PENDING RULES

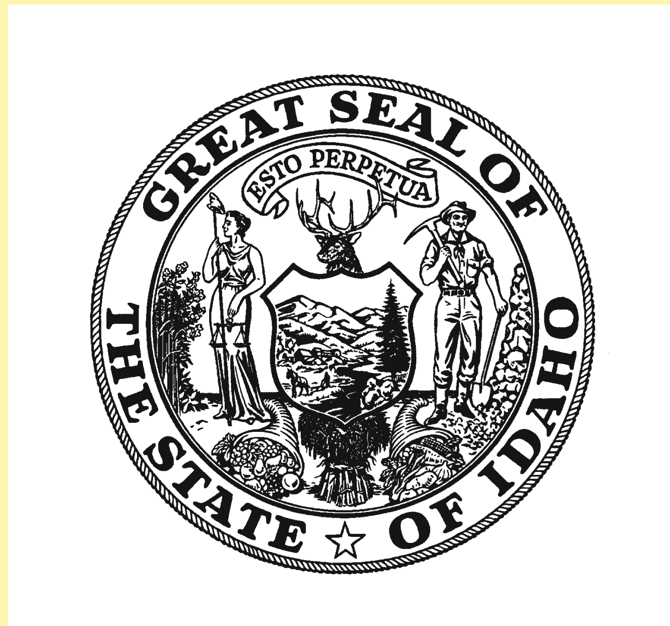
COMMITTEE RULES
REVIEW BOOK

Submitted for Review Before

House Health & Welfare Committee

67th Idaho Legislature

Second Regular Session – 2024



Prepared by:

Office of the Administrative Rules Coordinator
Division of Financial Management

January 2024

HOUSE HEALTH & WELFARE COMMITTEE

ADMINISTRATIVE RULES REVIEW

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IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.01.02 – EMERGENCY MEDICAL SERVICES (EMS) – RULE DEFINITIONS

DOCKET NO. 16-0102-2301

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2024 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. The pending rule will become final and effective upon the adjournment, *sine die*, of the Second Regular Session of the Sixty-seventh Idaho Legislature after approval.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 56-1003 and 56-1023, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

Under Executive Order 2020-01: Zero-Based Regulation, IDAPA 16.01.03, "Emergency Medical Services (EMS) - Agency Licensing Requirements," is being rewritten under companion Docket No. 16-0103-2301 publishing concurrently in this Bulletin. The changes being made in this definitions chapter align with the changes being made in the rewrite of the Agency Licensing chapter.

The text of the pending rule has been amended in accordance with Section 67-5227, Idaho Code. Only those sections that have changes that differ from the proposed text are printed in this bulletin. The complete text of the proposed rule was published in the August 2, 2023, Idaho Administrative Bulletin, Vol. 23-8, pages 16 through 27.

FEE SUMMARY: Pursuant to Section 67-5224(2)(d), Idaho Code, this pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature. The following is a description of the fee or charge imposed or increased in this rulemaking: Does not apply to this rulemaking.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state General Fund greater than ten thousand dollars ($10,000) during the fiscal year:

This rulemaking is not anticipated to have any fiscal impact on the state General Fund, or any other known funds.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Jathan Nalls at 208-334-4007.

DATED this 17th of November, 2023.

Trinette Middlebrook and Frank Powell
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THE FOLLOWING NOTICE PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 56-1003 and 56-1023, Idaho Code.

PUBLIC HEARING SCHEDULE: Two public hearings concerning this rulemaking will be held as follows:

VIRTUAL TELECONFERENCES Via WebEx
Tuesday, August 8, 2023 **2:00 p.m. - 3:00 p.m. (MT)**
Join from the meeting link **https://idhw.webex.com/idhw/j.php?MTID=m337cb21b92992e632f54cf068d12512d** **Join by meeting number** **Meeting number (access code): 2761 903 8177** **Meeting password: 3NWm7vJmNW4 (36967856 from phones and video systems)** **Join by phone** **+1-415-527-5035 United States Toll** **+1-303-498-7536 United States Toll (Denver)**
Wednesday, August 9, 2023 **6:30 p.m. - 7:30 p.m. (MT)**
Join from the meeting link **https://idhw.webex.com/idhw/j.php?MTID=m8c663b33f510ba8ee6ee35fdcbaebb41** **Join by meeting number** **Meeting number (access code): 2763 503 1838** **Meeting password: vkFk8pFDC33 (85358733 from phones and video systems)** **Join by phone** **+1-415-527-5035 United States Toll** **+1-303-498-7536 United States Toll (Denver)**

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below. Each meeting will conclude after 30 minutes if no participants sign in or wish to comment in the meeting.

DESCRIPTIVE SUMMARY: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

Under Executive Order 2020-01: Zero-Based Regulation, IDAPA 16.01.03, "Emergency Medical Services (EMS) - Agency Licensing Requirements," is being rewritten under companion Docket No. 16-0103-2301 publishing concurrently in this Bulletin. The changes being made in this definitions chapter align with the changes being made in the rewrite of the Agency Licensing chapter.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: There are no fees in this chapter of rules.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the State General Fund greater than ten thousand dollars ($10,000) during the fiscal year as a result of this rulemaking:

This rulemaking is not anticipated to have any fiscal impact on the State General Fund, or any other known funds.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted under this docket number. However, negotiated rulemaking was conducted for the companion docket (16-0103-2301) and input was received regarding the definitions contained herein. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking for IDAPA 16.01.03 was published in the April 5, 2023, Idaho Administrative Bulletin, Vol. 23-4, pages 25-26.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into this rule: There are no incorporations by reference in this chapter of rules.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Jathan Nalls at 208-334-4007.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before August 23, 2023.

DATED this 6th day of July, 2023.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0102-2301

Italicized text **indicates changes between the text of the proposed rule as adopted in the pending rule.**

000. LEGAL AUTHORITY.
~~The Idaho Board of Health and Welfare is authorized under~~ Section 56-1023, Idaho Code, authorizes the Board to adopt rules ~~and standards concerning the~~ for administration of the Idaho Emergency Medical Services Act~~, Sections 56-1011 through 56-1023, Idaho Code. The Director is authorized under~~. Section 56-1003, Idaho Code, authorizes the Director to supervise and administer an emergency medical services program. ~~(3-17-22)~~( )

001. ~~TITLE AND~~ SCOPE.

~~**01.**~~ ~~**Title**. These rules are titled IDAPA 16.01.02, "Emergency Medical Services (EMS) – Rule Definitions."~~ ~~(3-17-22)~~

~~**02.**~~ ~~**Scope**.~~ These rules contain the definitions used throughout the Emergency Medical Services

chapters of rules adopted by the Department.~~ Those chapters include:~~ ~~(3-17-22)~~(____)

~~a.~~ ~~IDAPA 16.01.01, "Emergency Medical Services (EMS) -- Advisory Committee (EMSAC)";~~ ~~(3-17-22)~~

~~b.~~ ~~IDAPA 16.01.03, "Emergency Medical Services (EMS) -- Agency Licensing Requirements";~~ ~~(3-17-22)~~

~~c.~~ ~~IDAPA 16.01.05, "Emergency Medical Services (EMS) -- Education, Instructor, and Examination Requirements";~~ ~~(3-17-22)~~

~~d.~~ ~~IDAPA 16.01.06, "Emergency Medical Services (EMS) -- Data Collection and Submission Requirements";~~ ~~(3-17-22)~~

~~e.~~ ~~IDAPA 16.01.07, "Emergency Medical Services (EMS) -- Personnel Licensing Requirements"; and~~ ~~(3-17-22)~~

~~f.~~ ~~IDAPA 16.01.12, "Emergency Medical Services (EMS) -- Complaints, Investigations and Disciplinary Actions."~~ ~~(3-17-22)~~

002. -- 009. (RESERVED)

010. DEFINITIONS AND ABBREVIATIONS A THROUGH B.

~~For the purposes of the Emergency Medical Services (EMS) chapters of rules~~ In addition to definitions under Section 56-1012, Idaho Code, the following definitions apply: ~~(3-17-22)~~(____)

01. **911 Call**. Any request for emergency services that is received or dispatched by a CECS or PSAP, regardless of the method the request was received. (____)

02. **911 Response Transport Service**. An ambulance service type that licenses an agency to provide emergency medical care at emergency scenes, during transports or transfers, and has the primary responsibility of responding to 911 calls dispatched by a CECS or PSAP within a specified geographical area. (____)

03. **911 Response Non-Transport Service**. A non-transport service type that licenses an agency to provide emergency medical care at emergency scenes but does not transport patients and has the primary responsibility of responding to 911 calls dispatched by a CECS or PSAP within a specified geographical area. (____)

0~~1~~4. **Advanced Emergency Medical Technician (AEMT)**. A~~n AEMT is a~~ person who: ~~(3-17-22)~~(____)

a. Has met the qualifications for licensure under Sections 56-1011 through 56-1023, Idaho Code, and IDAPA 16.01.07, "Emergency Medical Services (EMS) - Personnel Licensing Requirements"; (3-17-22)

b. Is licensed by the~~ Department~~ EMS Bureau under Sections 56-1011 through 56-1023, Idaho Code; ~~(3-17-22)~~(____)

c. Carries out the practice of emergency medical care within the scope of practice for AEMT determined by the ~~Idaho Emergency Medical Services Physician Commission (~~EMSPC~~),~~ under IDAPA 16.02.02, "Idaho Emergency Medical Services (EMS) Physician Commission"; and ~~(3-17-22)~~(____)

d. Practices under the supervision of a physician licensed in Idaho. (3-17-22)

0~~2~~5. **Advanced Life Support (ALS)**. The provision of medical care, medication administration and treatment with medical devices that correspond to the knowledge and skill objectives in the Paramedic curriculum currently approved by the State Health Officer and within the scope of practice~~ defined in~~ under IDAPA 16.02.02, "Idaho Emergency Medical Services (EMS) Physician Commission," by persons licensed as Paramedics by the ~~Department~~ EMS Bureau. ~~(3-17-22)~~(____)

0~~3~~6. **Advanced Practice Registered Nurse**. A person who meets~~ all~~ the~~ applicable~~ requirements and is licensed~~ to practice~~ as an Advanced Practice Registered Nurse under Sections 54-1401 through 54-1418, Idaho Code. ~~(3-17-22)~~(   )

0~~4~~7. **Advertise**. Communication of information to the public, institutions, or to any person concerned, by any oral, written, graphic means including handbills, newspapers, television, radio, telephone directories, billboards, or electronic communication methods. (3-17-22)

0~~5~~8. **Affiliation**. The formal association that exists between an agency and~~ those~~ licensed personnel who appear on the agency's roster, which includes active participation, collaboration, and involvement. Affiliation can be demonstrated by the credentialing of licensed personnel by the agency medical director. ~~(3-17-22)~~(   )

0~~6~~9. **Affiliating EMS Agency**. The licensed EMS agency(s)~~, or agencies,~~ under which licensed personnel are authorized to provide patient care. ~~(3-17-22)~~(   )

~~07~~10. **Air Ambulance**. Any privately or publicly owned fixed wing~~ aircraft~~ or rotary wing aircraft used for, or intended to be used for, the transportation of persons experiencing physiological or psychological illness or injury who may need medical attention during transport. This may include dual or multipurpose vehicles that ~~otherwise~~ comply with Sections 56-1011 through 56-1023, Idaho Code, and specifications~~ established in~~ under IDAPA 16.01.03, "Emergency Medical Services (EMS) - Agency Licensing Requirements." ~~(3-17-22)~~(   )

~~08~~11. **Air Medical~~ Agency~~ Service**. An agency licensed by the~~ Department~~ EMS Bureau that responds to requests for patient care and transportation from hospitals and EMS agencies using a fixed wing~~ aircraft~~ or rotary wing aircraft. ~~(3-17-22)~~(   )

~~09~~12. **Air Medical Transport Service**. ~~A service type available to a licensed air medical EMS agency that meets the requirements in IDAPA 16.01.03, "Emergency Medical Services (EMS) - Agency Licensing Requirements."~~ An air medical service type that licenses an agency to provide air medical response and transport of patients from an emergency scene, and hospital-to-hospital transfers of patients utilizing an air ambulance. ~~(3-17-22)~~(   )

1~~1~~3. **Air Medical~~ Support~~ Rescue Service**. An air medical service type~~ available to a~~ that licenseds~~ air medical EMS~~ an agency~~ that meets the requirements in IDAPA 16.01.03, "Emergency Medical Services (EMS) - Agency Licensing Requirements."~~ to provide air medical response and transport of patients from an emergency scene to a rendezvous with air medical transport or ground transport ambulance services. ~~(3-17-22)~~(   )

1~~0~~4. **Air Medical Response**. The deployment of an aircraft~~ licensed as an air ambulance~~ to respond to an emergency scene~~ intended~~ for the purpose of patient treatment and transportation. ~~(3-17-22)~~(   )

1~~2~~5. **Ambulance**. Any privately or publicly owned motor vehicle, or nautical vessel, used for, or intended to be used for, the transportation of sick or injured persons who may need medical attention during transport. This may include dual or multipurpose vehicles that~~ otherwise~~ comply with Sections 56-1011 through 56-1023, Idaho Code, and specifications~~ established in~~ under IDAPA 16.01.03, "Emergency Medical Services (EMS) - Agency Licensing Requirements." ~~(3-17-22)~~(   )

1~~3~~6. **Ambulance-Based Clinicians**. ~~Licensed~~ Registered Nurses and Advanced Practice Registered Nurses who are~~ currently~~ licensed under Sections 54-1401 through 54-1418, Idaho Code, and Physician Assistants who are~~ currently~~ licensed under Sections 54-1801 through 54-1841, Idaho Code. ~~(3-17-22)~~(   )

1~~5~~7. **Ambulance Certification**. Designation issued by the EMS Bureau to a licensed EMR indicating that the EMR has~~ successfully~~ completed ambulance certification training, examination, and credentialing as required by the EMS Bureau. The ambulance certification allows a licensed EMR to serve as the sole patient care provider in an ambulance during transport or transfer. ~~(3-17-22)~~(   )

1~~4~~8. **Ambulance~~ Agency~~ Service**. An agency licensed by the~~ Department under Sections 56-1011 through 56-1023, Idaho Code, and IDAPA 16.01.03, "Emergency Medical Services (EMS) - Agency Licensing~~

~~Requirements,”~~ EMS Bureau and operated with the intent to provide personnel and equipment for medical treatment at an emergency scene, during transportation or during transfer of persons experiencing physiological or psychological illness or injury who may need medical attention during transport. ~~(3-17-22)~~(____)

19. ***Ambulance Service Type****. An agency that is licensed as an ambulance service is intended for patient transport or transfer.* *(____)*

~~**16**~~***20*****.** **Applicant**. Any organization that is requesting an agency license under Sections 56-1011 through 56-1023, Idaho Code, and IDAPA 16.01.03, “Emergency Medical Services (EMS) - Agency Licensing Requirements,” including the following: (3-17-22)

a. An organization seeking a new license; (3-17-22)

b. An existing agency that intends to: (3-17-22)

i. Change the level of licensed personnel it utilizes; (3-17-22)

ii. Change its geographic coverage area (except by agency annexation); or (3-17-22)

iii. Begin or discontinue providing patient transport services. (3-17-22)

~~**17**~~***21*****.** **Assessment**. ~~The~~ Patient evaluation ~~of a patient~~ by EMS licensed personnel intending to provide treatment or transportation to that patient. ~~(3-17-22)~~(____)

~~**18**~~***22*****.** **Basic Life Support (BLS)**. The provision of medical care, medication administration, and treatment with medical devices that correspond to the knowledge and skill objectives in the EMR or EMT curriculum currently approved by the State Health Officer and within scope of practice ~~defined in~~ under IDAPA 16.02.02, “Idaho Emergency Medical Services (EMS) Physician Commission,” by persons licensed as EMRs or EMTs by the ~~Department~~ EMS Bureau. ~~(3-17-22)~~(____)

~~**19**~~***23*****.** **Board**. The Idaho Board of Health and Welfare. (3-17-22)

011. DEFINITIONS AND ABBREVIATIONS C THROUGH E.

~~For the purposes of the Emergency Medical Services (EMS) chapters of rules, the following definitions apply: (3-17-22)~~

01. **Call Volume**. The number of requests for service that an agency either anticipated or responded to during a designated period ~~of time~~. ~~(3-17-22)~~(____)

02. **Candidate**. Any individual who is requesting an EMS personnel license under Sections 56-1011 through 56-1023, Idaho Code, and IDAPA 16.01.07, “Emergency Medical Services (EMS) - Personnel Licensing Requirements.” ~~(3-17-22)~~(____)

03. **Certificate of Eligibility**. Documentation that an individual is eligible for affiliation with an EMS agency, having satisfied all requirements for an EMS Personnel Licensure except for affiliation, but is not licensed to practice. (3-17-22)

04. **Certification**. A credential issued by a designated certification body for a specified period ~~of time~~ indicating that minimum standards have been met. ~~(3-17-22)~~(____)

05. **Certified EMS Instructor**. An individual approved by the ~~Department~~ EMS Bureau, who has met the requirements in IDAPA 16.01.05, “Emergency Medical Services (EMS) -- Education, Instructor, and Examination Requirements,” to provide EMS education and training. ~~(3-17-22)~~(____)

06. **CoAEMSP**. Committee on Accreditation of Educational Programs for the Emergency Medical Services Professions. (3-17-22)

07. Cognitive Exam. Computer-based exam to demonstrate knowledge learned during an EMS education program. (3-17-22)

~~**08. Compensated Volunteer**. An individual who performs a service without promise, expectation, or receipt of compensation other than payment of expenses, reasonable benefits or a nominal fee to perform such services. This individual cannot be a part-time or full-time employee of the same organization performing the same services as a volunteer and employee. (3-17-22)~~

08. **Community Health EMS (CHEMS)**. The practice of deploying EMS personnel to provide evaluation, advice, or treatment of eligible recipients outside of a hospital setting as part of a community-based team of health and social services providers as authorized by local medical control. (____)

09. Conflict of Interest. A situation in which a decision by personnel acting in their official capacity is influenced by or may be a benefit to their personal interests. (3-17-22)

10. Consolidated Emergency Communications System (CECS). An emergency communication system operated or coordinated by a government entity that is composed of ~~F~~facilities, equipment, and dispatching services directly related to establishing, maintaining, or enhancing a 911 emergency communications service defined in Section 31-4802, Idaho Code. ~~(3-17-22)~~(____)

11. Core Content. Set of educational goals, explicitly taught (and not taught), focused on making sure that all students involved learn certain material tied to a specific educational topic and defines the entire domain of out-of-hospital practice and identifies the universal body of knowledge and skills for emergency medical services providers who do not function as independent practitioners. (3-17-22)

12. Course. The specific portions of an education program that delineate the beginning and ~~the~~ end of an individual's EMS education. A course is also referred to as a "section" on the NREMT website. ~~(3-17-22)~~(____)

13. Course Physician. A physician charged with reviewing and approving both the clinical and didactic content of a course. (3-17-22)

14. Credentialing. The local process by which licensed EMS personnel are authorized to provide medical care in the out-of-hospital, hospital, and medical clinic setting, including the determination of a local scope of practice. (3-17-22)

15. Credentialed EMS Personnel. Individuals who are authorized to provide medical care by the EMS medical director, hospital supervising physician, or medical clinic supervising physician. (3-17-22)

16. Critical Care. The treatment of a patient with continuous care, monitoring, medication, or procedures requiring knowledge or skills not contained within the Paramedic curriculum approved by the State Health Officer. Interventions provided by Paramedics are governed by the scope of practice defined in IDAPA 16.02.02, "Idaho Emergency Medical Services (EMS) Physician Commission." (3-17-22)

17. Critical Care Agency. An ambulance or air medical EMS agency that advertises and provides all of the skills and interventions defined as critical care in IDAPA 16.02.02, "Idaho Emergency Medical Services (EMS) Physician Commission." (3-17-22)

18. Department. The Idaho Department of Health and Welfare. (3-17-22)

19. Director. The Director of the ~~Idaho~~ Department ~~of Health and Welfare~~ or their designee. ~~(3-17-22)~~(____)

20. Division. The Department's Division of Public Health~~, Idaho Department of Health and Welfare~~. ~~(3-17-22)~~(____)

21. Emergency. A medical condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of health

and medicine, could reasonably expect the absence of immediate medical attention to result in placing the person's health in serious jeopardy, or in causing serious impairments of bodily function or serious dysfunction of any bodily organ or part. (3-17-22)

22. Emergency Driving Procedures*. Any EMS response to an emergency utilizing emergency lights, sirens, and traffic exemptions under Section 49-623, Idaho Code.* *(   )*

2~~2~~3. Emergency Medical Care. The care provided to a person suffering from a medical condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the person's health in serious jeopardy, or in causing serious impairments of bodily function or serious dysfunction of any bodily organ or part. (3-17-22)

2~~3~~4. Emergency Medical Responder (EMR). A~~n EMR is a~~ person who: ~~(3-17-22)~~(   )

a. Has met the qualifications for licensure in Sections 56-1011 through 56-1023, Idaho Code, and IDAPA 16.01.07, "Emergency Medical Services - Personnel Licensing Requirements"; (3-17-22)

b. Is licensed by the ~~Department~~ EMS Bureau under Sections 56-1011 through 56-1023, Idaho Code; ~~(3-17-22)~~(   )

c. Carries out the practice of emergency medical care within the scope of practice for EMR determined by the ~~Idaho Emergency Medical Services Physician Commission (~~EMSPC~~),~~ under IDAPA 16.02.02, "Emergency Medical Services (EMS) Physician Commission"; and ~~(3-17-22)~~(   )

d. Practices under the supervision of a physician licensed in Idaho. (3-17-22)

~~24~~25. Emergency Medical Services (EMS). Under Section 56-1012(16), Idaho Code,~~ emergency medical services or~~ EMS is aid rendered by an individual or group of individuals who do the following: ~~(3-17-22)~~(   )

a. Respond to a perceived need for medical care~~ in order~~ to prevent loss of life, aggravation of physiological or psychological illness, or injury; ~~(3-17-22)~~(   )

b. Are prepared to provide interventions that are within the scope of practice as defined by the ~~Idaho Emergency Medical Services Physician Commission (~~EMSPC~~),~~ under IDAPA 16.02.02, "~~Rules of the~~ Idaho Emergency Medical Services (EMS) Physician Commission"; ~~(3-17-22)~~(   )

c. Use an alerting mechanism to initiate a response to requests for medical care; and (3-17-22)

d. Offer, advertise, or attempt to respond as described in Subsection 011.2~~4~~5.a. through 011.2~~4~~5.c. of this rule. ~~(3-17-22)~~(   )

~~**25. Emergency Medical Services Advisory Committee (EMSAC)**. The statewide advisory board of the Department as described in IDAPA 16.01.01, "Emergency Medical Services (EMS) - Advisory Committee (EMSAC)." EMSAC members are appointed by the Director of the Idaho Department of Health and Welfare to provide counsel to the Department on administering the EMS Act. (3-17-22)~~

26. Emergency Medical Technician (EMT). A~~n EMT is a~~ person who: ~~(3-17-22)~~(   )

a. Has met the qualifications~~ for licensure in~~ under Sections 56-1011 through 56-1023, Idaho Code, and IDAPA 16.01.07, "Emergency Medical Services - Personnel Licensing Requirements"; ~~(3-17-22)~~(   )

b. Is licensed by the EMS Bureau under Sections 56-1011 through 56-1023, Idaho Code; (3-17-22)

c. Carries out the practice of emergency medical care within the scope of practice for EMT determined by the ~~Idaho Emergency Medical Services Physician Commission (~~EMSPC~~),~~ under IDAPA 16.02.02,

"Idaho Emergency Medical Services (EMS) Physician Commission"; and (3-17-22)( )

d. Practices under the supervision of a physician licensed in Idaho. (3-17-22)

27. **Emergency Response**. Any EMS response to an emergency utilizing emergency lights, sirens, and traffic exemptions under Section 49-623, Idaho Code. ( )

2728. **Emergency Scene**. Any setting outside of a hospital, with the exception of the inter-facility transfer, in which the provision of EMS may take place. (3-17-22)

2829. **EMS Agency**. Any organization licensed by the Department under Sections 56-1011 through 56-1023, Idaho Code, and IDAPA 16.01.03, "Emergency Medical Services (EMS) - Agency Licensing Requirements," that operates an air medical service, ambulance service, or non-transport service. (3-17-22)( )

2930. **EMS Bureau**. The Bureau of Emergency Medical Services (EMS) & and Preparedness of the Idaho Department of Health and Welfare. (3-17-22)( )

3031. **EMS Education Program**. The institution or agency holding an EMS education course. (3-17-22)

3132. **EMS Education Program Director**. The individual responsible for an EMS educational program(s) or programs. (3-17-22)( )

3233. **EMS Education Program Objectives**. The measurable outcome used by the program to determine student competencies. (3-17-22)

3334. **EMS Medical Director**. A physician who supervises the medical activities of licensed personnel affiliated with an EMS agency. (3-17-22)

3435. **EMS Physician Commission (EMSPC)**. The Idaho Emergency Medical Services Physician Commission created under Section 56-1013A, Idaho Code, also referred to as "the Commission." (3-17-22)

3536. **EMS Response**. A response to a request for assistance that would involve the medical evaluation or treatment of a patient, or both. (3-17-22)

012. DEFINITIONS AND ABBREVIATIONS F THROUGH N.
For the purposes of the Emergency Medical Services (EMS) chapters of rules, the following definitions apply: (3-17-22)

01. **Formative Evaluation**. Assessment, including diagnostic testing, that is a range of formal and informal assessment procedures employed by teachers during the learning process. (3-17-22)( )

02. **Full-Time Paid Personnel**. Personnel who perform a service with the promise, expectation, or receipt of compensation for performing such services. Full-time personnel differ from part-time personnel in that full-time personnel work a more regular schedule and typically work more than thirty-five (35) hours per week. (3-17-22)

032. **Glasgow Coma Score (GCS)**. A scale used to determine a patient's level of consciousness. It is a rating from three (3) to fifteen (15) of the patient's ability to open their eyes, respond verbally, and move normally. The GCS is used primarily during the examination of patients with trauma or stroke. (3-17-22)

043. **Ground Transport Time**. The total elapsed time calculated from departure of the ambulance from the scene to arrival of the ambulance at the patient destination. (3-17-22)

054. **Hospital**. A facility in Idaho licensed under Sections 39-1301 through 39-1314, Idaho Code, and defined in Section 39-1301(a)(1), Idaho Code. (3-17-22)

065. **Instructor**. Person who assists a student in the learning process and meets the requirements to obtain instructor certification. (3-17-22)

0~~7~~6. Instructor Certification. A credential issued to an individual by the~~ Department~~ EMS Bureau for a specified period of time indicating that minimum standards for providing EMS instruction under IDAPA 16.01.05, "Emergency Medical Services (EMS) -- Education, Instructor, and Examination Requirements," have been met. ~~(3-17-22)~~(   )

0~~8~~7. Intermediate Life Support (ILS). The provision of medical care, medication administration, and treatment with medical devices that correspond to the knowledge and skill objectives in the AEMT curriculum currently approved by the State Health Officer and within the scope of practice defined in IDAPA 16.02.02, "Idaho Emergency Medical Services (EMS) Physician Commission," by persons licensed as AEMTs by the~~ Department~~ EMS Bureau. ~~(3-17-22)~~(   )

0~~9~~8. Investigation. Research of the facts concerning a complaint or issue of non-compliance that may include performing or obtaining interviews, inspections, document review, detailed subject history, phone calls, witness statements, other evidence, and collaboration with other jurisdictions of authority. (3-17-22)

~~1~~09. License. A document issued by the~~ Department~~ EMS Bureau to an agency or individual authorizing specified activities and conditions~~ as described~~ under Sections 56-1011 through 56-1023, Idaho Code. ~~(3-17-22)~~(   )

~~1~~10. Licensed Personnel. Those individuals who are licensed by the~~ Department~~ EMS Bureau as Emergency Medical Responders (EMR), Emergency Medical Technicians (EMT), Advanced Emergency Medical Technicians (AEMT), and Paramedics. ~~(3-17-22)~~(   )

1~~2~~.1 Licensed Professional Nurse. A person who meets all the applicable requirements and is licensed to practice as a Licensed Professional Nurse under Sections 54-1401 through 54-1418, Idaho Code. (3-17-22)

1~~3~~2. Local Incident Management System. The local system of interagency communications, command, and control established to manage emergencies or demonstrate compliance with the National Incident Management System. (3-17-22)

1~~4~~3. Medical Supervision Plan. The written document describing the provisions for medical supervision of licensed EMS personnel. (3-17-22)

1~~5~~4. National Emergency Medical Services Information System (NEMSIS). ~~NEMSIS is t~~The national repository used to store national EMS data~~. NEMSIS~~ that sets the uniform data conventions and structure for the Data Dictionary~~. NEMSIS~~ and collects and provides aggregate data available for analysis and research through its technical assistance center accessed at http://www.nemsis.org. ~~(3-17-22)~~(   )

1~~6~~5. National Registry of Emergency Medical Technicians (NREMT). An independent, non-governmental, not-for-profit organization that prepares validated examinations for the state's use in evaluating candidates for licensure. ~~(3-17-22)~~(   )

1~~7~~6. Non-Transport~~ Agency~~ Service.~~ An agency licensed by the Department, operated with the intent to provide personnel or equipment for medical stabilization at an emergency scene, but not intended to be the service that will actually transport sick or injured persons~~ An *EMS* agency *that provides emergency medical care, but does not transport patients and does not respond to 911 calls or respond to calls using emergency driving procedures unless requested by CECS, PSAP, or a 911 Response agency*. ~~(3-17-22)~~*(   )*

17. Non-Transport Service Type. *An agency that is licensed as a non-transport service type, is not intended for patient transport or transfers, and cannot advertise ambulance services. (   )*

18. Non-Transport Vehicle. Any vehicle operated by an agency with the intent to provide personnel or equipment for medical stabilization at an emergency scene, but not intended as the vehicle that will actually transport sick or injured persons. (3-17-22)

19. Nurse Practitioner. An Advanced Practice Registered Nurse, licensed in the category of Nurse

Practitioner,~~ as defined in~~ under IDAPA 24.34.01, “Rules of the Idaho Board of Nursing.” ~~(3-17-22)~~( )

013. DEFINITIONS AND ABBREVIATIONS O THROUGH Z.
~~For the purposes of the Emergency Medical Services (EMS) chapters of rules, the following definitions apply:~~ ~~(3-17-22)~~

01. Optional Module (OM). ~~Optional modules (OMs) are s~~Skills identified by the EMSPC~~ Physician Commission~~ that exceed the floor level Scope of Practice for EMS personnel and may be adopted by the agency medical director. ~~(3-17-22)~~( )

02. Out-of-Hospital. Any setting outside of a hospital, including inter-facility transfers, in which the provision of EMS may take place. (3-17-22)

03. Paramedic. A~~ paramedic is a~~ person who: ~~(3-17-22)~~( )

a. Has met the qualifications~~ for licensure in~~ under Sections 56-1011 through 56-1023, Idaho Code, and IDAPA 16.01.07, “Emergency Medical Services - Personnel Licensing Requirements”; ~~(3-17-22)~~( )

b. Is licensed by the EMS Bureau under Sections 56-1011 through 56-1023, Idaho Code; (3-17-22)

c. Carries out the practice of emergency medical care within the scope of practice for paramedics determined by the ~~Idaho Emergency Medical Services Physician Commission (~~EMSPC~~),~~ under IDAPA 16.02.02, “Idaho Emergency Medical Services (EMS) Physician Commission”; and ~~(3-17-22)~~( )

d. Practices under the supervision of a physician licensed in Idaho. (3-17-22)

04. Paramedicine. Providing emergency care to sick and injured patients at the ~~advanced life support (~~ALS~~)~~ level with defined roles and responsibilities to be credentialed at the Paramedic level. ~~(3-17-22)~~( )

~~**05. Part-Time Paid Personnel**. Personnel who perform a service with the promise, expectation, or receipt of compensation for performing such services. Part-time personnel differ from the full-time personnel in that the part-time personnel typically work an irregular schedule and work less than thirty-five (35) hours per week.~~ ~~(3-17-22)~~

0~~6~~5. Patient. A sick, injured, incapacitated, or helpless person who is under medical care or treatment. (3-17-22)

0~~7~~6. Patient Assessment. The evaluation of a patient by EMS licensed personnel intending to provide treatment or transportation to that patient. (3-17-22)

0~~8~~7. Patient Care. The performance of acts or procedures under emergency conditions in responding to a perceived individual need for immediate care~~ in order~~ to prevent loss of life, aggravation of physiological or psychological illness, or injury. ~~(3-17-22)~~( )

0~~9~~8. Patient Movement. The relatively short distance transportation of a patient from an off-highway emergency scene to a rendezvous with an ambulance or air ambulance. (3-17-22)

~~10~~09. Patient Transport. The transportation of a patient by ambulance or air ambulance from a rendezvous or emergency scene to a medical care facility. (3-17-22)

~~11~~10. Physician. A person who holds a current active license~~ in accordance with~~ under Section 54-1803, Idaho Code, issued by the~~ State~~ Board of Medicine to practice medicine and surgery, osteopathic medicine and surgery, or osteopathic medicine~~ in Idaho~~ and is in good standing with no restrictions upon, or actions taken against, their license. ~~(3-17-22)~~( )

~~12~~11. Physician Assistant. A person who meets all the applicable requirements and is licensed to practice as a~~ licensed~~ physician assistant under Title 54, Chapter 18, Idaho Code. ~~(3-17-22)~~( )

~~*13*~~*12*. **Planned Deployment**. The deliberate, planned placement of EMS personnel outside of an affiliating agency's deployment model declared on the application under which the agency is currently licensed. (3-17-22)

~~*14*~~*13*. **Prehospital**. A setting where emergency medical care is provided prior to or during transport to a hospital. (3-17-22)

~~*15*~~*14*. **Psychomotor Exam**. Practical demonstration of skills learned during an EMS education course. (3-17-22)

15. **Public Safety Answering Point (PSAP)**. An emergency communication center operated or coordinated by a government entity that is connected to local 911 phone services for the purpose of dispatching emergency services. (   )

16. **REPLICA**. The Recognition of EMS Personnel Licensure Interstate Compact ~~known as REPLICA~~ that allows recognition of EMS personnel licensed in other jurisdictions that have enacted the compact to have personnel licenses reciprocated in the state of Idaho. ~~(3-17-22)~~(   )

17. **Response Time**. The total time elapsed from when the agency receives a call for service to when the agency arrives and is available at the scene. (3-17-22)

~~18.~~ ~~**Seasonal**. An agency that is active and operational only during a period of time each year that corresponds to the seasonal activity that the agency supports.~~ ~~(3-17-22)~~

~~*19*~~*18*. **Skills Proficiency**. The process overseen by an EMS agency medical director to verify competency in psychomotor skills. (3-17-22)

19. **Special Pathogens Transport (SPT)**. The practice of deploying specially trained EMS personnel and specialized equipment to provide medical care and transport of patients suffering from exposure or disease caused by highly infectious special pathogens. (   )

20. **State Health Officer**. The Administrator of the Department's Division of Public Health. ~~(3-17-22)~~(   )

21. **Summative Evaluation**. End of topic or end of course evaluation that covers both didactic and practical skills application. (3-17-22)

22. **Supervision**. The medical direction by a licensed physician of activities provided by licensed personnel affiliated with a licensed ambulance, air medical, or non-transport service, including: (3-17-22)

a. Establishing standing orders and protocols; (3-17-22)

b. Reviewing performance of ~~licensed~~ personnel; ~~(3-17-22)~~(   )

c. Providing instructions for patient care via radio or telephone; and (3-17-22)

d. Other oversight. (3-17-22)

23. **Third Service**. A public EMS agency that is neither law-enforcement nor fire-department-based. (3-17-22)

24. **Transfer**. The transportation of a patient from one (1) medical care facility to another. (3-17-22)

25. **Tactical EMS (TEMS)**. The practice of deploying specially trained EMS personnel to provide emergency medical care in support of law enforcement activities. (   )

26*.* **Transport Service**. An agency *that* provide*s* emergency medical care during transports *or* transfers, but does not respond to 911 calls*. Transport services only respond to calls using emergency driving procedures for emergency hospital-to-hospital transfers and when* requested by CECS, PSAP, or a 911 Response agency. *( )*

~~*25.*~~ ~~***Uncompensated Volunteer***~~~~*. An individual who performs a service without promise, expectation, or receipt of any compensation for the services rendered. An uncompensated volunteer cannot be a part-time or full-time employee of the same organization performing the same services as a volunteer and employee.* *(3-17-22)*~~

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.01.03 – EMERGENCY MEDICAL SERVICES (EMS) – AGENCY LICENSING REQUIREMENTS

DOCKET NO. 16-0103-2301 (ZBR CHAPTER REWRITE)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo and Incorporation By Reference Synopsis (IBRS)

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2024 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. The pending rule will become final and effective upon the adjournment, *sine die*, of the Second Regular Session of the Sixty-seventh Idaho Legislature after approval.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section(s) 56-1003 and 56-1023, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

Due to Executive Order 2020-01, Zero-Based Regulation, agencies are required to rewrite IDAPA chapters every 5 years on an approved schedule. This rulemaking is complying to this mandate and is scheduled for presentation to the 2024 Legislature. The Department is striving to prevent the accumulation of costly, ineffective, and outdated regulations and reduce regulatory burden to achieve a more efficient operation of government. The rule changes are intended to perform a comprehensive review of this chapter having collaborated with the public to streamline or simplify this rule language. The companion docket with this rulemaking is 16-0102-2301 publishing concurrently in this Bulletin.

The text of the pending rule has been amended in accordance with Section 67-5227, Idaho Code. Only those sections that have changes that differ from the proposed text are printed in this bulletin. The complete text of the proposed rule was published in the August 2, 2023, Idaho Administrative Bulletin, Vol. 23-8, pages 28 through 52.

FEE SUMMARY: Pursuant to Section 67-5224(2)(d), Idaho Code, this pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature. The following is a description of the fee or charge imposed or increased in this rulemaking: Does not apply to this rulemaking.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state General Fund greater than ten thousand dollars ($10,000) during the fiscal year:

This rulemaking is not anticipated to have any fiscal impact on the state General Fund, or any other known funds.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Jathan Nalls at 208-334-4007.

DATED this 17th day of November, 2023.

Trinette Middlebrook and Frank Powell
DHW – Administrative Rules Unit
450 W. State Street – 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
phone: (208) 334-5500
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e-mail:dhwrules@dhw.idaho.gov

THE FOLLOWING NOTICE PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 56-1003 and 56-1023, Idaho Code.

PUBLIC HEARING SCHEDULE: Two public hearings concerning this rulemaking will be held as follows:

VIRTUAL TELECONFERENCES Via WebEx
Tuesday, August 8, 2023 **2:00 p.m. - 3:00 p.m. (MT)**
Join from the meeting link **https://idhw.webex.com/idhw/j.php?MTID=m337cb21b92992e632f54cf068d12512d** **Join by meeting number** **Meeting number (access code): 2761 903 8177** **Meeting password: 3NWm7vJmNW4 (36967856 from phones and video systems)** **Join by phone** **+1-415-527-5035 United States Toll** **+1-303-498-7536 United States Toll (Denver)**
Wednesday, August 9, 2023 **6:30 p.m. - 7:30 p.m. (MT)**
Join from the meeting link **https://idhw.webex.com/idhw/j.php?MTID=m8c663b33f510ba8ee6ee35fdcbaebb41** **Join by meeting number** **Meeting number (access code): 2763 503 1838** **Meeting password: vkFk8pFDC33 (85358733 from phones and video systems)** **Join by phone** **+1-415-527-5035 United States Toll** **+1-303-498-7536 United States Toll (Denver)**

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below. Each meeting will conclude after 30 minutes if no participants sign in or wish to comment in the meeting.

DESCRIPTIVE SUMMARY: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

Due to Executive Order 2020-01, Zero-Based Regulation, agencies are required to rewrite IDAPA chapters every 5 years on an approved schedule. This rulemaking is complying to this mandate and is scheduled for presentation to the 2024 Legislature. Under this Executive Order, the Department is striving to prevent the accumulation of costly, ineffective, and outdated regulations and reduce regulatory burden to achieve a more efficient operation of government. The rule changes are intended to perform a comprehensive review of this chapter by collaborating with the public to streamline or simplify this rule language. As a result of changes made in this docket, changes have been made in IDAPA 16.01.02, "Emergency Medical Services (EMS) - Rule Definitions" under companion Docket No. 16-0102-2301 publishing concurrently in this Bulletin.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: There are no fees in this chapter of rules.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the State General Fund greater than ten thousand dollars ($10,000) during the fiscal year as a result of this rulemaking:

This rulemaking is not anticipated to have any fiscal impact on the State General Fund, or any other known funds.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the April 5, 2023, Idaho Administrative Bulletin, Vol. 23-4, pages 25-26.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into this rule: The following documents incorporated by reference in these rules are being updated: (1) the Minimum Equipment Standards for Licensed EMS Services, and (2) the Time Sensitive Emergency System Standards Manual. The EMS Agency Standards Manual is a new manual that is being added. These documents are incorporated by reference to save space in the chapter and ensure that they continue to have the force and effect of law.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Jathan Nalls at 208-334-4007.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before August 23, 2023.

DATED this 6th day of July, 2023.

THE FOLLOWING IS THE TEXT OF ZBR DOCKET NO. 16-0103-2301

16.01.03 – EMERGENCY MEDICAL SERVICES (EMS) – AGENCY LICENSING REQUIREMENTS

000. LEGAL AUTHORITY.
Section 56-1023, Idaho Code, authorizes the Board to adopt rules for the administration of the Idaho Emergency Medical Services Act. Section 56-1003, Idaho Code, authorizes the Director to supervise and administer an emergency medical service program. ( )

001. (RESERVED)

002. INCORPORATION BY REFERENCE.
The following documents are incorporated by reference: ( )

01. Minimum Equipment Standards for Licensed EMS Services. "Minimum Equipment Standards for Licensed EMS Services," Edition 2024-1, is the standard for minimum equipment requirements for licensed EMS Agencies. Copies may be obtained from the EMS Bureau at http://www.idahoems.org. ( )

02. Time Sensitive Emergency System Standards Manual. "Time Sensitive Emergency System Standards Manual," Edition 2023-1, is the standard for certifying EMS Agencies as TSE Designated EMS Agencies. Copies may be obtained from the Department at https://tse.idaho.gov/. ( )

03. EMS Data Collection Standards Manual. EMS Data Collection Standards Manual, Edition 2023-1 is the standard for data collection by licensed EMS agencies. Copies may be obtained from the EMS Bureau at http://www.idahoems.org/. ( )

04. EMS Agency Standards Manual. EMS Agency Standards Manual, Edition 2024-1, is the standard for policies and agreements required for Idaho EMS agency licensure. Copies may be obtained from the EMS Bureau at http://www.idahoems.org/ or from the Bureau of Emergency Medical Services and Preparedness located at 2224 East Old Penitentiary Road, Boise, ID 83712-8249. ( )

003. -- 009. (RESERVED)

010. DEFINITIONS.
For the purposes of this chapter, the definitions in IDAPA 16.01.02, "Emergency Medical Services (EMS) - Rule Definitions," apply. ( )

011. -- 074. (RESERVED)

075. INVESTIGATION OF COMPLAINTS FOR EMS LICENSING VIOLATIONS.
Investigation of complaints and disciplinary actions for EMS agency licensing are under IDAPA 16.01.12, "Emergency Medical Services (EMS) - Complaints, Investigations, and Disciplinary Actions." ( )

076. ADMINISTRATIVE LICENSE OR CERTIFICATION ACTION.
Any license or certification may be suspended, revoked, denied, or retained with conditions for noncompliance with any standard or rule. Administrative license or certification actions, including fines, imposed by the EMS Bureau for any action, conduct, or failure to act that is inconsistent with the professionalism, or standards, or both, are provided under Sections 56-1011 through 56-1023, Idaho Code, and IDAPA 16.01.12, "Emergency Medical Services (EMS) - Complaints, Investigations, and Disciplinary Actions." ( )

077. -- 099. (RESERVED)

EMS AGENCY GENERAL LICENSURE REQUIREMENT
(Sections 100 - 199)

100. AGENCY LICENSE REQUIRED.
Any organization that advertises or provides ambulance, air medical, or non-transport EMS in Idaho must be licensed as an EMS agency under Sections 56-1011 through 56-1023, Idaho Code, and these rules. ( )

101. EXEMPTION OF EMS AGENCY LICENSURE.
An organization, licensed without restriction to provide EMS in another state and not restricted from operating in Idaho by the EMS Bureau, may provide EMS in Idaho within the limits of its license without an Idaho EMS license only when the organization meets one (1) of the following: ( )

01. Interstate Compact with Idaho. The organization holds an EMS license in another state where an interstate compact specific to EMS agency licensure with Idaho is in effect. ( )

02. Emergency, Natural, or Man-made Disaster. The organization is responding to an emergency, or

a natural or man-made disaster, declared by federal, state, or local officials and the services of the organization are requested by an entity of local or state government in Idaho. ( )

03. Transfer of Patient From Out-of-State Medical Facility. The organization is transferring a patient from an out-of-state medical facility: ( )

a. To a medical facility in Idaho. The organization may return the patient to the point of origin; or ( )

b. Through the state of Idaho. ( )

04. Transport of Patient From Out-of-State Emergency Scene. The organization is transporting a patient: ( )

a. From an out-of-state emergency scene to a medical facility in Idaho; or ( )

b. To a rendezvous with another ambulance. ( )

102. SERVICES PROVIDED BY A LICENSED EMS AGENCY.
An EMS agency can provide only those services that are within the agency's service types and clinical levels stated on the most recent license issued by the EMS Bureau, except when the agency has a planned deployment agreement described in Section 604 of these rules. ( )

103. ELIGIBILITY FOR EMS AGENCY LICENSURE.
An entity is eligible for EMS agency licensure upon demonstrated compliance with Idaho statutes and administrative rules in effect at the time the EMS Bureau receives the application. ( )

104. -- 199. (RESERVED)

EMS AGENCY LICENSURE MODEL
(Sections 200 - 299)

200. EMS AGENCY-- LICENSING MODEL.

01. Licensing an EMS Agency. An eligible EMS agency is licensed using a descriptive model that bases the agency licensure on the declarations made in the most recent approved initial or renewal application. An EMS agency must provide only those EMS services described in the most recent application on which the agency was issued a license by the EMS Bureau. ( )

02. EMS Agency License Models. An EMS agency license is based on the agency's service types and clinical levels. Geographic coverage areas and resources may differ between the service types and clinical levels under which an agency is licensed. ( )

03. EMS Agency Providing Air Medical and Ground-Based EMS Services. An EMS agency that provides both air medical and ground-based EMS services must be licensed accordingly and meet all the requirements of an air medical and either an ambulance or non-transport agency, depending on the ground EMS services provided. ( )

04. Multiple Organization EMS Agency. An EMS agency may be comprised of multiple organizations licensed under a single responsible authority to which the governing officials of each organization agree. The authority must establish a deployment strategy that declares in which areas and at what times within their geographical response area will be covered by the declared service types and clinical levels. ( )

201. EMS AGENCY -- SERVICE TYPES.
An EMS agency may be licensed as one (1) or more service types. An agency that provides multiple service types must meet the requirements for each service type provided. The following are the agency services types available for EMS agency licensure. ( )

01. Ambulance Service Types. An agency that is licensed as an ambulance service is intended for patient transport or transfer. ( )

a. 911 Response Transport Service. Available to an agency that provides emergency medical care at emergency scenes, during transports or transfers, and has the primary responsibility of responding to 911 calls dispatched by a Public Safety Answering Point (PSAP) or Consolidated Emergency Communication System (CECS) within a specified geographical area. ( )

b. Transport Service. Available to an agency that provides emergency medical care during transports or transfers but does not respond to 911 calls. Transport services only respond to calls using emergency driving procedures for emergency hospital-to-hospital transfers and when requested by a CECS, PSAP, or a 911 Response agency. ( )

02. Non-Transport Service Types. An agency that is licensed as a non-transport service is not intended for patient transport or transfers and cannot advertise ambulance services. ( )

a. 911 Response Non-Transport Service. Available to an agency that provides emergency medical care at an emergency scene and has the primary responsibility of responding to 911 calls dispatched by a CECS or PSAP within a specified geographical area. ( )

b. Non-Transport Service. Available to an agency that provides emergency medical care but does not respond to 911 calls or respond to calls using emergency driving procedures unless requested by a CECS, PSAP, or a 911 Response agency. ( )

03. Air Medical Service Types. An agency that is licensed with an air medical service type is intended for patient transport, transfer, or rescue. ( )

a. Air Medical Transport Service. Available to an agency that provides air medical response and transport of patients from emergency scenes and hospitals utilizing a fixed-wing or rotary-wing air ambulance. ( )

b. Air Medical Rescue Service. Available to an agency that provides air medical response via fixed-wing or rotary-wing aircraft to emergency scenes for transportation of patients from an emergency scene to a rendezvous with a ground or air medical transport agency. ( )

202. EMS AGENCY -- CLINICAL LEVELS.

An EMS agency is licensed at one (1) or more of the following clinical levels depending on the agency's highest level of licensed personnel and life support services advertised or offered, and provided according to skill requirements under IDAPA 16.02.02, "Idaho Emergency Medical Services Physician Commission." ( )

01. Basic Life Support (BLS). Deploys licensed EMS personnel trained and equipped to provide all EMR or EMT skills. ( )

02. Intermediate Life Support (ILS). Deploys licensed EMS personnel trained and equipped to provide Advanced EMT skills. ( )

03. Advanced Life Support (ALS). Deploys licensed EMS personnel trained and equipped to provide Paramedic skills. ( )

203. EMS AGENCY -- SPECIALTY SERVICES.

Each EMS agency offering the following specialty services must report such services to the EMS Bureau. ( )

01. Critical Care (CC). The provision of EMS personnel trained, credentialed, and equipped to provide all critical care skills and required staffing under IDAPA 16.02.02, "Idaho Emergency Medical Services Physician Commission." ( )

02. Community Health EMS (CHEMS). The provision of evaluation, advice, or treatment of eligible recipients outside of a hospital setting as part of a community-based team of health and social services providers as authorized by local medical control. ( )

a. Clinical treatments and assessments of CHEMS patients cannot exceed the agency's licensed clinical level. ( )

b. Community Health EMS involving or related to emergency response must be provided by or in coordination with the primary 911 Response Transport agency for that area. ( )

03. Tactical EMS (TEMS). The provision of emergency medical care in support of law enforcement activities. ( )

a. The Tactical EMS specialty service must be formally affiliated with one (1) or more local law enforcement agencies. ( )

b. Clinical treatments of patients cannot exceed the agency's licensed clinical level unless authorized by the EMSPC. ( )

04. Special Pathogen Transport (SPT). The provision of emergency medical care and transport of patients suffering from exposure or disease caused by highly infectious special pathogens. ( )

204. – 211. (RESERVED)

212. NON-TRANSPORT EMS AGENCY -- PATIENT MOVEMENT.
A non-transport agency can move a patient by vehicle only when: ( )

01. Accessibility of Emergency Scene. The responding ambulance or air ambulance agency cannot access the emergency scene. ( )

02. Licensed Personnel Level. Patient care is provided by EMS personnel licensed at: ( )

a. EMT level or higher; or ( )

b. EMR level only when the patient care integration agreement under which the non-transport agency operates addresses and enables patient movement. The agency must ensure that its personnel are trained and credentialed in patient packaging and movement. ( )

03. Rendezvous with Transport EMS Agency. Movement of the patient is to rendezvous with an ambulance or air ambulance agency during which the EMS personnel must be in active communication with the ambulance or air ambulance with which they will rendezvous. ( )

04. Report Patient Movement. A non-transport agency must report all patient movement events to the EMS Bureau within thirty (30) days of the event. ( )

213. -- 299. (RESERVED)

PERSONNEL REQUIREMENTS FOR EMS AGENCY LICENSURE
(Sections 300 - 399)

300. EMS AGENCY -- GENERAL PERSONNEL REQUIREMENTS.
Personnel must be licensed under IDAPA 16.01.07, "Emergency Medical Services (EMS) -- Personnel Licensing Requirements." ( )

01. Personnel Requirements for EMS Agency Licensure. Each agency must ensure availability of affiliated personnel licensed and credentialed at or above the clinical level for the entire anticipated call volume, except that an agency holding a 911 Response Transport or 911 Response Non-transport license may request a waiver

of this requirement from the EMS Bureau. ( )

02. Personnel Requirements for an Agency Utilizing Emergency Medical Dispatch. An agency dispatched by a CECS that uses an emergency medical dispatch (EMD) process to determine the clinical needs of the patient must ensure availability of personnel licensed and credentialed at clinical levels appropriate to the anticipated call volume for each of the clinical levels the agency provides. ( )

03. Personnel Requirements for an Agency Utilizing Ambulance-Based Clinicians. An agency may use ambulance-based clinicians to meet the licensed personnel requirements for agency licensure as follows: ( )

a. 911 Response Transport, or 911 Response Non-transport Service licensed at the BLS or ILS clinical level. ( )

b. Transport Service licensed at the ALS clinical level. ( )

301. EMS AGENCY -- SPECIALTY SERVICE PERSONNEL REQUIREMENTS.

Each EMS agency offering specialty services under Section 203 of these rules is responsible for reporting personnel trained and credentialed to provide those services to the EMS Bureau. ( )

01. Critical Care. EMS personnel must have been formally trained, credentialed, and equipped to provide all critical care skills under IDAPA 16.02.02, "Idaho Emergency Medical Services Physician Commission." ( )

02. Community Health EMS. Licensed EMS personnel must have received standardized CHEMS training recognized by the EMS Bureau to participate in patient care related to CHEMS. ( )

03. Tactical EMS. Licensed EMS personnel must have received specialized training to provide emergency medical care in support of law enforcement activities. ( )

04. Special Pathogens Transport. Licensed EMS personnel must have received specialized training specific to the transport of patients suffering from exposure or disease caused by highly infectious special pathogens. Such training must include, at a minimum, proper use of appropriate PPE, avoiding disease exposure, use of specialized equipment and containment systems used during transport, crew member and public safety concerns, and proper waste management. ( )

302. AMBULANCE SERVICE -- PERSONNEL REQUIREMENTS.

Each ambulance service must ensure that there is one (1) EMS provider providing patient care, not including the driver, on each patient transport or transfer. The crew member providing patient care, at a minimum, must be a licensed EMR with an ambulance certification or a licensed EMT. ( )

01. Emergency Scene ALS. A licensed paramedic must be present whenever ALS services are provided at an emergency scene or during patient transport to a medical facility. ( )

02. Interfacility Transfers ALS. ( )

a. A licensed paramedic or ambulance-based clinician must provide ALS services during interfacility transfers. ( )

b. A BLS or ILS 911 Response Transport Service may conduct ALS interfacility transfers with a licensed paramedic or ambulance-based clinician if equipped with ALS equipment necessary to provide appropriate patient care and ALS interventions. ( )

03. Critical Care. A minimum of one (1) credentialed critical care provider and one (1) additional paramedic or ambulance-based clinician are required in the patient compartment during patient transport. Special consideration may be given for the second provider based on a specific specialized patient need. ( )

303. AIR MEDICAL TRANSPORT SERVICE -- PERSONNEL REQUIREMENTS.
Each air medical transport service must ensure that the standard medical flight crew consists of, at a minimum, one (1) licensed Paramedic and one (1) licensed Registered Nurse. At least one (1) crew member on each flight must hold critical care credentials under IDAPA 16.02.02, "Idaho Emergency Medical Services (EMS) Physician Commission." Air Medical Transport Services may utilize alternate medical crew configurations for specific situations as stated below: ( )

01. Emergency Scene Transports. Alternate crew configurations for emergency scene response and patient transport. ( )

a. Two (2) Paramedics. ( )

b. When no other crew with a licensed Paramedic and no other Air Medical Transport Service with a Paramedic crew member is available, an Air Medical Transport Service may deploy a crew of two (2) licensed Registered Nurses. ( )

02. Interfacility Transfers. Alternate crew configurations for interfacility transfers, based on patient need. ( )

a. Two (2) Registered Nurses. ( )

b. One (1) Registered Nurse and One (1) Respiratory Therapist. ( )

c. Two (2) Paramedics when both possess critical care credentials under IDAPA 16.02.02, "Idaho Emergency Medical Services Physician Commission." ( )

304. PERSONNEL FOR AIR MEDICAL RESCUE SERVICE.
An Air Medical Rescue service must ensure that each flight includes a minimum of one (1) patient care provider licensed at or above the agency's clinical level of licensure, not including the pilot. The crew member providing patient care, at a minimum, must be a licensed EMT. ( )

305. PLANNED DEPLOYMENT -- PERSONNEL REQUIREMENTS.
Planned deployment allows affiliated EMS personnel to act and provide predetermined services outside of their affiliating agency's geographic coverage area. It can allow EMS personnel licensed at a higher clinical level to provide patient care within their credentialed scopes of practice even when the agency into which the planned deployment occurs is licensed at a lower clinical level. A planned deployment agreement must be formally documented and meet the requirements under the incorporated document in Subsection 002.04 of these rules. ( )

306. AMBULANCE-BASED CLINICIANS -- PERSONNEL REQUIREMENTS.

01. Ambulance-Based Clinician Certified by the EMS Bureau. An EMS agency that advertises or provides out-of-hospital patient care by affiliating and utilizing a currently licensed registered nurse, advanced practice registered nurse, or physician assistant, under IDAPA 16.01.02, "Emergency Medical Services (EMS) - Rule Definitions," must ensure that those individuals maintain a current ambulance-based clinician certificate issued by the EMS Bureau. See Section 307 of these rules for exceptions to this requirement. ( )

02. Obtaining an Ambulance-Based Clinician Certificate. An agency, on behalf of an individual who desires an ambulance-based clinician certificate, must provide on the EMS Bureau's application documentation that the individual: ( )

a. Holds a current, unrestricted license to practice issued by the Board of Medicine or Board of Nursing; and ( )

b. Has successfully completed an EMS Bureau-approved ambulance-based clinician training; or ( )

c. Has successfully completed an EMT course. ( )

03. Maintaining an Ambulance-Based Clinician Certificate. An ambulance-based clinician certificate is valid for as long as the holder of the certificate is continuously licensed by their respective licensing board. ( )

04. Revocation of an Ambulance-Based Clinician Certificate. The EMS Bureau may revoke an ambulance-based clinician certificate based on the procedures for administrative license actions under IDAPA 16.01.12, "Emergency Medical Services (EMS) -- Complaints, Investigations, and Disciplinary Actions." ( )

05. Agency Responsibilities for Ambulance-Based Clinicians. The agency must verify that each ambulance-based clinician possesses a current Department-issued ambulance-based clinician certificate. The agency must ensure that any ambulance-based clinician meets additional requirements of the corresponding licensing board. ( )

307. UTILIZING PHYSICIAN ASSISTANTS, REGISTERED NURSES, OR ADVANCED PRACTICE REGISTERED NURSES.

An AEMT/ILS ambulance agency may use a non-certified physician assistant, licensed registered nurse, or advanced practice registered nurse as the crew member who is providing ILS patient services, only when accompanied by a licensed EMR with an ambulance certification or a licensed EMT in the patient compartment of the transport vehicle. ( )

308. -- 399. (RESERVED)

EMS AGENCY VEHICLE REQUIREMENTS
(Sections 400 - 499)

400. EMS AGENCY -- VEHICLE REQUIREMENTS.

Not all EMS agencies need to have emergency response vehicles. An agency's need for emergency response vehicles is based on the deployment needs of the agency that is declared on the most recent agency licensure application. An agency with a deployment pattern that requires emergency response vehicles must meet the following: ( )

01. Condition of Response Vehicles. Each of the agency's EMS response vehicles is in sound, safe, working condition. ( )

02. Quantity of Response Vehicles. Each EMS agency possesses a sufficient quantity of EMS response vehicles to ensure agency personnel can respond to the anticipated call volume of the agency. ( )

03. Motor Vehicle Licensing Requirements. Each of the EMS agency's response vehicles meets the Idaho motor vehicle license and insurance requirements. ( )

04. Configuration and Standards for EMS Response Vehicles. Each of the EMS agency's response vehicles is appropriately configured with the declared capabilities on the most recent agency license. Each EMS response vehicle meets the requirements for applicable federal, state, industry, or trade specifications and standards for ambulance or air ambulance vehicles as appropriate. Uniquely configured EMS response vehicles are approved by the EMS Bureau prior to being put into service. ( )

05. Location of Emergency Response Vehicles. Each of the agency's EMS response vehicles is stationed or staged within the agency's declared geographic coverage area in a manner that allows agency personnel to effectively respond to the anticipated volume and distribution of requests for service. ( )

401. NON-TRANSPORT EMS AGENCY -- VEHICLES.

A licensed non-transport EMS agency may use ambulance vehicles to provide non-transport services. ( )

402. EMS AGENCY -- MINIMUM EQUIPMENT INSPECTION REQUIREMENTS.

Any newly acquired EMS response vehicle must be inspected by the EMS Bureau for medical care supplies and devices as specified under Subsection 002.01 of these rules before being put into service, except when the newly acquired vehicle is a replacement vehicle and all equipment and supplies are transferred from the vehicle being taken

out of service. ( )

403. EMS AGENCY -- GROUND VEHICLE SAFETY INSPECTION REQUIREMENTS.
Each EMS agency that deploys emergency vehicles titled and registered for use on roads and highways, except for all-terrain vehicles and utility vehicles, must meet the following. ( )

01. New Vehicle Inspection. Each newly acquired, used EMS response vehicle has passed a safety inspection conducted by an inspector authorized to perform Department of Transportation (DOT) vehicle safety inspections prior to the vehicle being put in service. ( )

02. Response Vehicle Involved in a Crash. Each EMS response vehicle, that is involved in a crash that could result in damage to one (1) or more of the vehicle systems identified in Subsection 403.03 of this rule, has passed a safety inspection conducted by an inspector authorized to perform DOT vehicle safety inspections prior to being put back in service. ( )

03. Vehicle Inspection Standards. Each vehicle safety inspection has verified conformity to the fuel system, exhaust, wheels and tires, lights, windshield wipers, steering, suspension, brakes, frame, and electrical system elements of a DOT vehicle safety inspection defined in Appendix G to Subchapter B of Chapter III at 49 CFR Section 396.17. ( )

04. Vehicle Inspection Records. Each EMS agency keeps records of all emergency response vehicle safety inspections and are available to the EMS Bureau upon request. ( )

404. -- 499. (RESERVED)

EMS AGENCY REQUIREMENTS AND WAIVERS
(Sections 500 - 599)

500. EMS AGENCY -- GENERAL EQUIPMENT REQUIREMENTS AND MODIFICATIONS.
Each EMS agency must meet the requirements of Subsection 002.01 of these rules, in addition to the following: ( )

01. Equipment and Supplies. Each EMS agency maintains sufficient quantities of medical care supplies and devices specified in the minimum equipment standards to ensure availability for each response. ( )

02. Safety and Personal Protective Equipment. Each EMS agency maintains safety and personal protective equipment for licensed personnel and other vehicle occupants as specified in the minimum equipment standards. This includes equipment for body substance isolation and protection from exposure to communicable diseases and pathogens. ( )

03. Modifications to an EMS Agency's Minimum Equipment List. An EMS agency's minimum equipment list may be modified upon approval by the EMS Bureau. Requests for equipment modifications are submitted to the EMS Bureau and include clinical and operational justification for the modification and are signed by the EMS agency's medical director. Approved modifications are granted by the EMS Bureau as either an exception or an exemption. ( )

a. Exceptions to the agency's minimum equipment list requirements may be granted by the EMS Bureau upon inspection or review of a modification request, when the circumstances and available alternatives assure that appropriate patient care will be provided for all anticipated incidents. ( )

b. Exemptions that remove minimum equipment and do not provide an alternative may be granted by the EMS Bureau following review of a modification request. The request must describe the agency's deployment model and why there is no anticipated need for the specified equipment to provide appropriate patient care. ( )

04. Review of an Equipment Modification Request. Each request from an EMS agency for equipment modification will be reviewed by the EMS Bureau and may be reviewed by the EMSPC. The recommendations from EMSPC are submitted to the EMS Bureau which has the final authority to approve or deny

the modification request. ( )

05. Denial of an Equipment Modification Request. An EMS agency may appeal the denial of an equipment modification request under IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings." ( )

06. Renewal of Equipment Modification. An EMS agency's equipment modification must be reviewed and reaffirmed as follows: ( )

a. Annually, with the agency license renewal application; or ( )

b. When the EMS agency changes its medical director. ( )

501. AIR MEDICAL EMS AGENCY -- EQUIPMENT REQUIREMENTS AND MODIFICATIONS.
Each air medical agency must meet the requirements under Section 500 of these rules, and the following: ( )

01. FAA 135 Certification. The air medical agency holds a Federal Aviation Administration 135 certification. ( )

02. Configuration and Equipment Standards. Aircraft and equipment configuration that does not compromise the ability to provide appropriate care or prevent emergency care providers from safely performing emergency procedures, if necessary, while in flight. ( )

502. -- 509. (RESERVED)

510. EMS AGENCY -- COMMUNICATION REQUIREMENTS.
Each EMS agency must meet the following to obtain or maintain agency licensure. ( )

01. Air Medical EMS Agency. Each air medical agency has mobile radios of sufficient quantities to ensure that every aircraft and ground crew has the ability to communicate on the frequencies 155.340 MHZ and 155.280 MHZ, with continuous tone-coded squelch system encoding capabilities to allow access to the Idaho EMS radio communications system. ( )

02. Ambulance EMS Agency. Each ambulance EMS agency has mobile radios of sufficient quantities to ensure that every vehicle crew has the ability to communicate on the frequencies 155.340 MHZ and 155.280 MHZ, with continuous tone-coded squelch system encoding capabilities to allow access to the Idaho EMS radio communications system. ( )

03. Non-transport EMS Agency. Each non-transport EMS agency has mobile or portable radios of sufficient quantities to ensure that agency personnel at an emergency scene have the ability to communicate on the frequencies 155.340 MHZ and 155.280 MHZ, with continuous tone-coded squelch system encoding capabilities to allow access to the Idaho EMS radio communications system. ( )

511. EMS AGENCY -- DISPATCH REQUIREMENTS.

01. Twenty-four Hour Dispatch Arrangement. Each EMS agency must have a twenty-four (24) hour dispatch arrangement, except an agency with a twenty-four (24) hour response waiver may have a dispatch arrangement specific to the waiver deployment plan. ( )

02. Incoming Requests for Out-of-Hospital Response. Each ambulance agency that is not dispatched by a CECS or PSAP must record incoming requests for out-of-hospital transports and retain such recordings for a period of one (1) year. ( )

512. -- 519. (RESERVED)

520. EMS AGENCY -- RESPONSE REQUIREMENTS AND WAIVERS.
Each EMS agency must respond to calls on a twenty-four (24) hour a day basis within the agency's declared

geographic coverage area unless a waiver exists. ( )

521. NON-TRANSPORT EMS AGENCY -- WAIVER OF RESPONSE REQUIREMENT.
The controlling authority of a non-transport agency may petition the EMS Bureau for a waiver of the twenty-four (24) hour response requirement if one (1) or more of the following exist: ( )

01. Not Populated on 24-Hour Basis. The community, setting, industrial site, or event being served by the agency is not populated on a twenty-four (24) hour basis. ( )

02. Not on Daily Basis Per Year. The community, setting, industrial site, or event being served by the agency does not exist on a three hundred sixty-five (365) day per year basis. ( )

03. Undue Hardship on Community. The provision of twenty-four (24) hour response would cause an undue hardship on the community being served by the agency. ( )

04. Abandonment of Service. The provision of twenty-four (24) hour response would cause abandonment of the service provided by the agency. ( )

522. NON-TRANSPORT EMS AGENCY -- PETITION FOR WAIVER.

01. Petition for Waiver. The controlling authority of an existing non-transport agency desiring a waiver of the twenty-four (24) hour response requirement must submit a petition for waiver to the EMS Bureau and provide the information described under the incorporated document in Subsection 002.04 of these rules. ( )

02. Waiver Declared on Initial Application. The controlling authority of an applicant non-transport agency desiring a waiver of the twenty-four (24) hour response requirement must declare the request for waiver on the initial application for agency licensure to the EMS Bureau and provide the information described under the incorporated document in Subsection 002.04 of these rules. ( )

03. Renewal of Waivers. The controlling authority of a non-transport agency desiring to renew a waiver of the twenty-four (24) hour response requirement must declare the request for renewal of the waiver on the annual renewal application for agency licensure to the EMS Bureau. ( )

523. -- 524. (RESERVED)

525. AMBULANCE OR AIR MEDICAL EMS AGENCY -- WAIVER OF RESPONSE REQUIREMENT.
The controlling authority of an existing ambulance or air medical agency may petition the Board for a waiver of the twenty-four (24) hour response requirement if one (1) or more of the following exist as a result of the provision of twenty-four (24) hour response: ( )

01. Undue Hardship on the Community Being Served by the Agency. ( )

02. Abandonment of the Service by the Agency. ( )

526. AMBULANCE OR AIR MEDICAL EMS AGENCY -- PETITION FOR WAIVER.
The controlling authority of an existing ambulance or air medical agency desiring a waiver of the twenty-four (24) hour response requirement must submit a petition for waiver to the Board and provide the information described in the incorporated document under Subsection 002.04 of these rules. ( )

527. -- 529. (RESERVED)

530. EMS AGENCY -- MEDICAL SUPERVISION REQUIREMENTS.
Each EMS agency must comply with medical supervision plan requirements and designate a physician as the agency medical director who is responsible for the supervision of medical activities under IDAPA 16.02.02, “Idaho Emergency Medical Services (EMS) Physician Commission.” ( )

531. -- 534. (RESERVED)

535. RECORDS, DATA COLLECTION, AND SUBMISSION REQUIREMENTS.
Each licensed EMS agency must collect and submit EMS response records to the EMS Bureau as follows: ( )

01. Records to be Maintained. Include a Patient Care Report completed for each EMS Response. ( )

02. Records to be Submitted. Ensure that an accurate and complete electronic Patient Care Report (ePCR) is submitted to the EMS Bureau using approved and validated software in a format determined by the EMS Bureau. ( )

03. Time Frame for Submitting Records. Submit each month's data to the EMS Bureau by the 15th of the following month in a format determined by the EMS Bureau. ( )

536. -- 599. (RESERVED)

EMS AGENCY AGREEMENTS, PLANS, AND POLICIES
(Sections 600 - 699)

600. EMS AGENCY -- AGREEMENTS, PLANS, AND POLICIES.
When applicable, each EMS agency must make the following agreements, plans, and policies, under Sections 600 through 699 of these rules, available to the EMS Bureau upon request. ( )

601. EMS AGENCY – AMBULANCE SERVICE RESPONSE AGREEMENTS.
Each EMS agency with out-of-hospital customer service agreements to provide ambulance services that are not dispatched by the local CECS or PSAP must provide the customer with written criteria to reasonably identify potential medical emergencies that should be referred to a CECS or PSAP for dispatch of a 911 Response agency unless a staffed ambulance is already on site at the patient's location. ( )

602. EMS AGENCY -- PATIENT CARE INTEGRATION.

01. Cooperative Agreements for Common Geographic Coverage Area. Each ground EMS agency that shares common geographic coverage areas with other EMS agencies must develop cooperative written agreements that address integration of patient care between the agencies. A ground agency can not provide a level of care that exceeds the clinical level of a prehospital agency receiving the patient, unless the written patient integration plan specifically addresses the continuation of the higher level of care throughout the patient transport. ( )

02. Cooperative Agreement for Non-Transport Agency. Each 911 Response non-transport EMS agency must have a cooperative written agreement with each of the 911 Response Transport Services that provide response and patient transportation within that geographical area. The agreement must address integration of patient care between the agencies. A non-transport agency may not provide a level of care that exceeds the clinical level of the responding 911 Response Transport Service unless the integration plan specifically addresses the continuation of the higher level of care throughout the patient transport. ( )

603. AIR MEDICAL EMS AGENCY -- PATIENT CARE INTEGRATION.
Each air medical agency must declare and make available its patient care integration policies to the EMS Bureau upon request. ( )

604. EMS AGENCY -- PLANNED DEPLOYMENT AGREEMENTS.
Each EMS agency that utilizes a planned deployment must develop a cooperative planned deployment agreement between the EMS agencies under the incorporated document in Subsection 002.04 of these rules. ( )

605. -- 649. (RESERVED)

650. AIR MEDICAL EMS AGENCY -- REQUIRED POLICIES.
Each air medical EMS agency must have the following policies on file with the EMS Bureau as described under the incorporated document in Subsection 002.04 of these rules: ( )

01. Non-Discrimination Policy. ( )

02. Weather Turn Down Policy. ( )

03. Patient Destination Procedure. ( )

04. Safety Program Policy. ( )

05. Training Policy. ( )

651. -- 699. (RESERVED)

EMS AGENCY UTILIZATION OF AIR MEDICAL SERVICES
(Sections 700 - 799)

700. EMS AGENCY -- CRITERIA TO REQUEST AN AIR MEDICAL RESPONSE.
Each ground EMS agency must establish written criteria as described in the document incorporated under Section 002.04 of these rules for the agency's licensed EMS personnel that provides decision-making guidance for requesting an air medical response to an emergency scene. This criteria must be approved by the agency's medical director. ( )

701. EMS AGENCY -- EMS PERSONNEL REQUEST FOR AIR MEDICAL RESPONSE.
Licensed EMS personnel en route to, or at, the emergency scene have the primary responsibility and authority to request the response of air medical services using the local incident management system and licensed EMS agency written criteria under the incorporated document in Subsection 002.04 of these rules. ( )

702. EMS AGENCY -- CANCELLATION OF AN AIR MEDICAL RESPONSE.
Following dispatch of air medical services, an air medical response may only be canceled upon completion of a patient assessment performed by licensed EMS personnel. ( )

703. EMS AGENCY -- ESTABLISHED CRITERIA FOR SIMULTANEOUS DISPATCH.
Under the incorporated document in Subsection 002.04 of these rules, a ground EMS agency may establish criteria for simultaneous dispatch for air and ground medical response. ( )

704. EMS AGENCY-- SELECTION OF AIR MEDICAL AGENCY.
Each EMS agency has the responsibility to select an appropriate air medical service and have on file selection policies as described in the incorporated document under Subsection 002.04 of these rules. ( )

705. -- 729. (RESERVED)

730. EMS AGENCY -- LANDING ZONE PROCEDURES FOR AIR MEDICAL RESPONSE.
A licensed ambulance or non-transport EMS agency in conjunction with an air medical agency must have written procedures for the establishment of a landing zone. These procedures must be compatible with the local incident management system. ( )

731. EMS AGENCY -- REVIEW OF AIR MEDICAL RESPONSES.
Each EMS agency must provide incident-specific patient care related data identified and requested by the EMS Bureau in the review of air medical response criteria. ( )

732. -- 799. (RESERVED)

EMS AGENCY INSPECTIONS
(Sections 800 - 899)

800. EMS AGENCY -- INSPECTIONS BY THE EMS BUREAU.
The EMS Bureau is authorized to enter an agency's facility at reasonable times to inspect an agency's vehicles,

equipment, response records, and other necessary items to determine that the EMS agency is in compliance with Idaho statutes and administrative rules. ( )

801. EMS AGENCY -- INSPECTION REQUESTS AND SCHEDULING.
An applicant eligible for agency inspection must contact the EMS Bureau to schedule an inspection. In the event that the acquisition of capital equipment, hiring, or licensure of personnel is necessary for the inspection process, the applicant must notify the EMS Bureau when ready for the inspection. ( )

802. EMS AGENCY -- INSPECTION TIMEFRAME AFTER NOTIFICATION OF ELIGIBILITY.
An applicant must schedule and have an inspection completed within six (6) months of notification of eligibility by the EMS Bureau. An application without an inspection completed within six (6) months is void and must be resubmitted as an initial application. ( )

803. -- 804. (RESERVED)

805. EMS AGENCY -- INITIAL AGENCY INSPECTION.
The EMS Bureau will perform an initial inspection, which is an integral component of the application process, to ensure the EMS agency applicant is complying with the following: ( )

01. Validation of Initial Application. Validate the information contained in the application. ( )

02. Verification of Compliance. Verify the applicant is complying with Idaho statutes and administrative rules. ( )

806. EMS AGENCY -- DEMONSTRATION OF CAPABILITIES DURING INSPECTION.
The EMS Bureau will review historical and current information during the annual, random, and targeted inspections whereas an applicant must demonstrate the following during the initial inspection process: ( )

01. Validation of Ability to Submit Data. Each EMS agency applicant must demonstrate the ability to submit data described in Section 535 of these rules. ( )

02. Validation of Ability to Communicate. Each EMS agency applicant must demonstrate the ability to communicate via radio with the state EMS communications center, local dispatch center, neighboring EMS agencies on which the applicant will rely for support, first response, air and ground patient transport, higher level patient care, or other purposes. ( )

807. -- 829. (RESERVED)

830. EMS AGENCY -- CONDITION THAT RESULTS IN VEHICLE OR AGENCY OUT OF SERVICE.
Upon discovery of a condition during inspection that could reasonably pose an immediate threat to the safety of the public or agency staff, the EMS Bureau may declare the condition unsafe and remove the vehicle or agency from service until the unsafe condition is corrected. ( )

831. -- 839. (RESERVED)

840. EMS AGENCY -- EXEMPTIONS FOR AGENCIES CURRENTLY ACCREDITED BY A NATIONALLY RECOGNIZED PROFESSIONAL EMS ACCREDITATION AGENCY.
Upon petition by the accredited agency, the EMS Bureau will review the accreditation standards under which the accredited agency was measured and may waive specific duplicated annual inspection requirements where appropriate. If an external accreditation inspection is found to be more rigorous than that of the Department, the EMS Bureau may elect to relax the frequency of annual inspections or waive annual inspections altogether. ( )

841. -- 899. (RESERVED)

EMS AGENCY LICENSURE PROCESS
(Sections 900 - 999)

900. EMS AGENCY -- APPLICATION FOR INITIAL LICENSURE.
To be considered for initial EMS agency licensure, an organization seeking licensure must request, complete, and submit the standardized EMS agency initial license application form provided by the EMS Bureau. ( )

901. EMS AGENCY -- LICENSURE EXPIRATION.
Each EMS agency license, unless otherwise declared on the license, is valid for one (1) year from the end of the month of issuance by the EMS Bureau. ( )

902. -- 970. (RESERVED)

971. LAPSED LICENSE.

01. Application Not Submitted Prior to Expiration of Current License. An agency that does not submit a complete application as prescribed in these rules will be considered lapsed. The license will no longer be valid. ( )

02. Grace Period. No grace periods or extensions to an expiration date will be granted when an agency has not submitted a completed renewal application on, or before, the date the current license expires. ( )

03. Lapsed License. An agency that has a lapsed license cannot provide EMS services. ( )

04. Regaining Agency Licensure. An agency with a lapsed license will be considered an applicant for initial licensure and is bound by the same requirements and processes as an initial applicant. ( )

972. -- 979. (RESERVED)

980. EMS AGENCY LICENSE -- NONTRANSFERABLE.
An EMS agency license issued by the EMS Bureau cannot be transferred or sold. ( )

981. CHANGES TO A CURRENT LICENSE.
An agency's officials must submit an agency update to the EMS Bureau within sixty (60) days of any of the following: ( )

01. Changes Requiring Update. An agency's officials must submit an agency update to the EMS Bureau within sixty (60) days of any of the following: ( )

a. Changes made to the geographic coverage area by agency annexation; ( )

b. Licensed personnel added or removed from the agency affiliation roster. If licensed personnel are removed for cause, a description of the cause must be included; ( )

c. Vehicles or equipment added or removed from the agency; ( )

d. Changes to the agency communication plan or equipment; ( )

e. Changes to the agency dispatch agreement; or ( )

f. Changes to the agency Medical Supervision Plan. ( )

02. Changes Requiring Initial Licensure Application. When an agency decides to make any of the following changes, it must submit an initial agency application to the EMS Bureau and follow the initial application process described in Section 900 of these rules: ( )

a. Clinical level of licensed personnel it utilizes; ( )

b. Geographic coverage area changes, except by agency annexation; ( )

c. A non-transport agency that intends to provide patient transport or an ambulance agency that intends to discontinue patient transport and become a non-transport agency; or ( )

d. An agency that intends to add a 911 Response to an Ambulance Service license or Non-Transport Service license. ( )

982. -- 989. (RESERVED)

990. TIME SENSITIVE EMERGENCY CERTIFICATION.
The EMS Bureau will certify an EMS Agency as a TSE Designated EMS Agency when such agency, upon proper application and verification, is found to meet the applicable designation criteria under the incorporated document in Subsection 002.04 of these rules. ( )

991. -- 999. (RESERVED)

[Agency redlined courtesy copy]

Italicized text **indicates changes between the text of the proposed rule as adopted in the pending rule.**

16.01.03 – EMERGENCY MEDICAL SERVICES (EMS) – AGENCY LICENSING REQUIREMENTS

000. LEGAL AUTHORITY.
~~The Idaho Board of Health and Welfare is authorized under~~ Section 56-1023, Idaho Code, authorizes the Board to adopt rules ~~and standards concerning~~ for the administration of the Idaho Emergency Medical Services Act~~, Sections 56-1011 through 56-1023, Idaho Code~~. ~~The Director is authorized under~~ Section 56-1003, Idaho Code, authorizes the Director to supervise and administer an emergency medical service program. ~~(3-17-22)~~( )

001. ~~TITLE AND SCOPE.~~ (RESERVED)

~~**01.** **Title**. These rules are titled IDAPA 16.01.03, "Emergency Medical Services (EMS) – Agency Licensing Requirements." (3-17-22)~~

~~**02.** **Scope**. These rules include the categories of EMS agencies, eligibility requirements and standards for the licensing of EMS agencies, utilization of air medical services, and the initial application and renewal process for EMS agencies licensed by the state. (3-17-22)~~

002. INCORPORATION BY REFERENCE.
~~The Board and the Department of Health and Welfare have~~The following documents are incorporated by reference ~~the following documents~~: ~~(4-6-23)~~( )

01. Minimum Equipment Standards for Licensed EMS Services. "Minimum Equipment Standards for Licensed EMS Services," ~~e~~Edition 20~~16~~24-1, ~~version 1.0,~~ is the standard for minimum equipment requirements for licensed EMS Agencies. Copies ~~of these standards~~ may be obtained from the ~~Department~~ EMS Bureau~~, see~~ at http://www.idahoems.org. ~~(4-6-23)~~( )

02. Time Sensitive Emergency System Standards Manual. "Time Sensitive Emergency System Standards Manual," Edition 202~~0~~3-1, is the standard for certifying EMS Agencies as TSE Designated EMS Agencies. Copies ~~of these standards~~ may be obtained from the Department~~, see~~ at https://tse.idaho.gov/. ~~(4-6-23)~~( )

03. EMS Data Collection Standards Manual. EMS Data Collection Standards Manual, Edition 2023-1 is the standard for data collection by licensed EMS agencies. Copies ~~of the manual~~ may be obtained from the ~~Department~~ EMS Bureau at http://www.idahoems.org/ ~~or from the Bureau of Emergency Medical Services and~~

~~Preparedness located at 2224 East Old Penitentiary Road, Boise, ID 83712-8249~~. ~~(4-6-23)~~(____)

04. EMS Agency Standards Manual. EMS Agency Standards Manual, Edition 2024-1, is the standard for policies and agreements required for Idaho EMS agency licensure. Copies may be obtained from the EMS Bureau at http://www.idahoems.org/ or from the Bureau of Emergency Medical Services and Preparedness located at 2224 East Old Penitentiary Road, Boise, ID 83712-8249. (____)

003. -- 009. (RESERVED)

010. DEFINITIONS.

For the purposes of this chapter, the definitions in IDAPA 16.01.02, "Emergency Medical Services (EMS) - Rule Definitions," apply. ( )

011. -- 074. (RESERVED)

075. INVESTIGATION OF COMPLAINTS FOR EMS LICENSING VIOLATIONS.

Investigation of complaints and disciplinary actions for EMS agency licensing are ~~provided~~ under IDAPA 16.01.12, "Emergency Medical Services (EMS) - Complaints, Investigations, and Disciplinary Actions." ~~(3-17-22)~~(____)

076. ADMINISTRATIVE LICENSE OR CERTIFICATION ACTION.

Any license or certification may be suspended, revoked, denied, or retained with conditions for noncompliance with any standard or rule. Administrative license or certification actions, including fines, imposed by the EMS Bureau for any action, conduct, or failure to act that is inconsistent with the professionalism, or standards, or both, are provided under Sections 56-1011 through 56-1023, Idaho Code, and IDAPA 16.01.12, "Emergency Medical Services (EMS) - Complaints, Investigations, and Disciplinary Actions." ( )

077. -- 099. (RESERVED)

EMS AGENCY GENERAL LICENSURE REQUIREMENT
(Sections 100 - 199)

100. AGENCY LICENSE REQUIRED.

Any organization that advertises or provides ambulance, air medical, or non-transport ~~emergency medical services~~ EMS in Idaho must be licensed as an EMS agency under ~~the requirements in~~ Sections 56-1011 through 56-1023, Idaho Code, and ~~this chapter of~~ these rules. ~~(3-17-22)~~(____)

101. EXEMPTION OF EMS AGENCY LICENSURE.

An organization, licensed without restriction to provide ~~emergency medical services~~ EMS in another state and not restricted from operating in Idaho by the ~~Department~~ EMS Bureau, may provide ~~emergency medical services~~ EMS in Idaho within the limits of its license without an Idaho EMS license only when the organization meets one (1) of the following: ~~(3-17-22)~~(____)

01. Interstate Compact with Idaho. The organization holds an EMS license in another state where an interstate compact specific to EMS agency licensure with Idaho is in effect. ( )

02. Emergency, Natural, or Man-made Disaster. The organization is responding to an emergency, or a natural or man-made disaster, declared by federal, state, or local officials and the services of the organization are requested by an entity of local or state government in Idaho. ( )

03. Transfer of Patient From Out-of-State Medical Facility. The organization is transferring a patient from an out-of-state medical facility: ~~(3-17-22)~~(____)

a. ~~Transferring a patient from an out-of-state medical facility t~~To a medical facility in Idaho. The organization may return the patient to the point of origin; or ~~(3-17-22)~~(____)

b. ~~Transferring a patient from an out-of-state medical facility t~~Through the state of Idaho. ~~(3-17-22)~~(____)

04. Transport of Patient From Out-of-State Emergency Scene. The organization is transporting a patient: ~~(3-17-22)~~(____)

a. ~~Transporting a patient f~~From an out-of-state emergency scene to a medical facility in Idaho; or ~~(3-17-22)~~(____)

b. ~~Transporting a patient t~~To a rendezvous with another ambulance. ~~(3-17-22)~~(____)

102. SERVICES PROVIDED BY A LICENSED EMS AGENCY.

An EMS agency can provide only those services that are within the agency's service types~~,~~ and clinical levels~~, and operational declarations~~ stated on the most recent license issued by the ~~Department~~ EMS Bureau, except when the agency has a planned deployment agreement described in Section 60~~3~~4 of these rules. ~~(3-17-22)~~(____)

103. ELIGIBILITY FOR EMS AGENCY LICENSURE.

An entity is eligible for EMS agency licensure upon demonstrated compliance with ~~the requirements in~~ Idaho statutes and administrative rules in effect at the time the ~~Department~~ EMS Bureau receives the application. ~~(3-17-22)~~(____)

104. -- 199. (RESERVED)

EMS AGENCY LICENSURE MODEL
(Sections 200 - 299)

200. EMS AGENCY-- LICENSING MODEL.

01. Licensing an EMS Agency. An eligible EMS agency ~~in Idaho~~ is licensed using a descriptive model that bases the agency licensure on the declarations made in the most recent approved initial or renewal application. An EMS agency must provide only those EMS services described in the most recent application on which the agency was issued a license by the ~~Department~~ EMS Bureau. ~~(3-17-22)~~(____)

02. EMS Agency License Models. An EMS agency license is based on the agency's service types~~,~~ and clinical levels~~, license duration, and operational declarations~~. Geographic coverage areas and resources may differ between the service types~~,~~ and clinical levels~~, and operational declarations~~ under which an agency is licensed. ~~(3-17-22)~~(____)

03. EMS Agency Providing ~~Both~~ Air Medical and Ground-Based EMS Services. An EMS agency that provides both air medical and ground-based EMS services must be licensed accordingly and meet all the requirements of an air medical and either an ambulance or non-transport agency, depending on the ground EMS services provided. ~~(3-17-22)~~(____)

04. Multiple Organization EMS Agency. An EMS agency may be comprised of multiple organizations licensed under a single responsible authority to which the governing officials of each organization agree. The authority must establish a deployment strategy that declares in which areas and at what times within their geographical response area will be covered by ~~each~~ the declared service types~~,~~ and clinical levels~~, and operational declaration~~. ~~(3-17-22)~~ (____)

201. EMS AGENCY -- SERVICE TYPES.

An EMS agency may be licensed as one (1) or more service types. An agency that provides multiple service types must meet the ~~minimum~~ requirements for each service type provided. The following are the agency services types available for EMS agency licensure. ~~(3-17-22)~~(____)

01. ~~Ground Agency~~ Ambulance Service Types. An agency that is licensed as an ambulance service is intended for patient transport or transfer. ~~(3-17-22)~~(____)

a. ~~Non-transport.~~ 911 Response Transport Service. Available to an agency that provides emergency medical care at emergency scenes, during transports or transfers, and has the primary responsibility of responding to 911 calls dispatched by a Public Safety Answering Point (PSAP) or Consolidated Emergency Communication

System (CECS) within a specified geographical area. ~~(3-17-22)~~( )

b. ~~Ambulance.~~Transport Service. Available to an agency that provides emergency medical care during transports or transfers but does not respond *to 911 calls. Transport services only respond to calls using emergency driving procedures for* emergency hospital-to-hospital transfers and *when* requested by a CECS, PSAP, or a 911 Response agency. ~~(3-17-22)~~( )

02. ~~**Air Medical Agency**~~ **Non-Transport Service Types**. An agency that is licensed as a non-transport service is not intended for patient transport or transfers and cannot advertise ambulance services. ~~(3-17-22)~~( )

a. ~~Air Medical.~~911 Response Non-Transport Service. Available to an agency that provides emergency medical care at an emergency scene and has the primary responsibility of responding to 911 calls dispatched by a CECS or PSAP within a specified geographical area. ~~(3-17-22)~~( )

b. ~~Air Medical Support.~~Non-Transport Service. Available to an agency that provides emergency medical care but does not respond to 911 calls *or respond to calls using emergency driving procedures* unless requested by a CECS, PSAP, or a 911 Response agency. ~~(3-17-22)~~( )

03. **Air Medical Service Types**. An agency that is licensed with an air medical service type is intended for patient transport, transfer, or rescue. ( )

a. Air Medical Transport Service. Available to an agency that provides air medical response and transport of patients from emergency scenes and hospitals utilizing a fixed-wing or rotary-wing air ambulance. ( )

b. Air Medical Rescue Service. Available to an agency that provides air medical response via fixed-wing or rotary-wing aircraft to emergency scenes for transportation of patients from an emergency scene to a rendezvous with a ground or air medical transport agency. ( )

202. EMS AGENCY -- CLINICAL LEVELS.

An EMS agency is licensed at one (1) or more of the following clinical levels depending on the agency's highest level of licensed personnel and life support services advertised or offered, and provided according to skill requirements under IDAPA 16.02.02, "Idaho Emergency Medical Services Physician Commission." ~~(3-17-22)~~( )

01. ~~**Non-transport:**~~**Basic Life Support (BLS)**. Deploys licensed EMS personnel trained and equipped to provide all EMR or EMT skills. ~~(3-17-22)~~( )

~~**a.** EMR/BLS; (3-17-22)~~

~~**b.** EMT/BLS; (3-17-22)~~

~~**c.** AEMT/ILS; or (3-17-22)~~

~~**d.** Paramedic/ALS. (3-17-22)~~

02. ~~**Ambulance:**~~**Intermediate Life Support (ILS)**. Deploys licensed EMS personnel trained and equipped to provide Advanced EMT skills. ~~(3-17-22)~~( )

~~**a.** EMR (with Ambulance Certification)/BLS; (3-17-22)~~

~~**b.** EMT/BLS; (3-17-22)~~

~~**c.** AEMT/ILS; (3-17-22)~~

~~**d.** Paramedic/ALS; or (3-17-22)~~

~~**e.** Paramedic/ALS Critical Care. (3-17-22)~~

03. ~~**Air Medical**.~~**Advanced Life Support (ALS)**. Deploys licensed EMS personnel trained and equipped to provide Paramedic skills. ~~(3-17-22)~~( )

~~**a.** Paramedic/ALS; or (3-17-22)~~

~~**b.** Paramedic/ALS Critical Care. (3-17-22)~~

~~**04.** **Air Medical Support**; (3-17-22)~~

~~**a.** EMT/BLS; (3-17-22)~~

~~**b.** AEMT/ILS; or (3-17-22)~~

~~**c.** Paramedic/ALS. (3-17-22)~~

203. EMS AGENCY -- ~~**LICENSE DURATION**~~ **SPECIALTY SERVICES.**

Each EMS agency ~~must identify the license duration for each license type. License durations are:~~ offering the following specialty services must report such services to the EMS Bureau. ~~(3-17-22)~~( )

01. ~~**Ongoing**. The agency is licensed to provide EMS personnel and equipment for an ongoing period of time and plans to renew its license on an annual basis.~~ **Critical Care (CC)**. The provision of EMS personnel trained, credentialed, and equipped to provide all critical care skills and required staffing under IDAPA 16.02.02, "Idaho Emergency Medical Services Physician Commission." ~~(3-17-22)~~( )

02. ~~**Limited**. The agency is licensed to provide EMS personnel and equipment for the duration of a specific event or a specified period of time with no expectation of renewing the agency license.~~ **Community Health EMS (CHEMS)**. The provision of evaluation, advice, or treatment of eligible recipients outside of a hospital setting as part of a community-based team of health and social services providers as authorized by local medical control. ~~(3-17-22)~~( )

a. Clinical treatments and assessments of CHEMS patients cannot exceed the agency's licensed clinical level. ( )

b. Community Health EMS involving or related to emergency response must be provided by or in coordination with the primary 911 Response Transport agency for that area. ( )

03. ~~**Seasonal**. The agency is licensed to provide EMS personnel and equipment for the duration of time each year that corresponds to the seasonal activity that the agency supports.~~ **Tactical EMS (TEMS)**. The provision of emergency medical care in support of law enforcement activities. ~~(3-17-22)~~( )

a. *The Tactical EMS specialty service must be formally affiliated with one (1) or more local law enforcement agencies.* ( )

b. *Clinical treatments of patients cannot exceed the agency's licensed clinical level unless authorized by the EMSPC.* ( )

04. ***Special Pathogen Transport (SPT)****. The provision of emergency medical care and transport of patients suffering from exposure or disease caused by highly infectious special pathogens.* ( )

~~**204. GROUND EMS AGENCY -- OPERATIONAL DECLARATIONS.**~~

~~An agency providing ground services is licensed with one (1) or more of the following operational declarations depending on the services that the agency advertises or offers. (3-17-22)~~

~~**01.** **Prehospital**. The prehospital operational declaration is available to an agency that: (3-17-22)~~

~~**a.** Has primary responsibility for responding to calls for EMS within their designated geographic~~

~~coverage area; and~~ ~~(3-17-22)~~

~~**b.** Is dispatched to prehospital emergency medical calls by a consolidated emergency communications system.~~ ~~(3-17-22)~~

~~**02.** **Prehospital Support**. The prehospital support operational declaration is available to an agency that:~~ ~~(3-17-22)~~

~~**a.** Provides support under agreement to a prehospital agency having primary responsibility for responding to calls for EMS within a designated geographic coverage area; and~~ ~~(3-17-22)~~

~~**b.** Is dispatched to prehospital emergency medical calls by a consolidated emergency communications system.~~ ~~(3-17-22)~~

~~**03.** **Community Health EMS**. The community health EMS operational declaration is available to an agency with a prehospital operational declaration or prehospital support operational declaration that provides personnel and equipment for medical assessment and treatment at a non-emergency scene or at the direction of a physician or independent practitioner.~~ ~~(3-17-22)~~

~~**04.** **Transfer**. The transfer operational declaration is available to an ambulance agency that provides EMS personnel and equipment for the transportation of patients from one (1) medical care facility in their designated geographic coverage area to another. An agency with this operational declaration must declare which sending facilities it routinely responds to if requested.~~ ~~(3-17-22)~~

~~**05.** **Standby**. The standby operational declaration is available to an agency that provides EMS personnel and equipment to be staged at prearranged events within their designated geographic coverage area.~~ ~~(3-17-22)~~

~~**06.** **Non-Public**. The non-public operational declaration is available to an agency that provides EMS personnel and equipment intended to treat patients who are employed or contracted by the license holder. An agency with a non-public operational declaration is not intended to treat members of the general public. A non-public agency must maintain written plans for patient treatment and transportation.~~ ~~(3-17-22)~~

~~**07.** **Hospital**. The hospital operational declaration is available to an agency whose primary responsibility is hospital or clinic activity and utilizes licensed EMS personnel in its facility to assist with patient care and movement.~~ ~~(3-17-22)~~

~~**205. AIR MEDICAL AGENCY -- OPERATIONAL DECLARATIONS.**~~

~~An agency providing air medical services is licensed with one (1) or more of the following operational declarations depending on the services that the agency advertises or offers. Service levels, geographic coverage areas, and resources may differ between the operational declarations under which an agency is licensed.~~ ~~(3-17-22)~~

~~**01.** **Air Medical Transport**. The air medical transport operational declaration is available to an air medical agency that provides transportation of patients by air ambulance from a rendezvous or emergency scene to a medical care facility within its designated geographic coverage area.~~ ~~(3-17-22)~~

~~**02.** **Air Medical Transfer**. The air medical transfer operational declaration is available to an Air Medical I agency that provides transportation of patients by air ambulance from one (1) medical care facility in its designated geographic coverage area to another. An agency with this operational declaration must declare which sending facilities it routinely responds to if requested.~~ ~~(3-17-22)~~

~~**03.** **Air Medical Support**. The air medical support operational declaration is available to an air medical agency that provides transportation of patients from an emergency scene to a rendezvous with a ground or air medical transport agency within its designated response area.~~ ~~(3-17-22)~~

~~**206. -- 209. (RESERVED)**~~

~~**210. AMBULANCE EMS AGENCY -- PATIENT TRANSPORT OR TRANSFER.**~~
~~An agency that is licensed as an ambulance service is intended for patient transport or transfer. (3-17-22)~~

~~**01. Transport**. An ambulance agency may provide transportation of patients from a rendezvous or emergency scene to a rendezvous or medical care facility when that agency is licensed with one (1) of the following operational declarations: (3-17-22)~~

~~**a.** Prehospital; (3-17-22)~~

~~**b.** Prehospital Support; or (3-17-22)~~

~~**c.** Standby. (3-17-22)~~

~~**02. Transfer**. An ambulance agency that provides the operational declaration of transfer can provide transportation of patients from one (1) medical care facility within their designated geographic coverage area to another. (3-17-22)~~

~~**211. AIR MEDICAL EMS AGENCY -- PATIENT TRANSPORT, TRANSFER, OR SUPPORT.**~~
~~An agency that is licensed with an air medical service type is intended for patient transport, transfer, or support. (3-17-22)~~

~~**01. Transport**. An air medical agency that provides the operational declaration of air medical transport may provide transportation of patients from a rendezvous or emergency scene to a medical care facility. (3-17-22)~~

~~**02. Transfer**. An air medical agency that provides the operational declaration of air medical transfer can provide transportation of patients from one (1) medical care facility within their designated geographic coverage area to another. (3-17-22)~~

~~**03. Support**. An air medical agency that provides the operational declaration of air medical support can provide patient movement from a remote area or scene to a rendezvous point where care will be transferred to another licensed air medical or ground transport service for transport to definitive care. An air medical support agency must report all patient movement events to the Department within thirty (30) days of the event. (3-17-22)~~

204. – 211. (RESERVED)

212. NON-TRANSPORT EMS AGENCY -- PATIENT MOVEMENT.
~~A non-transport agency is an agency that is not intended for patient transport and cannot advertise ambulance services.~~ A non-transport agency can move a patient by vehicle only when: ~~(3-17-22)~~( )

01. Accessibility of Emergency Scene. The responding ambulance or air ambulance agency cannot access the emergency scene. ( )

02. Licensed Personnel Level. Patient care is provided by EMS personnel licensed at: ( )

a. EMT level or higher; or ( )

b. EMR level only when the patient care integration agreement under which the non-transport agency operates addresses and enables patient movement. The agency must ensure that its personnel are trained and credentialed in patient packaging and movement. ~~(3-17-22)~~( )

03. Rendezvous with Transport EMS Agency. Movement of the patient is to rendezvous with an ambulance or air ambulance agency during which the EMS personnel must be in active communication with the ambulance or air ambulance with which they will rendezvous. ( )

04. Report Patient Movement. A non-transport agency must report all patient movement events to the ~~Department~~ EMS Bureau within thirty (30) days of the event. ~~(3-17-22)~~( )

213. -- 299. (RESERVED)

PERSONNEL REQUIREMENTS FOR EMS AGENCY LICENSURE
(Sections 300 - 399)

300. EMS AGENCY -- GENERAL PERSONNEL REQUIREMENTS.
Personnel must be licensed~~ according to~~ under IDAPA 16.01.07, "Emergency Medical Services (EMS) -- Personnel Licensing Requirements." ~~(3-17-22)~~(____)

01. Personnel Requirements for EMS Agency Licensure. Each agency must ensure availability of affiliated personnel licensed and credentialed at or above the clinical level for the entire anticipated call volume~~ for each of the agency's operational declarations~~, except that an agency holding a~~ prehospital or prehospital support operational declaration~~ 911 Response Transport or 911 Response Non-transport license may request a waiver of this requirement from the EMS Bureau. ~~(3-17-22)~~(____)

02. Personnel Requirements for an Agency Utilizing Emergency Medical Dispatch. An agency dispatched by a~~ consolidated emergency communications system~~ CECS that uses an emergency medical dispatch (EMD) process to determine the clinical needs of the patient must ensure availability of personnel licensed and credentialed at clinical levels appropriate to the anticipated call volume for each of the clinical levels the agency provides. ~~(3-17-22)~~(____)

03. Personnel Requirements for~~ Prehospital ALS~~ an Agency Utilizing Ambulance-Based Clinicians.~~ A licensed Paramedic must be present whenever prehospital, prehospital support, or air medical transport ALS services are provided.~~ An agency may use ambulance-based clinicians to meet the licensed personnel requirements for agency licensure as follows: ~~(3-17-22)~~(____)

a. 911 Response Transport, or 911 Response Non-transport Service licensed at the BLS or ILS clinical level. (____)

b. Transport Service licensed at the ALS clinical level. (____)

301. ~~AMBULANCE~~ EMS AGENCY -- SPECIALTY SERVICE PERSONNEL REQUIREMENTS.
Each ~~ambulance~~ EMS agency ~~must ensure that there are two (2) crew members on each patient transport or transfer~~ offering specialty services under Section 203 of these rules is responsible for reporting personnel trained and credentialed to provide those services to the EMS Bureau.~~ The crew member providing patient care, at a minimum, must be a licensed EMR with an ambulance certification or a licensed EMT.~~ ~~(3-17-22)~~(____)

01. Critical Care. EMS personnel must have been formally trained, credentialed, and equipped to provide all critical care skills under IDAPA 16.02.02, "Idaho Emergency Medical Services Physician Commission." (____)

02. Community Health EMS. Licensed EMS personnel must have received standardized CHEMS training recognized by the EMS Bureau to participate in patient care related to CHEMS. (____)

03. Tactical EMS. Licensed EMS personnel must have received specialized training to provide emergency medical care in support of law enforcement activities. (____)

04. Special Pathogens Transport. Licensed EMS personnel must have received specialized training specific to the transport of patients suffering from exposure or disease caused by highly infectious special pathogens. Such training must include, at a minimum, proper use of appropriate PPE, avoiding disease exposure, use of specialized equipment and containment systems used during transport, crew member and public safety concerns, and proper waste management. (____)

302. ~~AIR MEDICAL EMS AGENCY~~ AMBULANCE SERVICE -- PERSONNEL REQUIREMENTS.
~~Each air medical agency must ensure that there are two (2) crew members, not including the pilot, on each patient transport or transfer. The crew member providing patient care, at a minimum, must be a licensed EMR with an~~

~~ambulance certification or a licensed EMT. An air medical agency must also demonstrate that the following exists.~~ Each ambulance service must ensure that there is one (1) EMS provider providing patient care, not including the driver, on each patient transport or transfer. The crew member providing patient care, at a minimum, must be a licensed EMR with an ambulance certification or a licensed EMT. ~~(3-17-22)~~( )

01. ~~**Personnel for Air Medical Agency**. An Air Medical agency must ensure that each flight includes at a minimum, one (1) licensed registered nurse and one (1) Paramedic. Based on the patient's need, an exception for transfer flights may include a minimum of one (1) licensed respiratory therapist and one (1) licensed registered nurse, or two (2) licensed registered nurses.~~ **Emergency Scene ALS**. A licensed paramedic must be present whenever ALS services are provided at an emergency scene or during patient transport to a medical facility. ~~(3-17-22)~~( )

02. ~~**Personnel for Air Medical Support Agency**. An Air Medical Support agency must ensure that each flight includes at a minimum, two (2) crew members with one (1) patient care provider licensed at or above the agency's highest clinical level of licensure.~~ **Interfacility Transfers ALS**. ~~(3-17-22)~~( )

a. A licensed paramedic or ambulance-based clinician must provide ALS services during interfacility transfers. ( )

b. A BLS or ILS 911 Response Transport Service may conduct ALS interfacility transfers with a licensed paramedic or ambulance-based clinician if equipped with ALS equipment necessary to provide appropriate patient care and ALS interventions. ( )

03. **Critical Care**. A minimum of one (1) credentialed critical care provider and one (1) additional paramedic or ambulance-based clinician are required in the patient compartment during patient transport. Special consideration may be given for the second provider based on a specific specialized patient need. ( )

303. ~~CRITICAL CARE~~ AIR MEDICAL TRANSPORT SERVICE -- PERSONNEL REQUIREMENTS.

