeast Corner (Split Rock):	47°24.50 N. Lat.	124°20.00 W. Lon.
• Northwest Corner:	47°24.50 N. Lat.	124°32.40 W. Lon.
• Southwest Corner:	47°08.00 N. Lat.	124°25.50 W. Lon.
• Southeast Corner (Copalis River):	47°08.00 N. Lat.	124°11.20 W. Lon.

(5) It is unlawful for a vessel to use more than 200 pots in the area between Split Rock (47º24.50) and Raft River (47º28.00) shoreward of a line approximating the 27-fathom depth curve from 8:00 a.m. February 29, 2016, until 8:00 a.m. March 31, 2016. Fishers must pre-register with the Department of Fish and Wildlife 24 hours prior to deploying gear in this area by one of the three following methods:

• Fax transmission to Carol Henry at 360-249-1229;

• E-mail to: Carol Henry at Carol.Henry@dfw.wa.gov; or

• Telephone call to Carol Henry at 360-249-1296.

(6) The Quileute special management area (SMA) is closed to fishing for Dungeness crab until further notice. The SMA includes the area shoreward of a line approximating the 30-fathom depth curve between Destruction Island and Cape Johnson according to the following points:

• Northeast Corner (Cape Johnson):	47°58.00' N. Lat.	124°40.40' W. Lon.
• Northwest Corner:	47°58.00' N. Lat.	124°49.00' W. Lon.
• Southwest Corner:	47°40.50' N. Lat.	124°40.00' W. Lon.
• Southeast Corner (Destruction Island):	47°40.50' N. Lat.	124°24.43' W. Lon.

(7) The Makah special management area (SMA) is open to fishing. The SMA includes the waters between 48°02.15 N. Lat. and 48°19.50 N. Lat. east of a line connecting those points and approximating the 25-fathom line according to the following coordinates:

• Northeast Corner:	Tatoosh Island	
• Northwest Corner:	48°19.50 N. Lat.	124°50.45 W. Lon.
• Southwest Corner:	48°02.15 N. Lat.	124°50.45 W. Lon.

• Southeast Corner: 48°02.15 N. Lat. 124°41.00 W. Lon.

(8) It is unlawful for a vessel to use more than 200 pots in the Makah SMA until 8:00 A.M. March 17, 2016. Fishers must pre-register with the Department of Fish and Wildlife 24 hours prior to deploying gear in this area by one of the three following methods:

• Fax transmission to Carol Henry at 360-249-1229;
• E-mail to Carol Henry at Carol.Henry@dfw.wa.gov; or
• Telephone call to Carol Henry at 360-249-1296.

(9) All other provisions of the permanent rule remain in effect.

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.

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 section of the Washington Administrative Code is repealed 8:00 a.m. February 29, 2016:

WAC 220-52-04500N Coastal crab seasons (16-27)

WSR 16-06-070
EMERGENCY RULES
HEALTH CARE AUTHORITY
(Washington Apple Health)

[Filed February 26, 2016, 8:09 a.m., effective February 26, 2016, 8:09 a.m.]

Effective Date of Rule: Immediately upon filing.

Purpose: The health care authority (HCA) is amending rules and creating new rules in order to implement new federal regulations under the federal Patient Protection and Affordable Care Act. This filing is to correctly reference rules that were final January 1, 2014, in the long-term care medical rule in addition to the elimination of the presumptive disability program as an eligibility group. Aging and long-term support administration is adding a residential waiver program to facilitate discharges from state hospitals. HCA is also amending and creating rules to implement the community first choice (CFC) option effective July 1, 2015, as directed by the Washington state legislature.

Citation of Existing Rules Affected by this Order: Repealing WAC 182-513-1300, 182-513-1301, 182-513-1305, 182-513-1364, 182-513-1365, 182-513-1366 and 182-515-1500; and amending WAC 182-507-0125, 182-512-0960, 182-512-0400, 182-513-1315, 182-513-1325, 182-513-1330, 182-513-1340, 182-513-1345, 182-513-1350, 182-513-1363, 182-513-1367, 182-513-1380, 182-513-1395, 182-513-1400, 182-513-1405, 182-513-1415, 182-513-1425, 182-513-1430, 182-513-1450, 182-513-1455, 182-515-1505, 182-515-1506, 182-515-1507, 182-515-1508, 182-515-1509, 182-515-1510, 182-515-1511, 182-515-1512, 182-515-1513, and 182-515-1514.

Statutory Authority for Adoption: RCW 41.05.021, 41.05.160.

Other Authority: Patient Protection and Affordable Care Act established under Public Law 111-148; and Code of Federal Regulations at 42 C.F.R. § 431, 435, and 457, and at 45 C.F.R. § 155; Section 1917 of the Social Security Act.

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 agency has been working with client advocates and other stakeholders in crafting the new rules to implement the provisions of the Affordable Care Act, including the expansion of medicaid. Although the permanent rule-making process is nearing completion, the permanent rules were delayed due in part to the receipt of final federal rules governing this process. These emergency rules are needed while the permanent rule-making process is being completed. Since the last emergency filing, the agency finished updating the rules for the treatment of entrance fees of individuals residing in continuing care retirement communities. The rules have been reviewed by stakeholders and the agency is preparing to file the CR-102 for public hearing.

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 16, Amended 36, Repealed 5.

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 36, Repealed 5.

Date Adopted: February 26, 2016.

Wendy Barcus
Rules Coordinator

AMENDATORY SECTION (Amending WSR 12-13-056, filed 6/15/12, effective 7/1/12)

WAC 182-507-0125 State-funded long-term care services program. (1) The state-funded long-term care services program is subject to caseload limits determined by legislative funding. Services cannot be authorized for eligible persons prior to a determination by the aging and ((~~disability services~~)) long-term supports administration (((~~(ADSA)~~))) (ALTSA) that caseload limits will not be exceeded as a result of the authorization.

(2) Long-term care services are defined in this section as services provided in one of the following settings:

(a) In a person's own home, as described in WAC 388-106-0010;

(b) Nursing facility, as defined in WAC 388-97-0001;

(c) Adult family home, as defined in RCW 70.128.010;

(d) Assisted living facility, as described in WAC ((~~388-513-1301~~)) 182-513-1301;

(e) Enhanced adult residential care facility, as described in WAC ((~~388-513-1301~~)) 182-513-1301;

(f) Adult residential care facility, as described in WAC ((~~388-513-1301~~)) 182-513-1301.

(3) Long-term care services will be provided in one of the facilities listed in subsection (2)(b) through (f) of this section unless nursing facility care is required to sustain life.

(4) To be eligible for the state-funded long-term care services program described in this section, an adult nineteen years of age or older must meet all of the following conditions:

(a) Meet the general eligibility requirements for medical programs described in WAC ((~~388-503-0505~~)) 182-503-0505 (2) and (3)(((~~(a), (b), (c), and (f)~~))) with the exception of subsection (3)(c) and (d) of this section;

(b) Reside in one of the settings described in subsection (2) of this section;

(c) Attain institutional status as described in WAC ((~~388-513-1320~~)) 182-513-1320;

(d) Meet the functional eligibility described in WAC 388-106-0355 for nursing facility level of care;

(e) Not have a penalty period due to a transfer of assets as described in WAC ((~~388-513-1363, 388-513-1364, 388-513-1365, and 388-513-1366~~)) 182-513-1363, 182-513-1364, or 182-513-1365;

(f) Not have equity interest in a primary residence more than the amount described in WAC ((~~388-513-1350 (7)(a)(ii)~~)) 182-513-1350; and

(g) Any annuities owned by the adult or spouse must meet the requirements described in chapter ((~~388-561~~)) 182-516 WAC.

(5) An adult who is related to the supplemental security income (SSI) program as described in WAC ((~~388-475-0050~~)) 182-512-0050 (1), (2), and (3) must meet the financial requirements described in WAC ((~~388-513-1325, 388-513-1330, and 388-513-1350~~)) 182-513-1315.

(6) An adult who does not meet the SSI-related criteria in subsection (2) of this section may be eligible under the family institutional medical program rules described in WAC ((~~388-505-0250 or 388-505-0255~~)) 182-514-0230.

(7) An adult who is not eligible for the state-funded long-term care services program under categorically needy (CN) rules may qualify under medically needy (MN) rules described in:

(a) WAC ((~~388-513-1395~~)) 182-513-1395 for adults related to SSI; or

(b) WAC ((~~388-505-0255~~)) 182-514-0255 for adults up to age twenty-one related to family institutional medical.

(8) All adults qualifying for the state-funded long-term care services program will receive CN scope of medical coverage described in WAC ((~~388-501-0060~~)) 182-500-0020.

(9) The department determines how much an individual is required to pay toward the cost of care using the following rules:

(a) For an SSI-related individual residing in a nursing home, see rules described in WAC ((~~388-513-1380~~)) 182-513-1380.

(b) For an SSI-related individual residing in one of the other settings described in subsection (2) of this section, see rules described in WAC ((~~388-515-1505~~)) 182-515-1505.

(c) For an individual eligible under the family institutional program, see WAC ((~~388-505-0265~~)) 182-514-0265.

(10) A person is not eligible for state-funded long-term care services if that person entered the state specifically to obtain medical care.

(11) A person eligible for the state-funded long-term care services program is certified for a twelve month period.

AMENDATORY SECTION (Amending WSR 14-07-059, filed 3/14/14, effective 4/14/14)

WAC 182-512-0400 SSI-related medical—Vehicles excluded as resources. (1) For SSI-related medical programs, a vehicle is defined as anything used for transportation. In addition to cars and trucks, a vehicle can include boats, snowmobiles, and animal-drawn vehicles.

(2) One vehicle is excluded regardless of its value, if it is used to provide transportation for the ((~~disabled~~)) SSI-related person or a member of the person's household.

(3) ((~~For a person receiving SSI-related institutional coverage who has a community spouse, one vehicle is excluded regardless of its value or its use. See WAC 182-513-1350 (7)(b).~~

~~(4)~~)) A vehicle used as the person's primary residence is excluded as the home, and does not count as the one excluded vehicle under subsection (2) ((~~or (3)~~)) of this section.

(((~~(5) All other vehicles, except those excluded under WAC 182-512-0350 (11) through (14), are treated as nonliquid resources and the equity value is counted toward the resource limit.~~)))

AMENDATORY SECTION (Amending WSR 14-07-059, filed 3/14/14, effective 4/14/14)

WAC 182-512-0960 SSI-related medical—Allocating income—((~~How the agency considers income and resources when determining eligibility for a person applying for noninstitutional Washington apple health (WAH) when another household member is receiving institutional WAH~~)) Determining eligibility for a spouse when the other spouse receives long-term services and supports (LTSS). (((~~(1) The agency follows rules described in WAC 182-513-1315 for a person considered to be in institutional WAH, which means a person who is either residing in a medical institution, or approved for a home and community based waiver, or approved for the WAH institutional hospice program. The rules in this section describe how the agency considers household income and resources when the household contains both institutional and noninstitutionalized household members.~~

~~(2) An institutionalized person (adult or child) who is not SSI-related may be considered under the long-term care for~~

~~families and children programs described in WAC 182-514-0230 through 182-514-0265.~~

~~(3) The agency considers the income and resources of spouses as available to each other through the end of the month in which the spouses stopped living together. See WAC 182-513-1330 and 182-513-1350 when a spouse is institutionalized.~~

~~(4) The agency considers income and resources separately as of the first day of the month following the month of separation when spouses stop living together because of placement into a boarding home (assisted living, enhanced adult residential center, adult residential center), adult family home (AFH), adult residential rehabilitation center/adult residential treatment facility (ARRC/ARTF), or division of developmental disabilities group home (DDD-GH) facility when:~~

~~(a) Only one spouse enters the facility;~~

~~(b) Both spouses enter the same facility but have separate rooms; or~~

~~(c) Both spouses enter separate facilities.~~

~~(5) The agency considers income and resources jointly when both spouses are placed in a boarding home, AFH, ARRC/ARTF, or DDD-GH facility and share a room.~~

~~(6) When determining SSI-related WAH categorically needy (CN) or medically needy (MN) eligibility for a community spouse applying for health care coverage, the agency counts:~~

~~(a) The separate income of the community spouse; plus~~

~~(b) One half of any community income received by the community spouse and the institutionalized spouse; plus~~

~~(c) Any amount allocated to the community spouse from the institutionalized spouse. The terms "community spouse" and "institutional spouse" are defined in WAC 182-513-1301.~~

~~(7) For the purposes of determining the countable income of a community spouse applying for health care coverage as described in subsection (6) of this section, it does not matter whether the spouses reside together or not. Income that is allocated and actually available to a community spouse is considered that person's income.~~

~~(8) For the purposes of determining the countable income of a community spouse or children applying for health care coverage under modified adjusted gross income (MAGI) based family, pregnancy or children's WAH programs, the agency uses the following rules to determine if the income of the institutionalized person is considered in the eligibility calculation:~~

~~(a) When the institutionalized spouse or parent lives in the same home with the community spouse and/or children, their income is counted in the determination of household income following the rules for the medical program that is being considered.~~

~~(b) When the institutionalized spouse or parent does not live in the same home as the spouse and/or children, only income that is allocated and available to the household is counted.~~

~~(9) When determining the countable income of a community spouse applying for health care coverage under the WAH MN program, the agency allocates income from the community spouse to the institutionalized spouse in an amount up to the one-person effective medically needy income level (MNIL) less the institutionalized spouse's income, when:~~

~~(a) The community spouse is living in the same household as the institutionalized spouse;~~

~~(b) The institutionalized spouse is receiving home and community-based waiver or institutional hospice services described in WAC 182-515-1505; and~~

~~(c) The institutionalized spouse has gross income of less than the MNIL.~~

~~(10) See WAC 182-506-0015 for rules on how to determine medical assistance units for households that include SSI-related persons. A separate medical assistance unit is always established for persons who meet institutional status described in WAC 182-513-1320.~~)) (1) General information.

(a) This section describes how the agency determines household income and resources when the household contains both institutional and noninstitutional household members.

(b) A separate medical assistance unit is always established for persons who meet institutional status under WAC 182-513-1320. See WAC 182-506-0015 for rules on how to determine medical assistance units for households that include SSI-related people.

(c) The agency follows rules and definitions under chapters 182-513 and 182-515 WAC for a person residing in a medical institution, approved for a home and community based (HCB) waiver, Program of All-Inclusive Care for the Elderly (PACE), roads to community living (RCL), community first choice (CFC), or for the hospice program.

(d) Throughout this section, "home" means "own home" as defined in WAC 388-106-0010.

(e) Eligibility for an institutionalized person who is not SSI-related may be determined under the MAGI-based long-term care program under chapter 182-514 WAC.

(f) The income and resources of each spouse are available to the other through the end of the month in which the spouses stopped living together.

(g) The agency determines income and resources separately starting the first day of the month following the month of separation if spouses stop living together because of placement in an alternate living facility (ALF) and:

(i) Only one spouse enters the ALF;

(ii) Both spouses enter the same ALF but have separate rooms; or

(iii) Both spouses enter separate ALFs.

(h) If spouses share a room in an ALF, the agency determines that they live together.

(2) If the community spouse applies for coverage but the spouse receiving LTSS lives in an institution:

(a) The agency counts income under this chapter, plus any allocation the institutionalized spouse has made available to the community spouse; and

(b) The agency counts resources under this chapter, plus any resources allocated to the community spouse when eligibility for the institutionalized spouse was determined, but that remain in the name of the institutionalized spouse.

(3) If the community spouse applies for coverage while living at home with his or her spouse, and his or her spouse

receives HCB waiver, PACE, RCL, or hospice, the agency counts income and resources under this chapter.

(4) If the spousal impoverishment protections community (SIPC) spouse applies for coverage while living at home with his or her spouse, and his or her spouse receives community first choice (CFC), the agency counts income and resources under this chapter.

(5) If the community spouse applies for coverage but his or her spouse receives HCB waiver, PACE, RCL, or hospice in an ALF:

(a) If the community spouse lives at home, in a separate room in the same ALF as his or her spouse, or in a separate ALF:

(i) The agency counts income under this chapter, plus any allocation the institutionalized spouse has made available to the community spouse; and

(ii) The agency counts resources under this chapter, plus any resources allocated to the community spouse when eligibility for the institutionalized spouse was determined, but that remain in the name of the institutionalized spouse.

(b) If the community spouse lives in the same room as his or her spouse, the agency counts income and resources under this chapter.

(6) If the SIPC spouse applies for coverage but his or her spouse receives CFC in an ALF:

(a) If the SIPC spouse lives at home, in a separate room in the same ALF as his or her spouse, or in a separate ALF:

(i) The agency counts income under this chapter; and

(ii) The agency counts resources under this chapter, plus any resources allocated to the SIPC spouse when eligibility for the spousal impoverishment protections institutionalized (SIPI) spouse was determined, but that remain in the name of the SIPI spouse.

(b) If the SIPC spouse lives in the same room as his or her spouse, the agency counts income and resources under this chapter.

(7) If the community spouse is not eligible for categorically needy (CN) coverage:

(a) If the community spouse is not eligible for CN coverage, the agency determines eligibility under the medically needy (MN) program;

(b) The agency allocates income to the institutionalized spouse before comparing the community spouse's income to the medically needy income level (MNIL) if:

(i) The community spouse lives in the same household as the institutionalized spouse;

(ii) The institutionalized spouse is receiving home and community-based waiver services under WAC 182-515-1505 or institutional hospice services under WAC 182-513-1240; and

(iii) The institutionalized spouse has gross income under the MNIL.

(c) The allocation cannot exceed the one-person effective MNIL minus the institutionalized spouse's income.

(8) Modified adjusted gross income (MAGI) determination for households that contain an institutionalized individual.

When determining the countable income of a community spouse or children applying for health care coverage under MAGI-based family, pregnancy, or children's programs, the agency uses rules under WAC 182-506-0010 to determine if the income of the institutionalized person is counted.

NEW SECTION

WAC 182-513-1100 Definitions related to long-term services and supports (LTSS). This section defines the meaning of certain terms used in chapters 182-513, 182-514, and 182-515 WAC. Within these chapters, institutional, home and community based (HCB) waiver, program of all-inclusive care for the elderly (PACE), and hospice in a medical institution are referred to collectively as long-term care (LTC). Long-term services and supports (LTSS) is a broader definition which includes institutional, HCB waiver, and other services such as medicaid personal care (MPC), community first choice (CFC), PACE, and hospice in the community. Additional medical definitions can be found in chapter 182-500 WAC.

"Adequate consideration" means the reasonable value of the goods or services received in exchange for transferred property that approximates the reasonable value of the property transferred.

"Agency" means the Washington state health care authority and includes the agency's designee.

"Aging and long-term support administration (ALTSA)" means the administration by that name within the Washington state department of social and health services (DSHS).

"Alternate living facility (ALF)" is not an institution under WAC 182-500-0050; it is one of the following community residential facilities:

(a) An adult family home (AFH) licensed under chapter 70.128 RCW.

(b) An adult residential care facility (ARC) licensed under chapter 18.20 RCW.

(c) An adult residential rehabilitation center (ARRC) described in WAC 388-865-0235.

(d) An assisted living facility (AL) licensed under chapter 18.20 RCW.

(e) A developmental disabilities administration (DDA) group home (GH) licensed as an adult family home under chapter 70.128 RCW or an assisted living facility under chapter 18.20 RCW.

(f) An enhanced adult residential care facility (EARC) licensed as an assisted living facility under chapter 18.20 RCW.

(g) An enhanced service facility (ESF) licensed under chapter 70.97 RCW.

"Authorization date" means the date payment begins for long-term services and supports (LTSS) described in WAC 388-106-0045.

"Comprehensive assessment reporting evaluation (CARE) assessment" means the evaluation process defined in chapter 388-106 WAC used by a department designated social services worker or a case manager to determine a person's need for long-term services and supports (LTSS).

"Clothing and personal incidentals (CPI)" means the cash payment (described in WAC 388-478-0090, 388-478-0006, and 388-478-0033) issued by the department for cloth-

ing and personal items for people living in an ALF or medical institution.

"Community first choice (CFC)" means a medicaid state plan home and community based service developed under the authority of section 1915(k) of the Social Security Act and described in chapter 388-106 WAC.

"Community options program entry system (COPES)" means a medicaid HCB waiver program developed under the authority of section 1915(c) of the Social Security Act described in chapter 388-106 WAC.

"Community spouse (CS)" means the spouse of an institutionalized spouse.

"Community spouse resource allocation (CSRA)" means the resource amount that may be transferred without penalty from:

(a) The institutionalized spouse (IS) to the community spouse (CS); or

(b) The spousal impoverishment protection institutionalized (SIPI) spouse to the spousal impoverishment protection community (SIPC) spouse.

"Community spouse resource evaluation" means the calculation of the total value of the resources owned by a married couple on the first day of the first month of the institutionalized spouse's most recent institutionalization.

"Developmental disabilities administration (DDA) home and community based (HCB) waiver" means a medicaid HCB waiver program developed under the authority of section 1915(c) of the Social Security Act described in chapter 388-845 WAC authorized by DDA.

"Dependent" means an adult child, a parent, or a sibling meeting the definition of a tax dependent under WAC 182-500-0105; or a minor child.

"Developmental disabilities administration (DDA)" means an administration within the Washington state department of social and health services (DSHS)**.**

"Equity" means the fair market value of real or personal property less any encumbrances (mortgages, liens, or judgments) on the property.

"Fair market value (FMV)" means the price an asset may reasonably be expected to sell for on the open market at the time of transfer or assignment.

"Home and community based services (HCBS)" means LTSS provided in the home or a residential setting to persons assessed by the department.