Each ~~ambulance or~~ air medical ~~agency that advertises the provision of critical care clinical capabilities must affiliate and deploy EMS personnel trained and credentialed to provide all critical care skills described in~~ transport service must ensure that the standard medical flight crew consists of, at a minimum, one (1) licensed Paramedic and one (1) licensed Registered Nurse. At least one (1) crew member on each flight must hold critical care credentials under IDAPA 16.02.02, "Idaho Emergency Medical Services (EMS) Physician Commission." Air Medical Transport Services may utilize alternate medical crew configurations for specific situations as stated below: ~~(3-17-22)~~( )

01. **Emergency Scene Transports**. Alternate crew configurations for emergency scene response and patient transport. ( )

a. Two (2) Paramedics. ( )

b. When no other crew with a licensed Paramedic and no other Air Medical Transport Service with a Paramedic crew member is available, an Air Medical Transport Service may deploy a crew of two (2) licensed Registered Nurses. ( )

02. **Interfacility Transfers**. Alternate crew configurations for interfacility transfers, based on patient need. ( )

a. Two (2) Registered Nurses. ( )

b. One (1) Registered Nurse and One (1) Respiratory Therapist. ( )

c. Two (2) Paramedics when both possess critical care credentials under IDAPA 16.02.02, "Idaho Emergency Medical Services Physician Commission." ( )

304. PERSONNEL FOR AIR MEDICAL RESCUE SERVICE.

An Air Medical Rescue service must ensure that each flight includes a minimum of one (1) patient care provider licensed at or above the agency's clinical level of licensure, not including the pilot. The crew member providing patient care, at a minimum, must be a licensed EMT. ( )

30~~4~~5. PLANNED DEPLOYMENT -- PERSONNEL REQUIREMENTS.
Planned deployment allows affiliated EMS personnel to act and provide predetermined services outside of their affiliating agency's geographic coverage area. It can allow EMS personnel licensed at a higher clinical level to provide patient care within their credentialed scopes of practice even when the agency into which the planned deployment occurs is licensed at a lower clinical level. A planned deployment agreement must be formally documented and meet ~~all~~ the requirements ~~listed in~~ under the incorporated document in Subsection ~~603~~ 002.04 of these rules. ~~(3-17-22)~~( )

30~~5~~6. AMBULANCE-BASED CLINICIANS -- PERSONNEL REQUIREMENTS.

01. Ambulance-Based Clinician Certified by ~~Department~~ the EMS Bureau. An EMS agency that advertises or provides out-of-hospital patient care by affiliating and utilizing a currently licensed registered nurse, advanced practice registered nurse, or physician assistant, ~~as defined in~~ under IDAPA 16.01.02, "Emergency Medical Services (EMS) - Rule Definitions," must ensure that those individuals maintain a current ambulance-based clinician certificate issued by the ~~Department~~ EMS Bureau. See Section 30~~6~~7 of these rules for exceptions to this requirement. ~~(3-17-22)~~( )

02. Obtaining an Ambulance-Based Clinician Certificate. An agency, on behalf of an individual who desires an ambulance-based clinician certificate, must provide ~~the following information~~ on the ~~Department's~~ EMS Bureau's application ~~for a certificate~~ documentation that the individual: ~~(3-17-22)~~( )

a. ~~Documentation that the individual h~~Holds a current, unrestricted license to practice issued by the Board of Medicine or Board of Nursing; and ~~(3-17-22)~~( )

b. ~~Documentation that the individual h~~Has successfully completed an EMS Bureau-approved ambulance-based clinician ~~course~~ training; or ~~(3-17-22)~~( )

c. ~~Documentation that the individual h~~Has successfully completed an EMT course. ~~(3-17-22)~~( )

03. Maintaining an Ambulance-Based Clinician Certificate. An ambulance-based clinician certificate is valid for as long as the holder of the certificate is continuously licensed by their respective licensing board. ( )

04. Revocation of an Ambulance-Based Clinician Certificate. The ~~Department~~ EMS Bureau may revoke an ambulance-based clinician certificate based on the procedures for administrative license actions ~~described in~~ under IDAPA 16.01.12, "Emergency Medical Services (EMS) -- Complaints, Investigations, and Disciplinary Actions." ~~(3-17-22)~~( )

~~**05. Licensed Personnel Requirements and Ambulance-Based Clinicians**. An EMR/BLS, EMT/BLS, or AEMT/ILS agency may use ambulance-based clinicians to meet the licensed personnel requirements for agency licensure. An ALS agency, licensed with an ALS transfer declaration described in Section 204.04 of these rules, may use ambulance-based clinicians to meet the licensed personnel requirements for the transfer declaration. (3-17-22)~~

0~~6~~5. Agency Responsibilities for Ambulance-Based Clinicians. The agency must verify that each ambulance-based clinician possesses a current Department-issued ambulance-based clinician certificate ~~issued by the Department~~. The agency must ensure that any ambulance-based clinician meets additional requirements of the corresponding licensing board. ~~(3-17-22)~~( )

30~~6~~7. UTILIZING PHYSICIAN ASSISTANTS, ~~LICENSED~~ REGISTERED NURSES, OR ADVANCED PRACTICE REGISTERED NURSES.
An AEMT/ILS ambulance agency may use a non-certified physician assistant, licensed registered nurse, or advanced practice registered nurse as the crew member who is providing ILS patient services, only when accompanied by a licensed EMR with an ambulance certification or a licensed EMT in the patient compartment of the transport vehicle. ( )

30~~7~~8. -- 399. (RESERVED)

EMS AGENCY VEHICLE REQUIREMENTS
(Sections 400 - 499)

400. EMS AGENCY -- VEHICLE REQUIREMENTS.
Not all EMS agencies ~~are required~~ need to have emergency response vehicles. An agency's need for emergency response vehicles is based on the deployment needs of the agency that is declared on the most recent agency licensure application. An agency with a deployment pattern that requires emergency response vehicles must meet the following ~~requirements~~: ~~(3-17-22)~~( )

01. Condition of Response Vehicles. Each of the agency's EMS response vehicles ~~must be~~ is in sound, safe, working condition. ~~(3-17-22)~~( )

02. Quantity of Response Vehicles. Each EMS agency ~~must~~ possesses a sufficient quantity of EMS response vehicles to ensure agency personnel can respond to the anticipated call volume of the agency. ~~(3-17-22)~~( )

03. Motor Vehicle Licensing Requirements. Each of the EMS agency's response vehicles ~~must~~ meets the ~~applicable~~ Idaho motor vehicle license and insurance requirements. ~~(3-17-22)~~( )

04. Configuration and Standards for EMS Response Vehicles. Each of the EMS agency's response vehicles ~~must be~~ is appropriately configured ~~in accordance~~ with the declared capabilities on the most recent agency license. Each EMS response vehicle ~~must~~ meets the ~~minimum~~ requirements for applicable federal, state, industry, or trade specifications and standards for ambulance or air ambulance vehicles as appropriate. Uniquely configured EMS response vehicles ~~must be~~ are approved by the ~~Department~~ EMS Bureau prior to being put into service. ~~(3-17-22)~~( )

05. Location of Emergency Response Vehicles. Each of the agency's EMS response vehicles ~~must be~~ is stationed or staged within the agency's declared geographic coverage area in a manner that allows agency personnel to effectively respond to the anticipated volume and distribution of requests for service. ~~(3-17-22)~~( )

401. NON-TRANSPORT EMS AGENCY -- VEHICLES.
A licensed non-transport EMS agency may use ambulance vehicles to provide non-transport services. ( )

402. EMS AGENCY -- MINIMUM EQUIPMENT INSPECTION REQUIREMENTS.
Any newly acquired EMS response vehicle must be inspected by the ~~Department~~ EMS Bureau for medical care supplies and devices as specified ~~in the "Minimum Equipment Standards for Licensed EMS Services,"~~ under Subsection 002.01 of these rules before being put into service, except when the newly acquired vehicle is a replacement vehicle and all equipment and supplies are transferred from the vehicle being taken out of service. ~~(3-17-22)~~( )

403. EMS AGENCY -- GROUND VEHICLE SAFETY INSPECTION REQUIREMENTS.
Each EMS agency that deploys emergency vehicles titled and registered for use on roads and highways, ~~with the exception of~~ except for all-terrain vehicles and utility vehicles, must meet the following ~~inspection requirements~~. ~~(3-17-22)~~( )

01. New Vehicle Inspection. Each newly acquired, used EMS response vehicle ~~must successfully~~ has passed a safety inspection conducted by an inspector authorized to perform Department of Transportation (DOT) vehicle safety inspections prior to the vehicle being put in service. ~~(3-17-22)~~( )

02. Response Vehicle Involved in a Crash. Each EMS response vehicle, that is involved in a crash that could result in damage to one (1) or more of the vehicle systems identified in Subsection 403.03 of this rule, ~~must successfully~~ has passed a safety inspection conducted by an inspector authorized to perform DOT vehicle safety inspections prior to being put back in service. ~~(3-17-22)~~( )

03. Vehicle Inspection Standards. Each vehicle safety inspection ~~must~~ has verif~~y~~ied conformity to the

fuel system, exhaust, wheels and tires, lights, windshield wipers, steering, suspension, brakes, frame, and electrical system elements of a DOT vehicle safety inspection defined in Appendix G to Subchapter B of Chapter III at 49 CFR Section 396.17. ~~(3-17-22)~~(____)

04. Vehicle Inspection Records. Each EMS agency ~~must~~ keeps records of all emergency response vehicle safety inspections~~. These records must be made~~ and are available to the ~~Department~~ EMS Bureau upon request. ~~(3-17-22)~~(____)

404. -- 499. (RESERVED)

EMS AGENCY REQUIREMENTS AND WAIVERS
(Sections 500 - 599)

500. EMS AGENCY -- GENERAL EQUIPMENT REQUIREMENTS AND MODIFICATIONS.
Each EMS agency must meet the requirements of ~~the "Minimum Equipment Standards for Licensed EMS Services," incorporated by reference in Section 004~~ Subsection 002.01 of these rules, in addition to the following ~~requirements~~: ~~(3-17-22)~~(____)

01. Equipment and Supplies. Each EMS agency ~~must~~ maintains sufficient quantities of medical care supplies and devices specified in the minimum equipment standards to ensure availability for each response. ~~(3-17-22)~~(____)

02. Safety and Personal Protective Equipment. Each EMS agency ~~must~~ maintains safety and personal protective equipment for licensed personnel and other vehicle occupants as specified in the minimum equipment standards. This includes equipment for body substance isolation and protection from exposure to communicable diseases and pathogens. ~~(3-17-22)~~(____)

03. Modifications to an EMS Agency's Minimum Equipment List. An EMS agency's minimum equipment list may be modified upon approval by the ~~Department~~ EMS Bureau. Requests for equipment modifications ~~must be~~ are submitted to the ~~Department~~ EMS Bureau and include clinical and operational justification for the modification and ~~be~~ are signed by the EMS agency's medical director. Approved modifications are granted by the ~~Department~~ EMS Bureau as either an exception or an exemption. ~~(3-17-22)~~(____)

a. Exceptions to the agency's minimum equipment list requirements may be granted by the ~~Department~~ EMS Bureau upon inspection or review of a modification request, when the circumstances and available alternatives assure that appropriate patient care will be provided for all anticipated incidents. ~~(3-17-22)~~(____)

b. Exemptions that remove minimum equipment and do not provide an alternative may be granted by the ~~Department~~ EMS Bureau following review of a modification request. The request must describe the agency's deployment model and why there is no anticipated need for the specified equipment to provide appropriate patient care. ~~(3-17-22)~~(____)

04. Review of an Equipment Modification Request. Each request from an EMS agency for equipment modification ~~may~~ will be reviewed by ~~either~~ the EMS ~~Advisory Committee (EMSAC), or~~ Bureau and may be reviewed by the ~~EMS Physician Commission (~~EMSPC~~), or both~~. The recommendations from ~~EMSAC and~~ EMSPC are submitted to the ~~Department~~ EMS Bureau which has the final authority to approve or deny the modification request. ~~(3-17-22)~~(____)

~~**a.** A modification request of an operational nature will be reviewed by EMSAC; (3-17-22)~~

~~**b.** A modification request of a clinical nature will be reviewed by the EMSPC; and (3-17-22)~~

~~**c.** A modification request that has both operational and clinical considerations will be reviewed by both. (3-17-22)~~

05. Denial of an Equipment Modification Request. An EMS agency may appeal the denial of an equipment modification request under ~~the provisions in~~ IDAPA 16.05.03, "Contested Case Proceedings and

Declaratory Rulings." ~~(3-17-22)~~( )

06. Renewal of Equipment Modification. An EMS agency's equipment modification must be reviewed and reaffirmed as follows: ( )

a. Annually, with the agency license renewal application; or ( )

b. When the EMS agency changes its medical director. ( )

501. AIR MEDICAL EMS AGENCY -- EQUIPMENT REQUIREMENTS AND MODIFICATIONS.

Each air medical agency must meet the requirements ~~outlined in~~ under Section 500 of these rules, ~~as well as~~ and the following: ~~(3-17-22)~~( )

01. FAA 135 Certification. The air medical agency ~~must~~ holds a Federal Aviation Administration 135 certification. ~~(3-17-22)~~( )

02. Configuration and Equipment Standards. Aircraft and equipment configuration that does not compromise the ability to provide appropriate care or prevent emergency care providers from safely performing emergency procedures, if necessary, while in flight. ( )

502. -- 509. (RESERVED)

510. EMS AGENCY -- COMMUNICATION REQUIREMENTS.

Each EMS agency must meet the following ~~communication requirements~~ to obtain or maintain agency licensure. ~~(3-17-22)~~( )

01. Air Medical EMS Agency. Each air medical agency ~~must have~~ has mobile radios of sufficient quantities to ensure that every aircraft and ground crew has the ability to communicate on the frequencies 155.340 MHZ and 155.280 MHZ, with continuous tone-coded squelch system encoding capabilities to allow access to the Idaho EMS radio communications system. ~~(3-17-22)~~( )

02. Ambulance EMS Agency. Each ambulance EMS agency ~~must have~~ has mobile radios of sufficient quantities to ensure that every vehicle crew has the ability to communicate on the frequencies 155.340 MHZ and 155.280 MHZ, with continuous tone-coded squelch system encoding capabilities to allow access to the Idaho EMS radio communications system. ~~(3-17-22)~~( )

03. Non-transport EMS Agency. Each non-transport EMS agency ~~must have~~ has mobile or portable radios of sufficient quantities to ensure that agency personnel at an emergency scene have the ability to communicate on the frequencies 155.340 MHZ and 155.280 MHZ, with continuous tone-coded squelch system encoding capabilities to allow access to the Idaho EMS radio communications system. ~~(3-17-22)~~( )

511. EMS AGENCY -- DISPATCH REQUIREMENTS.

~~Each EMS agency must have a twenty-four (24) hour dispatch arrangement. (3-17-22)~~

01. Twenty-four Hour Dispatch Arrangement. Each EMS agency must have a twenty-four (24) hour dispatch arrangement, except an agency with a twenty-four (24) hour response waiver may have a dispatch arrangement specific to the waiver deployment plan. ( )

02. **Incoming Requests for Out-of-Hospital Response**. Each ambulance agency that is not dispatched by a CECS or PSAP must record incoming requests for out-of-hospital transports and retain such recordings for a period of one (1) year. ( )

512. -- 519. (RESERVED)

520. EMS AGENCY -- RESPONSE REQUIREMENTS AND WAIVERS.

Each EMS agency must respond to calls on a twenty-four (24) hour a day basis within the agency's declared geographic coverage area unless a waiver exists. ( )

521. NON-TRANSPORT EMS AGENCY -- WAIVER OF RESPONSE REQUIREMENT.
The controlling authority of a non-transport agency may petition the ~~Department~~ EMS Bureau for a waiver of the twenty-four (24) hour response requirement if one (1) or more of the following ~~conditions~~ exist: ~~(3-17-22)~~( )

01. Not Populated on 24-Hour Basis. The community, setting, industrial site, or event being served by the agency is not populated on a twenty-four (24) hour basis. ( )

02. Not on Daily Basis Per Year. The community, setting, industrial site, or event being served by the agency does not exist on a three hundred sixty-five (365) day per year basis. ( )

03. Undue Hardship on Community. The provision of twenty-four (24) hour response would cause an undue hardship on the community being served by the agency. ( )

04. Abandonment of Service. The provision of twenty-four (24) hour response would cause abandonment of the service provided by the agency. ( )

522. NON-TRANSPORT EMS AGENCY -- PETITION FOR WAIVER.

01. ~~Submit~~ Petition for Waiver. The controlling authority of an existing non-transport agency desiring a waiver of the twenty-four (24) hour response requirement must submit a petition for waiver to the ~~Department~~ EMS Bureau and provide the information described under the incorporated document in Subsection 002.04 of these rules. ~~(3-17-22)~~( )

02. Waiver Declared on Initial Application. The controlling authority of an applicant non-transport agency desiring a waiver of the twenty-four (24) hour response requirement must declare the request for waiver on the initial application for agency licensure to the ~~Department~~ EMS Bureau and provide the information described under the incorporated document in Subsection 002.04 of these rules. ~~(3-17-22)~~( )

~~**03. Not Populated on a 24-Hour or Daily Basis -- Petition Content**. A non-transport agency with a service area with less than twenty-four (24) hours population or less than three-hundred sixty-five (365) days per year population must include the following information on the petition for waiver of the twenty-four (24) hour response requirement: (3-17-22)~~

~~**a.** A description of the hours or days the geographic area is populated. (3-17-22)~~

~~**b.** A staffing and deployment plan that ensures EMS response availability for the anticipated call volume during the hours or days of operation. (3-17-22)~~

~~**04. Undue Hardship or Abandonment of Service Waiver -- Petition Content**. A non-transport agency must include the following information on the application for waiver of the twenty-four (24) hour response requirement when that provision would cause an undue hardship on the community being served by the agency or abandonment of service: (3-17-22)~~

~~**a.** A description of the applicant's operational limitations to provide twenty-four (24) hour response. (3-17-22)~~

~~**b.** A description of the initiatives underway or planned to provide twenty-four (24) hour response. (3-17-22)~~

~~**c.** A staffing and deployment plan identifying the agency's response capabilities and back up plans for services to the community when the agency is unavailable. (3-17-22)~~

~~**d.** A description of the collaboration that exists with all other EMS agencies providing services within the applicant's geographic response area. (3-17-22)~~

0~~5~~3. Renewal of Waivers. The controlling authority of a non-transport agency desiring to renew a

waiver of the twenty-four (24) hour response requirement must declare the request for renewal of the waiver on the annual renewal application for agency licensure to the ~~Department~~ EMS Bureau. ~~(3-17-22)~~(   )

523. -- 524. (RESERVED)

525. AMBULANCE OR AIR MEDICAL EMS AGENCY -- WAIVER OF RESPONSE REQUIREMENT.
The controlling authority of an existing ambulance or air medical agency may petition the Board ~~of Health and~~ for a waiver of the twenty-four (24) hour response requirement if one (1) or more of the following ~~conditions~~ exist as a result of the provision of twenty-four (24) hour response: ~~(3-17-22)~~(   )

01. Undue Hardship on the Community Being Served by the Agency. ~~The provision of twenty-four (24) hour response would cause an undue hardship on the community being served by the agency.~~ ~~(3-17-22)~~(   )

02. Abandonment of the Service by the Agency. ~~The provision of twenty-four (24) hour response would cause abandonment of the service provided by the agency.~~ ~~(3-17-22)~~(   )

526. AMBULANCE OR AIR MEDICAL EMS AGENCY -- PETITION FOR WAIVER.

~~**01. Submit Petition for Waiver**.~~ The controlling authority of an existing ambulance or air medical agency desiring a waiver of the twenty-four (24) hour response requirement must submit a petition for waiver to the Board and provide the information described in the incorporated document under Subsection 002.04 of these rules. ~~(3-17-22)~~(   )

~~**02. Undue Hardship or Abandonment of Service Waiver -- Petition Content**. An ambulance EMS agency must include the following information on the petition for waiver of the twenty-four (24) hour response:~~ ~~(3-17-22)~~

~~**a.** A description of the petitioner's operational limitations to provide twenty-four (24) hour response.~~ ~~(3-17-22)~~

~~**b.** A description of the initiatives underway or planned to provide twenty-four (24) hour response.~~ ~~(3-17-22)~~

~~**c.** A staffing and deployment plan identifying the agency's response capabilities and back-up plans for services to the community when the agency is unavailable.~~ ~~(3-17-22)~~

~~**d.** A description of the collaboration that exists with all other EMS agencies providing services within the petitioner's geographic response area.~~ ~~(3-17-22)~~

527. -- 529. (RESERVED)

530. EMS AGENCY -- MEDICAL SUPERVISION REQUIREMENTS.
Each EMS agency must comply with medical supervision plan requirements and designate a physician as the agency medical director who is responsible for the supervision of medical activities ~~defined in~~ under IDAPA 16.02.02, "Idaho Emergency Medical Services (EMS) Physician Commission." ~~(3-17-22)~~(   )

531. -- 534. (RESERVED)

535. RECORDS, DATA COLLECTION, AND SUBMISSION REQUIREMENTS.
Each licensed EMS agency must collect and submit EMS response records to the EMS Bureau as follows: (   )

01. Records to be Maintained. ~~Maintain a record that i~~Include~~s~~ a Patient Care Report completed for each EMS Response. ~~(4-6-23)~~(   )

02. Records to be Submitted. Ensure that an accurate and complete electronic Patient Care Report (ePCR) is submitted to the EMS Bureau using approved and validated software in a format determined by the ~~Department~~ EMS Bureau. ~~(4-6-23)~~(   )

03. Time Frame for Submitting Records. Submit each month's data to the ~~Department~~ EMS Bureau by the 15th of the following month in a format determined by the ~~Department~~ EMS Bureau. ~~(4-6-23)~~( )

536. -- 599. (RESERVED)

EMS AGENCY AGREEMENTS, PLANS, AND POLICIES
(Sections 600 - 699)

600. EMS AGENCY -- AGREEMENTS, PLANS, AND POLICIES.
When applicable, each EMS agency must make the following agreements, plans, and policies, ~~described in~~ under Sections 600 through 699 of these rules, available to the ~~Department~~ EMS Bureau upon request. ~~(3-17-22)~~( )

601. EMS AGENCY – AMBULANCE SERVICE RESPONSE AGREEMENTS.
Each EMS agency with out-of-hospital customer service agreements to provide ambulance services that are not dispatched by the local CECS or PSAP must provide the customer with written criteria to reasonably identify potential medical emergencies *that should be referred to a CECS or PSAP for dispatch of a 911 Response agency unless a staffed ambulance is already on site at the patient's location.* ( )

60~~1~~2. EMS AGENCY -- PATIENT CARE INTEGRATION.

01. Cooperative Agreements for Common Geographic Coverage Area. Each ground EMS agency that shares common geographic coverage areas with other EMS agencies must develop cooperative written agreements that address integration of patient care between the agencies. A ground agency can not provide a level of care that exceeds the clinical level of a prehospital agency receiving the patient, unless the written patient integration plan specifically addresses the continuation of the higher level of care throughout the patient transport. ( )

02. Cooperative Agreement for Non-Transport Agency. Each 911 Response non-transport EMS agency must have a cooperative written agreement with ~~a prehospital agency that will provide patient transportation~~ each of the 911 Response Transport Services that provide response and patient transportation within that geographical area. The agreement must address integration of patient care between the agencies. A non-transport ~~prehospital~~ agency may not provide a level of care that exceeds the clinical level of the responding ~~transport prehospital agency~~ 911 Response Transport Service unless the integration plan specifically addresses the continuation of the higher level of care throughout the patient transport. ~~(3-17-22)~~( )

60~~2~~3. AIR MEDICAL EMS AGENCY -- PATIENT CARE INTEGRATION.
Each air medical agency must declare and make available its patient care integration policies to the ~~Department~~ EMS Bureau upon request. ~~(3-17-22)~~( )

60~~3~~4. EMS AGENCY -- PLANNED DEPLOYMENT AGREEMENTS.
Each EMS agency that utilizes a planned deployment must develop a cooperative planned deployment agreement between the EMS agencies under the incorporated document in Subsection 002.04 of these rules. ~~The agreement must include the following:~~ ~~(3-17-22)~~( )

~~**01. Chief Administrative Officials**. Approval of the chief administrative officials of each EMS agency entering into the agreement either as the receiver of the planned deployment or the provider of the planned deployment. (3-17-22)~~

~~**02. Medical Directors**. Approval of the medical directors of each EMS agency entering into the agreement either as the receiver of the planned deployment or the provider of the planned deployment. (3-17-22)~~

~~**03. Geographic Locations and Services**. The agreement must provide the geographic locations and the services to be provided by the planned deployment. (3-17-22)~~

~~**04. Shared Resources**. The agreement must provide for any sharing of resources between each EMS agency covered by the planned deployment. (3-17-22)~~

~~**05. Equipment and Medication.** The agreement must provide for the availability and responsibility of equipment and medications for each EMS agency covered by the planned deployment. (3-17-22)~~

~~**06. Patient Integration of Care**. The agreement must provide patient integration of care by each EMS agency covered by the planned deployment. (3-17-22)~~

~~**07. Patient Transport**. The agreement must provide for patient transport considerations by each EMS agency covered by the planned deployment. (3-17-22)~~

~~**08. Medical Supervision**. The agreement must have provisions for medical supervision of each EMS agency covered by the planned deployment. (3-17-22)~~

~~**09. Quality Assurance**. The agreement must provide for quality assurance and retrospective case reviews by each EMS agency covered by the planned deployment. (3-17-22)~~

60~~4~~5. -- 649. (RESERVED)

650. AIR MEDICAL EMS AGENCY -- REQUIRED POLICIES.
Each air medical EMS agency must have the following policies on file with the ~~Department~~ EMS Bureau as described under the incorporated document in Subsection 002.04 of these rules: ~~(3-17-22)~~(   )

01. Non-Discrimination Policy. ~~Each air medical EMS agency must have written non-discrimination policies to ensure that requests for service are not evaluated based on the patient's ability to pay. (3-17-22)~~(   )

02. Weather Turn Down Policy. ~~Each air medical EMS agency must immediately notify other air medical agencies in common geographical areas and the Idaho EMS State Communications Center about any requests for services declined or aborted due to weather. Notification to other agencies of flights declined or aborted due to weather must be documented. (3-17-22)~~(   )

03. Patient Destination Procedure. ~~Each air medical EMS agency must maintain written procedures for the determination of patient destination. These procedures must: (3-17-22)~~(   )

~~**a.** Consider the licensed EMS agency destination protocol and medical supervision received; (3-17-22)~~

~~**b.** Be made available to licensed EMS agencies that utilize their services; (3-17-22)~~

~~**c.** Honor patient preference if: (3-17-22)~~

~~i. The requested facility is capable of providing the necessary medical care; and (3-17-22)~~

~~ii. The requested facility is located within a reasonable distance not compromising patient care or the EMS system. (3-17-22)~~

04. Safety Program Policy. ~~Each air medical EMS agency must maintain a safety program policy that includes: (3-17-22)~~(   )

~~**a.** Designation of a safety officer; (3-17-22)~~

~~**b.** Designation of a multi-disciplinary safety committee that includes: pilot, medical personnel, mechanic, communication specialist, and administrative staff; (3-17-22)~~

~~**c.** Post-Accident Incident Plan; (3-17-22)~~

~~**d.** Fitness for Duty Requirements; (3-17-22)~~

~~**e.** Annual Air Medical Resource Management Training; (3-17-22)~~

~~f.~~ ~~Procedures for allowing a crew member to decline or abort a flight;~~ ~~(3-17-22)~~

~~g.~~ ~~Necessary personal equipment, apparel, and survival gear appropriate to the flight environment. Helmets must be required for each EMS crew member and pilot during helicopter operations; and~~ ~~(3-17-22)~~

~~h.~~ ~~A procedure to review each flight for safety concerns and report those concerns to the safety committee.~~ ~~(3-17-22)~~

05. Training Policy. ~~Each air medical EMS agency must have written documentation of initial and annual air medical specific recurrent training for air ambulance personnel. Education content must include:~~ ~~(3-17-22)~~( )

~~a.~~ ~~Altitude physiology;~~ ~~(3-17-22)~~

~~b.~~ ~~Stressors of flight;~~ ~~(3-17-22)~~

~~c.~~ ~~Air medical resource management;~~ ~~(3-17-22)~~

~~d.~~ ~~Survival;~~ ~~(3-17-22)~~

~~e.~~ ~~Navigation; and~~ ~~(3-17-22)~~

~~f.~~ ~~Aviation safety issues including emergency procedures.~~ ~~(3-17-22)~~

651. -- 699. (RESERVED)

EMS AGENCY UTILIZATION OF AIR MEDICAL SERVICES
(Sections 700 - 799)

700. EMS AGENCY -- CRITERIA TO REQUEST AN AIR MEDICAL RESPONSE.
Each ground EMS agency must establish written criteria as described in the document incorporated under Section 002.04 of these rules for the agency's licensed EMS personnel that provides decision-making guidance for requesting an air medical response to an emergency scene. This criteria must be approved by the agency's medical director. ~~The following conditions must be included in the criteria:~~ ~~(3-17-22)~~( )

~~**01.**~~ ~~**Clinical Conditions**. Each licensed EMS agency must develop written criteria based on best medical practice principles for requesting an air medical response for the following clinical conditions:~~ ~~(3-17-22)~~

~~a.~~ ~~The patient has a penetrating or crush injury to head, neck, chest, abdomen, or pelvis;~~ ~~(3-17-22)~~

~~b.~~ ~~Neurological presentation suggestive of spinal cord injury;~~ ~~(3-17-22)~~

~~c.~~ ~~Evidence of a skull fracture (depressed, open, or basilar) as detected visually or by palpation;~~ ~~(3-17-22)~~

~~d.~~ ~~Fracture or dislocation with absent distal pulse;~~ ~~(3-17-22)~~

~~e.~~ ~~A glasgow coma score of ten (10) or less;~~ ~~(3-17-22)~~

~~f.~~ ~~Unstable vital signs with evidence of shock;~~ ~~(3-17-22)~~

~~g.~~ ~~Cardiac arrest;~~ ~~(3-17-22)~~

~~h.~~ ~~Respiratory arrest;~~ ~~(3-17-22)~~

~~i.~~ ~~Respiratory distress;~~ ~~(3-17-22)~~

~~**j.** Upper airway compromise;~~ ~~(3-17-22)~~

~~**k.** Anaphylaxis;~~ ~~(3-17-22)~~

~~**l.** Near drowning;~~ ~~(3-17-22)~~

~~**m.** Changes in level of consciousness;~~ ~~(3-17-22)~~

~~**n.** Amputation of an extremity; and~~ ~~(3-17-22)~~

~~**o.** Burns greater than twenty percent (20%) of body surface or with suspected airway compromise.~~ ~~(3-17-22)~~

~~**02. Complications to Clinical Conditions**. Each licensed EMS agency must develop a written policy that provides guidance for requesting an air medical response when there are complicating conditions associated with the clinical conditions listed in Subsection 700.01 of this rule. The complicating conditions must include the following:~~ ~~(3-17-22)~~

~~**a.** Extremes of age;~~ ~~(3-17-22)~~

~~**b.** Pregnancy; and~~ ~~(3-17-22)~~

~~**c.** Patient "do not resuscitate" status.~~ ~~(3-17-22)~~

~~**03. Operational Conditions for Air Medical Response**. Each licensed EMS agency must have written criteria to provide guidance to the licensed EMS personnel for the following operational conditions:~~ ~~(3-17-22)~~

~~**a.** Availability of local hospitals and regional medical centers;~~ ~~(3-17-22)~~

~~**b.** Air medical response to the scene and transport to an appropriate hospital will be significantly shorter than ground transport time;~~ ~~(3-17-22)~~

~~**c.** Access to time sensitive medical interventions such as percutaneous coronary intervention, thrombolytic administration for stroke, or cardiac care;~~ ~~(3-17-22)~~

~~**d.** When the patient's clinical condition indicates the need for advanced life support and air medical is the most readily available access to advanced life support capabilities;~~ ~~(3-17-22)~~

~~**e.** As an additional resource for a multiple patient incident;~~ ~~(3-17-22)~~

~~**f.** Remote location of the patient; and~~ ~~(3-17-22)~~

~~**g.** Local destination protocols.~~ ~~(3-17-22)~~

701. EMS AGENCY -- EMS PERSONNEL REQUEST FOR AIR MEDICAL RESPONSE.
Licensed EMS personnel en route to, or at, the emergency scene have the primary responsibility and authority to request the response of air medical services using the local incident management system and licensed EMS agency written criteria ~~described in Section 700 of these rules~~ under the incorporated document in Subsection 002.04 of these rules. ~~(3-17-22)~~( )

702. EMS AGENCY -- CANCELLATION OF AN AIR MEDICAL RESPONSE.
Following dispatch of air medical services, an air medical response may only be canceled upon completion of a patient assessment performed by licensed EMS personnel. ( )

703. EMS AGENCY -- ESTABLISHED CRITERIA FOR SIMULTANEOUS DISPATCH.

Under the incorporated document in Subsection 002.04 of these rules, ~~A~~a ground EMS agency may establish criteria for simultaneous dispatch for air and ground medical response. ~~Air medical services will not launch to an emergency scene unless requested in accordance with Subsection 720.01 of these rules.~~ ~~(3-17-22)~~(   )

704. EMS AGENCY-- SELECTION OF AIR MEDICAL AGENCY.

Each EMS agency has the responsibility to select an appropriate air medical service ~~EMS agency~~ and have on file selection policies as described in the incorporated document under Subsection 002.04 of these rules. ~~(3-17-22)~~(   )

~~**01. Written Policy to Select Air Medical Agency**. Each EMS agency must have a written policy that establishes a process to select an air medical service.~~ ~~(3-17-22)~~

~~**02. Policy for Patient Requests**. The written policy must direct EMS personnel to honor a patient request for a specific air medical service when the circumstances will not jeopardize patient safety or delay patient care.~~ ~~(3-17-22)~~

705. -- ~~719.~~ ~~(RESERVED)~~

~~**720. EMS AGENCY -- COMMUNICATIONS WITH AIR MEDICAL SERVICES.**~~

~~**01. Responsibility to Request an Air Medical Response**. In compliance with the local incident management system, each EMS agency must establish a uniform method of communication to request an air medical response.~~ ~~(3-17-22)~~

~~**02. Required Information to Request an Air Medical Response**. Requests for an air medical response must include the following information as it becomes available:~~ ~~(3-17-22)~~

~~**a.** Type of incident;~~ ~~(3-17-22)~~

~~**b.** Landing zone location or GPS (latitude/longitude) coordinates, or both;~~ ~~(3-17-22)~~

~~**c.** Scene contact unit or scene incident commander, or both;~~ ~~(3-17-22)~~

~~**d.** Number of patients if known;~~ ~~(3-17-22)~~

~~**e.** Need for special equipment;~~ ~~(3-17-22)~~

~~**f.** Estimated weight of the patient;~~ ~~(3-17-22)~~

~~**g.** How to contact on scene EMS personnel; and~~ ~~(3-17-22)~~

~~**h.** How to contact the landing zone officer.~~ ~~(3-17-22)~~

~~**03. Notification of Air Medical Response**. The air medical agency must notify the State EMS Communication Center within ten (10) minutes of launching an aircraft in response to a request for medical transport. Notification must include:~~ ~~(3-17-22)~~

~~**a.** The name of the requesting entity;~~ ~~(3-17-22)~~

~~**b.** Location of the landing zone; and~~ ~~(3-17-22)~~

~~**c.** Scene contact unit and scene incident commander, if known.~~ ~~(3-17-22)~~

~~**04. Estimated Time of Arrival at the Specified Landing Zone**. Upon receipt of a request for air medical emergency services, the air medical agency must provide the requesting entity with an estimated time of arrival (ETA) at the location of the specified landing zone. All changes to that ETA must immediately be reported to the requesting entity. ETAs are to be reported in clock time, specific to the appropriate time zone.~~ ~~(3-17-22)~~

~~**05. Confirmation of Air Medical Response Availability**. Upon receipt of a request for an air medical response, the air medical agency must inform the requesting entity whether the specified air medical unit is immediately available to respond. (3-17-22)~~

~~721. --~~729. (RESERVED)

730. EMS AGENCY -- LANDING ZONE PROCEDURES FOR AIR MEDICAL RESPONSE.

~~**01. Establish Landing Zone Procedures**.~~ A licensed ambulance or non-transport EMS agency in conjunction with an air medical agency must have written procedures for the establishment of a landing zone. These procedures must be compatible with the local incident management system. ~~(3-17-22)~~( )

~~**02. Responsibilities of Landing Zone Officer**. The procedures for establishment of a landing zone must include identification of a Landing Zone Officer who is responsible for the following: (3-17-22)~~

~~**a.** Landing zone preparation; (3-17-22)~~

~~**b.** Landing zone safety; and (3-17-22)~~

~~**c.** Communication between the ground EMS agency and the air medical agency. (3-17-22)~~

~~**03. Final Decision to Use Established Landing Zone**. The air medical pilot may refuse the use of an established landing zone. In the event of a pilot's refusal to land, the landing zone officer must initiate communications to identify an alternate landing zone. (3-17-22)~~

731. EMS AGENCY -- REVIEW OF AIR MEDICAL RESPONSES.

Each EMS agency must provide incident-specific patient care related data identified and requested by the ~~Department~~ EMS Bureau in the review of air medical response criteria. ~~(3-17-22)~~( )

732. -- 799. (RESERVED)

EMS AGENCY INSPECTIONS
(Sections 800 - 899)

800. EMS AGENCY -- INSPECTIONS BY THE ~~DEPARTMENT~~ EMS BUREAU.

~~Representatives of t~~The ~~Department are~~ EMS Bureau is authorized to enter an agency's facility at reasonable times to inspect an agency's vehicles, equipment, response records, and other necessary items to determine that the EMS agency is in compliance with ~~governing~~ Idaho statutes and administrative rules. ~~(3-17-22)~~( )

801. EMS AGENCY -- INSPECTION REQUESTS AND SCHEDULING.

An applicant eligible for agency inspection must contact the ~~Department~~ EMS Bureau to schedule an inspection. In the event that the acquisition of capital equipment, hiring, or licensure of personnel is necessary for the inspection process, the applicant must notify the ~~Department~~ EMS Bureau when ready for the inspection. ~~(3-17-22)~~( )

802. EMS AGENCY -- INSPECTION TIMEFRAME AFTER NOTIFICATION OF ELIGIBILITY.

An applicant must schedule and have an inspection completed within six (6) months of notification of eligibility by the ~~Department~~ EMS Bureau. An application without an inspection completed within six (6) months is void and must be resubmitted as an initial application. ~~(3-17-22)~~( )

803. -- 804. (RESERVED)

805. EMS AGENCY -- INITIAL AGENCY INSPECTION.

The ~~Department~~ EMS Bureau will perform an initial inspection, which is an integral component of the application process, to ensure the EMS ~~A~~agency applicant is ~~in compliance regarding~~ complying with the following: ~~(3-17-22)~~( )

01. Validation of Initial Application. Validate the information contained in the application. ( )

02. Verification of Compliance. Verify the applicant is ~~in compliance~~ complying with ~~governing~~ Idaho statutes and administrative rules. ~~(3-17-22)~~( )

806. EMS AGENCY -- DEMONSTRATION OF CAPABILITIES DURING INSPECTION.
The ~~Department~~ EMS Bureau will review historical and current information during the annual, random, and targeted inspections whereas an applicant must demonstrate the following during the initial inspection process: ~~(3-17-22)~~( )

01. Validation of Ability to Submit Data. Each EMS agency applicant must demonstrate the ability to submit data described in Section 535 of these rules. ( )

02. Validation of Ability to Communicate. Each EMS agency applicant must demonstrate the ability to communicate via radio with the state EMS communications center, local dispatch center, neighboring EMS agencies on which the applicant will rely for support, first response, air and ground patient transport, higher level patient care, or other purposes. ( )

807. -- 829. (RESERVED)

830. EMS AGENCY -- CONDITION THAT RESULTS IN VEHICLE OR AGENCY OUT OF SERVICE.
Upon discovery of a condition during inspection that could reasonably pose an immediate threat to the safety of the public or agency staff, the ~~Department~~ EMS Bureau may declare the condition unsafe and remove the vehicle or agency from service until the unsafe condition is corrected. ~~(3-17-22)~~( )

831. -- 839. (RESERVED)

840. EMS AGENCY -- EXEMPTIONS FOR AGENCIES CURRENTLY ACCREDITED BY A NATIONALLY RECOGNIZED PROFESSIONAL EMS ACCREDITATION AGENCY.
Upon petition by the accredited agency, the ~~Department~~ EMS Bureau will review the accreditation standards under which the accredited agency was measured and may waive specific duplicated annual inspection requirements where appropriate. If an external accreditation inspection is found to be more rigorous than that of the Department, the ~~Department~~ EMS Bureau may elect to relax the frequency of ~~Department~~ annual inspections or waive ~~Department~~ annual inspections altogether. ~~(3-17-22)~~( )

841. -- 899. (RESERVED)

EMS AGENCY LICENSURE PROCESS
(Sections 900 - 999)

900. EMS AGENCY -- APPLICATION FOR INITIAL LICENSURE.
To be considered for initial EMS agency licensure, an organization seeking licensure must request, complete, and submit the standardized EMS agency initial license application form provided by the ~~Department~~ EMS Bureau. ~~(3-17-22)~~( )

901. EMS AGENCY -- LICENSURE EXPIRATION.
Each EMS agency license, unless otherwise declared on the license, is valid for one (1) year from the end of the month of issuance by the ~~Department~~ EMS Bureau. ~~(3-17-22)~~( )

902. -- 970. (RESERVED)

971. LAPSED LICENSE.

01. Application Not Submitted Prior to Expiration of Current License. An agency that does not submit a complete application as prescribed in these rules will be considered lapsed. The license will no longer be valid. ( )

02. Grace Period. No grace periods or extensions to an expiration date will be granted when an agency has not submitted a completed renewal application ~~within the timeframes described in Section 950 of these rules~~ on, or before, the date the current license expires. ~~(3-17-22)~~(   )

03. Lapsed License. An agency that has a lapsed license cannot provide EMS services. (   )

04. ~~To~~ Regaining Agency Licensure. An agency with a lapsed license will be considered an applicant for initial licensure and is bound by the same requirements and processes as an initial applicant. ~~(3-17-22)~~(   )

972. -- 979. (RESERVED)

980. EMS AGENCY LICENSE -- NONTRANSFERABLE.
An EMS agency license issued by the ~~Department~~ EMS Bureau cannot be transferred or sold. ~~(3-17-22)~~(   )

981. CHANGES TO A CURRENT LICENSE.
An agency's officials must submit an agency update to the ~~Department~~ EMS Bureau within sixty (60) days of any of the following ~~changes~~: ~~(3-17-22)~~(   )

01. Changes Requiring Update ~~to Department~~. An agency's officials must submit an agency update to the ~~Department~~ EMS Bureau within sixty (60) days of any of the following ~~changes~~: ~~(3-17-22)~~(   )

a. Changes made to the geographic coverage area by agency annexation; (   )

b. Licensed personnel added or removed from the agency affiliation roster. If licensed personnel are removed for cause, a description of the cause must be included; (   )

c. Vehicles or equipment added or removed from the agency; (   )

d. Changes to the agency communication plan or equipment; (   )

e. Changes to the agency dispatch agreement; or (   )

f. Changes to the agency Medical Supervision Plan. (   )

02. Changes Requiring Initial Licensure Application. When an agency decides to make any of the following changes, it must submit an initial agency application to the ~~Department~~ EMS Bureau and follow the initial application process described in Section~~s~~ 900 ~~through 922~~ of these rules: ~~(3-17-22)~~(   )

a. Clinical level of licensed personnel it utilizes; (   )

b. Geographic coverage area changes, except by agency annexation; (   )

c. A non-transport agency that intends to provide patient transport or an ambulance agency that intends to discontinue patient transport and become a non-transport agency; or (   )

d. An agency that intends to add ~~prehospital or transfer operational declarations~~ a 911 Response to an Ambulance Service license or Non-Transport Service license. ~~(3-17-22)~~(   )

982. -- 989. (RESERVED)

990. TIME SENSITIVE EMERGENCY CERTIFICATION.
The ~~Department's~~ EMS Bureau will certify an EMS Agency as a TSE Designated EMS Agency when such agency, upon proper application and verification, is found to meet the applicable designation criteria ~~established in the Time Sensitive Emergency System Standards Manual incorporated by reference under Section 004 of these rules~~ under the incorporated document in Subsection 002.04 of these rules. ~~(3-17-22)~~(   )

991. -- 999. (RESERVED)

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.02.02 – IDAHO EMERGENCY MEDICAL SERVICES (EMS) PHYSICIAN COMMISSION

DOCKET NO. 16-0202-2301 (ZBR CHAPTER REWRITE)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo and Incorporation By Reference Synopsis (IBRS)

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2024 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. The pending rule will become final and effective upon the adjournment, *sine die*, of the Second Regular Session of the Sixty-seventh Idaho Legislature after approval.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 56-1013A, and 56-1023, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

Under Executive Order 2020-01: Zero-Based Regulation, the Department is striving to prevent the accumulation of costly, ineffective, and outdated regulations and reduce regulatory burden to achieve a more efficient operation of government. The rule changes are intended to perform a comprehensive review of this chapter by collaborating with the public to streamline or simplify this rule language.

There are no changes to the pending rule and it is being adopted as originally proposed. The complete text of the proposed rule was published in the September 6, 2023, Idaho Administrative Bulletin, Vol. 23-9, pages 39 through 48.

FEE SUMMARY: Pursuant to Section 67-5224(2)(d), Idaho Code, this pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature. The following is a description of the fee or charge imposed or increased in this rulemaking: Does not apply to this rulemaking.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state General Fund greater than ten thousand dollars ($10,000) during the fiscal year:

This rulemaking is not anticipated to have any fiscal impact on the state General Fund, or any other known funds.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Jathan Nalls at 208-334-4007.

DATED this 17th of November, 2023.

Trinette Middlebrook and Frank Powell
DHW – Administrative Rules Unit
450 W. State Street – 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
phone: (208) 334-5500
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e-mail:dhwrules@dhw.idaho.gov

THE FOLLOWING NOTICE PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 56-1013A, and 56-1023, Idaho Code.

PUBLIC HEARING SCHEDULE: A public hearing concerning this rulemaking will be held as follows:

VIRTUAL TELECONFERENCE Via WebEx
Friday, September 8, 2023 **1:00 p.m. - 3:00 p.m. (MT)**
Join from the meeting link **https://idhw.webex.com/idhw/j.php?MTID=m53b8e38c43a0ad62ef739ff2c479b55c** **Join by meeting number** **Meeting number (access code): 2763 328 2701** **Meeting password: pU2Wp22gmwd (78297224 from phones and video systems)** **Join by phone** **+1-415-527-5035 United States Toll** **+1-303-498-7536 United States Toll (Denver)**

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below. Each meeting will conclude after 30 minutes if no participants sign in or wish to comment in the meeting.

DESCRIPTIVE SUMMARY: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

Under Executive Order 2020-01: Zero-Based Regulation, the Department is striving to prevent the accumulation of costly, ineffective, and outdated regulations and reduce regulatory burden to achieve a more efficient operation of government. The rule changes are intended to perform a comprehensive review of this chapter by collaborating with the public to streamline or simplify this rule language.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased:

This chapter contains no fees or charges.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year as a result of this rulemaking:

This rulemaking is not anticipated to have any fiscal impact on the State General Fund, or any other known funds.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the May 3, 2023, Idaho Administrative Bulletin, Vol. 23-5, pages 146 and 147.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into this rule:

This chapter incorporates by reference the revised Idaho Emergency Medical Services (EMS) Physician Commission Standards Manual, edition 2024-1. This document is incorporated by reference to save space in the chapter and ensure that it continues to have the force and effect of law.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Jathan Nalls at 208-334-4007.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before September 27, 2023.

DATED this 4th day of August, 2023.

THE FOLLOWING IS THE TEXT OF ZBR DOCKET NO. 16-0202-2301

16.02.02 – IDAHO EMERGENCY MEDICAL SERVICES (EMS) PHYSICIAN COMMISSION

000. LEGAL AUTHORITY.
Sections 56-1013A and 56-1023, Idaho Code, authorize the Emergency Medical Services Physician Commission (EMSPC) to promulgate rules to establish standards for scope of practice and medical supervision for licensed personnel, air medical, ambulance services, and nontransport agencies licensed by the Department. ( )

001. (RESERVED)

002. INVESTIGATIONS.

01. Physician Professional Disciplinary Enforcement Investigations. Section 54-1806A, Idaho Code, governs investigation of complaints regarding physicians. ( )

02. EMS Personnel and EMS Agency Complaint Investigations. IDAPA 16.01.12, “Emergency Medical Services (EMS) -- Complaints, Investigations, and Disciplinary Actions,” govern investigation of complaints regarding licensed EMS personnel and EMS Agencies. ( )

003. INCORPORATION BY REFERENCE.
The EMSPC has incorporated by reference the Idaho Emergency Medical Services (EMS) Physician Commission Standards Manual, edition 2024-1. Copies are available at https://healthandwelfare.idaho.gov/about-dhw/boards-councils-committees/ems-physician-commission or from the Bureau of Emergency Medical Services and Preparedness located at 2224 East Old Penitentiary Road, Boise, ID, 83712-8249; the mailing address is PO Box 83720, Boise, Idaho 83720-0036. ( )

004. EMS COMPLAINTS.
IDAPA 16.01.12, “Emergency Medical Services (EMS) -- Complaints, Investigations, and Disciplinary Actions,” governs the confidentiality of the investigation of complaints regarding licensed EMS personnel. ( )

005. -- 009. (RESERVED)

010. DEFINITIONS.

In addition to the applicable definitions in Section 56-1012, Idaho Code, and IDAPA 16.01.02, "Emergency Medical Services (EMS) -- Rule Definitions," the following are used in these rules: ( )

01. Credentialed EMS Personnel. Individuals authorized to provide medical care by the EMS medical director, hospital supervising physician, or medical clinic supervising physician. ( )

02. Credentialing. The local process by which licensed EMS personnel are authorized to provide medical care in the out-of-hospital, hospital, and medical clinic setting, including the determination of a local scope of practice. ( )

03. Designated Clinician. A Physician Assistant (PA) or Nurse Practitioner designated by the EMS medical director, hospital supervising physician, or medical clinic supervising physician responsible for direct (on-line) medical supervision of licensed EMS personnel in the temporary absence of the EMS medical director. ( )

04. Direct (On-Line) Supervision. Contemporaneous instructions and directives about a specific patient encounter provided by a physician or designated clinician to licensed EMS personnel providing medical care. ( )

05. Emergency Medical Services (EMS). Under Section 56-1012(12), Idaho Code, emergency medical services or EMS is aid rendered by an individual or group of individuals who do the following: ( )

a. Respond to a perceived need for medical care to prevent loss of life, aggravation of physiological or psychological illness, or injury; ( )

b. Are prepared to provide interventions that are within the scope of practice under IDAPA 16.02.02, "Idaho Emergency Medical Services (EMS) Physician Commission"; ( )

c. Use an alerting mechanism to initiate a response to requests for medical care; and ( )

d. Offer, advertise, or attempt to respond as described in Section 56-1012(12), (a) through (c), Idaho Code. ( )

e. Aid rendered by a ski patroller, as described in Section 54-1804(1)(h), Idaho Code, is not EMS. ( )

06. Emergency Medical Services (EMS) Bureau. The Bureau of Emergency Medical Services (EMS) and Preparedness for the Department. ( )

07. Emergency Medical Services) Physician Commission (EMSPC). The Idaho Emergency Medical Services Physician Commission as created under Section 56-1013A, Idaho Code. ( )

08. EMS Agency. An organization licensed by the EMS Bureau to provide emergency medical services in Idaho. ( )

09. EMS Medical Director. A physician who supervises the medical activities of licensed personnel affiliated with an EMS agency. ( )

10. Hospital. A facility in Idaho licensed under Sections 39-1301 through 39-1314, Idaho Code, and defined in Section 39-1301(a)(1), Idaho Code. ( )

11. Hospital Supervising Physician. A physician who supervises the medical activities of licensed EMS personnel while employed or utilized for delivery of services in a hospital. ( )

12. Indirect (Off-Line) Supervision. The medical supervision provided by a physician to licensed EMS personnel who are providing medical care including EMS system design, education, quality management, patient care guidelines, medical policies, and compliance. ( )

13. License. A license issued by the EMS Bureau to an individual for a specified period indicating that minimum standards corresponding to one (1) of several levels of EMS proficiency have been met. ( )

14. Licensed EMS Personnel. Individuals who possess a valid license issued by the EMS Bureau. ( )

15. Medical Clinic. A place devoted primarily to the maintenance and operation of facilities for outpatient medical, surgical, and emergency care of acute and chronic conditions or injury. ( )

16. Medical Clinic Supervising Physician. A physician who supervises the medical activities of licensed EMS personnel while employed or utilized for delivery of services in a medical clinic. ( )

17. Medical Supervision. The advice and direction provided by, or under the direction of a physician, to licensed EMS personnel who are providing medical care, including direct and indirect supervision. ( )

18. Medical Supervision Plan. The written document describing the provisions for medical supervision of licensed EMS personnel. ( )

19. Nurse Practitioner. An Advanced Practice Professional Nurse, licensed as a Nurse Practitioner, under IDAPA 24.34.01, "Rules of the Idaho Board of Nursing." ( )

20. Out-of-Hospital. Any setting outside of a hospital, including inter-facility transfers, in which the provision of emergency medical services may take place. ( )

21. Physician. Under Section 54-1803, Idaho Code, a person who holds a current active license issued by the Board of Medicine to practice medicine and surgery, osteopathic medicine and surgery, or osteopathic medicine in Idaho and is in good standing with no restriction upon, or actions taken against, their license. ( )

22. Physician Assistant. A person who meets the requirements to practice as a licensed physician assistant under Title 54, Chapter 18, Idaho Code, and IDAPA 24.33.02, "Rules for the Licensure of Physician Assistants." ( )

011. -- 094. (RESERVED)

095. GENERAL PROVISIONS.

01. Practice of Medicine. These rules may authorize the practice of medicine by licensed EMS personnel practicing within their defined scope of practice. ( )

02. Patient Consent. The provision or refusal of consent for individuals receiving emergency medical services under Title 39, Chapter 45, Idaho Code. ( )

03. System Consistency. All EMS medical directors, hospital supervising physicians, and medical clinic supervising physicians must collaborate to ensure EMS agencies and licensed EMS personnel have protocols, policies, standards of care, and procedures that are consistent and compatible with one another. ( )

096. -- 099. (RESERVED)

100. GENERAL DUTIES OF EMS PERSONNEL.

01. General Duties. General duties of EMS personnel include the following: ( )

a. Licensed EMS personnel must possess a valid license issued by the EMS Bureau equivalent to or higher than the scope of practice authorized by the EMS medical director, hospital supervising physician, or medical clinic supervising physician. ( )

b. Licensed EMS personnel must only provide patient care for which they have been trained, based on

curricula or specialized training approved under IDAPA 16.01.07, “Emergency Medical Services (EMS) -- Personnel Licensing Requirements,” or additional training approved by the hospital or medical clinic supervising physician. ( )

c. Licensed EMS personnel must not perform a task(s) within their scope of practice that has been specifically prohibited by their EMS medical director, hospital supervising physician, or medical clinic supervising physician. ( )

d. Licensed EMS personnel that possess a valid credential issued by the EMS medical director, hospital supervising physician, or medical clinic supervising physician are authorized to provide services when representing an Idaho EMS agency, hospital, or medical clinic and under any of the following conditions: ( )

i. When part of a documented, planned deployment of personnel resources approved by the EMS medical director, hospital supervising physician, or medical clinic supervising physician; ( )

ii. When, in a manner approved by the EMS medical director, hospital supervising physician, or medical clinic supervising physician, administering first aid or emergency medical attention under Section 5-330 or 5-331, Idaho Code, without expectation of remuneration; or ( )

iii. When participating in a training program approved by the EMS Bureau, the EMS medical director, hospital supervising physician, or medical clinic supervising physician. ( )

02. Scope of Practice. ( )

a. The EMSPC maintains an “EMS Physician Commission Standards Manual” that: ( )

i. Establishes the scope of practice of licensed EMS personnel; and ( )

ii. Specifies the type and degree of medical supervision for specific skills, treatments, and procedures by level of EMS licensure. ( )

b. The EMSPC will consider the United States Department of Transportation's National EMS Scope of Practice Model when preparing or revising the standards manual under Subsection 100.02.a. of this rule; ( )

c. The scope of practice established by the EMSPC determines the objectives of applicable curricula and specialized education of licensed EMS personnel; ( )

d. The scope of practice does not define a standard of care, nor does it define what should be done in a given situation; ( )

e. Licensed EMS personnel must not provide out-of-hospital patient care that exceeds the scope of practice established by theEMSPC; ( )

f. Licensed EMS personnel must be credentialed by the EMS medical director, hospital supervising physician, or medical clinic supervising physician to be authorized for their scope of practice; ( )

g. The credentialing of licensed EMS personnel affiliated with an EMS agency, under IDAPA 16.01.03, “Emergency Medical Services (EMS) -- Agency Licensing Requirements,” must not exceed the licensure level of that EMS agency; and ( )

h. The patient care provided by licensed EMS personnel must conform to the Medical Supervision Plan as authorized by the EMS medical director, hospital supervising physician, or medical clinic supervising physician. ( )

101. -- 199. (RESERVED)

200. EMS MEDICAL DIRECTOR, HOSPITAL SUPERVISING PHYSICIAN, AND MEDICAL CLINIC SUPERVISING PHYSICIAN QUALIFICATIONS.
The EMS Medical Director, Hospital Supervising Physician, and Medical Clinic Supervising Physician must: ( )

01. Accept Responsibility. Accept responsibility for the medical direction and medical supervision of the activities provided by licensed EMS personnel. ( )

02. Complete Medical Director Training. Complete any required Medical Director training within one (1) year of appointment. ( )

03. Maintain Knowledge of EMS Systems. Obtain and maintain knowledge of the contemporary design and operation of EMS systems. ( )

04. Maintain Knowledge of Idaho EMS. Obtain and maintain knowledge of Idaho EMS laws, regulations, and standards manuals. ( )

201. -- 299. (RESERVED)

300. EMS MEDICAL DIRECTOR, HOSPITAL SUPERVISING PHYSICIAN, AND MEDICAL CLINIC SUPERVISING PHYSICIAN RESPONSIBILITIES AND AUTHORITY.

01. Documentation of Written Agreement. The EMS medical director must document a written agreement with the EMS agency to supervise licensed EMS personnel and provide such documentation to the EMS Bureau annually and upon request. ( )

02. Approval for EMS Personnel to Function. ( )

a. The explicit approval of the EMS medical director, hospital supervising physician, or medical clinic supervising physician is required for licensed EMS personnel under their supervision to provide medical care. ( )

b. The EMS medical director, hospital supervising physician, or medical clinic supervising physician may credential licensed EMS personnel under their supervision with a limited scope of practice relative to that allowed by the EMSPC, or with a limited scope of practice corresponding to a lower level of EMS licensure. ( )

03. Restriction or Withdrawal of Approval for EMS Personnel to Function. The EMS medical director, hospital supervising physician, or medical clinic supervising physician: ( )

a. Can restrict the scope of practice of licensed EMS personnel under their supervision when such personnel fail to meet or maintain proficiencies established by the EMS medical director, hospital supervising physician, or medical clinic supervising physician, or the Idaho EMS Bureau. ( )

b. Can withdraw approval of licensed EMS personnel to provide services, under their supervision, when such personnel fail to meet or maintain proficiencies established by the EMS medical director, hospital supervising physician, or medical clinic supervising physician, or the EMS Bureau. ( )

c. Must report in writing such restriction or withdrawal of approval within fifteen (15) days of the action to the EMS Bureau in accordance with Section 39-1393, Idaho Code. ( )

04. Review Qualifications of EMS Personnel. The EMS medical director, hospital supervising physician, or medical clinic supervising physician must document the review of the qualification, proficiencies, and all other EMS agency, hospital, and medical clinic affiliations of EMS personnel prior to credentialing the individual. ( )

05. Document EMS Personnel Proficiencies. The EMS medical director, hospital supervising physician, or medical clinic supervising physician must document that the capabilities of licensed EMS personnel are

maintained on an ongoing basis through education, skill proficiencies, and competency assessment. ( )

06. Develop and Implement a Performance Assessment and Improvement Program. The EMS medical director must develop and implement a program for continuous assessment and improvement of services provided by licensed EMS personnel under their supervision. ( )

07. Review and Update Procedures. The EMS medical director must review and update protocols, policies, and procedures at least every two (2) years. ( )

08. Develop and Implement Plan for Medical Supervision. The EMS medical director, hospital supervising physician, or medical clinic supervising physician must develop, implement, and oversee a plan for supervision of licensed EMS personnel under Subsection 400.06 of these rules. ( )

09. Access to Records. The EMS medical director must have access to all relevant agency, hospital, or medical clinic records as permitted or required by statute to ensure responsible medical supervision of licensed EMS personnel. ( )

301. -- 399. (RESERVED)

400. PHYSICIAN SUPERVISION IN THE OUT-OF-HOSPITAL SETTING.

01. Medical Supervision Required. Under Section 56-1011, Idaho Code, licensed EMS personnel must provide emergency medical services under the supervision of a designated EMS medical director. ( )

02. Designation of EMS Medical Director. The EMS agency must designate a physician for the medical supervision of licensed EMS personnel affiliated with the EMS agency. ( )

03. Education of EMS Medical Director. Medical director must complete mandatory education required by the EMSPC. ( )

04. Delegated Medical Supervision of EMS Personnel. The EMS medical director can designate other physicians to supervise the licensed EMS personnel in the temporary absence of the EMS medical director. ( )

05. Direct Medical Supervision by Physician Assistants (PA) and Nurse Practitioners. The EMS medical director can designatePAs and Nurse Practitioners for purposes of direct medical supervision of licensed EMS personnel under the following conditions: ( )

a. A designated physician is not present in the anticipated receiving health care facility; and ( )

b. The Nurse Practitioner, when designated, must have a preexisting written agreement with the EMS medical director describing the role and responsibilities of the Nurse Practitioner; or ( )

c. The physician supervising the PA, under IDAPA 24.33.02, "Rules for the Licensure of Physician Assistants," authorizes the PA to provide direct (on-line) supervision; and ( )

d. The PA, when designated, must have a preexisting written agreement with the EMS medical director describing the role and responsibilities of the PA related to supervision of EMS personnel. ( )

e. Such designated clinician must possess and be familiar with the medical supervision plan, protocols, standing orders, and standard operating procedures authorized by the EMS medical director. ( )

06. Indirect Medical Supervision by Non-Physicians. Non-physicians can assist the EMS medical director with indirect medical supervision of licensed EMS personnel. ( )

07. Medical Supervision Plan. The medical supervision of licensed EMS personnel must be provided under a documented medical supervision plan that includes direct, indirect, on-scene, educational, and proficiency

standards components. The requirements for the medical supervision plan are found in the Idaho EMS Physician Commission Standards Manual under Section 004 of these rules. ( )

08. Out-of-Hospital Medical Supervision Plan Filed with EMS Bureau. The agency EMS medical director must submit the medical supervision plan within thirty (30) days of request to the EMS Bureau in a form described in the standards manual. ( )

a. The agency EMS medical director must identify the designated clinicians to the EMS Bureau annually in a form described in the standards manual. ( )

b. The agency EMS medical director must inform the EMS Bureau of any changes in designated clinicians or of a change in the agency medical director within thirty (30) days of the change(s). ( )

c. The EMS Bureau must provide the EMSPC with the medical supervision plans within thirty (30) days of request. ( )

d. The EMS Bureau must provide the EMSPC with the identification of EMS Medical directors and designated clinicians annually and upon request. ( )

401. -- 499. (RESERVED)

500. EMS PERSONNEL PRACTICE IN HOSPITALS AND CLINICS.

01. Medical Supervision Required. Under Section 56-1011, Idaho Code, licensed EMS personnel must provide emergency medical services under the supervision of a designated hospital supervising physician or medical clinic supervising physician. ( )

02. Credentialing of Licensed EMS Personnel in a Hospital or Medical Clinic. The hospital or medical clinic must maintain a current written description of acts and duties authorized to be performed by licensed EMS personnel. Any of these acts or duties that is outside the public scope of practice for the licensed EMS personnel, the hospital has sole responsibility in training and credentialing. ( )

501. -- 999. (RESERVED)

[Agency redlined courtesy copy]

16.02.02 – IDAHO EMERGENCY MEDICAL SERVICES (EMS) PHYSICIAN COMMISSION

000. LEGAL AUTHORITY.
~~Under~~ Sections 56-1013A and 56-1023, Idaho Code~~, the Idaho Emergency Medical Services (EMS) Physician Commission is~~ authorize~~d~~ the Emergency Medical Services Physician Commission (EMSPC) to promulgate ~~these~~ rules ~~for the purpose of~~ to establish~~ing~~ standards for scope of practice and medical supervision for licensed personnel, air medical, ambulance services, and nontransport agencies licensed by the Department ~~of Health and Welfare~~.
~~(3-17-22)~~( )

001. ~~TITLE AND SCOPE.~~(RESERVED)

~~**01.** **Title**. The title of these rules is IDAPA 16.02.02, "Idaho Emergency Medical Services (EMS) Physician Commission."~~ ~~(3-17-22)~~

~~**02.** **Scope**. The scope of these rules is to define the allowable scope of practice, acts, and duties that can be performed by persons licensed as emergency medical services personnel by the Department of Health and Welfare~~

Bureau of Emergency Medical Services and Preparedness and to define the required level of supervision by a physician. (3-17-22)

002. INVESTIGATIONS.

01. Physician Professional Disciplinary Enforcement Investigations. The provisions of Section 54-1806A, Idaho Code, governs investigation of complaints regarding physicians. (3-17-22)( )

02. EMS Personnel and EMS Agency Complaint Investigations. The provisions of IDAPA 16.01.12, "Emergency Medical Services (EMS) -- Complaints, Investigations, and Disciplinary Actions," govern investigation of complaints regarding licensed EMS personnel and EMS Agencies. (3-17-22)( )

003. INCORPORATION BY REFERENCE.
The Idaho Emergency Medical Services (EMS) Physician Commission EMSPC has adopted incorporated by reference the Idaho Emergency Medical Services (EMS) Physician Commission Standards Manual, edition 20204-1, and hereby incorporates this Standards Manual by reference. Copies of the manual may be obtained on the Internet are available at https://healthandwelfare.idaho.gov/about-dhw/boards-councils-committees/ems-physician-commission or from the Bureau of Emergency Medical Services and Preparedness located at 2224 East Old Penitentiary Road, Boise, ID, 83712-8249,; whose the mailing address is P.O. Box 83720, Boise, Idaho 83720-0036. (3-17-22)( )

004. EMS COMPLAINTS.
The provisions of IDAPA 16.01.12, "Emergency Medical Services (EMS) -- Complaints, Investigations, and Disciplinary Actions," governs the confidentiality of the investigation of complaints regarding licensed EMS personnel. (3-17-22)( )

005. -- 009. (RESERVED)

010. DEFINITIONS.
In addition to the applicable definitions in Section 56-1012, Idaho Code, and IDAPA 16.01.02, "Emergency Medical Services (EMS) -- Rule Definitions," the following terms are used in this chapter as defined below these rules: (3-17-22)( )

01. Credentialed EMS Personnel. Individuals who are authorized to provide medical care by the EMS medical director, hospital supervising physician, or medical clinic supervising physician. (3-17-22)( )

02. Credentialing. The local process by which licensed EMS personnel are authorized to provide medical care in the out-of-hospital, hospital, and medical clinic setting, including the determination of a local scope of practice. ( )

03. Designated Clinician. A licensed Physician Assistant (PA) or Nurse Practitioner designated by the EMS medical director, hospital supervising physician, or medical clinic supervising physician who is responsible for direct (on-line) medical supervision of licensed EMS personnel in the temporary absence of the EMS medical director. (3-17-22)( )

04. Direct (On-Line) Supervision. Contemporaneous instructions and directives about a specific patient encounter provided by a physician or designated clinician to licensed EMS personnel who are providing medical care. (3-17-22)( )

05. Emergency Medical Services (EMS). Under Section 56-1012(12), Idaho Code, emergency medical services or EMS is aid rendered by an individual or group of individuals who do the following: ( )

a. Respond to a perceived need for medical care in order to prevent loss of life, aggravation of physiological or psychological illness, or injury; (3-17-22)( )

b. Are prepared to provide interventions that are within the scope of practice as defined by the Idaho Emergency Medical Services Physician Commission (EMSPC), under IDAPA 16.02.02, "Idaho Emergency Medical

Services (EMS) Physician Commission"; ~~(3-17-22)~~(   )

c. Use an alerting mechanism to initiate a response to requests for medical care; and (   )

d. Offer, advertise, or attempt to respond as described in Section 56-1012(12), (a) through (c), Idaho Code. (   )

e. Aid rendered by a ski patroller, as described in Section 54-1804(1)(h), Idaho Code, is not EMS. (   )

06. Emergency Medical Services (EMS) Bureau. The Bureau of Emergency Medical Services (EMS) and Preparedness ~~of~~ for the ~~Idaho~~ Department ~~of Health and Welfare~~. ~~(3-17-22)~~(   )

07. Emergency Medical Services ~~(EMS~~) Physician Commission (EMSPC). The Idaho Emergency Medical Services Physician Commission as created under Section 56-1013A, Idaho Code~~, hereafter referred to as "the Commission."~~. ~~(3-17-22)~~(   )

08. EMS Agency. An organization licensed by the EMS Bureau to provide emergency medical services in Idaho. (   )

09. EMS Medical Director. A physician who supervises the medical activities of licensed personnel affiliated with an EMS agency. (   )

10. Hospital. A facility in Idaho licensed under Sections 39-1301 through 39-1314, Idaho Code, and defined in Section 39-1301(a)(1), Idaho Code. (   )

11. Hospital Supervising Physician. A physician who supervises the medical activities of licensed EMS personnel while employed or utilized for delivery of services in a hospital. (   )

12. Indirect (Off-Line) Supervision. The medical supervision~~,~~ provided by a physician~~,~~ to licensed EMS personnel who are providing medical care including EMS system design, education, quality management, patient care guidelines, medical policies, and compliance. ~~(3-17-22)~~(   )

13. License. A license issued by the EMS Bureau to an individual for a specified period ~~of time~~ indicating that minimum standards corresponding to one (1) of several levels of EMS proficiency have been met. ~~(3-17-22)~~(   )

14. Licensed EMS Personnel. Individuals who possess a valid license issued by the EMS Bureau. (   )

15. Medical Clinic. A place devoted primarily to the maintenance and operation of facilities for outpatient medical, surgical, and emergency care of acute and chronic conditions or injury. (   )

16. Medical Clinic Supervising Physician. A physician who supervises the medical activities of licensed EMS personnel while employed or utilized for delivery of services in a medical clinic. (   )

17. Medical Supervision. The advice and direction provided by, or under the direction of a physician, ~~or under the direction of a physician,~~ to licensed EMS personnel who are providing medical care, including direct and indirect supervision. ~~(3-17-22)~~(   )

18. Medical Supervision Plan. The written document describing the provisions for medical supervision of licensed EMS personnel. (   )

19. Nurse Practitioner. An Advanced Practice Professional Nurse, licensed ~~in the category of~~ as a Nurse Practitioner, ~~as defined in~~ under IDAPA 24.34.01, "Rules of the Idaho Board of Nursing." ~~(3-17-22)~~(   )

20. Out-of-Hospital. Any setting outside of a hospital, including inter-facility transfers, in which the

provision of emergency medical services may take place. ( )

21. Physician. ~~In accordance with~~ Under Section 54-1803, Idaho Code, a person who holds a current active license issued by the Board of Medicine to practice medicine and surgery, osteopathic medicine and surgery, or osteopathic medicine in Idaho and is in good standing with no restriction upon, or actions taken against, their license. ~~(3-17-22)~~( )

22. Physician Assistant. A person who meets ~~all~~ the ~~applicable~~ requirements to practice as a licensed physician assistant under Title 54, Chapter 18, Idaho Code, and IDAPA 24.33.02, "Rules for the Licensure of Physician Assistants." ~~(3-17-22)~~( )

011. -- 094. (RESERVED)

095. GENERAL PROVISIONS.

01. Practice of Medicine. ~~This chapter does not~~These rules may authorize the practice of medicine ~~or any of its branches by a person not licensed to do so by the Board of Medicine~~ by licensed EMS personnel practicing within their defined scope of practice. ~~(3-17-22)~~( )

02. Patient Consent. The provision or refusal of consent for individuals receiving emergency medical services ~~is governed by~~ under Title 39, Chapter 45, Idaho Code. ~~(3-17-22)~~( )

03. System Consistency. All EMS medical directors, hospital supervising physicians, and medical clinic supervising physicians must collaborate to ensure EMS agencies and licensed EMS personnel have protocols, policies, standards of care, and procedures that are consistent and compatible with one another. ( )

096. -- 099. (RESERVED)

100. GENERAL DUTIES OF EMS PERSONNEL.

01. General Duties. General duties of EMS personnel include the following: ( )

a. Licensed EMS personnel must possess a valid license issued by the EMS Bureau equivalent to or higher than the scope of practice authorized by the EMS medical director, hospital supervising physician, or medical clinic supervising physician. ( )

b. Licensed EMS personnel must only provide patient care for which they have been trained, based on curricula or specialized training approved ~~according to~~ under IDAPA 16.01.07, "Emergency Medical Services (EMS) -- Personnel Licensing Requirements," or additional training approved by the hospital or medical clinic supervising physician. ~~(3-17-22)~~( )

c. Licensed EMS personnel must not perform a task(s) ~~or tasks~~ within their scope of practice that ~~have~~ has been specifically prohibited by their EMS medical director, hospital supervising physician, or medical clinic supervising physician. ~~(3-17-22)~~( )

d. Licensed EMS personnel that possess a valid credential issued by the EMS medical director, hospital supervising physician, or medical clinic supervising physician are authorized to provide services when representing an Idaho EMS agency, hospital, or medical clinic and under any ~~one (1)~~ of the following conditions: ~~(3-17-22)~~( )

i. When part of a documented, planned deployment of personnel resources approved by the EMS medical director, hospital supervising physician, or medical clinic supervising physician; ~~or~~ ~~(3-17-22)~~( )

ii. When, in a manner approved by the EMS medical director, hospital supervising physician, or medical clinic supervising physician, administering first aid or emergency medical attention ~~in accordance with~~ under Section 5-330 or 5-331, Idaho Code, without expectation of remuneration; or ~~(3-17-22)~~( )

iii. When participating in a training program approved by the EMS Bureau, the EMS medical director, hospital supervising physician, or medical clinic supervising physician. ( )

02. Scope of Practice. ( )

a. The ~~Commission~~ EMSPC maintains an "EMS Physician Commission Standards Manual" that: ~~(3-17-22)~~( )

i. Establishes the scope of practice of licensed EMS personnel; and ( )

ii. Specifies the type and degree of medical supervision for specific skills, treatments, and procedures by level of EMS licensure. ( )

b. The ~~Commission~~ EMSPC will consider the United States Department of Transportation's National EMS Scope of Practice Model when preparing or revising the standards manual ~~described in~~ under Subsection 100.02.a. of this rule; ~~(3-17-22)~~( )

c. The scope of practice established by the EMSPC ~~Physician Commission~~ determines the objectives of applicable curricula and specialized education of licensed EMS personnel; ~~(3-17-22)~~( )

d. The scope of practice does not define a standard of care, nor does it define what should be done in a given situation; ( )

e. Licensed EMS personnel must not provide out-of-hospital patient care that exceeds the scope of practice established by the ~~Commission~~EMSPC; ~~(3-17-22)~~( )

f. Licensed EMS personnel must be credentialed by the EMS medical director, hospital supervising physician, or medical clinic supervising physician to be authorized for their scope of practice; ( )

g. The credentialing of licensed EMS personnel affiliated with an EMS agency, ~~in accordance with~~ under IDAPA 16.01.03, "Emergency Medical Services (EMS) -- Agency Licensing Requirements," must not exceed the licensure level of that EMS agency; and ~~(3-17-22)~~( )

h. The patient care provided by licensed EMS personnel must conform to the Medical Supervision Plan as authorized by the EMS medical director, hospital supervising physician, or medical clinic supervising physician. ( )

101. -- 199. (RESERVED)

200. EMS MEDICAL DIRECTOR, HOSPITAL SUPERVISING PHYSICIAN, AND MEDICAL CLINIC SUPERVISING PHYSICIAN QUALIFICATIONS.

The EMS Medical Director, Hospital Supervising Physician, and Medical Clinic Supervising Physician must: ( )

01. Accept Responsibility. Accept responsibility for the medical direction and medical supervision of the activities provided by licensed EMS personnel. ( )

02. Complete Medical Director Training. Complete any required Medical Director training within one (1) year of appointment. ( )

0~~2~~3. Maintain Knowledge of EMS Systems. Obtain and maintain knowledge of the contemporary design and operation of EMS systems. ( )

0~~3~~4. Maintain Knowledge of Idaho EMS. Obtain and maintain knowledge of Idaho EMS laws, regulations, and standards manuals. ( )

201. -- 299. (RESERVED)

300. EMS MEDICAL DIRECTOR, HOSPITAL SUPERVISING PHYSICIAN, AND MEDICAL CLINIC SUPERVISING PHYSICIAN RESPONSIBILITIES AND AUTHORITY.

01. Documentation of Written Agreement. The EMS medical director must document a written agreement with the EMS agency to supervise licensed EMS personnel and provide such documentation to the EMS Bureau annually and upon request. ( )

02. Approval for EMS Personnel to Function. ( )

a. The explicit approval of the EMS medical director, hospital supervising physician, or medical clinic supervising physician is required for licensed EMS personnel under their supervision to provide medical care. ( )

b. The EMS medical director, hospital supervising physician, or medical clinic supervising physician may credential licensed EMS personnel under their supervision with a limited scope of practice relative to that allowed by the EMSPC~~ Physician Commission~~, or with a limited scope of practice corresponding to a lower level of EMS licensure. ~~(3-17-22)~~( )

03. Restriction or Withdrawal of Approval for EMS Personnel to Function. The EMS medical director, hospital supervising physician, or medical clinic supervising physician: ~~(3-17-22)~~( )

a. ~~The EMS medical director, hospital supervising physician, or medical clinic supervising physician c~~Can restrict the scope of practice of licensed EMS personnel under their supervision when such personnel fail to meet or maintain proficiencies established by the EMS medical director, hospital supervising physician, or medical clinic supervising physician, or the Idaho EMS Bureau. ~~(3-17-22)~~( )

b. ~~The EMS medical director, hospital supervising physician, or medical clinic supervising physician c~~Can withdraw approval of licensed EMS personnel to provide services, under their supervision, when such personnel fail to meet or maintain proficiencies established by the EMS medical director, hospital supervising physician, or medical clinic supervising physician, or the EMS Bureau. ~~(3-17-22)~~( )

c. ~~The EMS medical director, hospital supervising physician, or medical clinic supervising physician m~~Must report in writing such restriction or withdrawal of approval within fifteen (15) days of the action to the EMS Bureau in accordance with Section 39-1393, Idaho Code. ~~(3-17-22)~~( )

04. Review Qualifications of EMS Personnel. The EMS medical director, hospital supervising physician, or medical clinic supervising physician must document the review of the qualification, proficiencies, and all other EMS agency, hospital, and medical clinic affiliations of EMS personnel prior to credentialing the individual. ( )

05. Document EMS Personnel Proficiencies. The EMS medical director, hospital supervising physician, or medical clinic supervising physician must document that the capabilities of licensed EMS personnel are maintained on an ongoing basis through education, skill proficiencies, and competency assessment. ( )

06. Develop and Implement a Performance Assessment and Improvement Program. The EMS medical director must develop and implement a program for continuous assessment and improvement of services provided by licensed EMS personnel under their supervision. ( )

07. Review and Update Procedures. The EMS medical director must review and update protocols, policies, and procedures at least every two (2) years. ( )

08. Develop and Implement Plan for Medical Supervision. The EMS medical director, hospital supervising physician, or medical clinic supervising physician must develop, implement, and oversee a plan for supervision of licensed EMS personnel~~ as described in~~ under Subsection 400.06 of these rules. ~~(3-17-22)~~( )

09. Access to Records. The EMS medical director must have access to all relevant agency, hospital, or

medical clinic records as permitted or required by statute to ensure responsible medical supervision of licensed EMS personnel. ( )

301. -- 399. (RESERVED)

400. PHYSICIAN SUPERVISION IN THE OUT-OF-HOSPITAL SETTING.

01. Medical Supervision Required. ~~In accordance with~~Under Section 56-1011, Idaho Code, licensed EMS personnel must provide emergency medical services under the supervision of a designated EMS medical director. ~~(3-17-22)~~( )

02. Designation of EMS Medical Director. The EMS agency must designate a physician for the medical supervision of licensed EMS personnel affiliated with the EMS agency. ( )

03. Education of EMS Medical Director. Medical director must complete mandatory education required by the EMSPC. ( )

0~~3~~4. Delegated Medical Supervision of EMS Personnel. The EMS medical director can designate other physicians to supervise the licensed EMS personnel in the temporary absence of the EMS medical director. ( )

0~~4~~5. Direct Medical Supervision by Physician Assistants (PA) and Nurse Practitioners. The EMS medical director can designate~~ Physician Assistants (~~PAs~~)~~ and Nurse Practitioners for purposes of direct medical supervision of licensed EMS personnel under the following conditions: ~~(3-17-22)~~( )

a. A designated physician is not present in the anticipated receiving health care facility; and ( )

b. The Nurse Practitioner, when designated, must have a preexisting written agreement with the EMS medical director describing the role and responsibilities of the Nurse Practitioner; or ( )

c. The physician supervising the PA,~~ as defined in~~ under IDAPA 24.33.02, "Rules for the Licensure of Physician Assistants," authorizes the PA to provide direct (on-line) supervision; and ~~(3-17-22)~~( )

d. The PA, when designated, must have a preexisting written agreement with the EMS medical director describing the role and responsibilities of the PA related to supervision of EMS personnel. ( )

e. Such designated clinician must possess and be familiar with the medical supervision plan, protocols, standing orders, and standard operating procedures authorized by the EMS medical director. ( )

0~~5~~6. Indirect Medical Supervision by Non-Physicians. Non-physicians can assist the EMS medical director with indirect medical supervision of licensed EMS personnel. ( )

0~~6~~7. Medical Supervision Plan. The medical supervision of licensed EMS personnel must be provided ~~in accordance with~~ under a documented medical supervision plan that includes direct, indirect, on-scene, educational, and proficiency standards components. The requirements for the medical supervision plan are found in the Idaho EMS Physician Commission Standards Manual~~ that is incorporated by reference~~ under Section 004 of these rules. ~~(3-17-22)~~( )

0~~7~~8. Out-of-Hospital Medical Supervision Plan Filed with EMS Bureau. The agency EMS medical director must submit the medical supervision plan within thirty (30) days of request to the EMS Bureau in a form described in the standards manual. ( )

a. The agency EMS medical director must identify the designated clinicians to the EMS Bureau annually in a form described in the standards manual. ( )

b. The agency EMS medical director must inform the EMS Bureau of any changes in designated clinicians or of a change in the agency medical director within thirty (30) days of the change(s). ( )

c. The EMS Bureau must provide the~~ Commission~~ EMSPC with the medical supervision plans within thirty (30) days of request. ~~(3-17-22)~~(   )

d. The EMS Bureau must provide the~~ Commission~~ EMSPC with the identification of EMS Medical directors and designated clinicians annually and upon request. ~~(3-17-22)~~(   )

401. -- 499. (RESERVED)

500. ~~PHYSICIAN SUPERVISION~~ EMS PERSONNEL PRACTICE IN HOSPITALS AND~~ MEDICAL~~ CLINICS.

01. Medical Supervision Required. ~~In accordance with~~Under Section 56-1011, Idaho Code, licensed EMS personnel must provide emergency medical services under the supervision of a designated hospital supervising physician or medical clinic supervising physician. ~~(3-17-22)~~(   )

~~**02. Level of Licensure Identification**. The licensed EMS personnel employed or utilized for delivery of services within a hospital or medical clinic, when on duty, must at all times visibly display identification specifying their level of EMS licensure. (3-17-22)~~

0~~3~~2. Credentialing of Licensed EMS Personnel in a Hospital or Medical Clinic. The hospital or medical clinic must maintain a current written description of acts and duties authorized~~ by the hospital supervising physician or medical clinic supervising physician for credentialed EMS personnel and must submit the descriptions upon request of the Commission or the EMS Bureau~~ to be performed by licensed EMS personnel. Any of these acts or duties that is outside the public scope of practice for the licensed EMS personnel, the hospital has sole responsibility in training and credentialing. ~~(3-17-22)~~(   )

~~**04. Notification of Employment or Utilization**. The licensed EMS personnel employed or utilized for delivery of services within a hospital or medical clinic must report such employment or utilization to the EMS Bureau within thirty (30) days of engaging such activity. (3-17-22)~~

~~**05. Designation of Supervising Physician**. The hospital or medical clinic administration must designate a physician for the medical supervision of licensed EMS personnel employed or utilized in the hospital or medical clinic. (3-17-22)~~

~~**06. Delegated Medical Supervision of EMS Personnel**. The hospital supervising physician or medical clinic supervising physician can designate other physicians to supervise the licensed EMS personnel during the periodic absence of the hospital supervising physician or medical clinic supervising physician. (3-17-22)~~

~~**07. Direct Medical Supervision by Physician Assistants and Nurse Practitioners**. The hospital supervising physician, or medical clinic supervising physician can designate Physician Assistants (PA) and Nurse Practitioners for purposes of direct medical supervision of licensed EMS personnel under the following conditions: (3-17-22)~~

~~**a.** The Nurse Practitioner, when designated, must have a preexisting written agreement with the hospital supervising physician or medical clinic supervising physician describing the role and responsibilities of the Nurse Practitioner; or (3-17-22)~~

~~**b.** The physician supervising the PA, as defined in IDAPA 24.33.02, "Rules for the Licensure of Physician Assistants," authorizes the PA to provide supervision; and (3-17-22)~~

~~**c.** The PA, when designated, must have a preexisting written agreement with the hospital supervising physician or medical clinic supervising physician describing the role and responsibilities of the PA related to supervision of EMS personnel. (3-17-22)~~

~~**d.** Such designated clinician must possess and be familiar with the medical supervision plan, protocols, standing orders, and standard operating procedures authorized by the hospital supervising physician or~~

~~medical clinic supervising physician.~~ ~~(3-17-22)~~

~~**08.**~~ ~~**On-Site Contemporaneous Supervision**. Licensed EMS personnel will only provide patient care with on-site contemporaneous supervision by the hospital supervising physician, medical clinic supervising physician, or designated clinicians.~~ ~~(3-17-22)~~

~~**09.**~~ ~~**Medical Supervision Plan**. The medical supervision of licensed EMS personnel must be provided in accordance with a documented medical supervision plan. The hospital supervising physician or medical clinic supervising physician is responsible for developing, implementing, and overseeing the medical supervision plan, and must submit the plan(s) within thirty (30) days of request by the Commission or the EMS Bureau.~~ ~~(3-17-22)~~

501. -- 999. (RESERVED)

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.02.06 – QUALITY ASSURANCE FOR CLINICAL LABORATORIES

DOCKET NO. 16-0206-2301 (ZBR CHAPTER REWRITE)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2024 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. The pending rule will become final and effective upon the adjournment, *sine die*, of the Second Regular Session of the Sixty-seventh Idaho Legislature after approval.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 56-1003, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

Under Executive Order 2020-01: Zero-Based Regulation, the Department is striving to prevent the accumulation of costly, ineffective, and outdated regulations and reduce regulatory burden to achieve a more efficient operation of government. The rule changes are intended to perform a comprehensive review of this chapter by collaborating with the public to streamline or simplify this rule language. The title of this IDAPA chapter is changing from 16.02.06, "Quality Assurance for Idaho Clinical Laboratories" to "Quality Assurance for Clinical Laboratories."

There are no changes to the pending rule and it is being adopted as originally proposed. The complete text of the proposed rule was published in the August 2, 2023, Idaho Administrative Bulletin, Vol. 23-8, pages 53 through 59.

FEE SUMMARY: Pursuant to Section 67-5224(2)(d), Idaho Code, this pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature. The following is a description of the fee or charge imposed or increased in this rulemaking: Does not apply to this rulemaking.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state General Fund greater than ten thousand dollars ($10,000) during the fiscal year:

This rulemaking is not anticipated to have any fiscal impact on the state General Fund, or any other known funds.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Christopher Ball at 208-334-0568 or Michael Dillon at 208-334-0545.

DATED this 17th of November, 2023.

Trinette Middlebrook and Frank Powell
DHW – Administrative Rules Unit
450 W. State Street – 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
phone: (208) 334-5500
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e-mail:dhwrules@dhw.idaho.gov

THE FOLLOWING NOTICE PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section 56-1003, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than August 16, 2023.

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

Under Executive Order 2020-01: Zero-Based Regulation, the Division of Public Health, Bureau of Laboratories, is striving to prevent the accumulation of costly, ineffective, and outdated regulations and reduce regulatory burden to achieve a more efficient operation of government. The rule changes are intended to perform a comprehensive review of this chapter by collaborating with the public to streamline or simplify this rule language. This IDAPA chapter title is changing to Quality Assurance for Clinical Laboratories.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: There are no fees associated with this chapter of rule.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the State General Fund greater than ten thousand dollars ($10,000) during the fiscal year as a result of this rulemaking:

This rulemaking is not anticipated to have any fiscal impact on the State General Fund, or any other known funds.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the March 1st, 2023 and April 5th, 2023, Idaho Administrative Bulletins, Vol. 23-3, pages 18 - 19 and Vol 23-4, pages 27 - 28.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into this rule: There are no incorporations by reference in this chapter of rules.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Christopher Ball at 208-334-0568 or Micheal Dillon at 208-334-0545.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before August 23, 2023.

DATED this 6th day of July, 2023.

THE FOLLOWING IS THE TEXT OF ZBR DOCKET NO. 16-0206-2301

16.02.06 – QUALITY ASSURANCE FOR CLINICAL LABORATORIES

000. LEGAL AUTHORITY.
Section 56-1003, Idaho Code, authorizes the Board of Health and Welfare to set standards for Idaho laboratories. ( )

001. -- 009. (RESERVED)

010. DEFINITIONS.

01. Board. The Idaho Board of Health and Welfare. ( )

02. Department. The Idaho Department of Health and Welfare, or its designee. ( )

03. Clinical Laboratory. A facility for the biological, microbiological, serological, chemical, immunohematological, hematological, biophysical, cytological, pathological, or other examinations of material derived from the human body for the purpose of providing information for the diagnosis, prevention, or treatment of any disease, or the impairment or assessment of human health. ( )

04. Laboratory Director. The person under whose supervision the laboratory is operating. ( )

05. Nonwaived Test. A moderate or high complexity test system, assay, or examination that does not meet the criteria for a waiver as specified under Title 42 USC, Section 263a (3). ( )

06. Proficiency Testing. Evaluation of a laboratory's ability to perform laboratory procedures within acceptable limits of accuracy through analysis of unknown specimens distributed at periodic intervals. ( )

07. Quality Control. Analysis of reference materials to ensure reproducibility and accuracy of laboratory results and an acceptable system to assure proper functioning of instruments, equipment, and reagents. ( )

08. Reviewer. The Department's representative who is knowledgeable and experienced in clinical laboratory methods and procedures. ( )

09. Waived Test. A low complexity test system, assay, or examination that meets the criteria for waiver specified under Title 42 USC, Section 263a (3). ( )

011. -- 099. (RESERVED)

100. REGISTRATION REQUIREMENTS.

01. Registration Timeframes. ( )

a. A clinical laboratory must register with the Department prior to accepting specimens for testing. ( )

b. Registered clinical laboratories must submit a completed registration form every two (2) years and indicate any changes in laboratory operations. ( )

02. Registration Form. Each clinical laboratory must use the Department-approved form. Forms are available upon request from the Department. Each form must include the following: ( )

a. Name and location of the clinical laboratory; ( )

b. Name of the laboratory director; ( )

c. Tests performed in the laboratory; and ( )

d. Any other information requested by the Department to evaluate clinical laboratory performance. ( )

101. -- 109. (RESERVED)

110. EXCLUSIONS.

01. Other Certifying Agencies. Clinical Laboratories will be excluded from compliance with these rules (except Sections 100, 130, and 200) upon submission of evidence of certification from one (1) of the following: ( )

a. Centers for Medicare and Medicaid Services (CMS), Clinical Laboratory Improvement Amendment (CLIA) certification program; ( )

b. Agencies approved by CMS as accreditation organizations. To review the current list of CMS-approved accreditation organizations go to, https://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/Downloads/AOList.pdf; ( )

c. Other certification programs approved by the Department. ( )

02. Facilities and Laboratories. The following laboratories and facilities are also excluded from compliance with these rules: ( )

a. Teaching, research, forensic, and pre-employment drug screening laboratories if test results are not used for diagnosis or treatment; ( )

b. Prosthetic dental laboratories; and ( )

c. Facilities performing skin testing solely for detection of allergies and sensitivities. ( )

111. -- 119. (RESERVED)

120. DEPARTMENT INSPECTIONS.

A Department representative is authorized to inspect any registered clinical laboratory to determine the adequacy of the supervision, staffing, and quality control program. ( )

121. -- 129. (RESERVED)

130. GENERAL REQUIREMENTS.

01. Clinical Laboratory Facilities. Each clinical laboratory must have adequate space, equipment, and supplies to perform the services offered, with accuracy, precision, and safety. ( )

02. Records. ( )

a. Clinical laboratory records must identify the person responsible for performing the procedure. ( )

b. Clinical Laboratories must maintain testing records for at least two (2) years. Test reports must be readily accessible upon request. ( )

c. Clinical laboratory records and reports must identify specimens referred to other certified

laboratories and must identify the reference laboratory by name and address. ( )

03. Test Orders and Results. ( )

a. Practitioners legally authorized to diagnose, treat, and prescribe are authorized to order both waived and nonwaived tests and receive results. ( )

b. Laboratory directors are authorized to order the waived tests listed on their approved registration form and receive test results. ( )

131. -- 149. (RESERVED)

150. PERSONNEL REQUIREMENTS.

The laboratory director must ensure that clinical laboratory staff have appropriate education, experience, and training to maintain records, perform tests, and report results. The clinical laboratory must employ enough staff to provide timely and accurate test results. Staff must receive in-service training appropriate to the type and complexity of testing. Staff must not perform testing outside of their scope of training. ( )

151. -- 199. (RESERVED)

200. PROFICIENCY TESTING.

01. Scope. Clinical laboratories must satisfactorily participate in proficiency testing programs approved by the Department. ( )

02. Results to the Department. The clinical laboratory must ensure that all proficiency testing results are available to the Department. ( )

201. -- 209. (RESERVED)

210. QUALITY CONTROL PROGRAM REQUIREMENTS.

01. Establishment of Quality Control Program. Clinical laboratories must establish a quality control program. ( )

02. Program Scope. An acceptable quality control program must include written documentation of: ( )

a. A preventive maintenance program that ensures proper functioning of all instruments and equipment; ( )

b. Proper testing of quality control materials along with patient specimens; ( )

c. Quality control checks on reagents and media utilized in the performance of tests; ( )

d. Quality control records that demonstrate the reliability of all procedures performed. ( )

211. -- 219. (RESERVED)

220. DEPARTMENT APPROVAL.

The Department will approve clinical laboratories for performance of tests on material from the human body if the laboratory meets the standards specified in these rules. ( )

221. -- 229. (RESERVED)

230. DEPARTMENT REVOCATION OF APPROVAL.

The Department may revoke approval, either in total or in part, for any one (1) of the following reasons: ( )

01. Failure to Participate in Proficiency Testing. The clinical laboratory fails to participate in a proficiency testing program. ( )

02. Failure to Participate in Quality Control. The clinical laboratory fails to implement a quality control program. ( )

03. Failure to Obtain Satisfactory Results. The Department, through the quality review process, determines that the clinical laboratory has failed to obtain satisfactory results on two (2) consecutive or on two (2) out of three (3) consecutive sets of proficiency test program specimens in one (1) or more testing categories. ( )

04. Failure to Submit Documentation. Failure to submit documentation of corrective action required by the Department. ( )

231. -- 239. (RESERVED)

240. REVOCATION PROCEDURE.

01. Unacceptable Results. Clinical laboratories that fail to obtain passing results on two (2) consecutive proficiency testing events, or two (2) out of three (3) events, will be required to submit documentation of corrective action within fifteen (15) working days after receipt of the notification of the failures. Evaluation of proficiency testing results may overlap from one year to the next. ( )

02. Corrective Action. Upon receipt of documentation of corrective action, a reviewer will determine the adequacy of the action taken. If the reviewer determines the corrective action is not adequate, the clinical laboratory must submit to an on-site inspection that may include on-site testing of unknown samples. ( )

03. On-Site Inspection. If the results of the on-site inspection indicate that the clinical laboratory performance is unacceptable in one (1) or more testing categories, the approval to perform the test(s) in question will be revoked. ( )

04. Satisfactory Performance. The clinical laboratory will continue to be approved for performance of all test procedures for which it has demonstrated satisfactory performance. ( )

05. Other Deficiencies. Failure to comply with other provisions of these rules may invoke revocation procedures. ( )

241. -- 249. (RESERVED)

250. RENEWAL OF APPROVAL OF DISAPPROVED TEST(S).

01. Renewal Granted. ( )

a. A clinical laboratory that has lost approval to perform certain tests may gain reapproval by requesting the Department review the unacceptable performance and the corrective action taken. ( )

b. Within ten (10) days after completion of this review, the reviewer will submit their report to the Department. ( )

c. Upon determination that corrections leading to satisfactory and acceptable performance have been made, the Department may reinstate approval. ( )

02. Renewal Denied. If the Department does not grant reapproval of the clinical laboratory, they will provide written notice of actions to be taken to correct deficiencies. The clinical laboratory may request a new review at any time after thirty (30) days from the date of last review. The clinical laboratory may also file a written appeal under IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings." ( )

251. -- 269. (RESERVED)

270. REGISTERED LABORATORIES.
The Department will maintain a list of registered clinical laboratories. ( )

271. -- 299. (RESERVED)

300. FAILURE TO REGISTER OR OPERATION OF AN UNREGISTERED CLINICAL LABORATORY.
Failure to register a clinical laboratory, operation of an unregistered clinical laboratory, or performance of unapproved testing constitutes a violation of these rules. Any violation of these rules constitutes a misdemeanor under Section 56-1008, Idaho Code. ( )

301. -- 999. (RESERVED)

[Agency redlined courtesy copy]

16.02.06 – QUALITY ASSURANCE FOR ~~IDAHO~~ CLINICAL LABORATORIES

000. LEGAL AUTHORITY.
~~Under~~ Section 56-1003, Idaho Code~~, the Idaho Legislature has delegated to~~ authorizes the Board of Health and Welfare ~~the authority~~ to set standards for Idaho laboratories ~~in the state of Idaho~~. ~~(3-17-22)~~( )

~~**001. TITLE AND SCOPE.**~~

~~**01. Title**. These rules are titled IDAPA 16.02.06, "Quality Assurance for Idaho Clinical Laboratories." (3-17-22)~~

~~**02. Scope**. These rules protect the public and individual health by requiring that all Idaho clinical laboratories develop satisfactory quality assurance programs that meet minimal standards approved by the Board. (3-17-22)~~

00~~2~~1. -- 009. (RESERVED)

010. DEFINITIONS.
~~For the purposes of these rules, the following terms apply: (3-17-22)~~

01. Board. The Idaho Board of Health and Welfare. ( )

02. Department. The Idaho Department of Health and Welfare, or its designee. ~~(3-17-22)~~( )

~~**03. Director**. The Director of the Idaho Department of Health and Welfare, or their designee. (3-17-22)~~

0~~4~~3. ~~Laboratory or~~ Clinical Laboratory. A facility for the biological, microbiological, serological, chemical, immunohematological, hematological, biophysical, cytological, pathological, or other examinations of material derived from the human body for the purpose of providing information for the diagnosis, prevention, or treatment of any disease, or the impairment or assessment of human health. ~~(3-17-22)~~( )

0~~5~~4. Laboratory Director. The person under whose supervision the laboratory is operating. ( )

~~**06. Pathologist**. A physician who is: (3-17-22)~~

~~**a.** Licensed by the Idaho State Board of Medicine in accordance with IDAPA 24.33.01, "Rules of the Board of Medicine for the Licensure to Practice Medicine and Surgery and Osteopathic Medicine and Surgery in Idaho"; and (3-17-22)~~

~~**b.** Board certified by the American Board of Anatomic and Clinical Pathology. (3-17-22)~~

05. **Nonwaived Test**. A moderate or high complexity test system, assay, or examination that does not meet the criteria for a waiver as specified under Title 42 USC, Section 263a (3). ( )

0~~7~~6. **Proficiency Testing**. Evaluation of a laboratory's ability to perform laboratory procedures within acceptable limits of accuracy through analysis of unknown specimens distributed at periodic intervals. ( )

0~~8~~7. **Quality Control**. ~~A day-to-day a~~Analysis of reference materials to ensure reproducibility and accuracy of laboratory results~~,~~ and ~~also includes~~ an acceptable system to assure proper functioning of instruments, equipment, and reagents. ~~(3-17-22)~~( )

0~~9~~8. **Reviewer**. ~~An employee or other designated representative of t~~The Department's ~~Idaho Bureau of Laboratories,~~ representative who is knowledgeable and experienced in clinical laboratory methods and procedures. ~~(3-17-22)~~( )

09. **Waived Test**. A low complexity test system, assay, or examination that meets the criteria for waiver specified under Title 42 USC, Section 263a (3). ( )

011. -- 099. (RESERVED)

100. REGISTRATION REQUIREMENTS ~~FOR CLINICAL LABORATORIES~~.

01. **Registration Timeframes**. ( )

a. ~~Every person responsible for the operation of a~~ A clinical laboratory ~~that performs tests on material derived from the human body~~ must register ~~such facility~~ with the Department ~~within thirty (30) days after first~~ prior to accepting specimens for testing. ~~(3-17-22)~~( )

b. ~~Existing~~ Registered clinical laboratories must submit a completed ~~laboratory~~ registration form every two (2) years and indicate any changes in laboratory operations. ~~(3-17-22)~~( )

02. **Registration Form**. Each clinical laboratory must ~~submit its registration information on~~ use the Department-approved form. ~~These f~~Forms are available upon request from the Department. Each ~~completed registration~~ form must include the following ~~information~~: ~~(3-17-22)~~( )

a. Name and location of the clinical laboratory; ~~(3-17-22)~~( )

b. Name of the laboratory director; ( )

c. ~~Types of laboratory t~~Tests performed in the laboratory; and ~~(3-17-22)~~( )

d. Any ~~O~~other information requested by the Department ~~that it deems necessary~~ to evaluate ~~the~~ clinical laboratory performance ~~of the laboratory~~. ~~(3-17-22)~~( )

101. -- 109. (RESERVED)

110. EXCLUSIONS.

01. **Other Certifying Agencies**. Clinical ~~L~~Laboratories will be excluded from compliance with these rules (except Sections 100, 130, and 200) upon submission of evidence of certification from one (1) of the following ~~agencies~~: ~~(3-17-22)~~( )

a. Centers for Medicare and Medicaid Services (CMS), Clinical Laboratory Improvement Amendment (CLIA) certification program ~~http://www.cms.gov/CLIA/01_Overview.asp;~~ ~~(3-17-22)~~( )

~~**b.** College of American Pathologists; (3-17-22)~~

~~c~~b. Agencies approved by CMS as accreditation organizations. To review the current list of CMS-approved accreditation organizations go to, https://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/Downloads/AOList.pdf; ( )

~~**d.** Laboratories located in hospitals approved by the Joint Commission http://www.jointcommission.org/; and (3-17-22)~~

~~e~~c. Other certification programs approved by the Department. ( )

02. Facilities and Laboratories. The following laboratories and facilities are also excluded from compliance with ~~this chapter~~ these rules: ~~(3-17-22)~~( )

a. Teaching, research, forensic, and pre-employment drug screening ~~L~~laboratories ~~operated for teaching or research purposes only, provided~~ if test~~s~~ results are not used for diagnosis or treatment; ~~(3-17-22)~~( )

b. Prosthetic dental laboratories; and ( )

c. Facilities performing skin testing solely for detection of allergies and sensitivities. ( )

111. -- 119. (RESERVED)

120. DEPARTMENT INSPECTIONS ~~OF CLINICAL LABORATORIES~~.

A ~~qualified representative of the~~ Department representative is authorized to inspect ~~the premises and operations of all approved laboratories for the purpose of determining~~ any registered clinical laboratory to determine the adequacy of the ~~quality control program and~~ supervision ~~of each laboratory~~, staffing, and quality control program. ~~(3-17-22)~~( )

121. -- 129. (RESERVED)

130. GENERAL REQUIREMENTS ~~FOR CLINICAL LABORATORIES~~.

01. Clinical Laboratory Facilities. Each clinical laboratory must have adequate space, equipment, and supplies to perform the services offered, with accuracy, precision, and safety. ~~(3-17-22)~~( )

02. Records. ( )

a. Clinical ~~L~~laboratory records must identify the person responsible for performing the procedure. ~~(3-17-22)~~( )

b. ~~Each laboratory~~ Clinical Laboratories must maintain ~~a suitable~~ testing record~~s~~ ~~of each test result~~ for ~~a period of~~ at least two (2) years. Test ~~R~~reports ~~of tests~~ must be ~~filed in a manner that permits ready identification and accessibility~~ readily accessible upon request. ~~(3-17-22)~~( )

c. Clinical ~~L~~laboratory records and reports must identify specimens referred to other certified laboratories and must identify the reference laboratory ~~testing such referred specimens~~ by name and address. ~~(3-17-22)~~( )

03. Test Orders and Results. ( )

a. Practitioners legally authorized to diagnose, treat, and prescribe are authorized to order both waived and nonwaived tests and receive results. ( )

b. Laboratory directors are authorized to order the waived tests listed on their approved registration form and receive test results. ( )

131. -- 149. (RESERVED)

150. PERSONNEL REQUIREMENTS~~ FOR CLINICAL LABORATORIES~~.
The laboratory director must ensure that~~ the~~ clinical laboratory staff ~~of the laboratory:~~ have appropriate education, experience, and training to maintain records, perform tests, and report results. The clinical laboratory must employ enough staff to provide timely and accurate test results. Staff must receive in-service training appropriate to the type and complexity of testing. Staff must not perform testing outside of their scope of training. ~~(3-17-22)~~( )

~~**01.** **Appropriate Education, Experience, and Training**. Have appropriate education, experience, and training to perform and report laboratory tests promptly and proficiently; (3-17-22)~~

~~**02.** **Sufficient in Number for the Scope and Complexity**. Are sufficient in number for the scope and complexity of the services provided; (3-17-22)~~

~~**03.** **In-service Training**. Receive in-service training appropriate to the type and complexity of the laboratory services offered; and (3-17-22)~~

~~**04.** **Procedures and Tests that are Outside the Scope of Training**. Do not perform procedures and tests that are outside the scope of training of the laboratory personnel. (3-17-22)~~

151. -- 199. (RESERVED)

200. PROFICIENCY TESTING~~ OF CLINICAL LABORATORIES~~.

01. Scope. ~~All~~ Clinical laboratories must~~ subscribe to, and~~ satisfactorily participate in~~, a~~ proficiency testing programs ~~that has been~~ approved by the Department. ~~(3-17-22)~~( )

02. Results to the~~ Bureau of Laboratories~~ Department. The clinical laboratory~~ director must furnish the Laboratory Improvement Section with copies of all proficiency testing results within thirty (30) days of receipt or make provisions for a duplicate of the results to be sent by the testing service directly~~ must ensure that all proficiency testing results are available to the Department. ~~(3-17-22)~~( )

201. -- 209. (RESERVED)

210. QUALITY CONTROL PROGRAM REQUIREMENTS~~ FOR CLINICAL LABORATORIES~~.

01. Establishment of Quality Control Program. ~~To ensure reliability of day-to-day results, each laboratory~~ Clinical laboratories must establish a quality control program~~ compatible with regional and statewide practices~~. ~~(3-17-22)~~( )

02. Program Scope. An acceptable quality control program must include~~ the following~~ written documentation of: ~~(3-17-22)~~( )

a. A~~n effective~~ preventive maintenance program that ensures proper functioning of all instruments and equipment; ~~(3-17-22)~~( )

b. ~~Routine~~ Proper testing of quality control materials along with patient specimens; ~~(3-17-22)~~( )

c. Quality control checks on reagents and media utilized in the performance of tests; ( )

d. ~~Maintenance of q~~Quality control records that~~ will enable determination of~~ demonstrate the reliability of all procedures performed. ~~(3-17-22)~~( )

211. -- 219. (RESERVED)

220. DEPARTMENT APPROVAL~~ OF CLINICAL LABORATORIES~~.
The Department will approve clinical laboratories for performance of tests on material from the human body if the laboratory meets the~~ minimum~~ standards specified in these~~ regulations~~ rules. ~~(3-17-22)~~( )

221. -- 229. (RESERVED)

230. DEPARTMENT REVOCATION OF APPROVAL.
The Department may revoke approval, either in total or in part, for any one (1) of the following reasons: ~~(3-17-22)~~( )

01. Failure to Participate in Proficiency Testing. The~~ approved~~ clinical laboratory fails to participate in a proficiency testing program~~ as outlined in Section 200 of these rules~~. ~~(3-17-22)~~( )

02. Failure to Participate in Quality Control. The~~ approved~~ clinical laboratory fails to implement a quality control program~~ as outlined in Section 210 of these rules~~. ~~(3-17-22)~~( )

03. Failure to Obtain Satisfactory Results. The Department, through the quality review process, determines that the~~ approved~~ clinical laboratory has failed to obtain satisfactory results on two (2) consecutive or on two (2) out of three (3) consecutive sets of proficiency test program specimens in one (1) or more testing categories. ~~(3-17-22)~~( )

04. Failure to Submit Documentation. Failure to submit documentation of corrective action~~ as indicated in Subsection 240.02 of these rules~~ required by the Department. ~~(3-17-22)~~( )

231. -- 239. (RESERVED)

240. REVOCATION PROCEDURE.

01. Unacceptable Results. Clinical ~~L~~laboratories that fail to obtain passing results on two (2) consecutive proficiency testing events, or two (2) out of three (3) events, will be required to submit documentation of corrective action within fifteen (15) working days after receipt of the notification of the failures. Evaluation of proficiency testing results may overlap from one year to the next. ~~(3-17-22)~~( )

02. Corrective Action. Upon receipt of documentation of corrective action, a reviewer will determine the adequacy of the action taken. If~~, in the opinion of~~ the reviewer~~,~~ determines the corrective action is not adequate, the clinical laboratory~~ will be required to~~ must submit to an on-site inspection that may include on-site testing of unknown samples. ~~(3-17-22)~~( )

03. On-Site Inspection. If the results of the on-site inspection indicate that the clinical laboratory~~'s~~ performance is unacceptable in one (1) or more testing categories, the approval to perform the test(s) in question will be revoked. ~~(3-17-22)~~( )

04. Satisfactory Performance. The clinical laboratory will continue to be approved for performance of all test procedures for which it has demonstrated satisfactory performance. ~~(3-17-22)~~( )

05. Other Deficiencies. Failure to comply with other provisions of these rules may invoke revocation procedures. ( )

241. -- 249. (RESERVED)

250. RENEWAL OF APPROVAL OF DISAPPROVED TEST(S)~~ OR TESTS~~.

01. Renewal Granted. ( )

a. A clinical laboratory that has lost approval to perform certain tests~~ for reasons outlined in Section~~

~~240 of these rules~~ may gain reapproval ~~by documenting corrective action taken, and~~ by requesting the Department review the unacceptable performance and the corrective action taken. ~~(3-17-22)~~(____)

b. Within ten (10) days after completion of this review, the reviewer will submit their report to the ~~Chief of the Bureau of Laboratories~~ Department. ~~(3-17-22)~~(____)

c. Upon determination that corrections leading to satisfactory and acceptable performance have been made, the ~~Chief of the Bureau of Laboratories~~ Department may reinstate approval. ~~(3-17-22)~~(____)

02. Renewal Denied. If the ~~Chief of the Bureau of Laboratories~~ Department does not grant reapproval of the clinical laboratory, they will provide ~~the laboratory supervisor with~~ written notice of actions to be taken to correct deficiencies. The clinical laboratory ~~supervisor~~ may request a new review at any time after thirty (30) days from the date of last review. The clinical laboratory ~~supervisor~~ may also file a written appeal ~~in accordance with~~ under IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings~~,~~." ~~Section 400.~~ ~~(3-17-22)~~(____)

251. -- 269. (RESERVED)

270. ~~LIST OF APPROVED~~REGISTERED LABORATORIES.

The Department will maintain a list of registered clinical laboratories ~~approved in accordance with this chapter. This list must include the name and address of each approved laboratory, and the name of the person directing the laboratory~~. ~~(3-17-22)~~(____)

271. -- 299. (RESERVED)

300. ~~PENALTY FOR~~ FAILURE TO REGISTER OR OPERATION OF AN ~~NON-APPROVED~~ UNREGISTERED CLINICAL LABORATORY.

Failure to register a clinical laboratory, operation of an ~~non-approved~~ unregistered clinical laboratory, or performance of unapproved testing constitutes a violation of these rules. Any violation of these rules constitutes a misdemeanor under Section 56-1008, Idaho Code. ~~(3-17-22)~~(____)

301. -- 999. (RESERVED)

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.02.24 – CLANDESTINE DRUG LABORATORY CLEANUP

DOCKET NO. 16-0224-2301 (ZBR CHAPTER REWRITE)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2024 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. The pending rule will become final and effective upon the adjournment, *sine die*, of the second Regular Session of the Sixty-seventh Idaho Legislature after approval.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 6-2604, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

Under Executive Order 2020-01: Zero-Based Regulation, the Department is striving to prevent the accumulation of costly, ineffective, and outdated regulations and reduce regulatory burden to achieve a more efficient operation of government. The rule changes are intended to perform a comprehensive review of this chapter by collaborating with the public to streamline or simplify this rule language.

There are no changes to the pending rule and it is being adopted as originally proposed. The complete text of the proposed rule was published in the August 2, 2023, Idaho Administrative Bulletin, Vol. 23-8, pages 60 through 66.

FEE SUMMARY: Pursuant to Section 67-5224(2)(d), Idaho Code, this pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature. The following is a description of the fee or charge imposed or increased in this rulemaking: Not Applicable.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state General Fund greater than ten thousand dollars ($10,000) during the fiscal year:

This rulemaking is not anticipated to have any fiscal impact on the state General Fund, or any other known funds.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Brigitta Gruenberg at 208-616-5271.

DATED this 9th day of November, 2023.

Trinette Middlebrook and Frank Powell
DHW – Administrative Rules Unit
450 W. State Street – 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
phone: (208) 334-5500
fax: (208) 334-6558
email: dhwrules@dhw.idaho.gov

THE FOLLOWING NOTICE PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section 6-2604, Idaho Code.

PUBLIC HEARING SCHEDULE: A public hearing concerning this rulemaking will be held as follows:

VIRTUAL TELECONFERENCE Via WebEx
Monday, August 21, 2023 **1:00 p.m. - 2:00 p.m. (MT)**
Join from the meeting link **https://idhw.webex.com/idhw/j.php?MTID=m7eada4d76a60f753bd9cbcb3f052c2ef** **Join by meeting number** **Meeting number (access code): 2764 132 7544** **Meeting password: wiSwXMmD252 (94799663 from phones and video systems)** **Join by phone** **+1-415-527-5035 United States Toll** **+1-303-498-7536 United States Toll (Denver)**

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below. Each meeting will conclude after 30 minutes if no participants sign in or wish to comment in the meeting.

DESCRIPTIVE SUMMARY: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

Under Executive Order 2020-01: Zero-Based Regulation, the Department is striving to prevent the accumulation of costly, ineffective, and outdated regulations and reduce regulatory burden to achieve a more efficient operation of government. The rule changes are intended to perform a comprehensive review of this chapter by collaborating with the public to streamline or simplify this rule language.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased:

This chapter contains no fees or charges.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the State General Fund greater than ten thousand dollars ($10,000) during the fiscal year as a result of this rulemaking:

This rulemaking is not anticipated to have any fiscal impact on the State General Fund, or any other known funds.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the April 5, 2023, Idaho Administrative Bulletin, Vol. 23-4, pages 29 through 30.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into this rule:

There are no incorporations by reference in this chapter rewrite.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Brigitta Gruenberg at 208-334-5929.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before August 23, 2023.

DATED this 6th day of July, 2023.

THE FOLLOWING IS THE TEXT OF ZBR DOCKET NO. 16-0224-2301

16.02.24 – CLANDESTINE DRUG LABORATORY CLEANUP

000. LEGAL AUTHORITY.
The Department is authorized to adopt rules under the "Clandestine Drug Laboratory Cleanup Act," Section 6-2604, Idaho Code. ( )

001. (RESERVED)

002. RIGHT TO APPEAL PROPERTY LISTING.
The certification by the reporting law enforcement agency that the property has been contaminated through use as a clandestine drug laboratory (CDL) is prima facie evidence for listing the property on the Clandestine Drug Laboratory Site Property List (CDLSPL). ( )

01. Property Owner's Right to Appeal. The property owner may appeal the listing by filing a written request for hearing with the Administrative Procedures Section, 10th Floor, 450 West State Street, P.O. Box 83720, Boise, ID 83720-0036, within twenty-eight (28) days of the mailing of the notification by the law enforcement agency. ( )

02. Burden of Proof. The burden is on the property owner to show, by a preponderance of evidence, the property has not been contaminated through use as a CDL. ( )

003. – 009. (RESERVED)

010. DEFINITIONS.
Definitions relevant to these rules but not found below may be under Section 6-2603, Idaho Code. ( )

01. Certificate of Delisting. A document issued by the Department certifying a property has met the cleanup standard. ( )

02. Certify. To guarantee as meeting a standard. ( )

03. Chain of Custody. A procedure used to document each person that has had custody or control of an environmental sample from its source to the analytical laboratory, including date and length of time of possession by

each person. ( )

04. Clandestine Drug Laboratory (CDL). Defined under Section 6-2603(1), Idaho Code. ( )

05. Clandestine Drug Laboratory Site Property List (CDLSPL). The Department list of properties that have been identified as clandestine drug laboratories. See Department website at https://healthandwelfare.idaho.gov/health-wellness/environmental-health/clandestine-labs. ( )

06. Cleanup Contractor. One (1) or more individuals or commercial entities hired to conduct cleanup under these rules. ( )

07. Cleanup Standard. The technology-based numerical value, under Section 500 of these rules. ( )

08. Clearance Sampling. Testing conducted by a qualified industrial hygienist to verify cleanup standards have been met. ( )

09. Contamination or Contaminated. The presence of chemical residues that exceed the cleanup standard under Section 500 of these rules. ( )

10. Delisted. Removal of a property from the CDLSPL. ( )

11. Demolish. To tear down and dispose of a structure under local, state, and federal laws and regulations. ( )

12. Department. The Idaho Department of Health and Welfare. ( )

13. Discrete Sample. A single sample taken. ( )

14. Documentation. Preserving a record of an observation through writings, drawings, photographs, or other appropriate means. ( )

15. Listed. Addition of a property to the CDLSPL. ( )

16. Methamphetamine. Dextro-methamphetamine, levo-methamphetamine, and any racemic mixture of dextro/levo methamphetamine. ( )

17. Non-Porous. Resistant to penetration or saturation of chemical substances. ( )

18. Porous. Subject to penetration or saturation by chemical substances. ( )

19. Qualified Industrial Hygienist. Must be one (1) of the following: ( )

a. Certified Industrial Hygienist. An individual who is certified in comprehensive practice by the American Board of Industrial Hygiene. ( )

b. Registered Professional Industrial Hygienist™. An individual who is a registered member of the Association of Professional Industrial Hygienists. ( )

20. Sampling. A surface sample collected by wiping a sample media on the surface being sampled. ( )

21. Technology-Based Standard. A cleanup level based on what is believed to be conservative and protective, while at the same time achievable by currently available technologies. ( )

22. Vacant. Being without an occupant for the purposes of habitation or occupancy. ( )

011. -- 099. (RESERVED)

100. POSTING THE CLANDESTINE DRUG LABORATORY (CDL) SITE.
Under Section 6-2605, Idaho Code, the law enforcement agency having jurisdiction is responsible for posting a sign on the property identified as a CDL. ( )

101. -- 109. (RESERVED)

110. NOTIFICATION PROCESS.
Once a property has been identified as a CDL, the law enforcement agency having jurisdiction is responsible for initiating notification to the property owner and the Department within seventy-two (72) hours using the Department-approved form. ( )

111. -- 119. (RESERVED)

120. RECORD-KEEPING, LISTING, AND DELISTING A PROPERTY.

01. Listing a Property. Upon notification by a law enforcement agency, the Department will place the property on the CDLSPL. No property may be listed unless the reporting law enforcement agency certifies, on the approved form, that it is more likely than not that the property has been contaminated through use as a CDL. The list is available online at: https://publicdocuments.dhw.idaho.gov/WebLink/DocView.aspx?id=1432&dbid=0&repo=PUBLIC-DOCUMENTS&cr=1. ( )

02. Delisting a Property. When a property is determined by a qualified industrial hygienist to meet the cleanup standard in these rules, or the property owner submits documentation establishing the property has been fully and lawfully demolished, the Department will issue the property owner a certificate of delisting. The certificate will include the date the property was listed as a CDL site and the date the property was delisted. ( )

03. Voluntary Compliance. When a property owner voluntarily reports their property as a CDL, the property will be placed on the CDLSPL and will be delisted under Subsection 120.02 of this rule. This action will afford the property owner immunity from civil actions under Section 6-2608, Idaho Code. ( )

121. -- 199. (RESERVED)

200. RESPONSIBILITIES OF THE PROPERTY OWNER.
The owner of a listed property must meet the requirements under Section 6-2606(2), Idaho Code, and the following: ( )

01. Ensure the Vacancy of the Listed Property. Ensure the property remains vacant until the property is delisted under Subsection 120.02 of these rules; and ( )

02. Ensure Cleanup Standards Are Met. ( )

a. Ensure property meets the standards in Section 500 of these rules and have the analytical results certified by a qualified industrial hygienist; or ( )

b. Ensure the property is demolished, in lieu of clean up, under Section 6-2606, Idaho Code. Demolition and removal of materials must comply with applicable local, state, and federal laws and regulations; and ( )

03. Provide Department With a Written Report Under Section 600 of these Rules. ( )

201. RESPONSIBILITIES OF THE QUALIFIED INDUSTRIAL HYGIENIST.

01. Conduct Sampling by Qualified Industrial Hygienist. A qualified industrial hygienist must conduct sampling under Section 400 of these rules and meet reporting requirements under Section 600 of these rules. ( )

02. Independent Qualified Industrial Hygienist. To prevent any real or potential conflicts of interest, qualified industrial hygienists conducting sampling must be independent of the company or entity conducting the cleanup or analysis, or both. ( )

202. -- 299. (RESERVED)

300. CLEANUP PROCESS.

01. Cleanup Options for the Property Owner. The property owner may choose to hire a cleanup contractor or conduct the cleanup themself under all applicable local, state, and federal laws and regulations. Cleanup must be conducted to reduce the concentration of methamphetamine to standards listed under Section 500 of these rules. ( )

02. Removal of Porous Materials from Property. Porous materials must be removed from the property unless a qualified industrial hygienist certifies the porous materials may remain. An adequate coating or sealant can be applied to a porous surface as an acceptable cleanup method, if it meets the requirements under Subsection 500.02 of these rules. ( )

301. DISPOSAL OF CLEANUP WASTE.
Waste disposal must comply with applicable local, state, and federal laws and regulations. ( )

302. -- 399. (RESERVED)

400. CLEARANCE SAMPLING REQUIREMENTS.

01. Qualified Industrial Hygienist Required. Sampling must be conducted by a qualified industrial hygienist to verify that cleanup standards have been met. ( )

02. General Sampling Procedures. All sample collection must be conducted with the following requirements: ( )

a. Sample locations are photographed and show the floor plan of the property, all of which are included in the final report required under Section 600 of these rules. ( )

b. Samples are obtained, preserved, and handled under professional standards for the types of samples and analytical testing to be conducted under the chain of custody protocol. ( )

c. Samples are analyzed by a laboratory certified by the U.S. Environmental Protection Agency or accredited by the American Industrial Hygiene Association laboratory accreditation program for the analyte being analyzed. ( )

d. Sampling locations are numerically identified and the numbered sampling locations delineated on the floor plan, visible in photographs, and linked to samples. ( )

e. Standard three inch by three (3x3) inch gauze are used for all sampling. The gauze must be wetted with analytical grade methanol or isopropanol and each surface sampled wiped at least five (5) times in two (2) perpendicular directions and the gauze turned onto itself throughout the wiping process. ( )

f. After sampling, the sample is placed in a new, clean sample container and sealed with a Teflon-lined lid. The sample container must be labeled with the site or project identification number, date, time, and sample location, and be handled by professional standards and conducted under the chain of custody protocol. ( )

g. Discrete sampling is used in areas expected to have the highest levels of contamination, as identified on the Department approved form. A ten (10) centimeter by ten (10) centimeter area (one hundred square centimeters (100 cm^2), or approximately sixteen (16) square inches) must be sampled from non-porous surfaces such as floors, walls, appliances, sinks, or countertops in each room. The sample area must be composed of no fewer than

three (3) discrete samples. ( )

h. All other rooms of the property with lowest levels of contamination are sampled using one (1) discrete sample per room. ( )

i. A ten (10) centimeter by ten (10) centimeter area (one hundred square centimeters (100 cm^2), or approximately sixteen (16) square inches) is sampled from the ventilation system in a location to be determined by the qualified industrial hygienist. ( )

401. -- 499. (RESERVED)

500. CLEANUP STANDARDS.

01. Cleanup Standard for Methamphetamine. A level of methamphetamine that does not exceed a concentration of point one (0.1) micrograms per one hundred (100) square centimeters (0.1 µg/100 cm^2) as demonstrated by clearance sampling conducted by a qualified industrial hygienist. ( )

02. Cleanup Standard for a Porous Surface. If a porous surface has a level of methamphetamine that does not exceed a concentration of point five (0.5) micrograms per one hundred (100) square centimeters (0.5 µg/100 cm^2) as demonstrated by clearance sampling conducted by a qualified industrial hygienist, an adequate coating or sealant appropriate to the material can be used as a method to meet the cleanup standard under Subsection 500.01 of this rule. ( )

03. Other Cleanup Standards. Standards may be established for the cleanup of other controlled substances found in clandestine drug laboratories on an individual basis, based on an inventory of chemicals found, and after consultation with the Department, the property owner, law enforcement, and a qualified industrial hygienist. ( )

501. -- 599. (RESERVED)

600. REPORTING REQUIREMENTS.
For the property to be delisted, the property owner must provide the Department with an original or certified copy of the final report that includes the following from a qualified industrial hygienist. ( )

01. Property Description. The property description including physical street address (apartment or motel number), city, zip code, legal description, ownership, and number and type of structures present. ( )

02. Documentation of Clearance Sampling Procedures. Documentation of sampling procedures as required under Section 400 of these rules. ( )

03. Laboratory Results. Analytical results from a laboratory as specified in Section 400 of these rules. ( )

04. Qualifications of the Qualified Industrial Hygienist. Qualified industrial hygienist statement of qualifications, including professional certification or documentation. ( )

05. Signed Certification Statement. A signed certification statement stating: “I certify that the cleanup standard established by the Idaho Department of Health and Welfare has been met as evidenced by testing I conducted.” ( )

06. Demolition Documentation. If the property owner chooses to demolish the property, documentation must be provided to the Department showing the structure was completely and lawfully demolished and disposed of complying with local, state, and federal laws and regulations. ( )

601. -- 999. (RESERVED)

[Agency redlined courtesy copy]

16.02.24 – CLANDESTINE DRUG LABORATORY CLEANUP

000. LEGAL AUTHORITY.
The Department is authorized to adopt rules under the "Clandestine Drug Laboratory Cleanup Act," Section 6-2604, Idaho Code. ( )

001. ~~TITLE AND SCOPE.~~(RESERVED)

~~**01. Title**. The title of these rules is IDAPA 16.02.24, "Clandestine Drug Laboratory Cleanup."~~ ~~(3-17-22)~~

~~**02. Scope**.~~ ~~(3-17-22)~~

~~**a.** These rules establish the acceptable processes and technology-based standards for the cleanup of clandestine drug laboratories in Idaho.~~ ~~(3-17-22)~~

~~**b.** The rules also establish a program to add and remove residential properties that housed a clandestine drug laboratory from a list maintained by the Department.~~ ~~(3-17-22)~~

002. RIGHT TO APPEAL PROPERTY LISTING.
~~Appeal of Property Listing.~~ The certification by the reporting law enforcement agency that ~~it is more likely than not that~~ the property has been contaminated through use as a clandestine drug laboratory (CDL) is prima facie evidence for listing the property on the Clandestine Drug Laboratory Site Property List (CDLSPL). ~~(3-17-22)~~( )

01. Property Owner's Right to Appeal. The property owner ~~listed on the Clandestine Drug Laboratory Site Property List~~ may appeal the listing by filing a written request for hearing with the Administrative Procedures Section, 10th Floor, 450 West State Street, P.O. Box 83720, Boise, ID 83720-0036, within twenty-eight (28) days of the mailing of the notification by the law enforcement agency. ~~(3-17-22)~~( )

02. Burden of Proof. The burden is on the property owner to show, by a preponderance of evidence, ~~that~~ the property has not been contaminated through use as a ~~clandestine drug laboratory~~ CDL. ~~(3-17-22)~~( )

003. – 009. (RESERVED)

010. DEFINITIONS.
~~For the purposes of these rules, the following terms are used as defined below:~~Definitions relevant to these rules but not found below may be under Section 6-2603, Idaho Code. ~~(3-17-22)~~( )

01. Certificate of Delisting. A document issued by the Department certifying ~~that~~ a property has met the cleanup standard. ~~(3-17-22)~~( )

02. Certify. To guarantee as meeting a standard. ( )

03. Chain of Custody. A procedure used to document each person that has had custody or control of an environmental sample from its source to the analytical laboratory, ~~and the~~ including date and length of time of possession by each person. ~~(3-17-22)~~( )

04. Clandestine Drug Laboratory (CDL). ~~The area(s) where controlled substances or their immediate precursors, as those terms are d~~Defined ~~in~~ under Section ~~37-2701~~ 6-2603(1), Idaho Code~~, have been, or were attempted to be, manufactured, processed, cooked, disposed of, or stored, and all proximate areas that are likely to be contaminated as a result of such manufacturing, processing, cooking, disposing or storing~~. ~~(3-17-22)~~( )

05. Clandestine Drug Laboratory Site Property List (CDLSPL). The Department list~~, maintained by the Department,~~ of properties that have been identified as clandestine drug laboratories. See Department website at https://healthandwelfare.idaho.gov/health-wellness/environmental-health/clandestine-labs. ~~(3-17-22)~~( )

06. Cleanup Contractor. One (1) or more individuals or commercial entities hired to conduct cleanup ~~in accordance with the requirements of this~~ under these rules. ~~(3-17-22)~~( )

07. Cleanup Standard. The technology-based numerical value~~, established in~~ under Section 500 of these rules. ~~(3-17-22)~~( )

08. Clearance Sampling. Testing conducted by a qualified industrial hygienist to verify ~~that~~ cleanup standards have been met. ~~(3-17-22)~~( )

09. Contamination or Contaminated. The presence of chemical residues that exceed the cleanup standard ~~established in~~ under Section 500 of these rules. ~~(3-17-22)~~( )

10. Delisted. Removal of a property from the ~~Clandestine Drug Laboratory Site Property List~~ CDLSPL. ~~(3-17-22)~~( )

11. Demolish. To ~~completely~~ tear down and dispose of a structure ~~in compliance with~~ under local, state, and federal laws and regulations. ~~(3-17-22)~~( )

12. Department. The Idaho Department of Health and Welfare. ( )

13. Discrete Sample. A single sample taken. ( )

14. Documentation. Preserving a record of an observation through writings, drawings, photographs, or other appropriate means. ( )

15. Listed. Addition of a property to the ~~Clandestine Drug Laboratory Site Property List~~ CDLSPL. ~~(3-17-22)~~( )

16. Methamphetamine. Dextro-methamphetamine, levo-methamphetamine, and any racemic mixture of dextro/levo methamphetamine. ( )

17. Non-Porous. Resistant to penetration or saturation of chemical substances. ( )

18. Porous. Subject to penetration or saturation by chemical substances. ( )

19. Qualified Industrial Hygienist. Must be one (1) of the following: ( )

a. Certified Industrial Hygienist. An individual who is certified in comprehensive practice by the American Board of Industrial Hygiene. ( )

b. Registered Professional Industrial Hygienist™. An individual who is a registered member of the Association of Professional Industrial Hygienists ~~and possesses a baccalaureate degree, issued by an accredited college or university, in industrial hygiene, engineering, chemistry, physics, biology, medicine, or related physical and biological sciences who has a minimum of three (3) years full-time industrial hygiene experience. A completed master's degree in a related physical or biological science, or in a related engineering discipline, may be substituted for one (1) year of the experience requirement; and a similar doctoral degree may be substituted for an additional year of the experience requirement~~. ~~(3-17-22)~~( )

20. Sampling. A surface sample collected by wiping a sample media on the surface being sampled. ( )

21. Technology-Based Standard. A cleanup level based on what is believed to be conservative and

protective, while at the same time achievable by currently available technologies. ( )

22. **Vacant**. Being without an occupant for the purposes of habitation or occupancy. ( )

011. -- 099. (RESERVED)

100. POSTING THE CLANDESTINE DRUG LABORATORY (CDL) SITE.
~~In accordance with~~ Under Section 6-2605, Idaho Code, the law enforcement agency having jurisdiction is responsible for posting ~~a property with~~ a sign ~~stating that it has been~~ on the property identified as a ~~clandestine drug laboratory~~ CDL. ~~(3-17-22)~~( )

101. -- 109. (RESERVED)

110. NOTIFICATION PROCESS.
Once a property has been identified as a ~~clandestine drug laboratory~~ CDL, the law enforcement agency having jurisdiction is responsible for initiating notification to the property owner and the Department within seventy-two (72) hours using the Department-approved form ~~available to law enforcement~~. ~~(3-17-22)~~( )

111. -- 119. (RESERVED)

120. RECORD-KEEPING, LISTING, AND DELISTING A PROPERTY.

01. **Listing a Property**. Upon notification by a law enforcement agency, ~~using the Department approved form,~~ the Department will place the property on ~~a Clandestine Drug Laboratory Site Property List~~ the CDLSPL. No property may be listed unless the reporting law enforcement agency certifies, on the approved form, that it is more likely than not that the property has been contaminated through use as a ~~clandestine drug laboratory~~ CDL. The list ~~will be publicly~~ is available online at: https://publicdocuments.dhw.idaho.gov/WebLink/DocView.aspx?id=1432&dbid=0&repo=PUBLIC-DOCUMENTS&cr=1. ~~(3-17-22)~~( )

02. **Delisting a Property**. When a property is determined by a qualified industrial hygienist to meet the cleanup standard ~~set forth by the Department~~ in these rules, or the property owner submits documentation establishing ~~that~~ the property has been fully and lawfully demolished, the Department will issue the property owner a certificate of delisting. The certificate will include the date the property was listed as a ~~clandestine drug laboratory~~ CDL site and the date the property was delisted. ~~(3-17-22)~~( )

03. **Voluntary Compliance**. When a property owner voluntarily reports their property as a ~~clandestine drug laboratory~~ CDL, the property will be placed on the ~~Clandestine Drug Laboratory Site Property List~~ CDLSPL and will be delisted ~~when the requirements of these rules are met~~ under Subsection 120.02 of this rule. This action will afford the property owner immunity from civil actions ~~as provided in~~ under Section 6-2608, Idaho Code. ~~(3-17-22)~~( )

121. -- 199. (RESERVED)

200. RESPONSIBILITIES OF THE PROPERTY OWNER.
The owner of a listed property must meet the requirements under Section 6-2606(2), Idaho Code, and the following: ~~(3-17-22)~~( )

01. **Ensure the Vacancy of the Listed Property**. Ensure the property remains vacant until the property is delisted ~~in accordance with~~ under Subsection 120.02 of these rules; and ~~(3-17-22)~~( )

02. **Ensure ~~That~~ Cleanup Standards Are Met**. ~~(3-17-22)~~( )

a. Ensure ~~that the~~ property ~~is cleaned up to~~ meets the ~~cleanup~~ standards in Section 500 of these rules and have the analytical results certified by a qualified industrial hygienist; or ~~(3-17-22)~~( )

b. Ensure ~~that~~ the property is demolished, in lieu of clean up, ~~as provided for in~~ under Section 6-2606, Idaho Code. Demolition and removal of materials must ~~be conducted in compliance~~ comply with applicable local,

state, and federal laws and regulations; and ~~(3-17-22)~~( )

03. Provide~~ the~~ Department With a Written Report Under Section 600 of these Rules. ~~Provide the Department with a written report in accordance with Section 600 of these rules.~~ ~~(3-17-22)~~( )

201. RESPONSIBILITIES OF THE QUALIFIED INDUSTRIAL HYGIENIST.

01. Conduct Sampling by Qualified Industrial Hygienist. A qualified industrial hygienist must conduct sampling~~ in accordance with~~ under Section 400 of these rules and meet~~ the~~ reporting requirements under Section 600 of these rules. ~~(3-17-22)~~( )

02. Independent Qualified Industrial Hygienist. To prevent any real or potential conflicts of interest, qualified industrial hygienists conducting~~ the~~ sampling must be independent of the company or entity conducting the cleanup or analysis, or both. ~~(3-17-22)~~( )

~~**202. DEPARTMENT LIST OF QUALIFIED INDUSTRIAL HYGIENISTS.**~~
~~The Department will maintain a list of qualified industrial hygienists on their website is https://healthandwelfare.idaho.gov/health-wellness/environmental-health/clandestine-labs.~~ ~~(3-17-22)~~

20~~3~~2. -- 299. (RESERVED)

300. CLEANUP PROCESS.

01. Cleanup Options for the Property Owner. The property owner may choose to hire a cleanup contractor or conduct the cleanup ~~him~~themself~~ in accordance with~~ under all applicable local, state, and federal laws and regulations. Cleanup must be conducted to reduce the concentration of methamphetamine to~~ the~~ standards ~~specified in~~ listed under Section 500 of these rules. ~~(3-17-22)~~( )

02. Removal of Porous Materials from Property. Porous materials must be removed from the property unless a qualified industrial hygienist certifies~~ that~~ the porous materials may remain~~ on the property~~. An adequate coating or sealant can be applied to a porous surface as an acceptable cleanup method, if it meets the requirements under Subsection 500.02 of these rules. ~~(3-17-22)~~( )

301. DISPOSAL OF CLEANUP WASTE.
Waste disposal must~~ be conducted in compliance~~ comply with applicable local, state, and federal laws and regulations. ~~(3-17-22)~~( )

302. -- 399. (RESERVED)

400. CLEARANCE SAMPLING REQUIREMENTS.

01. Qualified Industrial Hygienist Required. Sampling must be conducted by a qualified industrial hygienist to verify that cleanup standards have been met. ( )

02. General Sampling Procedures. All ~~S~~sample collection must be conducted~~ according to~~ with the following~~ minimum~~ requirements: ~~(3-17-22)~~( )

a. ~~All s~~Sample locations~~ must be~~ are photographed~~,~~ and~~ the photographs~~ show the floor plan of the property, all of which are included in the final report required under Section 600 of these rules. ~~(3-17-22)~~( )

~~**b.** All sample locations must be shown on a floor plan of the property, and the floor plan included in the final report required under Section 600 of these rules.~~ ~~(3-17-22)~~

~~c~~b. ~~All s~~Samples~~ must be~~ are obtained, preserved, and handled~~ in accordance with~~ under professional standards for the types of samples and analytical testing to be conducted under the chain of custody protocol. ~~(3-17-22)~~( )

~~d~~c. Samples~~ must be~~ are analyzed by a laboratory certified by the U.S. Environmental Protection Agency or accredited by the American Industrial Hygiene Association laboratory accreditation program for the analyte being analyzed. ~~(3-17-22)~~(   )

~~e~~d. ~~All s~~Sampling locations~~ must be~~ are numerically identified and the numbered sampling locations delineated on the floor plan, visible in photographs, and linked to samples. ~~(3-17-22)~~(   )

~~f~~e. Standard three inch by three (3x3) inch gauze~~ must be~~ are used for all sampling. The gauze must be wetted with analytical grade methanol or isopropanol~~.~~ and ~~E~~each surface~~ being~~ sampled~~ must be~~ wiped at least five (5) times in two (2) perpendicular directions and the gauze turned onto itself throughout the wiping process. ~~(3-17-22)~~(   )

~~g~~f. After sampling, the sample~~ must be~~ is placed in a new, clean sample container and sealed with a Teflon-lined lid. The sample container must be~~ properly~~ labeled with~~ at least~~ the site or project identification number, date, time, and~~ actual~~ sample location~~. The sample container must~~, and be handled~~ according to~~ by professional standards and conducted under the chain of custody protocol. ~~(3-17-22)~~(   )

~~h~~g. Discrete sampling~~ must be~~ is used in areas expected to have the highest levels of contamination, as identified on the Department approved form. A ten (10) centimeter by ten (10) centimeter area (one hundred square centimeters (100 cm^2), or approximately sixteen (16) square inches) must be sampled from non-porous surfaces such as floors, walls, appliances, sinks, or countertops in each room. The sample area must be composed of no fewer than three (3) discrete samples. ~~(3-17-22)~~(   )

~~i~~h. All other rooms of the property with lowest levels of contamination~~ must be~~ are sampled using one (1) discrete sample per room. ~~(3-17-22)~~(   )

~~j~~i. A ten (10) centimeter by ten (10) centimeter area (one hundred square centimeters (100 cm^2), or approximately sixteen (16) square inches)~~ must be~~ is sampled from the ventilation system in a location to be determined by the qualified industrial hygienist. ~~(3-17-22)~~(   )

401. -- 499. (RESERVED)

500. CLEANUP STANDARDS.

01. Cleanup Standard for Methamphetamine. A level of methamphetamine that does not exceed a concentration of point one (0.1) micrograms per one hundred (100) square centimeters (0.1 $\mu g/100\ cm^2$) as demonstrated by clearance sampling conducted by a qualified industrial hygienist. (   )

02. Cleanup Standard for a Porous Surface. If a porous surface has a level of methamphetamine that does not exceed a concentration of point five (0.5) micrograms per one hundred (100) square centimeters (0.5 $\mu g/100\ cm^2$) as demonstrated by clearance sampling conducted by a qualified industrial hygienist, an adequate coating or sealant appropriate to the material can be used as a method to meet the cleanup standard under Subsection 500.01 of this rule. (   )

03. Other Cleanup Standards. Standards may be established for the cleanup of other controlled substances found in clandestine drug laboratories on an~~ case by case~~ individual basis, based on an inventory of chemicals found, and after consultation with the Department, the property owner, law enforcement, and a qualified industrial hygienist. ~~(3-17-22)~~(   )

501. -- 599. (RESERVED)

600. REPORTING REQUIREMENTS.

~~In order f~~For the property to be delisted, the property owner must provide the Department with an original or certified copy of the final report that includes the following from~~ the~~ a qualified industrial hygienist.~~ The final report must include at least the following information:~~ ~~(3-17-22)~~(   )

01. Property Description. The property description including physical street address (apartment or

motel number~~, if applicable~~), city, zip code, legal description, ownership, and number and type of structures present. ~~(3-17-22)~~(   )

02. Documentation of Clearance Sampling Procedures. Documentation of sampling procedures ~~in accordance with the~~ as require~~ments~~d under Section 400 of these rules. ~~(3-17-22)~~(   )

03. Laboratory Results. Analytical results from a laboratory as specified in Section 400 of these rules. (   )

04. Qualifications of the Qualified Industrial Hygienist. Qualified industrial hygienist statement of qualifications, including professional certification or documentation. (   )

05. Signed Certification Statement. A signed certification statement ~~as~~ stating: "I certify that the cleanup standard established by the Idaho Department of Health and Welfare has been met as evidenced by testing I conducted." ~~(3-17-22)~~(   )

06. Demolition Documentation. If the property owner chooses to demolish the property, documentation must be provided to the Department showing ~~that~~ the structure was completely and lawfully demolished and disposed of ~~in compliance~~ complying with local, state, and federal laws and regulations. ~~(3-17-22)~~(   )

601. -- 999. (RESERVED)

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.02.25 – STATE LABORATORY FEES

DOCKET NO. 16-0225-2301 (FEE RULE)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo and Cost/Benefit Analysis (CBA)

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2024 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. The pending rule will become final and effective upon the adjournment, *sine die*, of the second Regular Session of the Sixty-seventh Idaho Legislature after approval.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 56-1003 and 56-1007, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

This rulemaking is being done to correct errors in the fees for total coliform testing procedures under Section 200 and align the fees to reflect negotiations held with stakeholders prior to the chapter rewrite approved by the 2022 legislature. Further, this assures that the state will not be in competition with commercial laboratories for these procedures.

There are no changes to the pending rule and it is being adopted as originally proposed. The complete text of the proposed rule was published in the July 5, 2023, Idaho Administrative Bulletin, Vol. 23-7, pages 37 through 41.

FEE SUMMARY: Pursuant to Section 67-5224(2)(d), Idaho Code, this pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature. The following is a description of the fee or charge imposed or increased in this rulemaking:

As authorized in Section 56-1007, Idaho Code, the fees in Subsection 200.02 for Total Coliform/E. coli, Presence/Absence are being revised from the pre-2022 price of $18 to the negotiated price of $21. Similarly, Total Coliform/E. coli, Quantitative are being revised from $20 to $33.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state General Fund greater than ten thousand dollars ($10,000) during the fiscal year:

This rulemaking is not anticipated to have any fiscal impact on the state General Fund, however, it will be an increase in receipt funds for the State Laboratory. The proposed revisions will be within the laboratory's appropriation for receipts so it should not result in a substantive budget impact. This increase will help offset higher operating costs associated with this testing. Based upon the 2022 testing volume for the laboratory, these fee revisions will result in approximately a $12,100 increase in receipts.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Chris Ball at (208) 334-0568.

DATED this 9th day of November, 2023.

Trinette Middlebrook and Frank Powell
DHW – Administrative Rules Unit
450 W. State Street – 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
phone: (208) 334-5500
fax: (208) 334-6558
email: dhwrules@dhw.idaho.gov

THE FOLLOWING NOTICE PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 56-1003 and 56-1007, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearings concerning this rulemaking will be held as follows:

VIRTUAL TELECONFERENCES Via WebEx
Wednesday, July 12, 2023 **9:00 a.m. - 11:00 a.m. (MT)**
Join from the meeting link **https://idhw.webex.com/idhw/j.php?MTID=m0cbfbb28f4e4cd018af8fbcdadd8dc59** **Join by meeting number** **Meeting number (access code): 2761 965 6543** **Meeting password: PMfYXvKg355 (76399854 from phones and video systems)** **Join by phone** **+1-415-527-5035 United States Toll** **+1-303-498-7536 United States Toll (Denver)**
Wednesday, July 19, 2023 **2:00 p.m. - 4:00 p.m. (MT)**
Join from the meeting link **https://idhw.webex.com/idhw/j.php?MTID=m5253cfb0ab7c5956de6bcef0b049c0dc** **Join by meeting number** **Meeting number (access code): 2764 823 7694** **Meeting password: G83gUA8SuU4 (48348287 from phones and video systems)** **Join by phone** **+1-415-527-5035 United States Toll** **+1-303-498-7536 United States Toll (Denver)**

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below. Each meeting will conclude after 30 minutes if no participants sign in or wish to comment in the meeting.

DESCRIPTIVE SUMMARY: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

This rulemaking is being done to correct errors in the fees for total coliform testing procedures under Section 200 and align the fees to reflect negotiations held with stakeholders prior to the chapter rewrite approved by the 2022 legislature. Further, this assures that the state will not be in competition with commercial laboratories for these procedures.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased:

The fees in Subsection 200.02 for Total Coliform/E. coli, Presence/Absence are being revised from the pre-2022 price of $18 to the negotiated price of $21. Similarly, Total Coliform/E. coli, Quantitative are being revised from $20 to $33.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year resulting from this rulemaking:

This rulemaking is not anticipated to have any fiscal impact on the State General Fund, however, it will be an increase in dedicated funds for the State Laboratory. The proposed revisions will be within the laboratory's appropriation for receipts so it should not result in a substantive budget impact. This increase will help offset higher operating costs associated with this testing. Based upon the 2022 testing volume for the laboratory, these fee revisions will result in approximately a $12,100 increase in receipts.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2)(b), Idaho Code, negotiated rulemaking was not conducted as it was deemed not feasible. This rulemaking is being done simply to correct laboratory fees as negotiated with stakeholders prior to the chapter rewrite approved by the 2022 legislature.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into this rule:

There are no documents incorporated by reference under this chapter of rules.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Chris Ball at (208) 334-0568.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before July 26, 2023.

DATED this 8th day of June, 2023.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0225-2301

200. FEES FOR LABORATORY TESTS.

01. Laboratory Test, Air -- Table.

Fees for Laboratory Tests -- Air	
Air Test Name	**Fee**
PM 2.5 Filter	$20.00

(3-15-22)

02. Laboratory Tests, Microbiology -- Table.

Fees for Laboratory Tests -- Microbiology	
Microbiology Test Name	**Fee**
Enzyme-Linked Immunoassay (EIA)	$146.00
Heterotrophic Plate Count	$28.00
Bacterial Isolate Identification	$80.00
Legionella pneumophila in Water, Quantitative	$29.00
Legionella spp. Culture and Identification	$154.00
Pathogen Screen by Polymerase Chain Reaction (PCR)	$131.00
Pseudomonas aeruginosa, in Water, Quantitative	$50.00
Total Coliform/E. coli, Presence/Absence	$~~18~~21.00
Total Coliform/E. coli, Quantitative	$~~20~~33.00

~~(3-15-22)~~(   )

03. Laboratory Tests, Inorganic Chemistry -- Table.

Fees for Laboratory Tests -- Inorganic Chemistry	
Inorganic Chemistry Test Name	**Fee**
Alkalinity ($CaCO_3$),	$18.00
Ammonia as N,	$22.00
Arsenic	$23.00
Bromate	$100.00
Bromide	$32.00
Chlorate	$100.00
Chloride	$20.00
Chlorite	$150.00
Chlorophyll A and Pheophytin A	$75.00
Conductivity	$11.00
Cyanide	$50.00
Direct Mercury Analysis	$50.00
Fluoride	$20.00
Hardness	$28.00
Lead	$23.00
Mercury	$40.00
Metals Digestion	$21.00

Fees for Laboratory Tests -- Inorganic Chemistry	
Inorganic Chemistry Test Name	**Fee**
Metals each (Aluminum, Antimony, Barium, Beryllium, Boron, Cadmium, Calcium, Chromium, Cobalt, Copper, Iron, Lithium, Magnesium, Manganese, Molybdenum, Nickel, Potassium, Selenium, Silicon, Silver, Sodium, Strontium, Thallium, Tin, Vanadium, Zinc)	$13.00
Metals Speciation	$50.00
Nitrate + Nitrite as N	$20.00
Nitrate as N	$20.00
Nitrite as N	$20.00
Orthophosphate as P	$20.00
pH	$10.00
Sulfate	$20.00
Total Dissolved Solids	$16.00
Total Kjeldahl Nitrogen	$40.00
Total Phosphorus	$28.00
Total Suspended Sediment	$16.00
Total Suspended Solids	$16.00
Turbidity	$15.00
Uranium	$23.00

(3-15-22)

04. Laboratory Tests, Organic Chemistry -- Table.

Fees for Laboratory Tests -- Organic Chemistry	
Organic ChemistryTest Name	**Fee**
1,2-dibromo-3-chloropropane/ethylene dibromide (DBCP/EDB/TCP)	$125.00
Carbamates	$175.00
Chlorinated Herbicides	$175.00
Diquat	$175.00
ELISA	$12.00
Endothall	$175.00
Glyphosate	$150.00
Haloacetic Acids	$150.00
Oil and Grease	$75.00
Organochlorine Pesticides / PCBs	$175.00
Semi-volatile Compounds	$225.00

Fees for Laboratory Tests -- Organic Chemistry	
Organic ChemistryTest Name	**Fee**
Semi-volatile, GC-MS Screen (Qualitative Results)	$150.00
Total Trihalomethanes (TTHMs)	$110.00
Unknown Identification	$100.00
Volatile Organic Compounds (VOC)	$190.00

(3-15-22)

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.03.01 – ELIGIBILITY FOR HEALTH CARE ASSISTANCE FOR FAMILIES AND CHILDREN

DOCKET NO. 16-0301-2301 (ZBR CHAPTER REWRITE)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2024 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. The pending rule will become final and effective upon the adjournment, *sine die*, of the second Regular Session of the Sixty-seventh Idaho Legislature after approval.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 56-202, 56-203, and 56-209, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

Under Executive Order 2020-01: Zero-Based Regulation, the Department is striving to prevent the accumulation of costly, ineffective, and outdated regulations and reduce regulatory burden to achieve a more efficient operation of government. The rule changes are intended to perform a comprehensive review of this chapter by collaborating with the public to streamline or simplify this rule language.

The text of the pending rule has been amended in accordance with Section 67-5227, Idaho Code. Only those sections that have changes that differ from the proposed text are printed in this bulletin. The complete text of the proposed rule was published in the September 6, 2023, Idaho Administrative Bulletin, Vol. 23-9, pages 49 through 72.

FEE SUMMARY: Pursuant to Section 67-5224(2)(d), Idaho Code, this pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature. The following is a description of the fee or charge imposed or increased in this rulemaking: Not Applicable.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year:

This rulemaking is not anticipated to have any fiscal impact on the State General Fund, or any other known funds.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Laura Schumaker at 208-799-4335.

DATED this 9th day of November, 2023.

Trinette Middlebrook and Frank Powell
DHW – Administrative Rules Unit
450 W. State Street – 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
phone: (208) 334-5500
fax: (208) 334-6558
email: dhwrules@dhw.idaho.gov

THE FOLLOWING NOTICE PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 56-202, 56-203, and 56-209, Idaho Code.

PUBLIC HEARING SCHEDULE: A public hearing concerning this rulemaking will be held as follows:

VIRTUAL TELECONFERENCE Via WebEx
Thursday, September 14, 2023 **9:00 a.m. - 11:00 a.m. (MT)**
Join from the meeting link **https://idhw.webex.com/idhw/j.php?MTID=mc5b44d8b37e5b0346b1d8ae2d5fa4a5a** **Join by meeting number** **Meeting number (access code): 2761 320 9796** **Meeting password: JwjXEgVJ822 (59593485 from phones and video systems)** **Join by phone** **+1-415-527-5035 United States Toll** **+1-303-498-7536 United States Toll (Denver)**

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

Under Executive Order 2020-01: Zero-Based Regulation, the Department is striving to prevent the accumulation of costly, ineffective, and outdated regulations and reduce regulatory burden to achieve a more efficient operation of government. The rule changes are intended to perform a comprehensive review of this chapter by collaborating with the public to streamline or simplify this rule language.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased:

This chapter contains no fees or charges.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year as a result of this rulemaking:

This rulemaking is not anticipated to have any fiscal impact on the State General Fund, or any other known funds.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the April 5, 2023, Idaho Administrative Bulletin, Vol. 23-4, pages 31 and 32.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into this rule:

There are no incorporations by reference in this chapter of rules.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Laura Schumaker at 208-799-4335.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before September 27, 2023.

DATED this 4th day of August, 2023.

THE FOLLOWING IS THE TEXT OF ZBR DOCKET NO. 16-0301-2301

16.03.01 – ELIGIBILITY FOR HEALTH CARE ASSISTANCE FOR FAMILIES AND CHILDREN

000. LEGAL AUTHORITY.
Sections 56-202, 56-203, 56-209, 56-239, 56-250, 56-253, 56-255, 56-256 and 56-257, Idaho Code, authorize the Department to adopt and enforce rules for the administration of Title XIX of the Social Security Act (Medicaid), and Title XXI of the Social Security Act. ( )

001. WRITTEN INTERPRETATIONS.
The Department has written statements that pertain to the interpretation of, or documentation of compliance with, these rules. The documents are available for public inspection and copying at cost at the Department or at any of its Regional Offices. ( )

002. -- 009. (RESERVED)

010. DEFINITIONS (A THROUGH L).

01. Advanced Payment of Premium Tax Credit. Payment of federal tax credits specified in 26 USC Part 36B (as added by Section 1401 of the Affordable Care Act) which are provided on an advance basis to an eligible individual enrolled in a Qualified Health Plan (QHP) through an exchange under Sections 1402 and 1412 of the Affordable Care Act. ( )

02. Adult. Any individual who has passed the month of their nineteenth birthday. ( )

03. Affordable Care Act. The Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (P L 111-152). ( )

04. Applicant. A person applying for public assistance from the Department, including individuals referred to the Department from a Health Insurance Exchange or Marketplace. ( )

05. Application. An application for benefits including an Application for Assistance (AFA) or other application recognized by the Department, including referrals from a Health Insurance Exchange or Marketplace. ( )

06. Application Date. The date the Application for Assistance (AFA) is received by the Department or by the Health Insurance Exchange or Marketplace electronically, telephonically, in person, or the date the application is postmarked, if mailed. ( )

07. Caretaker Relative. A relative of a child by full- or half-blood, adoption, or marriage with whom the child is living and who assumes primary responsibility for the child's care. A caretaker relative includes a child's natural, adoptive, or step-parents, grandparents, siblings, aunt, uncle, niece, nephew, or cousin. ( )

08. Child. Any individual from birth through the end of the month of their nineteenth birthday. ( )

09. Citizen. A person having status as a "national of the United States" defined in 8 USC 1101(a)(22)that includes both citizens of the United States and non-citizen nationals of the United States. ( )

10. Cost-Sharing. A participant payment for a portion of Medicaid service costs such as deductibles, co-insurance, or co-payment amounts. ( )

11. Creditable Health Insurance. Coverage that provides benefits for inpatient and outpatient hospital services and physicians' medical and surgical services. Creditable coverage excludes liability, limited scope dental, vision, specified disease, or other supplemental-type benefits. ( )

12. Department. The Idaho Department of Health and Welfare or its designee. ( )

13. Federal Poverty Guidelines (FPG). Issued annually by the Department of Health and Human Services (HHS).TheFPG are available on the U.S. Health and Human Services website at http://aspe.hhs.gov/poverty. ( )

14. Health Assessment. An examination performed by a primary care provider in order to determine the appropriate health plan for a Medicaid-eligible individual. ( )

15. Health Care Assistance (HCA). Health coverage that includes Medicaid coverage under Title XIX or Title XXI and private health insurance plans purchased with a Premium Tax Credit described in Subsection 010.01 of this rule granted by the Department for persons or families within Idaho. ( )

16. Health Insurance Premium Program (HIPP). The Premium Assistance program in which Title XIX and Title XXI participants may participate. ( )

17. Health Plan. A set of health services paid for by Idaho Medicaid, or health insurance coverage obtained through the Health Insurance Exchange or Marketplace. ( )

18. Health Questionnaire. A tool used to assist Department staff in determining the correct Health Plan for the Medicaid applicant. ( )

19. Internal Revenue Code. The federal tax law used to determine eligibility under Title 26 USC for individual income and self-employment income. ( )

20. Internal Revenue Service (IRS). The US government agency in charge of tax laws. These laws are used to determine income eligibility. The IRS website is at http://www.irs.gov. ( )

21. Insurance Affordability Programs. Include Title XIX, Title XXI, and all insurance programs available in the Health Insurance Exchange or Marketplace. ( )

22. Lawfully Present. An individual who is a qualified non-citizen under Section 221 of these rules. ( )

011. DEFINITIONS (M THROUGH Z).

01. MAGI-Based Income. Income calculated using the same financial methodologies used by the IRS to determine modified adjusted gross income (MAGI) for federal tax filers, with the following exceptions: ( )

a. Educational income under Section 382 of these rules; ( )

b. Indian monies excluded by federal law are not included in MAGI-based income; ( )

c. Lump sum income is counted only in the month received under Section 384 of these rules; and ( )

d. For Medicaid applicants, MAGI-based income is calculated based on income received in the month of application. ( )

02. Medicaid. Idaho's Medical Assistance Program administered by the Department and funded with federal and state funds under Title XIX of the Social Security Act that provides medical care for eligible individuals. ( )

03. Modified Adjusted Gross Income (MAGI). Adjusted Gross Income as defined by the IRS, plus certain tax-exempt income. ( )

04. Newborn Deemed Eligible. A child born to a woman who is eligible for and receiving medical assistance on the date of the child's birth, including during a month of retroactive eligibility for the mother. A child born under these conditions is eligible for Medicaid for the first year of their life. ( )

05. Non-Citizen. Same as "alien" under Section 101(a)(3) of the Immigration and Nationality Act (INA) (8 USC 1101 (a)(3)), and includes any individual who is not a citizen or national of the United States. ( )

06. Parent. For a household with a MAGI-based eligibility determination a parent can be: ( )

a. Natural; ( )

b. Biological; ( )

c. Adoptive; or ( )

d. Stepparent. ( )

07. Participant. An individual who is eligible for, and enrolled in, a Health Care Assistance program. ( )

08. Qualified Hospital. Has a Memorandum of Understanding (MOU) with the Department, participates as a provider under the Medicaid State Plan, may assist individuals in completing and submitting applications for health coverage, and has not been disqualified from doing presumptive eligibility determinations. ( )

09. Qualified Non-Citizen. Same as "qualified alien" under 8 USC164(b) and (c). ( )

10. Reasonable Opportunity Period. A period allowed for an individual to provide requested proof of citizenship or identity. A reasonable opportunity period extends for ninety (90) days beginning on the 5th day after the notice requesting the proof has been mailed to the applicant. This period may be extended if the Department determines that the individual is making a good faith effort to obtain necessary documentation. ( )

11. Sibling. For household with MAGI-based eligibility determination, a natural or biological, adopted, half- or stepsibling. ( )

12. Tax Dependent. A person, who is a related child, or other qualifying relative or person, under federal IRS standards for whom another individual can claim a deduction for a personal exemption when filing a

federal income tax for a taxable year. ( )

13. **Third-Party**. Includes a person, institution, corporation, public or private agency that is liable to pay all or part of the medical cost of injury, disease, or disability of a medical assistance participant. ( )

14. **Title XIX of the Social Security Act**. Also known as Medicaid, is a medical benefits program jointly financed by the federal and state governments and administered by the States. This program pays for medical assistance for certain individuals and families with low income, and for some program types, limited resources. ( )

15. **Title XXI of the Social Security Act**. Also known as the Children's Health Insurance Program (CHIP), is a federal and state partnership similar to Medicaid that expands health insurance to targeted, low-income children. ( )

012. -- 099. (RESERVED)

APPLICATION REQUIREMENTS
(Sections 100-199)

100. PARTICIPANT RIGHTS.

The participant has rights protected by federal and state laws and Department rules. The Department will inform participants of the following rights during the application process and eligibility reviews. ( )

01. **Right to Apply**. Any person has the right to apply for any Health Care Assistance program. Applications may be submitted by paper, electronically, fax, or telephonically. Application information must be in a form or format provided by the Department. ( )

02. **Right to Hearing**. Any participant can request a hearing to contest a Department decision under IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Ruling." ( )

03. **Right to Request Reinstatement of Benefits**. Any participant has the right to request reinstatement of benefits until a hearing decision is made if the request for the reinstatement is made before the effective date of the action taken on the notice of decision. Reinstatement pending a hearing decision is not provided if an application is denied because an individual did not provide citizenship or identity documentation during a reasonable opportunity period allowed by the Department. ( )

101. -- 110. (RESERVED)

111. SIGNATURES.

An individual who is applying for benefits, receiving benefits, or providing additional information as required by these rules, may do so with the depiction of the individual's name either handwritten, electronic, or recorded telephonically. Such signature serves as intention to execute or adopt the sound, symbol, or process for the purpose of signing the related record. ( )

112. -- 129. (RESERVED)

130. APPLICATION TIME LIMITS.

Each application will be processed as close to real time as practicable, but not longer than forty-five (45) days, from the date of application, unless prevented by events beyond the Department's control. ( )

131. -- 139. (RESERVED)

140. ELIGIBILITY EFFECTIVE DATES.

Title XIX and Title XXI coverage begins the first day of the application month. Coverage for a newborn is effective the date of birth. ( )

141. -- 149. (RESERVED)

150. RETROACTIVE MEDICAL ASSISTANCE ELIGIBILITY.
Title XIX and Title XXI can begin up to three (3) calendar months before the application month if the participant is eligible during the prior period. Coverage is provided if services that can be paid by Medicaid were received in the prior period. ( )

151. -- 199. (RESERVED)

NON-FINANCIAL REQUIREMENTS
(Sections 200-299)

200. NON-FINANCIAL CRITERIA FOR DETERMINING ELIGIBILITY.
Non-financial criteria are conditions of eligibility, other than income, that must be met before Health Care Assistance can be authorized. ( )

201. -- 209. (RESERVED)

210. RESIDENCY.
The participant must live in Idaho and have no immediate intention of leaving, including an individual who has entered the state to look for work, or who has no permanent, fixed address. ( )

211. -- 219. (RESERVED)

220. U.S. CITIZENSHIP VERIFICATION.

01. Citizenship Verified. Citizenship must be verified through electronic means when available. If an electronic verification is not immediately obtainable, the Department may request documentation from the applicant. The Department will not deny the application for health coverage until the applicant has had a reasonable opportunity period to obtain and provide the necessary proof of US citizenship. ( )

02. Benefits During Reasonable Opportunity Period. Benefits are provided during the reasonable opportunity period that is provided to allow the applicant time to obtain and provide documentation to verify U.S. citizenship. No overpayment exists for the reasonable opportunity period if the applicant does not provide necessary documentation during the reasonable opportunity period so that the application results in denial. ( )

221. U.S. CITIZENSHIP AND QUALIFIED NON-CITIZEN REQUIREMENTS.
Any individual who participates in Medicaid benefits must provide proof of US citizenship unless they have otherwise met the requirements under 42 CFR 435.406 Citizenship and Non-Citizen Eligibility. ( )

222. -- 249. (RESERVED)

250. EMERGENCY MEDICAL CONDITION.
An individual who meets eligibility criteria for a category of assistance but does not meet US citizenship requirements or eligible non-citizen requirements may receive medical assistance under a Title XIX or Title XXI coverage group as follows: ( )

01. Emergency Medical Conditions. An individual not meeting the US citizenship requirement may receive medical services necessary to treat an emergency medical condition, including labor and delivery. Emergency medical conditions have acute symptoms of severity, including severe pain. ( )

02. Determination of Emergency Medical Conditions. The Department determines if a condition meets criteria of an emergency medical condition. ( )

03. Limitation on Medical Assistance. Medical assistance is limited to the period established for the emergency medical condition. ( )

04. Documentation Waived. For undocumented individuals with emergency medical conditions, the

Social Security Number (SSN) requirement is waived because an SSN cannot be issued. Individuals must be otherwise eligible for Title XIX or XXI. ( )

251. SPONSOR DEEMING.
Income of a legal non-citizen's sponsor and the sponsor's spouse are counted in determining eligibility. ( )

252. SPONSOR RESPONSIBILITY.
Section 213 of the Immigration and Naturalization Act requires that a sponsor signing Form I-864, Affidavit of Support, reimburse the Department for Health Care Assistance benefits paid for a sponsored, qualified non-citizen. ( )

253. -- 269. (RESERVED)

270. SOCIAL SECURITY NUMBER (SSN) REQUIREMENT.

01. SSN Required. An applicant must provide their SSN, or proof they have applied for an SSN, to the Department before approval of eligibility. If the applicant has more than one (1) SSN, all numbers must be provided. ( )

a. The SSN must be verified by the Social Security Administration (SSA) electronically. When an SSN is unverified, the applicant is not eligible for Health Care Assistance. ( )

b. The Department will notify the applicant in writing if eligibility is being denied or lost for failure to meet the SSN requirement. ( )

02. Application for SSN. The applicant must apply for an SSN, or a duplicate SSN when they cannot provide their SSN to the Department. If the SSN has been applied for, but not issued by the SSA, the Department cannot deny, delay, or stop benefits. The Department will help an applicant with required documentation when the applicant applies for an SSN. ( )

03. Failure to Apply for SSN. The applicant may be granted good cause for failure to apply for an SSN if they have a well-established religious objection to applying for an SSN. A well-established religious objection means the applicant: ( )

a. Is a member of a recognized religious sect or division of the sect; and ( )

b. Adheres to the tenets or teachings of the sect, or division of the sect, and for that reason is conscientiously opposed to applying for or using a national identification number. ( )

04. SSN Requirement Waived. An applicant may have the SSN requirement waived when they are: ( )

a. Only eligible for emergency medical services under Section 250 of these rules; or ( )

b. A newborn deemed eligible child under Section 530 of these rules. ( )

271. -- 279. (RESERVED)

280. GROUP HEALTH PLAN ENROLLMENT.
Title XIX and Title XXI participants must apply for and enroll in a cost-effective group health plan if one is available. A cost-effective health plan is one which has premiums and co-payments at a lower cost than Medicaid would pay for full medical services. Medicaid will pay premiums and other co-payments for plans the Department finds cost-effective. ( )

281. MEDICAL EXCEPTION FOR INMATES.
An inmate can receive Medicaid while they are an inpatient in a medical facility, and must meet all Medicaid eligibility requirements. ( )

282. -- 289. (RESERVED)

290. ASSIGNMENT OF RIGHTS TO MEDICAL SUPPORT AND THIRD-PARTY LIABILITY.
Under Sections 56-203B and 56-209b(3), Idaho Code, medical support rights are assigned to the Department by signature on the application for assistance. The participant must cooperate to secure medical support from any liable third-party. The cooperation requirement may be waived if the participant has good cause for not cooperating. ( )

291. MEDICAL SUPPORT COOPERATION.
A Medicaid participant responsible for assigning their rights to medical support must cooperate to identify and locate the noncustodial parent, establish paternity, and establish, modify, and enforce a medical support order. ( )

01. Cooperation Defined. Cooperation includes providing all information to identify and locate the non-custodial parent and identify other liable third party-payers. The participant must provide the first and last name of the non-custodial parent, and at least two (2) of the following pieces of information about the non-custodial parent: ( )

a. Birth-date; ( )

b. SSN; ( )

c. Current address; ( )

d. Current phone number; ( )

e. Current employer; ( )

f. Make, model, and license number of any motor vehicle owned by the non-custodial parent; or ( )

g. Names, phone numbers, and addresses of the parents of the non-custodial parent. ( )

02. Good Cause Defined. The participant may claim good cause for failure to cooperate in securing medical support for a minor child. Good cause is limited to the following: ( )

a. Proof the child was conceived because of incest or rape; ( )

b. Proof the child's non-custodial parent may inflict physical or emotional harm to the participant, the child, the custodial parent, or the caretaker relative; ( )

c. A credible explanation is provided showing the participant cannot provide the minimum information regarding the non-custodial parent; or ( )

d. A participant who has good cause for not cooperating under Subsection 291.03.b of this rule. ( )

03. Conditions for Non-Denial of Medicaid. Medicaid cannot be denied for individuals who meet one (1) of the following conditions: ( )

a. A child or unmarried minor child who cannot legally assign their rights to medical support; or ( )

b. A pregnant woman whose income is at or below the FPG, and who does not cooperate in establishing paternity and obtaining medical support from, or derived from, the father of the unborn child. ( )

292. -- 295. (RESERVED)

296. COOPERATION WITH THE QUALITY CONTROL PROCESS.
When the Department or federal government selects a case for review in the quality control process, the participant must cooperate in the review of the case. ( )

297. -- 299. (RESERVED)

FINANCIAL REQUIREMENTS
(Sections 300-344)

300. HOUSEHOLD COMPOSITION AND FINANCIAL RESPONSIBILITY.
Household composition and financial responsibility are divided into two (2) categories: tax-filing and non-tax filing households. ( )

301. TAX FILING HOUSEHOLD.

01. Taxpayers. For an individual filing a federal tax return for the taxable year in which an initial determination or redetermination of eligibility is made, and who is not claimed as a tax dependent by another taxpayer, the tax filing household consists of the taxpayer, the taxpayer's spouse, and the taxpayer's tax dependents. ( )

02. Individuals Claimed as a Tax-Dependent. For an individual who is claimed as a tax dependent by another taxpayer, the tax filing household is the household of the taxpayer claiming such individual as a tax dependent, except when tax dependents meeting any of the following criteria will be treated as non-filers under Section 302 of these rules. Individuals: ( )

a. Claimed as a tax dependent by an individual other than a spouse or custodial parent; ( )

b. Under age nineteen (19) living with both parents, if the parents are not married, or married filing separately; and ( )

c. Under age nineteen (19) claimed as a tax dependent by a parent residing outside of the applicant household. ( )

03. Married Couples. For married couples living together, each spouse is included in the household of the other spouse, regardless of whether a joint federal tax return is filed, if one (1) spouse is claimed as a tax dependent by the other spouse, or if each filed separately. ( )

302. NON-TAX FILING HOUSEHOLD.

01. Individuals Not Filing a Tax Return and Not Claimed as a Tax Dependent. For an individual who does not expect to file a federal tax return and is not claimed as a tax dependent by a tax filer, or meets one (1) of the exceptions in this rule, the household consists of the individual and, if living with the individual the following: ( )

a. The individual's spouse; ( )

b. The individual's natural, adopted, and stepchildren under age nineteen (19); or ( )

c. If individuals are under age nineteen (19), the individual's natural, adopted, and step parents and natural, adoptive, and step siblings under age nineteen (19). ( )

02. Married Couples. Married couples living together will be included in the household of the other spouse. ( )

303. -- 344. (RESERVED)

INCOME
(Sections 345-394)

345. HOUSEHOLD INCOME.
The sum of calculated MAGI-based income of every individual whose income must be included in the household budget minus a standard disregard in the amount of five percent (5%) of federal poverty guidelines by family size, if the disregard is used to establish eligibility. ( )

346. DETERMINING INCOME ELIGIBILITY.
Financial eligibility for Medicaid applicants will be based on calculated monthly household income and household size. Eligibility for Health Care Assistance is determined by comparing the individual's calculated income against the income limit. ( )

347. EARNED INCOME.
Earned income is derived from labor or active participation in a business. Earned income includes taxable wages, tips, salary, commissions, bonuses, self-employment, and any other type of income defined as earnings by the Internal Revenue Service (IRS). Earned income is counted as income when it is received, or would have been received, except for the decision of the participant to postpone receipt. Earnings over a period of time and paid at one (1) time, such as the sale of farm crops, livestock, or poultry are annualized, and IRS-allowable self-employment expenses deducted. ( )

348. DEPENDENT CHILD'S EARNED INCOME.
A dependent child's earned income is excluded, unless the child is required to file a tax return based on his own income. ( )

349. (RESERVED)

350. IN-KIND INCOME.
An individual who receives a service, benefit, or durable goods instead of wages is earning in-kind income. In-kind income is excluded. ( )

351. SELF-EMPLOYMENT EARNED INCOME.
Income from self-employment is treated as earned income. Calculated self-employment income is the taxable self-employment income after gross receipts and the IRS allowable costs of producing the self-employment income, when the self-employment is expected to continue under Title 26, U.S.C. ( )

352. -- 369. (RESERVED)

370. UNEARNED INCOME.
Unearned income is any income the individual receives that is not gained through employment. Unearned income is not excluded income if it is taxable. ( )

371. – 383. (RESERVED)

384. LUMP SUM INCOME.
A non-recurring lump sum payment is income in the month the lump sum is received. Lump sum income is a retroactive monthly benefit or a windfall payment. The lump sum may be earned or unearned income that is paid in a single sum. Lump sum income includes retirement, survivors, and disability insurance (RSDI), severance pay, disability insurance, and lottery winnings. ( )

385. -- 387. (RESERVED)

388. DEPENDENT CHILD'S UNEARNED INCOME.
A child's unearned income is countable towards their household's eligibility, only when the child must file a tax return based on their own income. ( )

389. -- 394. (RESERVED)

DISREGARDS
(Section 395-399)

395. INCOME DISREGARDS.
A standard disregard in the amount of five percent (5%) of federal poverty guidelines by family size is applied to the calculated income of an individual in those situations where the application of the disregard is necessary in order for the individual to be eligible for the highest income limit health care coverage for which they may be eligible. ( )

396. -- 399. (RESERVED)

HEALTH COVERAGE FOR ADULTS
(Sections 400-499)

400. MEDICAID FOR ADULTS.
Medicaid is available for the following adults: ( )

01. Parent, Caretaker Relative, or a Pregnant Woman. The individual who: ( )

a. Is a parent, caretaker relative, or a pregnant woman in the household budget unit. ( )

b. Is responsible for an eligible dependent child, which includes the unborn child of a pregnant woman. ( )

c. Lives in the same household with the eligible dependent child. ( )

02. Adults Under Age 65. The individual must: ( )

a. Be age nineteen (19) or older and under age sixty-five (65); ( )

b. Not entitled to or enrolled in Medicare Part A or Part B; and ( )

c. Not otherwise eligible for any other coverage under the State Plan. ( )

03. MAGI Income Eligibility. For any of the eligibility groups under Subsections 400.01 and 02, the individual must meet all income requirements of the Medicaid program for eligibility determined under MAGI methodologies identified in Sections 300 through 303, and 411 of these rules. Eligibility is based on: ( )

a. The number of members included in the household budget unit; ( )

b. All countable income for the household budget unit; and ( )

c. Eligible individuals will have income calculated using their MAGI. Individuals with MAGI not greater than one hundred thirty-three per cent (133%) after applying a five per cent (5%) disregard to income are eligible to receive Medicaid in this rule. ( )

04. Member of More Than One Budget Unit. No person may receive benefits in more than one (1) budget unit during the same month. ( )

05. More Than One Medicaid Budget Unit in Home. If there is more than one (1) Medicaid budget unit in a home, each budget unit is considered a separate unit. ( )

401. -- 410. (RESERVED)

411. INCOME LIMITS FOR PARENTS AND CARETAKER RELATIVES.
The income limits are based on the number of household budget unit members. Parents and caretaker relatives, whose MAGI-based income does not exceed the guidelines listed in the table below for their household size, meet the

income limit for parent and caretaker relative Medicaid.