"Home and community based (HCB) waiver programs" means programs authorized under Section 1915(c) of the Social Security Act. The waiver authority enables states to waive federal medicaid requirements to provide LTSS to medicaid beneficiaries who would otherwise require the level of care provided in a hospital, nursing facility, or intermediate care facility for the intellectually disabled (ICF-ID).

"Institutionalized individual" means a person who has attained institutional status under WAC 182-513-1320.

"Institutional services" means services paid for by Washington apple health, and provided:

(a) In a medical institution;

(b) Through a home and community based (HCB) waiver; or

(c) Through programs based on HCB waiver rules for post-eligibility treatment of income described in chapter 182-515 WAC.

"Institutionalized spouse" means a person who, regardless of legal or physical separation:

(a) Has attained institutional status under WAC 182-513-1320; and

(b) Is legally married to a person who is not in a medical institution.

"Likely to reside" means the agency reasonably expects a person will remain in a medical institution for thirty consecutive days. Once made, the determination stands, even if the person does not actually remain in the facility for that length of time.

"Long-term care services" see "Institutional services."

"Long-term services and supports" includes institutional and noninstitutional services authorized by ALTSA and DDA.

"Look-back period" means the number of months prior to the month of application that the agency will consider transfers of assets for programs subject to transfer of asset penalties.

"Medicaid personal care (MPC)" means a medicaid state plan program authorized under RCW 74.09.520.

"Most recent continuous period of institutionalization (MRCPI)" means the current period an institutionalized spouse has maintained uninterrupted institutional status when the request for a community spouse resource evaluation is made. Institutional status is described in WAC 182-513-1320.

"Noninstitutional medical assistance" means any Washington apple health medical programs not based on HCB waiver rules in chapter 182-515 WAC, or rules based on residing in an institution thirty days or more.

"Nursing facility level of care (NFLOC)" is described in WAC 388-106-0355.

"Participation" means the amount a person must pay each month toward the cost of long-term care services they receive each month; it is the amount remaining after the post-eligibility process in WAC 182-513-1380, 182-515-1509, and 182-515-1514.

"Penalty period" means the period of time during which a person is not eligible to receive services subject to transfer of asset penalties.

"Personal needs allowance (PNA)" means an amount set aside from a person's income that is intended for clothing and other personal needs. The amount a person is allowed to keep as a PNA depends on whether the person lives in a medical institution, alternate living facility, or at home. Personal needs allowances are found at: http://hca.wa.gov/medicaid/eligibility/pages/standards.aspx.

"Residential support waiver (RSW)" means a 1915(c) medicaid waiver program authorized under RCW 74.39A.-030. Persons eligible for this program may receive long-term care services in a licensed adult family home with a contract to provide specialized behavior services.

"Short stay" means residing in a medical institution for a period of twenty-nine days or less.

"Special income level (SIL)" means the monthly income standard for the categorically needy (CN) program

that is three hundred percent of the SSI federal benefit rate (FBR).

"Spousal impoverishment" means financial provisions within Section 1924 of the Social Security Act that protect income and assets of the community spouse through income and resource allocation. The spousal allocation process is used to discourage the impoverishment of a spouse due to the need for LTSS by their spouse. This includes services provided in a medical institution, HCB waivers authorized under 1915(c) of the Social Security Act, and through December 31, 2018, services authorized under 1915 (i) and (k) of the Social Security Act.

"Spousal impoverishment protections institutionalized (SIPI) spouse" means a legally married person who only qualifies for the noninstitutional categorically needy (CN) Washington apple health SSI-related program because of the spousal impoverishment protections in WAC 182-513-1220.

"Spousal impoverishment protections community (SIPC) spouse" means the spouse of a SIPI spouse.

"State spousal resource standard" means minimum resource standard allowed for a community spouse.

"Third-party resource (TPR)" means funds paid to a person by a third party where the purpose of the funds is for payment of activities of daily living, medical services, or personal care. Third-party resources are described under WAC 182-501-0200.

"Transfer of a resource" or **"transfer of an asset"** means changing ownership or title of an asset such as income, real property, or personal property by one of the following:

(a) An intentional act that changes ownership or title; or

(b) A failure to act that results in a change of ownership or title.

"Transfer date for real property" or **"transfer date of interest in real property"** means:

(a) The date of transfer for real property is the day the deed is signed by the grantor if the deed is recorded; or

(b) The date of transfer for real property is the day the signed deed is delivered to the grantee.

"Transfer month" means the calendar month in which resources are legally transferred.

"Uncompensated value" means the fair market value (FMV) of an asset at the time of transfer minus the value of compensation the person receives in exchange for the asset.

"Undue hardship" means a person is not able to meet shelter, food, clothing, or health needs. A person may apply for an undue hardship waiver based on criteria described in WAC 182-513-1367.

"Value of compensation received" means the consideration the purchaser pays or agrees to pay. Compensation includes:

(a) All money, real or personal property, food, shelter, or services the person receives under a legally enforceable purchase agreement whereby the person transfers the asset; and

(b) The payment or assumption of a legal debt the seller owes in exchange for the asset.

"Veterans benefits" means different types of benefits paid by the federal department of veterans affairs (VA). Some may include additional allowances for:

(a) Aid and attendance for a person needing regular help from another person with the activities of daily living;

(b) A person who is housebound;

(c) Improved pension, the newest type of VA disability pension, available to veterans and their survivors whose income from other sources, including service connected disability, is below the improved pension amount;

(d) Unusual medical expenses (UME), determined by the VA based on the amount of unreimbursed medical expenses reported by the person who receives a needs-based benefit. The VA can use UME to reduce countable income to allow the person to receive a higher monthly VA payment, a one-time adjustment payment, or both;

(e) Dependent allowance veteran's payments made to, or on behalf of, spouses of veterans or children regardless of their ages or marital status. Any portion of a veteran's payment that is designated as the dependent's income is countable income to the dependent; or

(f) Special monthly compensation (SMC). Extra benefit paid to a veteran in addition to the regular disability compensation to a veteran who, as a result of military service, incurred the loss or loss of use of specific organs or extremities.

"Waiver programs/services" means programs for which the federal government authorizes exceptions to federal medicaid rules. In Washington state, home and community based (HCB) waiver programs are authorized by the developmental disabilities administration (DDA), or home and community services (HCS).

NEW SECTION

WAC 182-513-1200 Long-term services and supports authorized under Washington apple health programs. (1) Certain long-term services and supports (LTSS) programs are available to people eligible for noninstitutional Washington apple health (WAH) coverage who meet the functional requirements for the program based on either:

(a) An assessment for either in-home or residential services in an alternate living facility (ALF); or

(b) Placement in a medical institution.

(2) There are no transfer of asset penalties described in WAC 182-513-1363 for the following noninstitutional LTSS programs:

(a) WAC 182-513-1205 noninstitutional apple health in an ALF. This rule describes the SSI-related CN eligibility criteria for people who are eligible for department-contracted services in an ALF or mental health residential treatment facility (ARTF). It also describes the SSI-related MN eligibility criteria for private-pay clients.

(b) WAC 182-513-1210 Community first choice (CFC) —Overview. This program provides LTSS for both in-home and ALF settings for clients who meet nursing facility level of care.

(c) WAC 182-513-1215 Community first choice (CFC) —Eligibility. This section describes the financial eligibility rules for CFC.

(d) WAC 182-513-1220 Community first choice (CFC) —Spousal impoverishment protections for noninstitutional Washington apple health clients. This section describes how

spousal impoverishment protections apply to people who are determined functionally eligible for CFC.

(e) WAC 182-513-1225 Medicaid personal care (MPC). This section describes how a person is financially eligible for personal care services if the person doesn't meet the nursing facility level of care criteria for services under CFC.

(3) There are no transfer of asset penalties under the following programs; however, eligibility is determined using institutional rules described in WAC 182-513-1315 and 182-513-1380 or HCB waiver rules described in chapter 182-515 WAC depending on living arrangement:

(a) WAC 182-513-1230 Program of all-inclusive care for the elderly (PACE). This program provides LTSS under a managed care contract and is available for people who reside in the PACE designated service area.

(b) WAC 182-513-1235 Roads to community living (RCL). This program provides LTSS to people discharging from medical institutions to an in-home or ALF setting.

(c) WAC 182-513-1240 Hospice. This WAC describes the eligibility criteria used for a WAH applicant who has made an election of hospice services, but is not otherwise eligible for a noninstitutional CN or MN program as described in WAC 182-503-0510.

(4) A person who is eligible for CN or MN coverage is eligible for rehabilitation skilled nursing services as part of the benefit package associated with the coverage.

(5) Once a person meets institutional status under WAC 182-513-1320 or no longer meets rehabilitation skilled nursing criteria, the person must be assessed and approved by the department for payment of nursing facility care. Eligibility is redetermined using LTC rules described in WAC 182-513-1315, with the exception of a person who is eligible under a MAGI-based program described in WAC 182-503-0510(2).

NEW SECTION

WAC 182-513-1205 Determining eligibility for noninstitutional coverage in an alternate living facility. This section describes the monthly income standard used to determine eligibility for noninstitutional coverage for a person who lives in a department-contracted alternate living facility (ALF) described in WAC 182-513-1100.

(1) The eligibility criteria for noninstitutional Washington apple health (WAH) in an ALF follows SSI-related medical rules described in WAC 182-512-0050 through 182-512-0960 with the exception of the higher income standard described in subsection (2) of this section.

(2) A person is eligible for noninstitutional coverage under the categorically needy (CN) program if the person's gross monthly income after allowable exclusions described in chapter 182-512 WAC:

(a) Does not exceed the special income level (SIL); and

(b) Is less than or equal to the person's assessed state rate at a department contracted facility. To determine the CN standard: ((y × 31) + $38.84), where "y" is the state daily rate. $38.84 is based on the cash payment standard for a person living in an ALF setting described in WAC 388-478-0006.

(3) A person is eligible for noninstitutional coverage under the medically needy (MN) program if the person's gross monthly income after allowable exclusions described in chapter 182-512 WAC is less than or equal to the person's private rate at a department-contracted facility. To determine the MN standard: ((z × 31) + $38.84), where "z" is the facility's private daily rate. To determine MN spenddown liability, see chapter 182-519 WAC.

(4) A person's nonexcluded resources cannot exceed the standard described in WAC 182-512-0010.

(5) The agency approves CN noninstitutional coverage for twelve months.

(6) The agency approves MN noninstitutional coverage for a period of months described in chapter 182-504 WAC for an SSI-related person, provided the person satisfies any spenddown liability as described in chapter 182-519 WAC.

(7) A person receiving medicaid personal care (MPC) or community first choice (CFC) pays all of their income to the ALF except a personal needs allowance of $62.79.

(8) A person may have to pay third-party resources described in WAC 182-501-0200 in addition to the payment described in this subsection.

NEW SECTION

WAC 182-513-1210 Community first choice (CFC) —Overview. Community first choice (CFC) is a Washington apple health (WAH) state plan benefit authorized under Section 1915(k) of the Social Security Act. It enables the agency and its contracted entities to deliver person-centered home and community based long-term services and supports (LTSS) to Title XIX medicaid eligible people who meet the institutional level of care described in WAC 388-106-0355. See:

(1) WAC 388-106-0270 through 388-106-0295 for services included within the CFC benefit package.

(2) WAC 182-513-1215 for financial eligibility for CFC services.

NEW SECTION

WAC 182-513-1215 Community first choice (CFC) —Eligibility. (1) An applicant who is determined functionally eligible for community first choice (CFC) services under WAC 388-106-0270 through 388-106-0295 is financially eligible to receive CFC services if the applicant is:

(a) Eligible for a noninstitutional Washington apple health program which provides categorically needy (CN) or alternative benefit plan (ABP) scope of care;

(b) A spousal impoverishment protections institutional (SIPI) spouse under WAC 182-513-1230; or

(c) Determined eligible for a home and community based (HCB) waiver program under chapter 182-515 WAC.

(2) An applicant whose only coverage is through one of the following programs is not eligible for CFC:

(a) Medically needy program under WAC 182-519-0100;

(b) Premium-based children's program under WAC 182-505-0215;

(c) Medicare savings programs under WAC 182-517-0300;

(d) Family planning program under WAC 182-505-0115;

(e) Take charge program under WAC 182-532-0720;

(f) Medical care services program under WAC 182-508-0005;

(g) Pregnant minor program under WAC 182-505-0117;

(h) Alien emergency medical program under WAC 182-507-0110 through 182-507-0120;

(i) State-funded long-term care for noncitizens program under WAC 182-507-0125; or

(j) Kidney disease program under chapter 182-540 WAC.

(3) Transfer of asset penalties under WAC 182-513-1363 does not apply to CFC applicants, unless the applicant is applying for long-term services and supports that are only available through one of the HCB waivers under chapter 182-515 WAC.

(4) Post-eligibility treatment of income rules does not apply if eligible under subsection (1)(a) or (b) of this section. People who reside in a residential facility do pay up to the room and board standard. The room and board amount is based on the effective one-person medically needy income level (MNIL) minus the residential personal needs allowance (PNA) except when eligibility is based on the rules in WAC 182-513-1205.

(5) Post-eligibility treatment of income rules does apply if eligible under subsection (1)(c) of this section and receiving a HCB waiver service.

(6) A person may have to pay third-party resources described in WAC 182-501-0200 in addition to the room and board and participation.

(7) PNA, MNIL, and room and board standards are located at: http://www.hca.wa.gov/medicaid/eligibility/pages/standards.aspx.

NEW SECTION

WAC 182-513-1220 Community first choice (CFC) —Spousal impoverishment protections for noninstitutional Washington apple health clients. (1) The agency determines eligibility using spousal impoverishment protections under this section, when an applicant:

(a) Is married to, or marries a person not in a medical institution;

(b) Meets institutional level of care and eligibility for community first choice (CFC) services under WAC 388-106-0270 through 388-106-0295;

(c) Is ineligible for a noninstitutional categorically needy (CN) SSI-related program due to spousal deeming rules under WAC 182-512-0920, or due to exceeding the resource limit in WAC 182-512-0010, or both;

(d) Is ineligible for SSI-related noninstitutional medical assistance in an ALF due to combined spousal resources exceeding the resource limit in WAC 182-512-0010; and

(e) Meets the aged, blindness, or disability criteria under WAC 182-512-0050.

(2) The agency determines countable income using the SSI-related income rules under chapter 182-512 WAC but uses only the applicant's separate income and not the income of his or her spouse.

(3) The agency determines countable resources using the SSI-related resource rules under chapter 182-512 WAC:

(a) For the applicant/recipient the resource standard is two thousand dollars.

(b) For the spouse of the applicant/recipient, resources must be at or below the spousal resource transfer maximum resource standard on the first day of each month.

(c) The resources of the spousal impoverishment protections community (SIPC) spouse are unavailable to the spousal impoverishment protections institutionalized (SIPI) spouse the month after eligibility for CFC services is established unless subsection (8) of this section applies.

(4) The CFC recipient has until the end of the month of the first regularly scheduled eligibility review to transfer joint resources in excess of two thousand dollars to his or her spouse.

(5) If the applicant lives at home and the applicant's separate countable income is at or below the SSI categorically needy income level (CNIL) and the applicant is resource eligible, the applicant is a SIPI spouse and is eligible for noninstitutional CN coverage and CFC services.

(6) If the applicant lives in an alternate living facility (ALF) and the applicant's separate countable income is at or below the standard under WAC 182-513-1205(2) and the applicant is resource eligible, the applicant is a SIPI spouse and is eligible for non-institutional CN coverage and CFC services.

(7) If the applicant is employed and the applicant's separate countable income is at or below the standard under WAC 182-511-1060, the applicant is a SIPI spouse and is eligible for noninstitutional CN coverage and CFC services.

(8) Once a person no longer receives CFC services, eligibility is redetermined without using spousal impoverishment protection under WAC 182-504-0125.

(9) If the applicant's separate countable income is above the standards described in subsections (5), (6), and (7) of this section, the applicant is not eligible for CFC services under this section.

(10) The spousal impoverishment protections described in this section are time-limited and expire on December 31, 2018.

(11) Standards described in this section are located at: http://hca.wa.gov/medicaid/eligibility/pages/standards.aspx.

NEW SECTION

WAC 182-513-1225 Medicaid personal care (MPC). (1) Medicaid personal care (MPC) is a state-plan benefit available to a person who is determined functionally eligible for MPC services under WAC 388-106-0200 through 388-106-0235.

(2) A person is financially eligible for MPC services if the person is eligible for a noninstitutional categorically needy (CN) or alternative benefit plan (ABP) Washington apple health program.

(3) MPC services may be provided to a person who resides in their own home, in a department-contracted adult family home (AFH), or in a licensed assisted living facility that is contracted with the department of social and health services to provide adult residential care services.

(4) A person who resides in an alternate living facility (ALF) listed in subsection (3) of this section:

(a) Keeps a personal needs allowance (PNA) of $62.79; and

(b) Pays room and board up to the statewide room and board amount, unless CN eligibility is determined using rules under WAC 182-513-1205.

(5) A person who receives aged, blind, disabled (ABD) cash assistance in an adult family home keeps a clothing and personal incidentals (CPI) of $38.84 and pays the rest of his or her cash grant and other available income towards room and board.

(6) A person who receives MPC services under the workers with disabilities program described in chapter 182-511 WAC must pay his or her health care for workers with disabilities (HWD) premium in addition to room and board, if residing in a residential setting.

(7) A person may have to pay third-party resources described in WAC 182-501-0200 in addition to room and board.

(8) Current PNA and room and board standards are located at: http://www.hca.wa.gov/medicaid/eligibility/pages/standards.aspx.

NEW SECTION

WAC 182-513-1230 Program of all-inclusive care for the elderly (PACE). (1) The program of all-inclusive care for the elderly (PACE) provides long-term services and supports (LTSS), medical, mental health, and chemical dependency treatment through a department-contracted managed care plan using a personalized plan of care for each enrollee.

(2) Program rules governing functional eligibility for PACE are listed under WAC 388-106-0700, 388-106-0705, 388-106-0710, and 388-106-0715.

(3) A person is PACE eligible if the person:

(a) Is age:

(i) Fifty-five or older and disabled under WAC 182-512-0050; or

(ii) Sixty-five or older.

(b) Meets nursing facility level of care under WAC 388-106-0355;

(c) Lives in a designated PACE service area;

(d) Meets financial eligibility requirements under this section; and

(e) Agrees to receive services exclusively through the PACE provider and the PACE provider's network of contracted providers.

(4) Although PACE is not a home and community based (HCB) waiver program, financial eligibility is determined using the HCB waiver rules under WAC 182-515-1505 when living at home or in an alternate living facility (ALF), with the following exceptions:

(a) PACE enrollees are not subject to the transfer of asset provisions described in WAC 182-513-1363; and

(b) PACE enrollees may reside in a medical institution thirty days or longer and still remain eligible for PACE services. The eligibility rules for institutional coverage are under WAC 182-513-1315 and 182-513-1380.

(5) A person may have to pay third-party resources described in WAC 182-501-0200 in addition to the room and board and participation.

NEW SECTION

WAC 182-513-1235 Roads to community living (RCL). (1) Roads to community living (RCL) is a demonstration project, funded by a "money follows the person" grant originally authorized under Section 6071 of the Deficit Reduction Act of 2005 (P.L. 109-171) and extended through the Patient Protection and Affordable Care Act (P.L. 111-148).

(2) Program rules governing functional eligibility for RCL are described in WAC 388-106-0250 through 388-106-0265. RCL services may be authorized by home and community services (HCS) or the developmental disabilities administration (DDA).

(3) A person must have a continuous stay of at least ninety days in a qualified institutional setting (hospital, nursing home, residential habilitation center) to be eligible for RCL. The ninety-day count excludes days paid solely by medicare, must include at least one day of medicaid paid inpatient services, and the person must be eligible to receive medicaid on the day of discharge.

(4) Once a person is discharged to home or a residential setting under RCL, the person remains continuously eligible for medical coverage for a period of three hundred sixty-five days unless the person:

(a) Returns to an institution for thirty days or longer;

(b) Is incarcerated in a public jail or prison;

(c) No longer wants the RCL services;

(d) Moves out-of-state; or

(e) Dies.

(5) A person may receive RCL services under any federally funded categorically needy (CN), medically needy (MN), alternative benefit plan (ABP), noninstitutional medical, or home and community based (HCB) waiver program.

(6) Changes in income and resources during the continuous eligibility period do not affect eligibility for RCL services. Changes in income and deductions may affect the amount a person must pay toward the cost of care.

(7) A person approved for RCL is not subject to transfer of asset provisions under WAC 182-513-1363 during the continuous eligibility period, but transfer penalties may apply if the person needs HCB waiver or institutional services once the continuous eligibility period has ended.

(8) A person who is not otherwise eligible for a noninstitutional program who accesses RCL services using HCB waiver rules under chapter 182-515 WAC must pay participation toward the cost of RCL services. Cost of care calculations are described in:

(a) WAC 182-515-1509 for home and community services (HCS); and

(b) WAC 182-515-1514 for development disabilities administration (DDA) services.

(9) At the end of the continuous eligibility period, the agency redetermines a person's eligibility for other programs under WAC 182-504-0125.

NEW SECTION

WAC 182-513-1240 Hospice. (1) General information.

(a) The hospice program provides palliative care to people who elect to receive hospice services and are certified as terminally ill by their physician.

(b) Program rules governing election of hospice are under chapter 182-551 WAC.

(c) A person may revoke a hospice election at any time by signing a revocation statement.

(d) Personal needs allowance and income and resource standards for hospice and home and community based (HCB) waiver programs are located at: http://www.hca.wa.gov/medicaid/eligibility/pages/standards.aspx.

(2) When hospice is a covered service.

(a) A person who receives coverage under a categorically needy (CN), medically needy (MN), or alternative benefit plan (ABP) program is eligible for hospice services as part of the program specific benefit package.