TABLE 411 INCOME LIMITS	
Number of Household Members	**Income Limit**
1	$233
2	$289
3	$365
4	$439
5	$515
6	$590
7	$666
8	$741
9	$816
10	$982
Over 10 Persons	Add $75 Each

( )

412. -- 418. (RESERVED)

419. TRANSITIONAL MEDICAID FOR PARENT CARETAKER ADULTS.
Participants who no longer qualify for Medicaid due to an increase in earned income or working hours are eligible for an additional twelve (12) months of Medicaid. Participants must have been eligible for Medicaid during at least three (3) of the six (6) months immediately preceding the month in which the participant became ineligible. ( )

420. EXTENDED MEDICAID FOR SPOUSAL PARENT CARETAKER SUPPORT INCREASE.
Participants are eligible for four (4) calendar months of Extended Medicaid if an increase in the participant's spousal support causes them to exceed the income limit for their household budget unit size. The participant must have received Medicaid in Idaho in at least three (3) of the six (6) months before the month the participant became income ineligible. ( )

421. PREGNANT WOMAN INELIGIBLE BECAUSE OF EXCESS INCOME.
A pregnant woman who receives Health Care Assistance and becomes ineligible because of an increase in income will continue to receive coverage through the end of the month in which the sixtieth day of her postpartum period falls. ( )

422. -- 519. (RESERVED)

HEALTH COVERAGE FOR CHILDREN
(Sections 520-529)

520. FINANCIAL ELIGIBILITY.
Children are eligible for Health Care Assistance when the household's total MAGI-based income minus a standard disregard in the amount of five percent (5%) of FPG by family size is less than or equal to the applicable income limit for the age of the child. ( )

01. Title XIX Income Limit. For children age zero (0) to six (6), Title XIX income limit is one hundred forty-two percent (142%) of the FPG for the household size. For children age six (6) through age eighteen (18) the income limit is one hundred thirty three percent (133%) of the FPG for the household size. ( )

02. Title XXI Income Limit. For children age zero (0) to six (6), Title XXI income limit is between one hundred forty-two percent (142%) and one hundred eighty-five percent (185%) of the FPG for the household size. For children ages six (6) through eighteen (18) the income limit is between one hundred thirty-three percent (133%) and one hundred eighty five percent (185%) of the FPG for the household size. ( )

03. Disregard Applied. A standard disregard in the amount of five percent (5%) of FPG by family size is applied to the calculated income used to establish the child's eligibility when applying the disregard is necessary for the child to be financially eligible. ( )

521. HOUSEHOLD SIZE AND FINANCIAL RESPONSIBILITY.
Household size and financial responsibility for health coverage for children is determined using the methodology under Section 300 of these rules. ( )

522. (RESERVED)

523. ACCESS TO OR COVERAGE UNDER OTHER HEALTH PLANS.
A child is ineligible for coverage under the CHIP plan if they have access to or are enrolled in other health coverage plans as described below: ( )

01. Covered by Creditable Health Insurance. The child is covered by creditable health insurance at the time of application. ( )

02. Child is Eligible under Idaho's Title XIX State Plan. ( )

03. Idaho State Employee Benefit Plan. The child is eligible to receive health insurance benefits under Idaho's State employee benefit plan. ( )

524. CONTINUOUS HEALTH CARE ASSISTANCE ELIGIBILITY FOR CHILDREN UNDER AGE NINETEEN.
Children under age nineteen (19), who are found eligible for health coverage in an initial determination or at renewal, remain eligible for a period of twelve (12) months. The twelve (12) month continuous eligibility period does not apply if, for any reason, eligibility was determined incorrectly. ( )

01. Reasons Continuous Eligibility Ends. ( )

a. The child is no longer an Idaho resident; ( )

b. The child dies; ( )

c. The participant requests closure; or ( )

d. The child turns nineteen (19) years old under Subsection 010.05 of these rules. ( )

02. Reasons Children are not Eligible for Continuous Eligibility. ( )

a. A child is approved for emergency medical services; or ( )

b. A child is approved for pregnancy-related services. ( )

525. FORMER FOSTER CHILD.
An individual who is between the age of eighteen (18) and twenty-six (26), who was in foster care and became ineligible for Medicaid as a foster child due to age, may receive Medicaid coverage until their twenty-sixth birthday. There are no financial eligibility criteria. The only non-financial criteria are the receipt of foster care services and age. ( )

526. -- 529. (RESERVED)

SPECIAL CIRCUMSTANCES FOR CHILDREN
(Sections 530-549)

530. NEWBORN CHILD DEEMED ELIGIBLE FOR MEDICAID.
A child is deemed eligible for Medicaid for their first year of life when the following exists. ( )

01. Mother Filing an Application. The child is born to a mother who files an application for medical assistance. ( )

02. Mother Is Eligible for Medicaid. The mother is eligible for Medicaid in the newborn's birth month, including a month of retroactive coverage. This includes a mother who qualifies for coverage only for the delivery because of her alien status. ( )

531. MINOR PARENT LIVING WITH PARENTS.
A minor parent is a child under the age of eighteen (18) who is pregnant or has a child. Minor parents who live with their parents may be eligible for Health Care Assistance for themselves and their children. The minor parent's eligibility is determined under Section 300 of these rules related to tax filing households. ( )

532. RESIDENT OF AN ELIGIBLE INSTITUTION.
A resident of an eligible institution must meet all non-financial and financial criteria of Title XIX, Title XXI, or any other applicable program. ( )

533. CHILDREN WITH SPECIAL CIRCUMSTANCES AND MEDICAID.
Children who receive foster care or are in adoptive placements are eligible for Medicaid. The children must meet non-financial criteria and the financial requirements described for the children's coverage group. ( )

534. (RESERVED)

535. TITLE IV-E FOSTER CARE CHILD.
A child may be eligible for Medicaid under the Title IV-E foster care program if they meet the eligibility requirements in IDAPA 16.06.01, "Child and Family Services," Section 425. ( )

536. -- 539. (RESERVED)

540. YOUTH EMPOWERMENT SERVICES (YES) PROGRAM CHILDREN.

01. Payments for Children Under Eighteen (18) Years Old with SED. Under Section 56-254(2), Idaho Code, the Department will make payments for medical assistance for a child under eighteen (18) years old with serious emotional disturbance (SED), as defined in Section 16-2403, Idaho Code, and verified by an independent assessment: ( )

a. Whose family income does not exceed three hundred percent (300%) of the FPG as determined using MAGI-based eligibility standards; or ( )

b. Who meets other Title XIX Medicaid eligibility standards under the rules of the Department. ( )

02. Youth Empowerment Services (YES) Benefits. Applicants whose family income is equal to or less than three hundred percent (300%) of the FPG for children zero (0) to eighteen (18) years old and who meet the non-financial eligibility criteria in Sections 200 through 299 of these rules may receive the following benefits: ( )

a. YES State Plan option services and supports under IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Sections 635 through 638; and ( )

b. Additional covered services under IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Sections

075 through 799. ( )

03. Additional Eligibility Criteria and Program Requirements for YES. Additional eligibility criteria and program requirements applicable to the YES State Plan option are under IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Sections 635 through 638. ( )

541. -- 544. (RESERVED)

545. PRESUMPTIVE ELIGIBILITY FOR CHILDREN AND ADULTS.
Presumptive eligibility determination for qualifying medical coverage groups can only be provided by a qualified hospital defined in Section 011 of these rules. ( )

01. Presumptive Eligibility Decisions. Decisions of presumptive eligibility can be made for individuals who meet program requirements for MAGI-based Medicaid coverage. ( )

02. Presumptive Eligibility Determination. Presumptive eligibility determinations are made by a qualified hospital when an individual receiving medical services is not covered by health care insurance and the financial assessment by hospital staff indicates the individual is eligible for Medicaid coverage in Idaho. This determination is made by hospital staff through an online presumptive application process: ( )

a. Prior to completion of a full Medicaid application; and ( )

b. Prior to a determination being made by the Department on the full application. ( )

03. Presumptive Eligibility Period. The presumptive eligibility period begins on the date the presumptive application is filed online and ends with the earlier of the following: ( )

a. The date the full eligibility determination is completed by the Department; or ( )

b. The end of the month after the month the qualified hospital completed the presumptive eligibility determination. ( )

546. QUALIFIED HOSPITAL PRESUMPTIVE ELIGIBILITY PROCESSES.
A qualified hospital must have a Memorandum of Understanding (MOU) with the Department and follow all standards and processes agreed to in the MOU. ( )

01. Acceptance of Application. The qualified hospital accepts the request for services in the same manner as all applications for assistance are accepted. ( )

02. Standards and Processes. The presumptive eligibility determination must be based on standards and processes provided by the Department. ( )

03. Assistance to Applicant. The qualified hospital must assist the applicant in completing the Department's application process. ( )

04. Qualified Hospital Staff. Only qualified hospital staff who are trained in presumptive eligibility standards can make a presumptive eligibility determination. ( )

05. Notice to Applicant. The qualified hospital or the Department will provide notice to the applicant within two (2) business days on the presumptive eligibility determination. ( )

06. Notice and Hearing Rights. Presumptive eligibility decisions are not appealable and do not have hearing rights under the Title XIX Medicaid program. ( )

07. Number of Presumptive Eligibility Periods Allowed. Only one (1) presumptive eligibility period is allowed per applicant in any twelve (12) month period. ( )

547. -- 599. (RESERVED)

CASE MAINTENANCE REQUIREMENTS
(Sections 600-701)

600. ANNUAL ELIGIBILITY RENEWAL.
Participants must have an annual eligibility review of all eligibility factors. Exceptions to the annual eligibility renewal are listed in Section 601 of these rules. ( )

01. Continuing Eligibility. Is determined using available electronic verification sources without participant contact, unless information: ( )

a. Is not available; ( )

b. Sources provide conflicting information; or ( )

c. Is inconsistent with information provided by the participant. ( )

02. Inconsistency Impacts Eligibility. When inconsistency exists from electronic verification sources that impact participant eligibility, information must be verified by the participant. The Department provides the participant a document that displays household information currently being used to establish eligibility and asks the participant to verify correctness, and if not correct to provide updated information. ( )

601. EXCEPTIONS TO ANNUAL RENEWAL.
A participant who receives Title XIX or Title XXI through time-limited coverage does not require an annual renewal when the following exists. ( )

01. Extended Medicaid. A participant who receives extended Medicaid is eligible under Section 420 of these rules. ( )

02. Pregnant Woman. A pregnant woman of any age is eligible for the Pregnant Woman coverage if she meets all the non-financial and financial criteria of the coverage group. Coverage includes services as described in IDAPA 16.03.09, "Medicaid Basic Plan Benefits." The Pregnant Woman medical assistance coverage extends through the sixty (60) day postpartum period if she applied for medical assistance while pregnant and was receiving medical assistance when the child was born. An individual who applies for Pregnant Woman medical assistance after the child is born is not eligible for the sixty-day (60) postpartum period. ( )

03. Newborn Child of Medicaid-Eligible Mother. A participant receiving Medicaid as the newborn child of a Medicaid-eligible mother is eligible under Section 530 of these rules. ( )

602. -- 609. (RESERVED)

610. REPORTING REQUIREMENTS.
Changes in family circumstances must be reported to the Department by the tenth of the month following the month in which the change occurred. Report of changes may be made verbally, in writing, through personal contact, telephone, fax, electronic mail, or mail. ( )

611. TYPES OF CHANGES THAT MUST BE REPORTED.
Changes in circumstances the participant must report are the following: ( )

01. Name or Address. A name change for any participant or a change of address or location. ( )

02. Household Composition. Changes in family composition if a parent or relative caretaker receives Medicaid. ( )

03. Marital Status. Marriages or divorces of any family member if a parent or relative caretaker receives Medicaid. ( )

04. **New SSN**. SSN is newly assigned to a Medicaid Health Care Assistance program participant. ( )

05. **Health Insurance Coverage**. Enrollment or disenrollment of a participant in a health insurance plan. ( )

06. **End of Pregnancy**. Pregnant participants must report when pregnancy ends. ( )

07. **Earned Income**. Changes in the amount or source of earned income if a parent or relative caretaker receives Title XIX benefits. ( )

08. **Unearned Income**. Changes in the amount or source of unearned income if a parent or relative caretaker receives Title XIX benefits. ( )

09. **Support Income**. Changes in the amount of spousal support received by an adult household member. ( )

10. **Disability**. A family member who becomes disabled or is no longer disabled if a parent or relative caretaker receives Title XIX benefits. ( )

612. -- 619. (RESERVED)

620. NOTICE OF CHANGES IN ELIGIBILITY.
The Department will notify the participant of changes in their Health Care Assistance. The notice must give the effective date, the reason for the action, the rule that supports the action, and appeal rights. ( )

621. NOTICE OF CHANGE OF PLAN.
The Department can switch a participant from the Medicaid Basic Plan to the Medicaid Enhanced Plan within the same month. Advance notice must be given to the participant when there is a decrease in their benefits and they will be switched from the Enhanced Plan to the Basic Plan. ( )

622. ADVANCE NOTICE RESPONSIBILITY.
The Department must notify the participant at least ten (10) calendar days before the effective date when a reported change results in Health Care Assistance closure. ( )

623. ADVANCE NOTICE NOT REQUIRED.
Advance notice is not required when a condition under this rule exists. The participant will be notified no later than the date of the action. ( )

01. **The Department has Proof of the Participant's Death**. ( )

02. **The Participant Requests Closure in Writing**. ( )

03. **Participant in Institution**. The participant is admitted or committed to an institution. Further payments to the participant do not qualify for federal financial participation under the State Plan. ( )

04. **Nursing Care**. The participant is placed in a nursing facility or Intermediate Care Facility for Persons with Intellectual Disabilities (ICF/IID). ( )

05. **The Participant's Address is Unknown**. ( )

06. **The Participant is Approved for Medical Assistance in Another State**. ( )

07. **Eligible One Month**. The participant is eligible for aid only during the calendar month of their application for aid. ( )

08. Retroactive Medicaid. The participant's Title XIX or Title XXI eligibility is for a prior period. ( )

624. -- 699. (RESERVED)

700. OVERPAYMENTS.
Health Care Assistance overpayments occur when a participant receives benefits during a month they were not eligible. ( )

701. RECOVERY OF OVERPAYMENTS.
All Health Care Assistance overpayments are subject to recovery. Overpayments are recovered by direct payment from the participant. ( )

01. Notice of Overpayment. The participant must be informed of the Health Care Assistance overpayment and appeal rights. ( )

02. Notice of Recovery. The participant must be informed when their Health Care Assistance overpayment is fully recovered. ( )

702. -- 999. (RESERVED)

[Agency redlined courtesy copy]

Italicized text **indicates changes between the text of the proposed rule as adopted in the pending rule.**

16.03.01 – ELIGIBILITY FOR HEALTH CARE ASSISTANCE FOR FAMILIES AND CHILDREN

000. LEGAL AUTHORITY.
~~In accordance with~~ Sections 56-202, 56-203, 56-209, 56-239, 56-250, 56-253, 56-255, 56-256 and 56-257, Idaho Code, ~~the Idaho Legislature has~~ authorize~~d~~ the Department ~~of Health and Welfare~~ to adopt and enforce rules for the administration of Title XIX of the Social Security Act (Medicaid), and Title XXI of the Social Security Act. ~~(3-17-22)~~( )

~~**001. TITLE AND SCOPE.**~~

~~**01. Title**. These rules are titled IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children."~~ ~~(3-17-22)~~

~~**02. Scope**. These rules provide standards for issuing coverage for Title XIX and Title XXI of the Social Security Act.~~ ~~(3-17-22)~~

00~~2~~1. WRITTEN INTERPRETATIONS.
~~This agency~~ The Department has written statements that pertain to the interpretation of, or documentation of compliance with, these rules ~~of this chapter, or to the documentation of compliance with the rules of this chapter~~. The documents ~~is~~ are available for public inspection and copying at cost at the Department ~~of Health and Welfare~~ or at any of ~~the Department's~~ its Regional Offices. ~~(3-17-22)~~( )

00~~3~~2. -- 009. (RESERVED)

010. DEFINITIONS (A THROUGH L).
~~For the purposes of this chapter, the following terms apply.~~ ~~(3-17-22)~~

01. Advanced Payment of Premium Tax Credit. Payment of federal tax credits specified in 26 U~~.~~S~~.~~C~~.~~ Part 36B (as added by ~~s~~Section 1401 of the Affordable Care Act) which are provided on an advance basis to an eligible individual enrolled in a Qualified Health Plan (QHP) through an exchange~~ in accordance with~~ under ~~s~~Sections 1402 and 1412 of the Affordable Care Act. ~~(3-17-22)~~(   )

02. Adult. Any individual who has passed the month of~~ his~~ their nineteenth birthday. ~~(3-17-22)~~(   )

03. Affordable Care Act. The Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (P~~ub.~~ L~~.~~ 111-152). ~~(3-17-22)~~(   )

04. Applicant. A person applying for public assistance from the Department, including individuals referred to the Department from a Health Insurance Exchange or Marketplace. (   )

05. Application. An application for benefits including an Application for Assistance (AFA) or other application recognized by the Department, including referrals from a Health Insurance Exchange or Marketplace. (   )

06. Application Date. The date the Application for Assistance (AFA) is received by the Department or by the Health Insurance Exchange or Marketplace electronically, telephonically, in person, or the date the application is postmarked, if mailed. (   )

07. Caretaker Relative. A~~ caretaker relative is a~~ relative of a child by full- or half-blood, adoption, or marriage with whom the child is living and who assumes primary responsibility for the child's care. A caretaker relative includes a child’s natural, adoptive, or step-parents, grandparents, siblings, aunt, uncle, niece, nephew, or cousin. ~~(3-17-22)~~(   )

08. Child. Any individual from birth through the end of the month of~~ his~~ their nineteenth birthday. ~~(3-17-22)~~(   )

09. Citizen. A person having status as a “national of the United States” defined in 8 U~~.~~S~~.~~C~~.~~ 1101(a)(22) that includes both citizens of the United States and non-citizen nationals of the United States. ~~(3-17-22)~~(   )

10. Cost-Sharing. A participant payment for a portion of Medicaid service costs such as deductibles, co-insurance, or co-payment amounts. (   )

11. Creditable Health Insurance. ~~Creditable health insurance is c~~Coverage that provides benefits for inpatient and outpatient hospital services and physicians' medical and surgical services. Creditable coverage excludes liability, limited scope dental, vision, specified disease, or other supplemental-type benefits. ~~(3-17-22)~~(   )

12. Department. The Idaho Department of Health and Welfare or its designee. ~~(3-17-22)~~(   )

13. Federal Poverty Guidelines (FPG). ~~The federal poverty guidelines i~~Issued annually by the Department of Health and Human Services (HHS).The~~ Federal Poverty Guidelines (~~FPG~~)~~ are available on the U.S. Health and Human Services website at http://aspe.hhs.gov/poverty. ~~(3-17-22)~~(   )

14. Health Assessment. ~~Health Assessment is a~~An examination performed by a primary care provider in order to determine the appropriate health plan for a Medicaid-eligible individual. ~~(3-17-22)~~(   )

15. Health Care Assistance (HCA). Health coverage that includes Medicaid coverage under Title XIX or Title XXI~~ as well as~~ and private health insurance plans purchased with a Premium Tax Credit described in Subsection 010.01 of this rule granted by the Department for persons or families within~~ the State of~~ Idaho. ~~(3-17-22)~~(   )

16. Health Insurance Premium Program (HIPP). The Premium Assistance program in which Title XIX and Title XXI participants may participate. (   )

17. Health Plan. A set of health services paid for by Idaho Medicaid, or health insurance coverage

obtained through the Health Insurance Exchange or Marketplace. ( )

18. Health Questionnaire. A tool used to assist ~~Health and Welfare~~ Department staff in determining the correct Health Plan for the Medicaid applicant. ~~(3-17-22)~~( )

19. Internal Revenue Code. The federal tax law used to determine eligibility under Title 26 U~~.~~S~~.~~C~~.~~ for individual income and self-employment income. ~~(3-17-22)~~( )

20. Internal Revenue Service (IRS). The U~~.~~S~~.~~ government agency in charge of tax laws. These laws are used to determine income eligibility. The IRS website is at http://www.irs.gov. ~~(3-17-22)~~( )

21. Insurance Affordability Programs. ~~Insurance affordability programs i~~Include Title XIX, ~~t~~Title XXI, and all insurance programs available in the Health Insurance Exchange or Marketplace. ~~(3-17-22)~~( )

22. Lawfully Present. An individual who is a qualified non-citizen ~~as described in~~ under Section 221 of these rules. ~~(3-17-22)~~( )

011. DEFINITIONS (M THROUGH Z).
~~For the purposes of this chapter, the following terms apply.~~ ~~(3-17-22)~~

01. MAGI-Based Income. Income calculated using the same financial methodologies used by the IRS to determine modified adjusted gross income (MAGI) for federal tax filers, with the following exception~~that~~s: ~~(3-17-22)~~( )

a. Educational income ~~is excluded in~~ under Section 382 of these rules; ~~(3-17-22)~~( )

b. Indian monies excluded by federal law are not included in MAGI-based income; ( )

c. Lump sum income is counted only in the month received ~~in~~ under Section 384 of these rules; and ~~(3-17-22)~~( )

d. For Medicaid applicants, MAGI-based income is calculated based on income received in the month of application. ( )

02. Medicaid. Idaho's Medical Assistance Program administered by the Department and funded with federal and state funds ~~according to~~ under Title XIX of the Social Security Act that provides medical care for eligible individuals. ~~(3-17-22)~~( )

03. Modified Adjusted Gross Income (MAGI). ~~Modified Adjusted Gross Income (MAGI), is~~ Adjusted Gross Income as defined by the IRS, plus certain tax-exempt income. ~~(3-17-22)~~( )

04. Newborn Deemed Eligible. A child born to a woman who is eligible for and receiving medical assistance on the date of the child's birth, including during a month of retroactive eligibility for the mother. A child ~~so~~ born under these conditions is eligible for Medicaid for the first year of ~~his~~ their life. ~~(3-17-22)~~( )

05. Non-Citizen. Same as "alien" ~~defined in~~ under Section 101(a)(3) of the Immigration and Nationality Act (INA) (8 U~~.~~S~~.~~C~~.~~ 1101 (a)(3)), and includes any individual who is not a citizen or national of the United States. ~~(3-17-22)~~( )

06. Parent. For a household with a MAGI-based eligibility determination a parent can be: ( )

a. Natural; ( )

b. Biological; ( )

c. Adoptive; or ( )

d. Step~~-~~parent. ~~(3-17-22)~~( )

07. Participant. An individual who is eligible for, and enrolled in, a Health Care Assistance program. ( )

08. Qualified Hospital. ~~A qualified hospital h~~Has a Memorandum of Understanding (MOU) with the Department, participates as a provider under the Medicaid ~~s~~State ~~p~~Plan, may assist individuals in completing and submitting applications for ~~H~~health coverage, and has not been disqualified from doing presumptive eligibility determinations. ~~(3-17-22)~~( )

09. Qualified Non-Citizen. Same as "qualified alien"~~ defined at~~ under 8 U~~.~~S~~.~~ C~~.~~164(b) and (c). ~~(3-17-22)~~( )

10. Reasonable Opportunity Period. A period ~~of time~~ allowed for an individual to provide requested proof of citizenship or identity. A reasonable opportunity period extends for ninety (90) days beginning on the 5th day after the notice requesting the proof has been mailed to the applicant. This period may be extended if the Department determines that the individual is making a ~~"~~good faith~~"~~ effort to obtain necessary documentation. ~~(3-17-22)~~( )

11. Sibling. For household with MAGI-based eligibility determination~~:~~,~~ Is~~ a natural or biological, adopted, half- or step~~-~~sibling. ~~(3-17-22)~~( )

12. Tax Dependent. A person, who is a related child, or other qualifying relative or person,~~ according to~~ under federal IRS standards for whom another individual can claim a deduction for a personal exemption when filing a federal income tax for a taxable year. ~~(3-17-22)~~( )

13. Third-Party. Includes a person, institution, corporation, public or private agency that is liable to pay all or part of the medical cost of injury, disease, or disability of a medical assistance participant. ~~(3-17-22)~~( )

14. Title XIX of the Social Security Act.~~ Title XIX of the Social Security Act,~~ Also known as Medicaid, is a medical benefits program jointly financed by the federal and state governments and administered by the States. This program pays for medical assistance for certain individuals and families with low income, and for some program types, limited resources. ~~(3-17-22)~~( )

15. Title XXI of the Social Security Act.~~ Title XXI of the Social Security Act,~~ Also known as the Children's Health Insurance Program (CHIP), is a federal and state partnership similar to Medicaid~~,~~ that expands health insurance to targeted, low-income children. ~~(3-17-22)~~( )

012. -- 099. (RESERVED)

APPLICATION REQUIREMENTS
(Sections 100-199)

100. PARTICIPANT RIGHTS.
The participant has rights protected by federal and state laws and Department rules. The Department~~ must~~ will inform participants of the following rights during the application process and eligibility reviews. ~~(3-17-22)~~( )

01. Right to Apply. Any person has the right to apply for any Health Care Assistance program. Applications may be submitted by paper, electronically, fax, or telephonically. Application information must be in a form or format provided by the Department. ( )

02. Right to Hearing. Any participant can request a hearing to contest a Department~~ or Health Insurance Exchange or Marketplace~~ decision under~~ the provisions in~~ IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Ruling." ~~(3-17-22)~~( )

03. Right to Request Reinstatement of Benefits. Any participant has the right to request reinstatement of benefits until a hearing decision is made if the request for the reinstatement is made before the

effective date of the action taken on the notice of decision. Reinstatement pending a hearing decision is not provided ~~in the case of~~ if an application is denied because an individual did not provide citizenship or identity documentation during a reasonable opportunity period allowed by the Department. ~~(3-17-22)~~(   )

101. -- 110. (RESERVED)

111. SIGNATURES.
An individual who is applying for benefits, receiving benefits, or providing additional information as required by ~~this chapter~~ these rules, may do so with the depiction of the individual's name either handwritten, electronic, or recorded telephonically. Such signature serves as intention to execute or adopt the sound, symbol, or process for the purpose of signing the related record. ~~(3-17-22)~~(   )

112. -- 129. (RESERVED)

130. APPLICATION TIME LIMITS.
Each application ~~must~~ will be processed as close to real time as practicable, but not longer than forty-five (45) days, from the date of application, unless prevented by events beyond the Department's control. ~~(3-17-22)~~(   )

131. -- 139. (RESERVED)

140. ELIGIBILITY EFFECTIVE DATES.
Title XIX and Title XXI coverage begins the first day of the application month. Coverage for a newborn is effective the date of birth. (   )

141. -- 149. (RESERVED)

150. RETROACTIVE MEDICAL ASSISTANCE ELIGIBILITY.
Title XIX and Title XXI can begin up to three (3) calendar months before the application month if the participant is eligible during the prior period. Coverage is provided if services that can be paid by Medicaid were received in the prior period. (   )

151. -- 199. (RESERVED)

NON-FINANCIAL REQUIREMENTS
(Sections 200-299)

200. NON-FINANCIAL CRITERIA FOR DETERMINING ELIGIBILITY.
Non-financial criteria are conditions of eligibility, other than income, that must be met before Health Care Assistance can be authorized. (   )

201. -- 209. (RESERVED)

210. RESIDENCY.
The participant must live in Idaho and have no immediate intention of leaving, including an individual who has entered the state to look for work, or who has no permanent, fixed address. (   )

211. -- 219. (RESERVED)

220. U.S. CITIZENSHIP VERIFICATION.

01. Citizenship Verified. Citizenship must be verified through electronic means when available. If an electronic verification is not immediately obtainable, the Department may request documentation from the applicant. The Department will not deny the application for ~~H~~health ~~C~~coverage until the applicant has had a reasonable opportunity period to obtain and provide the necessary proof of U~~.~~S~~.~~ citizenship. ~~(3-17-22)~~(   )

02. Benefits During Reasonable Opportunity Period. Benefits are provided during the reasonable opportunity period that is provided to allow the applicant time to obtain and provide documentation to verify U.S.

citizenship. No overpayment exists for the reasonable opportunity period if the applicant does not provide necessary documentation during the reasonable opportunity period so that the application results in denial. ( )

221. U.S. CITIZENSHIP AND QUALIFIED NON-CITIZEN REQUIREMENTS.
~~To be eligible, an individual must be a lawfully present member of one (1) of the following groups:~~Any individual who participates in Medicaid benefits must provide proof of US citizenship unless they have otherwise met the requirements under 42 CFR 435.406 Citizenship and Non-Citizen Eligibility. ~~(3-17-22)~~( )

~~**01.** **U.S. Citizen**. A U.S. Citizen or a "national of the United States." (3-17-22)~~

~~**02.** **Child Born Outside the U.S.** A child born outside the U.S., as defined in Public Law 106-395, is considered a citizen if all of the following conditions are met: (3-17-22)~~

~~**a.** At least one (1) parent is a U.S. Citizen. The parent can be a citizen by birth or naturalization. This includes an adoptive parent; (3-17-22)~~

~~**b.** The child is residing permanently in the U.S. in the legal and physical custody of a parent who is a U.S. Citizen, and the child does not have IR-4 status; (3-17-22)~~

~~**c.** The child is under eighteen (18) years of age; (3-17-22)~~

~~**d.** The child is a lawful permanent resident; and (3-17-22)~~

~~**e.** If the child is an adoptive child, the child was residing in the U.S. at the time the parent was naturalized and was in the legal and physical custody of the adoptive parent. (3-17-22)~~

~~**03.** **Full-Time Active Duty U.S. Armed Forces Member**. A qualified non-citizen as defined in 8 U.S.C. 1641(b) or (c) who is currently on full-time active duty with the U.S. Army, U.S. Air Force, U.S. Marine Corps, U.S. Navy or U.S. Coast Guard, or a spouse or unmarried dependent child of the U.S. Armed Forces member. (3-17-22)~~

~~**04.** **Veteran of the U.S. Armed Forces**. A qualified non-citizen as defined in 8 U.S.C. 1641(b) or (c) who was honorably discharged from the U.S. Army, U.S. Air Force, U.S. Marine Corps, U.S. Navy, or U.S. Coast Guard for a reason other than their citizenship status, or a spouse, including a surviving spouse who has not remarried, or an unmarried dependent child of the veteran. (3-17-22)~~

~~**05.** **Non-Citizen Entering the U.S. Before August 22, 1996**. A non-citizen who entered the U.S. before August 22, 1996, who is currently a qualified non-citizen as defined in 8 U.S.C. 1641(b) or (c), who remained continuously present in the U.S. until he became a qualified non-citizen. (3-17-22)~~

~~**06.** **Non-Citizen Entering on or After August 22, 1996**. A non-citizen who entered the U.S. on or after August 22, 1996, and who is: (3-17-22)~~

~~**a.** A refugee admitted into the U.S. under 8 U.S.C. 1157, and can be eligible for seven (7) years from the date of entry; (3-17-22)~~

~~**b.** An asylee granted asylum into the U.S. under 8 U.S.C. 1158, and can be eligible for seven (7) years from the date asylee status is assigned; (3-17-22)~~

~~**c.** An individual whose deportation or removal from the U.S. has been withheld under 8 U.S.C. 1253 or 1231(b)(3) as amended by Section 305(a) of Division C of Public Law 104-208, and can be eligible for seven (7) years from the date deportation or removal was withheld; (3-17-22)~~

~~**d.** An Amerasian immigrant admitted into the U.S. under 8 U.S.C. 1612(b)(2)(A)(i)(V), and can be eligible for seven (7) years from the date of entry; or (3-17-22)~~

~~**e.** A Cuban or Haitian entrant to the U.S. under Section 501(e) of the Refugee Assistance Act under~~

~~Section 501(e) of P.L. 96-422 (1980), and can be eligible for seven (7) years from the date of entry. (3-17-22)~~

~~**07. Qualified Non-Citizen Entering on or After August 22, 1996**. A qualified non-citizen under 8 U.S.C. 1641(b) or (c), who entered the U.S. on or after August 22, 1996, and who has held a qualified non-citizen status for at least five (5) years. (3-17-22)~~

~~**08. American Indian Born in Canada**. An American Indian born in Canada, under 8 U.S.C. 1359. (3-17-22)~~

~~**09. American Indian Born Outside the U.S.** An American Indian born outside of the U.S., who is a member of a U.S. federally recognized tribe under 25 U.S.C. 450 b(e). (3-17-22)~~

~~**10. Qualified Non-Citizen Child Receiving Federal Foster Care**. A qualified non-citizen child as defined in 8 U.S.C. 1641(b) or (c), and receiving federal foster care assistance. (3-17-22)~~

~~**11. Victim of Severe Form of Trafficking**. A victim of a severe form of trafficking in persons, as defined in 22 U.S.C. 7102(13); who meets one (1) of the following: (3-17-22)~~

~~**a.** Is under the age of eighteen (18) years; or (3-17-22)~~

~~**b.** Is certified by the U.S. Department of Health and Human Services as willing to assist in the investigation and prosecution of a severe form of trafficking in persons; and (3-17-22)~~

~~i. Has made a bona fide application for a temporary visa under 8 U.S.C. 1104(a)(15)(T), which has not been denied; or (3-17-22)~~

~~ii. Is remaining in the U.S. to assist the U.S. Attorney General in the prosecution of traffickers in persons. (3-17-22)~~

~~**12. Afghan Special Immigrant**. An Afghan special immigrant, as defined in Public Law 110-161, who has special immigration status after December 26, 2007. (3-17-22)~~

~~**13. Iraqi Special Immigrant**. An Iraqi special immigrant, as defined in Public Law 110-181, who has special immigration status after January 28, 2008. (3-17-22)~~

~~**14. Individuals not Meeting the Citizenship or Qualified Non-Citizen Requirements**. An individual who does not meet the citizenship or qualified non-citizen requirements in Subsections 221.01 through 221.13 of this rule, may be eligible for emergency medical services if he meets all other conditions of eligibility. (3-17-22)~~

~~**222. U.S. CITIZENSHIP AND IDENTITY VERIFICATION REQUIREMENTS.**~~
~~Any individual who participates in a Title XIX Medicaid or Title XXI CHIP funded program must provide proof of U.S. citizenship and identity unless he has otherwise met the requirements under Section 226 of these rules. (3-17-22)~~

~~**223. DOCUMENTATION OF U.S. CITIZENSHIP.**~~

~~**01. Documents Accepted as Stand-Alone Proof of U.S. Citizenship and Identity**. The following documents are accepted as proof of both U.S. citizenship and identity: (3-17-22)~~

~~**a.** A U.S. passport or a U.S. passport card, without regard to expiration date as long as the passport or passport card was issued without limitation; (3-17-22)~~

~~**b.** A Certificate of Naturalization; (3-17-22)~~

~~**c.** A Certificate of U.S. Citizenship. (3-17-22)~~

~~**d.** Documented evidence, issued by a federally recognized Indian tribe, including tribes with an international border that identifies: (3-17-22)~~

~~i. The federally recognized Indian Tribe issuing the document; (3-17-22)~~

~~ii. The individual by name; (3-17-22)~~

~~iii. Confirms the individual's membership; and (3-17-22)~~

~~iv. Enrollment or affiliation with the Tribe. (3-17-22)~~

~~**e.** Verification of U.S. citizenship by a federal agency or another state on or after July 1, 2006, no further documentation of U.S. citizenship or identity is required. (3-17-22)~~

~~**02. Documents Accepted as Evidence of U.S. Citizenship**. The following documents are accepted as proof of U.S. citizenship if documented proof in Subsection 223.01 of this rule is not available. These documents are not proof of identity and must be used in combination with a least one (1) document listed in Subsection 223.03 or Section 224 of these rules to establish both citizenship and identity. (3-17-22)~~

~~**a.** A U.S. birth certificate that shows the individual was born in one (1) of the following: (3-17-22)~~

~~i. United States' fifty (50) states; (3-17-22)~~

~~ii. District of Columbia; (3-17-22)~~

~~iii. Puerto Rico, on or after January 13, 1941; (3-17-22)~~

~~iv. Guam; (3-17-22)~~

~~v. U.S. Virgin Islands, on or after January 17, 1917; (3-17-22)~~

~~vi. America Samoa; (3-17-22)~~

~~vii. Swain's Island; (3-17-22)~~

~~viii. Northern Mariana Islands, after November 4, 1986; or (3-17-22)~~

~~**b.** A cross match with a state's vital statistics agency that documents birth records. (3-17-22)~~

~~**c.** A certification of report of birth issued by the Department of State, Forms DS-1350 or FS-545; (3-17-22)~~

~~**d.** A report of birth abroad of a U.S. Citizen, Form FS 240; (3-17-22)~~

~~**e.** A U.S. Citizen I.D. card, DHS Form I-197; (3-17-22)~~

~~**f.** A Northern Mariana Identification Card; (3-17-22)~~

~~**g.** A final adoption decree showing the child's name and U.S. place of birth, or if the adoption is not final, a statement from the state-approved adoption agency that shows the child's name and U.S. place of birth; (3-17-22)~~

~~**h.** Evidence of U.S. Civil Service employment before June 1, 1976; (3-17-22)~~

~~**i.** An official U.S. Military record showing a U.S. place of birth; (3-17-22)~~

~~**j.** Certification of birth abroad, Form FS-545; (3-17-22)~~

~~**k.** Verification with the Department of Homeland Security's Systematic Alien Verification for Entitlements (SAVE) database; (3-17-22)~~

~~**l.** Evidence of meeting the automatic criteria for U.S. citizenship outlined in the Child Citizenship Act of 2000; (3-17-22)~~

~~**m.** Medical records from a hospital, clinic, or doctor, admission papers from nursing facility, skilled care facility, or other institution that indicates a U.S. place of birth: (3-17-22)~~

~~**n.** Life, health, or other insurance record that indicates a U.S. place of birth. (3-17-22)~~

~~**o.** Officially recorded religious record that indicates a U.S. place of birth; (3-17-22)~~

~~**p.** School records, including pre-school, Head Start, and daycare that shows the child's name and indicates a U.S. place of birth; (3-17-22)~~

~~**q.** Federal or state census record that shows U.S. Citizenship or indicates a U.S. place of birth; or (3-17-22)~~

~~**r.** When an applicant has none of the documents listed in Subsections 223.02.a. through q. of this rule, an affidavit signed by another individual under the penalty of perjury who can reasonably attest to the applicant's citizenship, and that contains the applicant's name, and indicates the date and U.S. place of birth, may be submitted. The affidavit does not need to be notarized. (3-17-22)~~

~~**03. Documents Accepted for Evidence of Identity**. The following documents are accepted as proof of identity provided the document has a photograph or other identifying information that includes name, age, sex, race, height, weight, eye color, or address. (3-17-22)~~

~~**a.** A driver's license issued by a state or territory. A driver's license issued by a Canadian government authority is not a valid indicator of identity in the U.S. and cannot be used as evidence of identity. (3-17-22)~~

~~**b.** An identity card issued by federal, state, or local government; (3-17-22)~~

~~**c.** School identification card; (3-17-22)~~

~~**d.** U.S. Military card or draft record; (3-17-22)~~

~~**e.** Military dependent's identification card; (3-17-22)~~

~~**f.** U. S. Coast Guard Merchant Mariner card; or (3-17-22)~~

~~**g.** A finding of identity from a federal or state governmental agency, when the agency has verified and certified the identity of the individual, including public assistance, law enforcement, internal revenue or tax bureau, or corrections agency; (3-17-22)~~

~~**h.** A finding of identity from another state benefits agency or program provided that it obtained verification of identity as a criterion of participation; (3-17-22)~~

~~**i.** Two (2) documents containing consistent information that corroborates the applicant's identity including: employer identification cards, high school or high school equivalency diplomas, college diplomas, marriage certificates, divorce decrees, property deeds or titles; (3-17-22)~~

~~**j.** Identity affidavits are acceptable evidence of identity for individuals living in a residential care facility. (3-17-22)~~

~~**k.** When an applicant has none of the specified findings or documents listed in Subsections 223.03.a.~~

~~through j. of this rule, the applicant may submit an affidavit signed by another individual under the penalty of perjury who can reasonably attest to the applicant's identity. The affidavit must contains the applicant's name, and identifying information to establish identity. The affidavit does not need to be notarized.~~ ~~(3-17-22)~~

~~224. IDENTITY RULES FOR CHILDREN.~~
~~The following additional sources of documentation of identity for children under nineteen (19) years of age may be used:~~ ~~(3-17-22)~~

~~01.~~ **~~School Records~~**~~. School records may be used to establish identity, including nursery or day care records.~~ ~~(3-17-22)~~

~~02.~~ **~~Medical Records~~**~~. Clinic, hospital, or doctor records may be used to establish identity.~~ ~~(3-17-22)~~

~~225. ELIGIBILITY FOR APPLICANTS WHO DO NOT PROVIDE U.S. CITIZENSHIP AND IDENTITY DOCUMENTATION.~~

~~01.~~ **~~U.S. Citizenship and Identity not Verified~~**~~. When the Department is unable to obtain verification of U.S. citizenship and identity through electronic means, or the applicant is unable to provide documentation at the time of application, the applicant will have a reasonable opportunity period of ninety (90) days to provide proof of U.S. citizenship and identity.~~ ~~(3-17-22)~~

~~02.~~ **~~Notice Mailed~~**~~. The reasonable opportunity period of ninety (90) days to provide needed documentation for proof of U.S. citizenship and identity begins five (5) days after the date the notice requesting the proof of documentation is mailed.~~ ~~(3-17-22)~~

~~03.~~ **~~Medicaid Benefits~~**~~. If the applicant meets all other eligibility requirements, Medicaid benefits will be approved pending verification of U.S. citizenship and identity. Medicaid benefits will be denied if the applicant refuses to obtain documentation.~~ ~~(3-17-22)~~

~~226. INDIVIDUALS CONSIDERED AS MEETING THE U.S. CITIZENSHIP AND IDENTITY DOCUMENTATION REQUIREMENTS.~~
~~The individuals listed in Subsections 226.01 through 226.06 of this rule are considered to have met the U.S. citizenship and identity requirements and are not required to provide further documentation.~~ ~~(3-17-22)~~

~~01.~~ **~~Supplemental Security Income (SSI) Recipients~~**~~.~~ ~~(3-17-22)~~

~~02.~~ **~~Social Security Disability Income (SSDI) Recipients~~**~~.~~ ~~(3-17-22)~~

~~03.~~ **~~Individuals Entitled or Enrolled in Medicare by SSA~~**~~. Individuals determined by the SSA to be entitled or enrolled in any part of Medicare.~~ ~~(3-17-22)~~

~~04.~~ **~~Adoptive or Foster Care Children Receiving Assistance~~**~~. Adoptive or foster care children receiving under Title IV-B or Title IV-E of the Social Security Act.~~ ~~(3-17-22)~~

~~05.~~ **~~Individuals Deemed Eligible for Medicaid~~**~~. A waived newborn under Section 530 of these rules.~~ ~~(3-17-22)~~

~~06.~~ **~~Individuals Whose Records Match Records of the SSA~~**~~. Confirmed records of SSA that match and include:~~ ~~(3-17-22)~~

~~a.~~ ~~Name;~~ ~~(3-17-22)~~

~~b.~~ ~~Social Security Number; and~~ ~~(3-17-22)~~

~~c.~~ ~~Declaration of U.S. Citizenship.~~ ~~(3-17-22)~~

~~227. ASSISTANCE IN OBTAINING DOCUMENTATION.~~

~~The Department will provide assistance to individuals who need assistance in securing satisfactory documentary evidence of U.S. citizenship.~~ ~~(3-17-22)~~

~~**228. VERIFICATION OF CITIZENSHIP AND IDENTITY ONE TIME.**~~
~~Once an individual's U.S. citizenship and identity have been verified, whether through an electronic data match or by provided documentation, changes in eligibility will not require an individual to provide the verification again. If later verification, documentation, or information provides the Department with good cause to question the validity of the individual's U.S. citizenship or identity, the individual may be requested to provide further verification.~~ ~~(3-17-22)~~

22~~9~~2. -- 249. (RESERVED)

250. EMERGENCY MEDICAL CONDITION.
An individual who meets eligibility criteria for a category of assistance but does not meet U~~.~~S~~.~~ citizenship requirements or eligible non-citizen requirements may receive medical assistance under a Title XIX or Title XXI coverage group as follows: ~~(3-17-22)~~( )

01. Emergency Medical Conditions. An individual not meeting the U~~.~~S~~.~~ citizenship requirement may receive medical services necessary to treat an emergency medical condition, including labor and delivery. Emergency medical conditions have acute symptoms of severity, including severe pain. ~~(3-17-22)~~( )

02. Determination of Emergency Medical Conditions. The Department determines if a condition meets criteria of an emergency medical condition. ( )

03. Limitation on Medical Assistance. Medical assistance is limited to the period ~~of time~~ established for the emergency medical condition. ~~(3-17-22)~~( )

04. Documentation Waived. For undocumented individuals with emergency medical conditions, the Social Security Number (SSN) requirement is waived because an SSN cannot be issued. Individuals must be otherwise eligible for Title XIX or XXI. ( )

251. SPONSOR DEEMING.
Income of a legal non-citizen's sponsor and the sponsor's spouse are counted in determining eligibility. ( )

252. SPONSOR RESPONSIBILITY.
Section 213 of the Immigration and Naturalization Act requires that a sponsor signing Form I-864, Affidavit of Support, reimburse the Department for Health Care Assistance benefits paid for a sponsored, qualified non-citizen. ( )

253. -- 269. (RESERVED)

270. SOCIAL SECURITY NUMBER (SSN) REQUIREMENT.

01. SSN Required. An applicant must provide ~~his social security number~~ their ~~(~~SSN~~)~~, or proof ~~he has~~ they have applied for an SSN, to the Department before approval of eligibility. If the applicant has more than one (1) SSN, all numbers must be provided. ~~(3-17-22)~~( )

a. The SSN must be verified by the Social Security Administration (SSA) electronically. When an SSN is unverified, the applicant is not eligible for Health Care Assistance. ( )

b. The Department ~~must~~ will notify the applicant in writing if eligibility is being denied or lost for failure to meet the SSN requirement. ~~(3-17-22)~~( )

02. Application for SSN. The applicant must apply for an SSN, or a duplicate SSN when ~~he~~ they cannot provide ~~his~~ their SSN to the Department. If the SSN has been applied for, but not issued by the SSA, the Department can-not deny, delay, or stop benefits. The Department will help an applicant with required documentation when the applicant applies for an SSN. ~~(3-17-22)~~( )

03. Failure to Apply for SSN. The applicant may be granted good cause for failure to apply for an SSN if they have a well-established religious objection to applying for an SSN. A well-established religious objection means the applicant: ( )

a. Is a member of a recognized religious sect or division of the sect; and ( )

b. Adheres to the tenets or teachings of the sect, or division of the sect, and for that reason is conscientiously opposed to applying for or using a national identification number. ( )

04. SSN Requirement Waived. An applicant may have the SSN requirement waived when~~ he is~~ they are: ~~(3-17-22)~~( )

a. Only eligible for emergency medical services~~ as described in~~ under Section 250 of these rules; or ~~(3-17-22)~~( )

b. A newborn deemed eligible child~~ as described in~~ under Section 530 of these rules. ~~(3-17-22)~~( )

271. -- 279. (RESERVED)

280. GROUP HEALTH PLAN ENROLLMENT.
Title XIX and Title XXI participants must apply for and enroll in a cost-effective group health plan if one is available. A cost-effective health plan is one which has premiums and co-payments at a lower cost than Medicaid would pay for full medical services. Medicaid will pay premiums and other co-payments for plans the Department finds cost-effective. ( )

281. MEDICAL EXCEPTION FOR INMATES.
An inmate can receive Medicaid while they are an inpatient in a medical facility~~. The inmate~~, and must meet all Medicaid eligibility requirements. ~~(3-17-22)~~( )

282. -- 289. (RESERVED)

290. ASSIGNMENT OF RIGHTS TO MEDICAL SUPPORT AND THIRD-PARTY LIABILITY.
~~By operation of~~ Under Sections 56-203B and 56-209b(3), Idaho Code, medical support rights are assigned to the Department by signature on the application for assistance. The participant must cooperate to secure medical support from any liable third-party. The cooperation requirement may be waived if the participant has good cause for not cooperating. ~~(3-17-22)~~( )

291. MEDICAL SUPPORT COOPERATION.
A Medicaid participant responsible for assigning their rights to medical support must cooperate to identify and locate the noncustodial parent, establish paternity, and establish, modify, and enforce a medical support order. ( )

01. Cooperation Defined. Cooperation includes providing all information to identify and locate the non-custodial parent~~,~~ and identify~~ing~~ other liable third party-payers. The participant must provide the first and last name of the non-custodial parent~~. The participant must also provide~~, and at least two (2) of the following pieces of information about the non-custodial parent: ~~(3-17-22)~~( )

a. Birth-date; ~~(3-17-22)~~( )

b. ~~Social Security Number~~SSN; ~~(3-17-22)~~( )

c. Current address; ( )

d. Current phone number; ( )

e. Current employer; ( )

f. Make, model, and license number of any motor vehicle owned by the non-custodial parent; or

( )

g. Names, phone numbers, and addresses of the parents of the non-custodial parent. ( )

02. Good Cause Defined. The participant may claim good cause for failure to cooperate in securing medical support for a minor child. Good cause is limited to the following~~ reasons~~: ~~(3-17-22)~~( )

a. ~~There is p~~Proof the child was conceived~~ as a result~~ because of incest or rape; ~~(3-17-22)~~( )

b. ~~There is p~~Proof the child's non-custodial parent may inflict physical or emotional harm to the participant, the child, the custodial parent, or the caretaker relative; ~~(3-17-22)~~( )

c. A credible explanation is provided showing the participant cannot provide the minimum information regarding the non-custodial parent; or ( )

d. A participant who has good cause for not cooperating~~ as described in~~ under Subsection 291.03.b of this rule. ~~(3-17-22)~~( )

03. Conditions for Non-Denial of Medicaid. Medicaid cannot be denied for individuals who meet one (1) of the following conditions: ( )

a. A child or unmarried minor child who cannot legally assign~~ his~~ their rights to medical support; or ~~(3-17-22)~~( )

b. A pregnant woman whose income is at or below the~~ federal poverty guideline~~FPG, and who does not cooperate in establishing paternity and obtaining medical support from, or derived from, the father of the unborn child. ~~(3-17-22)~~( )

292. -- 295. (RESERVED)

296. COOPERATION WITH THE QUALITY CONTROL PROCESS.
When the Department or federal government selects a case for review in the quality control process, the participant must cooperate in the review of the case. ( )

297. -- 299. (RESERVED)

FINANCIAL REQUIREMENTS
(Sections 300-344)

300. HOUSEHOLD COMPOSITION AND FINANCIAL RESPONSIBILITY.
Household composition and financial responsibility are divided into two (2) categories: tax-filing and non-tax filing households. ~~(3-17-22)~~( )

301. TAX FILING HOUSEHOLD.

01. Taxpayers. For an individual filing a federal tax return for the taxable year in which an initial determination or redetermination of eligibility is made, and who is not claimed as a tax dependent by another taxpayer, the tax filing household consists of the taxpayer, the taxpayer's spouse, and the taxpayer's tax dependents. ( )

02. Individuals Claimed as a Tax-Dependent. For an individual who is claimed as a tax dependent by another taxpayer, the tax filing household is the household of the taxpayer claiming such individual as a tax dependent,~~ with the exception that~~ except when tax dependents meeting any of the following criteria will be treated as non-filers~~ described in~~ under Section 302 of these rules. Individuals: ~~(3-17-22)~~( )

a. ~~Individuals c~~Claimed as a tax dependent by an individual other than a spouse or custodial parent; ~~(3-17-22)~~( )

b. ~~Individuals u~~Under age nineteen (19) living with both parents, if the parents are not married, or married filing separately; and ~~(3-17-22)~~(   )

c. ~~Individuals u~~Under age nineteen (19) claimed as a tax dependent by a parent residing outside of the applicant household. ~~(3-17-22)~~(   )

03. Married Couples. For married couples living together, each spouse is included in the household of the other spouse, regardless of whether a joint federal tax return is filed, if one (1) spouse is claimed as a tax dependent by the other spouse, or if each filed separately. (   )

302. NON-TAX FILING HOUSEHOLD.

01. Individuals Not Filing a Tax Return and Not Claimed as a Tax Dependent. For an individual who does not expect to file a federal tax return and is not claimed as a tax dependent by a tax filer, or meets one (1) of the exceptions in~~ Subsections 301.02.a. through 301.02.c. of these~~ this rule~~s~~, the household consists of the individual and, if living with the individual the following: ~~(3-17-22)~~(   )

a. The individual's spouse; (   )

b. The individual's natural, adopted, and stepchildren under age nineteen (19); or (   )

c. ~~In the case of~~If individuals are under age nineteen (19), the individual's natural, adopted, and step parents and natural, adoptive, and step siblings under age nineteen (19). ~~(3-17-22)~~(   )

02. Married Couples. Married couples living together will be included in the household of the other spouse. (   )

303. -- 344. (RESERVED)

INCOME
(Sections 345-394)

345. HOUSEHOLD INCOME.
The sum of calculated ~~Modified Adjusted Gross Income (~~MAGI-based income~~)~~ of every individual whose income must be included in the household budget minus a standard disregard in the amount of five percent (5%) of ~~F~~federal ~~P~~poverty ~~G~~guidelines~~ (FPG)~~ by family size, if the disregard is used to establish eligibility. ~~(3-17-22)~~(   )

346. DETERMINING INCOME ELIGIBILITY.
Financial eligibility for Medicaid applicants~~ must~~ will be based on calculated monthly household income and household size. Eligibility for Health Care Assistance is determined by comparing the individual's calculated income against the income limit. ~~(3-17-22)~~(   )

347. EARNED INCOME.
Earned income is derived from labor or active participation in a business. Earned income includes taxable wages, tips, salary, commissions, bonuses, self-employment, and any other type of income defined as earnings by the Internal Revenue Service (IRS). Earned income is counted as income when it is received, or would have been received, except for the decision of the participant to postpone receipt. Earnings over a period of time and paid at one (1) time, such as the sale of farm crops, livestock, or poultry are annualized, and IRS-allowable self-employment expenses deducted. ~~(3-17-22)~~(   )

348. DEPENDENT CHILD'S EARNED INCOME.
A dependent child's earned income is excluded, unless the child is required to file a tax return based on his own income. (   )

349. (RESERVED)

350. IN-KIND INCOME.
An individual who receives a service, benefit, or durable goods instead of wages is earning in-kind income. In-kind income is excluded. ( )

351. SELF-EMPLOYMENT EARNED INCOME.
Income from self-employment is treated as earned income. Calculated self-employment income is the taxable self-employment income after gross receipts and the IRS allowable costs of producing the self-employment income, when the self-employment is expected to continue~~ as provided in~~ under Title 26, U.S.C. ~~(3-17-22)~~( )

352. -- 369. (RESERVED)

370. UNEARNED INCOME.
Unearned income is any income the individual receives that is not gained through employment. Unearned income is not excluded income if it is taxable. ( )

371. – 383. (RESERVED)

384. LUMP SUM INCOME.
A non-recurring lump sum payment is income in the month the lump sum is received. Lump sum income is a retroactive monthly benefit or a windfall payment. The lump sum may be earned or unearned income that is paid in a single sum. Lump sum income includes retirement, survivors, and disability insurance (RSDI), severance pay, disability insurance, and lottery winnings. ( )

385. -- 387. (RESERVED)

388. DEPENDENT CHILD'S UNEARNED INCOME.
A child's unearned income is countable towards~~ his~~ their household's eligibility, only when the child must file a tax return based on~~ his~~ their own income. ~~(3-17-22)~~( )

389. -- 394. (RESERVED)

DISREGARDS
(Section 395-399)

395. INCOME DISREGARDS.
A standard disregard in the amount of five percent (5%) of ~~F~~federal ~~P~~poverty ~~G~~guidelines~~ (FPG)~~ by family size is applied to the calculated income of an individual in those situations where the application of the disregard is necessary in order for the individual to be eligible for the highest income limit ~~H~~health ~~C~~care coverage for which they may be eligible. ~~(3-17-22)~~( )

396. -- 399. (RESERVED)

HEALTH COVERAGE FOR ADULTS
(Sections 400-499)

400. MEDICAID FOR ADULTS.
Medicaid is available for the following adults: ( )

01. Parent, Caretaker Relative, or a Pregnant Woman. The individual who: ~~(3-17-22)~~( )

a. ~~The individual who i~~Is a parent, caretaker relative, or a pregnant woman in the household budget unit. ~~(3-17-22)~~( )

b. ~~The individual who i~~Is responsible for an eligible dependent child, which includes the unborn child of a pregnant woman. ~~(3-17-22)~~( )

c. ~~The individual who l~~Lives in the same household with the eligible dependent child. ~~(3-17-22)~~(____)

02. Adults Under Age 65. The individual must: ( )

a. Be age nineteen (19) or older and under age sixty-five (65); ( )

b. Not entitled to or enrolled in Medicare Part A or Part B; and~~.~~ ~~(3-17-22)~~(____)

c. Not otherwise eligible for any other coverage under the State Plan. ( )

03. MAGI Income Eligibility. For any of the eligibility groups ~~described in~~ under Subsections 400.01 and 02, the individual must meet all income requirements of the Medicaid program for eligibility determined ~~according to~~ under MAGI methodologies identified in Sections 300 through 303, and 411 of these rules. Eligibility is based on: ~~(3-17-22)~~(____)

a. The number of members included in the household budget unit; ( )

b. All countable income for the household budget unit; and ( )

c. Eligible individuals will have income calculated using their ~~modified adjusted gross income (~~MAGI~~)~~. Individuals with MAGI not greater than one hundred thirty-three per cent (133%) after applying a five per cent (5%) disregard to income are eligible to receive Medicaid in this ~~section~~ rule. ~~(3-17-22)~~(____)

04. Member of More Than One Budget Unit. No person may receive benefits in more than one (1) budget unit during the same month. ( )

05. More Than One Medicaid Budget Unit in Home. If there is more than one (1) Medicaid budget unit in a home, each budget unit is considered a separate unit. ( )

401. -- 410. (RESERVED)

411. INCOME LIMITS FOR PARENTS AND CARETAKER RELATIVES.
The income limits are based on the number of household budget unit members. Parents and caretaker relatives, whose MAGI-based income does not exceed the guidelines listed in the table below for their household size, meet the income limit for parent and caretaker relative Medicaid.

TABLE 411 INCOME LIMITS	
Number of Household Members	**Income Limit**
1	$233
2	$289
3	$365
4	$439
5	$515
6	$590
7	$666
8	$741
9	$816

TABLE 411 INCOME LIMITS	
Number of Household Members	**Income Limit**
10	$982
Over 10 Persons	Add $75 Each

( )

412. -- 418. (RESERVED)

419. TRANSITIONAL MEDICAID FOR PARENT CARETAKER ADULTS.
Participants who no longer qualify for Medicaid due to an increase in earned income or working hours are eligible for an additional twelve (12) months of Medicaid. Participants must have been eligible for Medicaid during at least three (3) of the six (6) months immediately preceding the month in which the participant became ineligible. ~~(3-17-22)~~( )

420. EXTENDED MEDICAID FOR SPOUSAL PARENT CARETAKER SUPPORT INCREASE.
Participants are eligible for four (4) calendar months of Extended Medicaid if an increase in the participant's spousal support causes them to exceed the income limit for their household budget unit size. The participant must have received Medicaid in Idaho in at least three (3) of the six (6) months before the month the participant became income ineligible. ~~(3-17-22)~~( )

421. PREGNANT WOMAN INELIGIBLE BECAUSE OF EXCESS INCOME.
A pregnant woman who receives ~~h~~Health ~~c~~Care ~~a~~Assistance and becomes ineligible because of an increase in income will continue to receive coverage through the end of the month in which the sixtieth day of her postpartum period falls. ~~(3-17-22)~~( )

422. -- 519. (RESERVED)

HEALTH COVERAGE FOR CHILDREN
(Sections 520-529)

520. FINANCIAL ELIGIBILITY.
Children are eligible for Health Care Assistance when the household's total MAGI-~~B~~based income minus a standard disregard in the amount of five percent (5%) of ~~Federal Poverty Guidelines (~~FPG~~)~~ by family size is less than or equal to the applicable income limit for the age of the child. ~~(3-17-22)~~( )

01. Title XIX Income Limit. For children age zero (0) to six (6), Title XIX income limit is one hundred forty-two percent (142%) of the FPG for the household size. For children age six (6) through age eighteen (18) the income limit is one hundred thirty three percent (133%) of the FPG for the household size. ( )

02. Title XXI Income Limit. For children age zero (0) to six (~~0-~~6), Title XXI income limit is between one hundred forty-two percent (142%) and one hundred eighty-five percent (185%) of the FPG for the household size. For children ages six (6) through eighteen (18) the income limit is between one hundred thirty-three percent (133%) and one hundred eighty five percent (185%) of the FPG for the household size. ~~(3-17-22)~~( )

03. Disregard Applied. A standard disregard in the amount of five percent (5%) of ~~Federal Poverty Guidelines (~~FPG~~)~~ by family size is applied to the calculated income used to establish the child's eligibility when applying the disregard is necessary for the child to be financially eligible. ~~(3-17-22)~~( )

521. HOUSEHOLD SIZE AND FINANCIAL RESPONSIBILITY.
Household size and financial responsibility for health coverage for children is determined using the methodology ~~described in~~ under Section 300 of these rules. ~~(3-17-22)~~( )

522. (RESERVED)

523. ACCESS TO OR COVERAGE UNDER OTHER HEALTH PLANS.
A child is ineligible for coverage under the CHIP plan if they have access to or are enrolled in other health coverage plans as described below: ( )

01. Covered by Creditable Health Insurance. The child is covered by creditable health insurance at the time of application. ( )

02. Child is Eligible ~~for~~ under Idaho's Title XIX State Plan. ~~The child is eligible under Idaho's Title XIX State Plan.~~ ~~(3-17-22)~~( )

03. Idaho State Employee Benefit Plan. The child is eligible to receive health insurance benefits under Idaho's State employee benefit plan. ( )

524. CONTINUOUS HEALTH CARE ASSISTANCE ELIGIBILITY FOR CHILDREN UNDER AGE NINETEEN.
Children under age nineteen (19), who are found eligible for health coverage in an initial determination or at renewal, remain eligible for a period of twelve (12) months. The twelve (12) month continuous eligibility period does not apply if, for any reason, eligibility was determined incorrectly. ( )

01. Reasons Continuous Eligibility Ends. ~~Continuous eligibility for children ends for one (1) of the following reasons:~~ ~~(3-17-22)~~( )

a. The child is no longer an Idaho resident; ( )

b. The child dies; ( )

c. The participant requests closure; or ( )

d. The child turns nineteen (19) years ~~of age as defined in~~ old under Subsection 010.05 of these rules. ~~(3-17-22)~~( )

02. Reasons Children are ~~N~~not Eligible for Continuous Eligibility. ~~Children are not eligible for continuous eligibility for one (1) of the following reasons:~~ ~~(3-17-22)~~( )

a. A child is approved for emergency medical services; or ( )

b. A child is approved for pregnancy-related services. ( )

525. FORMER FOSTER CHILD.
An individual who is between the age of eighteen (18) and twenty-six (26), who was in foster care ~~in Idaho~~ and became ineligible for Medicaid as a foster child due to age, may receive Medicaid coverage until ~~his~~ their twenty-sixth birthday. There are no financial eligibility criteria. The only non-financial criteria are the receipt of foster care services and age. ~~(3-17-22)~~( )

526. -- 529. (RESERVED)

SPECIAL CIRCUMSTANCES FOR CHILDREN
(Sections 530-549)

530. NEWBORN CHILD DEEMED ELIGIBLE FOR MEDICAID.
A child is deemed eligible for Medicaid for ~~his~~ their first year of life when the following exists. ~~(3-17-22)~~( )

01. Mother Filing an Application. The child is born to a mother who files an application for medical assistance. ( )

02. Mother Is Eligible for Medicaid. The mother is eligible for Medicaid in the newborn's birth

month, including a month of retroactive coverage. This includes a mother who qualifies for coverage only for the delivery because of her alien status. ( )

531. MINOR PARENT LIVING WITH PARENTS.
A minor parent is a child under the age of eighteen (18) who is pregnant or has a child. Minor parents who live with their parents may be eligible for Health Care Assistance for themselves and their children. The minor parent's eligibility is determined ~~according to the~~ under Section 300 of these rules related to tax filing households. ~~(3-17-22)~~( )

532. RESIDENT OF AN ELIGIBLE INSTITUTION.
A resident of an eligible institution must meet all non-financial and financial criteria of Title XIX, Title XXI, or any other applicable program. ~~(3-17-22)~~( )

533. CHILDREN WITH SPECIAL CIRCUMSTANCES AND MEDICAID.
Children who receive foster care or are in adoptive placements are eligible for Medicaid. The children must meet non-financial criteria and ~~must meet~~ the financial requirements described for the children's coverage group. ~~(3-17-22)~~( )

534. (RESERVED)

535. TITLE IV-E FOSTER CARE CHILD.
A child may be eligible for Medicaid under the Title IV-E foster care program if they meet the eligibility requirements in IDAPA 16.06.01, "Child and Family Services," Section 425. ( )

536. -- 539. (RESERVED)

540. YOUTH EMPOWERMENT SERVICES (YES) PROGRAM CHILDREN.

01. Payments for Children Under Eighteen (18) Years ~~of Age~~ Old with SED. ~~In accordance with~~ Under Section 56-254(2), Idaho Code, the Department will make payments for medical assistance for a child under eighteen (18) years ~~of age~~ old with serious emotional disturbance (SED), as defined in Section 16-2403, Idaho Code, and verified by an independent assessment: ~~(3-17-22)~~( )

a. Whose family income does not exceed three hundred percent (300%) of the ~~federal poverty guideline (~~FPG~~)~~ as determined using MAGI-based eligibility standards; or ~~(3-17-22)~~( )

b. Who meets other Title XIX Medicaid eligibility standards ~~in accordance with~~ under the rules of the Department. ~~(3-17-22)~~( )

02. Youth Empowerment Services (YES) Benefits. Applicants whose family income is equal to or less than three hundred percent (300%) of the ~~Federal Poverty Guidelines (~~FPG~~)~~ for children zero (0) to eighteen (18) years ~~of age~~ old and who meet the non-financial eligibility criteria in Sections 200 through 299 of these rules may receive the following benefits: ~~(3-17-22)~~( )

a. ~~Youth Empowerment Services (~~YES~~)~~ State Plan option services and supports ~~described in~~ under IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Sections 635 through 638; and ~~(3-17-22)~~( )

b. Additional covered services ~~set forth in~~ under IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Sections 075 through 799. ~~(3-17-22)~~( )

03. Additional Eligibility Criteria and Program Requirements for YES. Additional eligibility criteria and program requirements applicable to the ~~Youth Empowerment Services (~~YES~~)~~ State Plan option are ~~described in~~ under IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Sections 635 through 638. ~~(3-17-22)~~( )

541. -- 544. (RESERVED)

545. PRESUMPTIVE ELIGIBILITY FOR CHILDREN AND ADULTS.
Presumptive eligibility determination for qualifying medical coverage groups can only be provided by a qualified hospital defined in Section 011 o~~r~~f these rules. ~~(3-17-22)~~(   )

01. Presumptive Eligibility Decisions. Decisions of presumptive eligibility can be made for individuals~~,~~ who meet program requirements for MAGI-based Medicaid coverage. ~~(3-17-22)~~(   )

02. Presumptive Eligibility Determination. Presumptive eligibility determinations are made by a qualified hospital when an individual receiving medical services is not covered by health care insurance and the financial assessment by hospital staff indicates the individual is eligible for Medicaid ~~C~~coverage in Idaho. This determination is made by hospital staff through an online presumptive application process: ~~(3-17-22)~~(   )

a. Prior to completion of a full Medicaid application; and (   )

b. Prior to a determination being made by the Department on the full application. (   )

03. Presumptive Eligibility Period. The presumptive eligibility period begins on the date the presumptive application is filed online and ends with the earlier of the following: (   )

a. The date the full eligibility determination is completed by the Department; or (   )

b. The end of the month after the month the qualified hospital completed the presumptive eligibility determination. (   )

546. QUALIFIED HOSPITAL PRESUMPTIVE ELIGIBILITY PROCESSES.
A qualified hospital must have a Memorandum of Understanding (MOU) with the Department and follow all standards and processes agreed to in the MOU. (   )

01. Acceptance of Application. The qualified hospital accepts the request for services in the same manner as all applications for assistance are accepted. (   )

02. Standards and Processes. The presumptive eligibility determination must be based on standards and processes provided by the Department. (   )

03. Assistance to Applicant. The qualified hospital must assist the applicant in completing the Department's application process. (   )

04. Qualified Hospital Staff. Only qualified hospital staff who are trained in presumptive eligibility standards can make a presumptive eligibility determination. (   )

05. Notice to Applicant. The qualified hospital or the Department will provide notice to the applicant within two (2) business days on the presumptive eligibility determination. ~~(3-17-22)~~(   )

06. Notice and Hearing Rights. Presumptive eligibility decisions are not appealable and do not have hearing rights under the Title XIX Medicaid program. (   )

07. Number of Presumptive Eligibility Periods Allowed. Only one (1) presumptive eligibility period is allowed per applicant in any twelve (12) month period. (   )

547. -- 599. (RESERVED)

CASE MAINTENANCE REQUIREMENTS
(Sections 600-701)

600. ANNUAL ELIGIBILITY RENEWAL.
Participants must have an annual eligibility review of all eligibility factors. Exceptions to the annual eligibility renewal are listed in Section 601 of these rules. (   )

01. Continuing Eligibility. ~~Continuing eligibility i~~Is determined using available electronic verification sources without participant contact, unless information: ~~(3-17-22)~~( )

a. ~~Information i~~Is not available; ~~(3-17-22)~~( )

b. ~~Information s~~Sources provide conflicting information; or ~~(3-17-22)~~( )

c. ~~Information i~~Is inconsistent with information provided by the participant. ~~(3-17-22)~~( )

02. Inconsistency Impacts Eligibility. When inconsistency exists from electronic verification sources that impact participant eligibility, information must be verified by the participant. The Department provides the participant a document that displays household information currently being used to establish eligibility and asks the participant to verify correctness, and if not correct to provide updated information. ( )

601. EXCEPTIONS TO ANNUAL RENEWAL.

A participant who receives Title XIX or Title XXI through time-limited coverage does not require an annual renewal when the following exists. ( )

01. Extended Medicaid. A participant who receives extended Medicaid is eligible ~~as provided in~~ under Section 420 of these rules. ~~(3-17-22)~~( )

02. Pregnant Woman. ~~A participant who receives Medicaid as a Low Income Pregnant Woman is eligible as provided in Section 500 of these rules~~ A pregnant woman of any age is eligible for the Pregnant Woman coverage if she meets all the non-financial and financial criteria of the coverage group. *Coverage includes services as described in IDAPA 16.03.09, "Medicaid Basic Plan Benefits."* The Pregnant Woman medical assistance coverage extends through the sixty (60) day postpartum period if she applied for medical assistance while pregnant and was receiving medical assistance when the child was born. An individual who applies for Pregnant Woman medical assistance after the child is born is not eligible for the sixty-day (60) postpartum period. ~~(3-17-22)~~*( )*

03. Newborn Child of Medicaid-Eligible Mother. A participant receiving Medicaid as the newborn child of a Medicaid-eligible mother is eligible ~~as provided in~~ under Section 530 of these rules. ~~(3-17-22)~~( )

602. -- 609. (RESERVED)

610. REPORTING REQUIREMENTS.

Changes in family circumstances must be reported to the Department by the tenth of the month following the month in which the change occurred. Report of changes may be made verbally, in writing, through personal contact, telephone, fax, electronic mail, or mail. ( )

611. TYPES OF CHANGES THAT MUST BE REPORTED.

Changes in circumstances the participant must report are the following: ( )

01. Name or Address. A name change for any participant ~~must be reported. A~~ or a change of address or location ~~must be reported~~. ~~(3-17-22)~~( )

02. Household Composition. Changes in family composition ~~must be reported~~ if a parent or relative caretaker receives Medicaid. ~~(3-17-22)~~( )

03. Marital Status. Marriages or divorces of any family member ~~must be reported~~ if a parent or relative caretaker receives Medicaid. ~~(3-17-22)~~( )

04. New ~~Social Security Number~~ SSN. ~~A Social Security Number (~~SSN~~) that~~ is newly assigned to a Medicaid Health Care Assistance program participant ~~must be reported~~. ~~(3-17-22)~~( )

05. Health Insurance Coverage. Enrollment or disenrollment of a participant in a health insurance plan ~~must be reported~~. ~~(3-17-22)~~( )

06. End of Pregnancy. Pregnant participants must report when pregnancy ends. ( )

07. Earned Income. Changes in the amount or source of earned income~~ must be reported~~ if a parent or relative caretaker receives Title XIX benefits. ~~(3-17-22)~~( )

08. Unearned Income. Changes in the amount or source of unearned income~~ must be reported~~ if a parent or relative caretaker receives Title XIX benefits. ~~(3-17-22)~~( )

09. Support Income. Changes in the amount of spousal support received by an adult household member. ( )

10. Disability. A family member who becomes disabled or is no longer disabled~~ must be reported~~ if a parent or relative caretaker receives Title XIX benefits. ~~(3-17-22)~~( )

612. -- 619. (RESERVED)

620. NOTICE OF CHANGES IN ELIGIBILITY.

The Department will notify the participant of changes in~~ his~~ their Health Care Assistance. The notice must give the effective date, the reason for the action, the rule that supports the action, and appeal rights. ~~(3-17-22)~~( )

621. NOTICE OF CHANGE OF PLAN.

The Department~~ is allowed to~~ can switch a participant from the Medicaid Basic Plan to the Medicaid Enhanced ~~p~~Plan within the same month. Advance notice must be given to the participant when there is a decrease in their benefits and ~~he~~ they will be switched from the ~~e~~Enhanced ~~p~~Plan to the ~~b~~Basic ~~p~~Plan. ~~(3-17-22)~~( )

622. ADVANCE NOTICE RESPONSIBILITY.

The Department must notify the participant at least ten (10) calendar days before the effective date~~ of~~ when a reported change results in Health Care Assistance closure.~~ The effective date must allow for a five (5) day mailing period for any notice.~~ ~~(3-17-22)~~( )

623. ADVANCE NOTICE NOT REQUIRED.

Advance notice is not required when a condition~~ listed in Subsections 623.01 through 623.08 of~~ under this rule exists. The participant~~ must~~ will be notified no later than the date of the action. ~~(3-17-22)~~( )

01. ~~Death of~~The Department has Proof of the Participant's Death.~~ The Department has proof of the participant's death.~~ ~~(3-17-22)~~( )

02. The Participant Requests Closure in Writing.~~ The participant requests closure in writing.~~ ~~(3-17-22)~~( )

03. Participant in Institution. The participant is admitted or committed to an institution. Further payments to the participant do not qualify for federal financial participation under the ~~s~~State ~~p~~Plan. ~~(3-17-22)~~( )

04. Nursing Care. The participant is placed in a nursing facility or Intermediate Care Facility for Persons with Intellectual Disabilities (ICF/IID). ( )

05. The Participant's Address is~~-~~Unknown.~~ The participant's whereabouts are unknown.~~ ~~(3-17-22)~~( )

06. The Participant is Approved for Medical Assistance in Another State.~~ A participant is approved for medical assistance in another state.~~ ~~(3-17-22)~~( )

07. Eligible One Month. The participant is eligible for aid only during the calendar month of~~ his~~ their application for aid. ~~(3-17-22)~~( )

08. Retroactive Medicaid. The participant's Title XIX or Title XXI eligibility is for a prior period.

( )

624. -- 699. (RESERVED)

700. OVERPAYMENTS.
Health Care Assistance overpayments occur when a participant receives benefits during a month ~~he was~~ they were not eligible. ~~(3-17-22)~~( )

701. RECOVERY OF OVERPAYMENTS.
All Health Care Assistance overpayments are subject to recovery. Overpayments are recovered by direct payment from the participant. ( )

01. Notice of Overpayment. The participant must be informed of the Health Care Assistance overpayment and appeal rights. ( )

02. Notice of Recovery. The participant must be informed when ~~his~~ their Health Care Assistance overpayment is fully recovered. ~~(3-17-22)~~( )

702. -- 999. (RESERVED)

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.03.02 – SKILLED NURSING FACILITIES

DOCKET NO. 16-0302-2301 (ZBR CHAPTER REWRITE)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo and Incorporation By Reference Synopsis (IBRS)

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2024 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. The pending rule will become final and effective upon the adjournment, *sine die*, of the Second Regular Session of the Sixty-seventh Idaho Legislature after approval.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 39-1303a, 39-1306, 39-1307, 39-1307A, and 39-1307B, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

Under Executive Order 2020-01: Zero-Based Regulation, the Department is striving to prevent the accumulation of costly, ineffective, and outdated regulations and reduce regulatory burden to achieve a more efficient operation of government. The rule changes are intended to perform a comprehensive review of this chapter by collaborating with the public to streamline or simplify this rule language.

The text of the pending rule has been amended in accordance with Section 67-5227, Idaho Code. Only those sections that have changes that differ from the proposed text are printed in this bulletin. The complete text of the proposed rule was published in the September 6, 2023, Idaho Administrative Bulletin, Vol. 23-9, pages 73 through 108.

FEE SUMMARY: Pursuant to Section 67-5224(2)(d), Idaho Code, this pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature. The following is a description of the fee or charge imposed or increased in this rulemaking: Does not apply to this rulemaking.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state General Fund greater than ten thousand dollars ($10,000) during the fiscal year:

This rulemaking is not anticipated to have any fiscal impact on the State General Fund, or any other known funds.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Nate Elkins, 208-334-6626, option #5.

DATED this 30th of November, 2023.

Trinette Middlebrook and Frank Powell
DHW – Administrative Rules Unit
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P.O. Box 83720
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THE FOLLOWING NOTICE PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 39-1303a, 39-1306, 39-1307, 39-1307A, and 39-1307B, Idaho Code.

PUBLIC HEARING SCHEDULE: A public hearing concerning this rulemaking will be held as follows:

VIRTUAL TELECONFERENCE Via WebEx
Thursday, September 14, 2023 **11:00 a.m. - 12:00 a.m. (MT)**
Join from the meeting link **https://idhw.webex.com/idhw/j.php?MTID=m102d0ec5970f1519d63b19ebf0ca56fd** **Join by meeting number** **Meeting number (access code): 2763 693 1417** **Meeting password: ErJ9Gudc7n7 (37594832 from phones and video systems)** **Join by phone** **+1-415-527-5035 United States Toll** **+1-303-498-7536 United States Toll (Denver)**

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below. Meeting(s) will conclude after 30 minutes if no participants sign in or wish to comment in the meeting.

DESCRIPTIVE SUMMARY: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

Under Executive Order 2020-01: Zero-Based Regulation, the Department is striving to prevent the accumulation of costly, ineffective, and outdated regulations and reduce regulatory burden to achieve a more efficient operation of government. The rule changes are intended to perform a comprehensive review of this chapter by collaborating with the public to streamline or simplify this rule language.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased:

This chapter contains no fees or charges.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year as a result of this rulemaking:

This rulemaking is not anticipated to have any fiscal impact on the State General Fund, or any other known funds.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the May 3, 2023, Idaho Administrative Bulletin, Volume 23-5, pages 148 through 149.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into this rule:

This chapter of rule contains changes to the incorporation by reference materials by adding the following due to the size of these documents and to assure they have the force and effect of law.

- Title 42, Chapter IV, Subchapter G, and Part 483, Public Health, Centers for Medicare & Medicaid Services, Department of Health and Human Services, Standards and Certification, Requirements for States and Long Term Care Facilities.
- Guidelines for Design and Construction of Residential Health, Care, and Support Facilities. Facility Guidelines Institute.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Nate Elkins, 208-334-6626, option #5.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before September 27, 2023.

DATED this 4th day of August, 2023.

THE FOLLOWING IS THE TEXT OF ZBR DOCKET NO. 16-0302-2301

16.03.02 – SKILLED NURSING FACILITIES

000. LEGAL AUTHORITY.
Sections 39-1303a, 39-1306, 39-1307, 39-1307A, and 39-1307B, Idaho Code, authorize the Board to establish and enforce rules to promote safe and adequate treatment of individuals in Skilled Nursing Facilities. ( )

001. WRITTEN INTERPRETATIONS.
This agency may have written statements that pertain to the interpretations of these rules. ( )

002. INCORPORATION BY REFERENCE.
The following are incorporated by reference as provided by Section 67-5229(a), Idaho Code, and are available for public review upon request at the Department, 450 W. State Street, Boise, Idaho, 83702 or online for review as noted below. ( )

01. Title 42, Chapter IV, Subchapter G, Part 483. Public Health, Centers for Medicare & Medicaid Services, Department of Health and Human Services, Standards and Certification, Requirements for States and Long Term Care Facilities. August 1, 1989. Online at https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-483?toc=1. ( )

02. Guidelines for Design and Construction of Residential Health, Care, and Support Facilities. Facility Guidelines Institute. 2022 Edition, Specific Requirements for Nursing Homes. Available at https://healthandwelfare.idaho.gov/providers/facility-standards/facility-fire-safety-and-construction or by registering free at FGI Digital Library https://shop.fgiguidelines.org/login. ( )

003. – 008. (RESERVED)

009. BACKGROUND CHECK REQUIREMENTS.

01. Background Check. A skilled nursing facility (SNF) must complete a background check and receive a clearance on employees, volunteers, and contractors hired, recruited, or contracted with after October 1, 2007, who have direct patient access to residents in the SNF. A Department check conducted under IDAPA 16.05.06, "Criminal History and Background Checks," satisfies this requirement. Other background checks may be accepted provided they meet criteria in Subsection 009.02 of this rule and the entity conducting the check issues written findings. The entity must provide a copy of these written findings to both the facility and the employee. The following individuals must receive a background check clearance: ( )

a. Owners and Corporate Leaders; ( )

b. Administrators and Designees; ( )

c. Director of Nursing Services (DNS); ( )

d. Certified Nursing Assistants (CNA); ( )

e. Maintenance Director and Maintenance Personnel; ( )

f. Registered Nurses (RN); ( )

g. Licensed Practical Nurses (LPN); ( )

h. Environmental Services Personnel; ( )

i. Activity Director and Activity Assistants; ( )

j. Contracted staffing accruing at least twelve (12) hours weekly with direct patient contact; ( )

k. Volunteers utilized or credentialed by the facility with direct patient contact; ( )

l. Nursing Assistants; ( )

m. Hospitality Aides; ( )

n. Social Services Personnel; ( )

o. Business Office Personnel; ( )

p. Therapy Services Personnel; ( )

q. Registered Dietitians; ( )

r. Dietary Manager and Dietary Personnel; ( )

s. Laundry Service Personnel; ( )

t. Unlicensed Assistive Personnel (UAP); ( )

02. Scope of Background Check. The background check must be a fingerprint-based criminal history and background check that may include a search from the following: ( )

a. Federal Bureau of Investigation (FBI); ( )

b. Idaho State Police Bureau of Criminal Identification; ( )

c. Any State Sexual Offender Registry; ( )

d. Any state or federal Child Protection Registry; ( )

e. Any state or federal Adult Protection Registry. ( )

f. Office of Inspector General List of Excluded Individuals and Entities; ( )

g. Idaho Department of Transportation Driving Records; ( )

h. Nurse Aide Registry; and ( )

i. Records and findings from other states and jurisdictions. ( )

03. Availability to Work. Any direct resident access individual hired, retired or contracted with, on or after October 1, 2007, must self-disclose all arrests and convictions before having access to residents. The individual can only work under supervision until the background check is completed and a clearance received. If a disqualifying crime under IDAPA 16.05.06, "Criminal History and Background Checks," is disclosed, the individual cannot have access to any resident. ( )

04. Submission of Fingerprints. The individual's fingerprints must be submitted to the entity conducting the background check within twenty-one (21) days of their date of hire, contract, or recruitment. ( )

05. New Background Check. An individual must have a background check and clearance when: ( )

a. Accepting employment, a contract, or a position with a new employer; and ( )

b. Their last background check was completed more than three (3) years prior to their date of hire, contract, or recruitment. ( )

06. Use of Background Check Within Three Years of Completion. Any employer may use a previous criminal history and background check obtained under these rules if: ( )

a. The individual has received a background check with clearance within three (3) years preceding their date of hire, contract, or recruitment; ( )

b. The employer has documentation of the background check findings; ( )

c. The employer completes a state-only background check of the individual through the Idaho State Police Bureau of Criminal Identification; and ( )

d. No disqualifying crimes are found. ( )

07. Employer Discretion. The new employer, at its discretion, may require an individual to complete a background check at any time, even if the individual has received a background check within the three (3) years preceding their date of hire, contract, or recruitment. ( )

010. DEFINITIONS.

01. Administrator. The person delegated the responsibility for management of a facility by the legal owner, employed as a full-time administrator in each facility, and licensed by the State of Idaho. The administrator and legal owner may be the same individual. ( )

02. Advanced Practice Registered Nurse. An RN having specialized skills, knowledge and experience who is authorized under the Idaho Board of Nursing rules to provide certain health services in addition to those performed by registered nurses (RN). ( )

03. **Board**. The Idaho Board of Health and Welfare. ( )

04. **Change of Ownership**. The sale, purchase, exchange, or lease of an existing facility by the present owner or operator to a new owner or operator. ( )

05. **Charge Nurse**. One (1) or more licensed nurse(s) who has direct responsibility for nursing services in an operating unit or physical subdivision of a facility during one (1) eight (8)-hour shift, to be provided by themself and by any other licensed nurse or auxiliary personnel under their immediate charge. ( )

06. **Department**. The Idaho Department of Health and Welfare or its designee. ( )

07. **Director of Nursing Services (DNS)**. An RN currently licensed in Idaho and qualified by training and experience. ( )

08. **Existing Facility**. A nursing home currently licensed. ( )

09. **Governing Body**. Individuals such as facility owner(s), chief executive officer(s), or other individuals who are legally responsible to establish and implement policies regarding the management and operations of the facility. ( )

10. **Governmental Unit**. The State of Idaho, any county, municipality, or other political subdivision, or any department, division, board, or other agency thereof. ( )

11. **Hospital Licensing Act**. The Act under Sections 39-1301 through 39-1314, Idaho Code. ( )

12. **Licensed Nursing Personnel**. An RN or LPN currently licensed in Idaho. ( )

13. **New Construction**. ( )

a. New buildings to be used as a facility. ( )

b. Additions to existing buildings and/or added bed capacity. ( )

c. Conversion of existing buildings or portions thereof for use as a facility. ( )

d. Unlicensed buildings seeking licensing, federal certification, or both. ( )

14. **Person**. Any individual, firm, partnership, corporation, company, association, joint stock association, governmental unit, or legal successor thereof. ( )

15. **Pharmacist**. Any person licensed as a pharmacist in Idaho. ( )

16. **Physician**. Any person licensed by the Idaho Board of Medicine to practice medicine and surgery, osteopathic medicine and surgery, or osteopathic medicine, provided further, that others authorized by law to practice any of the healing arts will not be considered physicians (Section 54-1803(3), Idaho Code). ( )

17. **Resident**. An individual requiring and receiving skilled nursing care and residing in a facility licensed to provide the level of care required. ( )

18. **Skilled Nursing Facility (SNF)**. A facility designed to provide area, space, and equipment to meet the health needs of two (2) or more individuals who require inpatient care and services for twenty-four (24) or more consecutive hours for unstable chronic health problems requiring daily professional nursing supervision and licensed nursing care on a twenty-four (24) hour basis, restorative, rehabilitative care and assistance in meeting daily living needs. Medical supervision is necessary on a regular, but not daily, basis (Section 39-1301, Idaho Code). ( )

19. **Substantial Compliance**. A facility is in substantial compliance with these rules, regulations, and

minimum standards when there are no deficiencies that would endanger the health, safety, or welfare of the residents. ( )

20. Unlicensed Assistive Personnel (UAP). This term designates unlicensed personnel employed to perform nursing care services under the direction and supervision of licensed nurses. The term also includes licensed or credentialed health care workers whose job responsibilities extend to health care services beyond usual and customary roles and which activities are provided under the direction and supervision of licensed nurses. UAPs are prohibited from performing any licensed nurse functions under Section 54-1402, Idaho Code. UAPs may not be delegated procedures involving acts that require nursing assessment or diagnosis, establishment of a plan of care or teaching, the exercise of nursing judgment, or procedures requiring specialized nursing knowledge, skills, or techniques. ( )

21. Waiver or Variance. May be granted under the following conditions: ( )

a. Good cause is shown for such waiver and the health, welfare, or safety of residents will not be endangered by granting such a waiver; ( )

b. Precedent will not be set by granting of such waiver. The waiver may be renewed annually if sufficient written justification is presented to the Department. ( )

011. – 049. (RESERVED)

050. LICENSURE.

01. General Requirements. Before any person either directly or indirectly operates a facility, they must make an application for and receive a valid license for operation of the facility, and no resident must be admitted or cared for in a facility that is required under Idaho law to be licensed, until a license is obtained. ( )

a. The facility and all related buildings associated with the operation of the facility, as well as all records required under these rules, must always be accessible to authorized representatives of the Department for the purpose of inspection, with or without prior notice. ( )

b. Before any building is constructed or altered for use as a facility, written approval of construction or alteration of plans must be obtained from the Department. ( )

c. Information received by the Department through filed reports, inspection, or as otherwise authorized under this law, must not be disclosed publicly in such a manner as to identify individual residents except in a proceeding involving the question of licensure. Public disclosure of information obtained by the Department for the purposes of this law must be governed by these rules. ( )

02. Application for an Initial License. All persons planning the operation of a facility must provide a Department-approved application for an initial facility license at least three (3) months prior to the planned opening date with the following: ( )

a. Evidence of a request for a determination of applicability for Section 1122 (Social Security Act) regulatory review. ( )

b. A copy of the nursing home administrator's license. ( )

c. A certificate of occupancy from the local building and fire authority. ( )

03. Issuance of License. Every facility must be designated by a distinctive name in applying for a license, and the name must not be changed without first notifying the Department in writing at least thirty (30) days prior to the date the proposed name change is to be effective. ( )

a. Each license will be issued only for the premises and persons named in the application and will not be transferable. ( )

b. Each license will specify the maximum allowable number of beds in each facility, which may not be exceeded, except when authorized by the Department on a time-limited emergency basis. ( )

c. The facility license must be framed and posted to be visible to the general public. ( )

04. Expiration and Renewal of License. Each license to operate a facility must, unless sooner suspended or revoked, expire on the date designated on the license. Each application for renewal of a license must be submitted on a Department-prescribed form and prior to the expiration date of the current license. ( )

05. Denial or Revocation of License. The Department may deny the issuance of a license or revoke any license when persuaded by a preponderance of the evidence that conditions exist that endanger the health or safety of any resident, or that the facility is not in substantial compliance with these rules. ( )

a. Additional causes for denial of a license: ( )

i. The applicant has willfully misrepresented or omitted information on the application or other documents pertinent to obtaining a license. ( )

ii. The applicant of the person proposed as the administrator has been guilty of fraud, gross negligence, abuse, assault, battery, or exploitation in relationship to the operation of a health facility. ( )

iii. The applicant or the person proposed as the administrator of the facility: ( )

(1) Has been denied or has had revoked any health facility license; ( )

(2) Has been convicted of operating any health facility without a license; or ( )

(3) Has been prohibited from operating a health facility or shelter home. ( )

(4) Is directly under the control or influence of any person who has been the subject of any proceeding, or the actor in any circumstance, described in Subsection 050.05 of this rule. ( )

b. Additional causes for revocation of license: ( )

i. Any act adversely affecting the welfare of residents is being permitted, aided, performed, or abetted by the person(s) in charge of the facility. Acts include, but are not limited to, neglect, physical abuse, mental abuse, emotional abuse, violation of civil rights, or exploitation. ( )

ii. Any condition exists in the facility that endangers the health or safety of any resident. ( )

iii. The licensee has willfully misrepresented or omitted information on the application or other documents pertinent to obtaining a license. ( )

iv. The licensee or administrator has demonstrated lack of sound judgment in the operation or management of the SNF. ( )

v. The licensee or administrator of the facility: ( )

(1) Has been denied or has had revoked any health facility license; ( )

(2) Has been convicted of operating any health facility without a license; ( )

(3) Has been prohibited from operating a health facility or shelter home; or ( )

(4) Is directly under the control or influence of any person who has been the subject of any proceeding, or the actor in any circumstance, described in Subsection 050.05 of this rule. ( )

06. Change of Facility Ownership, Operator, or Lessee. When a change is contemplated, the owner/operator must notify the Department and provide a new application at least thirty (30) days prior to the proposed date of change. ( )

07. Penalty for Operating a Facility Without a License. Any person establishing, conducting, managing, or operating any facility without a license, under Sections 39-1301 through 39-1314, Idaho Code, is guilty of a misdemeanor punishable by imprisonment in a county jail for a period not exceeding six (6) months, or by a fine not exceeding three hundred dollars ($300), or both. Each day of continuing violation constitutes a separate offense. If the county prosecuting attorney in the county where the alleged violation occurred fails or refuses to act within sixty (60) days of notification of the violation, the attorney general is authorized to prosecute any violations under Section 39-1312, Idaho Code. ( )

051. -- 099. (RESERVED)

100. ADMINISTRATION.

01. Governing Body. The following requirements must be met: ( )

a. The true name and current address for each person or business entity having a five percent (5%) or more direct, or indirect, ownership interest in the facility is supplied to the Department at the time of licensure application or preceding any change in ownership. ( )

b. The names, addresses, and titles of offices held by all members of the facility's governing authority are submitted to the Department. ( )

c. A copy of the lease (if a building or buildings are leased to a person(s) to operate as a facility) showing clearly in the context which party to the agreement is to be held responsible for the maintenance and upkeep of the property to meet standards is available for review by the Department. Terms of the financial arrangement may be omitted from the copy of the lease available to the Department. ( )

02. Administrator. The governing body, owner, or partnership must appoint an Idaho-licensed nursing home administrator for each facility who is responsible and accountable for carrying out the policies determined by the governing body. The following requirements must be met: ( )

a. Each facility must employ an administrator on a full-time basis for day-to-day operations. ( )

b. In the administrator's absence, an individual who is responsible, accountable, and at least twenty-one (21) years of age is to be authorized, in writing, to act in their behalf to assure administrative direction of the facility. ( )

c. The administrator is responsible for establishing and assuring the implementation of written policies and procedures for each service offered by the facility or through arrangements with an outside service. ( )

d. The administrator, their relatives, or employees, are not to act as, the legal guardian of, or have power of attorney for, any residents unless specifically adjudicated by appropriate legal order. ( )

e. The administrator is to provide to the public and the resident an accurate description of the facility services and care. Representation of the facility's services to the public is not to be misleading. ( )

f. The administrator, owner, and employees of a facility are governed under Section 15-2-616, Idaho Code, concerning the devise or bequest of a resident's property by a last will and testament. ( )

g. The facility will notify the Department within seventy-two (72) hours when there is a change in the administrator because of resignation, transfer, personal/medical emergency, or redundancy. The notification will include the name, contact information, and Idaho license number of the new administrator. ( )

03. **Admission Policies**. The facility must establish written admission policies for all resident admissions and make a copy available to residents, their relatives, and to the public. ( )

04. **Accident or Injury**. The facility must show evidence of written safety procedures for handling of residents, equipment lifting, and the use of equipment. The following must be met: An incident-accident record needs to be kept of all incidents or accidents sustained by employees, residents, or visitors in the facility that includes the following: ( )

a. Name of employee, resident, or visitor; ( )

b. A factual description of the incident or accident; ( )

c. Description of the condition of the resident, employee, or visitor including any injuries resulting from the accident; and ( )

d. Time and date of notification to physician, if necessary. ( )

101. -- 104. (RESERVED)

105. PERSONNEL.

01. **Job Description**. Must be current, on file, and: ( )

a. Include the authority, responsibilities, and duties of each classification of personnel; and ( )

b. Be given to each employee consistent with their classification. ( )

02. **Age Limitations**. Employees, other than licensed personnel, who are less than eighteen (18) years old may not provide direct resident care except when employees are students or graduates of a recognized vocational health care training program. ( )

03. **Personnel Files**. Must be kept for each employee containing: ( )

a. Name, current address, and telephone number; ( )

b. Social security number; ( )

c. Qualifications for the position for which they are hired, including education and experience; ( )

d. If an Idaho license is required, verification of current active and unencumbered license; ( )

e. Position in facility; ( )

f. Date of employment; ( )

g. Date of termination and reason; and ( )

h. Verification of a negative TB test. ( )

106. FIRE AND LIFE SAFETY.
All facilities must be maintained, in good repair, structurally sound, equipped to assure safety of residents, employees the public and meet requirements for the fire and life safety standards for a health care facility as follows: ( )

01. **General Requirements for Fire and Life Standards for a Health Care Facility**. Where natural or man-made hazards are present, the facility must provide suitable fences, guards, and/or railings to isolate the

hazard from the resident's environment. ( )

02. Smoking. Because smoking has been acknowledged to be a potential fire hazard, a continuous effort must be made to reduce this hazard in the facility to include adopting written rules available to all facility personnel, residents, and the public with the following: ( )

a. Smoking is prohibited in any area where flammable liquids, gases, or oxygen are in use or stored and any other areas posted with "No Smoking" signs. ( )

b. Residents are not permitted to smoke in bed. ( )

c. Unsupervised smoking by residents not mentally or physically responsible is prohibited. This includes residents affected by medication. ( )

d. Designated areas are assigned for employee, resident, and public smoking. ( )

e. Nothing in this rule requires that smoking be permitted in facilities whose admission policies prohibit smoking. ( )

03. Report of Fire. A separate report of each fire incident occurring within the facility must be submitted to the Department within thirty (30) days of the occurrence. The reporting form "Facility Fire Incident Report" will be issued by the Department to secure specific data concerning date, origin, extent of damage, method of extinguishment, and injuries (if any). ( )

04. Storage, Heating Appliances, Hazardous Substances. The following requirements must be met: ( )

a. Attics and crawl spaces are not used for storage of any materials. ( )

b. Rooms housing heating appliances are not used for storage of combustible materials. ( )

107. (RESERVED)

108. WATER SUPPLY.
The following requirements must be met: ( )

01. Water Supply. An approved public or municipal water supply must be used wherever available. ( )

02. Private Water Supply. ( )

a. In areas where an approved public or municipal water supply is not available, a private water supply is provided, and meets the standards approved by the Department. ( )

b. If water is from a private supply, water samples are submitted to the Department through the district public health laboratory for bacteriological examination at least once every three (3) months. Copies of the laboratory reports are kept on file in the facility by the administrator. ( )

03. Sufficient Supply of Water. Always provide sufficient amount of water under adequate pressure to meet the sanitary requirements of the facility. ( )

109. -- 119. (RESERVED)

120. EXISTING CONSTRUCTION STANDARDS.
All existing buildings must meet the requirements in this rule, and also the standards, guidelines, and requirements contained in the sources incorporated by reference in Section 002 of these rules. In the event of a change in ownership of a facility, the facility must meet all requirements prior to issuance of a new license. ( )

01. Site Requirements. The location of an existing facility must be: ( )

a. Served by an all-weather road, always kept open and accessible to motor vehicles. ( )

b. A accessible to public utilities. ( )

c. In a lawfully constituted fire district. ( )

d. Providing off-street motor vehicle parking at the rate of one (1) space for every three (3) licensed beds. ( )

02. General Building Requirements. An existing facility must be of such character to be suitable for use as a facility. The facility is subject to approval by the Department. Other requirements are below: ( )

a. No facility is maintained in an apartment house or other multiple dwelling. ( )

b. Roomers or boarders are not accepted for lodging in any facility. ( )

c. Each building has a telephone for resident use so located as to provide wheelchair access for personal, private telephone communications. A telephone with amplifying equipment is available for the hearing impaired. ( )

d. A staff calling system is installed at each resident bed and in each resident toilet, bath, and shower room. The staff call in the toilet, bath, or shower room must be an emergency call. All calls are to register at the staff station and actuate a visible signal in the corridor at the resident's door. The activating mechanism within the resident's sleeping room is to be located as readily accessible to the resident at all times. ( )

03. Resident Accommodations. Must include the following: ( )

a. Each resident room is an outside room. ( )

b. Every resident sleeping room is provided with a window as follows: ( )

i. Equal to at least one-eighth (1/8) of the floor area. ( )

ii. Operable to obtain fresh air. ( )

iii. Provided with curtains, drapes, or shades. ( )

iv. Located to permit the resident a view from a sitting position. ( )

v. Has screens. ( )

c. No resident room can be located: ( )

i. So it can be reached only by passing through another individual's room, a utility room, or any other room. ( )

ii. So it opens into any room in which food is prepared or stored. ( )

d. Resident beds are not placed in hallways or in any location commonly used for other than bedroom purposes. ( )

e. Ceiling heights in resident rooms are a minimum of seven (7) feet, six (6) inches. ( )

f. All resident rooms are numbered and all other rooms numbered or identified as to purpose.

( )

g. Gardens, yards, or portions of yards are secure for outdoor use by all residents and bounded by a substantial enclosure if intended for unsupervised use by residents who may wander away from the facility. ( )

h. Toilet rooms, tub/shower rooms, and handwashing facilities are constructed as follows: ( )

i. Toilet rooms and bathrooms for residents and personnel are not to open directly into any room in which food, drink, or utensils are handled or stored. ( )

ii. Toilet and bathroom are separated from all other rooms by solid walls or partitions. ( )

iii. On floors where wheelchair residents are housed, there is at least one (1) toilet and one (1) bathing facility large enough to accommodate wheelchairs. ( )

iv. All inside bathrooms and toilet rooms have forced ventilation to the outside. ( )

v. Toilet rooms are situated such that an individual need not pass through or into another resident's room to reach the toilet facilities. ( )

vi. Handrails and/or grab bars are provided in resident toilet rooms and bathrooms and are located to be functionally adequate. ( )

vii. Each resident floor or nursing unit has at least one (1) tub or shower for every twelve (12) licensed beds; one (1) toilet for every eight (8) licensed beds; and one (1) lavatory with mirror for every eight (8) licensed beds. Tubs, showers, and lavatories are connected to hot and cold running water. ( )

04. Dining, Recreation Facilities, and Activity Areas. The location of these areas must encourage residents, participants, and visitor use. The space needed for dining, recreation, and activities must meet the needs of the residents and have adequate space for adaptive equipment and mobility aids. ( )

05. Isolation Units (Temporary). Each facility must have available a room with private toilet, lavatory, and other accessory facilities for temporary isolation of a resident with a communicable or infectious disease. ( )

06. Utility Areas and Clean and Soiled Areas. A room with a separate entrance and physically partitioned from any facility for toilet, bathing, or both, must be provided for the preparation, cleansing, sterilization, and storing of nursing supplies and equipment. A room must be provided on each floor in each nursing or staff unit of the facility. Provisions must be made for the separation of clean and soiled activities. Food and/or ice must not be stored or handled in this room. Soiled utility rooms must be provided with mechanical exhaust ventilation to the outside. ( )

07. Storage Space. The facility must provide general storage areas and medical storage areas as follows: ( )

a. General storage at the rate of ten (10) square feet per licensed bed, in addition to suitable storage provided in the resident's sleeping room. ( )

b. Safe and adequate storage space for medical supplies and equipment and a space appropriate for the preparation of medications. ( )

08. Electrical and Lighting. All electrical and lighting installation and equipment must adhere to applicable local and state regulations, and the standards, guidelines, and requirements contained in the sources incorporated by reference in Section 002 of these rules, and as follows: ( )

a. All resident personal electrical appliances are inspected and approved by the facility engineer, administrator, or both. ( )

b. All resident rooms have adequate lighting for the rooms and for reading surfaces. ( )

09. Heating, Ventilation, and Air Conditioning (HVAC). The system must be capable of maintaining a temperature of seventy degrees (70°F) to eighty-five degrees (85°F) Fahrenheit in all weather conditions. ( )

a. Facility must be ventilated, and take precautions to eliminate offensive odors in the facility. ( )

b. Oil space heaters, recessed gas wall heaters, and floor furnaces cannot be used as heating systems for facilities. ( )

10. Plumbing. In the absence of local plumbing codes, all plumbing systems must comply with requirements under IDAPA 24.39.20, "Rules Governing Plumbing," and the following: ( )

a. Vacuum breakers are installed where necessary to prevent backsiphonage. ( )

b. The temperature of hot water at plumbing fixtures used by residents is between one hundred degrees (100F) and one hundred twenty degrees (120F) Fahrenheit. ( )

121. NEW CONSTRUCTION STANDARDS.

All new buildings must meet the following requirements and the standards, guidelines, and requirements contained in the sources incorporated by reference in Section 002 in these rules. Where there are conflicts between the requirements, the most restrictive condition will apply. All new construction, plans, and specifications must be submitted to, and approved by, the Department to assure compliance with applicable standards, codes, rules, and regulations. All plans must be submitted electronically. ( )

01. Plans, Specifications, and Inspections. All new construction, plans, and specifications must be submitted to, and approved, by the Department to assure compliance with applicable standards, codes, rules, and regulations. All plans must be submitted electronically. ( )

a. A full set of architecture plans must be prepared, signed, stamped, and dated by an Idaho-licensed architect or engineer. A variance of this requirement may be granted by the Department when the project does not necessitate involvement of an architect or engineer. This must include all the following: ( )

i. The assignment of all spaces, size of areas and rooms, and indicated in outline the fixed and movable equipment and furniture. ( )

ii. The plans are drawn at a scale sufficiently large to clearly present the proposed design, but not less than a scale of one-eighth inch (1/8") equals one foot (1'). ( )

iii. The drawings include a plan for each floor, including the basement or ground floor with approach or site plan, showing roads, parking areas, sidewalks, etc. ( )

iv. The total floor area and number of beds are computed and noted on the drawings. ( )

v. Outline specifications provide a general description of the construction, including interior finishes, acoustical material, its extent and type and heating, electrical, and ventilation systems. ( )

vi. A physical address approved by the city or county. ( )

vii. Life safety plans. ( )

viii. Fire alarm shop drawings and specifications submitted by a qualified fire alarm contractor. ( )

ix. Sprinkler shop drawings and specifications submitted by an Idaho-licensed fire sprinkler

contractor. ( )

eb. Prior to occupancy, the facility must be inspected and approved by the Department. The facility will notify the Department at least two (2) weeks prior to completion to schedule a final inspection. ( )

122. FURNISHINGS AND EQUIPMENT.
For furnishings, resident rooms, and bedrooms the following must be met: ( )

01. Each resident is provided with their own bed that is at least thirty-six (36) inches wide, has a headboard and a footboard, is substantially constructed, and in good repair. Roll-away type beds, cots, folding beds, double beds, or Hollywood-type beds are not to be used. ( )

02. Each bed is provided with satisfactory type springs in good repair and a clean, comfortable mattress at least five (5) inches thick, (four (4) inches if of foam rubber construction and four and one-half (4-1/2) inches if of innerspring type) and standard in size for the bed. ( )

03. Each resident is provided with an individual rack with towel and washcloth. ( )

04. Each resident is provided with a cup and a covered pitcher of fresh water (or the equivalent) at the bedside within reach of resident. ( )

123. -- 199. (RESERVED)

200. TUBERCULOSIS (TB) CONTROL.
All facilities must meet the standards, guidelines, and requirements contained in the sources incorporated by reference in Section 002 of these rules. The following requirements must also be met: ( )

01. Tuberculosis Control. To assure the control of tuberculosis in the facility, there is a planned, organized program of prevention through written and implemented procedures that are consistent with current accepted practices and included as part of the facility's Infection Control Program. Facilities will remain current with screening and testing of TB for healthcare personnel based on the recommendations and guidelines from the Centers for Disease Control and Prevention and the National Tuberculosis Controllers Association. ( )

02. If Case of Tuberculosis is Found in the Facility. The facility must notify their local public health district following State reporting requirements in IDAPA 16.02.10, "Idaho Reportable Diseases" and follow their recommendations and guidance. ( )

201. PHARMACY SERVICES.
Medications must be provided to residents by licensed nursing staff or certified medication assistants (MA-C) per established written procedures which follow state and federal regulations, and professional standards of practice for medication administration and documentation. All facilities must also meet the standards, guidelines, and requirements contained in the sources incorporated by reference in Section 002 of these rules. ( )

202. PET THERAPY.
The following requirements must be met: ( )

01. Policies and Procedures. Are developed by the facility concerning the admission of pets through a visitation program or on a permanent basis. ( )

02. Type of Pet Allowed. The types of pets allowed are as follows: ( )

a. Only domesticated household pets (dogs, cats, birds, fish, hamsters, etc.) are permitted, with the exception under Subsection 202.02.b of this rule. ( )

b. Exotic pets and wild animals, even though trained, are not be permitted due to the high potential for spread of disease and injury to residents or staff, unless they are brought in for visitation, they are always kept on a leash and under the control of the trainer. ( )

03. Examination of Pets. Pets are to receive an examination by a veterinarian prior to admission to the facility. Appropriate vaccinations are to be given. Birds subject to transmission of psittacosis are included. This applies to both ownership and visitation. ( )

04. Enclosures. Small animals such as hamsters and birds are to be kept in enclosures. ( )

05. Permitted Areas. Pets are not to be allowed in food preparation or storage areas. They are also not to be allowed in any other area if their presence would pose a significant risk to residents, staff, or visitors. ( )

06. Interference. The presence of pets cannot interfere with the health and rights of other individuals, i.e., noise, odor, allergies, and interference with the free movement of individuals about the facility. ( )

203. (RESERVED)

204. DAY CARE SERVICES.

Day care services may be provided for up to twelve (12) hours per day as determined by facility policy. If provided, it cannot interfere with the regular services to facility residents. The following requirements must be met: ( )

01. Staffing. The facility is to provide additional staff depending upon the number of day care participants and assure that the day care participants receive the services necessary to meet their needs. ( )

02. Records. A day care participant record is to be maintained. ( )

03. Space and Supplies. That Facilities accepting day care participants are to provide such space and supplies as necessary to comfortably and efficiently meet the needs of both in-house residents and day care participants. ( )

205. CHILD CARE CENTERS.

The following requirements must be met: ( )

01. Policies and Procedures. Any facility that permits a child care center adjacent to or attached to the SNF is to establish well-defined written and implemented policies and procedures pertaining to the relationship between the child care center and the SNF. These include, but are not limited to infection control and prevention of disease transmission. ( )

02. Day Care Licensure. Any day care home or day care center for children, as defined under Basic Day Care License Act, Sections 39-1101 through 39-1120, Idaho Code, either attached as a distinct part or as a separate facility on the premises of the SNF facility is to be licensed separately by the appropriate state or local licensing agency. ( )

03. Day Care Compliance. Every child day care home or center is to comply with IDAPA 16.02.10, “Idaho Reportable Diseases.” ( )

04. Day Care Staff. Each child day care home or center is to be staffed appropriately to meet the needs of the children cared for, with a separate staff from the employees of the SNF facility. ( )

206. -- 300. (RESERVED)

301. RESPITE CARE SERVICES.

If the SNF offers respite care to relieve families or other individuals, there must be policies and procedures written and implemented regarding the program. The following requirements must be met: ( )

01. Admissions. Respite care residents are to be admitted to the facility in the same manner as any other admission that includes: ( )

a. Authorization by a physician. ( )

b. Current medical and other information sufficient to allow the facility to safely care for the resident. ( )

c. Medication and treatment orders signed and dated by the resident's attending physician. ( )

02. Limitations. No resident is to be considered as respite care when the stay at the facility is not for purposes of relief for other care givers or families and the stay exceeds a four (4) week period of time. Variances may be granted by the Department on a case-by-case basis. ( )

03. Records. Are to be maintained for all respite care residents that include at least the following: ( )

a. Medical information sufficient to care for the resident submitted by the attending physician. ( )

b. Signed and dated physician's orders for care, including diet, medications, treatments, and any physical activity limitations. ( )

c. Nursing and other notes by staff caring for the resident. ( )

d. Medication administration record. ( )

e. Pertinent resident data information such as name, address, next of kin, who to call in an emergency, name of physician, etc. ( )

04. Exceptions. Due to the short length of stay, certain documents and actions provided to and required for other in-house nonrespite care residents are not required for respite care residents. Exceptions to be considered at the discretion of the facility are as follows: ( )

a. A complete history and physical examination by the physician is not required so long as he provides the facility with sufficient information to care for the resident. ( )

b. Physician visits are required only if the resident needs such a visit due to illness or injury or if the resident exceeds the definition of respite care and remains in the facility beyond a four (4) week period. ( )

c. The resident care plan may be limited to include care and services to be provided during their stay and short-and long-term goals are not necessary. ( )

d. Activity assessments and plans are not necessary so long as any activity limitations are known and recorded on the resident's plan of care. ( )

302. -- 999. (RESERVED)

[Agency redlined courtesy copy]

***Italicized text* indicates changes between the text of the proposed rule as adopted in the pending rule.**

16.03.02 – SKILLED NURSING FACILITIES

000. LEGAL AUTHORITY.
~~The Idaho Legislature has delegated to the Board of Health and Welfare the responsibility to establish and enforce~~

~~rules to promote safe and adequate treatment of individuals within a Skilled Nursing Facility under~~ Sections 39-1303a, 39-1306, 39-1307, 39-1307A, and 39-1307B, Idaho Code, authorize the Board to establish and enforce rules to promote safe and adequate treatment of individuals in Skilled Nursing Facilities. ~~(3-17-22)~~( )

~~001. TITLE AND SCOPE.~~

~~**01. Title**. These rules are titled, IDAPA 16, Title 03, Chapter 02, "Skilled Nursing Facilities." (3-17-22)~~

~~**02. Scope**. These rules establish regulations and standards for the provision of adequate care and licensure of Skilled Nursing Facilities in the state of Idaho. These rules are expressly intended for the benefit of all skilled nursing residents. To this end, the Idaho State Board of Health and Welfare may issue variances to these rules under standards and procedures established by the Board. (3-17-22)~~

00~~2~~1. WRITTEN INTERPRETATIONS.
This agency may have written statements that pertain to the interpretations of these rules ~~of this chapter~~. ~~(3-17-22)~~( )

002. INCORPORATION BY REFERENCE.
The following are incorporated by reference as provided by Section 67-5229(a), Idaho Code, and are available for public review upon request at the Department, 450 W. State Street, Boise, Idaho, 83702 or online for review as noted below. ( )

01. Title 42, Chapter IV, Subchapter G, Part 483. Public Health, Centers for Medicare & Medicaid Services, Department of Health and Human Services, Standards and Certification, Requirements for States and Long Term Care Facilities. August 1, 1989. Online at https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-483?toc=1. ( )

02. Guidelines for Design and Construction of Residential Health, Care, and Support Facilities. Facility Guidelines Institute. 2022 Edition, Specific Requirements for Nursing Homes. Available at *https://healthandwelfare.idaho.gov/providers/facility-standards/facility-fire-safety-and-construction or by registering free at FGI Digital Library https://shop.fgiguidelines.org/login.* ( )

003. – 008. (RESERVED)

009. ~~CRIMINAL HISTORY AND~~ BACKGROUND CHECK REQUIREMENTS.

01. ~~Criminal History and~~ Background Check. A skilled nursing facility (SNF) must complete a ~~criminal history and~~ background check and receive a clearance on employees, volunteers, and contractors hired, recruited, or contracted with after October 1, 2007, who have direct patient access to residents in the ~~skilled nursing facility~~ SNF. A Department check conducted under IDAPA 16.05.06, "Criminal History and Background Checks," satisfies this requirement. Other ~~criminal history and~~ background checks may be accepted provided they meet ~~the~~ criteria in Subsection 009.02 of this rule and the entity conducting the check issues written findings. The entity must provide a copy of these written findings to both the facility and the employee. The following individuals must receive a background check clearance: ~~(3-17-22)~~( )

a. Owners and Corporate Leaders; ( )

b. Administrators and Designees; ( )

c. Director of Nursing Services (DNS); ( )

d. Certified Nursing Assistants (CNA); ( )

e. Maintenance Director and Maintenance Personnel; ( )

f. Registered Nurses (RN); ( )

g. Licensed Practical Nurses (LPN); ( )

h. Environmental Services Personnel; ( )

i. Activity Director and Activity Assistants; ( )

j. Contracted staffing accruing at least twelve (12) hours weekly with direct patient contact; ( )

k. Volunteers utilized or credentialed by the facility with direct patient contact; ( )

l. Nursing Assistants; ( )

m. Hospitality Aides; ( )

n. Social Services Personnel; ( )

o. Business Office Personnel; ( )

p. Therapy Services Personnel; ( )

q. Registered Dietitians; ( )

r. Dietary Manager and Dietary Personnel; ( )

s. Laundry Service Personnel; ( )

t. Unlicensed Assistive Personnel (UAP); ( )

02. Scope of ~~a Criminal History and~~ Background Check. The ~~criminal history and~~ background check must~~, at a minimum,~~ be a fingerprint-based criminal history and background check that ~~includes~~ may include a search ~~of~~ from the following ~~record sources~~: ~~(3-17-22)~~( )

a. Federal Bureau of Investigation (FBI); ( )

b. Idaho State Police Bureau of Criminal Identification; ( )

c. Any State Sexual Offender Registry; ~~(3-17-22)~~( )

d. Any state or federal Child Protection Registry; ( )

e. Any state or federal Adult Protection Registry. ( )

~~d~~f. Office of Inspector General List of Excluded Individuals and Entities;~~ and~~ ~~(3-17-22)~~( )

g. Idaho Department of Transportation Driving Records; ( )

~~e~~h. Nurse Aide Registry~~.~~; and ~~(3-17-22)~~( )

i. Records and findings from other states and jurisdictions. ( )

03. Availability to Work. Any direct resident access individual hired, retired or contracted with, on or after October 1, 2007, must self-disclose all arrests and convictions before having access to residents. The individual is ~~allowed to~~ can only work under supervision until the ~~criminal history and~~ background check is completed and a clearance received. If a disqualifying crime ~~as described in~~ under IDAPA 16.05.06, "Criminal History and Background Checks," is disclosed, the individual cannot have access to any resident. ~~(3-17-22)~~( )

04. Submission of Fingerprints. The individual's fingerprints must be submitted to the entity conducting the~~ criminal history and~~ background check within twenty-one (21) days of their date of hire, contract, or recruitment. ~~(3-17-22)~~( )

05. New~~ Criminal History and~~ Background Check. An individual must have a~~ criminal history and~~ background check and clearance when: ~~(3-17-22)~~( )

a. Accepting employment, a contract, or a position with a new employer; and ~~(3-17-22)~~( )

b. Their last~~ criminal history and~~ background check was completed more than three (3) years prior to their date of hire, contract, or recruitment. ~~(3-17-22)~~( )

06. Use of~~ Criminal History~~ Background Check Within Three Years of Completion. Any employer may use a previous criminal history and background check obtained under these rules if: ~~(3-17-22)~~( )

a. The individual has received a~~ criminal history and~~ background check with clearance within three (3) years~~ of~~ preceding their date of hire, contract, or recruitment; ~~(3-17-22)~~( )

b. The employer has documentation of the~~ criminal history and~~ background check findings; ~~(3-17-22)~~( )

c. The employer completes a state-only background check of the individual through the Idaho State Police Bureau of Criminal Identification; and ( )

d. No disqualifying crimes are found. ( )

07. Employer Discretion. The new employer, at its discretion, may require an individual to complete a ~~criminal history and~~ background check at any time, even if the individual has received a~~ criminal history and~~ background check within the three (3) years~~ of~~ preceding their date of hire, contract, or recruitment. ~~(3-17-22)~~( )

010. DEFINITIONS.

~~For the purposes of these rules the following terms are used, as defined herein:~~ ~~(3-17-22)~~

01. Administrator. The person delegated the responsibility for management of a facility by the legal owner, employed as a full-time administrator in each facility, and licensed by the ~~s~~State of Idaho. The administrator and legal owner may be the same individual. ~~(3-17-22)~~( )

02. Advanced Practice Registered Nurse. An~~ licensed registered nurse~~ RN having specialized skills, knowledge and experience who is authorized under the Idaho Board of Nursing rules to provide certain health services in addition to those performed by~~ licensed~~ registered nurses (R~~.~~N~~.~~). ~~(3-17-22)~~( )

03. Board. The Idaho~~ State~~ Board of Health and Welfare. ~~(3-17-22)~~( )

04. Change of Ownership. The sale, purchase, exchange, or lease of an existing facility by the present owner or operator to a new owner or operator. ( )

05. Charge Nurse. One (1) or more licensed nurse(s) who has direct responsibility for nursing services in an operating unit or physical subdivision of a facility during one (1) eight (8)-hour shift, to be provided by ~~herself~~themself and by any other licensed nurse or auxiliary personnel under~~ her~~ their immediate charge. ~~(3-17-22)~~( )

06. Department. The Idaho Department of Health and Welfare or its designee. ~~(3-17-22)~~( )

~~**07.** **Director**. The Director of the Department of Health and Welfare or designee.~~ ~~(3-17-22)~~

0~~8~~7. Director of Nursing Services (DNS). An~~ licensed registered nurse~~ RN currently licensed~~ by the state of~~ in Idaho and qualified by training and experience. ~~(3-17-22)~~( )

0~~9~~8. **Existing Facility**. A nursing home currently licensed. ( )

09. **Governing Body**. Individuals such as facility owner(s), chief executive officer(s), or other individuals who are legally responsible to establish and implement policies regarding the management and operations of the facility. ( )

10. **Governmental Unit**. The ~~s~~State of Idaho, any county, municipality, or other political subdivision, or any department, division, board, or other agency thereof. ~~(3-17-22)~~( )

11. **Hospital Licensing Act**. The ~~a~~Act~~ set out in~~ under Sections 39-1301 through 39-1314, Idaho Code. ~~(3-17-22)~~( )

~~12.~~ ~~**Licensee**. The person or organization to whom a license is issued.~~ ~~(3-17-22)~~

~~13.~~ ~~**Licensing Agency**. The Department of Health and Welfare.~~ ~~(3-17-22)~~

1~~4~~2. **Licensed Nursing Personnel**. An ~~licensed registered nurse (~~R~~.~~N~~.)~~ or ~~licensed practical nurse (~~L~~.~~P~~.~~N~~.)~~ currently licensed~~ by the~~ in Idaho~~ State Board of Nursing~~. ~~(3-17-22)~~( )

1~~5~~3. **New Construction**. ( )

a. New buildings to be used as a facility. ( )

b. Additions to existing buildings and/or added bed capacity. ( )

c. Conversion of existing buildings or portions thereof for use as a facility. ( )

d. Unlicensed buildings seeking licensing, federal certification, or both. ( )

1~~6~~4. **Person**. Any individual, firm, partnership, corporation, company, association, joint stock association, governmental unit, or legal successor thereof. ( )

1~~7~~5. **Pharmacist**. Any person licensed~~ by the Idaho Board of Pharmacy~~ as a~~ licensed~~ pharmacist in Idaho. ~~(3-17-22)~~( )

1~~8~~6. **Physician**. Any person~~ who holds a~~ licensed~~ issued~~ by the~~ State~~ Idaho Board of Medicine to practice medicine and surgery, osteopathic medicine and surgery, or osteopathic medicine, provided further, that others authorized by law to practice any of the healing arts will not be considered physicians (Section 54-1803(3), Idaho Code). ~~(3-17-22)~~( )

1~~9~~7. **Resident**. An individual requiring and receiving skilled nursing care and residing in a facility licensed to provide the level of care required. ( )

~~20~~18. **Skilled Nursing Facility (SNF)**. A facility designed to provide area, space, and equipment to meet the health needs of two (2) or more individuals who~~, at a minimum,~~ require inpatient care and services for twenty-four (24) or more consecutive hours for unstable chronic health problems requiring daily professional nursing supervision and licensed nursing care on a twenty-four (24) hour basis, restorative, rehabilitative care and assistance in meeting daily living needs. Medical supervision is necessary on a regular, but not daily, basis (Section 39-1301, Idaho Code). ~~(3-17-22)~~( )

~~21~~19. **Substantial Compliance**. A facility is in substantial compliance with these rules, regulations, and minimum standards when there are no deficiencies that would endanger the health, safety, or welfare of the residents. ~~(3-17-22)~~( )

~~22.~~ ~~**Supervising Nurse**. The one (1) licensed nurse designated by the DNS to be responsible for the overall direction and control of all nursing services throughout the entire facility during one (1) eight (8) hour shift.~~

(3-17-22)

20. Unlicensed Assistive Personnel (UAP). This term designates unlicensed personnel employed to perform nursing care services under the direction and supervision of licensed nurses. The term also includes licensed or credentialed health care workers whose job responsibilities extend to health care services beyond usual and customary roles and which activities are provided under the direction and supervision of licensed nurses. UAPs are prohibited from performing any licensed nurse functions under Section 54-1402, Idaho Code. UAPs may not be delegated procedures involving acts that require nursing assessment or diagnosis, establishment of a plan of care or teaching, the exercise of nursing judgment, or procedures requiring specialized nursing knowledge, skills, or techniques. ( )

231. Waiver or Variance. A waiver or variance to these rules and minimum standards in whole or in part that may May be granted under the following conditions: (3-17-22)( )

a. Good cause is shown for such waiver and the health, welfare, or safety of residents will not be endangered by granting such a waiver; (3-17-22)( )

b. Precedent will not be set by granting of such waiver. The waiver may be renewed annually if sufficient written justification is presented to the Licensing Agency Department. (3-17-22)( )

011. – 049. (RESERVED)

050. LICENSURE.

01. General Requirements. Before any person either directly or indirectly operates a facility, they must make an application for and receive a valid license for operation of the facility, and no resident must be admitted or cared for in a facility that is required under Idaho law to be licensed, until a license is obtained. ( )

a. The facility and all related buildings associated with the operation of the facility, as well as all records required under these rules, must always be accessible at any reasonable time to authorized representatives of the Department for the purpose of inspection, with or without prior notice. (3-17-22)( )

b. Before any building is constructed or altered for use as a facility, written approval of construction or alteration of plans must be obtained from the Department. ( )

c. Information received by the licensing agency Department through filed reports, inspection, or as otherwise authorized under this law, must not be disclosed publicly in such a manner as to identify individual residents except in a proceeding involving the question of licensure. Public disclosure of information obtained by the licensing agency Department for the purposes of this law must be governed by these rules, regulations, and minimum standards adopted by the Board. (3-17-22)( )

02. Application for an Initial License. In addition to obtaining prior approval of plans for construction or alterations, all All persons planning the operation of a facility must provide a Department-approved application for an initial facility license at least three (3) months prior to the planned opening date with the following: (3-17-22)( )

a. Evidence of a request for a determination of applicability for Section 1122 (Social Security Act) regulatory review. ( )

b. A copy of the nursing home administrator's license with the application. (3-17-22)( )

c. A certificate of occupancy from the local building and fire authority. ( )

03. Issuance of License. Every facility must be designated by a distinctive name in applying for a license, and the name must not be changed without first notifying the Department in writing at least thirty (30) days prior to the date the proposed change in name change is to be effective. (3-17-22)( )

a. Each license will be issued only for the premises and persons~~ or governmental units~~ named in the application and will not be transferable. ~~(3-17-22)~~( )

b. Each license will specify the maximum allowable number of beds in each facility, which may not be exceeded, except when authorized by the Department on a time-limited emergency basis~~, and authorized by the Department~~. ~~(3-17-22)~~( )

c. The facility license must be framed and posted~~ so as~~ to be visible to the general public. ~~(3-17-22)~~( )

04. Expiration and Renewal of License. Each license to operate a facility must, unless sooner suspended or revoked, expire on the date designated on the license. Each application for renewal of a license must be submitted on a Department-prescribed form~~ prescribed by the Department~~ and prior to the~~ renewal~~ expiration date of the current license. ~~(3-17-22)~~( )

05. Denial or Revocation of License. The~~ Director~~ Department may deny the issuance of a license or revoke any license when persuaded by a preponderance of the evidence that~~ such~~ conditions exist~~ as to~~ that endanger the health or safety of any resident, or that the facility is not in substantial compliance with these rules~~ and minimum standards~~. ~~(3-17-22)~~( )

a. Additional causes for denial of a license~~ may include the following~~: ~~(3-17-22)~~( )

i. The applicant has willfully misrepresented or omitted information on the application or other documents pertinent to obtaining a license. ( )

ii. The applicant of the person proposed as the administrator has been guilty of fraud, gross negligence, abuse, assault, battery, or exploitation in relationship to the operation of a health facility. ( )

iii. The applicant or the person proposed as the administrator of the facility: ( )

(1) Has been denied or has had revoked any health facility license;~~ or~~ ~~(3-17-22)~~( )

(2) Has been convicted of operating any health facility without a license; or ( )

(3) Has been~~ enjoined~~ prohibited from operating a health facility~~;~~ or shelter home. ~~(3-17-22)~~( )

(4) Is directly under the control or influence of any person who has been the subject of any proceeding, or the actor in any circumstance, described in Subsection 050.05 of this rule. ( )

b. Additional causes for revocation of license~~.~~: ~~(3-17-22)~~( )

i. Any act adversely affecting the welfare of residents is being permitted, aided, performed, or abetted by the person~~ or persons~~(s) in charge of the facility.~~ Such acts may~~ Acts include, but are not limited to, neglect, physical abuse, mental abuse, emotional abuse, violation of civil rights, or exploitation. ~~(3-17-22)~~( )

ii. Any condition exists in the facility that endangers the health or safety of any resident. ( )

iii. The licensee has willfully misrepresented or omitted information on the application or other documents pertinent to obtaining a license. ( )

iv. The~~ applicant~~ licensee or administrator has demonstrated lack of sound judgment in the operation or management of the~~ skilled nursing facility~~ SNF. ~~(3-17-22)~~( )

~~v. The facility lacks adequate staff to properly care for the number and type of residents residing at the facility. (3-17-22)~~

v~~i~~. The~~ applicant~~ licensee or administrator of the facility: ~~(3-17-22)~~( )

(1) Has been denied or has had revoked any health facility license;~~ or~~ ~~(3-17-22)~~( )

(2) Has been convicted of operating any health facility without a license;~~ or~~ ~~(3-17-22)~~( )

(3) Has been~~ enjoined~~ prohibited from operating a health facility or shelter home; or ~~(3-17-22)~~( )

(4) Is directly under the control or influence of any person who has been the subject~~ to the~~ of any proceeding~~s~~, or the actor in any circumstance, described in Subsection 050.05 of this rule. ~~(3-17-22)~~( )

06. Change of Facility Ownership, Operator, or Lessee. When a change~~ of a licensed facility's ownership, operator, or lessee~~ is contemplated, the owner/operator must notify the Department and provide a new application at least thirty (30) days prior to the proposed date of change~~ and new application submitted when there is a change of operator, ownership, or lessee~~. ~~(3-17-22)~~( )

07. Penalty for Operating a Facility~~ or Agency~~ Without a License. Any person establishing, conducting, managing, or operating any facility~~ or agency as defined,~~ without a license, under Sections 39-1301 through 39-1314, Idaho Code, is guilty of a misdemeanor punishable by imprisonment in a county jail for a period~~ of time~~ not exceeding six (6) months, or by a fine not exceeding three hundred dollars ($300), or~~ by~~ both.~~ such fine and imprisonment, and each~~ Each day of continuing violation constitutes a separate offense.~~ In the event that~~ If the county prosecuting attorney in the county where the alleged violation occurred fails or refuses to act within sixty (60) days of notification of the violation, the attorney general is authorized to prosecute any violations ~~(~~under Section 39-1312, Idaho Code~~)~~. ~~(3-17-22)~~( )

051. -- 099. (RESERVED)

100. ADMINISTRATION.

01. Governing Body.~~ Each facility must be organized and administered under one (1) authority which may be a proprietorship, partnership, association, corporation, or governmental unit.~~ The following requirements must be met: ~~(3-17-22)~~( )

a. ~~That t~~The true name and current address for each person or business entity having a five percent (5%) or more direct, or indirect, ownership interest in the facility is supplied to the Department at the time of licensure application or preceding any change in ownership. ~~(3-17-22)~~( )

b. ~~That t~~The names, addresses, and titles of offices held by all members of the facility's governing authority are submitted to the Department. ~~(3-17-22)~~( )

c. ~~That a~~A copy of the lease (if a building or buildings are leased to a person~~ or persons~~(s) to operate as a facility) showing clearly in the context which party to the agreement is to be held responsible for the maintenance and upkeep of the property to meet~~ minimum~~ standards is available for review by the Department. Terms of the financial arrangement may be omitted from the copy of the lease available to the Department. ~~(3-17-22)~~( )

02. Administrator. The governing body, owner, or partnership must appoint an Idaho-licensed nursing home administrator for each facility who is responsible and accountable for carrying out the policies determined by the governing body.~~ In combined hospital and nursing home facilities, the administrator may serve both the hospital and nursing home provided they are currently licensed as a nursing home administrator.~~ The following requirements must be met: ~~(3-17-22)~~( )

a. Each facility must employ an administrator on a full-time basis for day-to-day operations. ( )

~~a~~b. In the~~ absence of the~~ administrator's absence, an individual who is responsible~~ and~~, accountable, and at least twenty-one (21) years of age is to be authorized, in writing, to act in their behalf to assure administrative direction of the facility. ~~(3-17-22)~~( )

~~b~~c. The administrator is responsible for establishing and assuring the implementation of written

policies and procedures for each service offered by the facility~~,~~ or through arrangements with an outside service. ~~(3-17-22)~~( )

~~c~~d. The administrator, their relatives, or employees, are not to act as, the legal guardian of, or have power of attorney for, any residents unless specifically adjudicated~~ as such~~ by appropriate legal order. ~~(3-17-22)~~( )

~~d~~e. The administrator is to provide to the public and the resident an accurate description of the facility services and care. Representation of the facility's services to the public is not to be misleading. ( )

~~**e.** The administrator is responsible for providing sufficient and qualified staff to carry out all of the basic services offered by the facility. (3-17-22)~~

f. The administrator, owner, and employees of a facility are governed~~ by the provisions of~~ under Section 15-2-616, Idaho Code, concerning the devise or bequest of a resident's property by a last will and testament. ~~(3-17-22)~~( )

g. The facility will notify the Department within seventy-two (72) hours when there is a change in the administrator because of resignation, transfer, personal/medical emergency, or redundancy. The notification will include the name, contact information, and Idaho license number of the new administrator. ( )

03. Admission Policies. The~~ administrator~~ facility must establish written admission policies for all resident admissions and~~ be~~ make a copy available to residents, their relatives, and to the~~ general~~ public.~~ The following requirements must be met:~~ ~~(3-17-22)~~( )

~~**a.** A history and physical examination is recorded within forty-eight (48) hours after admission to the facility, unless the resident is accompanied by a record of a physical examination completed by a physician not more than five (5) days prior to admission. (3-17-22)~~

~~**b.** Information upon admission includes the results of a tuberculosis skin test, chest x-ray, medical and/or psycho-social diagnosis, physician's plan of care, the resident's activity limitation, and the rehabilitation potential, and are to be dated and signed by the physician. (3-17-22)~~

~~**c.** No children other than residents are to regularly occupy any portion of the resident living area. (3-17-22)~~

~~**d.** Reasonable precautions are taken in all admissions for the safety of other residents. (3-17-22)~~

~~**e.** Nothing in these rules and minimum standards should be construed as to require any facility to compel any person to undergo any medical screening, examination, diagnosis, or treatment or to accept any other health care or services provided under such plan for any purpose (other than for the purpose of discovering and preventing the spread of infection or other contagious disease or for the purpose of protecting environmental health), if such person objects (or, in case such person is a child, their parent or guardian objects), thereto on religious grounds. (3-17-22)~~

~~**04. Use of Restraints**. The following types of restraints must not be used under any conditions: canvas jackets, canvas sheets, canvas cuffs, leather belts, leather cuffs, leather hand mitts or restraints requiring a lock and key. (3-17-22)~~

~~**05. Record of Resident's Personal Valuables**. An inventory and proper accounting must be kept for all valuables entrusted to the facility for safekeeping and the status of the inventory is to be available to the resident, their conservator, guardian, or representative for review upon request. (3-17-22)~~

0~~6~~4. Accident or Injury. The~~ administrator~~ facility must show evidence of written safety procedures for handling of residents, equipment lifting, and the use of equipment. The following~~ requirements~~ must be met: ~~(3-17-22)~~

~~**a.**~~ ~~That an~~ An incident-accident record needs to be kept of all incidents or accidents sustained by employees, residents, or visitors in the facility ~~and~~ that includes the following ~~information~~: ~~(3-17-22)~~( )

~~i~~**a**. Name ~~and address~~ of employee, resident, or visitor; ~~(3-17-22)~~( )

~~ii~~**b**. A factual description of the incident or accident; ( )

~~iii~~**c**. Description of the condition of the resident, employee, or visitor including any injuries resulting from the accident; and ( )

~~iv~~**d**. Time and date of notification ~~of~~ to physician, if necessary. ~~(3-17-22)~~( )

~~**b.** That the physician is immediately notified regarding any resident injury or accident when there are significant changes requiring intervention or assessment. (3-17-22)~~

~~**c.** That immediate investigation of the cause of the incident or accident be instituted by the facility administrator and any corrective measures indicated adopted. (3-17-22)~~

101. -- 104. (RESERVED)

105. PERSONNEL.

~~**01. Daily Work Schedules**. Daily work schedules must be maintained that reflect: (3-17-22)~~

~~**a.** Personnel on duty at any given time for the previous three (3) months; (3-17-22)~~

~~**b.** The first and last names of each employee, including professional designation (R.N., L.P.N., etc.) and position; and (3-17-22)~~

~~**c.** Any adjustments made to the schedule. (3-17-22)~~

0~~2~~1. Job Description. ~~Job descriptions must~~ Must be current, on file, and: ~~(3-17-22)~~( )

a. Include the authority, responsibilities, and duties of each classification of personnel; and ( )

b. Be given to each employee consistent with their classification. ( )

0~~3~~2. Age Limitations. Employees, other than licensed personnel, who are less than eighteen (18) years ~~of age~~ old may not provide direct resident care except when employees are students or graduates of a recognized vocational health care training program. ~~(3-17-22)~~( )

~~**04. Resident Employment**. Whenever work of economic benefit to the facility is performed by a resident, such work will be subject to the provisions prescribed by law for any employee. (3-17-22)~~

~~**05. Employee Health**. Personnel policies relating to employee health must include: (3-17-22)~~

~~**a.** That the facility establishes, upon hiring a new employee, the current status of a tuberculin skin test. The determination may be based upon a report of the skin test taken prior to employment or within thirty (30) days after employment. If the skin test is positive, either by history or current test, a chest X-ray is taken, or a report of the results of a chest X-ray taken within three (3) months preceding employment and accepted. The TB Skin Test status is recorded and a chest X-ray alone is not a substitute. No subsequent chest X-ray or skin test is required for routine surveillance. (3-17-22)~~

~~**b.** That a repeat skin test is required if a resident or other staff develop tuberculosis. (3-17-22)~~

~~**c.** That the facility requires all employees report immediately to their supervisor any signs or symptoms of personal illness. (3-17-22)~~

~~**d.** That personnel who have a communicable disease, infectious wound, or other transmittable condition and who provide care or services to residents are required to implement protective infection control techniques approved by administration; are not to work until the infectious stage is corrected; are reassigned to a work area where contact with others is not expected and likelihood of transmission of infection is absent; or seeks other remedy to avoid spreading the employee's infection.~~ ~~(3-17-22)~~

0~~6~~3. Personnel Files. ~~Personnel files must~~ Must be kept for each employee containing: ~~(3-17-22)~~(   )

a. Name, current address, and telephone number ~~of the employee~~; ~~(3-17-22)~~(   )

b. Social security number; (   )

c. Qualifications for the position for which the ~~employee is~~y are hired, including education and experience; ~~(3-17-22)~~(   )

d. If an Idaho license is required, verification of current active and unencumbered license; ~~(3-17-22)~~(   )

e. Position in facility; (   )

f. Date of employment; (   )

g. Date of termination and reason; and (   )

h. Verification of a negative TB ~~skin~~ test ~~upon employment and any subsequent test results~~. ~~(3-17-22)~~(   )

106. FIRE AND LIFE SAFETY.

All ~~F~~facilities must be maintained, in good repair, structurally sound, equipped to assure safety of residents, employees the public and meet ~~general~~ requirements for the fire and life safety standards for a health care facility as follows: ~~(3-17-22)~~(   )

01. General Requirements for Fire and Life Standards for a Health Care Facility. ~~General requirements for the fire and life safety standards for a health care facility are as follows:~~ Where natural or man-made hazards are present, the facility must provide suitable fences, guards, and/or railings to isolate the hazard from the resident's environment. ~~(3-17-22)~~(   )

~~**a.** The facility must be structurally sound, maintained, and equipped to assure the safety of residents, employees, and the public.~~ ~~(3-17-22)~~

~~**b.** Where natural or man-made hazards are present on the premises, that the facility must provide suitable fences, guards, and/or railings to isolate the hazard from the resident's environment.~~ ~~(3-17-22)~~

~~**02. Life Safety Code Requirements**. The facility must meet provisions of the Life Safety Code of the National Fire Protection Association, 2012 Edition as are applicable to a health care facility except existing facilities licensed prior to the effective date of these rules and in compliance with a previous edition of the Life Safety Code may continue to comply with the edition in force at that time.~~ ~~(3-17-22)~~

0~~3~~2. Smoking. Because smoking has been acknowledged to be a potential fire hazard, a continuous effort must be made to reduce ~~such a~~ this hazard in the facility to include adopting written rules available to all facility personnel, residents, and the public with the following: ~~(3-17-22)~~(   )

a. ~~That s~~Smoking is prohibited in any area where flammable liquids, gases, or oxygen are in use or stored and any other areas posted with "No Smoking" signs. ~~(3-17-22)~~(   )

b. ~~That r~~Residents are not permitted to smoke in bed. ~~(3-17-22)~~(   )

c. ~~That u~~Unsupervised smoking by residents not mentally or physically responsible is prohibited. This includes residents affected by medication. ~~(3-17-22)~~(   )

d. ~~That d~~Designated areas are assigned for employee, resident, and public smoking. ~~(3-17-22)~~(   )

e. Nothing in ~~Section 106~~ this rule requires that smoking be permitted in facilities whose admission policies prohibit smoking. ~~(3-17-22)~~(   )

0~~4~~3. Report of Fire. A separate report of each fire incident occurring within the facility must be submitted to the ~~licensing agency~~ Department within thirty (30) days of the occurrence. The reporting form "Facility Fire Incident Report" will be issued by the ~~licensing agency~~ Department to secure specific data concerning date, origin, extent of damage, method of extinguishment, and injuries (if any). ~~(3-17-22)~~(   )

0~~5~~4. Storage, Heating Appliances, Hazardous Substances. The following requirements must be met: (   )

a. ~~That a~~Attics and crawl spaces are not used for storage of any materials. ~~(3-17-22)~~(   )

b. ~~That r~~Rooms housing heating appliances are not used for storage of combustible materials. ~~(3-17-22)~~(   )

~~**c.** That all fuel-fired heating devices have an easily accessible, plainly marked, functional remote fuel shut-off valve. (3-17-22)~~

~~**d.** That all ranges are provided with hoods, mechanical ventilation, and removable filters. (3-17-22)~~

~~**107. DIETARY SERVICE.**~~
~~The following requirements must be met: (3-17-22)~~

~~**01. Approved Diet Manual**. A current diet manual approved by the Department and available in the kitchen (the Idaho Diet Manual is approved by the Department). (3-17-22)~~

~~**02. Preparation and Correction of Menus**. That menus are prepared at least a week in advance and corrected to conform with food actually served (items not served deleted and food actually served written in.) The corrected copy of the menu and diet plan is to be dated and kept on file for thirty (30) days. (3-17-22)~~

~~**03. Variety and Adequacy of Food**. That menus provide a sufficient variety of foods in adequate amounts at each meal. Menus are to be different for the same days each week and adjusted for seasonal changes. (3-17-22)~~

107. (RESERVED)

108. ~~ENVIRONMENTAL SANITATION~~WATER SUPPLY.
The following requirements must be met: ~~(3-17-22)~~(   )

01. Water Supply. ~~An approved public or municipal water supply is used wherever available~~ An approved public or municipal water supply must be used wherever available. ~~(3-17-22)~~(   )

02. Private Water Supply. (   )

a. In areas where an approved public or municipal water supply is not available, a private water supply is provided, and meets the standards approved by the Department. (   )

b. If water is from a private supply, water samples are submitted to the Department through the district public health laboratory for bacteriological examination at least once every three (3) months. ~~Monthly bacteriological examinations are recommended.~~ Copies of the laboratory reports are kept on file in the facility by the administrator.

~~(3-17-22)~~(____)

~~e~~03. **Sufficient Supply of Water.** ~~There is~~ Always provide sufficient amount of water under adequate pressure to meet the sanitary requirements of the facility ~~at all times~~. ~~(3-17-22)~~(____)

~~**02.** **Linen-Laundry Facilities**. Personal Laundry. Residents' and employees' laundry must be collected, transported, sorted, washed, and dried in a sanitary manner and not be washed with bed linens. Residents' clothing is to be labeled to ensure proper return to the owner. (3-17-22)~~

109. -- 119. (RESERVED)

120. EXISTING ~~BUILDINGS~~ CONSTRUCTION STANDARDS.

~~These standards must be applied to all currently licensed health care facilities. Any minor alterations, repairs, and maintenance must meet these standards~~ All existing buildings must meet the requirements in this rule, and also the standards, guidelines, and requirements contained in the sources incorporated by reference in Section 002 of these rules. In the event of a change in ownership of a facility, the ~~entire~~ facility must meet ~~these standards~~ all requirements prior to issuance of a new license. ~~(3-17-22)~~(____)

~~**01.** **Codes and Standards**. Construction features of all existing facilities must be in accordance with applicable local, state, national codes, standards, and regulations in effect at the time of adoption of these rules. (3-17-22)~~

~~**a.** In the event of a conflict of requirement between the codes, the most restrictive apply. (3-17-22)~~

~~**b.** In addition, existing facilities are to comply with applicable fire and life safety codes and standards as set forth in Section 106. (3-17-22)~~

0~~2~~1. **Site Requirements**. The location of an existing facility must ~~meet the following criteria~~ be: ~~(3-17-22)~~(____)

a. ~~It must be s~~Served by an all-weather road, always kept open and accessible to motor vehicles ~~at all times of the year~~. ~~(3-17-22)~~(____)

~~**b.** It must be accessible to physician and medical services. (3-17-22)~~

~~**c.** It must be remote from railroads, factories, airports and similar noise, odor, smoke, dust and other nuisances. (3-17-22)~~

~~d~~b. ~~It must be~~A accessible to public utilities. ~~(3-17-22)~~(____)

~~e~~c. ~~It must be i~~In a lawfully constituted fire district. ~~(3-17-22)~~(____)

~~f~~d. ~~It must provide~~Providing off-street motor vehicle parking at the rate of one (1) space for every three (3) licensed beds. ~~(3-17-22)~~(____)

0~~3~~2. **General Building Requirements**. An existing facility must be of such character to be suitable for use as a facility. The facility is subject to approval by the Department. Other requirements are ~~as follows~~ below: ~~(3-17-22)~~(____)

~~**a.** That the building and all equipment are in good repair. (3-17-22)~~

~~**b.** That handrails of sturdy construction are provided on both sides of all corridors used by residents. (3-17-22)~~

~~c~~a. ~~That n~~No facility is maintained in an apartment house or other multiple dwelling. ~~(3-17-22)~~(____)

~~d~~b. ~~That r~~Roomers or boarders are not accepted for lodging in any facility. ~~(3-17-22)~~(____)

~~**04.** **Resident/Staff Communication**. Requirements governing communication must be as follows:~~ ~~(3-17-22)~~

~~**a**~~**c.** ~~That e~~Each building has a telephone for resident use so located as to provide wheelchair access for personal, private telephone communications. A telephone with amplifying equipment is available for the hearing impaired. ~~(3-17-22)~~(   )

~~**b**~~**d.** ~~That a~~A staff calling system is installed at each resident bed and in each resident toilet, bath, and shower room. The staff call in the toilet, bath, or shower room must be an emergency call. All calls are to register at the staff station and actuate a visible signal in the corridor at the resident's door. The activating mechanism within the resident's sleeping room is to be located as readily accessible to the resident at all times. ~~(3-17-22)~~(   )

0~~5~~3. **Resident Accommodations**. ~~Accommodations for the residents of the facility m~~Must include the following: ~~(3-17-22)~~(   )

a. ~~That e~~Each resident room is an outside room. ~~(3-17-22)~~(   )

~~**b.** That not more than four (4) residents can be housed in any multi-bed sleeping room.~~ ~~(3-17-22)~~

~~**c**~~**b.** ~~That e~~Every resident sleeping room is provided with a window as follows: ~~(3-17-22)~~(   )

i. Equal to at least one-eighth (1/8) of the floor area. (   )

ii. ~~Openable~~Operable to obtain fresh air. ~~(3-17-22)~~(   )

iii. Provided with curtains, drapes, or shades. (   )

iv. Located to permit the resident a view from a sitting position. (   )

v. Has screens. (   )

~~**d**~~**c.** No resident room can be located: (   )

~~i. In such a way that its outside walls are below grade.~~ ~~(3-17-22)~~

~~ii. In an attic, trailer house or in any room other than an approved room.~~ ~~(3-17-22)~~

i~~ii~~. So it can be reached only by passing through another individual's room, a utility room, or any other room. (   )

i~~v~~i. So it opens into any room in which food is prepared or stored. (   )

~~**e.** That resident rooms are a sufficient size to allow no less than eighty (80) square feet of usable floor space per resident in multiple-bed rooms. Private rooms will have no less than one hundred (100) square feet of usable floor space.~~ ~~(3-17-22)~~

~~**f**~~**d.** ~~That r~~Resident beds are not placed in hallways or in any location commonly used for other than bedroom purposes. ~~(3-17-22)~~(   )

~~**g.** That rooms have dimensions that allow no less than three (3) feet between beds and two (2) feet of space between the bed and side wall.~~ ~~(3-17-22)~~

~~**h**~~**e.** ~~That c~~Ceiling heights in resident rooms are a minimum of seven (7) feet, six (6) inches. ~~(3-17-22)~~(   )

~~**i.** That closet space in each sleeping room is twenty (20) inches by twenty-two (22) inches per~~

~~resident. Common closets utilized by two (2) or more residents are provided with substantial dividers for separation of each resident's clothing for prevention of cross contamination. All closets are equipped with doors. Freestanding closets will be deducted from the square footage in the sleeping room.~~ ~~(3-17-22)~~

~~**j.**~~ ~~That every health care facility provides a living room or recreation room for the sole use of the residents. Under no circumstances may these rooms be used as bedrooms by residents or personnel. A hall or entry is not acceptable as a living room or recreation room.~~ ~~(3-17-22)~~

~~k~~f. ~~That a~~All resident rooms are numbered and all other rooms numbered or identified as to purpose. ~~(3-17-22)~~(____)

~~**l.**~~ ~~That a drinking fountain is connected to cold running water, is accessible to both wheelchair and non-wheelchair residents, and located in each nursing or staff unit.~~ ~~(3-17-22)~~

~~**m.**~~ ~~That residents of the opposite sex are not housed in the same bedroom or ward, except in cases of husband and wife.~~ ~~(3-17-22)~~

~~n~~g. ~~That g~~Gardens, yards, or portions of yards are secure for outdoor use by all residents and bounded by a substantial enclosure if intended for unsupervised use by residents who may wander away from the facility. ~~(3-17-22)~~(____)

~~o~~h. ~~That t~~Toilet rooms, tub/shower rooms, and handwashing facilities are constructed as follows: ~~(3-17-22)~~(____)

i. Toilet rooms and bathrooms for residents and personnel are not to open directly into any room in which food, drink, or utensils are handled or stored. ( )

ii. Toilet and bathroom are separated from all other rooms by solid walls or partitions. ( )

iii. On floors where wheelchair residents are housed, there is at least one (1) toilet and one (1) bathing facility large enough to accommodate wheelchairs. ( )

iv. All inside bathrooms and toilet rooms have forced ventilation to the outside. ( )

v. Toilet rooms~~ for resident use are arranged that it is not necessary for~~ are situated such that an individual~~ to~~ need not pass through or into another resident's room to reach the toilet facilities. ~~(3-17-22)~~(____)

vi. Handrails and/or grab bars are provided in resident toilet rooms and bathrooms and are located~~ so as~~ to be functionally adequate. ~~(3-17-22)~~(____)

vii. Each resident floor or nursing unit has at least one (1) tub or shower for every twelve (12) licensed beds; one (1) toilet for every eight (8) licensed beds; and one (1) lavatory with mirror for every eight (8) licensed beds. Tubs, showers, and lavatories are connected to hot and cold running water. ( )

0~~6~~4. Dining~~/~~, Recreation Facilities, and Activity Areas.~~ Facilities must provide one (1) or more attractively furnished, multipurpose areas for dining/recreation purposes that meets the following requirements:~~ The location of these areas must encourage residents, participants, and visitor use. The space needed for dining, recreation, and activities must meet the needs of the residents and have adequate space for adaptive equipment and mobility aids. ~~(3-17-22)~~(____)

~~**a.**~~ ~~A minimum of twenty-five (25) square feet per licensed bed is to be provided. Any facility not in compliance on the effective date of this rule will not be required to comply until the number of licensed beds is increased or until there is a change of ownership of the facility. Provided, however, that a facility not in compliance may not reduce the number of licensed beds and reduce its present dining/recreation space until at least twenty-five (25) square feet per licensed bed is provided.~~ ~~(3-17-22)~~

~~**b.**~~ ~~It is for the sole use of the residents, and a hall or entry is not acceptable.~~ ~~(3-17-22)~~

0~~7~~5. Isolation Units (Temporary). Each ~~health care~~ facility must have available a room with private toilet, lavatory, and other accessory facilities for temporary isolation of a resident with a communicable or infectious disease. ~~(3-17-22)~~( )

0~~8~~6. Utility Areas and Clean and Soiled Areas. A ~~utility~~ room with a separate entrance and physically partitioned from any facility for toilet, ~~and/or~~ bathing, or both, ~~facility~~ must be provided for the preparation, cleansing, sterilization, and storing of nursing supplies and equipment. A ~~utility~~ room must be provided on each floor in each nursing or staff unit of the facility. Provisions must be made for the separation of clean and soiled activities. Food and/or ice must not be stored or handled in ~~a utility~~ this room. Soiled utility rooms must be provided with ~~forced~~ mechanical exhaust ventilation to the outside. ~~(3-17-22)~~( )

0~~9~~7. Storage Space. The facility must provide general storage areas and medical storage areas as follows: ( )

a. General storage at the rate of ten (10) square feet per licensed bed, in addition to suitable storage provided in the resident's sleeping room. ( )

b. ~~The facility provides s~~Safe and adequate storage space for medical supplies and equipment and a space appropriate for the preparation of medications. ~~(3-17-22)~~( )

~~10~~08. Electrical and Lighting. All electrical and lighting installation and equipment must ~~be in accordance with the National Electrical Code~~ adhere to applicable local and state regulations, and the standards, guidelines, and requirements contained in the sources incorporated by reference in Section 002 of these rules, and as follows: ~~(3-17-22)~~( )

~~**a.** All electrical equipment intended to be grounded is grounded. (3-17-22)~~

~~**b.** Frayed cords, broken plugs, and the like are repaired or replaced. (3-17-22)~~

~~**c.** Plug adaptors and multiple outlets are prohibited. (3-17-22)~~

~~**d.** Extension cords are U.L. approved, adequate in size (wire gauge), and limited to temporary usage. (3-17-22)~~

~~e~~a. All resident personal electrical appliances are inspected and approved by the facility engineer, ~~and/or~~ administrator, or both. ~~(3-17-22)~~( )

~~f~~b. All resident rooms have ~~a minimum of thirty (30) foot candles of light delivered to reading surfaces and ten (10) foot candles of light in the rest of the room~~ adequate lighting for the rooms and for reading surfaces. ~~(3-17-22)~~( )

~~**g.** All hallways, storerooms, stairways, inclines, ramps, exits, and entrances have a minimum of five (5) foot candles of light measured in the darkest corner. (3-17-22)~~

~~11~~09. Heating, Ventilation, and Air Conditioning (HVAC). ~~The facility must be ventilated and precautions taken to eliminate offensive odors in the facility~~ The system must be capable of maintaining a temperature of seventy degrees (70°F) to eighty-five degrees (85°F) Fahrenheit in all weather conditions. ~~(3-17-22)~~( )

~~**12. Heating**. A heating system must be provided for the facility that is capable of maintaining a temperature of seventy-five degrees (75F) to eighty degrees (80F) Fahrenheit in all weather conditions. (3-17-22)~~

a. Facility must be ventilated, and take precautions to eliminate offensive odors in the facility. ( )

~~a~~b. Oil space heaters, recessed gas wall heaters, and floor furnaces cannot be used as heating systems for ~~health care~~ facilities. ~~(3-17-22)~~( )

~~**b.**~~ ~~Portable comfort heating devices are not used.~~ ~~(3-17-22)~~

1~~3~~0. **Plumbing**. ~~Plumbing at the facility must be as follows~~ In the absence of local plumbing codes, all plumbing systems must comply with requirements under IDAPA 24.39.20, "Rules Governing Plumbing," and the following: ~~(3-17-22)~~( )

~~**a.**~~ ~~All plumbing complies with applicable local and state codes.~~ ~~(3-17-22)~~

~~b~~a. Vacuum breakers are installed where necessary to prevent backsiphonage. ( )

~~c~~b. The temperature of hot water at plumbing fixtures used by residents is between one hundred ~~five~~ degrees (10~~5~~0F) and one hundred twenty degrees (120F) Fahrenheit. ~~(3-17-22)~~( )

121. NEW CONSTRUCTION STANDARDS.

~~The following requirements must be met:~~ All new buildings must meet the following requirements and the standards, guidelines, and requirements contained in the sources incorporated by reference in Section 002 in these rules. Where there are conflicts between the requirements, the most restrictive condition will apply. All new construction, plans, and specifications must be submitted to, and approved by, the Department to assure compliance with applicable standards, codes, rules, and regulations. All plans must be submitted electronically. ~~(3-17-22)~~( )

01. Plans, Specifications, and Inspections. ~~New facility construction or any addition, conversion, or renovation of an existing facility is governed by the following rules:~~ All new construction, plans, and specifications must be submitted to, and approved, by the Department to assure compliance with applicable standards, codes, rules, and regulations. All plans must be submitted electronically. ~~(3-17-22)~~( )

a. ~~Prior to commencing work pertaining to construction of new buildings, any additions, structural changes to existing facilities, or conversion of buildings to be used as a facility, plans and specifications must be submitted to, and approved by, the Department to assure compliance with the applicable construction standards, codes, rules, and regulations.~~ A full set of architecture plans must be prepared, signed, stamped, and dated by an Idaho-licensed architect or engineer. A variance of this requirement may be granted by the Department when the project does not necessitate involvement of an architect or engineer. This must include all the following: ~~(3-17-22)~~( )

~~**b.**~~ ~~The plans and specifications must be prepared by, or executed under, the immediate supervision of a licensed architect registered in the state of Idaho. The employment of an architect may be waived by the Department in certain minor alterations.~~ ~~(3-17-22)~~

~~**c.**~~ ~~Preliminary plans must be submitted and include at least the following:~~ ~~(3-17-22)~~

i. The assignment of all spaces, size of areas and rooms, and indicated in outline the fixed and movable equipment and furniture. ( )

ii. The plans are drawn at a scale sufficiently large to clearly present the proposed design, but not less than a scale of one-eighth inch (1/8") equals one foot (1'). ( )

iii. The drawings include a plan for each floor, including the basement or ground floor with approach or site plan, showing roads, parking areas, sidewalks, etc. ( )

iv. The total floor area and number of beds are computed and noted on the drawings. ( )

v. Outline specifications provide a general description of the construction, including interior finishes, acoustical material, its extent and type and heating, electrical, and ventilation systems. ( )

vi. A physical address approved by the city or county. ( )

vii. Life safety plans. ( )

viii. Fire alarm shop drawings and specifications submitted by a qualified fire alarm contractor. ( )

ix. Sprinkler shop drawings and specifications submitted by an Idaho-licensed fire sprinkler contractor. ( )

~~**d.** Before commencing construction, the working drawings must be developed in close cooperation with, and approved by, the Department and other appropriate agencies with the following. (3-17-22)~~

~~i. Working drawings and specifications are prepared so that clear, distinct prints may be obtained, accurately dimensioned, and include all necessary explanatory notes, schedules, legends, and stamped with the licensed architect's seal. (3-17-22)~~

~~ii. Working drawings are complete and adequate for contract purposes. Separate drawings are prepared for each of the following branches of work: architectural, mechanical and electrical. (3-17-22)~~

~~e~~b. Prior to occupancy, the facility must be inspected and approved by the ~~licensing agency~~ Department. The ~~agency~~ facility will ~~be notified~~ notify the Department at least two (2) weeks prior to completion ~~in order~~ to schedule a final inspection. ~~(3-17-22)~~( )

~~**02. Codes and Standards**. New construction features must be in accordance with applicable local, state, national standards, codes, and regulations in effect at the time of the construction, addition, remodeling, or renovation. (3-17-22)~~

~~**a.** In the event of a conflict of requirements between codes, the most restrictive applies. (3-17-22)~~

~~**b.** Compliance with the applicable provisions of the following codes and standards must be required by, and reviewed for, by this agency: (3-17-22)~~

~~i. American National Standard Specifications for Making Buildings and Facilities Accessible to and Usable by Physically Handicapped People (ANSI A117.1). (3-17-22)~~

~~ii. Idaho Department of Health and Welfare Rules, IDAPA 16.02.19, "Idaho Food Code." (3-17-22)~~

~~**03. Site Requirements**. The location of all new facilities or conversion of existing buildings is controlled by the following criteria: (3-17-22)~~

~~**a.** That it is adjacent to an all-weather road(s). (3-17-22)~~

~~**b.** That it is accessible to physician's services and medical facilities. (3-17-22)~~

~~**c.** That it is accessible to public utilities. (3-17-22)~~

~~**d.** That it is in a lawfully constituted fire district. (3-17-22)~~

~~**e.** That each facility has parking spaces to satisfy the minimum needs of residents, employees, staff, and visitors. In the absence of a local requirement, each facility provides not less than one (1) space for each day shift staff member and employee, plus one (1) space for each five (5) resident beds. This ratio may be reduced in areas convenient to a public transportation system or to public parking facilities provided that approval of any reduction is obtained from the appropriate state agency. Space must be provided for emergency and delivery vehicles. (3-17-22)~~

~~**04. Resident Care Unit**. Each resident care unit must be in compliance with the following: (3-17-22)~~

~~**a.** That the number of beds in a unit does not exceed sixty (60); (3-17-22)~~

~~**b.** That at least eighty percent (80%) of the beds are located in rooms designed for one (1) or two (2) residents; (3-17-22)~~

~~c. That at least one (1) room in each facility is available for single occupancy for isolation of disease, for privacy in personality conflict, or disruptive resident situations. Each isolation room meets the following requirements: (3-17-22)~~

~~i. All features of regular resident rooms, as described in Subsection 121.05.d.; (3-17-22)~~

~~ii. Supply an entry area that is adequate for gowning; (3-17-22)~~

~~iii. Supply a handwashing lavatory in or directly adjacent to the resident room entry; (3-17-22)~~

~~iv. Provide a private toilet; (3-17-22)~~

~~v. Have finishes easily cleanable; and (3-17-22)~~

~~vi. Not be carpeted; (3-17-22)~~

~~d. That each resident room meets the following requirements: (3-17-22)~~

~~i. Minimum room area, exclusive of toilet rooms, closets, lockers, wardrobes, alcoves, or vestibules is one hundred (100) square feet in single-bed rooms and eighty (80) square feet in multiple bed rooms per resident; (3-17-22)~~

~~ii. Beds in all rooms are placed so that they are three (3) feet apart, two (2) feet away from the side wall parallel with beds, and three (3) feet, six (6) inches from the end of the bed to the opposite wall, or other obstructions; (3-17-22)~~

~~iii. A lavatory is provided in each resident room. The lavatory may be omitted from a single-bed or two (2) bed room when a lavatory is located in an adjoining toilet room that serves that room only; (3-17-22)~~

~~iv. Each resident has access to a toilet room without entering the general corridor area. One (1) toilet room serves no more than four (4) beds, and no more than two (2) resident rooms. The toilet room contains a water closet and a lavatory. The lavatory may be omitted from a toilet room if each resident room served by that toilet room contains a lavatory; (3-17-22)~~

~~v. Each resident is provided, within the room, a wardrobe, locker, or closet with a minimum of four (4) square feet. Common closets are not permitted. An adjustable clothes rod and adjustable shelf is provided; (3-17-22)~~

~~vi. Each resident room cannot be located more than one hundred twenty (120) feet from the soiled workroom or the soiled holding room; (3-17-22)~~

~~vii. Each room has a window that can be opened without the use of tools. The window sill must not be higher than three (3) feet above the floor and needs to be above grade. The window is at least one-eighth (1/8) of the floor area and provided with shades or drapes; (3-17-22)~~

~~viii. Cubicle curtains of fire retardant material, capable of enclosing the bed is provided in multiple-bed rooms to insure privacy for the residents. Alternatives to this arrangement may be allowed if the alternative provides the same assurance of privacy; (3-17-22)~~

~~ix. Mirror(s) are arranged for convenient use by residents in wheelchairs, as well as by residents in standing position; (3-17-22)~~

~~x. A staff calling system is installed at each resident bed and in each resident toilet, bath, and shower room. The staff call in the toilet, bath, and shower room is an emergency call. All calls register at the staff station and activate a visible signal in the corridor at the resident's door. The emergency call system is designed so that a signal light activated at the resident's station will remain lit until turned off at the resident's calling station; (3-17-22)~~

~~xi. All resident rooms are visible to a staffed nurse's station; (3-17-22)~~

~~xii. Each resident room is an outside room; (3-17-22)~~

~~xiii. Residents cannot be cared for or housed in any attic story, trailer house, or in any room other than an approved resident room; (3-17-22)~~

~~xiv. Resident beds are not be placed in hallways or any location commonly used for other than bedroom purposes; (3-17-22)~~

~~xv. Ceiling heights in resident rooms are a minimum of eight (8) feet; (3-17-22)~~

~~xvi. No room can be used for a resident room that can only be reached by passing through another resident room, utility room or any other room. All resident rooms have direct access to an exit corridor; (3-17-22)~~

~~xvii. Resident rooms do not open into any room in which food is prepared, served, or stored; and (3-17-22)~~

~~xviii. All resident rooms are numbered. All other rooms are numbered or identified as to purpose. (3-17-22)~~

~~**e.** Service Areas. That the following service areas are located in, or readily available to, each resident care unit. The size and disposition of each service will depend upon the number and types of beds to be served. Although identifiable spaces are required to be provided for each of the indicated functions, consideration will be given to design solutions that would accommodate some functions without specific designation of areas or rooms. Details of such proposals are submitted for prior approval. Each service area may be arranged and located to serve more than one (1) resident care unit, but at least (1) such service area is provided on each resident floor and as follows: (3-17-22)~~

~~i. Staff station with space for charting and storage for administrative supplies convenient to handwashing facilities; (3-17-22)~~

~~ii. Lounge and toilet room(s) for staff (toilet room may be unisex); (3-17-22)~~

~~iii. Individual closets or compartments for the safekeeping of coats and personal effects of personnel located close to the duty station of personnel or in a central location; (3-17-22)~~

~~iv. Clean workroom or clean holding room. If the room is used for work, that it contains a counter and handwashing facilities. When the room is used only for storage as part of a system for distributing clean and sterile supplies, the work counter and handwashing facilities may be omitted; (3-17-22)~~

~~v. A soiled workroom contains a clinical sink or equivalent flushing rim fixture sink for handwashing, work counter, waste receptacle, and soiled linen receptacle. When the room is used only for temporary holding of soiled materials, the work counter may be omitted; (3-17-22)~~

~~vi. Drug distribution station. Provisions are made for secure, convenient, and prompt twenty-four (24) hour availability of medicine to residents. A secure medicine preparation area is available and under the nursing staff's visual control and contains a work counter, refrigerator, and locked storage for controlled drugs, and has a minimum area of fifty (50) square feet. A medicine dispensing unit may be located at the nurse's station, in the clean workroom, or in an alcove or other space convenient to staff for staff control; (3-17-22)~~

~~vii. Clean linen storage. A separate closet or a designated area within the clean workroom is provided. If a closed cart system is used, storage may be in an alcove; (3-17-22)~~

~~viii. Nourishment station. The station contains a sink equipped for handwashing, equipment for serving nourishment between scheduled meals, refrigerator, and storage cabinets. Ice for residents' service and treatment is~~

~~provided only by icemaker-dispenser units;~~ ~~(3-17-22)~~

~~ix. Equipment storage room(s). Room(s) is available for storage of equipment such as I.V. stands, inhalators, air mattresses, and walkers;~~ ~~(3-17-22)~~

~~x. Resident bathing facilities. A minimum of one (1) bathtub or shower is provided for each ten (10) beds not otherwise served by bathing facilities at resident rooms. Residents have access to at least one (1) bathtub in each nursing unit. Each tub or shower is in an individual room or enclosure that provides space for private use of the bathing fixture, for drying and dressing, and for a wheelchair and attendant. At least one (1) shower in each central bathing facility has a minimum of four (4) feet square without curbs and designed for use by a wheelchair.~~ ~~(3-17-22)~~

~~**f.** Resident Toilet Facilities. That each resident toilet room meets the following criteria:~~ ~~(3-17-22)~~

~~i. The minimum dimensions of a room containing only a water closet is three (3) feet by six (6) feet. Additional space is provided if a lavatory is located within the same room. Water closets are accessible for use by wheelchair residents.~~ ~~(3-17-22)~~

~~ii. At least one (1) room on each floor is appropriate for toilet training. It is accessible from the corridor. A clearance of three (3) feet is provided at the front and at each side of the water closet and the room contains a lavatory.~~ ~~(3-17-22)~~

~~iii. A toilet room is accessible to each central bathing area without having to go through the general corridor. This may be arranged to serve as the required toilet training facility.~~ ~~(3-17-22)~~

~~**g.** Sterilizing Facilities. That a system for the sterilization of equipment and supplies is provided.~~ ~~(3-17-22)~~

~~**05.** **Resident Dining and Recreation Areas**. The following minimum requirements apply to dining/recreation areas.~~ ~~(3-17-22)~~

~~**a.** Area Requirement. The total area set aside for these purposes is at least thirty (30) square feet per bed with a minimum, total area of at least two hundred twenty-five (225) square feet. For facilities with more than one hundred (100) beds, the minimum area may be reduced to twenty-five (25) square feet per bed. If day care programs are offered, additional space is provided as needed to accommodate for day care residents needing naps or for dining and activities.~~ ~~(3-17-22)~~

~~**b.** Storage. Storage space is provided for recreational equipment and supplies.~~ ~~(3-17-22)~~

~~**06.** **Rehabilitation Therapy Facilities**. Each facility must include provisions for physical and occupational therapy for rehabilitation of long term care residents. Areas and equipment is necessary to meet the intent of the program. As a minimum, the following must be located on-site, convenient for use to the nursing unit:~~ ~~(3-17-22)~~

~~**a.** Space for files, records and administrative activities.~~ ~~(3-17-22)~~

~~**b.** Storage for supplies and equipment.~~ ~~(3-17-22)~~

~~**c.** Storage for clean and soiled linen.~~ ~~(3-17-22)~~

~~**d.** Handwashing facilities within the therapy unit.~~ ~~(3-17-22)~~

~~**e.** Space and equipment for carrying out each of the types of therapy that may be prescribed.~~ ~~(3-17-22)~~

~~**f.** Provisions for resident privacy.~~ ~~(3-17-22)~~

~~**g.** Janitor closets, in or near unit.~~ ~~(3-17-22)~~

~~**h.** If the program includes outpatient treatment, additional provisions include: (3-17-22)~~

~~i. Convenient access from exterior for use by the handicapped. (3-17-22)~~

~~ii. Lockers for secure storage of residents' clothing and personal effects. (3-17-22)~~

~~iii. Outpatient facilities for dressing and changing. (3-17-22)~~

~~iv. Showers for resident use. (3-17-22)~~

~~**i.** Waiting area with provision for wheelchair outpatients. (3-17-22)~~

~~**07. Personal Care Unit**. A separate room must be provided with equipment for hair care and grooming needs of the residents. (3-17-22)~~

~~**08. Dietary Facilities**. The following must be provided: (3-17-22)~~

~~**a.** Handwashing facilities in the food preparation area. (3-17-22)~~

~~**b.** Resident meal service space including facilities for tray assembly and distribution. (3-17-22)~~

~~**c.** Warewashing in a room or an alcove separate from food preparation and serving areas. This includes commercial type dishwashing equipment. Space is also provided for receiving, scraping, sorting, and stacking soiled tableware and for transferring clean tableware to the using area. Handwashing facilities are conveniently available. (3-17-22)~~

~~**d.** Potwashing facilities. (3-17-22)~~

~~**e.** Waste storage facilities that are easily accessible for direct pickup or disposal. (3-17-22)~~

~~**f.** Office or suitable work space for the dietitian or food service supervisor. (3-17-22)~~

~~**g.** Toilets for dietary staff with handwashing facility immediately available. (3-17-22)~~

~~**h.** Janitor's closet located within the dietary department. The closet contains a floor receptor or service sink and storage space for housekeeping equipment and supplies. (3-17-22)~~

~~**09. Administration and Public Areas**. The following must be provided: (3-17-22)~~

~~**a.** Entrance at grade level, sheltered from the weather and able to accommodate wheelchairs. (3-17-22)~~

~~**b.** Lobby space, including: (3-17-22)~~

~~i. Storage space for wheelchairs. (3-17-22)~~

~~ii. Reception and information counter or desk. (3-17-22)~~

~~iii. Waiting space(s). (3-17-22)~~

~~iv. Public toilet facilities. (3-17-22)~~

~~v. Public telephone(s). (3-17-22)~~

~~vi. Drinking fountain(s). (3-17-22)~~

~~**c.** General or individual office(s) assuring privacy for interviews, business transactions, medical and financial records, and administrative and professional staff. (3-17-22)~~

~~**d.** Multipurpose room for conferences, meetings, and health education purposes. (3-17-22)~~

~~**e.** Storage for office equipment and supplies. (3-17-22)~~

~~**10.** **Linen Services**. The following requirements apply: Laundry processing room with commercial type equipment with which a seven (7) days' need can be processed. (3-17-22)~~

~~**11.** **Central Stores**. General storage rooms must have a total area of not less than ten (10) square feet per bed and concentrated in one (1) area. (3-17-22)~~

~~**12.** **Janitors' Closets**. In addition to the janitors' closets called for in certain departments, sufficient janitor's closets must be provided throughout the facility to maintain a clean and sanitary environment. These contain a floor receptor or service sink and storage space for housekeeping equipment and supplies. (3-17-22)~~

~~**13.** **Engineering Services and Equipment Areas**. The following must be provided: (3-17-22)~~

~~**a.** Equipment room(s) or separate building(s) for boilers, mechanical equipment and electrical equipment. (3-17-22)~~

~~**b.** Office or suitable desk space for the engineer. (3-17-22)~~

~~**c.** Maintenance shop(s). (3-17-22)~~

~~**d.** Storage room(s) for building maintenance supplies. (3-17-22)~~

~~**e.** Yard equipment storage consisting of a separate room or building for yard maintenance equipment and supplies if ground maintenance is provided by the facility. (3-17-22)~~

~~**14.** **Details and Finishes**. A high degree of safety for the residents must be provided to minimize the incidence of accidents with special consideration for residents who will be ambulatory to assist them in self-care. Hazards such as sharp corners must be avoided. All details and finishes for modernization projects as well as for new construction must comply with the following requirements: (3-17-22)~~

~~**a.** Details: (3-17-22)~~

~~i. All rooms containing bathtubs, sitz baths, showers, and water closets subject to occupancy by residents are equipped with doors and hardware that will permit access from the outside of the rooms in an emergency. When such rooms have only one (1) opening or are small, the doors must open outwards or be designed to be opened without the need to push against a resident who may have collapsed within the room. (3-17-22)~~

~~ii. Windows and outer doors that may be frequently left in an open position are provided with insect screens. (3-17-22)~~

~~iii. Doors, sidelights, borrowed lights, and windows in which the glazing extends down to within eighteen (18) inches of the floor (thereby creating a possibility for accidental breakage by pedestrian traffic) is glazed with safety glass, wire glass, or plastic glazing material that will resist breaking and will not create dangerous cutting edges when broken. Similar materials are used in wall openings of recreation rooms and exercise rooms unless required otherwise for safety. Safety glass or plastic glazing materials as noted above are used for shower doors and bath enclosures. (3-17-22)~~

~~iv. Dumbwaiters, conveyors, and material handling systems do not open directly into a corridor or exitway. (3-17-22)~~

~~vi. Thresholds and expansion joint covers are made flush with the floor surface to facilitate use of~~

~~wheelchair and carts.~~ ~~(3-17-22)~~

~~vi. Grab bars are provided at all resident toilets, showers, tubs, and sitz baths. The bars have one and one-half (1-1/2) inches clearance to walls and sufficient strength and anchorage to sustain a concentrated load of two hundred fifty (250) pounds.~~ ~~(3-17-22)~~

~~vii. Recessed soap dishes are provided in showers and bathrooms.~~ ~~(3-17-22)~~

~~viii. Handrails are provided on both sides of corridors used by residents. A clear distance of one and one-half (1-1/2) inches is provided between the handrail and the wall. Ends are returned to the wall.~~ ~~(3-17-22)~~

~~ix. The arrangement of handwashing facilities provides sufficient clearance for blade-type operating handles and are installed to permit use by wheelchair residents.~~ ~~(3-17-22)~~