(b) A person who receives coverage under the alien emergency medical (AEM) program under WAC 182-507-0110 may be eligible for payment for hospice services if preapproved by the agency.

(3) The hospice program.

(a) A person who is not otherwise eligible for a CN, MN, or ABP noninstitutional program may be eligible for CN coverage for hospice services using home and community based (HCB) waiver rules under WAC 182-515-1505.

(b) When a person is only eligible for hospice using HCB waiver rules, the agency follows rules under WAC 182-515-1505 through 182-515-1509, and institutional rules under WAC 182-513-1315, except that:

(i) A person on the hospice program is not subject to the transfer of asset provisions under WAC 182-513-1363;

(ii) A person on the hospice program may reside in a medical institution, including a hospice care center, thirty days or longer and remain eligible for hospice services; and

(iii) A person residing at home on hospice with gross income over the special income limit (SIL) is not eligible for CN coverage. The rules under WAC 182-515-1508 (2)(c)(ii) apply only to people who receive an HCB waiver service. If gross income is over the SIL, the agency determines eligibility under WAC 182-519-0100.

(c) A person eligible for hospice using HCB waiver rules may be required to participate income and third-party resources (TPR) under WAC 182-501-0200 toward the cost of hospice services. The cost of care calculation is described in WAC 182-515-1509.

(d) A person may receive HCB waiver services in addition to hospice services. The person's responsibility to participate income and TPR toward the cost of care is applied to the HCB waiver service provider first.

(4) Hospice in a medical institution:

(a) A person who elects hospice who resides in a medical institution for thirty days or longer and has income:

(i) Equal to or less than the SIL is eligible for CN coverage. Eligibility for institutional hospice is determined under WAC 182-513-1315.

(ii) Over the SIL is eligible for MN coverage under WAC 182-513-1245.

(b) A person eligible for hospice in a medical institution may have to pay participation toward the cost of nursing facility or hospice care center services. The cost of care calculation is described in WAC 182-513-1380.

(5) Changes in coverage. The agency redetermines a person's eligibility under WAC 182-504-0125 if the person:

(a) Revokes hospice and is only eligible for coverage using HCB waiver rules described in subsection (3) of this section; or

(b) Loses eligibility under a CN, MN, or ABP program.

NEW SECTION

WAC 182-513-1245 Medically needy hospice in a medical institution. (1) General information.

(a) To be eligible for hospice when living in a medical institution under the SSI-related medically needy (MN) program, a person must:

(i) Meet program requirements under WAC 182-513-1315;

(ii) Have gross nonexcluded income in excess of the special income level (SIL) but below the monthly department-contracted rate in the institution;

(iii) Meet the financial requirements of subsection (4) or (5) of this section; and

(b) Elect hospice under chapter 182-551 WAC.

(2) Financial eligibility information.

(a) The agency determines a person's resource eligibility, excess resources, and medical expense deductions using WAC 182-513-1350.

(b) The agency determines a person's countable income by:

(i) Excluding income under WAC 182-513-1340;

(ii) Determining available income under WAC 182-513-1325 or 182-513-1330;

(iii) Disregarding income under WAC 182-513-1345; and

(iv) Deducting medical expenses that were not used to reduce excess resources under WAC 182-513-1350.

(3) Determining the department-contracted daily rate in an institution, and the institutional medically needy income level (MNIL).

(a) The agency determines the department-contracted daily rate in an institution and the institutional MNIL based on the living arrangement, and whether the person is entitled to medicare payment for hospice services.

(b) When the person resides in a hospice care center:

(i) If entitled to medicare payment for hospice services, the department-contracted daily rate is the state daily hospice care center rate. The institutional MNIL is calculated by multiplying the department-contracted daily rate by 30.42.

(ii) If not entitled to medicare payment for hospice services, the department-contracted daily rate is the state daily hospice care center rate, plus the state daily hospice rate. The institutional MNIL is calculated by multiplying the department-contracted daily rate by 30.42.

(c) When the person resides in a nursing facility:

(i) If entitled to medicare payment for hospice services, the department-contracted daily rate is ninety-five percent of the nursing facility's state daily rate. The institutional MNIL

is calculated by multiplying the department-contracted daily rate by 30.42.

(ii) If not entitled to medicare payment for hospice services, the department-contracted daily rate is ninety-five percent of the nursing facility's state daily rate, plus the state daily hospice rate. The institutional MNIL is calculated by multiplying the department-contracted daily rate by 30.42.

(4) Eligibility for payment of institutional hospice services and the MN program.

(a) If a person's countable income plus excess resources is less than, or equal to, the department-contracted daily rate, under subsection (3) of this section, times the number of days residing in the facility, the person:

(i) Is eligible for payment of institutional hospice services;

(ii) Is approved MN coverage for a twelve-month certification period; and

(b) Pays income and excess resources towards the cost of care under WAC 182-513-1380.

(5) Eligibility for institutional MN spenddown.

(a) If a person's countable income is more than the department-contracted daily rate times the number of days residing in the facility, but less than the private rate for the same period, the person:

(i) Is not eligible for payment of institutional hospice services; and

(ii) Is eligible for the MN spenddown program for a three- or six-month base period when qualifying medical expenses meet a person's spenddown liability.

(b) Spenddown liability is calculated by subtracting the institutional MNIL from the person's countable income for each month in the base period. The values from each month are added together to determine the spenddown liability.

(c) Qualifying medical expenses used to meet the spenddown liability are described in WAC 182-519-0110, with the following exception: Only costs for hospice services above the department-contracted daily rate times the number of days residing in the facility are qualifying medical expenses.

(6) Eligibility for MN spenddown.

(a) If a person's countable income is more than the private rate times the number of days residing in the facility, the person is not eligible for payment of institutional hospice services and institutional MN spenddown; and

(b) Eligibility for MN spenddown is determined under chapter 182-519 WAC.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-513-1315 ((~~Eligibility for long-term care (institutional, waiver, and hospice) services.~~)) General eligibility requirements for Washington apple health long-term care programs. ((~~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 aged, blind, or disabled (ABD) cash assistance, medical care services (MCS) and the state funded 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 182-503-0505 (2) and (3)(a) through (g);~~

~~(b) Attain institutional status as described in WAC 388-513-1320;~~

~~(c) Meet functional eligibility described in chapter 388-106 WAC for home and community services (HCS) waiver and nursing facility coverage; or~~

~~(d) Meet criteria for division of developmental disabilities (DDD) assessment under chapter 388-828 WAC for DDD waiver or institutional services;~~

~~(e) Not have a penalty period of ineligibility as described in WAC 388-513-1363, 388-513-1364, or 388-513-1365;~~

~~(f) Not have equity interest in their primary residence greater than the home equity standard described in WAC 388-513-1350; and~~

~~(g) 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 182-512-0050 (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 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 182-505-0210; or CN family medical described in WAC 182-505-0240; or family and children's institutional medical described in WAC 182-514-0230 through 182-514-0260. 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 for noncitizen children require prior approval by aging and disability services administration (ADSA) under the state funded nursing facility program described in WAC 182-507-0125; 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 182-512-0050 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.

(5) To be eligible for hospice services under the CN program, a client must:

(a) Meet the program requirements described in chapter 182-551 WAC; and

(b) Be eligible for a noninstitutional categorically needy program (CN) 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 effective one-person MNIL and gross income 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 182-514-0230, 182-514-0255, or 182-514-0260; or

(b) Related to the SSI program as described in WAC 182-512-0050 and meet all requirements described in WAC 388-513-1395; or

(c) Eligible for the MN SSI-related program described in WAC 182-512-0150 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, or 388-513-1365.

(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 for:

(a) Institutional services in a medical institution; or

(b) Hospice services in a medical institution.

(11) The department determines eligibility for state funded 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 182-507-0110 and 82-507-0125. 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.

(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.

(14) If an individual under age twenty one is not eligible for medicaid under SSI-related in WAC 182-512-0050 or ABD cash assistance described in WAC 388-400-0060 or MCS described in WAC 182-508-0005, consider eligibility under WAC 182-514-0255 or 182-514-0260.

(15) Noncitizen clients under age nineteen can be considered for the apple health for kids program described in WAC 182-505-0210 if they are admitted to a medical institution for less than thirty days. Once a client resides or is likely to reside in a medical institution for thirty days or more, the department determines eligibility under WAC 182-514-0260 and must be preapproved for coverage by ADSA as described in WAC 182-507-0125.

(16) Noncitizen clients not eligible under subsection (15) of this section can be considered for LTC services under WAC 182-507-0125. These clients must be preapproved 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; or~~

~~(d) For TANF related clients residing in a medical institution see WAC 182-514-0265.~~

~~(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 medicaid. These groups are described in WAC 182-512-0880.~~)) This section describes how the agency determines a person's eligibility for long-term care coverage for people residing in a medical institution, receiving home and community based (HCB) waiver services, or receiving hospice services under the categorically needy (CN) or medically needy (MN) programs. Also described are the eligibility requirements under the state-funded medical care services (MCS) program and the state-funded long-term care services program.

This chapter includes the following sections:

(1) WAC 182-513-1316, General eligibility requirements for Washington apple health long-term care programs.

(2) WAC 182-513-1317, Income and resource criteria for an institutionalized person.

(3) WAC 182-513-1318, Income and resource criteria for home and community based (HCB) waiver programs and hospice.

(4) WAC 182-513-1319, State-funded programs for non-citizens.

NEW SECTION

WAC 182-513-1316 General eligibility requirements for Washington apple health long-term care programs. (1) To be eligible for long-term care (LTC) services, a person must:

(a) Meet the general eligibility requirements for medical programs under WAC 182-503-0505;

(b) Attain institutional status under WAC 182-513-1320;

(c) Meet the functional eligibility under:

(i) Chapter 388-106 WAC for a home and community services (HCS) waiver or nursing facility coverage; or

(ii) Chapter 388-828 WAC for developmental disabilities administration (DDA) home and community based (HCB) waiver or institutional services; and

(d) Meet either:

(i) SSI-related criteria under WAC 182-512-0050; or

(ii) MAGI-based criteria under WAC 182-503-0510(2), if residing in a medical institution. A person who is eligible for MAGI-based coverage is not subject to the provisions described in subsection (2) of this section.

(2) A supplemental security income (SSI) person or an SSI-related person who needs LTC services must also:

(a) Not have a penalty period of ineligibility under WAC 182-513-1363;

(b) Not have equity interest in his or her primary residence greater than the home equity standard under WAC 182-513-1350; and

(c) Disclose to the state any interest the applicant or spouse has in an annuity, which must meet annuity requirements under chapter 182-516 WAC.

(3) An SSI recipient must submit a signed health care coverage application form attesting to the provisions described in subsection (2) of this section. A signed and completed eligibility review for long-term care benefits can be accepted for SSI people applying for long-term care services.

(4) To be eligible for HCB waiver services, a person must also meet the program requirements under:

(a) WAC 182-515-1505 through 182-515-1509 for HCS HCB waivers; or

(b) WAC 182-515-1510 through 182-515-1514 for DDA HCB waivers.

(5) The agency determines a person's eligibility as it does for a single person when the person's spouse has already been determined eligible for LTC services.

NEW SECTION

WAC 182-513-1317 Income and resource criteria for an institutionalized person. (1) This section provides an overview of the income and resource eligibility rules for a person who lives in an institutional setting.

(2) To determine income eligibility for an SSI-related long-term care (LTC) applicant under the categorically needy (CN) program,the agency:

(a) Considers income available under WAC 182-513-1325 and 182-513-1330;

(b) Excludes income under WAC 182-513-1340 and chapter 182-512 WAC;

(c) Compares remaining gross nonexcluded income to the special income level (SIL). A person's gross income must be equal to or less than the SIL to be eligible for CN coverage.

(3) To determine income eligibility for an SSI-related LTC client under the medically needy (MN) program, the agency follows the income standards and eligibility rules under WAC 182-513-1395.

(4) To be resource eligible under the SSI-related LTC CN or MN program, the person must:

(a) Meet the resource eligibility requirements under WAC 182-513-1350;

(b) Not have a penalty period of ineligibility due to a transfer of asset under WAC 182-513-1363;

(c) Disclose to the state any interest the person or his or her spouse has in an annuity, which must meet the annuity requirements under chapter 182-516 WAC.

(5) A person is eligible for medicaid as a resident in eastern or western state hospital if the person:

(a) Has attained institutional status under WAC 182-513-1320; and

(b) Is under age twenty-one at the time of application; or

(c) Is receiving active psychiatric treatment just prior to his or her twenty-first birthday and the services extend beyond this date and the person has not yet reached age twenty-two; or

(d) Is at least sixty-five years old.

(6) To determine long-term care CN or MN income eligibility for a person eligible under a MAGI-based program, the agency follows the rules under chapter 182-514 WAC.

(7) There is no asset test for MAGI-based LTC programs under WAC 182-514-0245.

(8) The agency determines a person's total responsibility to pay toward the cost of care for LTC services as follows:

(a) For an SSI-related person residing in a medical institution, see WAC 182-513-1380;

(b) For an SSI-related person on a home and community based waiver, see chapter 182-515 WAC.

NEW SECTION

WAC 182-513-1318 Income and resource criteria for home and community based (HCB) waiver programs and hospice. (1) This section provides an overview of the income and resource eligibility rules for a person to be eligible for a home and community based (HCB) waiver program described in chapter 182-515 WAC or the hospice program under WAC 182-513-1240 and 182-513-1245.

(2) To determine income eligibility for an SSI-related long-term care (LTC) HCB waiver under the categorically needy (CN) program, the medicaid agency:

(a) Considers income available under WAC 182-513-1325 and 182-513-1330;

(b) Excludes income under WAC 182-513-1340;

(c) Compares remaining gross nonexcluded income to:

(i) The special income level (SIL) (three hundred percent of the federal benefit rate (FBR)); or

(ii) For home and community based (HCB) service programs authorized by aging and long-term supports administration (ALTSA), a higher standard is determined following the rules described in WAC 182-515-1508 if a client's income is above the SIL but net income is below the medically needy income level (MNIL).

(3) A person who receives MAGI-based coverage is not eligible for HCB waiver services unless found eligible based on program rules in chapter 182-515 WAC.

(4) To be resource eligible under the SSI-related LTC CN HCB waiver programs, the person must:

(a) Meet the resource eligibility requirements and standards under WAC 182-513-1350;

(b) Not have a penalty period of ineligibility due to a transfer of asset under WAC 182-513-1363;

(c) Disclose to the state any interest the person or his or her spouse has in an annuity and meet the annuity requirements under chapter 182-516 WAC.

(5) The agency allows an HCB waiver person to use verified unpaid medical expenses to reduce countable resources in excess of the standard under WAC 182-513-1350.

(6) The agency determines a person's total responsibility to pay toward the cost of care for LTC services as follows:

(a) For people receiving HCS HCB waiver services, see WAC 182-515-1509;

(b) For people receiving DDA HCB waiver services, see WAC 182-515-1514.

(7) HCB waiver recipients who are "deemed eligible" for SSI benefits under WAC 182-512-0880 do not pay participation toward their cost of personal care. People living in a residential setting do pay room and board under WAC 182-515-1505 through 182-515-1509 or 182-515-1514.

(8) To be eligible for hospice services under the CN program, see WAC 182-513-1240.

(9) To be eligible for hospice services in a medical institution under the MN program, see WAC 182-513-1245.

NEW SECTION

WAC 182-513-1319 State-funded programs for noncitizens. (1) This section describes the state-funded programs that are available for noncitizens who do not meet the citizenship criteria under WAC 182-503-0535 for federally funded coverage.

(2) Lawfully residing noncitizens who need nursing facility care or care in an alternate living facility may receive coverage for long-term care (LTC) services if the person meets the eligibility and incapacity criteria of the medical care services (MCS) program under WAC 182-508-0005.

(3) People who receive MCS coverage are not eligible for home and community based (HCB) waiver programs or hospice care.

(4) Noncitizens under age nineteen who are eligible for the Washington apple health for kids program under WAC 182-505-0210 are eligible for LTC services if the person is admitted to a medical institution for less than thirty days. Once the person resides or is likely to reside in a medical institution for thirty days or more, the agency determines eligibility under WAC 182-514-0260.

(5) Noncitizens age nineteen or older may be eligible for the state-funded long-term care services program described in WAC 182-507-0125. A person must be preapproved by ALTSA for this program due to enrollment limits.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-513-1320 Determining institutional status for long-term care (LTC) services. (((~~(1) Institutional status is an eligibility requirement for long-term care services (LTC) and institutional medical programs. To attain institutional status, you must:~~

~~(a) Be approved for and receiving home and community based waiver services or hospice services; or~~

~~(b) Reside or based on a department assessment is likely to reside in a medical institution, institution for mental diseases (IMD) or inpatient psychiatric facility for a continuous period of:~~

~~(i) Thirty days if you are an adult eighteen and older;~~

~~(ii) Thirty days if you are a child seventeen years of age or younger admitted to a medical institution; or~~

~~(iii) Ninety days if you are a child seventeen years of age or younger receiving inpatient chemical dependency or inpatient psychiatric treatment.~~

~~(2) Once the department has determined that you meet institutional status, your status is not affected by:~~

~~(a) Transfers between medical facilities; or~~

~~(b) Changes from one kind of long-term care services (waiver, hospice or medical institutional services) to another.~~

~~(3) If you are absent from the medical institution or you do not receive waiver or hospice services for at least thirty consecutive days, you lose institutional status.~~)) (1) To attain institutional status, a person must be approved for and receive:

(a) Home and community based (HCB) waiver services under chapter 182-515 WAC; or

(b) Roads to community living (RCL) services under WAC 182-513-1235; or

(c) Program of all-inclusive care for the elderly (PACE) under WAC 182-513-1230; or

(d) Hospice services under WAC 182-513-1240(3); or

(e) Reside, or based on a department assessment, be likely to reside in a medical institution, institution for mental diseases (IMD), or inpatient psychiatric facility for thirty consecutive days.

(2) Once the agency has determined that the person meets institutional status, the person's status is not affected if the person:

(a) Transfers between medical facilities; or

(b) Changes from one kind of long-term care services (HCB waiver, RCL, PACE, hospice or medical institutional services) to another.

(3) A person loses institutional status if he or she is absent from a medical institution, or does not receive HCB waiver, RCL, PACE, or hospice services, for more than twenty-nine consecutive days.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-513-1325 Determining available income for an SSI-related single client for long-term care (LTC) services (institutional, waiver or hospice). This section describes income the ((~~department~~)) agency considers available when determining an SSI-related single client's eligibility for LTC services (institutional, waiver or hospice).

(1) Refer to WAC ((~~388-513-1330~~)) 182-513-1330 for rules related to available income for legally married couples.

(2) The ((~~department~~)) agency must apply the following rules when determining income eligibility for SSI-related LTC services:

(a) WAC 182-512-0600 Definition of income;

(b) WAC 182-512-0650 Available income;

(c) WAC 182-512-0700 Income eligibility;

(d) WAC 182-512-0750 Countable unearned income;

(e) WAC ((~~182-514-0840(3)~~)) 182-512-0840(3) Self-employment income-allowable expenses;

(f) WAC ((~~388-513-1315(15)~~)) 182-513-1315, Eligibility for long-term care (institutional, HCB waiver, and hospice) services; and

(g) WAC ((~~388-450-0155, 388-450-0156, 388-450-0160~~)) 182-512-0785, 182-512-0790, 182-512-0795, and 182-509-0155 for sponsored immigrants and how to determine if sponsors' income counts in determining benefits.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-513-1330 Determining available income for legally married couples for long-term care (LTC) services (institutional HCB waiver and hospice). This section describes income the ((~~department~~)) agency considers available when determining a legally married client's eligibility for LTC services.

(1) The ((~~department~~)) agency must apply the following rules when determining income eligibility for LTC services:

(a) WAC 182-512-0600, definition of income SSI-related medical;

(b) WAC 182-512-0650, available income;

(c) WAC 182-512-0700, income eligibility;

(d) WAC 182-512-0750, countable unearned income;

(e) WAC 182-512-0840(3), self-employment income-allowance expenses;

(f) WAC 182-512-0960((~~,~~)) SSI-related medical ((~~clients~~))—Allocating income—Determining eligibility for a spouse when the other spouse receives long-term services and supports (LTSS); and

(g) WAC ((~~388-513-1315,~~)) 182-513-1315 Eligibility for long-term care (institutional, HCB waiver, and hospice) services.

(2) For an institutionalized ((~~client married to a community spouse who is not applying or approved for LTC services, the department~~)) spouse, the agency considers the following income available, unless subsection (4) applies:

(a) Income received in the ((~~client's~~)) institutionalized spouse's name;

(b) Income paid to a representative on the ((~~client's~~)) institutionalized spouse's behalf;

(c) One-half of the income received in the names of both spouses; and

(d) Income from a trust as provided by the trust.

(3) The ((~~department~~)) agency considers the following income unavailable to an institutionalized ((~~client~~)) spouse:

(a) Separate or community income received in the name of the community spouse; and

(b) Income established as unavailable through a court order.

(4) For the determination of eligibility only, if available income described in subsection((~~s~~)) (2)(a) through (d) of this section minus income exclusions described in WAC ((~~388-513-1340~~)) 182-513-1340, exceeds the special income level (SIL)((~~, then~~)):

(a) The ((~~department~~)) agency follows community property law when determining ownership of income;

(b) Presumes all income received after marriage by either or both spouses to be community income; ((~~and~~))

(c) Considers one-half of all community income available to the institutionalized ((~~client.~~)) spouse; and

(d) If the total of ((~~subsection (4)~~)) (c) of this subsection plus the ((~~client's~~)) institutionalized spouse's own income is over the SIL, follow subsection (2) of this section; do not determine available income using this subsection.