~~x. Lavatories and handwashing facilities are securely anchored to withstand an applied vertical load of not less than two hundred fifty (250) pounds on the front of the fixture.~~ ~~(3-17-22)~~

~~xi. Mirrors are arranged for convenient use by residents in wheelchairs as well as by residents in a standing position.~~ ~~(3-17-22)~~

~~xii. Paper towel dispensers and waste receptacles are provided at all handwashing fixtures.~~ ~~(3-17-22)~~

~~xiii. Ceiling heights are as follows:~~ ~~(3-17-22)~~

~~(1) Boiler rooms have ceiling clearances not less than two (2) feet, six (6) inches above the main boiler header and connecting piping.~~ ~~(3-17-22)~~

~~(2) Rooms containing ceiling-mounted equipment have height required to accommodate the equipment.~~ ~~(3-17-22)~~

~~(3) All other rooms have not less than eight (8) foot ceilings except that corridors, storage rooms, toilet rooms, and other minor rooms may not have less than seven (7) feet, eight (8) inches. Suspended tracks, rails, and pipes located in the path of normal traffic are not less than six (6) feet, eight (8) inches above the floor.~~ ~~(3-17-22)~~

~~xiv. Recreation rooms, exercise rooms, and similar spaces where impact noises may be generated are not located directly over resident bed areas unless special provisions are made to minimize the noise.~~ ~~(3-17-22)~~

~~**b.** Finishes:~~ ~~(3-17-22)~~

~~i. Floor materials are easily cleaned and have wear resistance appropriate for the location involved. Floors in areas used for food preparation or food assembly are water resistant and grease proof. Joints in tile and similar materials in such areas are resistant to food acids. In all areas frequently subject to wet cleaning methods or spillage, floor materials are not physically affected by germicidal and cleaning solutions. Floors that are subject to traffic while wet (such as shower and bath areas, kitchens, and similar work areas) have an impervious nonslip surface. Vinyl asbestos tile is not acceptable for such areas.~~ ~~(3-17-22)~~

~~ii. Wall bases in kitchens, soiled workrooms, and other areas that are frequently subject to wet cleaning methods are made integral and coved with the floor, tightly sealed within the wall, and constructed without voids that can harbor insects.~~ ~~(3-17-22)~~

~~iii. Wall finishes are washable and in the immediate area of plumbing fixtures smooth and moisture resistant. Finish, trim, and wall and floor construction in dietary and food preparation areas are free from spaces that can harbor rodents and insects.~~ ~~(3-17-22)~~

~~iv. Floor and wall penetrations by pipes, ducts and conduits are tightly sealed to minimize entry of rodents and insects. Joints of structural elements are similarly sealed.~~ ~~(3-17-22)~~

~~v. Ceilings throughout the facility are easily cleanable. Ceilings in the dietary and food preparation areas have a finished ceiling covering all overhead piping and duct work. Finished ceilings may be omitted in mechanical and equipment spaces, shops, general storage areas and similar spaces, unless required for fire resistance purposes. (3-17-22)~~

~~**15. Construction Features**. The facility must be designed and constructed to sustain dead and live loads in accordance with local building codes. All construction must comply with applicable provisions of the codes and standards as listed in Section 121 and as follows: (3-17-22)~~

~~**a.** All buildings having resident use areas on more than one (1) floor have at least one (1) electrical or electrohydraulic elevator. (3-17-22)~~

~~**b.** All mechanical installations comply with applicable codes and the following: (3-17-22)~~

~~i. Prior to completion, all mechanical systems are tested, balanced, and operated to demonstrate to the owner or representative that the installation and operation conform to the plans and specifications. (3-17-22)~~

~~ii. Heating and cooling ventilating systems. (3-17-22)~~

~~(1) Normal comfort the design temperature for all occupied areas provides a minimum of sixty-eight degrees (68) and a maximum of eighty degrees (80) Fahrenheit. (3-17-22)~~

~~(2) All air supply and air exhaust systems are mechanically operated. All fans serving exhaust systems are located at the discharge end of the system. (3-17-22)~~

~~**c.** Outdoor air intakes are located as far as practical but not less than twenty-five (25) feet from exhaust outlets of ventilating systems, combustion equipment stacks, medical-surgical vacuum systems, plumbing vent stacks, or from areas that may collect vehicular exhaust and other noxious fumes. The bottom of outdoor air intakes serving central systems are located as high as practical but not less than six (6) feet above ground level or, if installed above the roof, three (3) feet above roof level. (3-17-22)~~

~~**d.** The bottom of ventilation opening is not be less than three (3) inches above the floor of any room. (3-17-22)~~

~~**e.** All central ventilation or air-conditioning systems are equipped with filters having efficiencies no less than: (3-17-22)~~

~~i. Eighty percent (80%) for resident care, treatment, diagnostic, and related areas that may be reduced to thirty-five (35%) for all outdoor air systems. (3-17-22)~~

~~ii. Eighty percent (80%) for food preparation areas and laundries. (3-17-22)~~

~~iii. Twenty-five percent (25%) for all administrative, bulk storage, and sorted holding areas. (3-17-22)~~

~~**f.** Plumbing standards. All plumbing systems are designed to meet the following: (3-17-22)~~

~~i. Shower bases and tubs are provided with nonslip surfaces. (3-17-22)~~

~~ii. The water supply system are designed to supply water at sufficient pressure to operate all fixtures and equipment during maximum demand periods. (3-17-22)~~

~~iii. Vacuum breakers are installed on hose bibs, janitors' sinks, bedpan flushing attachments, and on all other fixtures to which hoses or tubing can be attached. (3-17-22)~~

~~iv. Water distribution systems are arranged to provide hot water at each hot water outlet at all times. Hot water at shower, bathing, and handwashing facilities do not exceed one hundred twenty degrees (120) Fahrenheit. (3-17-22)~~

~~v. Hot water heating equipment has sufficient capacity to supply water at the temperature and amounts as follows: (3-17-22)~~

~~(1) Clinical. Six and one-half (6 1/2) gallons per hour per bed at one hundred twenty degrees (120) Fahrenheit. (3-17-22)~~

~~(2) Dietary. Four (4) gallons per hour per bed at one hundred eighty degrees (180) Fahrenheit. (3-17-22)~~

~~(3) Laundry. Four and one-half (4 1/2) gallons per hour per bed at one hundred sixty-five degrees (165) Fahrenheit. (3-17-22)~~

~~g. Electrical standards. All electrical installations comply with applicable codes and the following: (3-17-22)~~

~~i. General. Prior to completion, all electrical installations and systems are tested to show that the equipment is installed and operating as planned or specified. (3-17-22)~~

~~ii. Switchboards and power panels are located in a separate enclosure accessible only to authorized personnel. (3-17-22)~~

~~iii. Panel boards serving lighting and appliance circuits are located on the same floor as the circuits they serve. (3-17-22)~~

~~iv. Lighting: (3-17-22)~~

~~(1) All spaces occupied by people, machinery and equipment within buildings, approaches to buildings and parking lots have lighting. (3-17-22)~~

~~(2) Residents have general lighting and night lighting. A reading light is provided for each resident. At least one (1) light fixture for night lighting is switched at the entrance to each resident room. All switches for control of lighting in resident areas are of the quiet operating type. (3-17-22)~~

~~v. Receptacles (convenience outlets): (3-17-22)~~

~~(1) Resident rooms. Each resident room has duplex ground type receptacles as follows: One (1) on each side of the head of each bed; one (1) for television if used; and one (1) on another wall. (3-17-22)~~

~~(2) Corridors. Duplex receptacles for general use are installed approximately fifty (50) feet apart in all corridors and within twenty-five (25) feet of ends in corridors. (3-17-22)~~

~~vi. Equipment installation in special areas. The electrical circuits to fixed or portable equipment in hydrotherapy units are provided with five (5) milliampere ground fault interrupters. (3-17-22)~~

~~vii. Nurse/staff calling system. A nurse/staff calling system is provided as specified in Subsection 121.05.d.x. (3-17-22)~~

122. FURNISHINGS AND EQUIPMENT.
For furnishings, resident rooms, and bedrooms the following must be met: ( )

~~**01. Furnishings -- Resident Living Rooms and Bedrooms**. Living rooms for residents' use must be provided with a sufficient number of reading lamps, tables, chairs, or sofas of satisfactory design for age and condition of the residents. The following requirements must be met: (3-17-22)~~

~~a~~**01.** Each resident is provided with their own bed that is at least thirty-six (36) inches wide,~~ have~~ has a headboard and a footboard,~~ be~~ is substantially constructed, and in good repair. Roll-away type beds, cots, folding

beds, double beds, or Hollywood-type beds are not to be used. ~~(3-17-22)~~( )

~~b~~02. Each bed is provided with satisfactory type springs in good repair and a clean, comfortable mattress at least five (5) inches thick, (four (4) inches if of foam rubber construction and four and one-half (4-1/2) inches if of innerspring type) and standard in size for the bed. ( )

~~c~~03. Each resident is provided with an individual rack with towel and washcloth. ( )

~~**d.** In addition to basic resident care equipment, each resident is provided an individual reading light, bedside cabinet with drawer, comfortable chair, and storage space for clothing and other possessions. (3-17-22)~~

~~e~~04. Each resident is provided with a cup and a covered pitcher of fresh water (or the equivalent) at the bedside ~~if the resident needs assistance to ambulate but is able to drink without assistance~~ within reach of resident. ~~(3-17-22)~~( )

~~**02. General Requirements**. Equipment and supplies must be provided to satisfactorily meet the individualized needs of the residents of the facility. Equipment and supplies will vary according to the size of the facility and the type of residents. An authorized representative of the Department will make the final determination as to the adequacy and suitability of equipment and supplies. The following must be met: (3-17-22)~~

~~**a.** Cubicle curtains of fire-retardant material that are designed to enclose the bed are provided in multiple-bed rooms to ensure privacy for the residents. Alternatives may be provided if equivalent privacy is allowed. (3-17-22)~~

~~**b.** All furniture and equipment are maintained in a sanitary manner, kept in good repair, and be located for convenient use. (3-17-22)~~

~~**c.** An adequate supply of clean linen is available and in good repair to keep the resident clean, odor-free, and insures the comfort of the resident. (3-17-22)~~

~~**d.** Equipment and supplies are stored in a designated area specific for equipment and supplies. Utensils not in use are sterilized prior to being stored. Those that cannot be sterilized are thoroughly cleansed in accordance with procedures approved by the Department. (3-17-22)~~

~~**e.** All utensils are kept in good condition. Chipped and otherwise damaged utensils are not to be used. (3-17-22)~~

~~**f.** Any single-use or disposable equipment and supplies are not to be reused. (3-17-22)~~

123. -- 1~~50~~99. (RESERVED)

~~**151. ACTIVITIES PROGRAM.**~~
~~The facility must provide adequate funding for the activity program. Residents must not be required to support the funding. (3-17-22)~~

~~**152. SOCIAL SERVICES.**~~
~~The facility must provide for the identification of the social and emotional needs of the residents either directly or through arrangements with an outside resource and provide means to meet the needs identified. Sufficient staff must be provided to implement the program as follows: (3-17-22)~~

~~**01. Licensed Social Worker**. That a social worker is licensed by the state of Idaho as a social worker or who receives regular consultation from such a qualified social worker. (3-17-22)~~

~~**02. Outside Resources**. That if the facility does not provide the services directly but arranges with an outside resource to provide the services, a facility staff member is designated in writing as a liaison person. (3-17-22)~~

~~**03. Identify and Implement Programs**. That the facility ensures that identification of needs and~~

~~implementation of programs meets the needs and appropriate record keeping is accomplished.~~ ~~(3-17-22)~~

~~**153. (RESERVED)**~~

~~**154. PHYSICIAN SERVICES.**~~
~~The following standards must be met:~~ ~~(3-17-22)~~

~~**01. Physician Supervision**. That each resident is under the direct and continuing supervision of a physician of their own choice licensed by the Idaho Board of Medicine.~~ ~~(3-17-22)~~

~~**02. Necessary Medical Information**. That the physician provides the facility with medical information necessary to care for the resident that includes at least a current history and physical or medical findings completed made no longer than five (5) days prior to admission or within forty-eight (48) hours after admission. The information includes diagnosis, medical findings, activity limitations, and rehabilitation potential.~~ ~~(3-17-22)~~

~~**03. Physician's Plan of Care**. That a physician's plan of care is provided to the facility upon admission of the resident that reflects medication orders, treatments, diet orders, activity level approved, and any other directives to the facility for the care of the resident.~~ ~~(3-17-22)~~

~~**04. Plan of Care Review**. That the physician's plan of care for the resident is reviewed by the physician as follows:~~ ~~(3-17-22)~~

~~**a.** Every thirty (30) to sixty (60) days for skilled care residents depending upon the visit schedule authorized.~~ ~~(3-17-22)~~

~~**b.** The plan of care is reordered with any changes included by the physician and signed and dated by the physician at the time of the review.~~ ~~(3-17-22)~~

~~**155. -- 199. (RESERVED)**~~

200. ~~NURSING SERVICES~~TUBERCULOSIS (TB) CONTROL.
All facilities must meet the standards, guidelines, and requirements contained in the sources incorporated by reference in Section 002 of these rules. The following requirements must also be met: ~~(3-17-22)~~( )

~~**01. Director of Nursing Services (DNS)**. A licensed registered nurse currently licensed by the state of Idaho and qualified by training and experience is designated DNS in each SNF and is responsible and accountable for the following:~~ ~~(3-17-22)~~

~~**a.** Participating in the development and implementation of resident care policies;~~ ~~(3-17-22)~~

~~**b.** Developing and/or maintaining goals and objectives of nursing service, standards of nursing practice, and nursing policy and procedures manuals;~~ ~~(3-17-22)~~

~~**c.** Assisting in the screening and selection of prospective residents in terms of their needs, and the services available in the facility;~~ ~~(3-17-22)~~

~~**d.** Observing and evaluating the condition of each resident and developing a written, individualized patient care plan that is based upon an assessment of the needs of each resident, and that is kept current through review and revision;~~ ~~(3-17-22)~~

~~**e.** Recommending to the administrator the numbers and categories of nursing and auxiliary personnel to be employed and participating in their recruitment, selection, training, supervision, evaluation, counseling, discipline, and termination when necessary. Developing written job descriptions for all nursing and auxiliary personnel;~~ ~~(3-17-22)~~

~~**f.** Planning and coordinating orientation programs for new nursing and auxiliary personnel, as well as a formal, coordinated in-service education program for all nursing personnel;~~ ~~(3-17-22)~~

~~**g.** Preparing daily work schedule for nursing and auxiliary personnel that includes names of employees, professional designation, hours worked, and daily patient census; and (3-17-22)~~

~~**h.** Coordinating the nursing service with related resident care services; (3-17-22)~~

~~**02. Minimum Staffing Requirements**. That minimum staffing requirements include the following: (3-17-22)~~

~~**a.** A Director of Nursing Services (DNS) works full time on the day shift but the shift may be varied for management purposes. If the DNS is temporarily responsible for administration of the facility, there is a licensed registered nurse (RN) assistant to direct patient care. The DNS is required for all facilities five (5) days per week. (3-17-22)~~

~~i. The DNS in facilities with an average occupancy rate of sixty (60) residents or more has strictly nursing administrative duties. (3-17-22)~~

~~ii. The DNS. in facilities with an average occupancy rate of fifty-nine (59) residents or less may, in addition to administrative responsibilities, serve as the supervising nurse. (3-17-22)~~

~~**b.** A supervising nurse, licensed registered nurse, or a licensed practical nurse, and who meets the requirements designated by the Idaho Board of Nursing to assume responsibilities as a charge nurse and meets the definition in Subsection 002.35. (3-17-22)~~

~~**c.** A charge nurse, a licensed registered, or a licensed practical nurse, and who meets the requirements designated by the Idaho Board of Nursing to assume responsibilities as a charge nurse in accordance with the definition in Subsection 002.07. A charge nurse is on duty as follows: (3-17-22)~~

~~i. In SNFs with an average occupancy rate of fifty-nine (59) residents or less a licensed registered nurse is on duty eight (8) hours of each day and no less than a licensed practical nurse is on duty for each of the other two (2) shifts. (3-17-22)~~

~~ii. In SNFs with an average occupancy rate of sixty (60) to eighty-nine (89) residents a licensed registered nurse is on duty for each a.m. shift (approximately 7:00 a.m. - 3:00 p.m.) and p.m. shift (approximately 3:00 p.m. to 11:00 p.m.) and no less than a licensed practical nurse on the night shift. (3-17-22)~~

~~iii. In SNFs with an average occupancy rate of ninety (90) or more residents a licensed registered nurse is on duty at all times. (3-17-22)~~

~~iv. In those facilities authorized to utilize a licensed practical nurse as charge nurse, the facility must make documented arrangements for a licensed registered nurse to be on call for these shifts to provide professional nursing support. (3-17-22)~~

~~**d.** Nursing hours per resident per day are provided to meet the total needs of the residents. The minimum staffing is as follows: (3-17-22)~~

~~i. Skilled Nursing Facilities with a census of fifty-nine (59) or less residents provide two and four-tenths (2.4) hours per resident per day. Hours do not include the DNS but the supervising nurse on each shift may be counted in the calculations of the two and four-tenths (2.4) hours per resident per day. (3-17-22)~~

~~ii. Skilled Nursing Facilities with a census of sixty (60) or more residents provide two and four-tenths (2.4) hours per resident per day. Hours do not include the DNS or supervising nurse. (3-17-22)~~

~~iii. Nursing hours per resident per day are required seven (7) days a week with provision for relief personnel. (3-17-22)~~

~~iv. Skilled Nursing Facilities are considered in compliance with the minimum staffing ratios if, on~~

~~Monday of each week, the total hours worked by nursing personnel for the previous seven (7) days equal or exceed the minimum, staffing ratio for the same period when averaged on a daily basis and the facility has received prior approval from the Licensing Agency to calculate nursing hours in this manner. (3-17-22)~~

~~**e.** Combined Hospital and Skilled Nursing Facility. In a combined facility the DNS may serve both the hospital and long term care unit with supervising and charge nurses as required under Subsection 200.02.b. and 200.02.c. In a combined facility of less than forty-one (41) beds, the supervising or charge nurse may be an LPN. Combined beds (forty-one (41) or less) represent the total number of acute care (hospital) and long term care (nursing home) beds. (3-17-22)~~

~~**f.** Waiver of Licensed Registered Nurse as Supervising or Charge Nurse. In the event that a facility is unable to hire licensed registered nursing personnel to meet these regulation requirements, a licensed practical nurse will satisfy the requirements so long as: (3-17-22)~~

~~i. The facility continues to seek a licensed registered nurse at a compensation level at least equal to that prevailing in the community; (3-17-22)~~

~~ii. A documented record of efforts to secure employment of licensed registered nursing personnel is maintained in the facility; (3-17-22)~~

~~iii. The facility maintains at least forty (40) hours a week R.N. coverage. (3-17-22)~~

~~**g.** There is at least two (2) nursing personnel on duty on each shift to ensure resident safety in the event of accidents, fires, or other disasters. (3-17-22)~~

~~**h.** Nursing care is given only by licensed staff, nursing personnel, and auxiliary nursing personnel. (3-17-22)~~

~~**03.** **Resident Care**. That nursing staff must document on the resident medical record, any assessments of the resident, any interventions taken, effect of interventions, significant changes and observations, and the administration of medications, treatments, and any other services provided, and entries made at the time the action occurs with signature, date and time. At a minimum, a monthly summary of the resident's condition and reactions to care must be written by a licensed nursing staff person. (3-17-22)~~

~~**04.** **Medication Administration**. Medications must be provided to residents by licensed nursing staff or certified medication assistants (MA-C) per established written procedures that includes at least the following: (4-6-23)~~

~~**a.** Administered per physician's, dentist's, or nurse practitioner's written orders; (4-6-23)~~

~~**b.** The resident is identified prior to administering the medication; (3-17-22)~~

~~**c.** Medications are administered as soon as possible after preparation; (3-17-22)~~

~~**d.** Medications are administered only if properly identified; (3-17-22)~~

~~**e.** Medications are administered by the person preparing the medication for delivery to the resident (exception: Unit dose); (3-17-22)~~

~~**f.** Residents are observed for reactions to medications and if a reaction occurs, it is immediately reported to the charge nurse and attending physician; (3-17-22)~~

~~**g.** Each resident's medication is properly recorded on their individual medication record by the person administering the medication. The record includes: (3-17-22)~~

~~i. Method of administration; (3-17-22)~~

~~ii. Name and dosage of the medication; (3-17-22)~~

~~iii. Date and time of administration; (3-17-22)~~

~~iv. Site of injections; (3-17-22)~~

~~v. Name or initial (that has elsewhere been identified) of person administering the medication; (3-17-22)~~

~~vi. Medications omitted; (3-17-22)~~

~~vii. Medication errors (that are reported to the charge nurse and attending physician.) (3-17-22)~~

0~~5~~1. **Tuberculosis Control**. To assure the control of tuberculosis in the facility, there is a planned, organized program of prevention through written and implemented procedures that are consistent with current accepted practices and ~~includes:~~ included as part of the facility's Infection Control Program. Facilities will remain current with screening and testing of TB for healthcare personnel based on the recommendations and guidelines from the Centers for Disease Control and Prevention and the National Tuberculosis Controllers Association. ~~(4-6-23)~~( )

~~a. The results of a T.B. skin test is established for each resident upon admission. If the status is not known upon admission, a T.B. skin test is done as soon as possible, but no longer than thirty (30) days after admission. (3-17-22)~~

~~b. If the T.B. skin test is negative, the test does not have to be repeated. (3-17-22)~~

~~c. If the T.B. skin test is positive, if determined upon admission or following the test conducted after admission, the resident receives a chest x-ray. A chest x-ray conducted thirty (30) days prior to admission is acceptable. (3-17-22)~~

~~d. When a chest x-ray is indicated and the resident's condition presents a transportation problem to the x-ray machine, a Sputum culture for m.tuberculosis is acceptable instead of a chest x-ray until the resident's next visit for any purpose to a place where x-ray is available. (3-17-22)~~

~~e. Annual T.B. skin testing and/or chest x-rays are not required. (3-17-22)~~

~~f~~02. **If Case of Tuberculosis is Found in the Facility**. ~~If a case of T.B. is found in the facility, all residents and employees are retested~~ The facility must notify their local public health district following State reporting requirements in IDAPA 16.02.10, "Idaho Reportable Diseases" and follow their recommendations and guidance. ~~(3-17-22)~~( )

201. PHARMACY SERVICES.

~~The following requirements must be met:~~ Medications must be provided to residents by licensed nursing staff or certified medication assistants (MA-C) per established written procedures which follow state and federal regulations, and professional standards of practice for medication administration and documentation. All facilities must also meet the standards, guidelines, and requirements contained in the sources incorporated by reference in Section 002 of these rules. ~~(3-17-22)~~( )

~~01. **Pharmacy Service**. That each SNF has a written agreement with a pharmacist licensed by the state of Idaho to direct, supervise, and be responsible for pharmacy service in the facility and for coordinating services when more than one (1) supplier of medications is utilized by the facility. (3-17-22)~~

~~02. **Care of General Medications**. That the care and handling of medications is conducted in the following manner: (3-17-22)~~

~~a. Medications are administered to residents of the SNF only on the order of a person authorized by law in Idaho to prescribe medications. This order is recorded on the resident's medical record, dated and signed by the~~

~~ordering physician, dentist or nurse practitioner.~~ ~~(3-17-22)~~

~~**b.**~~ ~~All telephone and verbal orders are taken by licensed nurses, pharmacists and physicians only, and recorded on the resident's clinical record, dated and signed by the person taking the order. Telephone and verbal orders are countersigned by the ordering physician, dentist or nurse practitioner within seven (7) days.~~ ~~(3-17-22)~~

~~**c.**~~ ~~No person other than licensed nursing personnel and physicians administer medications. This does not include execution of duties of inhalation therapists as ordered by the attending physician.~~ ~~(3-17-22)~~

~~**d.**~~ ~~Nursing service personnel do not package or repackage, bottle or label any medication, in whole or in part.~~ ~~(3-17-22)~~

~~**e.**~~ ~~Prescription medication is administered only to the resident whose name appears on the prescription legend.~~ ~~(3-17-22)~~

~~**f.**~~ ~~All medications are labeled with the original prescription legend including the name and address of the pharmacy, resident's name, physician's name, prescription number, original date and refill date, dosage unit, number of dosage units, and instructions for use and drug name. (Exception: See Unit Dose System.)~~ ~~(3-17-22)~~

~~**g.**~~ ~~No alteration or replacement of original prescription legend is allowed.~~ ~~(3-17-22)~~

~~**h.**~~ ~~Prescription renewal or refill is made only under physician's, dentist's, or nurse practitioner's authorization.~~ ~~(3-17-22)~~

~~**i.**~~ ~~Drugs dispensed meet the standards established by the United States Pharmacopeia, the National Formulary, New Drugs, the Idaho Board of Pharmacy, and the U.S. Food and Drug Administration.~~ ~~(3-17-22)~~

~~**j.**~~ ~~All medications in the facility are maintained in a locked cabinet with the key for the lock carried only by licensed nursing personnel and/or the pharmacist.~~ ~~(3-17-22)~~

~~**k.**~~ ~~Poisons and toxic chemicals are stored in separate locked areas apart from medications.~~ ~~(3-17-22)~~

~~**03.**~~ ~~**Record of Medications**.~~ ~~(3-17-22)~~

~~**a.**~~ ~~An accurate and complete record of all medication given, both prescription and nonprescription, is recorded in the resident's chart. The record includes the time given, the medication given, date, dosage, method of administration, and the name and professional designation (R.N., L.P.N.) of the person preparing and administering the medication. The first and last name initials may be used if identified fully elsewhere in the medical record.~~ ~~(3-17-22)~~

~~**b.**~~ ~~Entries are made on the resident's medication record whenever medications are started or discontinued.~~ ~~(3-17-22)~~

~~**c.**~~ ~~Reasons for administration of a PRN medication and the resident's response to the medication are documented in the nurse's notes.~~ ~~(3-17-22)~~

~~**04.**~~ ~~**Unit Dose Pharmacy**. That a unit dose pharmacy system may be provided in a SNF as the drug distribution system under the following rules and regulations.~~ ~~(3-17-22)~~

~~**a.**~~ ~~All residents of the facility are served by the unit dose system.~~ ~~(3-17-22)~~

~~**b.**~~ ~~All medications distributed to the residents are under the unit dose system, if they are prepared and available in unit dose.~~ ~~(3-17-22)~~

~~**c.**~~ ~~The unit dose system is on a signed, written agreement basis between the facility and the pharmacist. If the facility employs a pharmacist to operate its own in-house pharmacy, a signed, written agreement is not necessary.~~ ~~(3-17-22)~~

~~**d.** All medications are packaged by individual unit dose, and labeled with drug (proprietary and/or generic) name, unit of dose, and lot identification number or date packaged, and such other rules that may be promulgated by the Board of Pharmacy. The pharmacist maintains a log identifying the drug lot number by date packaged.~~ ~~(3-17-22)~~

~~**e.** The pharmacist (or the facility) provides suitable drug-distribution cabinets that can be locked, or in lieu of a locked cabinet, medications are stored in a room that can be locked. Safe, orderly transport of the drug distribution cabinets are assured by the pharmacist.~~ ~~(3-17-22)~~

~~**f.** A direct copy of all medication orders from the resident's chart are supplied to the pharmacist in a timely manner so that they can maintain each individual resident's medication profile in the pharmacy from which they fill each resident's twenty-four (24) hour medication orders.~~ ~~(3-17-22)~~

~~**g.** The pharmacist is responsible to see that each individual resident's medication drawer is filled from the drug distribution cabinet each twenty-four (24) hours from the resident's medication profile; records individual doses not administered from returned sets of drawers; indicates the reason the medication was not administered; and records medications supplied for the next twenty-four (24) hour period.~~ ~~(3-17-22)~~

~~**h.** Designated nursing staff check each resident's medication drawer contents against their medication profile prior to distribution to the resident.~~ ~~(3-17-22)~~

~~**i.** The unit dose system is an alternate to packaging and labeling requirements and does not preclude the facility from meeting all other requirements of Section 201.~~ ~~(3-17-22)~~

~~**05.** **Customized Medication Packaging**. That the packaging of medications commonly referred to as "blister paks," "punch cards" and "bingo cards" may be utilized by the facility provided that measures of accountability, safety and sanitation are employed. Customized packaging is not to be interpreted to mean a unit dose system. All other requirements of Section 201 applies except for alternate packaging systems.~~ ~~(3-17-22)~~

202. PET THERAPY.
The following requirements must be met: ( )

01. Policies and Procedures. ~~That policies and procedures a~~Are developed by the facility concerning the admission of pets through a visitation program or on a permanent basis. ~~(3-17-22)~~( )

02. Type of Pet Allowed. ~~That t~~The types of pets allowed are as follows: ~~(3-17-22)~~( )

a. Only domesticated household pets (dogs, cats, birds, fish, hamsters, etc.) are permitted~~. Exotic pets and wild animals, even though trained, are not be permitted due to the high potential for spread of disease and injury to residents or staff. These include, but are not limited to, iguanas, snakes and other reptiles, monkeys, raccoons and skunks. Turtles are not permitted in the facility~~, with the exception under Subsection 202.02.b of this rule.
~~(3-17-22)~~( )

b. ~~If animals that are prohibited as designated in Subsection 202.02.a. of these rules~~Exotic pets and wild animals, even though trained, are not be permitted due to the high potential for spread of disease and injury to residents or staff, unless they are brought in for visitation, they are always kept on a leash and under the control of the trainer~~ at all times~~. ~~(3-17-22)~~( )

03. Examination of Pets. ~~That p~~Pets are to receive an examination by a veterinarian prior to admission to the facility. Appropriate vaccinations are to be given. Birds subject to transmission of psittacosis are included. This applies to both ownership and visitation. ~~(3-17-22)~~( )

04. Enclosures. ~~That s~~Small animals such as hamsters and birds are to be kept in enclosures.
~~(3-17-22)~~( )

05. Permitted Areas. ~~That p~~Pets are not to be allowed in food preparation or storage areas~~ or~~. They are

also not to be allowed in any other area if their presence would pose a significant risk to residents, staff, or visitors. (3-17-22)( )

06. Interference. That tThe presence of pets do cannot interfere with the health and rights of other individuals, i.e., noise, odor, allergies, and interference with the free movement of individuals about the facility. (3-17-22)( )

203. RESIDENT RECORDS.
The facility maintains medical records for all residents in accordance with accepted professional standards and practices. The following requirements must be met: (3-17-22)

01. Responsible Staff. That the administrator designates a staff member the responsibility for the accurate maintenance of medical records. If this person is not a Registered Health Information Administrator (RHIA) or a Registered Health Information Technician (RHIT), consultation from such a qualified individual is provided periodically to the designated staff person. (3-17-22)

02. Individual Medical Record. That an individual medical record is maintained for each admission with all entries kept current, dated, and signed. (3-17-22)

03. Confidentiality. That the facility safeguards medical record information against loss, destruction, and unauthorized use. (3-17-22)

203. (RESERVED)

204. DAY CARE SERVICES.
Day care services may be provided for up to twelve (12) hours per day as determined by facility policy. If provided, it cannot interfere with the regular services to facility residents. The following requirements must be met: ( )

01. Staffing. That tThe facility is to provides additional staff depending upon the number of day care participants with the following: and assure that the day care participants receive the services necessary to meet their needs. (3-17-22)( )

a. Assure that in-house facility residents are provided the nursing hours per resident per day as described in Subsection 200.02.c. (3-17-22)

b. Assure that the day care participants receive the services necessary to meet their needs. (3-17-22)

02. Records. That aA day care participant record is to be maintained. (3-17-22)( )

03. Space and Supplies. That fFacilities accepting day care participants are to provide such space and supplies as necessary to comfortably and efficiently meet the needs of both in-house residents and day care participants. (3-17-22)( )

205. CHILD CARE CENTERS.
The following requirements must be met: ( )

01. Policies and Procedures. That aAny facility that permits a child care center adjacent to or attached to the skilled nursing facility SNF is to establishes well-defined written and implemented policies and procedures pertaining to the relationship between the child care center and the SNF. These include, but are not limited to infection control and prevention of disease transmission. (3-17-22)( )

02. Day Care Licensure. That aAny day care home or day care center for children, as defined under Basic Day Care License Act, Sections 39-1101 through 39-111720, Idaho Code, either attached as a distinct part or as a separate facility on the premises of the SNF facility is to be licensed separately by the appropriate state or local licensing agency. (3-17-22)( )

03. Day Care Compliance. That eEvery child day care home or center complies is to comply with the

~~Idaho Department of Health and Welfare Rules,~~ IDAPA 16.02.10, "Idaho Reportable Diseases." ~~(3-17-22)~~(   )

04. Day Care Staff. ~~That e~~Each child day care home or center is to be staffed appropriately to meet the needs of the children cared for~~ as a completely~~, with a separate staff from~~ those~~ the employees of the SNF facility. ~~(3-17-22)~~(   )

206. -- 300. (RESERVED)

301. RESPITE CARE SERVICES.

If the SNF offers respite care to relieve families or other individuals, there must be policies and procedures written and implemented regarding the program. The following requirements must be met: (   )

01. Admissions. ~~That r~~Respite care residents are to be admitted to the facility in the same manner as any other admission that includes~~, but is not limited to~~: ~~(3-17-22)~~(   )

a. Authorization by a physician. (   )

b. Current medical and other information sufficient to allow the facility to safely care for the resident. (   )

c. Medication and treatment orders signed and dated by the resident's attending physician. (   )

02. Limitations. ~~That n~~No resident is to be considered as respite care when the stay at the facility is not for purposes of relief for other care givers or families and~~ that~~ the stay exceeds a four (4) week period of time. Variances may be granted by the Department on a case-by-case basis. ~~(3-17-22)~~(   )

03. Records. ~~That records a~~Are to be maintained for all respite care residents that include at least the following: ~~(3-17-22)~~(   )

a. Medical information sufficient to care for the resident submitted by the attending physician. (   )

b. Signed and dated physician's orders for care, including diet, medications, treatments, and any physical activity limitations. (   )

c. Nursing and other notes by staff caring for the resident. (   )

d. Medication administration record. (   )

e. Pertinent resident data information such as name, address, next of kin, who to call in an emergency, name of physician, etc. (   )

04. Exceptions. ~~That d~~Due to the short length of stay, certain documents and actions provided to and required for other in-house nonrespite care residents are not required for respite care residents.~~ Allowances~~ Exceptions to be considered at the discretion of the facility are as follows: ~~(3-17-22)~~(   )

a. A complete history and physical examination by the physician is not required so long as he provides the facility with sufficient information to care for the resident. (   )

b. Physician visits are required only if the resident needs such a visit due to illness or injury or if the resident exceeds the definition of respite care and remains in the facility beyond a four (4) week period~~ of time~~. ~~(3-17-22)~~(   )

c. The resident care plan may be limited to include care and services to be provided during their stay and short-and long-term goals are not necessary. ~~(3-17-22)~~(   )

d. Activity assessments and plans are not necessary so long as any activity limitations are known and

recorded on the resident's plan of care. ( )

~~**302. (RESERVED)**~~

~~**303. OTHER SERVICES.**~~
~~If a SNF offers home health, hospice, or other services from the facility, the needs and requirements for the delivery of those services must in no way interfere with the ongoing operation of the SNF. (3-17-22)~~

30~~4~~2. -- 999. (RESERVED)

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.03.04 – IDAHO FOOD STAMP PROGRAM

DOCKET NO. 16-0304-2301 (ZBR CHAPTER REWRITE)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2024 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. The pending rule will become final and effective upon the adjournment, *sine die*, of the Second Regular Session of the Sixty-seventh Idaho Legislature after approval.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 56-203, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

Under Executive Order 2020-01: Zero-Based Regulation, the Department is striving to prevent the accumulation of costly, ineffective, and outdated regulations and reduce regulatory burden to achieve a more efficient operation of government. The rule changes are intended to perform a comprehensive review of this chapter by collaborating with the public to streamline or simplify this rule language.

There are no changes to the pending rule and it is being adopted as originally proposed. The complete text of the proposed rule was published in the September 6, 2023, Idaho Administrative Bulletin, Vol. 23-9, pages 109 through 186. An additional Notice of Public Hearing was published in the October 4, 2023, Idaho Administrative Bulletin, Vol. 23-10, pages 342 through 343.

FEE SUMMARY: Pursuant to Section 67-5224(2)(d), Idaho Code, this pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature. The following is a description of the fee or charge imposed or increased in this rulemaking: Does not apply to this rulemaking.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state General Fund greater than ten thousand dollars ($10,000) during the fiscal year:

This rulemaking is not anticipated to have any fiscal impact on the State General Fund, or any other known funds.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Kristin Matthews at 208-334-5553.

DATED this 30th of November, 2023.

Trinette Middlebrook and Frank Powell
DHW – Administrative Rules Unit
450 W. State Street – 10th Floor
P.O. Box 83720
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THE FOLLOWING NOTICE PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 56-202, 56-203, and 56-209, Idaho Code.

PUBLIC HEARING SCHEDULE: Two Public hearings concerning this rulemaking will be held as follows:

VIRTUAL TELECONFERENCE Via WebEx
Thursday, September 14, 2023 **9:00 a.m. - 10:00 a.m. (MT)**
Join from the meeting link: **https://idhw.webex.com/idhw/j.php?MTID=m6661b45f3c92190294522950b035c34b** **Join by meeting number:** **Meeting number (access code): 2760 128 5419** **Meeting password: mpNmHbTX565 (67664289 from phones and video systems)** **Join by phone:** **+1-415-527-5035 United States Toll** **+1-303-498-7536 United States Toll (Denver)**

VIRTUAL TELECONFERENCE Via WebEx
Thursday, September 14, 2023 **2:30 p.m. - 3:30 p.m. (MT)**
Join from the meeting link: **https://idhw.webex.com/idhw/j.php?MTID=m3c521cf139a93c6b7ceb537cfda5aee9** **Join by meeting number:** **Meeting number (access code): 2761 665 4340** **Meeting password: NsJMMBGc234 (67566242 from phones and video systems)** **Join by phone:** **+1-415-527-5035 United States Toll** **+1-303-498-7536 United States Toll (Denver)**

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

Under Executive Order 2020-01: Zero-Based Regulation, the Department is striving to prevent the accumulation of costly, ineffective, and outdated regulations and reduce regulatory burden to achieve a more efficient operation of government. The rule changes are intended to perform a comprehensive review of this chapter by collaborating with the public to streamline or simplify this rule language.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased:

This chapter contains no fees or charges.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state General Fund greater than ten thousand dollars ($10,000) during the fiscal year as a result of this rulemaking:

This rulemaking is not anticipated to have any fiscal impact on the state General Fund, or any other known funds.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2)(b), Idaho Code, negotiated rulemaking was not conducted because it was deemed to be not feasible as changes in this IDAPA chapter will be for clarity and simplification of language and will not include the removal or change in content that would affect the program requirements.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into this rule:

There are no incorporations by reference in this chapter of rules.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Kristin Matthews at 208-334-5553.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before September 27, 2023.

DATED this 4th day of August, 2023.

THE FOLLOWING IS THE TEXT OF ZBR DOCKET NO. 16-0304-2301

16.03.04 – IDAHO FOOD STAMP PROGRAM

000. LEGAL AUTHORITY.
Sections 56-202, 56-203, and 56-209, Idaho Code, authorizes the Department to enter into contracts and agreements with the federal government and to engage in rulemaking for the administration and management of public assistance or welfare services. ( )

001. -- 007. (RESERVED)

008. AUDIT, INVESTIGATION AND ENFORCEMENT.
The Department may audit, investigate and take enforcement action under these rules and the provisions of IDAPA 16.05.07, "Investigation and Enforcement of Fraud, Abuse or Misconduct." ( )

009. (RESERVED)

010. DEFINITIONS A THROUGH D.

01. Adequate Notice. Notice a household must receive on or before the first day of the month an

action by the Department is effective. ( )

02. Administrative Error Claim. A claim resulting from an overissuance caused by the Department's action or failure to act. ( )

03. Aid to the Aged, Blind and Disabled (AABD). Cash, excluding in-kind assistance, financed by federal, state, or local government and provided to cover living expenses or other basic needs. ( )

04. Application for Participation. The application form filed by the head of the household or authorized representative. ( )

05. Authorized Representative. A person designated by the household to act on behalf of the household to apply for, or receive and use Food Stamps. ( )

06. Battered Women and Children's Shelter. A shelter for battered women and children which is a public or private nonprofit residential facility. ( )

07. Boarder. An individual paying a reasonable amount for meals and lodging. ( )

08. Boarding House. A licensed commercial enterprise offering meals and lodging for payment to make a profit. ( )

09. Broad-Based Categorical Eligibility. If a participant meets the eligibility requirements found in 7 CFR Section 273.2(j)(2) and also all other Food Stamp eligibility criteria, then the participant is eligible for Food Stamps. Participants who are eligible under this definition are also subject to resource, gross, and net income eligibility standards. ( )

10. Categorical Eligibility. If all household members receive or are authorized to receive monthly cash payment through TAFI, AABD, or SSI, the household is categorically eligible. Categorically eligible households are exempt from resource, gross, and net income eligibility standards. ( )

11. Certification Period. The period for which a household is certified to receive Food Stamp benefits. The month of application counts as the first month of certification. ( )

12. Contact (Six-Month). A recertification that waives the interview requirement, allowing for written contact and verification of the participant's circumstances in lieu of the interview. ( )

13. Claim Determination. The action taken by the Department establishing the household's liability for repayment when an overissuance of Food Stamps occurs. ( )

14. Department. The Idaho Department of Health and Welfare. ( )

15. Disqualified Household Members. Individuals required to be excluded from participation in the Food Stamp Program are Disqualified Household Members. ( )

011. DEFINITIONS E THROUGH L.

01. Electronic Benefit Transfer (EBT). A method of issuing Food Stamps to an eligible household. ( )

02. Eligible Foods. Any food or food product for human consumption excluding alcohol, tobacco, and hot food products ready for immediate consumption. Eligible foods also include garden seeds and plants to grow food for human consumption. ( )

03. Eligible Household. A household living in Idaho and meeting the eligibility criteria in these rules. ( )

04. **Exempt**. A household member who is not required to register for, or participate in, the JSAP program is exempt. A household member who is not required to register for work is exempt. ( )

05. **Extended Certification Household (EC)**. A household in which all members are elderly or disabled, and no one has earned income. ( )

06. **Fair Hearing**. A fair hearing in an appeal of a Department decision. ( )

07. **Federal Fiscal Year (FFY)**. The period from October 1 to September 30. ( )

08. **Field Office**. A Department service delivery site. ( )

09. **Food and Nutrition Service (FNS)**. The federal entity under the US Department of Agriculture (USDA) that administers the Food Stamp program. ( )

10. **Group Living Arrangement**. A public or private nonprofit residential setting serving no more than sixteen (16) residents. The residents are blind or disabled and receiving benefits under Title II or XVI of the Social Security Act, certified by the Department under Section 1616(e) of the Social Security Act, or under standards determined by the Secretary of USDA to be comparable to Section 1616(e) of the Social Security Act. ( )

11. **Homeless Person**. A person: ( )

a. Who has no fixed or regular nighttime residence. ( )

b. Whose primary nighttime residence is a temporary accommodation for not more than ninety (90) days in the home of another individual or household. ( )

c. Whose primary nighttime residence is a temporary residence in a supervised public or private shelter providing temporary residence for homeless persons. ( )

d. Whose primary nighttime residence is a temporary residence in an institution which provides temporary residence for people who are being transferred to another institution. ( )

e. Whose primary nighttime residence is a temporary residence in a public or private place which is not designed or customarily used as sleeping quarters for people. ( )

12. **Homeless Meal Provider**. A public or private nonprofit establishment or a profit-making restaurant that provides meals to homeless people. The establishment or restaurant must be approved by the Department and authorized as a retail food store by FNS. ( )

13. **Identification Card**. The card identifying the bearer as eligible to receive and use Food Stamps. ( )

14. **Inadvertent Household Error Claim (IHE)**. A claim resulting from an overissuance, caused by the household's misunderstanding or unintended error. ( )

15. **Income and Eligibility Verification System (IEVS)**. A system of information acquisition and exchange for income and eligibility verification which meets Section 1137 of the Social Security Act requirements. ( )

16. **Institution of Higher Education**. Any institution that normally requires a high school diploma or equivalency certificate for enrollment. These institutions include colleges, universities, and business, vocational, technical, or trade schools at the post-secondary level. ( )

17. **Institution of Post-Secondary Education**. Educational institutions normally requiring a high school diploma or equivalency certificate for enrollment or admits persons beyond the age of compulsory school attendance. The institution must be legally authorized by the state and provide a program of training to prepare

students for gainful employment. ( )

18. **Legal Noncitizen**. A qualified alien under 8 USC Section 1641(b). ( )

19. **Limited Utility Allowance (LUA)**. Utility deduction given to a food stamp household that has a cost for more than one (1) utility. This includes electricity and fuel for purposes other than heating or cooling, water, sewage, well and septic tank installation and maintenance, telephone, and garbage or trash collection. ( )

012. DEFINITIONS M THROUGH Z.

01. **Migrant Farmworker Household**. Has a member who travels from community to community to do agricultural work. ( )

02. **Minimum Utility Allowance (MUA)**. Utility deduction given to a food stamp household that has a cost for one (1) utility that is not heating, cooling, or telephone. ( )

03. **Nonexempt**. A household member who must register for work and participate in the JSAP program. ( )

04. **Nonprofit Meal Delivery Service**. A political subdivision or a private nonprofit organization that prepares and delivers meals and is authorized to accept Food Stamps. ( )

05. **Overissuance**. The amount Food Stamps issued exceeds the Food Stamps a household was eligible to receive. ( )

06. **Parental Control**. Means that an adult household member has a minor in the household who is dependent financially or otherwise on the adult. Minors living with children of their own are not under parental control. ( )

07. **Participant**. A person who receives Food Stamp benefits. ( )

08. **Program**. The Food Stamp Program created under the Food Stamp Act and administered in Idaho by the Department. ( )

09. **Recertification**. A recertification is a process for determining ongoing eligibility for Food Stamps. ( )

10. **Retail Food Store**. For Food Stamp purposes means: ( )

a. An establishment, or recognized department of an establishment, or a house-to-house food trade route, whose food sales volume is more than fifty percent (50%) staple food items for home preparation and consumption. ( )

b. Public or private communal dining facilities and meal delivery services. ( )

c. Private nonprofit drug addict or alcohol treatment and rehabilitation programs. ( )

d. Public or private nonprofit group living arrangements. ( )

e. Public or private nonprofit shelters for battered women and children. ( )

f. Private nonprofit cooperative food purchasing ventures, including those whose members pay for food prior to the receipt of the food. ( )

g. A farmers' market. ( )

h. An approved public or private nonprofit establishment that feeds homeless persons. The

establishment must be approved by FNS. ( )

11. **Sanction**. A penalty period when an individual is ineligible for Food Stamps. ( )

12. **Seasonal Farmworker Household**. Has a member who does agricultural work of a seasonal or other temporary nature. ( )

13. **Self-Employment**. The process of actively earning income directly from one's own business, trade, or profession. To be considered self-employed, a person is responsible for obtaining or providing a service or product that generates, or is expected to generate, income. ( )

14. **Spouse**. Persons who are legally married under Idaho law. ( )

15. **Standard Utility Allowance (SUA)**. Utility deduction given to a food stamp household that has a cost for heating or cooling. ( )

16. **State**. Any of the fifty (50) States, the District of Columbia, Puerto Rico, Guam, Northern Mariana Islands, and Virgin Islands of the United States. ( )

17. **Student**. An individual between the ages of eighteen (18) and fifty (50), physically and intellectually fit, and enrolled at least half-time in an institution of higher education. An institution of higher education usually requires a high school or general equivalency diploma for enrollment. This includes colleges, universities, and vocational or technical schools at the post-secondary school level. ( )

18. **Substance Use Disorder Treatment Program**. Any drug or alcohol rehabilitation program conducted by a private nonprofit organization or institution or a publicly operated community mental health center under Part B of Title XIX of the Public Health Service Act (42 USC 300x, et seq.). Indian reservation-based centers may qualify if FNS requirements are met and the program is funded by the National Institute on Alcohol Abuse under Public Law 91-616 or was transferred to Indian Health Service funding. ( )

19. **Supplemental Security Income (SSI)**. Monthly cash payments under Title XVI of the Social Security Act. Payments include state or federally administered supplements. ( )

20. **Systematic Alien Verification for Entitlements (SAVE)**. The federal automated system that provides immigration status needed to determine an applicant's eligibility for many public benefits, including Food Stamps. ( )

21. **Telephone Utility Allowance (TUA)**. Utility deduction given to a Food Stamp household that has a cost for telephone services and no other utilities. ( )

22. **Timely Notice**. Notice that is mailed electronically, at least ten (10) days before the effective date of an action taken by the Department. ( )

23. **Tribal General Assistance**. Cash, excluding in-kind assistance, financed by federal, state, or local government and provided to cover living expenses or other basic needs. ( )

24. **Verification**. Third party data or documents used to prove the accuracy of information used to make an eligibility determination. ( )

25. **Verified Upon Receipt**. Information received from certain authorized automated system matches that are considered automatically verified unless questionable. ( )

26. **Written Notice**. Correspondence that is generated by any method including handwritten, typed, or electronic, delivered to the customer by hand, U.S. Mail, professional delivery service, or by any electronic means. The terms “notice” and “written notice” are used interchangeably. ( )

013. ABBREVIATIONS A THROUGH G.

01. **AABD**. Aid to the Aged, Blind, and Disabled. ( )

02. **ABAWD**. Able-bodied adults without dependents. ( )

03. **AE**. Administrative Error. ( )

04. **AFA**. Application for Assistance. ( )

05. **CSS**. Bureau of Child Support Services. ( )

06. **DHW**. Department of Health and Welfare in Idaho. ( )

07. **EBT**. Electronic Benefit Transfer. ( )

08. **EWS**. Enhanced Work Services. ( )

09. **FNS**. Food and Nutrition Service of the USDA. ( )

10. **FFY**. Federal fiscal year. ( )

11. **FPG**. Federal Poverty Guideline(s). ( )

12. **FQC**. Federal Quality Control. ( )

13. **HUD**. US Department of Housing and Urban Development. ( )

014. ABBREVIATIONS I THROUGH Z.

01. **IHE**. Inadvertent household error. ( )

02. **IPV**. Intentional program violation. ( )

03. **IRS**. Internal Revenue Service. ( )

04. **JSAP**. Job Search Assistance Program. ( )

05. **LUA**. Limited utility allowance. ( )

06. **MUA**. Minimum utility allowance. ( )

07. **PA**. Public Assistance. ( )

08. **RSDI**. Retirement, Survivors, Disability Insurance received from SSA. ( )

09. **SAVE**. Systematic Alien Verification for Entitlements. ( )

10. **SDX**. State Data Exchange. ( )

11. **SQC**. State Quality Control. ( )

12. **SUA**. Standard utility allowance. ( )

13. **SSA**. Social Security Administration. ( )

14. **SSI**. Federal Supplemental Security Income Program for the aged, blind, or disabled. ( )

15. **SSN**. Social Security Number. ( )

16. **TAFI**. Temporary Assistance for Families in Idaho. ( )

17. **TOP**. Treasury Offset Program. ( )

18. **TUA**. Telephone Utility Allowance. ( )

19. **UI**. Unemployment Insurance. ( )

20. **USDA**. U S Department of Agriculture. ( )

21. **VA**. Veterans Administration. ( )

22. **WIOA**. Workforce Innovation and Opportunity Act. ( )

015. -- 098. (RESERVED)

099. SIGNATURES.
An individual who is applying for benefits, receiving benefits, or providing additional information as required in these rules, may do so with the representation of the individual's name either handwritten, electronic, or recorded telephonically. Such signature serves as intention to execute or adopt the sound, symbol, or process for the purpose of signing the related record. ( )

100. APPLICATION.
To apply for Food Stamps, the household or an authorized representative must complete and file an application with the Department, complete an interview, and verify information. There is no age requirement for applicants. Applicants may bring anyone to the interview. The Department will act on all applications and will grant Food Stamps to eligible households back to the date of application. ( )

101. APPLICATION FORMS.
Households can file an application the first day they contact the Department. The Department will have AFA forms readily available to households and will provide an AFA to any person making a request. Requests for the application can be made by telephone, in person, or by another person. The Department will mail or give the AFA to the person on the day requested. ( )

102. (RESERVED)

103. FILING AN APPLICATION.
The AFA must contain the applicant's name, address, signature, and application date. A household can file for Food Stamps by turning in page one of the AFA to the Food Stamp office. This protects the application date. If the household is eligible, Food Stamps for the first month will be prorated from the application date. The AFA can be submitted at the field office by the household or authorized representative. The AFA can be submitted by mail, fax, or email. ( )

104. -- 105. (RESERVED)

106. DETERMINATION OF WHEN A NEW APPLICATION FOR ASSISTANCE (AFA) IS REQUIRED.
The Department must follow the procedure outlined in 7 CFR 273.2(g) and (h) in determining when a food stamp household is required to fill out a new AFA. ( )

107. -- 112. (RESERVED)

113. HOUSEHOLD COOPERATION.
The household must cooperate with the Department. The application must be denied if the household refuses to cooperate. Refusal to cooperate includes failing to act without a sound and timely excuse. Giving false information on

purpose is failure to cooperate. If an application is denied or Food Stamps are stopped for refusal to cooperate, the household may reapply. The household is not eligible until it cooperates with the Department. ( )

114. APPLICATION WITHDRAWAL.
Households can withdraw their application any time before the eligibility decision. The Department will document the case record with the withdrawal reason. The Department will tell the household of the right to reapply. ( )

115. AUTHORIZED REPRESENTATIVE.
The household can choose a nonhousehold member to act as an authorized representative. The household can designate in writing another responsible household member or a responsible adult outside the household as an authorized representative. An adult employee of an authorized substance use disorder treatment and rehabilitation center, or an authorized group living arrangement center, may act as an authorized representative for the household. Conditions for an authorized representative are: ( )

01. Designating Authorized Representative. Households may designate an authorized representative to act on behalf of a household to apply for, receive, or use food stamps. The authorized representative should be aware of household circumstances. ( )

02. Persons Who Cannot Be an Authorized Representative. Persons with a conflict of interest may not act as an authorized representative without the Department's written approval. The field office supervisor must determine if no one else is available and give written approval. Persons with a conflict of interest are listed below: ( )

a. Retailers allowed to accept Food Stamps. ( )

b. Department employees involved in the certification or issuance process. ( )

c. A person disqualified for IPV during the penalty period, unless they are the only adult household member and no one else is available. ( )

d. Homeless meal providers. ( )

03. Department Responsibilities. The Department will: ( )

a. Make sure authorized representatives are properly selected. ( )

b. Record the representative's name in the case record. ( )

c. Inform the household it will be liable for any overissuance resulting from wrong information given by the representative. ( )

d. Make sure the household freely requested the representative. ( )

04. Authorized Representative Removed. The Department may remove an authorized representative for up to one (1) year if the person knowingly gives false information, or improperly uses the Food Stamps. This provision does not apply to substance use disorder centers and group homes. Written notice must be sent to the household and the authorized representative thirty (30) days before the penalty begins. The notice must list: ( )

a. The proposed action. ( )

b. The reason for the action. ( )

c. The right to a fair hearing. ( )

d. The name and telephone number to contact for more information. ( )

05. Authorized Representatives for Substance Use Disorder Treatment Centers and Group

Homes. Substance use disorder treatment centers and the heads of group living arrangements that act as authorized representatives for their residents, and which intentionally misrepresent households' circumstances, may be prosecuted under applicable federal and state statutes for their acts. ( )

116. -- 119. (RESERVED)

120. HOUSEHOLD INTERVIEWS.
The Department must conduct an interview with the applicant, a member of the household, or the authorized representative. Interviews must be conducted either face-to-face or via telephone The frequency of the interview must be as follows: ( )

01. Twenty-Four Months. At least once every twenty-four (24) months for households certified for twenty-four (24) months. ( )

02. Twelve Months. Every twelve (12) months for all other households. ( )

121. -- 132. (RESERVED)

133. VERIFICATION.
The Department must have verification to support the benefit determination. The Department must give the applicant household a clear written statement of the proof to bring to the interview. The statement will indicate the Department will help the household get proof, if needed. The Department must give the household ten (10) calendar days from the request date to provide proof. Proof can be provided in person, by mail, or by electronic interfaces. If the proof supplied is questionable, the Department can require further proof. The Department will notify the household of any other steps necessary to complete the application process. ( )

134. (RESERVED)

135. SOURCES OF VERIFICATION.
The following sources of verification must be considered: ( )

01. Written Confirmation. A primary source of proof is written confirmation of circumstances. Written proof includes driver's licenses, work or school identification, birth certificates, wage stubs, award letters, court orders, divorce decrees, separation agreements, insurance policies, rent receipts, and utility bills. Acceptable proof is not limited to a single document. Proof can be obtained from the household or other sources. Secondary sources of proof must be used to verify a household's circumstances if the primary source cannot be obtained or does not prove eligibility or benefit level. ( )

02. Collateral Contact. An oral confirmation of a household's circumstances by a person outside of the household. The collateral contact may be made either in-person or over the telephone. ( )

03. Automated System Data. Information that is obtained through interfacing with other government agency computer systems or authorized systems. ( )

136. (RESERVED)

137. PROOF FOR QUESTIONABLE INFORMATION.
Prior to the certification, a six-month or twelve-month contact, or recertification of the household, the Department must verify all questionable information regarding eligibility and benefit level. Proof is required when details are not consistent with information received by the Department. Proof may be obtained either verbally or in writing. ( )

138. PROVIDING PROOF TO SUPPORT APPLICATION STATEMENTS.
The household has primary responsibility to provide proof supporting its statements on the application and to resolve any questionable information. The Department must assist the household in obtaining proof. Households may supply proof in person, or by mail, facsimile, or other electronic interfaces. The Department will not require the household to present proof in person. ( )

139. -- 141. (RESERVED)

142. PROCESSING STANDARDS.
The Department will determine Food Stamp eligibility within thirty (30) days of the application date. The application date is the day the AFA is received and date stamped by the field office. The application date for a person released from a public institution is the release date if the person applied for Food Stamps before their release. The AFA must contain at least the applicant's name and address and be signed by a responsible household member or representative. ( )

143. -- 145. (RESERVED)

146. DENIAL OF FOOD STAMP APPLICATION.
The Department will deny the Food Stamp application under conditions listed below and send the household notice of denial. ( )

01. Household Ineligible. The Department will deny the application for ineligible households as soon as possible, but not later than thirty (30) calendar days following the application date. ( )

02. Household Fails to Appear for Interview. If the household fails to appear for an interview, and fails to contact the Department, the application will be denied thirty (30) calendar days after the application date. ( )

03. Household Does Not Provide Proof After Interview. If the household did not provide requested proof after an interview or later request, the Department will deny the application ten (10) calendar days after the request for proof. ( )

147. DELAYS IN PROCESSING.
The Department must follow the procedure outlined in 7 CFR 273.2(h) in determining the appropriate action to take on food stamp benefits when there are delays in completing the application process. ( )

148. -- 154. (RESERVED)

155. EXPEDITED SERVICE ELIGIBILITY.
Applicants must be screened to determine if the household is entitled to expedited service. The household must meet one (1) of the expedited service criteria below. The household must have provided proof postponed by the last expedited service or have been certified under the normal standards since the last expedited service. ( )

01. Low Income and Resources. To receive expedited services, the household's monthly countable gross income must be less than one hundred fifty dollars ($150) and the household's liquid resources must not exceed one hundred dollars ($100). ( )

02. Destitute. To receive destitute expedited services, the household must be a destitute migrant or seasonal farmworker household. The household's liquid resources must not exceed one hundred dollars ($100). ( )

03. Income Less Than Rent and Utilities. The household's combined monthly gross income and liquid resources are less than their monthly rent or mortgage, and utilities cost. ( )

156. TIME LIMITS FOR EXPEDITED FOOD STAMPS.
Time limits for acting on expedited Food Stamp applications are listed below: ( )

01. Seven Day Limit for Food Stamps. For households entitled to expedited service, the Department will provide Food Stamps to the household within seven (7) days of the application date. ( )

02. Seven Days After Discovery. If not discovered at initial screening, the Department will provide expedited services to an expedite-eligible household within seven (7) days, which begins the day after the Department finds the household is entitled to expedited service. ( )

03. Seven Days for Waived Interview. The Department will provide expedited services within seven (7) days of the application date for households entitled to an office interview waiver. Seven (7) days is counted from the application date. ( )

157. EXPEDITED FOOD STAMP WORK REGISTRATION.
The applicant must complete work registration unless they are exempt or have a representative register them. Other non- exempt household members must register if the registration can be done in seven (7) days. ( )

158. EXPEDITED VERIFICATION.
The Department will verify the applicant's identity through readily available proof or a collateral contact. Proof may include identification such as a driver's license, birth certificate, or voter registration card. The Department will try to get proof so that benefits can be issued within seven (7) days of the application date. Expedited Food Stamps must not be delayed beyond seven (7) days for proof other than identity. Other proof can be postponed to issue expedited Food Stamps. ( )

159. (RESERVED)

160. EXPEDITED CERTIFICATION.
If all required proof is provided for expedited certification, a normal certification period is assigned. Certification based on application date, household type, and proof is listed below: ( )

01. Non-migrant Household Applying from the First Through the Fifteenth of the Month. ( )

a. For a non-migrant household applying from the first through the fifteenth of the month, if proof of eligibility factors is postponed, assign a normal certification period; the Department will issue the first month's benefits. The Department will not issue the second month's benefits until the postponed proof is received. ( )

b. When proof is postponed, the household has thirty (30) days from the application date to provide the proof. The household must be given timely and adequate notice that no further benefits will be issued until proof is completed. If the proof results in changes in the household's Food Stamps, the Department will act on the changes without advance notice. ( )

c. If postponed proof is provided before the second month, the Department will process an issuance for the first working day of the second month. If proof is provided in the second month, the Department will issue benefits within seven (7) calendar days from the date the proof is received. If postponed proof is not provided within thirty (30) days from the application date, the Department will close the case. ( )

02. Non-migrant Household Applying from the Sixteenth Through the End of the Month. ( )

a. For a non-migrant household applying from the sixteenth to the end of the month, if proof of eligibility factors is postponed, the Department will assign a normal certification period, and issue the first- and second-month's benefits within the expedited time frame. ( )

b. When proof is postponed, the household has thirty (30) days from the application date to complete the proof. The household must be given timely and adequate notice that no further benefits will be issued until proof is completed. If the proof results in changes in the household's Food Stamps, the Department will act on the changes without advance notice. ( )

c. If postponed proof is provided within thirty (30) days, the Department will process an issuance for the first working day of the third month. If postponed proof is not provided within thirty (30) days from the application date, the Department will close the case. ( )

03. Migrant Household Applying from the First Through the Fifteenth of the Month. ( )

a. For a migrant household applying from the first (1st) through the fifteenth (15th) of the month, if proof of eligibility factors is postponed, the Department will assign a normal certification period, and issue the first

month's benefits. ( )

b. When proof is postponed, the household has thirty (30) days from the application date to complete in-state proof. The household has sixty (60) days from the application date to complete out-of-state proof. The household must be given adequate and timely notice no further benefits will be issued until the postponed proof is completed. Before the second month's benefits are issued, the household must provide all in-state postponed proofs. Before the third month's benefits are issued, the household must provide all out-of-state postponed proof. If the proofs result in changes in the household's Food Stamps, the Department will act on these changes, without providing advance notice. ( )

c. Migrants are entitled to postponed out-of-state proof only once each season. If postponed in-state proof is provided before the second month, the Department will process an issuance for the first working day of the second month. If postponed out-of-state proof is provided before the third month, the Department will process a regular issuance for the third month. If postponed out-of-state proof is provided in the third month, the Department will issue benefits within seven (7) calendar days from the date proof is received. If postponed in-state proof is not provided within thirty (30) days from the application date, the Department will close the case. If postponed out-of-state proof is not provided within sixty (60) days from the application date, the Department will close the case. ( )

04. Migrant Household Applying from the Sixteenth Through the End of the Month. ( )

a. For a migrant household applying from the Sixteenth to the end of the month, if proof of eligibility factors is postponed, the Department will assign a normal certification period, and issue the first- and second-months' benefits within the expedited time frame. ( )

b. When proof is postponed, the household has thirty (30) days from the application date to provide in-state proof. The household has sixty (60) days from the application date to provide out-of-state proof. The household must be given adequate and timely notice no further benefits will be issued until the postponed proof is completed. Before the third month's benefits are issued, the household must provide all in-state and out-of-state postponed proofs. If the proofs result in changes in the household's Food Stamps, the Department will act on these changes without providing advance notice. ( )

c. Migrants are entitled to postponed out-of-state proof only once each season. If postponed proof is provided before the third month, the Department will process a regular issuance for the third month. If postponed out-of-state proof is provided in the third month, the Department will issue benefits within seven (7) calendar days from the date proof is received. If postponed in-state proof is not provided within thirty (30) days from the application date, the Department will close the case. If postponed out-of-state proof is not provided within sixty (60) days from the application date, the Department will close the case. ( )

05. Reapplying Household. When a household granted postponed proof at the last expedited certification reapplies, it must provide the postponed proof before it is again eligible for expedited certification. The Department does not require postponed proof if the household was certified under normal standards since the last expedited certification. ( )

161. NO LIMIT TO EXPEDITED CERTIFICATIONS.
There is no limit to the number of times a household can receive expedited certification. ( )

162. EXPEDITED SERVICES FOR DESTITUTE HOUSEHOLDS.
Migrant or seasonal farmworker households meeting destitute conditions below can get expedited services. The rules for destitute households apply at initial application, the six-month or twelve-month contact, and recertification, but only for the first month of each contact or certification period. ( )

01. Terminated Source of Income. When the household's only income for the application month was received before the application date and was from a terminated source the Department will consider the household destitute. Terminated income is income received monthly or more often, no longer received from the same source the rest of the application month, or the next month or income received less often than monthly and not expected in the month the next regular payment is normally due. ( )

02. New Income in Application Month. When only new income is expected in the application month, the household is considered destitute. Only twenty-five dollars ($25), or less, of new income can be received in the ten (10) days after the application date. Income is new if twenty-five dollars ($25), or less, is received during the thirty (30) days before the application date. New income was received less often than monthly, was not received in the last normal payment interval, or was twenty-five dollars ($25) or less. ( )

03. Terminated Income and New Income in Application Month. Destitute households can get terminated income before the application date and new income before and after the application date. New income must not be received for ten (10) days after application and not exceed twenty-five dollars ($25). The household must get no other income in the application month. ( )

04. Application Month. For the application month, the Department will count only income received between the first day of the month and the application date, and will not count income from a new source expected after the application date. ( )

163. SPECIAL CONSIDERATION OF INCOME FOR DESTITUTE HOUSEHOLDS.
Special consideration of income for destitute households is listed below. The rules for destitute households apply at initial application, a six-month or twelve-month contact, and recertification, but only for the first month of each contact or certification period. ( )

01. Travel Advances. For destitute eligibility and benefit level, travel advances: ( )

a. Rom employers for travel costs to a new employment location are excluded. ( )

b. Against future wages are counted as income, but not a new source of income. ( )

02. Household Member Changes Job. A person changing jobs with the same employer is still getting income from the same source. A migrant's income source is the grower, not the crew chief. When a migrant moves with a crew chief from one (1) grower to another, the income from the first grower is ended. The income from the next grower is new income. ( )

03. Recertification or Six-Month or Twelve-Month Contact. The Department will disregard income from the new source for the first month of the new certification period if more than twenty-five dollars ($25) will not be received by the tenth calendar day after the normal issuance. ( )

164. DENIAL OF EXPEDITED SERVICE.
The Department will deny expedited service if the household does not meet expedite criteria or fails to cooperate in the application process. Failure to cooperate includes missing a scheduled expedited service appointment. The Department will still process the application under standard methods. ( )

165. CONTESTING DENIED EXPEDITED SERVICE.
The Department will offer an agency conference to a household contesting denial of expedited services. The Department will tell households they can request an agency conference; the conference will not delay or replace a fair hearing. Migrant farmworker households and households planning to move are entitled to expedited fair hearings. ( )

166. -- 177. (RESERVED)

178. CATEGORICALLY ELIGIBLE HOUSEHOLDS.
Households with all members meeting one (1) of the criteria below are categorically eligible for Food Stamps. The Department will not compute resource eligibility, gross or net income limits, social security number information, sponsored alien information, and residency. Categorically eligible households must meet all other Food Stamp eligibility criteria, and have the same rights as other households. ( )

01. Cash Benefits. All household members are approved for or already receive TAFI, AABD, or SSI cash benefits. ( )

02. Benefits Recouped. All household members have AABD or SSI benefits being recouped. ( )

03. Grant Less Than Ten Dollars. All household members not receiving TAFI, AABD, or SSI because their grant is less than ten dollars ($10). ( )

179. HOUSEHOLDS NOT CATEGORICALLY ELIGIBLE.
The households listed below are not categorically eligible for Food Stamps. ( )

01. IPV. Households are not categorically eligible, if any household member is disqualified for a Food Stamp IPV. ( )

02. Work Requirements. Households are not categorically eligible, if any household member fails to comply with the Food Stamp work requirements. ( )

03. Ineligible Legal Non-Citizen or Student. Households are not categorically eligible if any member is an ineligible legal non-citizen or ineligible student. ( )

04. Nonexempt Institution. Households are not categorically eligible if any member is a person living in a nonexempt institution. ( )

180. CATEGORICAL ELIGIBILITY ENDS.
Categorical eligibility ends when the household member is no longer eligible for TAFI, AABD, or SSI. If the household is still eligible under Food Stamp rules, the household will continue to receive Food Stamps. If categorical eligibility ends and household income or resources exceed the Food Stamp limits, the household is no longer eligible for Food Stamps. Food Stamps will stop after timely advance notice. ( )

181. BROAD -BASED CATEGORICALLY ELIGIBLE HOUSEHOLD EXCEPTIONS.
If a household contains any of the following members, the household is not eligible under Broad-Based Categorical Eligibility. ( )

01. IPV. Any household member is disqualified for an IPV. ( )

02. Drug-Related Felony. Any household member is ineligible because of a drug-related felony. ( )

03. Strike. Any household member is on strike. ( )

04. Transferred Resources. Any household member transferred resources to qualify for benefits. ( )

05. Refusal to Cooperate. Any household member refused to cooperate in providing information that is needed to determine initial or ongoing eligibility. ( )

182. VERIFICATION FOR TAFI OR AABD HOUSEHOLDS.
To determine eligibility for Food Stamps in TAFI or AABD households, the Department will use TAFI or AABD proof. ( )

183. TIME LIMITS FOR CATEGORICALLY ELIGIBLE HOUSEHOLDS.
The Food Stamp application must not be delayed or denied because of a delayed public assistance decision. ( )

184. -- 194. (RESERVED)

195. DISASTER CERTIFICATION.
When allowed by FNS, under Section 302(a) of the Disaster Relief Act of 1974, the Department can certify households affected by a natural disaster. If the Secretary of USDA declares a disaster area, the Department will follow disaster instructions issued by the USDA. ( )

196. -- 199. (RESERVED)

200. NONFINANCIAL CRITERIA.
Nonfinancial criteria are identification, residency, Social Security Number, citizenship, and work requirements. Households must meet these nonfinancial criteria to be eligible for Food Stamps. ( )

201. IDENTIFICATION.
The person making application for Food Stamps, including an authorized representative, must prove identity. Proof includes a driver's license, school identification, wage stubs, and birth certificates. The Department will accept other reasonable proof of identity. ( )

202. RESIDENCY.
A household must live in Idaho when applying for Food Stamps. A person can get Food Stamps as a member of only one (1) household a month. ( )

01. Place of Residency. An eligible Food Stamp household is not required to live in a permanent dwelling or have a fixed mailing address. There is no residence duration requirement. ( )

02. Vacationing Persons Not Residents. Persons in Idaho for vacation only are not residents for Food Stamp eligibility. Vacation is the period a household spends away from their usual activity, work, or home for travel, rest, or recreation. ( )

03. Different Physical and Mailing Addresses. The physical and mailing addresses of a Food Stamp household can be different. If the mailing address is not the household's physical address, the household must provide proof of the physical address. ( )

203. SOCIAL SECURITY NUMBER (SSN) REQUIREMENT.

01. Expectations. Before certification, households must provide the Department the SSN, or proof of application for SSN, for each household member. If a household member has more than one (1) SSN, they must provide all SSNs. Each SSN must be verified by the SSA. A household member with an unverified SSN is not eligible for Food Stamp benefits. The ineligible person's income and resources must be counted in the Food Stamp budget. If benefits are reduced or ended, because one (1) or more persons fail to meet the SSN requirement, the household must be notified in writing. ( )

02. Good Cause for Not Applying for SSN. If a household member can show good cause why an SSN application was not completed in a timely manner, an extension must be granted to allow them to receive Food Stamp benefits for one (1) month in addition to the month of application. Good cause for failure to apply must be shown monthly for such a household member to continue to participate. ( )

204. CITIZENSHIP AND QUALIFIED NON-CITIZEN REQUIREMENTS.
To be eligible for Food Stamps, an individual must meet the requirements under 7 CFR 273.4, "Citizenship and alien status." ( )

205. WRITTEN DECLARATION OF CITIZENSHIP OR IMMIGRATION STATUS.
To get Food Stamps, one (1) adult household member must certify by signing a statement, under penalty of perjury, regarding the citizenship and immigration status of household members applying for benefits. ( )

206. PROOF OF PROPER IMMIGRATION STATUS.

01. Expectations. Households are required to submit documents to verify the immigration status of the legal non-citizen applicants. ( )

02. Failure to Provide Legal Non-Citizen Documents. If a household says it is unable or unwilling to provide legal non-citizen status documents for a legal non-citizen household member, the legal non-citizen member must be classified as an ineligible legal non-citizen. ( )

207. NON-CITIZEN ELIGIBILITY PENDING VERIFICATION.
When an application is delayed after the Department has submitted a request to a federal agency for proof of eligible alien status, the Department must certify the person applying as eligible for Food Stamps pending the results of the investigation. The certification can last up to six (6) months from the date of the original request for proof. ( )

208. -- 211. (RESERVED)

212. FOOD STAMP HOUSEHOLDS.
A Food Stamp household is composed of a person, or group of persons, applying for or getting Food Stamps. The composition of Food Stamp households is listed below: ( )

01. A Person Living Alone. ( )

02. Living with Others Preparing Separate Meals. Person(s) living with others, but customarily purchasing food and preparing meals separately from the others. ( )

03. Living with Others with Furnished Meals. Person(s) living with others and being furnished both meals and lodging. The person(s) pays less than the thrifty food plan. ( )

04. Living Together Preparing Common Meals. A group of persons who live, purchase food, and customarily prepare meals together for home consumption. ( )

05. Women Living in Shelter. Women, or women with their children, temporarily residing in a shelter for battered women and children. ( )

06. Living in Substance Use Disorder Treatment Center. Person living in a publicly operated community health center or in a private nonprofit center for substance use disorder treatment and rehabilitation. ( )

07. Resident of Group Living Center. Person residing in a group living arrangement center certified by the Department. ( )

213. SEPARATE FOOD STAMP HOUSEHOLD COMPOSITION FOR RELATED MEMBERS.
One (1) of the conditions below must be met for related persons living together to be separate Food Stamp households. ( )

01. Children Age Twenty-Two and Older Living With Parents. Can be separate Food Stamp households. The households must purchase and prepare their food separately. ( )

02. Households Must Prepare Food Together Because of Age and Disability. Households that must purchase and prepare food together because one (1) household contains a person sixty (60) years old or older unable to purchase and prepare meals because of a disability, can be separate Food Stamp households. The spouse of the disabled person must be considered a member of that person's household. These households must meet the following conditions: ( )

a. The disability must be permanent under the Social Security Act or a nondisease-related, severe permanent disability. ( )

b. The income of the household, which does not contain the person unable to purchase and prepare meals separately, must not exceed one hundred sixty-five percent (165%) of the net monthly income limit for the household size. To count income for the one hundred sixty-five percent (165%) net monthly income standard, exclude the income of the disabled person and their spouse. ( )

c. Count all available income to the household not containing the disabled person. Compare the net monthly income eligibility standard for that size household. ( )

214. CHILD CUSTODY.
For a child under eighteen (18) years old, the parent with primary physical custody is eligible to receive Food Stamp benefits for that child. If both parents request food stamp benefits for the child, primary custody is determined by where the child is expected to spend fifty-one percent (51%) or more of the nights during a certification period. When only one (1) parent applies for food stamp benefits, the child may be included in that parent's household even though they do not have primary physical custody of the child. ( )

215. PERSONS NOT ELIGIBLE FOR SEPARATE FOOD STAMP HOUSEHOLD STATUS.
Persons listed below cannot be separate Food Stamp households. For Food Stamps, they are part of the household where they live. ( )

01. Spouses. ( )

02. Parents and Children Together. Children under age twenty-two (22), living together with their parents. Parents and children living together include natural, adopted, or stepchildren. ( )

03. Child Under Age Eighteen Under Parental Control. A child under age eighteen (18) and under parental control of an adult household member, unless the child is a foster child. ( )

216. ELDERLY OR DISABLED FOOD STAMP HOUSEHOLD MEMBERS.
To be counted as an elderly or disabled Food Stamp household member, the person must meet one (1) of the following: ( )

01. Age Sixty or Older. ( )

02. Entitled to SSI Benefits. This includes SSI presumptive disability payments, SSI emergency advance payments, or special SSI status. ( )

03. Entitled to Social Security Payments Based on Disability or Blindness (RSDI). ( )

04. State Supplement. Entitled to state or federally funded State supplement payments to the SSI program such as AABD. ( )

05. Entitled to Medicaid Based on SSI-Related Disability or Blindness. ( )

06. Disability Retirement. Entitled to federal or state funded-disability retirement benefits because of a disability considered permanent by SSA. ( )

07. Disabled Veteran. A veteran with a service- or nonservice-connected disability rated or paid as total. ( )

08. Veteran Needing Aid and Attendance. A veteran considered in need of regular aid and attendance or permanently housebound under USC Title 38. ( )

09. Veteran's Surviving Spouse. In need of aid and attendance or permanently housebound. ( )

10. Veteran's Surviving Child. Permanently incapable of self-support under USC Title 38. ( )

11. Veteran's Survivor Entitled. A veteran's surviving spouse or child entitled to receive payment for a service-connected death under USC Title 38. The veteran's surviving spouse or child must be permanently disabled under Section 221(i) of the Social Security Act. A veteran's surviving spouse or child entitled to pension benefits for a nonservice death under USC Title 38. The veteran's surviving spouse or child must be permanently disabled under Section 221(i) of the Social Security Act. "Entitled" refers to veterans, surviving spouses, and children receiving pay or benefits, or who have been approved for payments, but are not yet receiving them. ( )

12. Railroad Retirement and Medicare. Entitled to an annuity payment under Section 2(a)(1)(iv) of the Railroad Retirement Act of 1974 and determined eligible for Medicare by the Railroad Retirement Board. ( )

13. Railroad Retirement and Disability. Entitled to an annuity payment under Section 2(a)(1)(v) of the Railroad Retirement Act of 1974 and is determined disabled by the Board under SSI criteria. ( )

217. NONHOUSEHOLD MEMBERS.

Nonhousehold members are persons not counted in determining Food Stamp household size. Their income and resources do not count toward the Food Stamp household. Nonhousehold members may be eligible as a separate household and are listed below: ( )

01. Roomers. A person who pays for lodging, but not meals. ( )

02. Live-In Attendants. A person living with a household to provide medical, housekeeping, child care, or other similar services. ( )

03. Ineligible Students. A person between the ages of eighteen (18) and fifty (50), physically and intellectually fit, enrolled at least half-time in an institution of higher education, and not meeting Food Stamp eligibility requirements for students. ( )

04. Residents of Institutions. A resident of an institution is an ineligible household member because the institution provides the resident over fifty percent (50%) of three (3) meals daily, as part of the normal services. The institution is not allowed to accept Food Stamps. ( )

218. PERSONS DISQUALIFIED AS FOOD STAMP HOUSEHOLD MEMBERS.

Persons disqualified as Food Stamp household members must not participate in the Food Stamp program. Disqualified household members include, but are not limited to, sanctioned individuals, fleeing felons, and ineligible non-citizens. Treatment of disqualified household members is described under 7 CFR 273.11(c). ( )

219. CIRCUMSTANCES UNDER WHICH FOOD STAMP PARTICIPATION IS PROHIBITED.

01. Prohibition from Receiving Food Stamp Benefits. An individual is prohibited from receiving Food Stamp benefits at the time of application if they: ( )

a. Receive tribal commodities; ( )

b. Are incarcerated; ( )

c. Are in an institution; ( )

d. Are in foster care and the foster parents are receiving a cash benefit for providing care and maintenance for the child; ( )

e. Receive Food Stamp benefits in another household; ( )

f. Are deceased; or ( )

g. Receive cash benefits in a TAFI Caretaker Relative household. ( )

02. Prohibited Participation During the Certification Period. If the Department learns of prohibited participation during the certification period, it will act to end benefits for that individual. ( )

220. -- 225. (RESERVED)

226. JOB SEARCH ASSISTANCE PROGRAM (JSAP).

01. JSAP Status. All household members, unless exempt, must participate in JSAP, including members who are on strike and members who are not migrants in the job stream. The Department determines the JSAP status of a participant at certification, a six-month or twelve-month contact, recertification, and when

household changes occur. ( )

02. JSAP Information. The Department will explain the JSAP requirement, rights, responsibilities, and the result of failure to comply. ( )

227. EXEMPTIONS FROM JSAP.

01. Parents or Caretakers Responsible for the Care of a Child Under Six Years Old. If the child becomes six (6) during the certification period, the parent or caretaker must register for JSAP at the next scheduled six-month or twelve-month contact or recertification, unless exempt for another reason. ( )

02. Parents and Caretakers of an Incapacitated Person. A parent or caretaker responsible for the care of a person incapacitated due to illness or disability is exempt from JSAP. ( )

03. Persons Who Are Incapacitated. A person physically or intellectually unfit for employment is exempt from JSAP. ( )

04. Students Enrolled Half-Time. A student eighteen (18) years or older is exempt from JSAP if they: ( )

a. Are enrolled at least half-time in any institution of higher learning and if they meet the definition of an eligible student in Section 282 of these rules; or ( )

b. Are enrolled at least half-time in any other recognized school or training program. ( )

c. Remain enrolled during normal periods of class attendance, vacation, and recess. If they graduate, enroll less than half-time, are suspended or expelled, drop out, or do not intend to register for the next normal school term (excluding summer), they must register for work at the next scheduled six-month or twelve-month contact or recertification. ( )

05. SSI Applicants. Are exempt from JSAP until SSI eligibility is determined. ( )

06. Persons Who Are Employed or Self-Employed. Are exempt from JSAP if they are: ( )

a. Working at least thirty (30) hours per week; ( )

b. Receiving earnings equal to the federal minimum wage multiplied by thirty (30) hours; or ( )

c. A migrant or seasonal farm worker under contract or agreement to begin employment within thirty (30) days. ( )

07. Persons in Treatment for a Substance Use Disorder. A regular participant in a substance use disorder treatment and rehabilitation program is exempt from JSAP. ( )

08. Unemployment Insurance (UI) Applicant/Recipient. A person receiving UI is exempt from JSAP. A person applying for, but not receiving UI, is exempt from JSAP if they are required to register for work with the Department of Commerce and Labor as part of the UI application process. ( )

09. Children Under Age Sixteen. Are exempt from JSAP. A child who turns sixteen (16) within a certification period must register for JSAP at the six-month or twelve-month contact or recertification, unless exempt for another reason. ( )

10. Persons Age Sixteen or Seventeen. Are exempt from JSAP if they are attending school at least half-time, or are enrolled in an employment and training program, including GED, at least half-time. ( )

11. Participants Age Sixty or Older. Are exempt from JSAP. ( )

12. **Pregnant Women**. In their third trimester are exempt from JSAP. ( )

228. DEFERRALS FROM JSAP FOR HOUSEHOLD MEMBERS PARTICIPATING IN TAFI.
Deferrals from JSAP for household members participating in the TAFI program are listed below. ( )

01. **Reasonable Distance**. Appropriate child care is not available within a reasonable distance from the participant's home or work site. ( )

02. **Relative Child Care**. Informal child care by relatives or others is not available or is unsuitable. ( )

03. **Child Care Not Available**. Appropriate and affordable child care is not available. ( )

229. PARTICIPANTS LOSING JSAP EXEMPT STATUS.
If an exempt household member becomes mandatory, the Department must notify the participant of JSAP requirements. ( )

230. -- 235. (RESERVED)

236. GOOD CAUSE.
A mandatory participant may get a deferral from JSAP requirements, if the Department determines a valid reason exists. ( )

237. SANCTIONS FOR FAILURE TO COMPLY WITH JSAP WORK PROGRAM REQUIREMENTS.
When a JSAP participant fails or refuses to comply with work program requirements without good cause, sanctions listed below must be applied. In determining which sanction to impose, sanctions previously imposed for voluntary quit or reduction in work hours under Section 271 of these rules must be considered. ( )

01. **Noncomplying Household Member**. The participant who commits the work program violation is excluded as a household member when determining the Food Stamp allotment. The person cannot receive Food Stamps, but their income and resources are counted in the Food Stamp computation for the household. The person must serve a minimum sanction period plus take corrective action to become eligible for Food Stamps again. If the sanctioned household member becomes exempt from JSAP requirements, the Department will end the sanction. ( )

a. First work program violation. A minimum sanction period of one (1) month is imposed. ( )

b. Second work program violation. A minimum sanction period of three (3) months is imposed. ( )

c. Third and subsequent work program violations. A minimum sanction period of six (6) months is imposed. ( )

02. **Joins Another Household**. If a sanctioned household member leaves the original household and joins another Food Stamp household, treat the sanctioned member as an excluded household member. The person cannot receive Food Stamps, but their income and resources are counted in the Food Stamp computation for the household. The person is excluded for the rest of the sanction period and until corrective actions are taken. ( )

03. **Closure Reason**. The household must be informed of the reason for the closure. ( )

04. **Sanction Notice**. The household must be informed of the proposed sanction period. ( )

05. **Sanction Start**. The household must be informed the sanction will begin the first month after timely notice. ( )

06. **Actions to End Sanction**. The household must be informed of the actions the household can take to end the sanction. ( )

07. **Fair Hearing**. The household must be informed of the right to a fair hearing. ( )

238. NOTICE OF SANCTIONS FOR FAILURE TO COMPLY WITH JSAP.
A Notice of Decision is sent when a participant fails to comply with JSAP requirements. The Notice of Decision must contain data listed below. If the member complies before the effective date of the action, the sanction does not take effect. The Notice of Decision must: ( )

01. **Include the Proposed Sanction Period**. ( )

02. **Include the Reason for Sanction**. ( )

03. **Include the Actions the Sanctioned Person Takes to End Sanction**. ( )

04. **Tell the Household of its Right to Fair Hearing**. ( )

239. RIGHT TO APPEAL SANCTION.
The participant has the right to appeal the decision to sanction. The participant may contest a decision of mandatory status or a denial, reduction, or termination of benefits, due to failure to comply with JSAP. Appeals are conducted under IDAPA 16.05.03, Section 350, "Contested Case Proceedings and Declaratory Rulings." The Department will notify JSAP of the fair hearing. ( )

240. JSAP SANCTION BEGINS.
The sanction period begins the first month after the Notice of Decision unless a fair hearing is requested. ( )

241. ENDING SANCTIONS FOR FAILURE TO COMPLY WITH JSAP.
Household members sanctioned for not complying with JSAP are ineligible until a condition listed below is met. ( )

01. **Fair Hearing Reversal**. Sanction ends if a fair hearing reverses the sanction. ( )

02. **Sanctioned Member Becomes Exempt**. Sanction ends if the sanctioned member becomes exempt from JSAP. ( )

03. **Member Complies With JSAP**. Sanction ends if the member, who refused to comply with a JSAP requirement, complies. The member must complete corrective action and serve the minimum sanction period. ( )

242. CORRECTIVE ACTION FOR WORK PROGRAMS.
A mandatory participant can requalify for Food Stamps after a sanction by becoming exempt from work requirements, or serving the sanction period and correcting noncompliance with JSAP. ( )

243. -- 250. (RESERVED)

251. ABLE-BODIED ADULTS WITHOUT DEPENDENTS (ABAWD) WORK REQUIREMENT.
To participate in the Food Stamp program, a person must meet one (1) of the following. A person who does not meet one (1) of these conditions may not participate in the Food Stamp program as a member of any household for more than three (3) full months (consecutive or otherwise) in a fixed thirty-six (36) month period. ( )

01. **Work at Least Eighty Hours per Month**. The person must work at least eighty (80) hours per month. The definition of work is any combination of: ( )

a. Work in exchange for money. ( )

b. Work in exchange for goods or services, known as "in-kind" work. ( )

c. Unpaid work, with a public or private non-profit agency. ( )

02. Participate in JSAP or Another Work Program. The person must participate in and comply with the requirements of the JSAP program (other than job search or job readiness activities), the WIOA program, a program under Section 236 of the Trade Act of 1974, or another work program recognized by the Department. The person must participate for at least eighty (80) hours per month. ( )

03. Combination of Work and Work Programs. The person must work and participate in a work program. Participation in work and work programs must total at least eighty (80) hours per month. ( )

04. Participate in Work Opportunities. The person must participate in and comply with the requirements of a Work Opportunities program. ( )

05. Residents of High Unemployment Areas. ABAWDs residing in a county identified by the Department as having high unemployment or lack of jobs may not be subject to the three (3) month limitation of benefits. ABAWDs residing in these counties are subject to JSAP work requirement. ( )

252. PROOF REQUIRED FOR ABAWDS.

The Department requires proof of compliance with the ABAWD requirements. If there is evidence the ABAWD got Food Stamps in another state, the Department will get proof of the number of countable months from that state, before certification. A written or verbal statement from the other state agency of countable months is acceptable proof. ( )

253. ABAWD GOOD CAUSE.

The work requirement is met if an ABAWD would have worked at least eighty (80) hours per month but missed work for good cause. The absence from work must be temporary. The ABAWD must keep the job. Circumstances beyond control of the ABAWD are the basis of good cause. These include illness, illness of a household member requiring the presence of the ABAWD, household emergency, and lack of transportation. ( )

254. REPORTING ABAWD CHANGES.

ABAWDs must report within the first ten (10) days of the month following the date of change if total work or work program hours drop below eighty (80) hours per month. ( )

255. REGAINING ELIGIBILITY.

ABAWDs whose three (3) month eligibility expires may regain eligibility for Food Stamps. During any thirty (30) consecutive days, the person must meet one (1) of the work requirements below. The Department will prorate Food Stamp benefits from the date the person regains eligibility. ABAWDs must continue to meet the work requirement to get Food Stamps or meet conditions for the three (3) additional months. There is no limit on the number of times an ABAWD may regain and maintain eligibility by meeting the work requirement. ( )

01. Work Eighty Hours. The person must work eighty (80) or more hours per month. ( )

02. Participate in JSAP. The person must participate in and comply with the requirements of the JSAP program (other than job search or job search training), the WIOA program, or a program under Section 236 of the Trade Act of 1974 for eighty (80) or more hours per month. ( )

256. THREE ADDITIONAL MONTHS OF FOOD STAMPS AFTER REGAINING ELIGIBILITY.

A person who regained eligibility under Section 255 of these rules, but is no longer fulfilling the ABAWD work requirements in Section 251 of these rules through no fault of their own, may get Food Stamps for an additional three (3) consecutive months. For an applicant, the three (3) consecutive months begin the first full month of benefits. For a participant, the three (3) consecutive months begin the month following the month the participant no longer meets the work requirements. A person is eligible for the additional three (3) consecutive months only once in a thirty-six (36) month period. ( )

257. PERSONS NOT CONSIDERED ABAWD.

Persons meeting any of the following are not considered ABAWD. ( )

01. Age. Persons under eighteen (18) and fifty-three (53) years old or older. Beginning October 1, 2024, the age limit increases to fifty-five (55). ( )

02. Disability. Persons medically certified as physically or intellectually unfit for employment. A person is medically certified as physically or intellectually unfit for employment if: ( )

a. Receiving temporary or permanent disability benefits issued by a government or private source. ( )

b. Obviously intellectually or physically unfit for employment, as determined by the Department. ( )

c. The person has a statement from a physician, physician's assistant, nurse, nurse practitioner, designated representative of the physician's office, licensed or certified psychologist, a social worker, or any other medical personnel the Department determines appropriate, verifying physical or intellectual unfitness for employment. ( )

03. All Persons Residing in a Household Where a Household Member Is Under Age Eighteen. ( )

04. Pregnant Persons. ( )

05. A homeless individual, as defined under 7 CFR 271.2. ( )

06. A veteran who served in the US Armed Forces and was discharged or released from service, regardless of the reason for discharge or release. ( )

07. An individual who was eighteen (18) years old or older (at a state agency's option), who at the time aged out of foster care program and who is under twenty-five (25) years old. ( )

258. FOOD STAMPS ISSUED TO INELIGIBLE ABAWD.
If benefits are paid to an ABAWD in error, the months count against the three- (3) month time limit until repaid. ( )

259. STRIKES.
Households must be denied Food Stamps if a member is unemployed because of a strike, unless the household was eligible for or getting Food Stamps the day before the strike. ( )

260. GOVERNMENT EMPLOYEES DISMISSED FOR STRIKE.
State, federal, and local government employees dismissed because of joining in a strike against the governmental entity have voluntarily quit a job without good cause. ( )

261. VOLUNTARY JOB QUIT.
An employed household member who voluntarily quits a job without good cause is not eligible for Food Stamps. The Department is required to make a voluntary job quit determination when it learns that any employed household member has quit their job and any of the following circumstances apply. ( )

01. Voluntary Job Quit Timeframes. The Department must make a voluntary job quit determination: ( )

a. For any applicant who quits their job within sixty (60) days of the application date. ( )

b. For any new household member who quits their job within the sixty (60) days prior to entering the household. ( )

c. For any recipient who quits their job at any time during the certification period. ( )

02. Job Definition for Voluntary Job Quit. The Department must make a voluntary job quit determination for any household member who is not exempt from work registration for any reason other than

employment if: ( )

a. They quit a job of at least thirty (30) hours a week; or ( )

b. Their weekly earnings from the job they quit are equivalent to the federal minimum wage multiplied by thirty (30) hours. ( )

262. VOLUNTARY REDUCTION IN WORK HOURS.
An employed household member who voluntarily reduces hours of work without good cause is not eligible for Food Stamps. The Department is required to make a reduction in work hours determination when it learns that any employed household member has voluntarily reduced their work hours and any of the following circumstances apply. ( )

01. Voluntary Work Reduction Timeframe. The Department must make a reduction in work hours determination if the hours of work were voluntarily reduced by a(n): ( )

a. Applicant, within sixty (60) days of the application date. ( )

b. New household member, within the sixty (60) days prior to entering the household. ( )

c. Recipient, at any time during the certification period. ( )

02. What Counts as a Significant Voluntary Work Reduction. For any household member's eligibility for Food Stamps to be affected, the Department must determine that: ( )

a. Prior to the voluntary reduction in hours, the job was at least thirty (30) hours a week; and ( )

b. The hours of work have been voluntarily reduced to less than thirty (30) hours per week without good cause. ( )

263. -- 264. (RESERVED)

265. SITUATIONS NOT CONSIDERED VOLUNTARY JOB QUIT OR REDUCTION OF WORK.
Situations not counted as a voluntary job quit or reduction of work hours are listed below: ( )

01. The Person Ends Self-Employment. ( )

02. Employer Demands Resignation and Person Resigns. ( )

03. Laid Off From New Job. A person quits a job, secures new employment at comparable salary or hours, and then is laid off or loses the new job through no fault of their own. ( )

266. HOUSEHOLD MEMBER LEAVES DURING A PENALTY PERIOD.
When the household member who committed a voluntary quit or reduction in hours penalty leaves the household, the penalty follows the household member who caused it. If the household member who committed the penalty joins another household, they are ineligible for the balance of the penalty period unless they meet the conditions stated in Subsection 275.01 of these rules. ( )

267. GOOD CAUSE FOR VOLUNTARILY QUITTING A JOB OR REDUCING WORK HOURS.
If a household member voluntarily quits a job, the Department will determine if the quit was for good cause. All facts and circumstances submitted by the household and the employer must be considered. Good cause reasons are listed in 7 CFR 273.7(i)(3). ( )

268. PROOF OF JOB QUIT OR REDUCTION OF WORK HOURS.
Verification from the household is required if the household's job quit or reduction of work hours is questionable. When proof of the voluntary quit cannot be obtained, the household must not be denied Food Stamps. If a household member refuses, without good cause, to provide enough information to determine voluntary quit or work reduction, a

penalty must be imposed. ( )

269. (RESERVED)

270. PENALTY FOR APPLICANT QUITTING A JOB OR REDUCING WORK HOURS.
If the Department determines a voluntary quit or reduction of work hours was not for good cause, the member who quit is not eligible for a ninety (90) day penalty period. The penalty period begins the date the household member quit. The applicant household must be told the job quit and work reduction penalty information listed below: ( )

01. Denial Reason. The household must be informed of the reason for the Food Stamp denial for the member. ( )

02. Sanction Period. The household must be informed of the proposed voluntary quit or work reduction sanction period. ( )

03. Fair Hearing. The household must be informed of the right to a fair hearing. ( )

04. Right to Reapply. The household must be informed of the right to reapply after the ninety (90) day penalty period. ( )

271. PENALTY FOR RECIPIENT QUITTING A JOB OR REDUCING WORK HOURS.
If the Department determines a member of the household voluntarily quit a job or reduced work hours, the penalty listed in Subsection 271.01 of this rule must be imposed. Food Stamps must be reduced, beginning the first month after timely notice. The household must be told the information listed in this rule within ten (10) calendar days of the voluntary quit or reduction in work ruling. When determining the sanction to impose, previous sanctions for noncompliance with JSAP and work registration requirements as described in Section 237 of these rules must be considered. Previous sanctions for recipient voluntary quit or work reduction must also be considered. If the sanctioned household member becomes exempt from JSAP requirements, the Department will end the sanction. The voluntary quit sanction does not end if the sanctioned household member becomes exempt due to application or receipt of Unemployment Insurance. ( )

01. Non-Complying Household Member. The participant who commits the work program violation is excluded as a household member when determining the Food Stamp allotment. The person cannot receive Food Stamps, but their income and resources are counted in the Food Stamp computation for the household. The person must serve a minimum sanction period plus take corrective action to become eligible for Food Stamps again. Corrective action includes: returning to work, increasing work hours to meet the work exemption, or completing required activities with JSAP. ( )

a. First work program violation. A minimum sanction period of one (1) month is imposed. ( )

b. Second work program violation. A minimum sanction period of three (3) months is imposed. ( )

c. Third and subsequent work program violation. A minimum sanction period of six (6) months is imposed. ( )

02. Joins Another Household. If a sanctioned household member leaves the original household and joins another Food Stamp household, the Department will treat the sanctioned member as an excluded household member. The person cannot receive Food Stamps, but their income and resources are counted in the Food Stamp computation for the other household. The person is excluded for the rest of the sanction and until corrective actions are taken. ( )

03. Closure Reason. The household must be informed of the reason for the closure. ( )

04. Sanction Notice. The household must be informed of the proposed sanction period. ( )

05. Sanction Start. The household must be informed the sanction will begin the first month after

timely notice. ( )

06. Actions to End Sanction. The household must be informed of the actions the household can take to end the sanction. ( )

07. Fair Hearing. The household must be informed of the right to a fair hearing. ( )

272. PARTICIPANT VOLUNTARY QUIT OR REDUCTION OF WORK HOURS.
If it is discovered a household member voluntarily quit a job or reduced work hours without good cause during the certification period the Department must provide the individual with a notice of adverse action within ten (10) days after the determination of a quit or reduction in work effort. The individual will be disqualified according to the minimum mandatory sanction schedule under Subsection 271.01 of these rules. ( )

273. – 274. (RESERVED)

275. ENDING VOLUNTARY QUIT WORK PROGRAM PENALTIES.
Eligibility may be reestablished before the end of the penalty period for an otherwise eligible household member when they meet the conditions in Subsection 275.01 of this rule. Eligibility may be reestablished after a voluntary quit or work reduction penalty period has elapsed for an otherwise eligible household member when they meet a condition in Subsection 275.02 of this rule. ( )

01. Ending Voluntary Quit or Reduction Penalty Before the End of the Penalty Period. If the sanctioned household member becomes exempt from JSAP requirements, their eligibility for Food Stamps may be reestablished. The voluntary quit penalty does not end if the sanctioned household member becomes exempt due to application or receipt of Unemployment Insurance. ( )

02. Ending Voluntary Quit or Reduction Penalty After Penalty Period. ( )

a. If the sanctioned household member gets a new job comparable in salary or hours to the job they quit, their eligibility for Food Stamps may be reestablished. A comparable job may entail fewer hours or a lower net salary than the job which was quit. To be comparable, the hours for the new job cannot be less than thirty (30) hours per week and the salary or earnings for the new job cannot be less than federal minimum wage multiplied by thirty (30) hours per week. ( )

b. If the sanctioned household member's hours of work are restored to more than thirty (30) hours per week before reduction, their eligibility for Food Stamps may be reestablished. ( )

c. A sanctioned household member can requalify for Food Stamps after serving the minimum sanction period and completing corrective action. The participant must contact the Department and request an opportunity to correct the sanction. ( )

276. FAILURE TO COMPLY WITH A REQUIREMENT OF ANOTHER MEANS - TESTED PROGRAM.
Food Stamps must not increase when a failure to comply causes other means-tested benefits to decrease. Benefits from means-tested programs like TAFI may decrease due to failure to comply with a program requirement. Food Stamp benefits must not increase because of this income loss. If a reduction in benefits from another means-tested program occurs, the Department will verify the reason for the reduction. If the reason for the reduction cannot be verified, the Department will document the case record to reflect the good faith effort to verify the information. ( )

277. PENALTY FOR FAILURE TO COMPLY WITH A REQUIREMENT OF ANOTHER MEANS - TESTED PROGRAM.
To prevent an increase in Food Stamp benefits, penalties will be applied to a Food Stamp case for failure to comply with a requirement of another means-tested program such as TAFI. When a Food Stamp recipient fails to comply with a requirement of the TAFI program, the Department will count that portion of the benefit decrease attributed to the TAFI penalty. Conditions for ending the penalty are listed below. ( )

01. Time-Limited TAFI Penalty. If the TAFI penalty is time-limited, the Department will end the Food Stamp penalty when the TAFI penalty is ended. ( )

02. Lifetime TAFI Penalty. If the TAFI penalty is a lifetime penalty, apply the Food Stamp penalty for a length of time to match the remaining months of TAFI eligibility for the household. The Department will end the Food Stamp penalty if the household subsequently reapplies for TAFI and is denied for a reason other than the noncompliance that caused the TAFI penalty. ( )

03. Member Who Caused the TAFI Penalty Leaves the Household. The Department will end the Food Stamp penalty when the member who caused the TAFI penalty leaves the household. ( )

278. COOPERATION IN ESTABLISHMENT OF PATERNITY AND OBTAINING SUPPORT.
A natural or adoptive parent or other individual living with and exercising parental control over a minor child who has an absent parent must cooperate in establishing paternity for the child and obtaining support for the child. ( )

279. FAILURE TO COOPERATE.
When a parent or individual fails to cooperate in establishing paternity and obtaining support, they are not eligible to participate in the Food Stamp Program. ( )

280. EXEMPTIONS FROM THE COOPERATION REQUIREMENT.
The parent or individual will not be required to provide information about the absent or alleged parent or otherwise cooperate in establishing paternity or obtaining support if good cause for not cooperating exists. Good cause for failure to cooperate in obtaining support is listed below: ( )

01. Rape or Incest. Proof the child was conceived because of incest or forcible rape. ( )

02. Physical or Emotional Harm. Proof the absent parent may inflict physical or emotional harm to the children, the participant, or individual exercising parental control. This must be supported by medical evidence, police reports, or as a last resort, an affidavit from a knowledgeable source. ( )

03. Minimum Information Cannot be Provided. Substantial and credible proof is provided indicating the participant cannot provide the minimum information regarding the non-custodial parent. ( )

281. – 282. (RESERVED)

283. STUDENT ENROLLMENT.
A student is considered enrolled in an institution of higher education if participating in a regular curriculum there. Enrollment status of a student begins the first day of the school term for the institution of higher education. The enrollment continues through normal periods of class attendance, vacation, and recess. Enrollment stops if the student graduates, is suspended or expelled, drops out, or does not intend to register for the next normal school term. Summer school terms are not normal school terms. ( )

284. DETERMINING STUDENT ELIGIBILITY.
To be eligible for Food Stamps, a student must meet at least one (1) of the following: ( )

01. Employment. The student: ( )

a. Is employed a minimum of eighty (80) hours per month and is paid for such employment; or ( )

b. Is self-employed a minimum of eighty (80) hours per month; and ( )

c. Must earn at least the federal minimum wage times eighty (80) hours. ( )

02. Work Study Program. The student is in a state or federally financed work study program during the regular school year. The student exemption begins the month the school term begins, or the month the work study is approved, whichever is later. The exemption continues until the end of the month the school term ends, or it

becomes known the student has refused an assignment. The student work study exemption stops when there are breaks of a full calendar month or longer between terms, without approved work study. The exemption only applies to months the student is approved for work study. ( )

03. Caring for Dependent Child. The student is: ( )

a. Responsible for the care of a dependent household member under the age of six (6). ( )

b. Responsible for the care of a dependent household member who has reached the age of six (6), but is under age twelve (12) when the state agency has determined that adequate child care is not available to enable the student to attend class and comply with the eighty (80) hour work requirement. ( )

c. A single parent enrolled in an institution of higher education on a full-time basis, as determined by the institution, and be responsible for the care of a dependent child under age twelve (12). ( )

04. TAFI Participant. The student gets cash benefits from the TAFI program. ( )

05. Training. The student is assigned to or placed in an institution of higher education through, or complying with, the following programs: WIOA, JOBS, JSAP, a program under Section 236 of the Trade Act of 1974, or a program for employment and training operated by a state or local government. ( )

285. INELIGIBILITY OF FUGITIVE FELONS AND PROBATION AND PAROLE VIOLATORS.
Individuals who are fleeing to avoid prosecution or custody for a crime, or an attempt to commit a crime, classified as a felony (or in the state of New Jersey, a high misdemeanor), or who are violating a condition of probation or parole under a federal or state law, cannot be considered eligible household members. ( )

286. EFFECTIVE DATE OF INELIGIBILITY.
The effective date of disqualification for Food Stamps is the month following the date the Department has documented evidence the individual is fleeing or violating parole/probation. ( )

287. INELIGIBILITY FOR A FELONY CONVICTION FOR POSSESSION, USE, OR DISTRIBUTION OF A CONTROLLED SUBSTANCE.
Individuals convicted under federal or state law of a felony involving the possession, use, or distribution of a controlled substance can receive Food Stamps when they comply with the terms of a withheld judgment, probation, or parole. Controlled substance felons who are not complying with the terms of a withheld judgment, probation, or parole are not eligible for Food Stamps. ( )

288. -- 299. (RESERVED)

300. RESOURCES DEFINED.
Resources include, but are not limited to, cash, bank accounts, stocks, bonds, personal property, and real property. A household must have the right, authority, or power to change the resource to cash for the resource to be counted. The household must have the legal right to use the resource for support and maintenance for the resource to be counted.
( )

301. DETERMINING RESOURCES.
The resources of all household members are counted unless the resource is excluded. ( )

302. -- 304. (RESERVED)

305. RESOURCE LIMIT.
The Food Stamp resource limit is five thousand dollars ($5,000) for Broad-Based Categorically Eligible households. Households that do not meet the requirements for Broad-Based Categorical Eligibility are subject to resource limits published by the FNS. ( )

306. -- 307. (RESERVED)

308. EQUITY VALUE OF RESOURCES.
Equity value is the current market value of a resource, minus any encumbrance. The current market value is the price the resource is expected to sell for, on the open market, in the geographic area involved. An encumbrance is a legally binding debt against property. The encumbrance on the property does not prevent the property owner from selling to a third party. ( )

309. LIQUID RESOURCES.
All liquid resources are counted, unless excluded. Liquid resources are listed below and can be easily converted to cash. ( )

01. Cash on Hand. ( )

02. All Bank and Credit Union Accounts. ( )

03. Lump Sum Payments. Such as insurance, SSI, retirement, and income tax refund. ( )

04. Trusts. Unrestricted trust accounts and any available amounts from restricted trust accounts. ( )

05. Stocks, less Fees for Transfer and Penalty for Early Sale. ( )

06. Savings Bonds, Treasury Bonds, Commercial Bonds at Current Market Value. ( )

07. Savings Certificates or Certificates of Deposit. Issued by banks, credit unions, or other financial concerns, less the penalty for early withdrawal. ( )

310. NONLIQUID RESOURCES.
Countable nonliquid resources are resources not easily converted to cash and are listed below. ( )

01. Real Property. Equity value of real property (land and buildings, including mobile homes) unless specifically excluded. Property may be excluded if the property is: ( )

a. Used as a home. ( )

b. Income-producing, and the income is consistent with the property's fair market value. ( )

c. Essential to employment or self-employment. ( )

d. Used in connection with an excluded vehicle. ( )

02. Vehicles. Licensed and unlicensed automobiles, trucks, vans, motorcycles, self-propelled motor homes, snowmobiles, boats, aircraft, all-terrain vehicles, and mopeds. ( )

03. Personal Property. Personal property not otherwise excluded. Personal property includes trailers pulled by another means or campers placed on the bed of a truck or pickup. ( )

311. FACTORS MAKING PROPERTY A RESOURCE.
Property of any kind, including cash, can be a resource and must meet all criteria listed below: ( )

01. Ownership Interest. A participant must have ownership interest in property for it to be counted as a resource. Property is not a resource if the participant does not own all or part of the property. ( )

02. Legal Right to Spend or Convert Property. A participant must have a legal right to spend or convert property to cash. Physical possession of property is not needed if the owner has the legal ability to spend or convert the property to cash. ( )

03. Legal Ability to Use for Support and Maintenance. Property is not a resource if it cannot legally

be used for the owner's support and maintenance. ( )

312. -- 313. (RESERVED)

314. JOINTLY OWNED RESOURCES.
A resource owned jointly by members of two (2) or more households is counted in its entirety for each household, unless the household proves the resource is not available. If the household shows it has access to only a portion of a resource, that portion of the resource is counted. ( )

315. JOINTLY OWNED RESOURCES EXCLUDED.
A jointly owned resource is excluded, if the household shows it cannot sell or divide the resource without consent of the other owner, and the other owner will not sell or divide the resource. A jointly owned resource is excluded, if owned by a resident in a shelter for battered women and children and access to the resource requires agreement of a joint owner living in the former household. A vehicle, jointly owned by a household member and a person not living in the household, may be excluded. The household member must not have possession of the vehicle. The household member must not be able to sell the vehicle. ( )

316. -- 322. (RESERVED)

323. LUMP SUM RESOURCES.
Nonrecurring lump sum payments are considered a resource in the month received, unless excluded under these rules. A household is not required to report changes in resources during a certification period. Some lump sum payments are listed below: ( )

01. Retroactive Payments. ( )

a. Social Security. ( )

b. SSI. ( )

c. Public Assistance. ( )

d. Railroad Retirement Benefits. ( )

e. Unemployment Compensation Benefits. ( )

f. Child Support. ( )

02. Insurance Settlements. ( )

03. Income Tax Refunds, Rebates, or Credits. ( )

04. Property Payments. Lump sum payments and contract payments from sale of property are counted as income. ( )

05. Security Deposits. Refunds of security deposits on rental property or utilities. ( )

06. Disability Pension. Annual adjustment payments in VA disability pensions. ( )

07. Vacation Pay. Vacation pay, withdrawn in one (1) lump sum by a terminated employee. ( )

08. Military Reenlistment Bonuses. ( )

09. Job Corps Readjustment Pay. ( )

10. Severance Pay. Paid in one (1) lump sum to a former employee. ( )

11. TAFI One-Time Cash Diversion Payment. ( )

324. -- 333. (RESERVED)

334. VEHICLES.
The value of any vehicle that is primarily for recreational use counts toward the household's resource limit. All other vehicles in the household will have their values counted as provided in 7 CFR 273. ( )

335. -- 350. (RESERVED)

351. EXCLUDED RESOURCES.
Some resources do not count against the limit because they are excluded. Resources excluded by federal law are also excluded for Food Stamps. Exclusions from resources are under Sections 352 through 382 of these rules. ( )

352. HOUSEHOLD GOODS EXCLUDED.
Household goods are items of personal property normally found in the home. The items must be used for maintenance, use, and occupancy of the home. Household goods include, but are not limited to, furniture, appliances, television sets, carpets, and utensils for cooking and eating. ( )

353. PERSONAL EFFECTS EXCLUDED.
Personal effects are items worn or carried by a participant, or items having an intimate relation to the participant. They include, but are not limited to, clothing, jewelry, personal care items, and prosthetic devices. Personal effects include items for education or recreation, such as books, musical instruments, or hobby materials. ( )

354. HOME AND LOT EXCLUDED.
The home and surrounding land and buildings not separated by property owned by others, are excluded as a resource. A public road or right of way that separates any plot from the home will not affect the exclusion. The home may be a house, trailer, or vehicle. ( )

01. Unoccupied Home Exclusion. A temporarily unoccupied home is excluded if the household members intend to return. The household members must be absent because of employment, training for future employment, illness, or the home must be temporarily uninhabitable from casualty or natural disaster. ( )

02. Building Lot Exclusion. The following are excluded as a resource: ( )

a. A lot where a household is building a permanent home ( )

b. A lot where a household intends to build a permanent home; and ( )

c. A lot and partly completed home ( )

d. The household can only have one (1) home and lot excluded. The household cannot own a home and lot and have a building lot exclusion for another property. ( )

355. LIFE INSURANCE EXCLUDED AS A RESOURCE.
The cash surrender value of life insurance policies is excluded as a resource. ( )

356. BURIAL SPACE OR PLOT AND FUNERAL AGREEMENT EXCLUSIONS.
Burial spaces or plots and funeral agreements are excluded from resources as listed below. ( )

01. Burial Space or Plot Exclusion. One (1) burial space or plot, for each household member, from resources. The value of the burial space or plot does not affect this exclusion. ( )

02. Funeral Agreement Exclusion. Up to the equity value of one (1) bona fide funeral agreement, for each household member, from resources. ( )

357. PENSION PLANS OR FUNDS EXCLUDED AS A RESOURCE.

The cash value of any funds in a plan, contract, or account, under Sections 401(a), 403(a), 403(b), 408, 408A, 457(b), and 501(c) of the Internal Revenue Code of 1986. and the value of funds in a Federal Thrift Savings Plan Account under 5 U.S.C. 8439 are excluded as a resource. This exclusion includes any current or future tax preferred retirement accounts approved under federal or state law. ( )

358. INCOME-PRODUCING PROPERTY EXCLUDED.
Property that annually produces income consistent with its fair market value is excluded as a resource. Real property, not used as a home, is excluded as a resource if it produces income consistent with its fair market value. This exclusion includes land and buildings. Annual income is consistent with the property's fair market value when consistent with area market trends. ( )

359. LIVESTOCK EXCLUDED.
Livestock includes cows, pigs, sheep, llamas, and horses. Farm animals kept for food are excluded. ( )

360. PROPERTY USED FOR SELF-SUPPORT EXCLUDED.
Property essential to the employment or self-employment of a household member, such as tools of a trade or the farm land and machinery of a farmer, is excluded as a resource. Essential work-related equipment of an ineligible legal non-citizen or disqualified person is excluded as a resource. Self-support property is excluded during employment and temporary periods of unemployment. For a household member engaged in farming, property essential to self-employment continues to be excluded for one (1) year from the date the household member ends self-employment from farming. ( )

361. PROPERTY USED WITH EXCLUDED VEHICLE.
Portions of real or personal property are excluded as a resource if used in connection with an excluded vehicle. The vehicle must be used to produce income or be necessary for transporting a physically disabled household member. ( )

362. SALABLE ITEM WITHOUT SIGNIFICANT RETURN EXCLUDED.
Resources that cannot be sold for a significant return are excluded. "Significant return" means any return, after estimating costs of sale or disposition, and taking into account the ownership interest of the household, is more than one thousand five hundred dollars ($1,500). ( )

363. HUD FAMILY SELF-SUFFICIENCY (FSS) ESCROW ACCOUNT.
Escrow accounts and the interest earned on an escrow account established by HUD for families participating in the FSS Program under Section 544 of the National Affordable Housing Act, are excluded as a resource when determining eligibility for food stamps. The federal exclusion for the funds in this program and other similar type escrow funds are only excluded while the funds are still in the escrow account or being used for a HUD approved purpose. Participants in the FSS program may withdraw funds from the escrow account before completing the program, with permission from the public housing authority, but only for purposes related to the goal of the FSS contract, such as completion of higher education, job training, or to meet start-up expenses involved in creation of a small business. ( )

364. EDUCATIONAL ACCOUNTS EXCLUDED AS A RESOURCE.
The cash value of any funds in a qualified tuition program under Section 529 of the Internal Revenue Code of 1986, or in a Coverdell education savings account under Section 530 of the Internal Revenue Code, are excluded as resources. ( )

365. INDIVIDUAL DEVELOPMENT ACCOUNT EXCLUDED AS A RESOURCE.
The cash value of an Individual Development Account (IDA) under Section 56-1101(5), Idaho Code, is excluded as a resource. ( )

366. -- 372. (RESERVED)

373. GOVERNMENT PAYMENTS EXCLUDED.
Government payments for the restoration of a home damaged in a disaster are excluded as a resource. The household must be subject to legal sanction if the funds are not used as intended. ( )

374. EXCLUDED INACCESSIBLE RESOURCES.
The cash value of resources not legally available to the household is excluded as a resource. The household must provide proof resources are not available. ( )

375. FROZEN OR SECURED ACCOUNTS EXCLUDED.
Frozen bank accounts used as security for a loan or due to bankruptcy proceedings are excluded as resources. ( )

376. REAL PROPERTY EXCLUDED IF ATTEMPT TO SELL.
Real property is excluded as a resource if the household is making a good faith effort to sell it at a reasonable price. The Department will verify the property is for sale and the household has not refused a reasonable offer. ( )

377. TRUST FUNDS EXCLUDED.
Trust funds are excluded if all conditions listed below are met: ( )

01. Trust Irrevocable or Not Changeable by Household. The household must be unable to revoke the trust agreement or change the name of the beneficiary during the certification period. ( )

02. Trust Unlikely to End During Certification. The trust arrangement must be unlikely to end during the certification period. ( )

03. Trustee Independent from Household Control. The trustee of the fund is either a court, institution, corporation, or organization not under the direction or ownership of a household member, or a court-appointed person who has court-imposed limits placed on the use of funds. ( )

04. Trust Not Under Control of Household-Directed Business. The trust investments do not directly involve or help any business or corporation under the control, direction, or influence of a household member. ( )

05. Origin and Use of Trust. The funds held in an irrevocable trust are: ( )

a. Set up from the household's own funds. The trustee uses the funds only to make investments for the trust, or to pay education or medical expenses of the beneficiary; or ( )

b. Set up from nonhousehold funds by a nonhousehold member. ( )

378. INSTALLMENT CONTRACTS EXCLUDED.
An installment contract for the sale of land and buildings is excluded as a resource. The purchase price must be consistent with the property's fair market value. The contract or agreement must produce income consistent with the property's fair market value. Income is consistent with the property's fair market value when consistent with area market trends. The actual property sold under an excluded installment contract is excluded as a resource. Property held as security for the fulfillment of an excluded installment contract is excluded as a resource. ( )

379. TREATMENT OF EXCLUDED RESOURCES.
An excluded resource kept in a separate account is excluded for an unlimited period. If an excluded resource is combined with countable resources, the resource is not counted for six (6) months from the date the funds are combined. After six (6) months, the total combined resources are counted. ( )

380. (RESERVED)

381. NONLIQUID RESOURCES WITH LIENS EXCLUDED.
A nonliquid resource, with a lien placed against it, is excluded. The lien must result from a business loan. The lien agreement must forbid the household to sell the resource. ( )

382. (RESERVED)

383. EXCLUDED RESOURCE CHANGES TO COUNTED RESOURCE.
Resource value increases when a participant replaces an excluded resource with a counted resource. ( )

384. -- 385. (RESERVED)

386. TRANSFER OF RESOURCES.
Households that knowingly transfer resources for the purpose of qualifying or attempting to qualify for Food Stamps benefits are disqualified from participation in the program for up to one (1) year from the date of the discovery of the transfer. ( )

387. TRANSFER OF RESOURCE NOT COUNTED FOR DISQUALIFICATION.
A transferred resource is not counted for disqualification, under the conditions below: ( )

01. Three Months Before Application. The transfer of a resource was more than three (3) months before the date of Food Stamp application. ( )

02. Resources Less Than Limit. The transfer, when added to the other countable resources, does not exceed the resource limit. ( )

03. Transfer at Fair Market Value. The sale or trade of a resource, made at or near the fair market value, is not counted. ( )

04. Transfer Between Household Members. A resource transferred between members of the same household, including ineligible legal non-citizens or disqualified persons whose resources are considered available to the household, is not counted. ( )

05. Transfer for Reasons Other Than Food Stamps. A resource transferred for reasons other than trying to qualify for Food Stamps is not counted. ( )

388. DISQUALIFICATION FOR TRANSFERRING RESOURCES.
The Department will base the disqualification period on the amount the transferred resource exceeds the resource limit, when added to other countable resources. Disqualification periods are listed in Table 388. The disqualification period begins in the first month of application or recertification.

Amount in Excess of the Resource Limit	Months of Disqualification
$0 - 249.99	1
$250 - 999.99	3
$1,000 - 2999.99	6
$3,000 - 4,999.99	9
$5,000 or more	12

( )

389. -- 399. (RESERVED)

400. INCOME.
All household income is counted in the Food Stamp budget unless excluded under these rules. Income can be earned or unearned. ( )

401. EARNED INCOME.
Earned income includes, but is not limited to the following. ( )

01. Wages or Salary. Wages and salaries of an employee, advances, tips, commissions, meals, and military pay are earned income. Garnishments from wages are earned income. ( )

02. Self-Employment Income. Income from self-employment, including capital gains, is earned

income. Rental property is self-employment income if a household member manages the property an average of twenty (20) or more hours per week. Payment from a roomer or boarder is self-employment income. ( )

03. **Training Allowances**. From programs such as Vocational Rehabilitation. ( )

04. **Payments Under Title I**. Such as VISTA and University Year for Action under P.L. 93-113. ( )

05. **On-the-Job Training Programs**. WIOA income includes monies paid by WIOA or the employer. Income from WIOA on-the-job training programs is earned income, unless paid to a household member under age nineteen (19). The household member under age nineteen (19) must be under the control of another household member. ( )

06. **Basic Allowance for Housing (BAH)**. An Armed Services housing allowance. ( )

402. UNEARNED INCOME.
Unearned income includes, but is not limited to the following: ( )

01. **Public Assistance (PA)**. Payments from SSI, TAFI, AABD, GA, or other Public programs. ( )

02. **Retirement Income**. Payments from annuities, pensions, and retirement. ( )

03. **Strike Benefits**. ( )

04. **Veteran's Benefits**. ( )

05. **Disability Income**. ( )

06. **Workers' Compensation**. ( )

07. **Unemployment Insurance**. ( )

08. **Contributions**. ( )

09. **Rental Property Income**. Minus the cost of doing business, if a household member is not managing the property at least twenty (20) hours per week. ( )

10. **Support Payments**. Includes child support payments. ( )

11. **Alimony**. ( )

12. **Educational Benefits Unless Excluded**. ( )

13. **Regular Payments from a Government Source**. Payments or allowances a household receives that are funded from a government source. ( )

14. **Dividends, Interest, and Royalties**. ( )

15. **Contract Income From the Sale of Property**. ( )

16. **Funds From Trusts.** Monies withdrawn from trusts exempt as a resource. Dividends paid or dividends that could be paid from trusts exempt as a resource. ( )

17. **Recurring Lump Sum Payments**. ( )

18. **Cash Prizes, Gifts, and Lottery Winnings**. ( )

19. Diverted Support or Alimony. Child support or alimony payments diverted by the provider to a third party to pay a household expense. ( )

20. Agent Orange Payments. Payments made under the Agent Orange Act of 1991 and disbursed by the US Treasury. ( )

21. Garnishments. ( )

22. Tribal Gaming Income. The participant can choose to count the income in the month received, or prorate the income over the period it is intended to cover. ( )

23. Other Monetary Benefits Not Otherwise Counted or Excluded. ( )

403. -- 404. (RESERVED)

405. EXCLUDED INCOME.
Income excluded when computing Food Stamp eligibility is listed below: ( )

01. Money Withheld. Money withheld voluntarily or involuntarily, from an assistance payment, earned income, or other income source, to repay an overpayment from that income source. ( )

02. Child Support Payments. Child support payments received by TAFI recipients that are withheld by the state. ( )

03. Earnings of Household Member Under Age Eighteen Attending School. The member must be under parental control of another household member and attending elementary or secondary school. In this rule, a student is someone who attends elementary or secondary school, or who attends GED or home-school classes that are recognized, operated, or supervised by the school district. This exclusion applies during semester and summer vacations if enrollment will resume after the break. If the earnings of the child and other household members cannot be differentiated, the Department will prorate equally among the working members and exclude the child's share. ( )

04. Educational Income. Includes grants, scholarships, fellowships, work study, educational loans on which payment is deferred, and veterans' educational benefits. To be excluded, education benefits must meet requirements under 7 CFR 273.9(c)(3). ( )

05. Infrequent or Irregular Income. If it does not exceed thirty dollars ($30) total in a three (3) month period. ( )

06. Cash Donations. Based on need and received from one (1) or more private nonprofit charitable organizations. The donations must not exceed three hundred dollars ($300) in a calendar quarter of an FFY. ( )

07. Income in Kind. Any gain or benefit, such as meals, garden produce, clothing, or shelter, not paid in money. ( )

08. Vendor Payments. Payment made on behalf of a household by a person or organization outside of the household directly to either the household's creditors or to a person or organization providing a service to the household. ( )

09. Third Party Payments. Payment by a third party on behalf of a household using funds that are not owed to the household. ( )

10. Loans. Money received that is to be repaid ( )

11. Money for Third Party Care. Money received and used for the care and maintenance of a third party who is not in the household. If a single payment is for both household members and nonhousehold members, the identifiable portion of the payment for nonhousehold members is excluded. If a single payment is for both

household members and nonhousehold members, the Department will exclude the lesser of: ( )

a. The prorated share of the nonhousehold members if the portion cannot be identified. ( )

b. The amount used for the care and maintenance of the nonhousehold members. ( )

12. Reimbursements. For past or future expenses not exceeding actual costs. Payments must not represent a gain or benefit, be used for the purpose intended, and be for other than normal living expenses. Excluded reimbursements are not limited to: ( )

a. Travel, per diem, and uniforms for job or training. ( )

b. Out-of-pocket expenses of volunteer workers. ( )

c. Medical and dependent care expenses. ( )

d. Pay for services provided by Title XX of the Social Security Act. ( )

e. Repayment of loans made by the household from their personal property limit. The repayment must not exceed the amount of the loan. ( )

f. Work-related and dependent care expenses paid by the JSAP program. ( )

g. Transitional child care payments. ( )

h. Child care payments under the Child Care and Dependent Block Grant Act of 1990. ( )

13. Federal Earned Income Tax Credit (EITC). ( )

14. Work Study. Work Study income received while attending post-secondary school. ( )

15. HUD FSS Escrow Account. The federal exclusion for these funds is only excluded while the funds are in the escrow account or being used for a HUD-approved purpose. See Section 363 of these rules for further clarification. ( )

16. Temporary Census Earnings. Wages earned for temporary employment related to US Census activities during the regularly scheduled ten (10) year US Census. ( )

17. Income Excluded by Federal Law. ( )

406. (RESERVED)

407. INCOME AND ELIGIBILITY VERIFICATION SYSTEM (IEVS).
Income must be verified with the IEVS system for all households applying for or getting Food Stamps and for disqualified members with income counted toward the household Food Stamp benefits. ( )

408. (RESERVED)

409. USE OF IEVS INFORMATION FOR APPLICANT HOUSEHOLDS.
IEVS data must be used to compute eligibility and benefits if IEVS data is received before the application is processed. IEVS data on applicant households must be used as soon as possible, even if the applicant household was approved before the IEVS data was received. Action on applications must not be delayed pending receipt of IEVS data. If IEVS data requiring further proof is received before application approval the proof must be obtained and resolved before approving the application. If an applicant household cannot provide an SSN at application, IEVS data must be used as soon as possible after the SSN is known. IEVS data must be used for all household members, eligible, excluded or disqualified. ( )

410. (RESERVED)

411. VERIFIED UPON RECEIPT IEVS DATA.
The IEVS data listed below is considered verified upon receipt, unless it is questionable: ( )

01. Benefit Data Exchange (BENDEX). BENDEX Social Security retirement and disability income data. ( )

02. State Data Exchange (SDX). Benefit and eligibility data from SSA under Titles II and XVI of the Social Security Act accessed through the SDX. ( )

03. TAFI. ( )

04. AABD. ( )

05. Medicaid. The Federally aided program for medical care (Title XIX, Social Security Act). ( )

412. UNVERIFIED IEVS DATA.
The IEVS data listed below is considered unverified: ( )

01. IRS Reported Unearned Income. Data from IRS, including any unreported assets producing income. ( )

02. Wage File. Data from Department of Commerce and Labor or its counterpart in another state. Wage data from Beneficiary Earning Exchange Record (BEER). ( )

03. Self-Employment Earnings. Data from BEER. ( )

04. Income Information the Department Deems Questionable. ( )

413. -- 427. (RESERVED)

428. CALCULATION OF SELF-EMPLOYMENT INCOME.
Self-employment is generally considered annual or seasonal. The Department will add all gross self-employment income, either actual or anticipated, and capital gains and exclude the costs of producing the self-employment income and divide the remaining amount of self-employment income by the number of months over which the income will be averaged. This amount is the monthly self-employment income. ( )

01. Self-Employment Expense Deduction.The Department will use a standard fifty percent (50%) self-employment deduction unless the applicant claims the actual allowable expenses exceed the standard deduction and provides proof of the expenses. ( )

02. Allowable Costs of Producing Self-Employment Income. Costs of labor, stock, raw material, seed and fertilizer, payments on the principal of the purchase price of income-producing real estate and capital assets, equipment, machinery, and other durable goods, interest paid to purchase income-producing property, insurance premium, and taxes paid on income-producing property. ( )

03. Costs Not Allowable. Net losses from previous periods, federal, state, and local income taxes, money set aside for retirement, work-related personal expenses (such as transportation to and from work), depreciation, amount that exceeds the payment a household receives from a boarder for lodging and meals, net losses from previous periods, and federal, state, and local income taxes. ( )

429. SELF-EMPLOYED FARMER.
To be considered a self-employed farmer, a person must receive, or expect to receive, an annual gross income of one thousand dollars ($1,000) or more earned from farming activities. If a farmer's cost of producing self-employment income results in a loss, the Department subtracts the loss from other countable income in the household under 7 CFR 273.11(a)(2)(ii)(A) and (B). ( )

430. -- 500. (RESERVED)

501. INITIAL CHANGES IN FOOD STAMP CASE.
The Department will act on changes in household circumstances found during the application or the initial interview. ( )

01. Food Stamp Issuance Changes. The Department will make changes to the household's Food Stamp issuance when it is required to act on a change. ( )

02. Change Before Certification. If a household reports a change in household circumstances before certification, the Department will include the reported information in determining Food Stamp eligibility and amount. ( )

03. Change After Certification. If a household reports a change after the initial Food Stamp benefit has been paid, the Department must act on the change as required by policy for acting on changes within a certification period. Notice of the change must be given to the Food Stamp household. ( )

502. EARNED INCOME WHEN A HOUSEHOLD MEMBER TURNS AGE EIGHTEEN.
When a child attending elementary or secondary school turns age eighteen (18), the Department will not count earned income received or expected by that person until the next six-month or twelve-month contact, or recertification. ( )

503. -- 507. (RESERVED)

508. PROJECTING MONTHLY INCOME.
Income is projected for each month. Past income may be used to project future income. Changes expected during the certification period must be considered. Criteria for projecting monthly income is listed below: ( )

01. Income Already Received. The Department will count income already received by the household during the month. If the actual amount of income from any pay period is known, use the actual pay period amounts to determine the total month's income. The Department will convert the actual income to a monthly amount if a full month's income has been received or is expected to be received. ( )

02. Anticipated Income. The Department will count income that the household and the Department anticipate the household will get during the remainder of the certification period. If the exact income amount is uncertain or unknown, that portion must not be counted. If the date of receipt of income cannot be anticipated for the month of the eligibility determination, that portion must not be counted. If the income has not changed and no changes are anticipated, the Department will use the income received in the past thirty (30) days as one (1) indicator of anticipated income. If changes in income have occurred or are anticipated, past income cannot be used as an indicator of anticipated income. If income changes and income received in the past thirty (30) days do not reflect anticipated income, the Department can use the household income received over a longer period to anticipate income. If income changes seasonally, the Department can use the household income from the last season, comparable to the certification period, to anticipate income. ( )

509. TYPES OF INCOME TO BE AVERAGED.
Types of income to be averaged are listed below. Income for a destitute migrant or seasonal farm worker household is not averaged. ( )

01. Self-Employment Income. ( )

02. Contract Income. Income over the period of the contract, if not received on an hourly or piecework basis. Households with averaged contract income include school employees, share croppers, and farmers. These households do not include migrants or seasonal farm workers. ( )

03. Income Received Less Often Than Monthly. When receipt of income is less often than monthly, the anticipated income can be averaged over the period intended to cover to determine the average monthly income.

( )

04. Child Support Income. Can be averaged to make a valid projection for ongoing income. ( )

510. -- 511. (RESERVED)

512. SPECIAL CASES FOR COUNTING INCOME.
Special cases for counting income are listed below: ( )

01. Wages Held at the Request of Employee. Income in the month the wages would have been paid by the employer. ( )

02. Garnishments Held by Employer. Income in the month the wages would have been paid. ( )

03. Wages Held by Employer, Other Than Garnishment and Employee Request. Even if in violation of law, are not counted as income. ( )

04. Advances on Wages. Count as income if the household reasonably expects the advance to be paid. ( )

05. Varying Payment Cycles. Households getting unearned or earned income on a recurring monthly or semi-monthly basis do not have varying income merely because mailing or payment cycles cause additional payments to be received in a month. The income is counted for the month it is intended. ( )

06. Nonrecurring Lump Sum Payments and Capital Gains. Nonrecurring lump sum payments must not be counted as income, but are counted as a resource starting in the month received. Nonrecurring lump sum payments include capital gains from the sale or transfer of securities, real estate, or other real property held as an investment for a set period. The capital gains are income only if the assets were used in self-employment. ( )

513. -- 531. (RESERVED)

532. GROSS INCOME LIMIT.
Households exceeding the gross income limit for the household size are not eligible unless they are categorically eligible or have an elderly or disabled member. A household with an elderly or disabled household member is exempt from the gross income limit. ( )

533. HOUSEHOLD ELIGIBILITY AND BENEFIT LEVEL.
A household's eligibility and benefit level is calculated under 7 CFR 273.10, except as indicated below. The deductions in this rule are subtracted from non-excluded income. ( )

01. Standard Deductions. Are determined by federal law. ( )

02. Earned Income Deduction. Is twenty percent (20%) of gross earned income. ( )

03. Homeless Shelter Deduction. Is established by FNS. ( )

04. Excess Medical Deduction. Excess medical expense is nonreimbursed medical expense of more than thirty-five dollars ($35) per household per month. The household member must be either age sixty (60) or older or disabled to get this expense deduction. Special diets are not deductible. For allowable medical expenses, see Section 535 of these rules. ( )

05. Dependent Care Expense Deduction. Is for monthly dependent care expenses. The dependent care may be needed for children or adults. ( )

06. Child Support Expense Deduction. Is the legally obligated child support and arrearage the household pays, or expects to pay, to or for a non-household member. ( )

07. Excess Shelter Expense Deduction. Excess shelter expense is the monthly shelter cost over fifty percent (50%) of the household's income after all other deductions, and is not deducted if the household has received the homeless shelter deduction. For allowable shelter expenses, see Section 542 of these rules. ( )

534. AVERAGING INFREQUENT, FLUCTUATING, OR ONE-TIME ONLY EXPENSES.
Infrequent, fluctuating, or one-time only expenses for medical, child support, shelter, or child care may be averaged. ( )

535. MEDICAL EXPENSES.
Elderly or disabled household members that incur medical expenses over thirty-five dollars ($35) per month are allowed a Standard Medical Expense (SME) deduction. Eligible households must verify monthly medical expenses of more than thirty-five dollars ($35) at initial application. Households with medical expenses that exceed the monthly SME may either verify the minimum amount to receive the SME or request and verify excess costs to receive an actual expense deduction at application and recertification. The household must provide proof of the incurred or anticipated cost before a deduction is allowed. ( )

536. DEPENDENT CARE EXPENSES.
The care of a dependent must be necessary to maintain employment, conduct job search, or attend school or training. The dependent care expenses must be deducted from income. ( )

537. DEPENDENT CARE RESTRICTIONS.
The following types of dependent care cannot be deducted: ( )

01. Care by Household Member. If the care is provided by another household member. ( )

02. In-Kind Payment. Such as food or exchanges for shelter. ( )

03. Vendor Payment. ( )

04. Spouse Can Give Care. If the spouse in the home is physically capable of the dependent care and is not working, seeking work, or registered for work. ( )

05. Dependent Care. If paid or reimbursed under a federal child care program. ( )

538. CHILD SUPPORT EXPENSES.
Child support expense may be deducted for a household paying or expecting to pay legally obligated child support to or for a person living outside the household. The child support expense deducted must reflect the child support the household pays or expects to pay during the certification period, rather than the obligated amount. ( )

539. -- 541. (RESERVED)

542. COSTS ALLOWED FOR SHELTER DEDUCTION.
Shelter costs are current charges for the shelter occupied by the household and include costs for the home temporarily not occupied because of employment or training away from home or illness. ( )

543. UTILITY ALLOWANCES.
The shelter deduction is computed using one (1) of four (4) utility allowances: SUA, LUA, MUA, or TUA. Utility allowances are not prorated. ( )

01. Standard Utility Allowance (SUA). ( )

a. The household must have a primary heating or cooling cost to qualify for SUA. The heating or cooling costs must be separate from rent or mortgage payments. ( )

b. Households are limited to one (1) SUA. ( )

02. Limited Utility Allowance (LUA). The household must be billed for more than one (1) utility that

is not for heating or cooling. ( )

03. **Minimum Utility Allowance (MUA)**. The household must be billed for one (1) utility that is not for heating, cooling, or telephone service. ( )

04. **Telephone Utility Allowance (TUA)**. The household must be billed for telephone service and have no other verified utility expenses. ( )

544. -- 546. **(RESERVED)**

547. **COSTS NOT ALLOWED FOR THE SHELTER DEDUCTION.**
The costs listed below are not allowed in computing the shelter deduction. ( )

01. **Fees for a One-Time Utility Deposit**. ( )

02. **Damage or Advance Deposits on Rentals**. ( )

03. **Payments Made to Pay Past Due Rent**. ( )

04. **Cost to Cut the Household's Own Wood for Heating**. ( )

05. **Furniture Rental Fees**. ( )

06. **Insurance on Furniture or Personal Belongings**. ( )

07. **Vehicle Not Used as Residence**. Payments or gasoline costs on vehicles used only for recreation. ( )

08. **Repairs Not Paid by Household**. Costs for repairing or replacing shelter paid by private or public agencies, insurance companies, or any other source. ( )

09. **Shelter Not Paid by Household but Paid by a Vendor or Employer**. ( )

10. **Utility Costs Paid by HUD or FmHA Negative Utility Payment**. ( )

548. **COMPUTING THE SHELTER DEDUCTION.**
The shelter deduction is computed as listed below: ( )

01. **If Household has Elderly or Disabled Member**. The Department will deduct the monthly shelter cost exceeding fifty percent (50%) of the household's income after all other deductions. ( )

02. **If Household has No Elderly or Disabled Member**. The Department will deduct the excess of fifty percent (50%) of the household's income, after all other deductions, up to the maximum limit under Title 7 USC Section 2014. ( )

549. **NET INCOME LIMIT TEST.**
Categorically eligible households do not have to meet the net income limit. All other households, including those with an elderly or disabled household member, must not exceed the net income limit to be eligible for Food Stamps. ( )

550. **DETERMINATION OF FOOD STAMP BENEFIT.**
The Food Stamp benefit is computed under 7 CFR 273.9 and 273.10. ( )

551. **ROUNDING FOOD STAMP PAYMENT.**
Income and deductions are not rounded in determining gross or net income. Only the final Food Stamp amount is rounded. ( )

552. -- 561. (RESERVED)

562. PRORATING INITIAL MONTH'S BENEFITS.
Prorating is based on a thirty (30) day calendar month. Benefits are prorated from the application date to the end of the month. ( )

563. FOOD STAMP PRORATING FORMULA.
The prorated Food Stamp amount is determined under 7 CFR 273.10(a)(1)(iii)(B). If the amount for the initial month is less than ten dollars ($10), benefits must not be issued. ( )

564. BENEFITS AFTER THE INITIAL MONTH.
After the initial month, benefits must be issued as described below. ( )

01. All Eligible One and Two Person Households. Receive a minimum allotment equal to eight percent (8%) of the maximum one (1) person allotment. ( )

02. All Eligible Three or More Person Households. When the calculation of benefits would yield a zero benefit, the Department will deny the household's application on the grounds that its net income exceeds the level at which benefits are issued. ( )

03. Not Categorically Eligible. All households, except categorically eligible households, must be denied if the household's net income exceeds the level at which benefits are issued. ( )

565. -- 572. (RESERVED)

573. ACTING ON HOUSEHOLD COMPOSITION CHANGES.
Changes in household composition are not required to be reported. If a household does report a change in household composition, the Department will act on the change using options under 7 CFR 273.12(c). ( )

574. (RESERVED)

575. HOUSEHOLD COMPOSITION CHANGES FOR STUDENT.
Ineligible students are defined as nonhousehold members. When a student's status changes, the change is treated as a new person entering or leaving the Food Stamp household. ( )

576. -- 587. (RESERVED)

588. NOTICE OF DECISION TO HOUSEHOLDS.
The Department must send the household a written notice as soon as Food Stamps are approved or denied. The household must get the notice no later than thirty (30) days after the application date. ( )

589. -- 600. (RESERVED)

601. REPORTING REQUIREMENTS AND RESPONSIBILITIES.
Changes may be reported by phone, mail, other electronic interfaces, or in person to the Department. Households must report when: ( )

01. Household's Total Gross Income Exceeds One Hundred Thirty Percent (130%) of FPG for the Household Size. ( )

02. There is a Decrease in the Household's ABAWD Hours to Less Than Eighty (80) Hours Per Month. ( )

03. There are Substantial Lottery Winnings. Defined as equal to or greater than the financial resource limit for elderly or disabled households not subject to the Broad-Based Categorical Eligibility (BBCE) resource limit. ( )

602. (RESERVED)

603. PERSON OUTSIDE HOUSEHOLD FAILS TO PROVIDE PROOF -- CHANGES.
Food Stamps cannot be closed solely because a person outside the household fails to provide requested proof. The Department will attempt to get another source of proof if a person outside the household does not provide requested proof. Disqualified household members are not persons outside the household. ( )

604. -- 610. (RESERVED)

611. TIME FRAMES FOR REPORTING CHANGES IN HOUSEHOLD CIRCUMSTANCES.
Households reporting required changes to the Department must do so by the tenth day of the month following the month in which the change occurred. If Food Stamps are over-issued because a household fails to report required changes, a claim determination must be prepared. A person can be disqualified for failure to report a change if they commit an IPV. ( )

612. (RESERVED)

613. CHANGES ON WHICH THE DEPARTMENT MUST ACT.
The Department must follow the procedures for acting on reported changes under 7 CFR 273.12. ( )

614 -- 616. (RESERVED)

617. INCREASES IN FOOD STAMP BENEFITS.

01. Household Reports a Change. If a household reports a change that results in an increase in Food Stamps and the proof cannot be obtained through interfaces or data brokers, the Department must allow the household ten (10) days to provide proof. ( )

02. Failure to Provide Proof of Change. If the household fails to provide proof of a change that would increase the benefit level, the Food Stamp benefit remains at the amount already established. ( )

03. Proof Provided Within Ten Days. If the household provides proof within ten (10) days of reporting the change, the Department will increase the Food Stamp benefits beginning the month immediately following the month in which the change was reported. For changes reported after the 20th of the month, a supplement is issued for the next month no later than the 10th of the next month. If the change is reported and verified after the final date to adjust Food Stamp benefits for the following month in the Department's automated eligibility system, the change to the Food Stamp benefits must be made by the following month, even if a supplement must be issued. ( )

04. Proof Not Provided Within Ten Days. If the household fails to provide proof within ten (10) days of reporting the change, but provides proof later, benefits are increased the month after the proof of the change is provided. ( )

618. DECREASES IN FOOD STAMP BENEFITS.
If the Department acts on a change that results in a decrease in Food Stamp benefits, the Department must give timely notice, if required. The notice must explain the reason for the action. ( )

619 -- 620. (RESERVED)

621. TAFI OR AABD HOUSEHOLD REPORTING CHANGES.
If a change in the AABD or TAFI grant results in a change in the household's Food Stamp benefits, the Department must count the new grant amount, regardless of whether the Food Stamps increase or decrease. If a change requires a reduction or ending of TAFI or AABD and Food Stamp benefits, the Department will issue a Notice of Decision for both programs. If the household makes a timely request for a fair hearing and continued benefits, Food Stamp benefits continue pending the hearing. The household must reapply if certification expires before the hearing is complete. ( )

622. CHANGE ENDS TAFI OR AABD INCOME.
Food Stamp benefits will be closed only if there is a change on which the Department is required to act. If TAFI or AABD ends and the household remains Food Stamp eligible, the Department must advise the household of any applicable work registration requirements. ( )

623. FAILURE TO TAKE REQUIRED ACTION.
If the Department is unable to make a change in Food Stamp eligibility or issuance and an overissuance results, the Department will collect the overpayment. If the Department fails to act on a change that increases household benefits, the Department will restore lost benefits. ( )

624. -- 628. (RESERVED)

629. NOTICE OF LOWERING OR ENDING BENEFITS.
Households must be sent a Notice of Decision when Food Stamps are ended or reduced unless notice is not required under these rules. ( )

630. ADEQUATE NOTICE.
Adequate notice is a written statement telling the household the action the Department is taking. The notice must tell the reasons for the action and advise the household of the right to a hearing. All notices must be adequate. If Food Stamps are reduced, the household must receive the notice on or before the first day of the month the action is effective. ( )

631. TIMELY NOTICE.
Timely notice must be mailed at least ten (10) days before the effective date of the action. ( )

632. TIMELY NOTICE NOT REQUIRED.
Timely notice is not required when the conditions listed below are met. Adequate notice must be given. ( )

01. Statement of Household. The Department gets a clear, written, signed statement from the household. Food Stamps can be ended or reduced from the facts given in the household statement. ( )

02. Food Stamps Reduced After Closure Notice. The household is sent a notice of closure because it did not provide requested proof. The household provides the proof before the first day of the month of closure. If the proof results in reduced Food Stamps, the reduced benefits are issued. ( )

03. Food Stamps Closed or Reduced Because of IPV Penalty. The Department must impose the IPV penalty the first of the month after the month it gives written notice to the participant. ( )

633. NOTICE OF CHANGES NOT REQUIRED.
Notice to individual Food Stamp households is not required when the conditions under Subsection 633.01 in this rule are met. Mass notice must be given in some situations under Subsection 633.02 in this rule: ( )

01. Waiver by the Household. A household member or authorized representative provides a written statement requesting closure. The person gives information causing reduction or an end to benefits and states, in writing, they know adverse action will be taken. The person acknowledges in writing continuation of benefits is waived if a fair hearing is requested. ( )

02. Mass Changes. Include changes: ( )

a. In the income limit tables. ( )

b. In the issuance tables. ( )

c. In Social Security benefits. ( )

d. In SSI payments. ( )

e. In TAFI or AABD grants. ( )

f. Caused by a reduction, suspension, or cancellation of Food Stamps ordered by the Secretary of USDA. ( )

g. When the Department performs mass changes, it notifies Food Stamp households of the mass change by one (1) of the following methods: ( )

i. Media notices. ( )

ii. Posters in the Food Stamp offices and issuance locations. ( )

iii. A general notice mailed to households. ( )

03. Mass Changes in TAFI or AABD. When a mass change to TAFI or AABD causes a Food Stamp change, the Department will use the following criteria: ( )

a. If the Department has thirty (30) days advance notice of the TAFI or AABD mass change, Food Stamps must be adjusted the same month as the change. ( )

b. If the Department does not have advance notice, Food Stamp benefits must be changed no later than the month after the TAFI or AABD mass change. ( )

c. Ten (10) day advance notice to Food Stamp households is not required. Adequate notice must be sent to Food Stamp households. ( )

d. If a household requests a fair hearing because of an issue other than mass change, the Department will continue Food Stamps. ( )

04. Notice of Death. Notice is not required when the Department learns of the death of all household members. ( )

05. Completion of Restored Benefits. Notice is not required when an increased allotment, due to restored benefits, ends. The household must have been notified in writing when the increase would end. ( )

06. Joint Public Assistance and Food Stamp Applications. Notice is not required if the household jointly applies for TAFI or AABD and Food Stamps and gets Food Stamps pending TAFI or AABD approval. The household must be notified at certification that Food Stamps will be reduced upon TAFI or AABD approval. ( )

07. Converting From Repayment to Benefit Reduction. Notice is not required if a household with an IHE or IPV claim fails to repay under the repayment schedule. An allotment reduction is enforced. ( )

08. Households Receiving Expedited Service. Notice is not required if all the following conditions are met: ( )

a. The applicant received expedited services. ( )

b. Proof was postponed. ( )

c. A regular certification period was assigned. ( )

d. Written notice, stating future Food Stamps depend on postponed proof, was given at approval. ( )

09. Residents of a Substance Use Disorder Treatment Center or a Group Living Arrangement Center. Notice is not required when the Department ends Food Stamps to residents of a substance use disorder treatment center or group living arrangement center if: ( )

a. The Department revokes the center's certification. ( )

b. FNS disqualifies the center as a retailer. ( )

634. VERBAL REQUEST FOR END OF FOOD STAMPS.
If a household makes a verbal request for closure, the Department will end the benefits, and notify the household with a ten (10) day advance Notice of Decision. ( )

635. -- 638. (RESERVED)

639. CONTINUATION OF BENEFITS PENDING A HEARING.
The household retains the right to continued benefits when the household requests a fair hearing within the ten (10) day notice period. The household must request this continuation of Food Stamps. If certification has not expired, Food Stamps can continue at the former level. Benefits must be continued within five (5) working days of the household's request for a fair hearing. ( )

640. (RESERVED)

641. REDUCING OR ENDING BENEFITS BEFORE HEARING DECISION.
Benefits may be ended or reduced before the hearing decision, if any of the following is met: ( )

01. Appeal of Federal Law. The hearing official states, in writing, the sole issue being appealed is one of federal law, regulation, or policy. ( )

02. Food Stamp Issuance Changes. Food Stamp eligibility or benefit level changes occur before the hearing decision and a new hearing is not requested. ( )

03. Food Stamp Certification Period Expires. ( )

04. Mass Change Occurs Before the Hearing Decision. ( )

642. -- 643. (RESERVED)

644. EXPIRATION OF CERTIFICATION PERIOD.
Household eligibility ends when the certification period expires. ( )

645. RECERTIFICATION PROCESS.
The Department must follow the recertification procedures under 7 CFR 273.14. ( )

646. NOTICE OF DECISION FOR TIMELY RECERTIFICATION.
A Notice of Decision must be sent to households that reapply for Food Stamps. To receive Food Stamps with no break in issuance, households must complete a six-month or twelve-month contact or recertification before the fifteenth day of the last month of certification or six-month or twelve-month contact period. If the household applies before the fifteenth day of the month, the Department will notify the household of eligibility or denial by the end of the current certification period. ( )

647. -- 649. (RESERVED)

650. RESTORATION OF LOST BENEFITS.
Lost benefits must be restored. The Department may find Food Stamps have been incorrectly denied, ended, or underissued to an eligible household. The Department may learn of lost benefits from case reviews, Quality Control reviews, or other sources. Benefits are restored when caused by a Department error, when a fair hearing is reversed, or an IPV disqualification is reversed. The Department will restore benefits to eligible and previously eligible households and to households who have moved out of state. The Department will restore benefits for SSA joint processing errors. ( )

651. TIME FRAMES FOR RESTORATION OF BENEFITS.
Benefits must not be restored if lost more than twelve (12) months before notification or discovery. ( )

01. Lost Benefits Reported by Household. Are restored when the Department learns of lost benefits reported by the household, a person outside the household, or by another agency. Twelve (12) months are counted from the month the Department is notified of the lost benefits. ( )

02. Lost Benefits Discovered by Department. Are restored when the Department discovers lost benefits during the course of business. Twelve (12) months are counted from the month the Department discovers the benefits were lost. ( )

03. Lost Benefits From Fair Hearing. Are restored to a household that requests a fair hearing and the decision is in the household's favor. Twelve (12) months are counted from the effective date of the adverse action causing the fair hearing. ( )

652. -- 655. (RESERVED)

656. REPLACING FOOD DESTROYED BY A DISASTER.
Conditions and procedures for replacing food destroyed by a disaster are listed below. The food must have been purchased with Food Stamps. ( )

01. Food Destroyed in a Disaster. The actual value of loss, not to exceed one (1) month's allotment, can be replaced. The food bought with Food Stamps must have been destroyed in a disaster. The disaster may involve only the household, such as a house fire, or a larger scope, such as a flood. There is no limit on the number of times food destroyed in a disaster may be replaced. ( )

02. Replacement Time Limit for Disaster Loss. The Department must provide either disaster Food Stamps or replacement Food Stamps, but not both, within ten (10) days of the reported loss, if: ( )

a. The household reports the disaster within ten (10) days of the incident. ( )

b. The disaster is verified by collateral contact, an organization such as the Fire Department or Red Cross, or by home visit. ( )

657. -- 674. (RESERVED)

675. IPV, IHE, AND AE FOOD STAMP CLAIMS.
An overissuance exists when the amount of Food Stamps issued exceeds the Food Stamps a household is eligible to receive. The Department must establish a claim against the household, to recover the value of Food Stamps overissued or misused. The types of Food Stamp claims are listed below. ( )

01. Intentional Program Violation (IPV) Claim. A overissuance caused by an intentional, knowing, and willful program violation. ( )

02. Inadvertent Household Error (IHE) Claims. An error, without intent to cause an overissuance, which results in a Food Stamp overissuance. Causes of IHE claims are: ( )

a. Failure to give information. A household, without intent to cause an overissuance, fails to give correct or complete information. ( )

b. Failure to report change that was required to be reported. A household, without intent to cause an overissuance, fails to report changes or to report at all. ( )

c. Failure to comply. A household, without intent to cause an overissuance, fails to comply due to language barrier, educational level, or not understanding written or verbal instructions. ( )

d. Pending IPV. An IHE claim occurs between the time of an IPV referral and the IPV decision.

( )

03. Agency Error Claim (AE). A claim that results from an overissuance caused by a Department action or a failure to act. ( )

676. PERSONS LIABLE FOR FOOD STAMP CLAIMS.
The persons listed below are responsible for paying a claim. ( )

01. Adult Household Members. Adult members of the household at the time of the overissuance or trafficking are liable. They are individually and jointly liable, whether residing in the household where the claim arose, or in any other household. ( )

02. Sponsor of an Alien. The sponsor of an alien household member if the sponsor is at fault for the claim. ( )

03. Person Connected to the Household. A person connected to the household, such as an authorized representative, who trafficks or causes an overissuance or trafficking. ( )

677. COMPUTING FOOD STAMP CLAIMS.
The Department computes Food Stamp claims as described below. ( )

01. Claims Not Related to Trafficking. The Department computes claims not related to trafficking back to a minimum of twelve (12) months before it became aware of the overissuance. The Department does not compute these claims back more than six (6) years. For an IPV claim, the Department computes back to the month the first IPV occurred. The Department continues to compute back a minimum of twelve (12) months before the first IPV. The Department does not compute IPV claims back more than six (6) years before the first IPV. ( )

02. Trafficking-Related Claims. Are the value of the trafficked Food Stamps as determined by: ( )

a. The individual's admission. ( )

b. Adjudication. ( )

c. The documentation forming the basis for the trafficking determination. ( )

678. -- 691. (RESERVED)

692. DETERMINING DELINQUENT CLAIMS.
The Department determines if a claim is delinquent using the following. ( )

01. Claim Not Paid by Due Date. Is delinquent if there is not a satisfactory payment arrangement. The claim remains delinquent until paid in full, a satisfactory repayment agreement is negotiated, or allotment reduction is invoked. ( )

02. Payment Arrangement Not Followed. The claim is delinquent if a payment arrangement is established, but scheduled payment is not made by the due date. The claim remains delinquent until paid in full, allotment reduction is invoked, or the Department agrees to resume or renegotiate the repayment schedule. ( )

03. Previous Claim. A claim is not delinquent if another claim for the same household is being paid through an installment agreement or allotment reduction. The Department begins collection on the new claim after the first claim is settled. ( )

04. Collection Coordinated Through Court. A claim is not delinquent if the Department is unable to determine delinquency status because collection is coordinated through the court system. ( )

05. Claim Awaiting Hearing Decision. Is not delinquent. If later, the hearing officer affirms a claim

does exist against the household, the Department notifies the household. ( )

693. (RESERVED)

694. COLLECTING CLAIMS.
The Department collects payment for claims using the methods listed below. ( )

01. Allotment Reduction. The Department reduces the Food Stamp allotment to collect the claim. ( )

a. For an IPV claim, the allotment reduction limit is the greater of twenty dollars ($20) per month or twenty percent (20%) of the household's monthly allotment. ( )

b. For an IHE or AE claim, the allotment reduction limit is the greater of ten dollars ($10) per month or ten percent (10%) of the household's monthly allotment. The household can agree to a higher amount. ( )

c. The Department does not reduce the initial month's Food Stamps unless the household agrees to this reduction. ( )

02. Household Repays the Claim from its EBT Account. ( )

03. Payment by Cash, Check, or Money Order. ( )

04. Household Performing Public Service. Payment by public service as ordered by a court, specifically as payment of a claim. ( )

05. Collection by Treasury Offset Program (TOP). The Department submits claims delinquent for one hundred and eighty (180) days, or more, for collection through TOP. ( )

695. TOP NOTICES.
The Department will provide the household with a notice of intent to collect via Treasury offset. The notice must inform the household of the right to request a Department review of the intended collection action. The Department must receive the request for review within sixty (60) days of the notice of intent to collect. The notice of review determination must inform the household of the right to request that FNS review the Department's decision. The notice must include instructions for requesting a review by FNS and the address of the FNS regional office. ( )

696. EFFECTS OF TOP ON THE FOOD STAMP HOUSEHOLD.
When a claim is referred to TOP, any eligible federal payment owed to the household may be intercepted and applied to the claim to reduce the debt. The household may be required to pay collection or processing fees charged by the federal government to intercept the payment. ( )

697. REMOVING A CLAIM FROM TOP.
The Department removes a claim from TOP under the conditions listed below. ( )

01. Instructed by FNS or Treasury. ( )

02. Household Undergoing Allotment Reduction. ( )

03. Claim Is Paid in Full. ( )

04. Claim Is Satisfied Through a Hearing, Termination, Compromise, or Other Means. ( )

05. Household Arranges to Resume Payments. ( )

698. INTENTIONAL PROGRAM VIOLATION (IPV).
An IPV includes the actions listed below. The participant must intentionally, knowingly, and willfully commit a program violation. ( )

01. False Statement. A person makes a false statement to the Department, either orally or in writing, to get Food Stamps. ( )

02. Misleading Statement. A person makes a misleading statement to the Department, either orally or in writing, to get Food Stamps. ( )

03. Misrepresenting. A person misrepresents facts to the Department, either orally or in writing, to get Food Stamps. ( )

04. Concealing. A person conceals or withholds facts to get Food Stamps. ( )

05. Violation of Regulations. A person commits any act violating the Food Stamp Act, federal regulations, or state Food Stamp regulations. The violation may relate to use, presentation, transfer, acquisition, receipt, or possession of Food Stamps. ( )

06. Trafficking in Food Stamps. Means any of the following: ( )

a. The buying, selling, stealing, or otherwise effecting an exchange of food stamp benefits issued and accessed via EBT cards, card numbers, and personal identification numbers (PINs), or by manual voucher and signature, for cash or consideration other than eligible food, either directly, indirectly, in complicity or collusion with others, or acting alone; ( )

b. Attempting to buy, sell, steal, or otherwise affect an exchange of food stamp benefits issued and accessed via EBT cards, card numbers, and PINs, or by manual voucher and signatures, for cash or consideration other than eligible food, either directly, indirectly, in complicity or collusion with others, or acting alone; ( )

c. The exchange of firearms, ammunition, explosives, or controlled substances, defined under Section 802 of Title 21, USC, for food stamp benefits; ( )

d. Purchasing a product with food stamp benefits that has a container requiring a return deposit with the intent of obtaining cash by discarding the product and returning the container for the deposit amount, intentionally discarding the product, and intentionally returning the container for the deposit amount; ( )

e. Purchasing a product with food stamp benefits with the intent of obtaining cash or consideration other than eligible food by reselling the product, and subsequently intentionally reselling the product purchased with food stamp benefits in exchange for cash or consideration other than eligible food; or ( )

f. Intentionally purchasing products originally purchased with food stamp benefits in exchange for cash or consideration other than eligible food. ( )

699. ESTABLISHING AN INTENTIONAL PROGRAM VIOLATION (IPV).
The Department establishes an IPV by the actions listed below. ( )

01. Waiver. The participant signs a waiver to a disqualification hearing. ( )

02. Hearing. An administrative disqualification hearing determines an IPV. ( )

03. Judgement. A court judgement determines an IPV. ( )

700. ADMINISTRATIVE RESPONSIBILITY FOR ESTABLISHING IPV.
The Department must investigate and refer cases for an IPV determination. If there is enough recorded evidence to establish an IPV, the Department must take the actions listed below: ( )

01. Act to Collect. The Department must act to collect overissuances. The Department must set up IHE overissuance claims when a suspected IPV claim is not pursued under administrative or prosecution procedures. ( )

02. Obtain Administrative Disqualification. The Department pursues administrative disqualification when: ( )

a. The case facts do not warrant civil or criminal prosecution. ( )

b. The case referred for prosecution was declined. ( )

c. The case was referred for prosecution and no action was taken in a reasonable time. ( )

d. The case was referred for prosecution, but the case was withdrawn by the Department. ( )

03. Do Not Obtain Administrative Disqualification. The Department must not pursue an administrative disqualification in cases: ( )

a. Being referred for prosecution. ( )

b. After any prosecutor action against the accused if the case issues are the same or related circumstances. ( )

701. PENALTIES FOR AN IPV.

IPV persons are ineligible for Food Stamps for twelve (12) months for the first violation, for twenty-four (24) months for the second violation, and permanently for the third violation. The Department will disqualify only the person(s) who committed the IPV. The Department will notify the person in writing of the disqualification penalty. The penalty continues without interruption until completed, regardless of the eligibility of the disqualified person. An IPV penalty can be imposed even if no overissuance claim exists. ( )

01. Administrative Disqualification Hearings. The disqualification begins no later than the first day of the second month following the date the person gets written notice of the disqualification. ( )

02. Waivers. The disqualification begins the first day of the month following the date the person gets the written notice of disqualification. ( )

03. Court Decisions. The disqualification begins on the date imposed by the court (to start the beginning of the following month) or, if no date is specified, within forty-five (45) days of the date the disqualification was ordered, beginning the first day of the month. ( )

702. PENALTIES FOR IPV TRAFFICKING.

IPV persons are ineligible for Food Stamps for two (2) years for the first finding by a court the recipient purchased illegal drugs with Food Stamps, are permanently ineligible for Food Stamps for a second finding by the court the recipient purchased illegal drugs with Food Stamps, and are permanently ineligible for Food Stamps for a first finding by a court the recipient purchased firearms, ammunition, or explosives with Food Stamps. A person convicted of trafficking in Food Stamp benefits of five hundred dollars ($500) or more is permanently disqualified from the Food Stamp program. ( )

703. PENALTIES FOR IPV RECEIPT OF MULTIPLE BENEFITS.

A person found making a fraudulent statement or representation about identity or residence to get multiple benefits is ineligible for Food Stamps for ten (10) years for the first and second offenses and permanently for the third offense. ( )

704. -- 714. (RESERVED)

715. WAIVED HEARINGS.

Persons accused of an IPV may waive their right to an administrative disqualification hearing by completing and signing a Waiver of Disqualification Hearing. If the reviewers determine a waiver is proper, each household member suspected of IPV must be mailed or given a Waiver of Disqualification Hearing. ( )

716. DISQUALIFICATION AFTER WAIVED HEARING.
Persons waiving their right to an IPV administrative disqualification hearing must have penalties imposed. ( )

717. COURT REFERRALS.
Procedures for court referrals are listed below: ( )

01. Referred Cases. The Department may refer persons to law enforcement or county prosecutor who are suspected of getting or receiving Food Stamps by committing an IPV, or persons suspected of committing an IPV. ( )

02. Impose Court Penalties. The Department must disqualify a person found guilty of IPV by a court for the length of time specified by the court. The disqualified member's household will remain responsible for the overissuance, resulting from the disqualified member's IPV, regardless of the household's eligibility. If the court fails to specify a period, the Department will use the IPV penalty periods under Section 701 of these rules unless they are contrary to the court order. ( )

718. DEFERRED ADJUDICATION.
Deferred Adjudication is an out-of-court settlement between the accused IPV member and the prosecutor. Terms of the settlement are listed below: ( )

01. Deferred Judgement Conditions. Guilt is not decided by the court because the accused person has met the terms of a court order or an agreement with the prosecutor. ( )

02. Agreement with Prosecutor. If the Department has an agreement with the prosecutor, the prosecutor may defer adjudication. The prosecutor must agree to give advance written notice to the member stating the consequences of consenting to disqualification. ( )

03. Notice to Food Stamp Member. If the prosecutor decides deferred adjudication is fitting, the household member suspected of IPV must be mailed or presented with a Deferred Adjudication Disqualification Consent Agreement. ( )

04. Disqualification Period. The period of disqualification must begin within forty-five (45) days of the date the member signed the Deferred Adjudication Disqualification Consent Agreement. The period of disqualification must begin as agreed upon with the prosecutor. Once a disqualification penalty is imposed against a member, the period continues uninterrupted regardless of the household's eligibility. The disqualified member's household continues to be responsible for overissuance repayment resulting from the disqualified member's IPV regardless of the household's eligibility. ( )

05. Notice of Disqualification. The Department must provide a completed Notice of Disqualification before the disqualification to the disqualified member and remaining household members. The Department must provide a Demand Letter for Overissuance and Repayment Agreement. ( )

719. (RESERVED)

720. CLAIMS DISCHARGED BY BANKRUPTCY.
The Department will act for FNS in bankruptcy proceedings against households owing claims. The Department may file proofs of claims, objections to discharge, exceptions, petitions, and any other documents, motions, or objectives FNS might have filed. ( )

721. (RESERVED)

722. INTERSTATE CLAIMS COLLECTION.
Idaho is responsible for initiating and continuing collection action on any Food Stamp recipient claim regardless of whether the household remains in Idaho. ( )

723. -- 727. (RESERVED)

728. FOOD STAMP REDUCTION, SUSPENSION, OR CANCELLATION.
Food Stamps for all Food Stamp households must be reduced suspended, or cancelled, if ordered by the USDA Secretary to comply with Section 18 of the Food Stamp Act of 1977. Reduced Food Stamps are computed using the thrifty food plan amounts and are reduced by a percentage defined by FNS. Food Stamp reduction, suspension, and cancellation rules are described below: ( )

01. Reducing Food Stamps. FNS will notify the Department of the effective date of reduction and of the thrifty food plan reduction percentage. The Department must: ( )

a. Act immediately to carry out the reduction. ( )

b. Guarantee one (1) and two (2) person households a minimum benefit of equal to eight percent (8%) of the maximum one (1) person allotment unless the reduction is ninety percent (90%) or more of total projected monthly benefits. ( )

02. Restoring Lost Benefits. Households whose Food Stamps are reduced or cancelled under this rule are not entitled to restoration of benefits. Reductions or cancellations of Food Stamps may be ordered restored by the USDA Secretary. ( )

03. Suspension or Cancellation. If a suspension or cancellation is in effect, no Food Stamps are to be issued to the applicant. ( )

04. Hearings. Any household whose allotment was reduced, suspended, or cancelled under this rule can request a fair hearing. ( )

729. -- 750. (RESERVED)

751. BOARDERS.
Rules for Food Stamp boarders are listed below: ( )

01. Boarder Included with Food Stamp Household. Boarders may be included in the Food Stamp household providing board. The Food Stamp household must request the boarder be included. The household must be otherwise eligible. ( )

02. Foster Children and Foster Adults. Foster children and foster adults are boarders. Foster care payments and guardianship payments are not income for Food Stamps if the foster child and adult do not get Food Stamps as part of the household. If the household requests the foster child and adult be included in the Food Stamp household, foster care payments and guardianship payments are counted. ( )

03. Certified Family Home (CFH). CFH residents are considered boarders and may be included in the CFH providers household. ( )

04. Meal Compensation. Boarder status must be given to persons paying a reasonable monthly amount for meals. ( )

a. Payments for more than two (2) meals a day must equal or exceed the thrifty food plan for the boarder household size. ( )

b. Payments for two (2) meals or less per day must equal or exceed two-thirds (2/3) of the thrifty food plan for the boarder household size. ( )

05. Nonboarder Status. A person paying less than a reasonable amount for meals is a member of the household providing board. ( )

06. Income from Boarders. If the boarder is not a Food Stamp household member: ( )

a. The meals and lodging payment is self-employment income for the Food Stamp household. ( )

b. The boarder's income and resources are not counted for the Food Stamp household. ( )

752. STRIKERS.
Households with strikers are not eligible to get Food Stamps unless the household was eligible the day before the strike. ( )

753. SPONSORED LEGAL NON-CITIZENS.
Sponsored legal non-citizens are lawfully admitted for permanent United States residence. A sponsor executes an I-864 affidavit of support on behalf of legal non-citizen. The income and resources of the sponsor will be deemed until the legal non-citizen becomes a naturalized citizen or until they have worked forty (40) qualifying quarters of coverage under Title II of the Social Security Act, or the sponsor dies. A qualifying quarter includes a quarter worked by the legal non-citizen's parent while the legal non-citizen was under eighteen (18) and a quarter worked by the legal noncitizen's spouse during marriage if the legal non-citizen remains married to the spouse or the spouse is deceased. Any quarter after January 1, 1997, in which a legal non-citizen received any federal means-tested benefit is not counted as a qualifying quarter. ( )

754. DEEMING INCOME AND RESOURCES TO SPONSORED LEGAL NON-CITIZEN.
Income and resources of the sponsor are deemed available to the legal non-citizen. If the sponsor lives with their spouse, the spouse's income and resources are also deemed available to the legal non-citizen. The income and resources are deemed, even if the sponsor and spouse were married after the sponsor signed the sponsorship agreement. The Department counts income and resources deemed to the legal non-citizen toward Food Stamp eligibility and issuance level of the legal non-citizen's household. ( )

01. Battered Legal Non-Citizen Whose Sponsor Signed an Affidavit of Support. For sponsor deeming, a battered legal non-citizen includes the non-citizen and the child of the non-citizen. The non-citizen or child must be battered in the US by a spouse, parent, or member of the family in the same household. The non-citizen must not participate in, or acquiesce to, the battering of the child. ( )

a. A battered legal non-citizen whose sponsor signed an affidavit of support is exempt from the sponsor deeming requirement for one (1) year if the need for Food Stamps is connected to the battery and the legal non-citizen no longer lives with the batterer. ( )

b. The exemption from the sponsor deeming requirement can exceed more than one (1) year if the legal non-citizen demonstrates the battery has been recognized in an order of a judge or by the INS and the need for Food Stamps is connected to the battery. ( )

02. Indigent Legal Non-Citizen Whose Sponsor Signed an Affidavit of Support. A non-citizen is indigent if the household income does not exceed one-hundred thirty percent (130%) of the poverty income guideline (gross income limit) for the household size. ( )

a. For an indigent non-citizen, the Department counts the noncitizen's own income and the cash or in-kind income and resources provided by the sponsor and spouse who signed an affidavit of support. ( )

b. A legal non-citizen that satisfies the indigent exemption criteria is exempt from deeming for twelve (12) months. The exemption can be renewed for additional twelve-month periods. ( )

c. If a legal non-citizen is granted an indigence exemption, the Department must provide written notification to the Statistics Branch of the INS on an annual basis. Required information includes written notice of the determination, the sponsored legal non-citizen's name, and the sponsor's name. ( )

d. A legal non-citizen can elect to decline the indigent exemption to avoid sponsor liability and notification to the INS. ( )

e. If the legal non-citizen declines the indigent exemption, the household is subject to sponsored deeming. ( )

755. – 756. (RESERVED)

757. SPONSORED LEGAL NON-CITIZEN'S RESPONSIBILITY.
The legal non-citizen and their spouse are responsible for getting the sponsor to cooperate with the Department in determining Food Stamp eligibility. The legal non-citizen and their spouse are responsible for providing the information and proof to determine the income and resources of the sponsor and sponsor's spouse. The legal non-citizen and their spouse are responsible for providing information and proof to determine if the sponsor sponsors other legal non-citizens and how many. ( )

758. – 760. (RESERVED)

761. COLLECTING CLAIMS AGAINST SPONSORS WHO SIGNED AN I-864 AFFIDAVIT OF SUPPORT ON OR AFTER DECEMBER 19, 1997.
Claims may be collected against a sponsor who signed an I-864 affidavit of support on or after December 19, 1997, and is found to have provided false statements or withheld information. ( )

762. COLLECTING CLAIMS AGAINST SPONSORED LEGAL NON-CITIZENS.
Claims may be collected against sponsored legal non-citizens with a sponsor who signed an I-864 affidavit of support on or after December 19, 1997. Action may be taken to collect by submitting an IHE or IPV. ( )

763. REIMBURSEMENT FOR BENEFITS RECEIVED.
A sponsor who signed an affidavit on or after December 19, 1997, must reimburse the Department for the amount of Food Stamps received by the sponsored legal non-citizen if false information is provided or information is withheld. At the time of application for a sponsored legal non-citizen, the legal non-citizen's sponsor must be notified that he will be required to reimburse the Department for the entire amount of Food Stamps received by the sponsored legal non-citizen. ( )

764. -- 790. (RESERVED)

791. RESIDENT OF AN INSTITUTION.
A resident of an institution is not eligible for Food Stamps unless the resident meets one (1) of the requirements listed below. A person is a resident of an institution if the institution provides over fifty percent (50%) of the person's meals as a part of normal services. Residents must be otherwise Food Stamp eligible. ( )

01. Resident Under Housing Act. The resident is in federally subsidized housing for the elderly, under Section 202 of the Housing Act or 236 of the National Housing Act. ( )

02. Person with Substance Use Disorder. The resident is a person with a substance use disorder living and taking part in a treatment and rehabilitation program. ( )

03. Blind or Disabled. The person is a disabled or blind resident of a group living arrangement. ( )

04. Battered Woman and Child(ren). The resident is a woman or a woman and her child(ren), temporarily living in a shelter for battered women and children. ( )

a. The woman is a separate household from other shelter residents for Food Stamps. ( )

b. The woman and her children are a separate household from other shelter residents for Food Stamps. ( )

05. Homeless Person. The resident is a person living in a public or private nonprofit shelter for homeless persons. ( )

792. PRERELEASE APPLICANTS FROM PUBLIC INSTITUTIONS.
Residents of public institutions who apply for prerelease program SSI may apply for Food Stamps before their release from public institutions. The application date is the date the person is released from the institution. Eligibility is based

on the best estimate of a household's circumstances for the release month and the month after. Eligibility and Food Stamp amount are based on income and resources. Food Stamps for the initial month are prorated from the date the person is released from the institution to the end of the calendar month. ( )

793. SUBSTANCE USE DISORDER TREATMENT CENTERS.

01. Center Provides Certification List. Each month, each center must give the field office a list of current participant residents. The list's accuracy must be certified in writing by the center manager or designee. The Department must conduct random on-site visits to assure list accuracy. If the list is not accurate, or the Department fails to act on the change, the Department may transfer the Food Stamp amount from the center's account to the household's Food Stamp account, for the months the household was not living in the center. ( )

02. Center Misusing Food Stamps. The Department must promptly notify FNS if it believes a center is misusing Food Stamps. The Department must not act before FNS takes action against the center. ( )

794. TREATMENT CENTER RESPONSIBILITIES.
Each treatment center must follow Food Stamp application standards, except for: ( )

01. Return Food Stamps. ( )

a. The center must return to the Department all issue documents and Food Stamps not given to a departing resident. ( )

b. Food Stamps must be returned to the Department if the participant left before the sixteenth of the month and the center was unable to give them the Food Stamps. ( )

c. Food Stamps must be returned to the Department if they were left over for a resident who left on or after the sixteenth of the month. ( )

02. Give Food Stamps to Departing Participant. ( )

a. The center must give the departing participant the ID card and any unredeemed Food Stamps. ( )

b. The center must give the participant a full month's Food Stamps if they have been issued, but none have been spent on behalf of the participant. ( )

c. The center must give the departing participant one-half (1/2) of the monthly Food Stamps if the participant leaves before the sixteenth of the month and a portion of the Food Stamps have been spent on behalf of the participant. ( )

d. If the participant leaves the center on or after the sixteenth, and Food Stamps were issued and used, the center is not required to give Food Stamps to the participant. ( )

03. Food Stamp Misuse. The center must be disqualified if it is administratively or judicially found the center misappropriated or used Food Stamps for purchases not contributing to a certified participant's meals. ( )

04. FNS Disqualifies Center. If FNS disqualifies a center as a retailer, the Department must close residents' cases. Individual notice of adverse action is not required. ( )

795. RESIDENTS OF GROUP LIVING ARRANGEMENTS.
Disabled or blind residents of public or private non-profit group living arrangements, serving no more than sixteen (16) residents, may get Food Stamps. Residents get Food Stamps under the same standards as other households. Group living arrangements rules are listed below: ( )

01. FNS-Authorized Retailer or Department Certified. The center must be an FNS-authorized

retailer or be certified by the Department as a non-profit group living center. Center status must comply with Section 1616(e) of the Social Security Act or comparable standards of the Secretary of USDA. ( )

02. Application Option. Residents may apply on their own, as a group, or through an authorized representative employed and designated by the center. Residents may apply through an authorized representative of the resident's choice. ( )

03. Residents Apply on Their Own Behalf. A person or a group of residents making up a household can apply on their own behalf. The center must determine the resident is physically and intellectually capable of handling their own affairs. If the resident is eligible, the center does not act as the authorized representative. The resident or group is responsible for reporting any changes affecting eligibility or benefit level. The resident is responsible for overissuances. ( )

04. Certification. Residents of a center applying through the center's authorized representative must be certified as a one (1) person household. Residents of a center applying on their own behalf must be certified according to household size. ( )

05. Residents Are Exempt From Work Registration. ( )

06. Residents Are Entitled to Notices of Adverse Action. If a group living arrangement center loses its authorization or certification, notice is not required. ( )

07. Using Food Stamps. The Food Stamps may be used by the resident, a group of residents, or by the center to purchase food for the resident. The center may accept Food Stamps as payment for meals. If residents purchase or prepare food for home consumption, the center must ensure each resident's Food Stamps are used for meals intended for that resident. ( )

796. SHELTERS FOR BATTERED WOMEN AND CHILDREN.
The Department must determine if the shelter for battered women and children is a public or private non-profit residential facility. The Department must determine if the shelter serves only battered women and their children. If the facility serves other persons, the Department must determine if a portion of the facility is set aside to serve only battered women and children. Shelters having FNS authorization to redeem Food Stamps on a wholesale basis meet the shelter definition. Battered women and children shelter rules are listed below: ( )

01. Food Stamp Eligibility. Women and children who recently left a household containing a person who abused them may get Food Stamps, even if the household they left was getting Food Stamps. Shelter residents may apply for and get separate Food Stamps only once in a month. The original Food Stamp certification must have included the person who subjected them to abuse. The resident household must meet eligibility criteria for income, resources, and expenses. ( )

02. Income, Resources, and Expenses of the Household Are Counted. Income, resources, and expenses of their former household, containing the person who subjected them to abuse, are not counted. Jointly held resources are inaccessible if the resources are jointly owned by the shelter resident and members of the abusive household. Jointly held resources are inaccessible if the shelter residents' access to the resource is dependent on the agreement of the joint owner still living in the former household. Room payments to the shelter are shelter expenses. ( )

03. Food Stamps for Former Household. The Department must take prompt action to correct the former household's eligibility and allotment. The Department must issue a ten (10) day advance notice of adverse action. ( )

797. -- 815. (RESERVED)

816. PURCHASE OF PREPARED MEALS.
Persons listed below may purchase prepared meals with their Food Stamps at sites authorized to accept Food Stamps. ( )

01. Older Persons Eating at Communal Dining Facility. Persons sixty (60) or older and their spouses, or persons who receive SSI and their spouses, can use Food Stamps to buy meals made for them at communal dining facilities authorized to accept Food Stamps. ( )

02. Persons Unable to Prepare Meals Getting Meal Delivery Service. A person sixty (60) years of age or over, and a spouse, can elect to use Food Stamps to purchase meals from a nonprofit meal delivery service. A housebound, physically handicapped, or otherwise disabled person, unable to adequately prepare all meals, and a spouse, can elect to use Food Stamps to purchase meals from a nonprofit meal delivery service. ( )

03. Resident Center. A resident of a residential treatment center for substance use disorders can use Food Stamps at the center. The person must be enrolled in a treatment and rehabilitation program operated by a nonprofit organization or institution. ( )

04. Battered Women and Children. A resident of a shelter for battered women and children can use Food Stamps to purchase meals prepared by the shelter. ( )

05. Homeless. A homeless Food Stamp participant can use Food Stamps to buy meals prepared by a homeless meal provider. ( )

817. -- 849. (RESERVED)

850. FOOD STAMP HOUSEHOLD RIGHTS.
The Food Stamp household has rights protected by federal and state laws and Department rules. The Department must inform participants of their rights during the application process and eligibility reviews. Food Stamp rights are listed below: ( )

01. Application. The right to get an application on the date requested. ( )

02. Application Registered. The right to have the signed application accepted right away. ( )

03. Representative. The right to have an authorized representative if the applicant cannot get to the Food Stamp office. The authorized representative must have knowledge of the applicant's situation. ( )

04. Thirty Day Processing. The right to have the application processed and Food Stamps issued within thirty (30) days. ( )

05. Notification. The right to be told in writing of: ( )

a. The reasons for the Department's action if the application is rejected. ( )

b. The reasons for the Department's action if Food Stamps are reduced or stopped. ( )

06. Fair Hearing. The right to request a fair hearing about the Department's decision. The right to request a fair hearing if the household feels discrimination has taken place in any way. Food Stamp fair hearings must be requested within ninety (90) days from the day notice is mailed. In certain situations, Food Stamps may continue if a fair hearing is requested. ( )

851. (RESERVED)

852. FOOD STAMP HOUSEHOLD RESPONSIBILITIES.
The Food Stamp household must provide correct and complete information so the Department can make accurate eligibility and benefit decisions. The responsibilities of the Food Stamp household are listed below: ( )

01. Provide Information. The Food Stamp household must provide information to determine Food stamp eligibility. This includes, but is not limited to, all information about household income, work, and housing cost. ( )

02. Quality Control. The Food Stamp household must cooperate with Quality Control if the case is selected for review. ( )

853. DEPARTMENT INFORMING RESPONSIBILITIES.
The Department must inform the Food Stamp household of what is expected of the household in the eligibility determination process and advise the household of the information listed below: ( )

01. Households Rights and Responsibilities. ( )

02. Eligibility Factors That Must be Met and Proven. ( )

03. Consequences for Failure to Provide Proof of Eligibility Factors. ( )

04. Alternate Methods to Prove Eligibility When Household is Unable to Provide Proof. ( )

05. Methods the Department Uses to Prove Eligibility When Household is Unable to Provide Proof. ( )

06. Social Security Numbers the Department Will Use to Get Wage, Income, and Employment Information. ( )

854. DEPARTMENT WILL DOCUMENT ELIGIBILITY DECISIONS.
The Department will document eligibility, ineligibility, and Food Stamp issuance in the case record. The Department must record enough detail to support the Food Stamp determination. ( )