(5) ((~~The department considers income generated by a transferred resource to be the separate income of the person or entity to which it is transferred.~~

((~~(6) The department~~)) The agency considers a stream of income, not generated by a transferred resource, available to the ((~~client not generated by a transferred resource available to the client~~)) institutionalized spouse, even when the ((~~client~~)) institutionalized spouse transfers or assigns the rights to the stream of income to:

(a) The community spouse; or

(b) A trust for the benefit of ((~~their~~)) the community spouse.

(((~~(8) The department~~)) (6) The agency evaluates ((~~the transfer of a resource described in subsection (5) according to WAC 388-513-1363, 388-513-1364, and 388-513-1365 to determine whether a penalty period of ineligibility is required~~)) income and resource transfers under WAC 182-513-1363.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-513-1340 Determining excluded income for long-term care (LTC) services. This section describes income the ((~~department~~)) agency excludes when determining a ((~~client's~~)) person's eligibility and participation in the cost of care for LTC services with the exception described in subsection (31) of this section.

(1) Crime victim's compensation;

(2) Earned income tax credit (EITC) for twelve months after the month of receipt;

(3) Native American benefits excluded by federal statute (refer to WAC ((~~388-450-0040~~)) 182-512-0700);

(4) Tax rebates or special payments excluded by other statutes;

(5) Any public agency's refund of taxes paid on real property and/or on food;

(6) Supplemental security income (SSI) and certain state public assistance based on financial need;

(7) The amount a representative payee charges to provide services when the services are a requirement for the ((~~client~~)) person to receive the income;

(8) The amount of expenses necessary for a ((~~client~~)) person to receive compensation, e.g., legal fees necessary to obtain settlement funds;

(9) ((~~Any portion of a grant, scholarship, or fellowship used to pay tuition, fees, and/or other necessary educational expenses at any educational institution~~)) Education benefits described in WAC 182-509-0335;

(10) Child support payments received from an absent parent for a child living in the home are considered the income of the child;

(11) Self-employment income allowed as a deduction by the Internal Revenue Service (IRS);

(12) Payments to prevent fuel cut-offs and to promote energy efficiency that are excluded by federal statute;

(13) Assistance (other than wages or salary) received under the Older Americans Act;

(14) Assistance (other than wages or salary) received under the foster grandparent program;

(15) Certain cash payments a ((~~client~~)) person receives from a governmental or nongovernmental medical or social service agency to pay for medical or social services;

(16) Interest earned on excluded burial funds and any appreciation in the value of an excluded burial arrangement that are left to accumulate and become part of the separately identified burial funds set aside;

(17) Tax exempt payments received by Alaska natives under the Alaska Native Settlement Act established by P.L. 100-241;

(18) Compensation provided to volunteers in ACTION programs under the Domestic Volunteer Service Act of 1973 established by P.L. 93-113;

(19) Payments made from the Agent Orange Settlement Fund or any other funds to settle Agent Orange liability claims established by P.L. 101-201;

(20) Payments made under section six of the Radiation Exposure Compensation Act established by P.L. 101-426;

(21) Payments made under the Energy Employee Occupational Compensation Program Act of 2000, (EEOICPA) Pub. L. 106-398;

(22) Restitution payment, and interest earned on such payment to a civilian of Japanese or Aleut ancestry established by P.L. 100-383;

(23) Payments made under sections 500 through 506 of the Austrian General Social Insurance Act;

(24) Payments made from *Susan Walker v. Bayer Corporation, et, al*., 95-C-5024 (N.D. Ill.) (May 8, 1997) settlement funds;

(25) Payments made from the Ricky Ray Hemophilia Relief Fund Act of 1998 established by P.L. 105-369;

(26) Payments made under the Disaster Relief and Emergency Assistance Act established by P.L. 100-387;

(27) Payments made under the Netherlands' Act on Benefits for Victims of Persecution (WUV);

(28) Payments made to certain survivors of the Holocaust under the Federal Republic of Germany's Law for Compensation of National Socialist Persecution or German Restitution Act;

(29) Interest or dividends received by the ((~~client~~)) institutionalized individual is excluded as income. Interest or dividends received by the community spouse of an institutional individual is counted as income of the community spouse. Dividends and interest are returns on capital investments such as stocks, bonds, or savings accounts. Institutional status is defined in WAC ((~~388-513-1320~~)) 182-513-1320;

(30) Income received by an ineligible or nonapplying spouse from a governmental agency for services provided to an eligible ((~~client~~)) person, e.g., chore services;

(31) Department of Veterans Affairs benefits designated for:

(a) The veteran's dependent when determining LTC eligibility for the veteran. The VA dependent allowance is considered countable income to the dependent unless it is paid due to unusual medical expenses (UME);

(b) Unusual medical expenses, aid and attendance allowance, special monthly compensation (SMC) and housebound allowance, with the exception described in subsection (32) of this section;

(32) Benefits described in subsection (31)(b) of this section for a ((~~client~~)) person who receives long-term care services are excluded when determining eligibility, but are considered available as a third-party resource (TPR) when deter-

mining the amount the ((~~client~~)) institutionalized individual contributes in the cost of care.

(33) Any other income excluded by federal law.

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 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-513-1345 Determining disregarded income for institutional or hospice services under the medically needy (MN) program. This section describes income the ((~~department~~)) agency disregards when determining a ((~~client's~~)) person's eligibility for institutional or hospice services under the MN program. The ((~~department~~)) agency considers disregarded income available when determining a ((~~client's~~)) person's participation in the cost of care.

(1) The ((~~department~~)) agency disregards the following income amounts in the following order:

(a) Income that is not reasonably anticipated, or is received infrequently or irregularly, when such income does not exceed:

(i) Twenty dollars per month if unearned; or

(ii) Ten dollars per month if earned.

(b) The first twenty dollars per month of earned or unearned income, unless the income paid to a ((~~client~~)) person is:

(i) Based on need; and

(ii) Totally or partially funded by the federal government or a private agency.

(2) For a ((~~client~~)) person who is related to the supplemental security income (SSI) program as described in WAC 182-512-0050(1), the first sixty-five dollars per month of earned income not excluded under WAC ((~~388-513-1340~~)) 182-513-1340, plus one-half of the remainder.

(3) Department of Veterans Affairs benefits designated for:

(a) The veteran's dependent when determining LTC eligibility for the veteran. The VA dependent allowance is considered countable income to the dependent unless it is paid due to unusual medical expenses (UME);

(b) Unusual medical expenses, aid and attendance allowance, special monthly compensation (SMC) and housebound allowance, with the exception described in subsection (4) of this section.

(4) Benefits described in subsection (3)(b) of this section for a ((~~client~~)) person who receives long-term care services are excluded when determining eligibility, but are considered available as a third-party resource (TPR) when determining the amount the ((~~client~~)) person contributes in the cost of care.

(5) Income the Social Security Administration (SSA) withholds from SSA Title II benefits for the recovery of an SSI overpayment.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-513-1350 Defining the resource standard and determining resource eligibility for SSI-related 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 (9) through (12) of this section; or~~

~~(b) Three thousand dollars for a legally married couple, unless subsection (4) of this section applies.~~

~~(2) Effective January 1, 2012 if an individual purchases a qualified long-term care partnership policy approved by the Washington insurance commissioner under the Washington long-term care partnership program, the department allows the individual with the long-term care partnership policy to retain a higher resource amount based on the dollar amount paid out by a partnership policy. This is described in WAC 388-513-1400.~~

~~(3) 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.~~

~~(4) 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.~~

~~(5) 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.~~

~~(6) When a single institutionalized individual marries, the department will redetermine eligibility applying the rules for a legally married couple.~~

~~(7) The department applies the following rules when determining available resources for LTC services:~~

~~(a) WAC 182-512-0300, Resource eligibility;~~

~~(b) WAC 182-512-0250, How to determine who owns a resource; and~~

~~(c) WAC 388-470-0060, Resources of an alien's sponsor.~~

~~(8) 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 182-512-0350 through 182-512-0550 and resources excluded by federal law with the exception of:~~

~~(i) WAC 182-512-0550 pension funds owned by an:~~

(I) Ineligible spouse. Pension funds are defined as funds held in an individual retirement account (IRA) as described by the IRS code; or

(II) Work-related pension plan (including plans for self-employed individuals, known as Keogh plans).

(ii) WAC 182-512-0350 (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 (3), (6) and (9)(a) or (b) apply, but not if subsection (4) or (5) 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. Expenses for nursing facility care are reduced at the state rate for the facility that the client owes the expense to.

(ii) As long as the incurred medical expenses:

(A) Were not incurred more than three months before the month of the medicaid application;

(B) Are not subject to third-party payment or reimbursement;

(C) Have not been used to satisfy a previous spend down liability;

(D) Have not previously been used to reduce excess resources;

(E) Have not been used to reduce client responsibility toward cost of care;

(F) Were not incurred during a transfer of asset penalty described in WAC 388-513-1363, 388-513-1364, and 388-513-1365; and

(G) 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 assisted living facility 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 based on the number of days in the medical institution in the month.

(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 countable income, the combined total is less than the:

(A) State medical institution rate based on the number of days in the medical institution in the month, plus the amount of recurring medical expenses; or

(B) State hospice rate based on the number of days in the medical institution in the month plus the amount of recurring medical expenses, 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.

(9) 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.

(10) If subsection (9)(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 may change 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 first day of the month of the current period of institutional status, up to the amount described in subsection (10)(a) of this section; or~~

~~(ii) The state spousal resource standard of forty-eight thousand six hundred thirty-nine dollars (this standard may change every odd year on July 1st). This standard 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.~~

~~(c) Resources are verified on the first moment of the first day of the month institutionalization began as described in WAC 182-512-0300(1).~~

~~(11) The amount of the spousal share described in (10)(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.~~

~~(12) The amount of allocated resources described in subsection (10) 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.~~

~~(13) The department considers resources of the community spouse unavailable to the institutionalized spouse the month after eligibility for LTC services is established, unless subsection (6) or (14)(a), (b), or (c) of this section applies.~~

~~(14) A redetermination of the couple's resources as described in subsection (8) is required, if:~~

~~(a) The institutionalized spouse has a break of at least thirty consecutive days in a period of institutional status; or~~

~~(b) The institutionalized spouse's countable resources exceed the standard described in subsection (1)(a), if subsection (9)(b) applies; or~~

~~(c) The institutionalized spouse does not transfer the amount described in subsections (10) or (12) to the community spouse by either:~~

~~(i) The end of the month of 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.~~)) (1) General information.

(a) This section describes how the agency defines the resource standard and countable or excluded resources when determining a person's eligibility for SSI-related LTC services.

(b) The agency uses the term "resource standard" to describe the maximum amount of resources a person can have and still be resource eligible for program benefits.

(c) For a person not related to SSI, the agency applies the program specific resource rules to determine eligibility.

(d) Institutional resource standards are found at: http://www.hca.wa.gov/medicaid/eligibility/pages/standards.aspx.

(2) Resource standards.

(a) The resource standard for the following people is two thousand dollars:

(i) A single person; or

(ii) A legally married institutionalized spouse. (Determine the amount of resources allocated to the community spouse under WAC 182-513-1355.)

(b) The resource standard for a legally married couple is three thousand dollars, unless subsection (3)(b)(ii) of this section applies.

(c) The resource standard for a person with a qualified long-term care partnership policy under WAC 182-513-1400 may be higher based on the dollar amount paid out by a partnership policy.

(d) Determining the amount of resources that can be allocated to the community spouse when determining resource eligibility is under WAC 182-513-1355.

(3) Availability of resources.

(a) General. The agency applies the following rules when determining available resources for LTC services:

(i) WAC 182-512-0300 SSI-related medical—Resources eligibility;

(ii) WAC 182-512-0250 SSI-related medical—Ownership and availability of resources; and

(iii) WAC 182-512-0260 SSI-related medical—How to count a sponsor's resources.

(b) Married couples.

(i) When both spouses apply for LTC services, the agency considers the resources of both spouses available to each other through the month in which the spouses stopped living together.

(ii) When both spouses are institutionalized, the agency determines the eligibility of each spouse as a single person the month following the month of separation.

(iii) If the agency 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 institutionalized spouse, then the agency applies the standard described in subsection (2)(a) of this section to each spouse. If doing this would make one of the spouses ineligible, then the agency applies subsection (2)(b) of this section for a couple.

(iv) The agency considers resources of the community spouse unavailable to the institutionalized spouse the month after eligibility for LTC services is established, unless (v) or (vi) of this subsection applies.

(v) When a single institutionalized person marries, the agency redetermines eligibility applying the rules for a legally married couple.

(vi) A redetermination of the couple's resources under this section 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 under subsection (2)(a) of this section, if WAC 182-513-1355 (1)(b) applies; or

(C) The institutionalized spouse does not transfer the amount, under WAC 182-513-1355 (2) or (4), to the community spouse by either:

(I) The end of the month of 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.

(4) Countable resources.

(a) The agency determines countable resources using the following sections:

(i) WAC 182-512-0350 SSI-related medical—Property and contracts excluded as resources;

(ii) WAC 182-512-0400 SSI-related medical—Vehicles excluded as resources;

(iii) WAC 182-512-0450 SSI-related medical—Life insurance excluded as a resource; and

(iv) WAC 182-512-0500 SSI-related medical—Burial funds, contracts and spaces excluded as resources.

(b) The agency determines excluded resources based on federal law and WAC 182-512-0550 SSI-related medical—All other excluded resources, with the following exceptions:

(i) For institutional and HCB waiver programs, pension funds owned by a nonapplying spouse are counted toward the resource standard.

(ii) WAC 182-512-0350 (1)(b), one home. For long-term services and supports (LTSS), one home is excluded only if it meets the home equity limits of subsection (8) of this section.

(c) The agency adds together the countable resources of both spouses if subsections (3)(b)(i) and (iv) apply, but not if subsection (3)(b)(ii) or (iii) apply. For a person with a community spouse, see WAC 182-513-1355.

(5) Excess resources.

(a) For LTC programs, a person may reduce resources over the standard by allowing deductions for incurred medical expenses as described in subsection (6) of this section;

(b) The amount of excess resources is limited to the following amounts:

(i) For LTC services provided under the categorically needy (CN) program:

(A) Gross nonexcluded income must be at or below the special income level (SIL).

(B) In a medical institution, excess resources and gross nonexcluded income must be under the state medicaid rate based on the number of days in the medical institution in the month.

(C) For HCB waiver eligibility, incurred medical expenses must reduce resources within allowable resource standards. The cost of care for the HCB waiver services cannot be allowed as a projected expense.

(ii) For LTC services provided under the medically needy (MN) program, see:

(A) WAC 182-513-1395 for LTC programs; and

(B) WAC 182-513-1245 for hospice.

(6) Allowable medical expenses.

(a) The following incurred medical expenses are allowed to reduce excess resources:

(i) Premiums, deductibles, and coinsurance or copayment charges for health insurance and medicare;

(ii) Medically necessary care recognized under state law, but not covered under the state's medicaid plan;

(iii) Medically necessary care covered under the state's medicaid plan incurred prior to medicaid eligibility. Expenses for nursing facility care are reduced at the state rate for the specific facility that is owed the expense.

(b) To be allowed, the medical expense must meet the following criteria. The expense:

(i) Was not incurred more than three months before the month of the medicaid application;

(ii) Is not subject to third-party payment or reimbursement;

(iii) Has not been used to satisfy a previous spenddown liability;

(iv) Has not previously been used to reduce excess resources;

(v) Has not been used to reduce participation;

(vi) Was not incurred during a transfer of asset penalty under WAC 182-513-1363; and

(vii) Is an amount for which the person remains liable.

(7) Nonallowable medical expenses. The following expenses are not allowed to reduce excess resources:

(a) Unpaid expenses prior to HCB waiver eligibility to an adult family home (AFH) or assisted living facility;

(b) Personal care cost in excess of approved hours determined by the CARE assessment described in chapter 388-106 WAC; and

(c) Expenses excluded by federal law.

(8) Excess home equity.

(a) A person with an equity interest in his or her primary residence in excess of the home equity limit is ineligible for long-term services and supports (LTSS) unless one of the following persons lawfully resides in the home:

(i) The applicant's spouse; or

(ii) A blind, disabled, or dependent child under age twenty-one.

(b) The home equity provision applies to all applications for LTSS received on or after May 1, 2006.

(c) A person's equity interest equals the fair market value of the home minus encumbrances.

(d) Effective January 1, 2015, the excess home equity limit is five hundred fifty-two thousand dollars. On January 1, 2016, and on January 1 of each year thereafter, this standard may change by the percentage in the consumer price index-urban (CPIU).

(e) A person who is denied or terminated LTC services due to excess home equity may apply for an undue hardship waiver under WAC 182-513-1367.

NEW SECTION

WAC 182-513-1355 Determining the amount of resources allocated to the community spouse when determining resource eligibility for long-term services and supports (LTSS) under WAC 182-513-1350. (1) For legally married people when only one spouse meets institutional status, the following rules apply. If the person's current period of institutional status began:

(a) Before October 1, 1989, the agency adds together one-half the total amount of countable resources held in the name of:

(i) The institutionalized spouse; and

(ii) Both spouses.

(b) On or after October 1, 1989, the agency adds together the total amount of nonexcluded resources held in the name of:

(i) Either spouse; and

(ii) Both spouses.

(2) If subsection (1)(b) of this section applies, the agency determines the amount of resources allocated to the community spouse, before determining countable resources used to establish eligibility for the institutionalized spouse under WAC 182-513-1350, as follows:

(a) If the person's current period of institutional status began on or after October 1, 1989, and before August 1, 2003, the agency allocates the maximum amount of resources ordinarily allowed by law; or

(b) If the person's current period of institutional status began on or after August 1, 2003, the agency allocates the greater of:

(i) A spousal share equal to one-half of the couple's combined countable resources as of the first day of the month of the current period of institutional status, up to the amount described in subsection (2)(a) of this section; or

(ii) The state spousal resource standard.

(c) Resources are verified on the first moment of the first day of the month institutionalization began under WAC 182-512-0300(1).

(3) The amount of the spousal share described in subsection (2)(b)(i) of this section can be determined anytime between the date that the current period of institutional status began and the date that eligibility for LTSS is determined. The following rules apply to the determination of the spousal share:

(a) Prior to an application for LTSS, 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 LTSS if the person was institutionalized prior to the month of application, and declares the spousal share exceeds the state spousal resource standard. The person is required to provide verification of the couple's combined countable resources held at the beginning of the current period of institutional status.

(4) The amount of allocated resources described in subsection (2) 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 an administrative hearing under chapter 182-526 WAC, that the amount is inadequate to provide a minimum monthly maintenance needs amount for the community spouse.

(5) The institutionalized spouse has until the end of the month of the first regularly scheduled eligibility review to transfer joint resources in excess of two thousand dollars to his or her community spouse

(6) Standards in this section are located at: http://www.hca.wa.gov/medicaid/eligibility/pages/standards.aspx.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-513-1363 Evaluating the transfer of assets ((~~on or after May 1, 2006 for persons~~)) for people applying for or receiving long-term care (LTC) services. ((~~This section describes how the department evaluates asset transfers made on or after May 1, 2006 and their affect on LTC services. This applies to transfers by the client, spouse, a guardian or through an attorney in fact. Clients subject to asset transfer penalty periods are not eligible for LTC services. LTC services for the purpose of this rule include nursing facility services, services offered in any medical institution equivalent to nursing facility services, and home and community-based services furnished under a waiver program. Program of all-inclusive care of the elderly (PACE) and hospice services are not subject to transfer of asset rules. The department must consider whether a transfer made within a specified time before the month of application, or while the client is receiving LTC services, requires a penalty period.~~

~~• Refer to WAC 388-513-1364 for rules used to evaluate asset transfers made on or after April 1, 2003 and before May 1, 2006.~~

~~• Refer to WAC 388-513-1365 for rules used to evaluate asset transfer made prior to April 1, 2003.~~

~~(1) When evaluating the effect of the transfer of asset made on or after May 1, 2006 on the client's eligibility for LTC services the department counts sixty months before the month of application to establish what is referred to as the "look-back" period.~~

~~(2) The department does not apply a penalty period to transfers meeting the following conditions:~~

(a) The total of all gifts or donations transferred do not exceed the average daily private nursing facility rate in any month;

(b) The transfer is an excluded resource described in WAC 388-513-1350 with the exception of the client's home, unless the transfer of the home meets the conditions described in subsection (2)(d);

(c) The asset is transferred for less than fair market value (FMV), if the client can provide evidence to the department of one of the following:

(i) An intent to transfer the asset at FMV or other adequate compensation. To establish such an intent, the department must be provided with written evidence of attempts to dispose of the asset for fair market value as well as evidence to support the value (if any) of the disposed asset.

(ii) The transfer is not made to qualify for LTC services, continue to qualify, or avoid Estate Recovery. Convincing evidence must be presented regarding the specific purpose of the transfer.

(iii) All assets transferred for less than fair market value have been returned to the client.

(iv) The denial of eligibility would result in an undue hardship as described in WAC 388-513-1367.

(d) The transfer of ownership of the client's home, if it is transferred to the client's:

(i) Spouse; or

(ii) Child, who:

(A) Meets the disability criteria described in WAC 182-512-0050 (1)(b) or (c); or

(B) Is less than twenty-one years old; or

(C) Lived in the home for at least two years immediately before the client's current period of institutional status, and provided verifiable care that enabled the individual to remain in the home. A physician's statement of needed care is required; or

(iii) Brother or sister, who has:

(A) Equity in the home, and

(B) Lived in the home for at least one year immediately before the client's current period of institutional status.

(e) The asset is transferred to the client's spouse or to the client's child, if the child meets the disability criteria described in WAC 182-512-0050 (1)(b) or (c);

(f) The transfer meets the conditions described in subsection (3), and the asset is transferred:

(i) To another person for the sole benefit of the spouse;

(ii) From the client's spouse to another person for the sole benefit of the spouse;

(iii) To trust established for the sole benefit of the individual's child who meets the disability criteria described in WAC 182-512-0050 (1)(b) or (c);

(iv) To a trust established for the sole benefit of a person who is sixty-four years old or younger and meets the disability criteria described in WAC 182-512-0050 (1)(b) or (c); or

(3) The department considers the transfer of an asset or the establishment of a trust to be for the sole benefit of a person described in subsection (2)(f), if the transfer or trust:

(a) Is established by a legal document that makes the transfer irrevocable;

(b) Provides that no individual or entity except the spouse, blind or disabled child, or disabled individual can benefit from the assets transferred in any way, whether at the time of the transfer or at any time during the life of the primary beneficiary; and

(c) Provides for spending all assets involved for the sole benefit of the individual on a basis that is actuarially sound based on the life expectancy of that individual or the term of the trust, whichever is less; and

(d) The requirements in subsection (2)(c) of this section do not apply to trusts described in WAC 388-561-0100 (6)(a) and (b) and (7)(a) and (b).

(4) The department does not establish a period of ineligibility for the transfer of an asset to a family member prior to the current period of long-term care service if:

(a) The transfer is in exchange for care services the family member provided the client;

(b) The client has a documented need for the care services provided by the family member;

(c) The care services provided by the family member are allowed under the medicaid state plan or the department's waiver services;

(d) The care services provided by the family member do not duplicate those that another party is being paid to provide;

(e) The FMV of the asset transferred is comparable to the FMV of the care services provided;

(f) The time for which care services are claimed is reasonable based on the kind of services provided; and

(g) Compensation has been paid as the care services were performed or with no more time delay than one month between the provision of the service and payment.

(5) The department considers the transfer of an asset in exchange for care services given by a family member that does not meet the criteria as described under subsection (4) as the transfer of an asset without adequate consideration.

(6) If a client or the client's spouse transfers an asset within the look-back period without receiving adequate compensation, the result is a penalty period in which the individual is not eligible for LTC services.

(7) If a client or the client's spouse transfers an asset on or after May 1, 2006, the department must establish a penalty period by adding together the total uncompensated value of all transfers made on or after May 1, 2006. The penalty period:

(a) For a LTC services applicant, begins on the date the client would be otherwise eligible for LTC services based on an approved application for LTC services or the first day after any previous penalty period has ended; or

(b) For a LTC services recipient, begins the first of the month following ten-day advance notice of the penalty period, but no later than the first day of the month that follows three full calendar months from the date of the report or discovery of the transfer; or the first day after any previous penalty period has ended; and

(c) Ends on the last day of the number of whole days found by dividing the total uncompensated value of the assets by the statewide average daily private cost for nursing facilities at the time of application or the date of transfer, whichever is later.

(8) If an asset is sold, transferred, or exchanged, the portion of the proceeds:

~~(a) That is used within the same month to acquire an excluded resource described in WAC 388-513-1350 does not affect the client's eligibility;~~

~~(b) That remain after an acquisition described in subsection (8)(a) becomes an available resource as of the first day of the following month.~~

~~(9) If the transfer of an asset to the client's spouse includes the right to receive a stream of income not generated by a transferred resource, the department must apply rules described in WAC 388-513-1330 (5) through (7).~~

~~(10) If the transfer of an asset for which adequate compensation is not received is made to a person other than the client's spouse and includes the right to receive a stream of income not generated by a transferred resource, the length of the penalty period is determined and applied in the following way:~~

~~(a) The total amount of income that reflects a time frame based on the actuarial life expectancy of the client who transfers the income is added together;~~

~~(b) The amount described in subsection (10)(a) is divided by the statewide average daily private cost for nursing facilities at the time of application; and~~

~~(c) A penalty period equal to the number of whole days found by following subsections (7)(a), (b), and (c).~~

~~(11) A penalty period for the transfer of an asset that is applied to one spouse is not applied to the other spouse, unless both spouses are receiving LTC services. When both spouses are receiving LTC services;~~

~~(a) We divide the penalty between the two spouses.~~

~~(b) If one spouse is no longer subject to a penalty (e.g. the spouse is no longer receiving institutional services or is deceased) any remaining penalty that applies to both spouses must be served by the remaining spouse.~~

~~(12) If a client or the client's spouse disagrees with the determination or application of a penalty period, that person may request a hearing as described in chapter 388-02 WAC.~~

~~(13) Additional statutes which apply to transfer of asset penalties, real property transfer for inadequate consideration, disposal of realty penalties, and transfers to qualify for assistance can be found at:~~

~~(a) RCW 74.08.331 Unlawful practices—Obtaining assistance—Disposal of realty;~~

~~(b) RCW 74.08.338 Real property transfers for inadequate consideration;~~

~~(c) RCW 74.08.335 Transfers of property to qualify for assistance; and~~

~~(d) RCW 74.39A.160 Transfer of assets—Penalties.~~))

(1) When determining a person's eligibility for long-term care (LTC) services, the agency must evaluate the effect of an asset transfer made within the sixty-month period before the month that the person:

(a) Attained institutional status, or would have attained institutional status; and

(b) Has applied for LTC services.

(2) The agency must evaluate all transfers for recipients of LTC services made on or after the month the recipient attained institutional status.

(3) The agency establishes a period of ineligibility during which the person is not eligible for LTC services if the person, the person's spouse, or someone acting on behalf of either:

(a) Transfers an asset within the time period described in subsection (1) or (2) of this section; and

(b) Does not receive adequate compensation for the asset, unless the transfer meets one of the conditions in subsection (4)(a) through (g) of this section.

(4) The agency does not apply a period of ineligibility because of an uncompensated transfer if:

(a) The total of all transfers in a month does not exceed the average daily private nursing facility rate in that month;

(b) The transfer is an excluded resource under WAC 182-513-1350 with the exception of a home, unless the transfer of the home meets the conditions described in (d) of this subsection;

(c) The asset is transferred for less than fair market value (FMV), and the person can establish one of the following:

(i) An intent to transfer the asset at FMV. To establish such an intent, the agency must be provided with convincing evidence of the attempt to dispose the asset for FMV;

(ii) The transfer is not made to qualify for medicaid, continue to qualify for medicaid, or avoid estate recovery. Convincing evidence must be presented regarding the specific purpose of the transfer;

(iii) All assets transferred for less than FMV have been returned to the person or his or her spouse;

(iv) The denial of eligibility would result in an undue hardship under WAC 182-513-1367;

(d) The asset transferred is a home, if the home is transferred to the person's:

(i) Spouse;

(ii) Child who meets the disability criteria under WAC 182-512-0050 (1)(b) or (c);

(iii) Child who is less than age twenty-one; or

(iv) Child who lived in the home and provided care, if:

(A) The child lived in the person's home for at least two years;

(B) The child provided verifiable care during the time period in (d)(iv)(A) of this subsection for at least two years;

(C) The period of care described in (d)(iv)(B) of this subsection is immediately before the person's current period of institutional status;

(D) The care was not paid for by medicaid;

(E) The care enabled the person to remain in his or her home; and

(F) The person provided physician's documentation that the in-home care was necessary to prevent the person's current period of institutional status; or

(v) Sibling, who has lived in and has had an equity interest in the home for at least one year immediately before the date the person became an institutionalized individual.

(e) The asset is transferred to the person's spouse; or to the person's child, if the child meets the disability criteria under WAC 182-512-0050 (1)(b) or (c);

(f) The transfer is to a family member prior to the current period of institutional status, and all the following conditions are met. If all the following conditions are not met, the transfer is an uncompensated transfer:

(i) The transfer is in exchange for care services the family member provided to the person;

(ii) The person had a documented need for the care services provided by the family member;

(iii) The care services provided by the family member are allowed under the medicaid state plan or the department's home and community based waiver services;

(iv) The care services provided by the family member do not duplicate those that another party is being paid to provide;

(v) The FMV of the asset transferred is comparable to the FMV of the care services provided;

(vi) The time for which care services are claimed is reasonable based on the kind of services provided; and

(vii) The assets were transferred as the care services were performed, or with no more time delay than one month between the provision of the service and the transfer.

(g) The transfer meets the conditions described in subsection (5) of this section, and the asset is transferred:

(i) To another party for the sole benefit of the person's spouse;

(ii) From the person's spouse to another party for the sole benefit of the spouse;

(iii) To a trust established for the sole benefit of the person's child who meets the disability criteria under WAC 182-512-0050 (1)(b) or (c);

(iv) To a trust established for the sole benefit of a person who is age sixty-four or younger who meets the disability criteria under WAC 182-512-0050 (1)(b) or (c).

(5) The agency determines the transfer of an asset or the establishment of a trust to be for the sole benefit of a person described in subsection (4)(g) of this section, if the transfer or trust is established by a legal document that makes the transfer irrevocable, and the document:

(a) Provides that only the person's spouse, blind or disabled child, or another disabled person can benefit from the assets transferred; and

(b) Provides for spending all assets involved for the sole benefit of the person who is actuarially sound, based on the life expectancy of that person or the term of the document, whichever is less, unless the document is a trust that meets the conditions under WAC 182-516-0100 (6)(a), (b), (7)(a), or (b).

(6) The period of ineligibility described in subsection (3) of this section is calculated by:

(a) Adding together the total uncompensated value of all transfers under subsection (3) of this section; and

(b) Dividing the total in (a) of this subsection by the statewide average daily private cost for nursing facilities at the time of application or the date of transfer, whichever is later. The result is the length, in days rounded down to the nearest whole day, of the period of ineligibility;

(7) The period of ineligibility calculated in subsection (6) of this section begins:

(a) For a LTC services applicant: The date the person would be otherwise eligible for LTC services, but for the transfer, based on an approved application for LTC services or the first day after any previous period of ineligibility has ended; or

(b) For a LTC services recipient: The first of the month following ten-day advance notice of the period of ineligibility, but no later than the first day of the month that follows three full calendar months from the date of the report or discovery of the transfer; or the first day after any previous period of ineligibility has ended; and

(8) The period of ineligibility ends after the number of whole days, calculated in subsection (6) of this section, elapse from the date the period of ineligibility began in subsection (7) of this section.

(9) If the transfer is to the person's spouse, and it includes the right to receive an income stream, the agency determines availability of the income stream under WAC 182-513-1330 (5) and (6).

(10) If the transfer of an asset for which adequate compensation is not received is made to someone other than the person's spouse and includes the right to receive a stream of income not generated by the transferred asset, the length of the period of ineligibility is calculated and applied in the following way:

(a) The amount of reasonably anticipated future monthly income, after the transfer, is multiplied by the actuarial life expectancy (in months) of the person who owned the income. The actuarial life expectancy is based on age of the person in the month the transfer occurs;

(b) The amount in (a) of this subsection is divided by the statewide average daily private cost for nursing facilities at the time of application or the date of transfer, whichever is later. The result is the length, in days rounded down to the nearest whole day, of the period of ineligibility; and

(c) The period of ineligibility will begin under subsection (7) of this section and end under subsection (8) of this section.

(11) A period of ineligibility for the transfer of an asset that is applied to one spouse is not applied to the other spouse, unless both spouses have attained institutional status. When both spouses are institutionalized, the agency divides the penalty equally between the two spouses. If one spouse is no longer subject to a period of ineligibility, the remaining period of ineligibility that applied to both spouses will be applied to the other spouse.

(12) If a person or his or her spouse disagrees with the determination or application of a period of ineligibility, that person may request a hearing under chapter 182-526 WAC.

(13) Additional statutes that apply to transfer of asset penalties, real property transfer for inadequate consideration, disposal of realty penalties, and transfers to qualify for assistance can be found at:

(a) RCW 74.08.331 Unlawful practices—Obtaining assistance—Disposal of realty—Penalties;

(b) RCW 74.08.338 Real property transfers for inadequate consideration;

(c) RCW 74.08.335 Transfers of property to qualify for assistance; and

(d) RCW 74.39A.160 Transfer of assets—Penalties.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-513-1367 Hardship waivers for long-term care (LTC) services. ((~~Clients~~)) People who are denied or terminated from LTC services due to a transfer of asset penalty (described in WAC ((~~388-513-1363, 388-513-1364 and 388-513-1365~~)) 182-513-1363), or having excess home

equity (described in WAC ((~~388-513-1350~~)) 182-513-1350) may apply for an undue hardship waiver. Notice of the right to apply for an undue hardship waiver will be given whenever there is a denial or termination based on an asset transfer or excess home equity. This section:

• Defines undue hardship;

• Specifies the approval criteria for an undue hardship request;

• Establishes the process the department follows for determining undue hardship; and

• Establishes the appeal process for a client whose request for an undue hardship is denied.

(1) When does undue hardship exist?

(a) Undue hardship may exist:

(i) When a transfer of an asset occurs between:

(A) Registered domestic partners as described in chapter 26.60 RCW; or

(B) Same-sex couples who were married in states and the District of Columbia where same-sex marriages are legal; and

(C) The transfer would not have caused a period of ineligibility if made between an opposite sex married couple under WAC ((~~388-513-1363~~)) 182-513-1363.

(ii) When a ((~~client~~)) person who transferred the assets or income, or on whose behalf the assets or income were transferred, either personally or through a spouse, guardian or attorney-in-fact, has exhausted all reasonable means including legal remedies to recover the assets or income or the value of the transferred assets or income that have caused a penalty period; and

(iii) The ((~~client~~)) person provides sufficient documentation to support their efforts to recover the assets or income; or

(iv) The ((~~client~~)) person is unable to access home equity in excess of the standard described in WAC ((~~388-513-1350~~)) 182-513-1350; and

(v) When, without LTC benefits, the ((~~client~~)) person is unable to obtain:

(A) Medical care to the extent that his or her health or life is endangered; or

(B) Food, clothing, shelter or other basic necessities of life.

(b) Undue hardship can be approved for an interim period while the client is pursuing recovery of the assets or income.

(2) Undue hardship does not exist:

(a) When the transfer of asset penalty period or excess home equity provision inconveniences a client or restricts their lifestyle but does not seriously deprive him or her as defined in subsection (1)(a)(iii) of this section;

(b) When the resource is transferred to a person who is handling the financial affairs of the ((~~client~~)) person; or

(c) When the resource is transferred to another person by the individual that handles the financial affairs of the ((~~client~~)) person.

(((~~d~~))) (3) Undue hardship may exist under subsection (2)(b) and (c) of this section if DSHS has found evidence of financial exploitation.

(((~~3~~))) (4) How is an undue hardship waiver requested?

(a) An undue hardship waiver may be requested by:

(i) The ((~~client~~)) person;

(ii) The ((~~client's~~)) person's spouse;

(iii) The ((~~client's~~)) person's authorized representative;

(iv) The ((~~client's~~)) person's power of attorney; or

(v) With the consent of the ((~~client or their~~)) person or his or her guardian, a medical institution, as defined in WAC ((~~182-500-0005~~)) 182-500-0050, in which an institutionalized ((~~client~~)) person resides.

(b) Request must:

(i) Be in writing;

(ii) State the reason for requesting the hardship waiver;

(iii) Be signed by the requestor and include the requestor's name, address and telephone number. If the request is being made on behalf of a ((~~client~~)) person, then the ((~~client's~~)) person's name, address and telephone number must be included;

(iv) Be made within thirty days of the date of denial or termination of LTC services; and

(v) Returned to the originating address on the denial/termination letter.

(((~~4~~))) (5) What if additional information is needed to determine a hardship waiver? (((~~a~~))) A written notice to the ((~~client~~)) person is sent requesting additional information within fifteen days of the request for an undue hardship waiver. Additional time to provide the information can be requested by the ((~~client~~)) person.

(((~~5~~))) (6) What happens if my hardship waiver is approved?

(a) The ((~~department~~)) agency sends a notice within fifteen days of receiving all information needed to determine a hardship waiver. The approval notice specifies a time period the undue hardship waiver is approved.

(b) Any changes in a ((~~client's~~)) person's situation that led to the approval of a hardship must be reported to the ((~~department by the tenth of the month following~~)) agency within thirty days of the change per WAC ((~~388-418-0007~~)) 182-504-0110.

(((~~6~~))) (7) What happens if my hardship waiver is denied?

(a) The ((~~department~~)) agency sends a denial notice within fifteen days of receiving the requested information. The letter will state the reason it was not approved.

(b) The denial notice will have instructions on how to request an administrative hearing. The ((~~department~~)) agency must receive an administrative hearing request within ninety days of the date of the adverse action or denial.

(((~~7~~))) (8) What statute or rules govern administrative hearings? (((~~a~~))) An administrative hearing held under this section is governed by chapters 34.05 RCW and ((~~chapter 388-02~~)) 182-526 WAC and this section. If a provision in this section conflicts with a provision in chapter ((~~388-02~~)) 182-526 WAC, the provision in this section governs.

(((~~8~~))) (9) Can the ((~~department~~)) agency revoke an approved undue hardship waiver? (((~~a~~))) The ((~~department~~)) agency may revoke approval of an undue hardship waiver if any of the following occur:

(((~~i~~))) (a) A ((~~client~~)) person, or his or her authorized representative, fails to provide timely information and/or resource verifications as it applies to the hardship waiver when requested by the ((~~department~~)) agency per WAC

((~~388-490-0005 and 388-418-0007~~)) 182-503-0050 and 182-504-0120 or 182-504-0125;

(((~~ii~~))) (b) The lien or legal impediment that restricted access to home equity in excess of five hundred thousand dollars is removed; or

(((~~iii~~))) (c) Circumstances for which the undue hardship was approved have changed.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-513-1380 Determining a ((~~client's~~)) person's financial participation in the cost of care for long-term care (LTC) services. This rule describes how the ((~~department~~)) agency allocates income and excess resources when determining participation in the cost of care (the post-eligibility process). The ((~~department~~)) agency applies rules described in WAC ((~~388-513-1315~~)) 182-513-1315 to define which income and resources must be used in this process.

(1) For a ((~~client~~)) person receiving institutional or hospice services in a medical institution, the ((~~department~~)) agency applies all subsections of this rule.

(2) For a ((~~client~~)) person receiving waiver services at home or in an alternate living facility, the ((~~department~~)) agency applies only those subsections of this rule that are cited in the rules for those programs.

(3) For a ((~~client~~)) person receiving hospice services at home, or in an alternate living facility, the ((~~department~~)) agency applies rules used for the community options program entry system (COPES) for hospice applicants with gross income under the medicaid special income level (SIL) (three hundred percent of the federal benefit rate (FBR)), if the ((~~client~~)) person is not otherwise eligible for another noninstitutional categorically needy medicaid program. (Note: For hospice applicants with income over the medicaid SIL, medically needy medicaid rules apply.)

(4) The ((~~department~~)) agency allocates nonexcluded income in the following order and the combined total of (((~~4~~))) (a), (b), (c), and (d) of this subsection cannot exceed the effective one-person medically needy income level (MNIL):

(a) A personal needs allowance (PNA) of:

(i) Seventy dollars for the following ((~~clients~~)) people 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~~)) subsection who receive a veteran's pension less than ninety dollars.

(iii) One hundred sixty dollars for a ((~~client~~)) person 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~~)) people in a medical institution receiving aged, blind, disabled, (ABD) or temporary assistance for needy families (TANF) cash assistance.

(v) For all other ((~~clients~~)) people in a medical institution the PNA is fifty-seven dollars and twenty-eight cents.

(vi) Current PNA and long-term care standards can be found at ((~~http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml~~)) http://www.hca.wa.gov/medicaid/Eligibility/Pages/index.aspx.

(b) Mandatory federal, state, or local income taxes owed by the ((~~client~~)) person.

(c) Wages for a ((~~client~~)) person who:

(i) Is related to the supplemental security income (SSI) program as described in WAC 182-512-0050(1); and

(ii) Receives the wages as part of ((~~a department-approved~~)) an agency-approved training or rehabilitative program designed to prepare the ((~~client~~)) person 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~~)) agency allocates nonexcluded income after deducting amounts described in subsection (4) of this section in the following order:

(a) Current or back child support garnished or withheld from income according to a child support order in the month of the garnishment if it is for the current month:

(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 may change each January based on the consumer price index. 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~~)) http://www.hca.wa.gov/medicaid/Eligibility/Pages/index.aspx. 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 may change annually on July 1st; 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~~)) person'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~~))) For each child, one hundred and fifty percent of the two-person FPL minus that child's income and divided by three (child support received from a noncustodial parent is considered the child's income). This standard is called the community spouse (CS) and family maintenance standard and can be found at: ((~~http://www.dshs.wa.gov/manuals/eaz/sections/LongTerm~~

~~Care/LTCstandardspna.shtml~~)) http://www.hca.wa.gov/medicaid/Eligibility/Pages/index.aspx.

(ii) Does not reside with the community spouse or institutionalized person, in an amount equal to the effective one-person 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~~)) institutionalized individual and not used to reduce excess resources. Allowable medical expenses and reducing excess resources are described in WAC ((~~388-513-1350~~)) 182-513-1350.

(e) Maintenance of the home of a single institutionalized ((~~client~~)) person 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 may change annually on July 1st and is found at: http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml; 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 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~~)) person 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.

(7) A person may have to pay third-party resources described in WAC 182-501-0200 in addition to the participation.

(8) A person is only responsible to participate up to the state rate for cost of care. If long-term care insurance pays a portion of the state rate cost of care, a person only participates the difference up to the state rate cost of care.

(9) Standards described in this section for long-term care can be found at: ((~~http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml~~)) http://www.hca.wa.gov/medicaid/Eligibility/Pages/index.aspx.

NEW SECTION

WAC 182-513-1385 Determining the spousal and dependent allocation allowed in post-eligibility treatment of income for Washington apple health long-term care (LTC) programs. (1) This section describes the calculation to determine the monthly maintenance-needs allowance in post-eligibility treatment of income for long-term care (LTC) programs for a community spouse or dependents of the institutionalized individual.

(2) The community spouse maintenance-needs allowance is found in the institutional section of the Washington apple health income and resource standards chart located at http://www.hca.wa.gov/medicaid/eligibility/pages/standards.aspx unless a greater amount is allocated as described in subsection (4) of this section. The allowance may change each January based on the consumer price index.

(3) The community spouse maintenance-needs allowance:

(a) Is allowed only to the extent that the institutionalized spouse's income is made available to the community spouse; and

(b) Consists of a combined total of both:

(i) One hundred fifty percent of the two-person federal poverty level (FPL). (This standard may change annually on July 1st); and

(ii) Excess shelter expenses. Excess shelter expenses are the actual required maintenance expenses for the community spouse's principal residence. To determine this amount:

(A) Add:

(I) Rent, including space rent for mobile homes;

(II) Mortgage;

(III) Real property taxes;

(IV) Homeowner's insurance;

(V) Required maintenance fees for a condominium, cooperative, or homeowner's association that are recorded in a covenant;

(VI) The food assistance standard utility allowance (SUA) under WAC 388-450-0195 minus the cost of any utilities that are included in (b)(ii)(A)(V) of this subsection.

(B) Subtract the standard shelter allocation from the total in (b)(ii)(A) of this subsection. The standard shelter allocation is thirty percent of one hundred fifty percent of the two-person FPL. This standard may change annually on July 1st.

(c) The total of (b) of this subsection is reduced by the community spouse's gross countable income.

(4) The amount allocated to the community spouse may be greater than the amount determined in subsection (3) of this section only if:

(a) There is a court order approving a higher amount for the support of the community spouse; or

(b) An administrative law judge determines a greater amount is needed because of exceptional circumstances resulting in extreme financial duress.

(5) The agency determines monthly maintenance-needs allowance for dependents of the institutionalized individual or his or her spouse. The amount the agency allows depends on whether the dependent resides with the community spouse.

(a) For each dependent who resides with the community spouse:

(i) Subtract the dependent's income from one hundred fifty percent of the two-person FPL;

(ii) Divide the amount determined in (a)(i) of this subsection by three;

(iii) The remainder is the amount that can be allocated to the dependent.

(b) For each dependent who does not reside with the community spouse:

(i) The agency determines the effective MNIL standard based on the number of dependent family members in the home;

(ii) Subtracts the dependent's separate income;

(iii) The difference is the amount that can be allocated to the dependents.

(c) Child support received from a noncustodial parent is considered the child's income.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-513-1395 Determining eligibility for institutional ((~~or hospice~~)) services for ((~~individuals~~)) people living in ((~~a~~)) medical institutions under the SSI-related medically needy ((~~(MN)~~)) program. ((~~This section describes how the department determines a client's eligibility for institutional or hospice services in a medical institution and for facility care only under the MN program. In addition, this section describes rules used by the department to determine whether a client approved for these benefits is also eligible for noninstitutional medical assistance in a medical institution under the MN program.~~

~~(1) To be eligible for institutional or hospice services under the MN program for individuals living in a medical institution, a client must meet the financial requirements described in subsection (5). In addition, a client must meet program requirements described in WAC 388-513-1315; and~~

~~(a) Be an SSI-related client with countable income as described in subsection (4)(a) that is more than the special income level (SIL); or~~

~~(b) Be a child not described in subsection (1)(a) with countable income as described in subsection (4)(b) that exceeds the categorically needy (CN) standard for the children's medical program.~~

~~(2) For an SSI-related client, excess resources are reduced by medical expenses as described in WAC 388-513-1350 to the resource standard for a single or married individual.~~

~~(3) The department determines a client's countable resources for institutional and hospice services under the MN programs as follows:~~

~~(a) For an SSI-related client, the department determines countable resources per WAC 388-513-1350.~~

~~(b) For a child not described in subsection (3)(a), no determination of resource eligibility is required.~~

~~(4) The department determines a client's countable income for institutional and hospice services under the MN program as follows:~~

~~(a) For an SSI-related client, the department reduces available income as described in WAC 388-513-1325 and 388-513-1330 by:~~

~~(i) Excluding income described in WAC 388-513-1340;~~

~~(ii) Disregarding income described in WAC 388-513-1345; and~~

~~(iii) Subtracting previously incurred medical expenses incurred by the client and not used to reduce excess resources. Allowable medical expenses and reducing excess resources are described in WAC 388-513-1350.~~

~~(b) For a child not described in subsection (4)(a), the department:~~

~~(i) Follows the income rules described in WAC 182-505-0210 for the children's medical program; and~~

~~(ii) Subtracts the medical expenses described in subsection (4).~~

~~(5) If the income remaining after the allowed deductions described in WAC 388-513-1380, plus countable resources in excess of the standard described in WAC 388-513-1350 (1), is less than the department-contracted rate times the number of days residing in the facility the client:~~

~~(a) Is eligible for institutional or hospice services in a medical institution, and medical assistance;~~

~~(b) Is approved for twelve months; and~~

~~(c) Participates income and excess resources toward the cost of care as described in WAC 388-513-1380.~~

~~(6) If the income remaining after the allowed deductions described in WAC 388-513-1380 plus countable resources in excess of the standard described in WAC 388-513-1350(1) is more than the department-contracted rate times the number of days residing in the facility the client:~~

~~(a) Is not eligible for payment of institutional services; and~~

~~(b) Eligibility is determined for medical assistance only as described in chapter 182-519 WAC.~~

~~(7) If the income remaining after the allowed deductions described in WAC 388-513-1380 is more than the department contracted nursing facility rate based on the number of days the client is in the facility, but less than the private nursing rate plus the amount of medical expenses not used to reduce excess resources the client:~~

~~(a) Is eligible for nursing facility care only and is approved for a three or six month based period as described in chapter 182-519 WAC. This does not include hospice in a nursing facility; and~~

~~(i) Pays the nursing home at the current state rate;~~

~~(ii) Participates in the cost of care as described in WAC 388-513-1380; and~~

~~(iii) Is not eligible for medical assistance or hospice services unless the requirements in (6)(b) is met.~~

~~(b) Is approved for medical assistance for a three or six month base period as described in chapter 182-519 WAC, if:~~

~~(i) No income and resources remain after the post eligibility treatment of income process described in WAC 388-513-1380.~~

~~(ii) Medicaid certification is approved beginning with the first day of the base period.~~

~~(c) Is approved for medical assistance for up to three or six months when they incur additional medical expenses that are equal to or more than excess income remaining after the post eligibility treatment of income process described in WAC 388-513-1380.~~

~~(i) This process is known as spenddown and is described in WAC 182-519-0100.~~

~~(ii) Medicaid certification is approved on the day the spenddown is met.~~

~~(8) If the income remaining after the allowed deductions described in WAC 388-513-1380, plus countable resources in excess of the standard described in WAC 388-513-1350 is more than the private nursing facility rate times the number of days in a month residing in the facility, the client:~~

~~(a) Is not eligible for payment of institutional services.~~

~~(b) Eligibility is determined for medical assistance only as described in chapter 182-519 WAC.~~)) (1) General information. To be eligible for institutional services when living in a medical institution under the SSI-related medically needy (MN) program, a person must:

(a) Meet program requirements described in WAC 182-513-1315;

(b) Have gross nonexcluded income in excess of the special income level (SIL); and

(c) Meet the financial requirements of subsection (3) or (4) of this section.

(2) Financial eligibility information.

(a) The agency determines a person's resource eligibility, excess resources, and medical expense deductions using WAC 182-513-1350.

(b) The agency determines a person's countable income by:

(i) Excluding income described in WAC 182-513-1340;

(ii) Determining available income described in WAC 182-513-1325 or 182-513-1330;

(iii) Disregarding income described in WAC 182-513-1345; and

(iv) Deducting medical expenses that were not used to reduce excess resources described in WAC 182-513-1350.

(c) For the purposes of this section only, "remaining income" means all gross nonexcluded income remaining after the post-eligibility calculation described in WAC 182-513-1380.

(3) Eligibility for payment of institutional services and the MN program.

(a) If a person's remaining income plus excess resources is less than, or equal to, the department-contracted daily rate times the number of days residing in the facility, the person:

(i) Is eligible for payment of institutional services and the MN program; and

(ii) Is approved for a twelve-month certification period.

(b) The person must pay income and excess resources towards the cost of care as described in WAC 182-513-1380.

(4) Eligibility for payment of institutional services and MN spenddown. If a person's remaining income is more than the department contracted daily rate times the number of days residing in the facility, but less than the private nursing facility rate for the same period, the person:

(a) Is eligible for payment of institutional services at the department-contracted rate; and

(i) Is approved for a three- or six-month base period;

(ii) Pays income and excess resources towards the department-contracted cost of care as described in WAC 182-513-1380; and

(b) Is eligible for the MN program for the same three- or six-month base period when the total of additional medical expenses incurred during the base period exceeds:

(i) The total remaining income for all months of the base period; minus

(ii) The total department-contracted rate for all months of the base period.

(5) If a person has excess resources and his or her remaining income is more than the department-contracted daily rate times the number of days residing in the facility, the person is not eligible for payment of institutional services and the MN program.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-513-1400 Long-term care (LTC) partnership program (index). Under the long-term care (LTC) partnership program, ((~~individuals~~)) people who purchase qualified long-term care partnership insurance policies can apply for long-term care medicaid under special rules for determining financial eligibility. These special rules generally allow the ((~~individual~~)) person to protect assets up to the insurance benefits received from a partnership policy so that such assets will not be taken into account in determining financial eligibility for long-term care medicaid and will not subsequently be subject to estate recovery for medicaid and long-term care services paid. The Washington long-term care partnership program is effective on December 1, 2011.

The following rules govern long-term care eligibility under the long-term care partnership program:

(1) WAC ((~~388-513-1405~~)) 182-513-1405 Definitions.

(2) WAC ((~~388-513-1410~~)) 182-513-1410 What qualifies as a LTC partnership policy?

(3) WAC ((~~388-513-1415~~)) 182-513-1415 What assets can't be protected under the LTC partnership provisions?

(4) WAC ((~~388-513-1420~~)) 182-513-1420 Who is eligible for asset protection under a LTC partnership policy?

(5) WAC ((~~388-513-1425~~)) 182-513-1425 When would I not qualify for LTC medicaid if I have a LTC partnership policy that does not have exhausted benefits?

(6) WAC ((~~388-513-1430~~)) 182-513-1430 What change of circumstances must I report when I have a LTC partnership policy paying a portion of my care?

(7) WAC ((~~388-513-1435~~)) 182-513-1435 Will Washington recognize a LTC partnership policy purchased in another state?

(8) WAC ((~~388-513-1440~~)) 182-513-1440 How many of my assets can be protected?

(9) WAC ((~~388-513-1445~~)) 182-513-1445 How do I designate a protected asset and what proof is required?

(10) WAC ((~~388-513-1450~~)) 182-513-1450 How does transfer of assets affect LTC partnership and medicaid eligibility?

(11) WAC ((~~388-513-1455~~)) 182-513-1455 If I have protected assets under a LTC partnership policy, what happens after my death?

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-513-1405 Definitions. For purposes of this section, the following terms have the meanings given them. Additional definitions can be found at chapter ((~~388-500~~)) 182-500 WAC and WAC ((~~388-513-1301~~)) 182-513-1100.

"Issuer" means any entity that delivers, issues for delivery, or provides coverage to, a resident of Washington, any policy that claims to provide asset protection under the Washington long-term care partnership act, chapter 48.85 RCW. Issuer as used in this chapter specifically includes insurance companies, fraternal benefit societies, health care service contractors, and health maintenance organizations.

"Long-term care (LTC) insurance" means a policy described in Chapter 284-83 WAC.

"Long-term care services" means services received in a medical institution, or under a home and community based waiver authorized by home and community services (HCS) or ((~~division of~~)) developmental disabilities administration (DDA). Hospice services are considered long-term care services for the purposes of the long-term care partnership when medicaid eligibility is determined under chapter ((~~388-513 or 388-515~~)) 182-513 or 182-515 WAC.

"Protected assets" means assets that are designated as excluded or not taken into account upon determination of long-term care medicaid eligibility described in WAC ((~~388-513-1315~~)) 182-513-1315. The protected or excluded amount is up to the dollar amount of benefits that have been paid for long-term care services by the qualifying long-term care partnership policy on the medicaid applicant's or client's behalf. The assets are also protected or excluded for the purposes of estate recovery described in chapter ((~~388-527~~)) 182-527 WAC, in up to the amount of benefits paid by the qualifying policy for medical and long-term care services.

"Qualified long-term care insurance partnership" means an agreement between the Centers for Medicare and Medicaid Services (CMS), and the health care authority (HCA) which allows for the disregard of any assets or resources in an amount equal to the insurance benefit payments that are made to or on behalf of an individual who is a beneficiary under a long-term care insurance policy that has been determined by the Washington state insurance commission to meet the requirements of section 1917 (b)(1)(c)(iii) of the act. These policies are described in chapter 284-83 WAC.

"Reciprocity Agreement" means an agreement between states approved under section 6021(b) of the Deficit Reduction Act of 2005, Public Law 109-171 (DRA) under which the states agree to provide the same asset protections for qualified partnership policies purchased by an individual while residing in another state and that state has a reciprocity agreement with the state of Washington.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-513-1415 What assets can't be protected under the LTC partnership provisions? The following assets cannot be protected under a LTC partnership policy.

(1) Resources in a trust described in WAC ((~~388-561-0100~~)) 182-516-0100 (6) and (7).

(2) Annuity interests in which Washington must be named as a preferred remainder beneficiary as described in WAC ((~~388-561-0201~~)) 182-516-0201.

(3) Home equity in excess of the standard described in WAC ((~~388-513-1350~~)) 182-513-1350. Individuals who have excess home equity interest are not eligible for long-term care medicaid services.

(4) Any portion of the value of an asset that exceeds the dollar amount paid out by the LTC partnership policy.

(5) The unprotected value of any partially protected asset (an example would be the home) is subject to estate recovery described in chapter ((~~388-527~~)) 182-527 WAC.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-513-1425 When would I not qualify for LTC medicaid if I have a LTC partnership policy in pay status? You are not eligible for LTC medicaid when the following applies:

(1) The income you have available to pay toward your cost of care described in WAC ((~~388-513-1380~~)) 182-513-1380, combined with the amount paid under the qualifying LTC partnership policy, exceeds the monthly private rate at the institution.

(2) The income you have available to pay toward your cost of care on a home and community based (HCB) waiver described in chapter ((~~388-515~~)) 182-515 WAC, combined with the amount paid under the qualifying LTC partnership policy, exceeds the monthly private rate in a home or residential setting.

(3) You fail to meet another applicable eligibility requirement for LTC medicaid.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-513-1430 What change of circumstances must I report when I have a LTC partnership policy paying a portion of my care? You must report changes described in WAC ((~~388-418-0005~~)) 182-504-0105 plus the following:

(1) You must report and verify the value of the benefits that your issuer has paid on your behalf under the LTC partnership policy upon request by the ((~~department~~)) agency, and at each annual eligibility review.

(2) You must provide proof when you have exhausted the benefits under your LTC partnership policy.

(3) You must provide proof if you have given away or transferred assets that you have previously designated as pro-

tected. Although, there is no penalty for the transfer of protected assets once you have been approved for LTC medicaid, the value of transferred assets reduces the total dollar amount that is designated as protected and must be verified.

(4) You must provide proof if you have sold an asset or converted a protected asset into cash or another type of asset. You will need to make changes in the asset designation and verify the type of transaction and new value of the asset.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-513-1445 How do I designate a protected asset and what proof is required? (1) Complete a DSHS LTCP asset designation form listing assets and the full fair market value that are earmarked as protected at the time of initial application for LTC medicaid.

(a) The full fair market value (FMV) of real property or interests in real property will be based on the current assessed value for property tax purposes for real property. A professional appraisal by a licensed appraiser can establish the current value if the assessed value is disputed.

(b) The value of a life estate in real property is determined using the life estate tables found in: ((~~http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCOappendix2.shtml~~)) http://www.hca.wa.gov/medicaid/manual/Pages/65-310.aspx.

(c) If you own an asset with others, you can designate the value of your ((~~pro-rata~~)) pro rata equity share.

(d) If the dollar amount of the benefits paid under a LTCP policy is greater than the fair market value of all assets protected at the time of the application for long-term care medicaid you may designate additional assets for protection under this section. The DSHS LTCP asset designation form must be submitted with the updated assets indicated along with proof of the current value of designated assets.

(e) The value of your assets protected for you under your LTC partnership policy do not carry over to your spouse should they need medicaid long-term care services during your lifetime or after your death. If your surviving spouse has their own LTC partnership policy he or she may designate assets based on the dollar amount paid under his or her own policy.

(f) Assets designated as protected under this subsection will not be subject to transfer penalties described in WAC ((~~388-513-1363~~)) 182-513-1363.

(2) Proof of the current fair market value of all protected assets is required at the initial application and each annual review.

(3) Submit current verification from the issuer of the LTCP policy of the current dollar value paid toward long-term care benefits. This verification is required at application and each annual eligibility review.

(4) Any individual or the personal representative of the individual's estate who asserts that an asset is protected has the initial burden of:

(a) Documenting and proving by clear and convincing evidence that the asset or source of funds for the asset in question was designated as protected;

(b) Demonstrating the value of the asset and the proceeds of the asset beginning from the time period the LTC partnership has paid out benefits to the present; and

(c) Documenting that the asset or proceeds of the asset remained protected at all times.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-513-1450 How does transfer of assets affect LTC partnership and medicaid eligibility? (1) If you transfer an asset within the sixty months prior to the medicaid application or after medicaid eligibility has been established, we will evaluate the transfer based on WAC ((~~388-513-1363~~)) 182-513-1363 and determine if a penalty period applies unless:

(a) You have already been receiving institutional services;

(b) Your LTC partnership policy has paid toward institutional services for you; and

(c) The value of the transferred assets has been protected under the LTC partnership policy.

(2) The value of the transferred assets that exceed your LTC partnership protection will be evaluated for a transfer penalty.

(3) If you transfer assets whose values are protected, you lose that value as future protection unless all the transferred assets are returned.

(4) The value of your protected assets less the value of transferred assets equals the adjusted value of the assets you are able to protect.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-513-1455 If I have protected assets under a LTC partnership policy, what happens after my death? Assets designated as protected prior to death are not subject to estate recovery for medical or LTC services paid on your behalf as described in chapter ((~~388-527~~)) 182-527 WAC as long as the following requirements are met:

(1) A personal representative who asserts an asset is protected under this section has the initial burden of providing proof as described in chapter ((~~388-527~~)) 182-527 WAC.

(2) A personal representative must provide verification from the LTC insurance company of the dollar amount paid out by the LTC partnership policy.

(3) If the LTC partnership policy paid out more than was previously designated, the personal representative has the right to assert that additional assets should be protected based on the increased protection. The personal representative must use the DSHS LTCP asset designation form and send it to the office of financial recovery.

(4) The amount of protection available to you at death through the estate recovery process is decreased by the FMV of any protected assets that were transferred prior to death.

REPEALER

The following sections of the Washington Administrative Code are repealed:

WAC 182-513-1300	Payment standard for persons in medical institutions.
WAC 182-513-1301	Definitions related to long-term care (LTC) services.
WAC 182-513-1305	Determining eligibility for noninstitutional medical assistance in an alternate living facility (ALF).
WAC 182-513-1364	Evaluating the transfer of an asset made on or after April 1, 2003 for long-term care (LTC) services.
WAC 182-513-1365	Evaluating the transfer of an asset made on or after March 1, 1997 and before April 1, 2003 for long-term care (LTC) services.
WAC 182-513-1366	Evaluating the transfer of an asset made before March 1, 1997 for long-term care (LTC) services.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-515-1505 ((~~Long-term care home and community based services authorized by home and community services (HCS) and hospice.~~)) Home and community based (HCB) waiver services. (((~~(1)~~))) This chapter describes the general and financial eligibility requirements for categorically needy (CN) home and community based (HCB) waiver services administered by home and community services (HCS) ((~~and hospice services administered by the health care authority (HCA)~~)). The definitions in WAC 182-513-1100 and chapter 182-500 WAC apply throughout this chapter.

(((~~(2)~~))) (1) 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~~)); or

(c) Residential support waiver (RSW).

(2) WAC 182-515-1506 describes the general eligibility requirements for HCB waiver services authorized by HCS.

(3) WAC 182-515-1507 describes financial requirements for eligibility for HCB waiver services authorized by HCS when a person is eligible for a noninstitutional SSI-related categorically needy (CN) medicaid program.

(4) WAC 182-515-1508 describes the financial eligibility requirements for HCB waiver services authorized by HCS when a person is not eligible for SSI-related noninstitutional CN medicaid described in WAC 182-515-1507.

(5) WAC 182-515-1509 describes the rules used to determine a person's participation in the cost of care and room and board for HCB waiver services if the person is not eligible under WAC 182-515-1507.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-515-1506 ((~~What are the general eligibility requirements for~~)) Home and community based (HCB) waiver services authorized by home and community services (HCS) ((~~and hospice?~~)) general eligibility. (1) To be eligible for home and community based (HCB) waiver services ((~~and hospice you~~)) a person must:

(a) Meet the program and age requirements for the specific program:

(i) Community options program entry system (COPES), per WAC 388-106-0310;

(ii) ((~~PACE, per WAC 388-106-0705;~~

~~(iii) WMIP waiver services, per WAC 388-106-0750;~~

~~(iv)~~)) Residential support waiver (RSW), per WAC 388-106-0310; or

(iii) New Freedom, per WAC ((~~388-106-1410;~~

~~(v) Hospice, per chapter 182-551 WAC; or~~

~~(vi) Roads to community living (RCL), per WAC 388-106-0250, 388-106-0255 and 388-106-0260~~)) 388-106-0338.

(b) Meet the disability criteria for the supplemental security income (SSI) program as described in WAC 182-512-0050;

(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 182-500-0050, or be likely to be placed in one within the next thirty days without HCB waiver services provided under one of the programs listed in ((~~subsection (1)~~)) (a) of this subsection;

(e) ((~~Have attained~~)) Attain institutional status as described in WAC ((~~388-513-1320~~)) 182-513-1320;

(f) Be ((~~determined in need of~~)) assessed for HCB waiver services and be approved for a plan of care ((~~as described in subsection (1)~~)) under (a) of this subsection;

(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 388-513-1365;~~

~~(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~~)) alternate living facility described in WAC 182-513-1100.

(2) A person is not eligible for home and community based (HCB) waiver services if the person:

(a) Is subject to a penalty period of ineligibility for the transfer of an asset as described in WAC 182-513-1363;

(b) Has a home with equity in excess of the requirements described in WAC 182-513-1350.

(3) Refer to WAC 182-513-1315 for rules used to determine countable resources, income, and eligibility standards for long-term care services.

(((~~3~~))) (4) Current income and resource standard charts are located at: ((~~http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.html~~)) http://www.hca.wa.gov/medicaid/Eligibility/Pages/index.aspx.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-515-1507 ((~~What are the financial requirements for~~)) Home and community based (HCB) waiver services authorized by home and community services (HCS) ((~~when you are~~))—Financial eligibility if a person is eligible for ((~~a~~)) an SSI-related 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 182-512-0100 (2)(a) and (b);~~

~~(c) SSI-related health care for workers with disabilities program (HWD) described in WAC 182-511-1000. If you are receiving HWD, you are responsible to pay your HWD premium as described in WAC 182-511-1250;~~

~~(d) Aged, blind, or disabled (ABD) cash assistance described in WAC 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 388-513-1365. 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 182-511-1000, you are responsible to pay your HWD premium as described in WAC 182-511-1250, in addition to the ADSA room and board standard.~~

~~(7) If you are eligible for 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 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 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 an ABD cash grant of thirty-eight dollars and eighty-four cents as described in WAC 388-478-0045, 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)~~))) (1) A person is financially eligible for home and community based (HCB) waiver services if:

(a) Receiving coverage under one of the following supplemental security income (SSI)-related categorically needy (CN) medicaid programs:

(i) SSI program under WAC 182-510-0001. This includes SSI clients under Section 1619B of the Social Security Act;

(ii) SSI-related noninstitutional CN program under chapter 182-512 WAC;

(iii) Health care for workers with disabilities program (HWD) under chapter 182-511 WAC.

(b) The person does not have a penalty period of ineligibility for the transfer of an asset under WAC 182-513-1363; and

(c) The person does not own a home with equity in excess of the requirements described in WAC 182-513-1350.

(2) A person eligible under this section does not pay participation toward the cost of personal care services, but must pay room and board if living in an alternate living facility.

(3) A person who lives in a department-contracted alternate living facility described in WAC 182-513-1100:

(a) Keeps a personal needs allowance (PNA) of sixty-two dollars and seventy-nine cents; and

(b) Pays remaining available income as room and board up to the room and board standard. The room and board standard is the federal benefit rate (FBR) minus sixty-two dollars and seventy-nine cents.

(4) A person who is eligible under the HWD program must pay the HWD premium described in WAC 182-511-1250, in addition to room and board if residing in an alternate living facility.

(5) A person who is eligible for the aged, blind, disabled (ABD) cash assistance program under WAC 388-400-0060 does not pay participation toward the cost of personal care and keeps the following:

(a) The cash grant amount authorized under WAC 388-478-0033 when living at home;

(b) A PNA of thirty-eight dollars and eighty-four cents, and pays the remaining income and ABD cash grant to the facility for the cost of room and board up to the room and board standard when living in an adult family home (AFH); or

(c) The cash grant of thirty-eight dollars and eighty-four cents under WAC 388-478-0006 when living in an assisted living facility or enhanced adult residential center (EARC).

(6) Current resource, income, PNA and ADSA room and board standards are located at: ((~~http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/ltestandardsPNAchartsubfile.shtml~~)) http://www.hca.wa.gov/medicaid/Eligibility/Pages/index.aspx.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-515-1508 ((~~How does the department determine if you are financially eligible for~~)) Home and community based (HCB) waiver services authorized by home and community services (HCS) ((~~and hospice if you are not eligible for medicaid under a categorically needy (CN) program listed in WAC 388-515-1507(1)?~~)) —Financial eligibility using SSI-related institutional rules. (1) If ((~~you are~~)) a person is not eligible for ((~~medicaid under~~)) a categorically needy (CN) program ((~~listed in~~)) under WAC ((~~388-515-1507(1)~~)) 182-515-1507, the ((~~department must~~)) agency determines ((~~your~~)) eligibility for home and community based (HCB) waiver services authorized by home and community services (HCS) using institutional medicaid rules. This section explains how ((~~you~~)) a person may qualify using institutional ((~~medicaid~~)) rules described in this section.

(2) ((~~You~~)) A person must meet ((~~the~~)):

(a) General eligibility requirements ((~~described in WAC 388-513-1315 and 388-515-1506.~~

~~(3) You must meet the following resource requirements:~~

~~(a) Resource limits described in WAC 388-513-1350.~~

~~(b) If you have resources over the standard allowed in WAC 388-513-1350, the department reduces resources over the standard by your unpaid medical expenses described in WAC 388-513-1350 if you verify these expenses.~~

~~(4) You must meet~~)) under WAC 182-513-1315 and 182-515-1506;

(b) The resource requirements under WAC 182-513-1350;

(c) The following income requirements:

(((~~(a) Your~~)) (i) Gross nonexcluded income must be at or below the special income level (SIL) which is three hundred percent of the federal benefit rate (FBR); or

(((~~(b) For home and community based (HCB) service programs authorized by HCS your gross nonexcluded income is:~~

~~(i) Above the special income level (SIL) which is three hundred percent of the federal benefit rate (FBR); and~~))

(ii) ((~~Net~~)) If gross nonexcluded income is above the special income level (SIL), net nonexcluded income is no greater than the effective one-person medically needy income level (MNIL). Net income is calculated by reducing gross nonexcluded income by:

(A) Medically needy (MN) disregards found ((~~in WAC 388-513-1345~~)) under WAC 182-513-1345; and

(B) The average monthly nursing facility state rate ((~~is five thousand six hundred and twenty-six dollars. This rate will be updated annually starting October 1, 2012 and each year thereafter on October 1. This standard will be updated annually in the long-term care standard section of the EAZ manual described at http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml~~)).

(((~~(5)~~))) (3) The ((~~department~~)) agency follows the rules in WAC ((~~388-515-1325, 388-513-1330, and 388-513-1340~~)) 182-513-1325, 182-513-1330, and 182-513-1340 to determine available income and income exclusions.

(((~~(6)~~))) (4) A person eligible under this section may be required to participate available income toward the cost of care as described in WAC 182-515-1509.

(5) Current resource ((~~and~~)), income standards (((~~including the SIL, MNIL and FBR)~~)), and the average state nursing facility rate for long-term care are found at: ((~~http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml~~)) http://www.hca.wa.gov/medicaid/Eligibility/Pages/index.aspx.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-515-1509 ((~~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?~~)) Home and community based (HCB) waiver services authorized by home and community services (HCS) —Client financial responsibility. ((~~If you are only eligible for medicaid under WAC 388-515-1508, the department determines how much you must pay based upon~~)) (1) The agency determines how much a person must pay toward the cost of care for home and community based (HCB) waiver services authorized by home and community services (HCS) when living at home based on the following:

(((~~(1) If you are~~)) (a) A single ((~~and living~~)) person who lives at home (as defined in WAC 388-106-0010)((~~, you~~)) keeps ((~~all your income up to the federal poverty level (FPL) for your personal needs allowance (PNA)~~)) a personal needs

allowance (PNA) of up to the federal poverty level (FPL) and pays the remainder of his or her gross nonexcluded income toward cost of care after allowable deductions described in subsection (3) of this section.

(((~~(2) If you are~~)) (b) A married ((~~living~~)) person who lives with his or her spouse at home ((~~as defined in WAC 388-106-0010, you keep all your income up to the effective one-person medically needy income level (MNIL) for your PNA if your spouse lives at home with you. If you are married and living apart from your spouse, you're allowed to keep your income up to the FPL 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 nonexcluded 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~~)) (under WAC 388-106-0010), keeps a PNA of up to the effective one-person medically needy income level (MNIL) and pays the remainder of his or her gross nonexcluded income toward cost of care after allowable deductions described in subsection (3) of this section.

(c) A married person who lives at home and apart from his or her spouse keeps a PNA of up to the FPL and pays the remainder of his or her gross nonexcluded income toward cost of care after allowable deductions described in subsection (3) of this section.

(d) A married couple who receive HCB HCS waiver services are each allowed to keep a PNA of up to the FPL and pays the remainder of each of their gross nonexcluded income toward cost of care after allowable deductions described in subsection (3) of this section.

(e) A married couple living at home where each person receives HCB waiver services, one authorized by developmental disabilities administration (DDA) and the other authorized by HCS is allowed the following:

(i) The DDA waiver person pays toward his or her cost of care under WAC 182-515-1512 or 182-515-1514; and

(ii) The HCS waiver person retains the federal poverty level (FPL) and pays the remainder of his or her gross nonexcluded income toward cost of care after allowable deductions under subsection (3) of this section.

(2) The agency determines how much a person must pay toward the cost of care and room and board when living in a department contracted alternate living facility under WAC 182-513-1100 based on the following:

A single person or a married person who lives apart from his or her spouse:

(a) Keeps a PNA of sixty-two dollars and seventy-nine cents;

(b) Pays room and board up to the room and board standard. The room and board standard is the federal benefit rate (FBR) minus sixty-two dollars and seventy-nine cents; and

(c) Pays the remainder of gross nonexcluded income toward the cost of care after allowable deductions described in subsection (3) of this section.

(3) If income remains after the PNA and room and board liability described in subsections (1) and (2) of this section, the remaining gross nonexcluded income must be paid toward the cost of care after it is reduced by ((~~allowable~~)) deductions in the following order:

(a) ((~~If you are~~)) For a working person, the ((~~department~~)) agency 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~~)) the person's income according to a child support order in the month of the garnishment if it is for the current month. If the ((~~department~~)) agency allows this as deduction from ((~~your~~)) income, the ((~~department will~~)) agency does not count it as ((~~your~~)) the child's income when determining the family allocation amount in WAC 182-513-1385;

(d) A monthly maintenance needs allowance for ((~~your~~)) the 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 may change annually on July 1st and can be found at: http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml; 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, plus;~~

~~(V) The food assistance standard utility allowance (SUA) 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 may change annually on July 1st and can be found at: http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml; and~~

~~(VII) Is reduced by your community spouse's gross countable income.~~

~~(iii) The amount allocated to the community spouse 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.)) as determined using the calculation described in WAC 182-513-1385;

(e) A monthly maintenance needs ((amount)) allowance for each minor or dependent child, dependent parent, ((or)) dependent sibling of ((your)) the institutionalized person, institutionalized person's community spouse, or institutionalized person's institutionalized spouse((. The amount the department allows is based on the living arrangement of the dependent. If the dependent:

(i) Resides with your community spouse, for each child, one hundred fifty percent of the two-person FPL minus that child's income and divided by three (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 effective one person 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))), as determined using the calculation described in WAC 182-513-1385.

(f) ((Your unpaid)) Incurred medical expenses which have not been used to reduce excess resources. Allowable medical expenses are described in WAC ((388-513-1350)) 182-513-1350 (8)(d).

(g) The total of the following deductions cannot exceed the special income level (SIL (((three hundred percent of the FBR))):

(i) ((Personal needs allowance)) The PNA allowed in subsection((s)) (1)((,)) or (2) ((and (3)(a) and (b))) of this section; and

(ii) The earned income deduction ((of the first sixty-five dollars plus one-half of the remaining earned income in subsection (4))) in (a) of this subsection; and

(iii) The guardianship fees and administrative costs in ((subsection (4))) (b) of this subsection.

(4) A person may have to pay third-party resources described under WAC 182-501-0200 in addition to the room and board and participation.

(5) ((You)) A person must pay ((your provider the combination of)) his or her provider the sum of the room and board amount, and the cost of personal care services after all allowable deductions, and any third-party resources.

(6) ((You may have to pay third party resources described in WAC 182-501-0200 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)) A person is responsible only to participate up to the state rate for cost of care. If long-term care insurance pays a portion of the state rate cost of care, a person participates only the difference up to the state rate cost of care.

(7) When a person lives 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)) agency allows ((you)) the highest PNA available based on all the living arrangements and services ((you have)) the person has in a month.

(((9) Current PNA and ADSA room and board)) (8) Standards described in this section are located at: ((http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/ltcstandardsPNAchartsubfile.shtml)) http://www.hca.wa.gov/medicaid/Eligibility/Pages/index.aspx.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-515-1510 ((Division of)) Home and community based (HCB) waiver services authorized by developmental disabilities (((DDD) home and community based services waivers)) administration (DDA). The ((four)) following five sections ((that follow)) describe the general and financial eligibility requirements for home and community based (HCB) waivers authorized by the ((division of)) developmental disabilities (((DDD) home and community based services (HCBS) waivers)) administration (DDA).

(1) The DDA waiver programs are:

(a) Basic Plus;

(b) Core;

(c) Community protection;

(d) Children's intensive in-home behavioral support (CIIBS); and

(e) Individual and family services (IFS).

(((1) WAC 388-515-1511)) (2) WAC 182-515-1511 describes the general eligibility requirements ((under the DDD HCBS)) for HCB waiver((s)) services authorized by DDA.

(((2) WAC 388-515-1512)) (3) WAC 182-515-1512 describes the ((financial)) general eligibility requirements for ((the DDD waivers if you are)) HCB waivers authorized by DDA when a person is eligible for ((medicaid under the)) a noninstitutional SSI-related categorically needy (CN) program (((CN))).

(((3) WAC 388-515-1513)) (4) WAC 182-515-1513 describes the ((initial)) financial eligibility requirements for the ((DDD)) HCB waiver((s if you are)) services authorized by DDA waivers when a person is not eligible for ((medicaid under)) a noninstitutional SSI-related categorically needy (CN) program (((CN) listed in)) under WAC ((388-515-1512(1))) 182-515-1512.

(((4) WAC 388-515-1514)) (5) WAC 182-515-1514 describes the ((post eligibility financial requirements for the DDD waivers if you are not eligible for medicaid under a categorically needy program CN listed in)) rules used to determine a person's participation in the cost of care and room and board for HCB waiver services authorized by DDA if the person is not eligible under WAC ((388-515-1512(1))) 182-515-1512.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-515-1511 ((What are the general eligibility requirements for)) Home and community based (HCB)

waiver services ((~~under the division of~~)) authorized by developmental disabilities ((~~(DDD) home and community based services (HCBS) waivers?~~)) administration (DDA)—General eligibility. (((~~(1) This section describes the general eligibility requirements for waiver services under the DDD home and community based services (HCBS) waivers.~~

~~(2) The requirements for services for DDD HCBS waivers are described in chapter 388-845 WAC. The department establishes eligibility for DDD HCBS waivers.~~)) (1) To be eligible((~~, you~~)) for home and community based (HCB) waiver services authorized by the developmental disabilities administration (DDA), a person must:

(a) Meet the program requirements for the specific program as described in chapter 388-845 WAC;

(b) Be an eligible client of the ((~~division of developmental disabilities (DDD)~~)) DDA;

(((~~(b)~~)) (c) Meet the disability criteria for the supplemental security income (SSI) program as described in WAC 182-512-0050;

(((~~(c)~~)) (d) Require the level of care provided in an intermediate care facility for the intellectually disabled (ICF/ID);

(((~~(d)~~)) (e) Have attained institutional status ((~~as described in WAC 388-513-1320~~)) under WAC 182-513-1320;

(((~~(e)~~)) (f) Be able to reside in the community and choose to do so as an alternative to living in an ICF/ID;

(((~~(f) Need waiver services as determined by your~~)) (g) Be assessed for HCB waiver services as determined by the person's plan of care or individual support plan, and:

(i) Be able to live at home with HCB waiver services; or

(ii) Live in a department-contracted facility, which includes:

(A) A group home;

(B) A group training home;

(C) A child foster home, group home, or staffed residential facility;

(D) An adult family home (AFH); or

(E) An adult residential care (ARC) facility.

(iii) Live in ((~~your~~)) his or her own home with supported living services from a certified residential provider; or

(iv) Live in the home of a contracted companion home provider((~~; and~~

~~(g) Be both medicaid eligible under the categorically needy program (CN) and be approved for services by the division of developmental disabilities~~)).

(2) A person is not eligible for home and community based (HCB) waiver services if the person:

(a) Is subject to a penalty period of ineligibility for the transfer of an asset under WAC 182-513-1363;

(b) Has a home with equity in excess of the requirements under WAC 182-513-1350.

(3) Refer to WAC 182-513-1315 for rules used to determine countable resources, income, and eligibility standards for long-term care services.

(4) Current income and resource standard charts are located at: http://www.hca.wa.gov/medicaid/eligibility/pages/standards.aspx.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-515-1512 ((~~What are the financial requirements for the DDD waiver services if I am eligible for medicaid under the noninstitutional categorically needy program (CN)?~~)) Home and community based (HCB) waiver services authorized by the developmental disabilities administration (DDA)—Financial eligibility if a person is eligible for a noninstitutional SSI-related categorically needy (CN) program. (((~~(1) You automatically meet income and resource eligibility for DDD waiver services if you are eligible for medicaid under a categorically needy program (CN) 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) Health care for workers with disabilities (HWD) described in WAC 182-511-1000 through 182-511-1250;~~

~~(c) SSI-related (CN) medicaid described in WAC 182-512-0100 (2)(a) and (b) or meets the requirements in WAC 182-512-0880 and is (CN) eligible after the income disregards have been applied;~~

~~(d) CN medicaid for a child as described in WAC 182-505-0210 (1), (2), (7) or (8); or~~

~~(e) Aged, blind or disabled (ABD) cash assistance described in WAC 388-400-0060.~~

~~(2) If you are eligible for a CN 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 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 medicaid program listed in subsection (1), you pay up to the ADSA room and board standard described in WAC 388-515-1507. Room and board and long-term care standards are located at http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandard-spna.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 health care for workers with disabilities (HWD), you must continue to pay the medicaid premium to remain eligible for that CN-P program.~~)) (1) A person is financially eligible for HCB waiver services if:

(a) Receiving coverage under one of the following SSI-related categorically needy (CN) medicaid programs:

(i) Supplemental security income (SSI) program under WAC 182-510-0001. This includes SSI clients under 1619B status;

(ii) Health care for workers with disabilities (HWD) under WAC 182-511-1000 through 182-511-1250;

(iii) SSI-related noninstitutional (CN) program under chapter 182-512 WAC;

(iv) The foster care program under WAC 182-505-0211 and meeting disability requirements described in WAC 182-512-0050.

(b) The person does not have a penalty period of ineligibility for the transfer of an asset as under WAC 182-513-1363; and

(c) The person does not own a home with equity in excess of the requirements under WAC 182-513-1350.

(2) A person eligible under this section does not pay participation toward the cost of services, but must pay room and board if living in an alternate living facility (ALF) under WAC 182-513-1100.

(3) A person who lives in a department-contracted ALF:

(a) Keeps a personal needs allowance (PNA) of sixty-two dollars and seventy-nine cents; and

(b) Pays remaining available income as room and board up to the room and board standard. The room and board standard is the federal benefit rate (FBR) minus sixty-two dollars and seventy-nine cents.

(4) A person who is eligible under the HWD program must pay the HWD premium under WAC 182-511-1250, in addition to room and board if residing in an ALF.

(5) A person who is eligible for the aged, blind, disabled (ABD) cash assistance program under WAC 388-400-0060 does not pay participation toward the cost of services and keeps the following:

(a) The cash grant amount authorized under WAC 388-478-0033 when living at home;

(b) A PNA of thirty-eight dollars and eighty-four cents, and pays the remaining income and ABD cash grant to the facility for the cost of room and board up to the room and board standard when living in an adult family home (AFH); or

(c) The cash grant of thirty-eight dollars and eighty-four cents authorized under WAC 388-478-0006 when living in an adult residential center (ARC) or DDA group home.

(6) Current resource, income, PNA and room and board standards are located at: http://www.hca.wa.gov/medicaid/eligibility/pages/standards.aspx.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-515-1513 ((~~How does the department determine if I am financially eligible for DDD waiver service medical coverage if I am not eligible for medicaid under a categorically needy program (CN) listed in WAC 388-515-1512(1)?~~)) Home and community based (HCB) waiver services authorized by the developmental disabilities administration (DDA)—Financial eligibility using institutional rules. ((~~If you are not eligible for medicaid under a categorically needy program (CN) listed in WAC 388-515-1512(1), we must determine your eligibility using institutional medicaid rules. This section explains how you may qualify under this program. You may be required to pay towards the cost of your care if you are eligible under this program. The rules explaining how much you have to pay are listed in WAC 388-515-1514. To qualify, you must meet both the resource and income requirements.~~

~~(1) Resource limits are described in WAC 388-513-1350. If you have resources which are higher than the standard allowed, we may be able to reduce resources by your unpaid medical expenses described in WAC 388-513-1350.~~

~~(2) You are not subject to a transfer of asset penalty described in WAC 388-513-1363 through 388-513-1365.~~

~~(d) Not have a home with equity in excess of the requirements described in WAC 388-513-1350.~~

~~(3) Your gross nonexcluded income must be at or below the special income level (SIL) which is three hundred percent of the federal benefit level. The department follows the rules in WAC 388-515-1325, 388-513-1330 and 388-513-1340 to determine available income and income exclusions.~~

~~(4) Refer to WAC 388-513-1315 for rules used to determine countable resources, income and eligibility standards for long-term care services.~~

~~(5) Current income and resources standards are located at: http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml.~~)) (1) If a person is not eligible for a categorically needy (CN) program under WAC 182-515-1512, the agency determines eligibility for home and community based (HCB) waiver services authorized by the developmental disabilities administration (DDA) using institutional rules described in this section.

(2) A person must meet:

(a) General eligibility requirements under WAC 182-513-1315 and 182-515-1511;

(b) The resource requirements under WAC 182-513-1350.

(c) Gross nonexcluded income must be at or below the special income level (SIL).

(3) The agency follows the rules in WAC 182-513-1325, 182-513-1330, and 182-513-1340 to determine available income and income exclusions.

(4) A person eligible under this section may be required to pay participation toward the cost of care under WAC 182-515-1514.

(5) Current resource, income standards are found at: http://www.hca.wa.gov/medicaid/Eligibility/Pages/index.aspx.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-515-1514 ((~~How does the department determine how much of my income I must pay towards the cost of my DDD waiver services if I am not eligible for medicaid under a categorically needy program (CN) listed in WAC 388-515-1512(1)?~~)) Home and community based (HCB) services authorized by developmental disabilities administration (DDA) —Client financial responsibility. ((~~If you are not eligible for medicaid under a categorically needy program (CN) 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://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml.~~

~~(3) 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 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 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 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 may change annually on July 1st and can be found at: http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml; 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 plus;~~

~~(V) The food assistance standard utility allowance (SUA) 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 may change annually on July 1st and can be found at: http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml; 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, for each child, one hundred fifty percent of the two-person FPL minus that child's income and divided by three (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 effective one-person 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 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 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 ABD cash grant to the facility for the cost of room and board up to the ADSA room and board standard described in http://www.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) You may have to pay third party resources (TPR) described in WAC 182-501-0200 in addition to room and board 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.~~)) (1) The agency determines how much a person must pay toward the cost of care for home and community based (HCB) waiver services authorized by the developmental disabilities administration (DDA) when living at home based on the following:

(a) A single person who lives at home (as defined in WAC 388-106-0010) keeps a personal needs allowance (PNA) of up to the SIL.

(b) A single person who lives at home on roads to community living authorized by DDA keeps a PNA up to the SIL and pays the remainder of his or her gross nonexcluded income toward cost of care after allowable deductions described in subsection (3) of this section.

(c) A married person who lives with his or her spouse at home (as defined in WAC 388-106-0010) keeps a PNA of up to the SIL and pays the remainder of his or her gross nonexcluded income toward cost of care after allowable deductions described in subsection (3) of this section.

(d) A married couple living at home where each person receives HCB waiver services, one authorized by DDA and the other authorized by home and community services (HCS) is allowed the following:

(i) The DDA waiver person retains the SIL as a PNA and pays the remainder of his or her gross nonexcluded income towards his or her cost of care after allowable deductions in subsection (3) of this section; and

(ii) The HCS waiver person pays toward his or her cost of care under WAC 182-515-1507 or 182-515-1509.

(2) The agency determines how much a person must pay toward the cost of care and room and board when living in a department-contracted ALF based on the following: A single person or a married person who lives apart from his or her spouse:

(a) Keeps a PNA of sixty-two dollars and seventy-nine cents effective July 1, 2008; and

(b) Pays room and board up to the room and board standard. The room and board standard is the federal benefit rate (FBR) minus sixty-two dollars and seventy-nine cents; and

(c) Pays the remainder toward the cost of care after allowable deductions described in subsection (3) of this section.

(3) If income remains after the PNA and room and board liability described in subsections (1) and (2) of this section, the remaining income must be paid toward the cost of care after it is reduced by allowable deductions in the following order:

(a) For a working person, the agency 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 income according to a child support order in the month of the garnishment if it is for the current month. If the agency allows this as a deduction from income, the agency does not count it as the child's income when determining the family allocation amount in WAC 182-513-1385;

(d) A monthly maintenance-needs allowance for the community spouse as determined using the calculation under WAC 182-513-1385;

(e) A monthly maintenance-needs allowance for each minor or dependent child, dependent parent, dependent sibling of the institutionalized person, institutionalized person's community spouse, or institutionalized person's institutionalized spouse, as determined using the calculation described in WAC 182-513-1385;

(f) Incurred medical expenses which have not been used to reduce excess resources. Allowable medical expenses are described in WAC 182-513-1350;

(g) The total of the following deductions cannot exceed the SIL:

(i) The PNA described in subsection (1) or (2) of this section;

(ii) The earned income deduction in (a) of this subsection; and

(iii) The guardianship fees and administrative costs in (b) of this subsection.

(4) A person may have to pay third-party resources described in WAC 182-501-0200 in addition to the room and board and participation.

(5) A person must pay his or her provider the sum of the room and board amount, the cost of services after all allowable deductions, and any third-party resources.

(6) A person is only responsible to participate up to the state rate for cost of care. If long-term care insurance pays a portion of the state rate cost of care, a person participates only the difference up to the state rate cost of care.

(7) When a person lives in multiple living arrangements in a month, the agency allows the highest PNA available based on all the living arrangements and services received within the month.

(8) Standards described in this section are located at: http://www.hca.wa.gov/medicaid/eligibility/pages/standards.aspx.

REPEALER

The following section of the Washington Administrative Code is repealed:

WAC 182-515-1500	Payment standard for persons in certain group living facilities.

WSR 16-06-079
EMERGENCY RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 16-33—Filed February 26, 2016, 1:18 p.m., effective February 26, 2016, 1:18 p.m.]

Effective Date of Rule: Immediately upon filing.

Purpose: The purpose of this rule making is to provide for treaty Indian fishing opportunity in the Columbia River while protecting salmon listed as threatened or endangered under the Endangered Species Act (ESA). This rule making implements federal court orders governing Washington's relationship with treaty Indian tribes and federal law governing Washington's relationship with Oregon.

Citation of Existing Rules Affected by this Order: Repealing WAC 220-32-05100R; and amending WAC 220-32-051.

Statutory Authority for Adoption: RCW 77.04.012, 77.04.020, 77.04.130, 77.12.045, and 77.12.047.

Other Authority: *United States v. Oregon*, Civil No. 68-513-KI (D. Or.), Order Adopting 2008-2017 *United States v. Oregon* Management Agreement (Aug. 12, 2008) (Doc. No. 2546); *Northwest Gillnetters Ass'n v. Sandison*, 95 Wn.2d 638, 628 P.2d 800 (1981); Washington fish and wildlife commission policies concerning Columbia River fisheries; 40 Stat. 515 (Columbia River Compact).

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: Extends the ongoing seasons in SMCRA 1G and 1F (The Dalles and John Day pools). Harvest to date has been low and sturgeon remain available under the current harvest guidelines for each pool. The regulation continues to allow the sale of fish as outlined in Section 2. The season is consistent with the 2008-2017 Management Agreement and the associated biological opinion. Rule is consistent with action of the Columbia River Compact on January 27, February 11, 18, and 25, 2016. Conforms state rules with tribal rules. There is insufficient time to promulgate permanent regulations.

The Yakama, Warm Springs, Umatilla, and Nez Perce Indian tribes have treaty fishing rights in the Columbia River and inherent sovereign authority to regulate their fisheries. Washington and Oregon also have some authority to regulate fishing by treaty Indians in the Columbia River, authority that the states exercise jointly under the congressionally ratified Columbia River compact. *Sohappy v. Smith*, 302 F. Supp. 899 (D. Or. 1969). The tribes and the states adopt parallel regulations for treaty Indian fisheries under the supervision of the federal courts. A court order sets the current parameters. *United States v. Oregon*, Civil No. 68-513-KI (D. Or.), Order Adopting 2008-2017 *United States v. Oregon* Management Agreement (Aug. 12, 2008) (Doc. No. 2546). Some salmon and steelhead stocks in the Columbia River are listed as threatened or endangered under the federal ESA. On May 5, 2008, the National Marine Fisheries Service issued a biological opinion under 16 U.S.C. § 1536 that allows for some incidental take of these species in the fisheries as described in the 2008-2017 *U.S. v. Oregon* Management Agreement.

Columbia River fisheries are monitored very closely to ensure consistency with court orders and ESA guidelines. Because conditions change rapidly, the fisheries are managed almost exclusively by emergency rule. As required by court order, the Washington (WDFW) and Oregon (ODFW) departments of fish and wildlife convene public hearings and invite tribal participation when considering proposals for new emergency rules affecting treaty fishing rights. *Sohappy*, 302 F. Supp. at 912. WDFW and ODFW then adopt regulations reflecting agreements reached.

Number of Sections Adopted in Order to Comply with Federal Statute: New 1, Amended 0, Repealed 1; Federal Rules or Standards: New 1, Amended 0, Repealed 1; 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: February 26, 2016.

J. W. Unsworth
Director

NEW SECTION

WAC 220-32-05100S Columbia River salmon seasons above Bonneville Dam. Notwithstanding the provisions of WAC 220-32-050, WAC 220-32-051, WAC 220-32-052 and WAC 220-32-058, effective immediately until further notice, it is unlawful for a person to take or possess salmon, steelhead, sturgeon, shad, carp, catfish, walleye, bass, or yellow perch taken for commercial purposes in Columbia River Salmon Management and Catch Reporting Areas 1F, 1G, and 1H. However, those individuals possessing treaty fishing rights under the Yakima, Warm Springs, Umatilla, and Nez Perce treaties may fish for salmon, steelhead, sturgeon, shad, carp, catfish, walleye, bass, or yellow perch under the following provisions:

(1) Open Areas: SMCRA 1G and 1H (The Dalles Pool and John Day Pool):

(a) Season: Immediately through 6:00 p.m. March 5, 2016.

(b) Gear: Gill nets, hoop nets, dip bag nets, and rod and reel with hook and line. No mesh restriction on gillnets.

(c) Allowable sale: Salmon, steelhead, shad, carp, catfish, walleye, bass, or yellow perch. Sturgeon between 43-54 inches in fork length may be sold or kept for subsistence. Live release of all oversize and under-size sturgeon is required.

(2) Open Areas: SMCRA 1F, 1G, and 1H (Zone 6):

(a) Season: Immediately through 6:00 p.m. March 21, 2016.

(b) Gear: Hoop nets, dip bag nets, and rod and reel with hook and line.

(c) Allowable sale: Salmon, steelhead, shad, carp, catfish, walleye, bass, or yellow perch. Sturgeon from 43-54 inches caught in the John Day and Dalles pools may be sold only if caught during open commercial gillnet periods for that pool. Sturgeon between 38-54 inches in fork length in SMCRA 1F may only be kept for subsistence. Live release of all oversize and under-size sturgeon is required.

(3) 24-hour quick reporting is required for Washington wholesale dealers for all areas as provided in WAC 220-69-240, except that all landings from treaty fisheries described above must be reported within 24-hours of completing the fish ticket (not 24-hours after the period concludes).

(4) Fish caught during the open period may be sold after the period concludes.

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 section of the Washington Administrative Code is repealed:

WAC 220-32-05100R Columbia River salmon seasons above Bonneville Dam. (16-29)

WSR 16-06-081
EMERGENCY RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 16-34—Filed February 26, 2016, 3:47 p.m., effective February 26, 2016, 3:47 p.m.]

Effective Date of Rule: Immediately upon filing.

Purpose: Amend recreational fishing rules for razor clams.

Citation of Existing Rules Affected by this Order: Repealing WAC 220-56-36000J and 220-56-36000K; amending WAC 220-56-360.

Statutory Authority for Adoption: RCW 77.04.012, 77.04.020, and 77.12.047.

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 and 5. Washington department of health has certified clams from this [these] beach[es] 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 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: February 26, 2016.

J. W. Unsworth
Director

NEW SECTION

WAC 220-56-36000K 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, 3, 4, 5, 6 or 7 except as provided for in this section:

(1) Effective immediately through 11:59 p.m. March 10, 2016, razor clam digging is permissible in Razor Clam Area 1. Digging is permissible from 12:01 p.m. to 11:59 p.m. each day only.

(2) Effective 12:01 a.m. March 11 through 11:59 a.m. March 14, 2016, razor clam digging is permissible in Razor Clam Area 1. Digging is permissible from 12:01 a.m. to 11:59 a.m. each day only.

(3) Effective 12:01 p.m. March 15 through 11:59 p.m. March 23, 2016, razor clam digging is permissible in Razor Clam Area 1. Digging is permissible from 12:01 p.m. to 11:59 p.m. each day only.

(4) Effective 12:01 a.m. March 24 through 11:59 a.m. March 31, 2016, razor clam digging is permissible in Razor Clam Area 1. Digging is permissible from 12:01 a.m. to 11:59 a.m. each day only.

(5) Effective 12:01 p.m. March 5 through 11:59 p.m. March 8, 2016, razor clam digging is permissible in Razor Clam Area 5. Digging is permissible from 12:01 p.m. to 11:59 p.m. each day only.

(6) It is unlawful to dig for razor clams at any time in the Long Beach or Copalis Beach Clam sanctuaries defined in WAC 220-56-372.

REPEALER

The following section of the Washington Administrative Code is repealed:

WAC 220-56-36000J Razor clams—Areas and seasons. (16-26)

The following section of the Washington Administrative Code is repealed effective 12:01 p.m. March 31, 2016:

WAC 220-56-36000K Razor clams—Areas and seasons.

WSR 16-06-088
EMERGENCY RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 16-35—Filed February 29, 2016, 12:34 p.m., effective March 10, 2016]

Effective Date of Rule: March 10, 2016.

Purpose: Amend recreational fishing rules.

Citation of Existing Rules Affected by this Order: Amending WAC 220-310-185.

Statutory Authority for Adoption: RCW 77.04.012, 77.04.020, and 77.12.047.

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: (1) Hatchery winter steelhead smolts are released into Abernathy Creek as part of a United States Fish and Wildlife Service hatchery research program. Returning hatchery adults have similar run timing to wild steelhead and may stray to neighboring Mill and Germany creeks. The regulation extends the fishing season for hatchery steelhead in order to support volunteer angling needed for a research study on hatchery strays in Mill, Abernathy, and Germany creeks. Selective gear rules will be in effect to aid in the release of any wild juvenile or adult salmonids that are inadvertently encountered.

(2) The preseason forecast is for four thousand nine hundred adult spring Chinook to return to the Kalama in 2016. The hatchery escapement goal of four hundred fish is expected to be met and surplus hatchery fish are available for harvest.

(3) The preseason forecast is for a return of one thousand one hundred adult spring Chinook to the Lewis River in 2016 compared to a hatchery escapement goal of approximately one thousand three hundred fifty fish. The closure is necessary to provide the hatchery with as many returning fish as possible to minimize the shortfall. There is insufficient time to promulgate 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: February 29, 2016.

J. W. Unsworth
Director

NEW SECTION

WAC 220-310-18500G Freshwater exceptions to statewide rules—Southwest. Notwithstanding the provisions of WAC 220-310-185, it is unlawful to violate the provisions below. Unless otherwise amended, all permanent rules remain in effect.

(1) Abernathy Creek (Cowlitz County) from mouth (Hwy. 4 Bridge) upstream to 500 feet below Abernathy Fish Technology Center: Effective March 16, 2016 through April 15, 2016, up to 3 hatchery steelhead may be retained. Selective gear rules in effect.

(2) Germany Creek (Cowlitz County) including all tributaries: Effective March 16, 2016 through April 15, 2016, up to 3 hatchery steelhead may be retained.

(3) Kalama River (Cowlitz County) from the boundary markers at the mouth upstream to 1000 feet below fishway at the upper salmon hatchery**:** Effective March 10, 2016 until further notice, up to 2 hatchery adult Chinook may be retained.

(4) Lewis River (Clark/Cowlitz counties): Effective March 10, 2016 until further notice, all Chinook must be released from the mouth upstream to the overhead powerlines below Merwin Dam.

(5) Mill Creek (Cowlitz County): Effective March 16, 2016 through April 15, 2016, up to 3 hatchery steelhead may be retained.

WSR 16-06-120
EMERGENCY RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 16-37—Filed March 2, 2016, 9:46 a.m., effective March 2, 2016, 9:46 a.m.]

Effective Date of Rule: Immediately upon filing.

Purpose: Amend Puget Sound commercial crab fishing rules.

Citation of Existing Rules Affected by this Order: Repealing WAC 220-52-04000K; and amending WAC 220-52-040.

Statutory Authority for Adoption: RCW 77.04.012, 77.04.020, and 77.12.047.

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 increase pot limits in Region 1. Also will maintain the closure for commercial harvest in Region 2 East, Region 2 West and Region 3-2. There is sufficient allocation in Region 1, Region 3-1 and Region 3-3 for them to remain open. These provisions are in conformity with agreed management plans and addendums with applicable tribes. These management plans are entered into as required by court order. The Puget Sound commercial season is structured to meet harvest allocation objectives negotiated with applicable treaty tribes and outlined in the management plans. 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: March 2, 2016.

J. W. Unsworth
Director

NEW SECTION

WAC 220-52-04000N Commercial crab fishery—Lawful and unlawful gear, methods, and other unlawful acts. Notwithstanding the provisions of WAC 220-52-040:

(1) Effective 7:30 AM, Saturday, March 5, 2016 until 7:00 PM, Tuesday, March 15, 2016, it is unlawful for any person to fish for crabs for commercial purposes with more than 75 pots per license per buoy tag number in Crab Management Region 1. Region 1 includes Marine Fish-Shellfish Catch Reporting Areas 20A, 20B, 21A, 21B, 22A and 22B.

(2) Effective immediately, until further notice 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 Region 3-1. Region 3-1 includes Marine Fish-Shellfish Catch Reporting Areas 23A and 23B.

(3) The remaining buoy tags per license per region must be onboard the designated vessel and available for inspection.

(4) Effective immediately, until further notice, Crab Management Region 2 East and Region 2 West are closed. Region 2 East includes all waters of Marine Fish-Shellfish Management and Catch Reporting Areas 24A, 24B, 24C, 24D and 26A East. Region 2 West includes all waters of Marine Fish-Shellfish Management and Catch Reporting Areas 25D, 25B and 26A West.

(5) Effective immediately, until further notice, Crab Management Region 3-2 is closed. Region 3-2 includes all waters of Marine Fish-Shellfish Management and Catch Reporting Areas 25E, 25A and 23D.

REPEALER

The following section of the Washington Administrative code is repealed:

WAC 220-52-04000K	Commercial crab fishery—Lawful and unlawful gear, methods, and other unlawful acts. (15-453)

WSR 16-06-121
EMERGENCY RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 16-38—Filed March 2, 2016, 9:47 a.m., effective March 3, 2016]

Effective Date of Rule: March 3, 2016.

Purpose: Amend recreational fishing rules.

Citation of Existing Rules Affected by this Order: Repealing WAC 220-56-51000B; and amending WAC 220-56-510.

Statutory Authority for Adoption: RCW 77.04.012, 77.04.020, 77.12.045, and 77.12.047.

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 change is needed for the lower Columbia River waters in Washington to be consistent with similar regulations in shared waters with Oregon. The Oregon rules became effective January 1, 2016. This rule is interim until permanent rules take effect on July 1, 2016.

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: March 2, 2016.

J. W. Unsworth
Director

NEW SECTION

WAC 220-56-51000B Game fish possession limits and size limits. Notwithstanding the provisions of WAC 220-56-510 and WAC 220-310-185, effective March 3, through June 30, 2016, the daily and size limits are rescinded for Walleye, Channel Catfish, Largemouth Bass and Smallmouth Bass on the following waters:

The main stem of the Columbia River and Washington tributaries in shared boundary waters with Oregon. The included tributaries are:

(1) Abernathy Creek (Cowlitz Co.) mouth to 500 feet downstream from Abernathy Technology Center,

(2) Camas Slough, Chinook River (Pacific Co.),

(3) Coal Creek (Cowlitz Co.) mouth to 400 feet below falls,

(4) Cowlitz River mouth to Mayfield Dam,

(5) Deep River (Wahkiakum Co.) mouth to town bridge,

(6) Drano Lake,

(7) Elochoman River (Wahkiakum Co.) mouth to Elochoman Hatchery Bridge,

(8) Falls Creek (Cowlitz Co.),

(9) Germany Creek (Cowlitz Co.) all tributaries including John and Loper Creeks,

(10) Grays River (Wahkiakum Co.) mouth to Hwy. 4 Bridge,

(11) Hamilton Creek (Skamania Co.),

(12) Kalama River mouth to Kalama Falls Hatchery,

(13) Klickitat River mouth to Fisher Hill Bridge,

(14) Lewis River mouth to Merwin Dam,

(15) Mill Creek (Cowlitz Co.),

(16) Rock Creek (Klickitat Co.)

(17) Rock Creek (Skamania Co.) mouth to falls,

(18) Salmon Creek (Clark Co.) mouth to 182nd Avenue Bridge,

(19) Skamokawa Creek (Wahkiakum Co.),

(20) Washougal River mouth to bridge at Salmon Falls,

(21) White Salmon River mouth to former location of the powerhouse,

(22) Wind River (Skamania Co.) mouth to Shipherd Falls,

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.

REPEALER

The following section of the Washington Administrative Code is repealed effective July 1, 2016:

WAC 220-56-51000B	Game fish possession limits and size limits.