855. -- 860. (RESERVED)

861. NO DISCRIMINATION IN FOOD STAMP PROGRAM.
The Department must not allow human rights discrimination in the Food Stamp Program. The Department will administer the Food Stamp program so no applicant or recipient in Idaho is discriminated for or against due to race, color, gender, or age. The Department will administer the Food Stamp program so no applicant or recipient in Idaho is discriminated for or against, due to political or religious belief or affiliation, national origin, handicap, or disability. ( )

862. PUBLIC NOTICE FOR NO DISCRIMINATION.
The Department will inform the public via the application form that the Food Stamp Program is conducted without discrimination. The Department must display the USDA poster "And Justice for All" in all field offices. The application form must inform the public the Food Stamp Program is conducted without discrimination. ( )

863. (RESERVED)

864. DISCRIMINATION COMPLAINT PROCEDURE.
Any person can file a discrimination complaint. The person may use the Department's complaint procedure. The person may file a complaint directly to FNS, to the Department, or both. The field office must explain both procedures orally or in writing. ( )

865. DISCLOSURE OF INFORMATION.
The Department will make available to any federal, state, or local law enforcement officer the address, SSN, and (if available) photograph of a Food Stamp recipient. The officer must furnish the recipient's name and provide the Department the federally required evidence the person is fleeing to avoid prosecution, custody, or confinement for a felony, violating a condition of parole or probation, or has information necessary for the officer to conduct an official duty related to a felony or parole violation. ( )

866. AVAILABILITY OF PUBLIC INFORMATION.
Rules, state plans of operation, procedures, handbooks, manuals, and instructions used to certify households must be available to the public. These materials must be available for public examination during regular office hours and workdays. See 7 CFR 272.1(d). ( )

867. FOOD STAMP INFORMATION REQUIREMENTS.
Federal regulations and procedures in FNS notices and policy memos must be available for examination by the public. State plans of operation must be available for examination by the public. Examination may take place during office hours at Department headquarters. Handbooks must be available for examination upon request at each field office. The Department must provide information about Food Stamps through mass media, posters, fliers, pamphlets, and face-to-face contacts. Minimum requirements are listed below: ( )

01. Rights and Responsibilities. Households must be informed of Food Stamp program rights and responsibilities. ( )

02. Bilingual Information. All program information must be available in Spanish. ( )

868. -- 871. (RESERVED)

872. PROGRAM TRANSFER DURING CERTIFICATION PERIOD.
Households changing from Food Stamps to Food Distribution Program on Indian Reservations (FDPIR) must end their participation the last day of the month they choose to change programs. ( )

873. -- 878. (RESERVED)

879. REVIEW OF CASE FILE.
The participant or their representative can review their case file under IDAPA 16.05.01, "Use and Disclosure of Department Records." ( )

880. -- 882. (RESERVED)

883. REFUSAL TO COOPERATE WITH QUALITY CONTROL REVIEWS.
The Department is required to conduct monthly random quality control reviews of food stamp cases, denials of food stamp applications, and issuance amounts. If a household is selected and refuses to cooperate in a quality control review, it is not eligible for food stamp benefits. ( )

01. Advance Notice to End Food Stamps. The Department must send the household advance notice to end Food Stamps. The notice must list the reason for the proposed action, the right to a hearing, the right to schedule a conference or to continue the review. ( )

02. Food Stamp Eligibility During Quality Control Review Period, After Refusal to Cooperate. The household is not eligible for Food Stamps during the Quality Control review period until it cooperates with the review. ( )

884. -- 999. (RESERVED)

[Agency redlined courtesy copy]

16.03.04 – IDAHO FOOD STAMP PROGRAM

000. LEGAL AUTHORITY.
~~The Idaho Legislature has granted the Department of Health and Welfare authority to enter into contracts and agreements with the Federal government to carry out the purposes of any Federal acts pertaining to public assistance or welfare services. The Department of Health and Welfare has authority to make rules governing the administration and management of the Department's business, pursuant to~~ Sections 56-202, 56-203, and 56-209, Idaho Code, authorizes the Department to enter into contracts and agreements with the federal government and to engage in

rulemaking for the administration and management of public assistance or welfare services. ~~(3-17-22)~~( )

~~**001. TITLE, SCOPE, AND PURPOSE.**~~

~~**01. Title**. These rules are titled IDAPA 16.03.04 "Idaho Food Stamp Program." (3-17-22)~~

~~**02. Scope**. These rules contain the requirements for application and the eligibility criteria to receive benefits in the Food Stamp Program. These rules are administered by the Department of Health and Welfare for the United States Department of Agriculture. (3-17-22)~~

~~**03. Purpose**. The purpose of these rules is to raise the nutritional level among low-income households whose limited food purchasing power contributes to hunger and malnutrition among members of such households. These rules also provide the regulatory basis for that procedure. (3-17-22)~~

00~~2~~1. -- 007. (RESERVED)

008. AUDIT, INVESTIGATION AND ENFORCEMENT.

~~In addition to any actions specified in these rules, t~~The Department may audit, investigate and take enforcement action under these rules and the provisions of IDAPA 16.05.07, "Investigation and Enforcement of Fraud, Abuse or Misconduct." ~~(3-17-22)~~( )

009. (RESERVED)

010. DEFINITIONS A THROUGH D.

~~For the Food Stamp Program, the following definitions apply: (3-17-22)~~

01. Adequate Notice. Notice a household must receive on or before the first day of the month an action by the Department is effective. ( )

02. Administrative Error Claim. A claim resulting from an overissuance caused by the Department's action or failure to act. ( )

03. Aid to the Aged, Blind and Disabled (AABD). Cash, excluding in-kind assistance, financed by federal, state, or local government and provided to cover living expenses or other basic needs. ( )

~~**04. Applicant**. A person applying for Food Stamps. (3-17-22)~~

0~~5~~4. Application for Participation. The application form filed by the head of the household or authorized representative. ( )

~~**06. Application for Recertification**. When a household applies for recertification within thirty (30) days of the end of the certification period, it is considered an application for recertification even if a partial month of benefits is received. (3-17-22)~~

0~~7~~5. Authorized Representative. A person designated by the household to act on behalf of the household to apply for, or receive and use Food Stamps.~~ Authorized representatives include private nonprofit organizations or institutions conducting a drug addiction or alcoholic treatment and rehabilitation center acting for center residents. Authorized representatives include group living arrangement centers acting for center residents. Authorized representatives include battered women's and children's shelters acting for the shelters' residents. Homeless meal providers may not be authorized representatives for homeless Food Stamp recipients.(3-17-22)~~( )

0~~8~~6. Battered Women and Children's Shelter. A shelter for battered women and children which is a public or private nonprofit residential facility.~~ If the facility serves others, a portion of the facility must be set aside on a long-term basis to serve only battered women and children.~~ ~~(3-17-22)~~( )

0~~9~~7. Boarder.~~ Any person or group to whom a household, other than a commercial boarding house, furnishes meals and lodging in exchange for an amount equal to or greater than the thrifty food plan. Children,~~

~~parents and spouses in a household must not be treated as boarders.~~ An individual paying a reasonable amount for meals and lodging. ~~(3-17-22)~~( )

~~1~~08. **Boarding House**. A licensed commercial enterprise offering meals and lodging for payment to make a profit. ( )

~~11~~09. **Broad-Based Categorical Eligibility**. If a participant meets the eligibility requirements found in 7 CFR Section 273.2(j)(2) ~~as well as~~ and also all other Food Stamp eligibility criteria, then the participant is eligible for Food Stamps. Participants who are eligible under this definition are also subject to resource, gross, and net income eligibility standards. ~~(3-17-22)~~( )

1~~2~~0. **Categorical Eligibility**. If all household members receive or are authorized to receive monthly cash payment through TAFI, AABD, or SSI, the household is categorically eligible. Categorically eligible households are exempt from resource, gross, and net income eligibility standards. ( )

1~~3~~1. **Certification Period**. The period ~~of time~~ for which a household is certified to receive Food Stamp benefits. The month of application counts as the first month of certification. ~~(3-17-22)~~( )

1~~4~~2. **Contact (Six-Month)**. A ~~six-month contact is a~~ recertification that waives the interview requirement, allowing for written contact and verification of the participant's circumstances in lieu of the interview. ~~(3-17-22)~~( )

1~~5~~3. **Claim Determination**. The action taken by the Department establishing the household's liability for repayment when an overissuance of Food Stamps occurs. ( )

~~16.~~ ~~**Client**. A person entitled to or receiving Food Stamps.~~ ~~(3-17-22)~~

1~~7~~4. **Department**. The Idaho Department of Health and Welfare. ( )

1~~8~~5. **Disqualified Household Members**. Individuals required to be excluded from participation in the Food Stamp Program are Disqualified Household Members. ~~These include:~~ ~~(3-17-22)~~( )

~~a.~~ ~~Ineligible legal non-citizen who do not meet the citizenship or eligible legal non-citizen requirements.~~ ~~(3-17-22)~~

~~b.~~ ~~Individuals awaiting proof of citizenship when citizenship is questionable.~~ ~~(3-17-22)~~

~~c.~~ ~~Individuals disqualified for failure or refusal to provide a Social Security Number (SSN).~~ ~~(3-17-22)~~

~~d.~~ ~~Individuals disqualified for Intentional Program Violation (IPV).~~ ~~(3-17-22)~~

~~e.~~ ~~Individuals disqualified for receiving three (3) months of Food Stamps in a three (3) year period in which they did not meet the work requirement for able-bodied adults without dependent children.~~ ~~(3-17-22)~~

~~f.~~ ~~Individuals disqualified as a fugitive felon or probation or parole violator.~~ ~~(3-17-22)~~

~~g.~~ ~~Individuals disqualified for a voluntary quit or reduction of hours of work to less than thirty (30) hours per week.~~ ~~(3-17-22)~~

~~h.~~ ~~Individuals disqualified for failure to cooperate in establishing paternity and obtaining support for a child under eighteen (18).~~ ~~(3-17-22)~~

~~i.~~ ~~Individuals convicted under federal or state law of any offense classified as a felony involving the possession, use, or distribution of a controlled substance when they do not comply with the terms of a withheld judgment, probation, or parole. The felony must have occurred after August 22, 1996.~~ ~~(3-17-22)~~

~~**19. Documentation**. The method used to record information establishing eligibility. The information must sufficiently explain the action taken and the proof and how it was used. (3-17-22)~~

~~**20. Drug Addiction or Alcoholic Treatment Program**. Any drug addiction or alcoholic treatment rehabilitation program conducted by a private nonprofit organization or institution or a publicly operated community mental health center under Part B of Title XIX of the Public Health Service Act (42 USC 300x, et seq.). Indian reservation based centers may qualify if FNS requirements are met and the program is funded by the National Institute on Alcohol Abuse under Public Law 91-616 or was transferred to Indian Health Service funding. (3-17-22)~~

011. DEFINITIONS E THROUGH L.

~~For the Food Stamp Program, the following definitions apply: (3-17-22)~~

01. Electronic Benefit Transfer (EBT). A method of issuing Food Stamps to an eligible household. ~~(3-17-22)~~( )

02. Eligible Foods. Any food or food product for human consumption excluding alcohol, tobacco,~~ and hot foods~~ and hot food products ready for immediate consumption. Eligible foods also include~~:~~ garden seeds and plants to grow food for human consumption. ~~(3-17-22)~~( )

~~**a.** Garden seeds and plants to grow food for human consumption. (3-17-22)~~

~~**b.** Meals prepared for the elderly at a communal dining facility. (3-17-22)~~

~~**c.** Meals prepared and delivered by an authorized meal delivery service. (3-17-22)~~

~~**d.** Meals served to a narcotics addict or alcoholic who participate and reside in a rehabilitation center program. (3-17-22)~~

~~**e.** Meals prepared and served by an authorized group living center to blind or disabled residents who receive benefits under Titles I, II or X, XIV, XVI of the Social Security Act. (3-17-22)~~

~~**f.** Meals prepared and served at a shelter for battered women and children to eligible residents. (3-17-22)~~

~~**g.** Meals prepared and served by an authorized public or private nonprofit establishment to homeless Food Stamp participants. (3-17-22)~~

03. Eligible Household. A household living in Idaho and meeting the eligibility criteria in these rules. ( )

~~**04. Emancipated Minor**. A person, age fourteen (14) but under age eighteen (18), who has been married or whose circumstances show the parent and child relationship has been renounced such as a child in the military service. (3-17-22)~~

~~**05. Enumeration**. The requirement that each household member provide the Department either their Social Security Number (SSN) or proof that they have applied. (3-17-22)~~

0~~6~~4. Exempt. A household member who is not required to register for, or participate in, the JSAP program is exempt. A household member who is not required to register for work is exempt. ( )

0~~7~~5. Extended Certification Household (EC). A household in which all members are elderly or disabled, and no one has earned income. ( )

0~~8~~6. Fair Hearing. A fair hearing in an appeal of a Department decision.~~ See Section 003 of these rules for appeals.~~ ~~(3-17-22)~~( )

0~~9~~7. Federal Fiscal Year (FFY).~~ The federal fiscal year (FFY) is~~ The period from October 1 to

September 30. ~~(3-17-22)~~( )

~~1~~08. **Field Office**. A Department~~ of Health and Welfare~~ service delivery site. ~~(3-17-22)~~( )

~~11~~09. **Food and Nutrition Service (FNS)**. The~~ Food and Nutrition Service of the~~ federal entity under the U~~.~~S~~.~~ Department of Agriculture (USDA)~~. This is the federal entity~~ that administers the Food Stamp program. ~~(3-17-22)~~( )

1~~2~~0. **Group Living Arrangement**. A public or private nonprofit residential setting serving no more than sixteen (16) residents. The residents are blind or disabled and receiving benefits under Title II or XVI of the Social Security Act, certified by the Department under~~ regulations issued under~~ Section 1616(e) of the Social Security Act, or under standards determined by the Secretary of USDA to be comparable to Section 1616(e) of the Social Security Act. ~~(3-17-22)~~( )

1~~3~~1. **Homeless Person**. A person: ( )

a. Who has no fixed or regular nighttime residence. ( )

b. Whose primary nighttime residence is a temporary accommodation for not more than ninety (90) days in the home of another individual or household. ( )

c. Whose primary nighttime residence is a temporary residence in a supervised public or private shelter providing temporary residence for homeless persons. ( )

d. Whose primary nighttime residence is a temporary residence in an institution which provides temporary residence for people who are being transferred to another institution. ( )

e. Whose primary nighttime residence is a temporary residence in a public or private place which is not designed or customarily used as sleeping quarters for people. ( )

1~~4~~2. **Homeless Meal Provider**. A public or private nonprofit establishment or a profit-making restaurant~~ which~~ that provides meals to homeless people. The establishment or restaurant must be approved by the Department and authorized as a retail food store by FNS. ~~(3-17-22)~~( )

1~~5~~3. **Identification Card**. The card identifying the bearer as eligible to receive and use Food Stamps. ( )

1~~6~~4. **Inadvertent Household Error Claim (IHE)**. A claim resulting from an overissuance, caused by the household's misunderstanding or unintended error.~~ A household error claim pending an intentional program violation decision.~~ ~~(3-17-22)~~( )

1~~7~~5. **Income and Eligibility Verification System (IEVS)**. A system of information acquisition and exchange for income and eligibility verification which meets Section 1137 of the Social Security Act requirements. ( )

1~~8~~6. **Institution of Higher Education**. Any institution~~ which~~ that normally requires a high school diploma or equivalency certificate for enrollment. These institutions include colleges, universities, and business, vocational, technical, or trade schools at the post-~~high school~~secondary level. ~~(3-17-22)~~( )

1~~9~~7. **Institution of Post-Secondary Education**. Educational institutions normally requiring a high school diploma or equivalency certificate for enrollment or admits persons beyond the age of compulsory school attendance. The institution must be legally authorized by the state and provide a program of training to prepare students for gainful employment. ( )

~~20~~18. **Legal Noncitizen**. A qualified alien under 8 USC Section 1641(b). ( )

~~21~~19. **Limited Utility Allowance (LUA)**. Utility deduction given to a food stamp household that has a

cost for more than one (1) utility. This includes electricity and fuel for purposes other than heating or cooling, water, sewage, well and septic tank installation and maintenance, telephone, and garbage or trash collection. ( )

012. DEFINITIONS M THROUGH Z.
~~For the Food Stamp Program, the following definitions apply:~~ ~~(3-17-22)~~

01. Migrant Farmworker Household. ~~A migrant farmworker household h~~Has a member who travels from community to community to do agricultural work. ~~(3-17-22)~~( )

02. Minimum Utility Allowance (MUA). Utility deduction given to a food stamp household that has a cost for one (1) utility that is not heating, cooling, or telephone. ( )

03. Nonexempt. A household member who must register for work and participate in the JSAP program. ~~A household member who must register for work.~~ ~~(3-17-22)~~( )

04. Nonprofit Meal Delivery Service. A political subdivision or a private nonprofit organization ~~which~~ that prepares and delivers meals~~,~~ and is authorized to accept Food Stamps. ~~(3-17-22)~~( )

05. Overissuance. The amount Food Stamps issued exceeds the Food Stamps a household was eligible to receive. ( )

06. Parental Control. ~~Parental control m~~Means that an adult household member has a minor in the household who is dependent financially or otherwise on the adult. ~~Minors, emancipated through marriage, are not under parental control.~~ Minors living with children of their own are not under parental control. ~~(3-17-22)~~( )

07. Participant. A person who receives Food Stamp benefits. ( )

08. Program. The Food Stamp Program created under the Food Stamp Act and administered in Idaho by the Department. ( )

~~**09. Public Assistance**. Public assistance means Temporary Assistance for Families in Idaho (TAFI), and Aid to the Aged, Blind, and Disabled (AABD).~~ ~~(3-17-22)~~

~~1~~09. Recertification. A recertification is a process for determining ongoing eligibility for Food Stamps. ( )

1~~1~~0. Retail Food Store. ~~A retail food store, f~~For Food Stamp purposes means: ~~(3-17-22)~~( )

a. An establishment, or recognized department of an establishment, or a house-to-house food trade route, whose food sales volume is more than fifty percent (50%) staple food items for home preparation and consumption. ( )

b. Public or private communal dining facilities and meal delivery services. ( )

c. Private nonprofit drug addict or alcohol treatment and rehabilitation programs. ( )

d. Public or private nonprofit group living arrangements. ( )

e. Public or private nonprofit shelters for battered women and children. ( )

f. Private nonprofit cooperative food purchasing ventures, including those whose members pay for food prior to the receipt of the food. ( )

g. A farmers' market. ( )

h. An approved public or private nonprofit establishment ~~which~~ that feeds homeless persons. The establishment must be approved by FNS. ~~(3-17-22)~~( )

1~~2~~1. **Sanction**. A penalty period when an individual is ineligible for Food Stamps. ( )

1~~3~~2. **Seasonal Farmworker Household**. ~~A seasonal farmworker household h~~Has a member who does agricultural work of a seasonal or other temporary nature. ~~(3-17-22)~~( )

1~~4~~3. **Self-Employment**. ~~Self-employment is t~~The process of actively earning income directly from one's own business, trade, or profession. To be considered self-employed, a person is responsible for obtaining or providing a service or product that generates, or is expected to generate, income. ~~Self-employment applies only to a business owned by one (1) person. A business owned by more than one (1) person is considered employment, not self-employment.~~ ~~(3-17-22)~~( )

1~~5~~4. **Spouse**. Persons who are legally married under Idaho law. ( )

1~~6~~5. **Standard Utility Allowance (SUA)**. Utility deduction given to a food stamp household that has a cost for heating or cooling. ( )

1~~7~~6. **State**. Any of the fifty (50) States, the District of Columbia, Puerto Rico, Guam, ~~the~~ Northern Mariana Islands, and ~~the~~ Virgin Islands of the United States. ~~(3-17-22)~~( )

~~18.~~ ~~**State Agency**. The Idaho Department of Health and Welfare.~~ ~~(3-17-22)~~

1~~9~~7. **Student**. An individual between the ages of eighteen (18) and fifty (50), physically and intellectually fit, and enrolled at least half-time in an institution of higher education. An institution of higher education usually requires a high school or general equivalency diploma for enrollment. This includes colleges, universities, and vocational or technical schools at the post-secondary school level. ~~(3-17-22)~~( )

18. **Substance Use Disorder Treatment Program**. Any drug or alcohol rehabilitation program conducted by a private nonprofit organization or institution or a publicly operated community mental health center under Part B of Title XIX of the Public Health Service Act (42 USC 300x, et seq.). Indian reservation-based centers may qualify if FNS requirements are met and the program is funded by the National Institute on Alcohol Abuse under Public Law 91-616 or was transferred to Indian Health Service funding. ( )

~~20~~19. **Supplemental Security Income (SSI)**. Monthly cash payments under Title XVI of the Social Security Act. Payments include state or federally administered supplements. ( )

2~~1~~0. **Systematic Alien Verification for Entitlements (SAVE)**. The federal automated system that provides immigration status needed to determine an applicant's eligibility for many public benefits, including Food Stamps. ( )

2~~2~~1. **Telephone Utility Allowance (TUA)**. Utility deduction given to a Food Stamp household that has a cost for telephone services and no other utilities. ( )

2~~3~~2. **Timely Notice**. Notice that is mailed ~~via the U. S. Postal Service, or~~ electronically, at least ten (10) days before the effective date of an action taken by the Department. ~~(3-17-22)~~( )

~~24.~~ ~~**Twelve Month Contact**. For households that have a twenty-four (24) month certification period, Department staff contact the household during the twelfth month of the certification period for the purpose of determining continued eligibility.~~ ~~(3-17-22)~~

2~~5~~3. **Tribal General Assistance**. Cash, excluding in-kind assistance, financed by federal, state, or local government and provided to cover living expenses or other basic needs. ~~This cash is intended to promote the health and well-being of recipients.~~ ~~(3-17-22)~~( )

2~~6~~4. **Verification**. ~~The proof obtained to establish the accuracy of information and the household's eligibility.~~ Third party data or documents used to prove the accuracy of information used to make an eligibility determination. ~~(3-17-22)~~( )

2~~7~~5. **Verified Upon Receipt**.~~ Food stamp benefits are adjusted on open food stamp cases when information is received from "verified upon receipt" sources.~~ Information~~ "verified upon receipt" is~~ received from~~ a manual query or~~ certain authorized automated system match~~es~~ ~~with the Social Security Administration or Homeland Security query for citizenship status~~ that are considered automatically verified unless questionable. ~~(3-17-22)~~( )

2~~8~~6. **Written Notice**. Correspondence that is generated by any method including handwritten, typed, or electronic, delivered to the customer by hand, U.S. Mail, professional delivery service, or by any electronic means. The terms "notice" and "written notice" are used interchangeably. ( )

013. ABBREVIATIONS A THROUGH G.
~~For the purposes of the Food Stamp Program, the following abbreviations are used.~~ ~~(3-17-22)~~

01. **AABD**. Aid to the Aged, Blind, and Disabled. ( )

02. **ABAWD**. Able-bodied adults without dependents. ( )

03. **AE**. Administrative Error. ( )

04. **AFA**. Application for Assistance. ( )

~~**05.** **BIA**. Bureau of Indian Affairs.~~ ~~(3-17-22)~~

~~**06.** **BIA GA**. Bureau of Indian Affairs-general assistance.~~ ~~(3-17-22)~~

~~**07.** **COLA**. Cost of Living Allowance. COLA data comes from SSA.~~ ~~(3-17-22)~~

0~~8~~5. **CSS**. Bureau of Child Support Services. ( )

0~~9~~6. **DHW**.~~ The~~ Department of Health and Welfare in Idaho. ~~(3-17-22)~~( )

~~**10.** **DMV**. Department of Motor Vehicles in Idaho.~~ ~~(3-17-22)~~

~~11~~07. **EBT**. Electronic Benefit Transfer. ( )

~~12~~08. **EWS**. Enhanced Work Services. ( )

~~13~~09. **FNS**.~~ The~~ Food and Nutrition Service of the U~~.~~S~~.~~ D~~epartment of~~ A~~griculture~~. ~~(3-17-22)~~( )

1~~4~~0. **FFY**. Federal fiscal year. ( )

~~**15.** **FMV**. Fair market value.~~ ~~(3-17-22)~~

1~~6~~1. **FPG**. Federal Poverty Guideline(s). ( )

1~~7~~2. **FQC**. Federal Quality Control. ( )

1~~8~~3. **HUD**.~~ The~~ U~~.~~S~~.~~ Department of Housing and Urban Development. ~~(3-17-22)~~( )

014. ABBREVIATIONS I THROUGH Z.
~~For the purposes of the Food Stamp Program, the following abbreviations are used.~~ ~~(3-17-22)~~

~~**01.** **ICCP**. Idaho Child Care Program.~~ ~~(3-17-22)~~

0~~2~~1. **IHE**. Inadvertent household error. ( )

~~**03.** **INS**. Immigration and Naturalization Service, in 2003, became the United States Citizenship and~~

~~Immigration Service (USCIS), a Division of Homeland Security.~~ ~~(3-17-22)~~

~~04.~~ ~~**INA**. Immigration and Nationality Act.~~ ~~(3-17-22)~~

0~~5~~2. **IPV**. Intentional program violation. ( )

0~~6~~3. **IRS**. Internal Revenue Service. ( )

0~~7~~4. **JSAP**. Job Search Assistance Program. ( )

0~~8~~5. **LUA**. Limited utility allowance. ( )

0~~9~~6. **MUA**. Minimum utility allowance. ( )

~~1~~07. **PA**. Public Assistance. ( )

~~11~~08. **RSDI**. Retirement, Survivors, Disability Insurance received from SSA. ( )

~~12~~09. **SAVE**. Systematic Alien Verification for Entitlements. ( )

1~~3~~0. **SDX**. State Data Exchange. ( )

1~~4~~1. **SQC**. State Quality Control. ( )

~~15.~~ ~~**SRS**. Self Reliance Specialist.~~ ~~(3-17-22)~~

1~~6~~2. **SUA**. Standard utility allowance. ( )

1~~7~~3. **SSA**. Social Security Administration. ( )

1~~8~~4. **SSI**. ~~The~~ Federal Supplemental Security Income Program for the aged, blind, or disabled. ~~(3-17-22)~~( )

1~~9~~5. **SSN**. Social Security ~~n~~Number. ~~(3-17-22)~~( )

~~20~~16. **TAFI**. Temporary Assistance for Families in Idaho. ( )

~~2~~17. **TOP**. Treasury Offset Program. ( )

~~22~~18. **TUA**. Telephone Utility Allowance. ( )

~~23~~19. **UI**. Unemployment Insurance. ( )

24~~0~~. **USDA**. U~~nited~~ S~~tates~~ Department of Agriculture. ~~(3-17-22)~~( )

2~~5~~1. **VA**. ~~The~~ Veterans Administration. ( )

2~~6~~2. **WIOA**. ~~The~~ Workforce Innovation and Opportunity Act. ( )

~~27.~~ ~~**WIC**. The special supplemental Food Program for Women, Infants, and Children.~~ ~~(3-17-22)~~

015. -- 098. (RESERVED)

099. SIGNATURES.

An individual who is applying for benefits, receiving benefits, or providing additional information as required ~~by this chapter~~ in these rules, may do so with the ~~depiction~~ representation of the individual's name either handwritten, electronic, or recorded telephonically. Such signature serves as intention to execute or adopt the sound, symbol, or

process for the purpose of signing the related record. ~~(3-17-22)~~(   )

100. APPLICATION.
To apply for Food Stamps, the household or an authorized representative must complete and file ~~the~~ an application ~~form,~~ with the Department, complete an interview, ~~with the Department~~ and verify information. There is no age requirement for applicants. Applicants may bring anyone to the interview. The Department will act on all applications~~. The Department~~ and will grant Food Stamps to eligible households back to the date of application. ~~(3-17-22)~~(   )

101. APPLICATION FORMS.
Households can file an application the first day they contact the Department. The Department will have ~~Application for Assistance (~~AFA~~) (HW 0901)~~ forms readily available to households and will provide an AFA to any person making a request. Requests for the application can be made by telephone, in person, or by another person. The Department will mail or give the AFA to the person on the day requested. ~~(3-17-22)~~(   )

~~**01. Expectation**. The household must turn in page one (1) of the AFA to file for Food Stamps. The Department will provide an AFA to any person making a request. Requests for the application can be made by telephone, in person or by another person. The Department will mail or give the AFA to the person on the day requested. (3-17-22)~~

~~**02. Explanation of Application Process**. The Department will provide a written statement telling what the household must do to complete the application process. The statement will identify sources of the proof needed to complete the application process. (3-17-22)~~

102. (RESERVED)

103. FILING AN APPLICATION.
The AFA must contain the applicant's name, address, signature, and application date. A household can file for Food Stamps by turning in page one of the AFA to the Food Stamp office. This protects the application date. If the household is eligible, Food Stamps for the first month will be prorated from the application date. The AFA can be submitted at the ~~F~~field ~~O~~office by the household or authorized representative. The AFA can be submitted by mail, fax, or email. ~~(3-17-22)~~(   )

104. -- 105. (RESERVED)

106. DETERMINATION OF WHEN A NEW APPLICATION FOR ASSISTANCE (AFA) IS REQUIRED.
The Department must follow the procedure outlined in 7 CFR 273.2(g) and (h) in determining when a food stamp household is required to fill out a new ~~application for assistance (~~AFA~~)~~. ~~(3-17-22)~~(   )

107. -- 112. (RESERVED)

113. HOUSEHOLD COOPERATION.
The household must cooperate with the Department. The application must be denied if the household refuses to cooperate. Refusal to cooperate includes failing to act without a sound and timely excuse. Giving false information on purpose is failure to cooperate.~~ The Department must show false information was given on purpose before denying the application. The household is ineligible if it refuses to cooperate in a six-month or twelve-month contact, recertification, program review or evaluation.~~ If an application is denied or Food Stamps are stopped for refusal to cooperate, the household ~~can~~ may reapply. The household is not eligible until it cooperates with the Department. ~~(3-17-22)~~(   )

114. APPLICATION WITHDRAWAL.
Households can withdraw their application any time before the eligibility decision. The Department will document the case record with the withdrawal reason ~~in the case record and whether the household was contacted to confirm the withdrawal~~. The Department will tell the household of the right to reapply. ~~(3-17-22)~~(   )

115. AUTHORIZED REPRESENTATIVE.

The household can choose a nonhousehold member to act as an authorized representative. The household can designate in writing another responsible household member or a responsible adult outside the household as an authorized representative. An adult employee~~,~~ of an authorized ~~drug addiction or alcoholic~~ substance use disorder treatment and rehabilitation center, or an authorized group living arrangement center, may act as an authorized representative for the household. Conditions for an authorized representative are: ~~(3-17-22)~~( )

01. Designating Authorized Representative. ~~When household members cannot apply for, receive or use Food Stamps, the household can choose an authorized representative. The household must appoint the authorized representative in writing.~~ Households may designate an authorized representative to act on behalf of a household to apply for, receive, or use food stamps. The authorized representative should be aware of household circumstances. ~~The household should prepare or review the AFA when the authorized representative will be interviewed.~~ ~~(3-17-22)~~( )

02. Persons Who Cannot Be an Authorized Representative. Persons with a conflict of interest may not act as an authorized representative without the Department's written approval. The ~~F~~field ~~O~~office supervisor must determine if no one else is available and give written approval. Persons with a conflict of interest are listed below: ~~(3-17-22)~~( )

a. Retailers allowed to accept Food Stamps. ( )

b. Department employees involved in the certification or issuance process. ( )

c. A person disqualified for IPV during the penalty period, unless ~~he is~~ they are the only adult household member and no one else is available. ~~(3-17-22)~~( )

d. Homeless meal providers. ( )

03. Department Responsibilities. The Department will: ( )

a. Make sure authorized representatives are properly selected. ( )

b. Record the representative's name in the case record. ( )

~~**c.** Not place limits on the number of households a representative may represent. (3-17-22)~~

~~d~~c. Inform the household it will be liable for any overissuance resulting from wrong information given by the representative. ( )

~~e~~d. Make sure the household freely requested the representative. ( )

~~**f.** Make sure the household is getting the correct amount of benefits. (3-17-22)~~

~~**g.** Make sure the representative is properly using the Food Stamps. (3-17-22)~~

04. Authorized Representative Removed. The Department may remove an authorized representative for up to one (1) year if the person knowingly ~~distorts a household's circumstances,~~ gives false information, or improperly uses the Food Stamps. This provision does not apply to ~~drug and alcohol~~ substance use disorder centers and group homes. Written notice must be sent to the household and the authorized representative thirty (30) days before the penalty begins. The notice must list: ~~(3-17-22)~~( )

a. The proposed action. ( )

b. The reason for the action. ( )

c. The right to a fair hearing. ( )

d. The name and telephone number to contact for more information. ( )

~~**05.** **Contingency Designation**. A household member able to apply for and get Food Stamps can name an authorized representative, in writing, in case the household becomes unable to use Food Stamps. (3-17-22)~~

~~**06.** **Emergency Designation**. The household may choose an emergency authorized representative if unforeseen circumstances arise. The household must complete a statement appointing the person as the authorized representative. The authorized representative must sign the statement. The household cannot be required to go to the Field Office to complete this statement. (3-17-22)~~

05. **Authorized Representatives for Substance Use Disorder Treatment Centers and Group Homes**. Substance use disorder treatment centers and the heads of group living arrangements that act as authorized representatives for their residents, and which intentionally misrepresent households' circumstances, may be prosecuted under applicable federal and state statutes for their acts. (   )

116. -- 119. (RESERVED)

120. HOUSEHOLD INTERVIEWS.
The Department must conduct an interview with the applicant, a member of the household, or the authorized representative. Interviews must be conducted either face-to-face or via telephone~~, based on hardship criteria evident in the case record. The applicant may bring any other person to the interview. The Department does not require households to report for an in-office interview during their certification period.~~ The frequency of the interview must be as follows: ~~(3-17-22)~~(   )

01. **Twenty-Four Months**. ~~The interview must be a~~At least once every twenty-four (24) months for households certified for twenty-four (24) months. ~~(3-17-22)~~(   )

02. **Twelve Months**. ~~The interview must be e~~Every twelve (12) months for all other households. ~~(3-17-22)~~

121. -- 132. (RESERVED)

133. VERIFICATION.
The Department must have verification to support the benefit determination.~~ Verification is third party data or documents used to prove the accuracy of AFA information.~~ The Department must give the applicant household a clear written statement of the proof to bring to the interview. The statement will indicate the Department will help the household get proof, if needed. The Department must give the household ten (10) calendar days from the request date to provide proof. Proof can be provided in person, by mail, or by~~ an authorized representative~~ electronic interfaces. If the proof supplied is~~ faulty, not complete or not consistent~~ questionable, the Department can require further proof. The Department~~ must~~ will notify the household of any other steps necessary to complete the application process. ~~(3-17-22)~~(   )

134. (RESERVED)

135. SOURCES OF VERIFICATION.
The following sources of verification must be considered: (   )

01. **Written Confirmation**. A primary source of proof is written confirmation of circumstances. Written proof includes driver's licenses, work or school identification, birth certificates, wage stubs, award letters, court orders, divorce decrees, separation agreements, insurance policies, rent receipts, and utility bills. Acceptable proof is not limited to a single document. Proof can be obtained from the household or other sources. Secondary sources of proof must be used to verify a household's circumstances if the primary source cannot be obtained or does not prove eligibility or benefit level. (   )

02. **Collateral Contact~~s~~**. A~~ collateral contact is a~~n oral confirmation of a household's circumstances by a person outside of the household. The collateral contact may be made either in-person or over the telephone. ~~(3-17-22)~~(   )

03. Automated System Data. Information that is obtained through interfacing with other government agency computer systems or authorized systems. ~~(3-17-22)~~( )

136. (RESERVED)

137. PROOF FOR QUESTIONABLE INFORMATION.
Prior to the certification, a six-month or twelve-month contact, or recertification of the household, the Department must verify all questionable information regarding eligibility and benefit level. Proof is required when details are not consistent with information received by the Department. Proof may be obtained either verbally or in writing. ( )

138. PROVIDING PROOF TO SUPPORT APPLICATION STATEMENTS.
The household has primary responsibility to provide proof supporting its statements on the application~~. The household has primary responsibility~~ and to resolve any questionable information. The Department must assist the household in obtaining proof. Households may supply proof in person~~, through the~~ or by mail~~, by~~ facsimile, or other electronic~~ device, or through an authorized representative~~ interfaces. The Department will not require the household to present proof in person. ~~(3-17-22)~~( )

139. -- 141. (RESERVED)

142. PROCESSING STANDARDS.
The Department will determine Food Stamp eligibility within thirty (30) days of the application date. The application date is the day the AFA is received and date stamped by the ~~F~~field ~~O~~office. The application date for a person released from a public institution is the release date~~,~~ if the person applied for Food Stamps before~~ his~~ their release. The AFA must contain at least the applicant's name and address~~. The AFA must~~ and be signed by a responsible household member or representative. ~~(3-17-22)~~( )

143. -- 145. (RESERVED)

146. DENIAL OF FOOD STAMP APPLICATION.
The Department will deny the Food Stamp application under conditions listed below~~. The Department will~~ and send the household notice of denial. ~~(3-17-22)~~( )

01. Household Ineligible. The Department will deny the application for ineligible households as soon as possible, but not later than thirty (30) calendar days following the application date. ( )

02. Household Fails to Appear for Interview. If the household fails to appear for an interview, and fails to contact the Department, the application will be denied thirty (30) calendar days after the application date. ( )

03. Household Does Not Provide Proof After Interview. If the household did not provide requested proof after an interview or later request, the Department will deny the application ten (10) calendar days after the request for proof. ( )

147. ~~CASE ACTION AFTER DELAY CAUSED BY HOUSEHOLD~~DELAYS IN PROCESSING.
~~The Department must follow the procedure outlined in 7 CFR 273.2(g) and (h) in determining the appropriate action to take on food stamp benefits when the household has delayed completing the application process.~~The Department must follow the procedure outlined in 7 CFR 273.2(h) in determining the appropriate action to take on food stamp benefits when there are delays in completing the application process. ~~(3-17-22)~~( )

~~**148. DELAYS IN PROCESSING CAUSED BY THE DEPARTMENT.**~~
~~A processing delay exists when the Department does not determine Food Stamp eligibility within thirty (30) days of application. The Department will determine the cause of the delay. Delays caused by the Department are: (3-17-22)~~

~~**01. No Application Help**. The Department did not offer or try to offer help to complete the application. (3-17-22)~~

~~**02. Work Registration**.~~ ~~(3-17-22)~~

~~a. The Department did not register household members for work.~~ ~~(3-17-22)~~

~~b. The Department did not inform the household of the need to register for work.~~ ~~(3-17-22)~~

~~c. The Department did not give the household ten (10) days from the notice date to register for work.~~ ~~(3-17-22)~~

~~**03. Application Forms Mailed Late**. Application forms were requested in writing or by telephone. The Department did not mail the application forms the same day the household made the request.~~ ~~(3-17-22)~~

~~**04. Proof**. The Department did not allow the household ten (10) days from the notice date to provide the missing proof.~~ ~~(3-17-22)~~

~~**149. (RESERVED)**~~

~~**150. DELAYS OVER SIXTY DAYS.**~~
~~If the Department caused the delay, the Department will process the original application until an eligibility decision is made. The original application must be used even if the second thirty (30) day period has passed. If the household is found eligible and the delay was the Department's fault during the first thirty (30) days, provide Food Stamps back to the application date. If the household is found eligible and the delay was the household's fault during the first thirty (30) days and the Department's fault during the second thirty (30) days, issue Food Stamps for the month after the application month. If the household is at fault for the first and second thirty (30) day delay, deny the application. A new application is required.~~ ~~(3-17-22)~~

1~~51~~48. -- 154. (RESERVED)

155. EXPEDITED SERVICE ELIGIBILITY.
Applicants must be screened to determine if the household is entitled to expedited service. The household must meet one (1) of the expedited service criteria below. The household must have provided proof postponed by the last expedited service or have been certified under the normal standards since the last expedited service. ( )

01. Low Income and Resources. To receive expedited services, the household's monthly countable gross income must be less than one hundred fifty dollars ($150) and the household's liquid resources must not exceed one hundred dollars ($100). ( )

02. Destitute. To receive destitute expedited services, the household must be a destitute migrant or seasonal farmworker household. The household's liquid resources must not exceed one hundred dollars ($100). ( )

03. Income Less Than Rent and Utilities. The household's combined monthly gross income and liquid resources are less than their monthly rent or mortgage, and utilities cost. ( )

156. TIME LIMITS FOR EXPEDITED FOOD STAMPS.
Time limits for acting on expedited Food Stamp applications are listed below: ( )

01. Seven Day Limit for Food Stamps. For households entitled to expedited service, the Department will provide Food Stamps to the household within seven (7) days of the application date. ( )

02. Seven Days After Discovery. If not discovered at initial screening, the Department will provide expedited services to an expedite-eligible household within seven (7) days~~. Seven (7) days~~, which begins the day after the Department finds the household is entitled to expedited service. ~~(3-17-22)~~( )

03. Seven Days for Waived Interview. The Department will provide expedited services within seven (7) days of the application date for households entitled to an office interview waiver. Seven (7) days is counted from the application date.~~ If a telephone interview is conducted, the AFA must be mailed to the household for signature.~~

~~The mailing time must not be included in the seven (7) days. Mailing time includes the days the AFA is in the mail to and from the household. Mailing time includes the days the AFA is at the household pending signature and mailing.~~ ~~(3-17-22)~~( )

~~**04. Treatment Centers**. For residents of drug addiction or alcoholic treatment centers, Food Stamps must be provided within seven (7) days of the application date.~~ ~~(3-17-22)~~

~~**05. Shelter Residents**. For residents of shelters for battered women and children, Food Stamps must be provided within seven (7) days of the application date.~~ ~~(3-17-22)~~

157. EXPEDITED FOOD STAMP WORK REGISTRATION.
The applicant must complete work registration unless ~~he is~~ they are exempt or ha~~s~~ve a representative register ~~him~~ them. Other non- exempt household members must register if the registration can be done in seven (7) days. ~~(3-17-22)~~( )

158. EXPEDITED VERIFICATION.
The Department will verify the applicant's identity through readily available proof or a collateral contact. Proof may include identification such as a driver's license, birth certificate, or voter registration card. The Department will try to get proof so that benefits can be issued within seven (7) days of the application date. Expedited Food Stamps must not be delayed beyond seven (7) days for proof other than identity. Other proof can be postponed to issue expedited Food Stamps. ( )

159. (RESERVED)

160. EXPEDITED CERTIFICATION.
If all required proof is provided for expedited certification, a normal certification period is assigned. Certification based on application date, household type, and proof is listed below: ( )

01. Non-migrant Household Applying from the First Through the Fifteenth of the Month. ( )

a. For a non-migrant household applying from the first through the fifteenth of the month, if proof of eligibility factors is postponed, assign a normal certification period~~.~~; the Department will ~~I~~issue the first month's benefits. ~~Do~~ The Department will not issue the second month's benefits until the postponed proof is received. ( )

b. When proof is postponed, the household has thirty (30) days from the application date to provide the proof. The household must be given timely and adequate notice that no further benefits will be issued until proof is completed. If the proof results in changes in the household's Food Stamps, the Department will act on the changes without advance notice. ( )

c. If postponed proof is provided before the second month, the Department will process an issuance for the first working day of the second month. If proof is provided in the second month, the Department will issue benefits within seven (7) calendar days from the date the proof is received. If postponed proof is not provided within thirty (30) days from the application date, the Department will close the case. ~~(3-17-22)~~( )

02. Non-migrant Household Applying from the Sixteenth Through the End of the Month. ( )

a. For a non-migrant household applying from the sixteenth to the end of the month, if proof of eligibility factors is postponed, the Department will assign a normal certification period~~.~~, and ~~I~~issue the first- and second-month's benefits within the expedited time frame. ( )

b. When proof is postponed, the household has thirty (30) days from the application date to complete the proof. The household must be given timely and adequate notice that no further benefits will be issued until proof is completed. If the proof results in changes in the household's Food Stamps, the Department will act on the changes without advance notice. ( )

c. If postponed proof is provided within thirty (30) days, the Department will process an issuance for the first working day of the third month. If postponed proof is not provided within thirty (30) days from the

application date, the Department will close the case. ~~(3-17-22)~~( )

03. Migrant Household Applying from the First Through the Fifteenth of the Month. ( )

a. For a migrant household applying from the first (1st) through the fifteenth (15th) of the month, if proof of eligibility factors is postponed, the Department will assign a normal certification period~~.~~, and ~~I~~issue the first month's benefits. ( )

b. When proof is postponed, the household has thirty (30) days from the application date to complete in-state proof. The household has sixty (60) days from the application date to complete out-of-state proof. The household must be given adequate and timely notice no further benefits will be issued until the postponed proof is completed. Before the second month's benefits are issued, the household must provide all in-state postponed proofs. Before the third month's benefits are issued, the household must provide all out-of-state postponed proof. If the proofs result in changes in the household's Food Stamps, the Department will act on these changes, without providing advance notice. ( )

c. Migrants are entitled to postponed out-of-state proof only once each season. If postponed in-state proof is provided before the second month, the Department will process an issuance for the first working day of the second month. If postponed out-of-state proof is provided before the third month, the Department will process a regular issuance for the third month. If postponed out-of-state proof is provided in the third month, the Department will issue benefits within seven (7) calendar days from the date proof is received. If postponed in-state proof is not provided within thirty (30) days from the application date, the Department will close the case. If postponed out-of-state proof is not provided within sixty (60) days from the application date, the Department will close the case. ~~(3-17-22)~~( )

04. Migrant Household Applying from the Sixteenth Through the End of the Month. ( )

a. For a migrant household applying from the Sixteenth to the end of the month, if proof of eligibility factors is postponed, the Department will assign a normal certification period~~.~~, and ~~I~~issue the first- and second-months' benefits within the expedited time frame. ( )

b. When proof is postponed, the household has thirty (30) days from the application date to provide in-state proof. The household has sixty (60) days from the application date to provide out-of-state proof. The household must be given adequate and timely notice no further benefits will be issued until the postponed proof is completed. Before the third month's benefits are issued, the household must provide all in-state and out-of-state postponed proofs. If the proofs result in changes in the household's Food Stamps, the Department will act on these changes without providing advance notice. ( )

c. Migrants are entitled to postponed out-of-state proof only once each season. If postponed proof is provided before the third month, the Department will process a regular issuance for the third month. If postponed out-of-state proof is provided in the third month, the Department will issue benefits within seven (7) calendar days from the date proof is received. If postponed in-state proof is not provided within thirty (30) days from the application date, the Department will close the case. If postponed out-of-state proof is not provided within sixty (60) days from the application date, the Department will close the case. ~~(3-17-22)~~( )

05. Reapplying Household. When a household granted postponed proof at the last expedited certification reapplies, it must provide the postponed proof before it is again eligible for expedited certification. The Department does not require postponed proof if the household was certified under normal standards since the last expedited certification. ~~(3-17-22)~~( )

161. NO LIMIT TO EXPEDITED CERTIFICATIONS.
There is no limit to the number of times a household can receive expedited certification. ~~The household must provide proof postponed at the last expedited certification. The Department does not require postponed proof if the household was certified under normal standards since the last expedited certification.~~ ~~(3-17-22)~~( )

162. EXPEDITED SERVICES FOR DESTITUTE HOUSEHOLDS.
Migrant or seasonal farmworker households meeting destitute conditions below can get expedited services. The rules

for destitute households apply at initial application, the six-month or twelve-month contact, and recertification, but only for the first month of each contact or certification period. ( )

01. Terminated Source of Income. When ~~T~~the household's only income for the application month was received before the application date and was from a terminated source~~. T~~the Department will consider the household~~ is considered~~ destitute. Terminated income is income received monthly or more often, no longer received from the same source the rest of the application month, or the next month or income received less often than monthly~~,~~ and not expected in the month the next regular payment is normally due. ~~(3-17-22)~~( )

02. New Income in Application Month. When only new income is expected in the application month, the household is considered destitute. Only twenty-five dollars ($25), or less, of new income can be received in the ten (10) days after the application date. Income is new if twenty-five dollars ($25), or less, is received during the thirty (30) days before the application date. New income was received less often than monthly, was not received in the last normal payment interval, or was twenty-five dollars ($25) or less. ~~(3-17-22)~~( )

03. Terminated Income and New Income in Application Month. Destitute households can get terminated income before the application date and new income before and after the application date. New income must not be received for ten (10) days after application and~~ must~~ not exceed twenty-five dollars ($25). The household must get no other income in the application month. ~~(3-17-22)~~( )

04. Application Month. For the application month, the Department will count only income received between the first day of the month and the application date~~. Do~~, and will not count income from a new source expected after the application date. ~~(3-17-22)~~( )

163. SPECIAL CONSIDERATION OF INCOME FOR DESTITUTE HOUSEHOLDS.
Special consideration of income for destitute households is listed below. The rules for destitute households apply at initial application, a six-month or twelve-month contact, and recertification, but only for the first month of each contact or certification period. ( )

01. Travel Advances. For destitute eligibility and benefit level, travel advances~~ apply as follows~~:~~ ~~ ( )

a. ~~Travel advances f~~Rom employers for travel costs to a new employment location are excluded.~~ ~~ ( )

b. ~~Travel advances a~~Against future wages are counted as income, but not a new source of income. ~~(3-17-22)~~( )

02. Household Member Changes Job. A person changing jobs with the same employer is still getting income from the same source. A migrant's income source is the grower, not the crew chief. When a migrant moves with a crew chief from one (1) grower to another, the income from the first grower is ended. The income from the next grower is new income. ( )

03. Recertification or Six-Month or Twelve-Month Contact. The Department will ~~D~~disregard income from the new source for the first month of the new certification period if more than twenty-five dollars ($25) will not be received by the tenth calendar day after the normal issuance. ~~(3-17-22)~~( )

164. DENIAL OF EXPEDITED SERVICE.
The Department will deny expedited service if the household does not meet expedite criteria~~. The Department will deny expedited service if the household~~ or fails to cooperate in the application process. Failure to cooperate includes missing a scheduled expedited service appointment. The Department will still process the application under standard methods. ~~(3-17-22)~~( )

165. CONTESTING DENIED EXPEDITED SERVICE.
The Department will offer an agency conference to a household contesting denial of expedited services. The Department will tell households they can request an agency conference~~. The Department will tell a household an agency~~; the conference will not delay or replace a fair hearing. Migrant farmworker households and households

planning to move are entitled to expedited fair hearings. ~~(3-17-22)~~(____)

166. -- 17~~6~~7. (RESERVED)

~~**177. FOOD STAMPS FOR TAFI OR AABD HOUSEHOLDS.**~~
~~The Department will tell TAFI or AABD applicants they can apply for Food Stamps when they apply for TAFI or AABD. Households, applying for TAFI or AABD and Food Stamps at the same time, must complete an application for TAFI or AABD and Food Stamps. Households may be eligible for an out-of-office interview. The Food Stamps must be issued by Food Stamp rules. The Department will tell Food Stamp households, applying for TAFI, that TAFI time limits and requirements do not apply to the Food Stamp program. Households no longer receiving TAFI may still be eligible for Food Stamps. (3-17-22)~~

178. CATEGORICALLY ELIGIBLE HOUSEHOLDS.
Households with all members meeting one (1) of the criteria below are categorically eligible for Food Stamps. The Department will not compute resource eligibility~~. The Department will not compute~~, gross or net income~~ eligibility limits~~, social security number information, sponsored alien information, and residency. Categorically eligible households must meet all other Food Stamp eligibility criteria~~. Categorically eligible households~~, and have the same rights as other households. ~~(3-17-22)~~(____)

01. Cash Benefits. All household members are approved for~~,~~ or already receive~~,~~ TAFI,~~ or~~ AABD, or SSI cash benefits.~~ The household is categorically eligible.~~ ~~(3-17-22)~~(____)

02. Benefits Recouped. All household members have AABD or SSI benefits being recouped.~~ The household is categorically eligible.~~ ~~(3-17-22)~~(____)

03. Grant Less Than Ten Dollars. All household members not receiving TAFI,~~ or~~ AABD, or SSI because their grant is less than ten dollars ($10).~~ The household is categorically eligible.~~ ~~(3-17-22)~~(____)

179. HOUSEHOLDS NOT CATEGORICALLY ELIGIBLE.
The households listed below are not categorically eligible for Food Stamps. ( )

~~**01. Medicaid Only**. Households are not categorically eligible if any household member receives Medicaid benefits only. (3-17-22)~~

0~~2~~1. IPV. Households are not categorically eligible, if any household member is disqualified for a Food Stamp ~~Intentional Program Violation (~~IPV~~)~~. ~~(3-17-22)~~(____)

0~~3~~2. Work Requirements. Households are not categorically eligible, if any household member fails to comply with the Food Stamp work requirements. ( )

0~~4~~3. Ineligible Legal Non-Citizen or Student. Households are not categorically eligible if any member is an ineligible legal non-citizen or ineligible student. ( )

0~~5~~4. Nonexempt Institution. Households are not categorically eligible if any member is a person living in a nonexempt institution. ( )

180. CATEGORICAL ELIGIBILITY ENDS.
Categorical eligibility ends when the household member is no longer eligible for TAFI, AABD, or SSI. If the household is still eligible under Food Stamp rules, the household will continue to receive Food Stamps. If categorical eligibility ends and household income or resources exceed the Food Stamp limits, the household is no longer eligible for Food Stamps. Food Stamps will stop after timely advance notice. ( )

181. BROAD -BASED CATEGORICALLY ELIGIBLE HOUSEHOLD EXCEPTIONS.
If a household contains any of the following members, the household is not eligible under Broad-Based Categorical Eligibility. ( )

01. IPV. Any household member is disqualified for an ~~Intentional Program Violation (~~IPV~~)~~.

~~(3-17-22)~~( )

02. Drug-Related Felony. Any household member is ineligible because of a drug-related felony. ( )

03. Strike. Any household member is on strike. ( )

04. Transferred Resources. Any household member transferred resources ~~in order~~ to qualify for benefits. ~~(3-17-22)~~( )

05. Refusal to Cooperate. Any household member refused to cooperate in providing information that is needed to determine initial or ongoing eligibility. ( )

182. VERIFICATION FOR TAFI OR AABD HOUSEHOLDS.
To determine eligibility for Food Stamps in TAFI or AABD households, the Department will use TAFI or AABD proof. ( )

183. TIME LIMITS FOR CATEGORICALLY ELIGIBLE HOUSEHOLDS.
~~Food Stamp eligibility can be determined before a public assistance eligibility determination is made.~~ The Food Stamp application must not be delayed or denied because of a delayed public assistance decision. ~~If a Food Stamp household might be categorically eligible, the application cannot be denied until thirty (30) days after the application date.~~ ~~(3-17-22)~~( )

184. -- 194. (RESERVED)

195. DISASTER CERTIFICATION.
When allowed by FNS, under ~~the authority of~~ Section 302(a) of the Disaster Relief Act of 1974, the Department can certify households affected by a natural disaster. If the Secretary of USDA declares a disaster area, the Department will follow disaster instructions issued by the USDA. ~~(3-17-22)~~( )

196. -- 199. (RESERVED)

200. NONFINANCIAL CRITERIA.
Nonfinancial criteria are identification, residency, Social Security Number, citizenship, and work requirements. Households must meet these nonfinancial criteria to be eligible for Food Stamps. ( )

201. IDENTIFICATION.
The person making application for Food Stamps, including an authorized representative, must prove identity. ~~The authorized representative, applying on behalf of a household, must prove identity. If an authorized representative is used, the identity of the head of the household must also be proved.~~ Proof includes a driver's license, school identification, wage stubs, and birth certificates. The Department will accept other reasonable proof of identity.
~~(3-17-22)~~( )

202. RESIDENCY.
A household must live in Idaho when ~~it~~ appl~~ies~~ying for Food Stamps. A person can get Food Stamps as a member of only one (1) household a month. ~~(3-17-22)~~( )

01. Place of Residency. ~~Households must live in the project area in which they make application.~~ An eligible Food Stamp household is not required to live in a permanent dwelling or have a fixed mailing address. There is no residence duration requirement. ~~(3-17-22)~~( )

02. Vacationing Persons Not Residents. Persons in Idaho for vacation only are not residents for Food Stamp eligibility. Vacation is the period a household spends away from their usual activity, work, or home~~. Vacation is taken~~ for travel, rest, or recreation. ~~(3-17-22)~~( )

03. Different Physical and Mailing Addresses ~~Different~~. The physical ~~address~~ and ~~the~~ mailing addresses of a Food Stamp household can be different. If the mailing address is not the household's physical address,

the household must provide proof of the physical address. ~~(3-17-22)~~(   )

203. SOCIAL SECURITY NUMBER (SSN) REQUIREMENT.

01. Expectations. Before certification, households must provide the Department the SSN, or proof of application for SSN, for each household member. If a household member has more than one (1) SSN, they must provide all~~ of his~~ SSNs. Each SSN must be verified by the ~~Social Security Administration (~~SSA~~)~~. A household member with an unverified SSN is not eligible for Food Stamp benefits. The ineligible person's income and resources must be counted in the Food Stamp budget. If benefits are reduced or ended, because one (1) or more persons fail to meet the SSN requirement, the household must be notified in writing. ~~(3-17-22)~~(   )

02. Good Cause for Not Applying for SSN. If a household member can show good cause why an SSN application was not completed in a timely manner, an extension must be granted to allow~~ him~~ them to receive Food Stamp benefits for one (1) month in addition to the month of application. Good cause for failure to apply must be shown monthly~~ in order~~ for such a household member to continue to participate.~~ Good cause is described below:~~ ~~(3-17-22)~~(   )

204. CITIZENSHIP AND QUALIFIED NON-CITIZEN REQUIREMENTS.
To be eligible for Food Stamps, an individual must meet the requirements~~ specified in~~ under 7 CFR 273.4, "Citizenship and alien status."~~ In addition, special immigrants from Iraq and Afghanistan have refugee status under Public Law 111-118, Subsection 8120.~~ ~~(3-17-22)~~(   )

205. WRITTEN DECLARATION OF CITIZENSHIP OR IMMIGRATION STATUS.
To get Food Stamps, one (1) adult household member must certify by signing a statement, under penalty of perjury, regarding the citizenship and immigration status of household members applying for benefits. (   )

206. PROOF OF PROPER IMMIGRATION STATUS.

01. Expectations. Households are required to submit documents to verify the immigration status of the legal non-citizen applicants.~~ An alien number, by itself, is not considered proof of immigration status.~~ ~~(3-17-22)~~(   )

02. Failure to Provide Legal Non-Citizen Documents. If a household says it is unable or unwilling to provide legal non-citizen status documents for a legal non-citizen household member, the legal non-citizen member must be classified as an ineligible legal non-citizen. (   )

207. NON-CITIZEN ELIGIBILITY PENDING VERIFICATION.
When~~ the applicant or~~ an application is delayed after the Department has submitted a request to a federal agency for proof of eligible alien status, the Department must certify the person applying as eligible for Food Stamps pending the results of the investigation. The certification can last up to six (6) months from the date of the original request for proof. ~~(3-17-22)~~(   )

208. -- 211. (RESERVED)

212. FOOD STAMP HOUSEHOLDS.
A Food Stamp household is composed of a person, or group of persons, applying for or getting Food Stamps. The composition of Food Stamp households is listed below: (   )

01. A Person Living Alone.~~ A person living alone.~~ ~~(3-17-22)~~(   )

02. Living with Others Preparing Separate Meals. ~~Preparing Separate Meals. A p~~Person(s)~~ or persons~~ living with others, but customarily purchasing food and preparing meals separately from the others. ~~(3-17-22)~~(   )

03. Living with Others~~, But Paying for~~ with Furnished Meals. ~~A p~~Person(s)~~ or persons~~ living with others and being furnished both meals and lodging. The person(s) ~~or persons~~ pays less than the thrifty food plan. ~~(3-17-22)~~(   )

04. Living Together~~ and~~ Preparing Common Meals. A group of persons who live, purchase food, and customarily prepare meals together for home consumption. ~~(3-17-22)~~( )

05. Women Living in Shelter. Women, or women with their children, temporarily residing in a shelter for battered women and children. ( )

06. Living in~~ Drug or Alcohol~~ Substance Use Disorder Treatment Center. Person living in a publicly operated community health center or in a private nonprofit center for~~ drug addiction or alcoholic~~ substance use disorder treatment and rehabilitation. ~~(3-17-22)~~( )

07. Resident of Group Living Center. Person residing in a group living arrangement center certified by the Department. ( )

213. SEPARATE FOOD STAMP HOUSEHOLD COMPOSITION FOR RELATED MEMBERS.
One (1) of the conditions below must be met for related persons living together to be separate Food Stamp households. ( )

01. Children Age Twenty-Two and Older Living With Parents. ~~Children age twenty-two (22) and older, living with their parents, c~~Can be separate Food Stamp households. The households must purchase and prepare their food separately. ~~(3-17-22)~~( )

02. Households Must Prepare Food Together Because of Age and Disability. Households that must purchase and prepare food together because one (1) household contains a person sixty (60) years ~~of age~~ old or older unable to purchase and prepare meals because of a disability, can be separate Food Stamp households. The spouse of the disabled person must be considered a member of that person's household. These households must meet the following conditions:~~-~~ ( )

a. The disability must be permanent under the Social Security Act or a nondisease-related, severe permanent disability.~~-~~ ( )

b. The income of the household, which does not contain the person unable to purchase and prepare meals separately, must not exceed one hundred sixty-five percent (165%) of the net monthly income limit for the household size. To count income for the one hundred sixty-five percent (165%) net monthly income standard~~:~~, ~~E~~exclude the income of the disabled person and~~ his~~ their spouse.~~-~~ ( )

c. Count all available income to the household not containing the disabled person. Compare the net monthly income eligibility standard for that size household. ~~(3-17-22)~~( )

214. CHILD CUSTODY.
For a child~~ who is~~ under~~ the age of~~ eighteen (18) years old, the parent~~ who has~~ with primary physical custody is eligible to receive Food Stamp benefits for that child. If both parents request food stamp benefits for the child, primary custody is determined by where the child is expected to spend fifty-one percent (51%) or more of the nights during a certification period. When only one (1) parent applies for food stamp benefits, the child may be included in that parent's household even though they do not have primary physical custody of the child. ~~(3-17-22)~~( )

215. PERSONS NOT ELIGIBLE FOR SEPARATE FOOD STAMP HOUSEHOLD STATUS.
Persons listed below cannot be separate Food Stamp households. For Food Stamps, they are part of the household where they live. ( )

01. Spouses.~~ Spouses are not separate Food Stamp households.~~ ~~(3-17-22)~~( )

~~**02. Boarder**. Boarders are not separate Food Stamp households.~~ ~~(3-17-22)~~

0~~3~~2. Parents and Children Together. Children under age twenty-two (22), living together with their parents~~, are not separate Food Stamp households~~. Parents and children living together include natural, adopted, or stepchildren.~~ Parents and children living together include natural, adopted, or stepparents.~~ ~~(3-17-22)~~( )

0~~4~~3. **Child Under Age Eighteen Under Parental Control**. A child under age eighteen (18) and under parental control of an adult household member~~ is not a separate household~~, unless the child is a foster child. ~~(3-17-22)~~(____)

216. ELDERLY OR DISABLED FOOD STAMP HOUSEHOLD MEMBERS.

To be counted as an elderly or disabled Food Stamp household member, the person must meet one (1) of the~~ criteria listed below~~ following: ~~(3-17-22)~~(____)

01. **Age Sixty or Older**.~~ Age sixty (60) or older.~~ ~~(3-17-22)~~(____)

02. **Entitled to SSI Benefits**.~~ Entitled to Supplemental Security Income (SSI) benefits.~~ This includes SSI presumptive disability payments, SSI emergency advance payments, or special SSI status. ~~(3-17-22)~~(____)

03. **Entitled to Social Security Payments Based on Disability or Blindness (RSDI)**.~~ Entitled to Social Security payments based on disability or blindness.~~ ~~(3-17-22)~~(____)

04. **State Supplement**. Entitled to ~~S~~state or ~~F~~federally funded State supplement payments to the SSI program such as AABD. ~~(3-17-22)~~(____)

05. **Entitled to Medicaid Based on SSI-Related Disability or Blindness**.~~ Entitled to Medicaid based on SSI related disability or blindness.~~ ~~(3-17-22)~~(____)

06. **Disability Retirement**. Entitled to ~~F~~federal or ~~S~~state funded-disability retirement benefits because of a disability considered permanent by~~ the~~ S~~ocial~~ ~~Security~~ A~~dministration~~. ~~(3-17-22)~~(____)

07. **Disabled Veteran**. A veteran with a service- or nonservice-connected disability rated or paid as total. ~~(3-17-22)~~(____)

08. **Veteran Needing Aid and Attendance**. A veteran considered in need of regular aid and attendance or permanently housebound under USC Title 38~~ of the U.S. Code~~. ~~(3-17-22)~~(____)

09. **Veteran's Surviving Spouse**. ~~A veteran's surviving spouse i~~In need of aid and attendance or permanently housebound. ~~(3-17-22)~~(____)

10. **Veteran's Surviving Child**. ~~A veteran's surviving child p~~Permanently incapable of self-support under USC Title 38~~ of the U.S. Code~~. ~~(3-17-22)~~(____)

11. **Veteran's Survivor Entitled**. A veteran's surviving spouse or child entitled to receive payment for a service-connected death under USC Title 38~~ of the U.S. Code~~. The veteran's surviving spouse or child must be permanently disabled under Section 221(i) of the Social Security Act. A veteran's surviving spouse or child entitled to pension benefits for a nonservice death under USC Title 38~~ of the U.S. Code~~. The veteran's surviving spouse or child must be permanently disabled under Section 221(i) of the Social Security Act. "Entitled" refers to veterans, surviving spouses, and children receiving pay or benefits, or who have been approved for payments, but are not yet receiving them. ~~(3-17-22)~~(____)

12. **Railroad Retirement and Medicare**. Entitled to an annuity payment under Section 2(a)(1)(iv) of the Railroad Retirement Act of 1974 and determined eligible for Medicare by the Railroad Retirement Board. (   )

13. **Railroad Retirement and Disability**. Entitled to an annuity payment under Section 2(a)(1)(v) of the Railroad Retirement Act of 1974 and is determined disabled by the Board~~ according to~~ under SSI criteria. ~~(3-17-22)~~(____)

217. NONHOUSEHOLD MEMBERS.

Nonhousehold members are persons not counted in determining Food Stamp household size. Their income and resources do not count toward the Food Stamp household. Nonhousehold members may be eligible as a separate

household~~. Nonhousehold members~~ and are listed below: ~~(3-17-22)~~(   )

01. Roomers. A person who pays for lodging, but not meals. (   )

02. Live-In Attendants. A person living with a household to provide medical, housekeeping, child care, or other similar services. (   )

03. Ineligible Students. A person between the ages of eighteen (18) and fifty (50), physically and intellectually fit, enrolled at least half-time in an institution of higher education, and not meeting Food Stamp eligibility requirements for students. (   )

04. Residents of Institutions. ~~A resident of an institution is not a member of the Food Stamp household.~~ A resident of an institution is an ineligible household member because the institution provides the resident over fifty percent (50%) of three (3) meals daily, as part of the normal services. The institution is not allowed to accept Food Stamps. ~~(3-17-22)~~(   )

218. PERSONS DISQUALIFIED AS FOOD STAMP HOUSEHOLD MEMBERS.

Persons disqualified as Food Stamp household members must not participate in the Food Stamp program. Disqualified household members ~~are not counted in the household size. Disqualified household members' income and resources are counted. Disqualified household members are listed below:~~ include, but are not limited to, sanctioned individuals, fleeing felons, and ineligible non-citizens. Treatment of disqualified household members is described under 7 CFR 273.11(c). ~~(3-17-22)~~(   )

~~**01. Ineligible Legal Non-Citizen**. Ineligible legal non-citizens not meeting citizenship or eligible legal non-citizen requirements. (3-17-22)~~

~~**02. Persons with Citizenship Questionable**. Persons refusing to sign a declaration attesting to citizenship or legal non-citizen status. (3-17-22)~~

~~**03. Person Refusing SSN**. Persons disqualified for failure or refusal to provide a Social Security Number. (3-17-22)~~

~~**04. JSAP or Work Registration Noncompliance**. Persons disqualified for failure to comply with JSAP or work registration requirements. (3-17-22)~~

~~**05. Persons With IPV**. Persons disqualified for an Intentional Program Violation (IPV). (3-17-22)~~

~~**06. Voluntary Quit or Reduction of Hours of Work**. Persons disqualified for a voluntary quit or reduction in hours of work. (3-17-22)~~

~~**07. ABAWD Not Meeting Work Requirement**. Persons who have received three (3) months of Food Stamp benefits in a three (3) year period without meeting the ABAWD work requirement. (3-17-22)~~

~~**08. Fugitive Felon**. Individuals who are fleeing to avoid prosecution or custody for a crime, or an attempt to commit a crime, that would be classified as a felony (or in the State of New Jersey, a high misdemeanor) or who are violating a condition of probation or parole under a federal or state law. (3-17-22)~~

~~**09. Drug Convicted Felon**. Individuals convicted under federal or state law of any offense classified as a felony involving the possession, use or distribution of a controlled substance when they do not comply with the terms of a withheld judgment, probation or parole. The felony must have occurred after August 22, 1996. (3-17-22)~~

~~**10. Failure to Cooperate in Paternity Establishment or Obtaining Support**. Persons disqualified for failure to cooperate in establishing paternity and obtaining support for a child under eighteen (18). (3-17-22)~~

219. CIRCUMSTANCES UNDER WHICH FOOD STAMP PARTICIPATION IS PROHIBITED.

01. Prohibition from Receiving Food Stamp Benefits. An individual is prohibited from receiving

Food Stamp benefits at the time of application if theyy: ~~(3-17-22)~~( )

a. Receive~~s~~ tribal commodities; ~~(3-17-22)~~( )

b. ~~Is~~Are incarcerated; ~~(3-17-22)~~( )

c. ~~Is~~Are in an institution; ~~(3-17-22)~~( )

d. ~~Is~~Are in foster care and the foster parents are receiving a cash benefit for providing care and maintenance for the child; ~~(3-17-22)~~( )

e. Receive~~s~~ Food Stamp benefits in another household; ~~(3-17-22)~~( )

f. ~~Is~~Are deceased; or ( )

g. Receive~~s~~ cash benefits in a TAFI Caretaker Relative household. ~~(3-17-22)~~( )

02. Prohibited Participation During the Certification Period. If the Department learns of prohibited participation during the certification period, it will act to end benefits for that individual. ( )

220. -- 225. (RESERVED)

226. JOB SEARCH ASSISTANCE PROGRAM (JSAP).
~~The JSAP program is designed to help Food Stamp recipients become self-sufficient.~~ ~~(3-17-22)~~

01. JSAP Status. All household members, unless exempt, must participate in JSAP~~. Household~~, including members who are on strike~~ must participate in JSAP.~~ and ~~M~~members who are not migrants in the job stream~~ must participate in JSAP~~. The Department ~~D~~determines the JSAP status of a participant at certification, a six-month or twelve-month contact, recertification, and when household changes occur. ~~(3-17-22)~~( )

02. JSAP Information. The Department will explain the JSAP requirement, rights, responsibilities, and the result of failure to comply. ( )

227. EXEMPTIONS FROM JSAP.
~~Exemptions from JSAP are listed in Subsections 227.01 through 227.13 of these rules.~~ ~~(3-17-22)~~

01. Parents or Caretakers Responsible for the Care of a Child Under Six Years~~ of Age~~ Old.~~ A parent or caretaker responsible for the care of a dependent child under age six (6) is exempt from JSAP.~~ If the child becomes six (6) during the certification period, the parent or caretaker must register for JSAP at the next scheduled six-month or twelve-month contact or recertification, unless exempt for another reason. ~~(3-17-22)~~( )

02. Parents and Caretakers of an Incapacitated Person. A parent or caretaker responsible for the care of a person incapacitated due to illness or disability is exempt from JSAP. ( )

03. Persons Who Are Incapacitated. A person~~ who is~~ physically or intellectually unfit for employment is exempt from JSAP.~~ If a disability is claimed which is not evident, proof to support the disability can be required. Acceptable proof includes receipt of permanent or temporary disability benefits, or a statement from a physician or licensed or certified psychologist.~~ ~~(3-17-22)~~( )

04. Students Enrolled Half-Time. A student~~ who is~~ eighteen (18) years or older is exempt from JSAP if they: ~~(3-17-22)~~( )

a. ~~He is~~Are enrolled at least half-time in any institution of higher learning and if they meet~~s~~ the definition of an eligible student in Section 282 of these rules; or ~~(3-17-22)~~( )

b. ~~He is~~Are enrolled at least half-time in any other recognized school or training program. ~~(3-17-22)~~( )

c. ~~He r~~Remain~~s~~ enrolled during normal periods of class attendance, vacation, and recess. If they graduate~~s~~, enroll~~s~~ less than half-time, ~~is~~ are suspended or expelled, drop~~s~~ out, or do~~es~~ not intend to register for the next normal school term (excluding summer), they must register for work at the next scheduled six-month or twelve-month contact or recertification. ~~(3-17-22)~~(   )

05. SSI Applicants. ~~A person who is applying for SSI is~~ Are exempt from JSAP until SSI eligibility is determined. ~~(3-17-22)~~(   )

06. Persons Who Are Employed or Self-Employed. ~~A person who is employed is~~ Are exempt from JSAP if they are: ~~(3-17-22)~~(   )

a. ~~He is w~~Working at least thirty (30) hours per week; ~~or~~ ~~(3-17-22)~~(   )

b. ~~He is r~~Receiving earnings equal to the ~~F~~federal minimum wage multiplied by thirty (30) hours; or ~~(3-17-22)~~(   )

c. ~~He is a~~A migrant or seasonal farm worker under contract or agreement to begin employment within thirty (30) days. ~~(3-17-22)~~(   )

~~**07. Persons Who Are Self-Employed**. A person who is self-employed is exempt from JSAP when the person is working a minimum of thirty (30) hours per week and is receiving earnings equal to or greater than the Federal minimum wage multiplied by thirty (30) hours. (3-17-22)~~

0~~8~~7. Persons in Treatment for a Substance Use Disorder. A regular participant in a ~~drug or alcohol~~ substance use disorder treatment and rehabilitation program is exempt from JSAP. ~~(3-17-22)~~(   )

0~~9~~8. Unemployment Insurance (UI) Applicant/Recipient. A person receiving UI is exempt from JSAP. A person applying for, but not receiving UI, is exempt from JSAP if they ~~is~~ are required to register for work with the Department of Commerce and Labor as part of the UI application process. ~~(3-17-22)~~(   )

~~1~~09. Children Under Age Sixteen. ~~A child under age sixteen (16) is~~ Are exempt from JSAP. A child who turns sixteen (16) within a certification period must register for JSAP at the six-month or twelve-month contact or recertification, unless exempt for another reason. ~~(3-17-22)~~(   )

1~~1~~0. Persons Age Sixteen or Seventeen. ~~A household member age sixteen (16) or seventeen (17) is~~ Are exempt from JSAP if they ~~is~~ are attending school at least half-time, or ~~is~~ are enrolled in an employment and training program, including GED, at least half-time. ~~(3-17-22)~~(   )

1~~2~~1. Participants Age Sixty or Older. ~~A participant age sixty (60) or older is~~ Are exempt from JSAP. ~~(3-17-22)~~(   )

1~~3~~2. Pregnant Women. ~~A pregnant woman i~~In their third trimester ~~is~~ are exempt from JSAP. ~~(3-17-22)~~(   )

228. DEFERRALS FROM JSAP FOR HOUSEHOLD MEMBERS PARTICIPATING IN TAFI.
Deferrals from JSAP for household members participating in the TAFI program are listed ~~in Subsections 228.01 through 228.03~~ below. ~~(3-17-22)~~(   )

01. Reasonable Distance. Appropriate child care is not available within a reasonable distance from the participant's home or work site. (   )

02. Relative Child Care. Informal child care by relatives or others is not available or is unsuitable. (   )

03. Child Care Not Available. Appropriate and affordable child care is not available. (   )

229. PARTICIPANTS LOSING JSAP EXEMPT STATUS.
If an exempt household member becomes mandatory, the Department must notify the participant of JSAP requirements.~~ Mandatory JSAP participants must sign a JSAP agreement.~~ ~~(3-17-22)~~( )

230. -- 235. (RESERVED)

236. GOOD CAUSE.
A mandatory participant may get a deferral from JSAP requirements, if the Department determines a valid reason exists. ( )

237. SANCTIONS FOR FAILURE TO COMPLY WITH JSAP WORK PROGRAM REQUIREMENTS.
When a JSAP participant fails or refuses to comply with work program requirements without good cause, sanctions listed~~ in Subsections 237.01 and 237.02 of these rules~~ below must be applied. In determining which sanction to impose, sanctions previously imposed for voluntary quit or reduction in work hours~~ as described in~~ under Section 271 of these rules must be considered. ~~(3-17-22)~~( )

01. Noncomplying Household Member. The participant who commits the work program violation is excluded as a household member when determining the Food Stamp allotment. The person cannot receive Food Stamps, but~~ his~~ their income and resources are counted in the Food Stamp computation for the household. The person must serve a minimum sanction period plus take corrective action to become eligible for Food Stamps again. If the sanctioned household member becomes exempt from JSAP requirements, the Department will end the sanction. ~~(3-17-22)~~( )

a. First work program violation. A minimum sanction period of one (1) month is imposed. ( )

b. Second work program violation. A minimum sanction period of three (3) months is imposed. ( )

c. Third and subsequent work program violations. A minimum sanction period of six (6) months is imposed. ( )

02. Joins Another Household. If a sanctioned household member leaves the original household and joins another Food Stamp household, treat the sanctioned member as an excluded household member. The person cannot receive Food Stamps, but~~ his~~ their income and resources are counted in the Food Stamp computation for the household. The person is excluded for the rest of the sanction period and until corrective actions are taken. ~~(3-17-22)~~( )

03. Closure Reason. The household must be informed of the reason for the closure. ( )

04. Sanction Notice. The household must be informed of the proposed sanction period. ( )

05. Sanction Start. The household must be informed the sanction will begin the first month after timely notice. ( )

06. Actions to End Sanction. The household must be informed of the actions the household can take to end the sanction. ( )

07. Fair Hearing. The household must be informed of the right to a fair hearing. ( )

238. NOTICE OF SANCTIONS FOR FAILURE TO COMPLY WITH JSAP.
~~Send the household a~~A Notice of Decision is sent when a participant fails to comply with JSAP requirements. The Notice of Decision must contain data listed~~ in Subsections 238.01 through 238.04~~ below. If~~ Notice of Decision is sent, and the Department proves~~ the member complied~~s~~~~ by~~ before the effective date of the action, the~~ action to end Food Stamps~~ sanction does not take effect. The Notice of Decision must: ~~(3-17-22)~~( )

01. Include the Proposed Sanction Period.~~ The Notice of Decision must include the proposed sanction period.~~ ~~(3-17-22)~~( )

02. **Include the Reason for Sanction**. ~~The Notice of Decision must include the reason for sanction.~~ ~~(3-17-22)~~(____)

03. **Include the Actions the Sanctioned Person Takes to End Sanction**. ~~The Notice of Decision must include the actions the sanctioned person must take to end the sanction.~~ ~~(3-17-22)~~(____)

04. **Tell the Household of its Right to ~~Appeal~~ Fair Hearing**. ~~The Notice of Decision must tell the household of it's right to a fair hearing.~~ ~~(3-17-22)~~(____)

239. RIGHT TO APPEAL SANCTION.
The participant has the right to appeal the decision to sanction. The participant may contest a decision of mandatory status or a denial, reduction, or termination of benefits, due to failure to comply with JSAP. Appeals are conducted under ~~Idaho Department of Health and Welfare Rules,~~ IDAPA 16.05.03, Section 350, "Contested Case Proceedings and Declaratory Rulings." The Department will notify JSAP of the fair hearing. ~~(3-17-22)~~(____)

240. JSAP SANCTION BEGINS.
The sanction period begins the first month after the Notice of Decision unless a fair hearing is requested. (   )

241. ENDING SANCTIONS FOR FAILURE TO COMPLY WITH JSAP.
Household members sanctioned for not complying with JSAP are ineligible until a condition listed below is met. (   )

01. **Fair Hearing Reversal**. Sanction ends if a fair hearing reverses the sanction. (   )

02. **Sanctioned Member Becomes Exempt**. Sanction ends if the sanctioned member becomes exempt from JSAP. (   )

03. **Member Complies With JSAP**. Sanction ends if the member, who refused to comply with a JSAP requirement, complies. The member must complete corrective action and serve the minimum sanction period. (   )

242. CORRECTIVE ACTION FOR WORK PROGRAMS.
A mandatory participant can requalify for Food Stamps after a sanction by becoming exempt from work requirements, or serving the sanction period and correcting noncompliance with JSAP. ~~The participant must contact the Department and request an opportunity to comply. The participant must show that failure to comply has ended. Before certifying failure to comply has ended, the Department may require the participant to attend an assigned activity for up to two (2) weeks, to show willingness to comply with work program requirements.~~ ~~(3-17-22)~~(____)

243. -- 250. (RESERVED)

251. ABLE-BODIED ADULTS WITHOUT DEPENDENTS (ABAWD) WORK REQUIREMENT.
To participate in the Food Stamp program, a person must meet one (1) of the ~~conditions in Subsections 251.01 through 251.05 of this rule~~ following. A person who does not meet one (1) of these conditions may not participate in the Food Stamp program as a member of any household for more than three (3) full months (consecutive or otherwise) in a fixed thirty-six (36) month period. ~~(3-17-22)~~(____)

01. **Work at Least Eighty Hours per Month**. The person must work at least eighty (80) hours per month. The definition of work ~~under Section 251 of this rule~~ is any combination of: ~~(3-17-22)~~(____)

a. Work in exchange for money. (   )

b. Work in exchange for goods or services, known as "in-kind" work. (   )

c. Unpaid work, with a public or private non-profit agency. (   )

02. **Participate in JSAP or Another Work Program**. The person must participate in and comply with

the requirements of the JSAP program (other than job search or job readiness activities), the WIOA program, a program under Section 236 of the Trade Act of 1974, or another work program recognized by the Department. The person must participate for at least eighty (80) hours per month. ( )

03. Combination of Work and Work Programs. The person must work and participate in a work program. Participation in work and work programs must total at least eighty (80) hours per month. ( )

04. Participate in Work Opportunities. The person must participate in and comply with the requirements of a Work Opportunities program. ( )

05. Residents of High Unemployment Areas. ABAWDs residing in a county identified by the Department as having high unemployment or lack of jobs are may not be subject to the three (3) month limitation of benefits. ABAWDs residing in these counties are subject to JSAP work requirement but will not lose Food Stamp eligibility after three (3) months if they participate fewer than eighty (80) hours per month. An ABAWD residing in a high unemployment area must participate according to his plan. (3-17-22)( )

252. PROOF REQUIRED FOR ABAWDS.

The Department requires proof of compliance with the ABAWD requirements. If there is evidence the ABAWD got Food Stamps in another state, the Department will get proof of the number of countable months from that state, before certification. A written or verbal statement from the other state agency of countable months is acceptable proof. (3-17-22)( )

01. Proof of Hours Worked. Each month the ABAWD must supply proof of work hours, participation in work programs, or participation in work opportunities. (3-17-22)

02. Food Stamp Months in Another State. If there is evidence the ABAWD got Food Stamps in another state, get proof of the number of countable months from that state, before certification. A written or verbal statement from the other state agency of countable months is acceptable proof. (3-17-22)

253. ABAWD GOOD CAUSE.

The work requirement is met if an ABAWD would have worked at least eighty (80) hours per month but missed work for good cause. The absence from work must be temporary. The ABAWD must keep the job. Circumstances beyond control of the ABAWD are the basis of good cause. These include illness, illness of a household member requiring the presence of the ABAWD, household emergency, and lack of transportation. ( )

254. REPORTING ABAWD CHANGES.

ABAWDs must report within the first ten (10) days of the month following the date of change if total work or work program hours drop below eighty (80) hours per month. (3-17-22)( )

255. REGAINING ELIGIBILITY.

ABAWDs whose three (3) month eligibility expires may regain eligibility for Food Stamps. During any thirty (30) consecutive days, the person must meet one (1) of the work requirements in Subsections 255.01 and 255.02 below. The Department will Pprorate Food Stamp benefits from the date the person regains eligibility. ABAWDs must continue to meet the work requirement to get Food Stamps, or meet conditions for the three (3) additional months. There is no limit on the number of times an ABAWD may regain and maintain eligibility by meeting the work requirement. (3-17-22)( )

01. Work Eighty Hours. The person must work eighty (80) or more hours per month. ( )

02. Participate in JSAP. The person must participate in and comply with the requirements of the JSAP program (other than job search or job search training), the WIOA program, or a program under Section 236 of the Trade Act of 1974 for eighty (80) or more hours per month. ( )

256. THREE ADDITIONAL MONTHS OF FOOD STAMPS AFTER REGAINING ELIGIBILITY.

A person who regained eligibility under Section 255 of these rules, but is no longer fulfilling the ABAWD work requirements in Section 251 of these rules through no fault of his their own, may get Food Stamps for an additional three (3) consecutive months. For an applicant, the three (3) consecutive months begin the first full month of benefits.

For a participant, the three (3) consecutive months begin the month following the month the participant no longer meets the work requirements. A person is eligible for the additional three (3) consecutive months only once in a thirty-six (36) month period. ~~(3-17-22)~~(____)

257. PERSONS NOT CONSIDERED ABAWD.

Persons meeting any of the following ~~condition in Subsections 257.01 through 257.04 of this rule~~ are not considered ABAWD. ~~(3-17-22)~~(____)

01. Age. Persons under eighteen (18) and ~~fifty (50)~~ fifty-three (53) years ~~of age~~ old or older. Beginning October 1, 2024, the age limit increases to fifty-five (55). ~~(3-17-22)~~(____)

02. Disability. Persons medically certified as physically or intellectually unfit for employment. ~~Proof of the disability is required.~~ A person is medically certified as physically or intellectually unfit for employment if: ~~(3-17-22)~~(____)

a. Receiving temporary or permanent disability benefits issued by a government or private source. (   )

b. Obviously intellectually or physically unfit for employment, as determined by the Department. (   )

c. The person has a statement from a physician, physician's assistant, nurse, nurse practitioner, designated representative of the physician's office, licensed or certified psychologist, a social worker, or any other medical personnel the Department determines appropriate, verifying physical or intellectual unfitness for employment. (   )

03. All Persons Residing in a Household Where a Household Member Is Under Age Eighteen. ~~All persons residing in a household where a household member is under eighteen (18) years old.~~ ~~(3-17-22)~~(____)

04. Pregnan~~cy~~t Persons. ~~Pregnant persons.~~ ~~(3-17-22)~~(____)

05. A homeless individual, as defined under 7 CFR 271.2. (____)

06. A veteran who served in the US Armed Forces and was discharged or released from service, regardless of the reason for discharge or release. (____)

07. An individual who was eighteen (18) years old or older (at a state agency's option), who at the time aged out of foster care program and who is under twenty-five (25) years old. (____)

258. FOOD STAMPS ISSUED TO INELIGIBLE ABAWD.

~~If an ineligible ABAWD gets a Food Stamp issuance, the issuance is an overissuance until the ABAWD pays it back in full. The overpaid months count against the ABAWD~~If benefits are paid to an ABAWD in error, the months count against the three- (3) month time limit until repaid. ~~(3-17-22)~~(____)

259. STRIKES.

Households must be denied Food Stamps if a member is unemployed because of a strike, unless the household was eligible for or getting Food Stamps the day before the strike. (   )

260. GOVERNMENT EMPLOYEES DISMISSED FOR STRIKE.

State, federal, and local government employees dismissed because of joining in a strike against the governmental entity have voluntarily quit a job without good cause. (   )

261. VOLUNTARY JOB QUIT.

An employed household member who voluntarily quits a job without good cause is not eligible for Food Stamps. The Department is required to make a voluntary job quit determination when it learns that any employed household member has quit ~~his~~ their job and any of the following circumstances apply ~~that are listed in Subsections 261.01 through 261.02 of this rule~~. ~~(3-17-22)~~(____)

01. Voluntary Job Quit Timeframes. The Department must make a voluntary job quit determination: ( )

a. For any applicant who quits ~~his~~ their job within sixty (60) days of the application date. ~~(3-17-22)~~( )

b. For any new household member who quits ~~his~~ their job within the sixty (60) days prior to entering the household. ~~(3-17-22)~~( )

c. For any recipient who quits ~~his~~ their job at any time during the certification period. ~~(3-17-22)~~( )

02. Job Definition for Voluntary Job Quit. The Department must make a voluntary job quit determination for any household member who is not exempt from work registration for any reason other than employment if: ( )

a. ~~He~~They quit a job of at least thirty (30) hours a week; or ~~(3-17-22)~~( )

b. ~~His~~Their weekly earnings from the job they quit are equivalent to the ~~F~~federal minimum wage multiplied by thirty (30) hours. ~~(3-17-22)~~( )

262. VOLUNTARY REDUCTION IN WORK HOURS.
An employed household member who voluntarily reduces hours of work without good cause is not eligible for Food Stamps. The Department is required to make a reduction in work hours determination when it learns that any employed household member has voluntarily reduced ~~his~~ their work hours and any of the following circumstances apply ~~that are listed in Subsections 262.01 through 262.02 of this rule~~. ~~(3-17-22)~~( )

01. Voluntary Work Reduction Timeframe. The Department must make a reduction in work hours determination if the hours of work were voluntarily reduced by a(n): ~~(3-17-22)~~( )

a. ~~By an a~~Applicant, within sixty (60) days of the application date. ~~(3-17-22)~~( )

b. ~~By a n~~New household member, within the sixty (60) days prior to entering the household. ~~(3-17-22)~~( )

c. ~~By a r~~Recipient, at any time during the certification period. ~~(3-17-22)~~( )

02. What Counts as a Significant Voluntary Work Reduction. ~~In order f~~For any household member's eligibility for Food Stamps to be affected, the Department must determine that: ~~(3-17-22)~~( )

a. Prior to the voluntary reduction in hours, the job was at least thirty (30) hours a week; and ( )

b. The hours of work have been voluntarily reduced to less than thirty (30) hours per week without good cause. ( )

263. -- 264. (RESERVED)

265. SITUATIONS NOT CONSIDERED VOLUNTARY JOB QUIT OR REDUCTION OF WORK.
Situations not counted as a voluntary job quit or reduction of work hours are listed below: ( )

01. The Person End~~ing~~s Self-Employment. ~~The person ends self-employment enterprise.~~ ~~(3-17-22)~~( )

02. Employer Demands Resignation and Person Resigns. ~~A person resigns from a job at the demand of the employer.~~ ~~(3-17-22)~~( )

03. Laid Off From New Job. A person quits a job, secures new employment at comparable salary or hours, and then is laid off or loses the new job through no fault of their own. ~~A person quits a job, secures new employment at comparable salary or hours and through no fault of his own loses the new job.~~ ~~(3-17-22)~~( )

266. HOUSEHOLD MEMBER LEAVES DURING A PENALTY PERIOD.
When the household member who committed a voluntary quit or reduction in hours penalty leaves the household, the penalty follows the household member who caused it. If the household member who committed the penalty joins another household, ~~he is~~ they are ineligible for the balance of the penalty period unless they meet~~s~~ the conditions stated in Subsection 275.01 of these rules. ~~(3-17-22)~~( )

267. GOOD CAUSE FOR VOLUNTARILY QUITTING A JOB OR REDUCING WORK HOURS.
If a household member voluntarily quits a job, the Department will determine if the quit was for good cause. All facts and circumstances submitted by the household and the employer must be considered. Good cause ~~includes the~~ reasons are listed ~~below:~~ in 7 CFR 273.7(i)(3). ~~(3-17-22)~~( )

~~**01. Personal Difficulties**. Personal difficulties include: (3-17-22)~~

~~a. Health problems; (3-17-22)~~

~~b. Structured drug and alcohol treatment; (3-17-22)~~

~~c. Jailed or necessary court appearances; and (3-17-22)~~

~~d. Conflicts with verified and practiced religious and ethical beliefs. (3-17-22)~~

~~**02. Family Emergencies**. Family emergencies include: (3-17-22)~~

~~a. Crisis in family health; and (3-17-22)~~

~~b. Child legal or behavioral problems. (3-17-22)~~

~~**03. Environmental Barriers**. Environmental barriers include: (3-17-22)~~

~~a. Weather conditions preventing the person from reaching the work site; (3-17-22)~~

~~b. Unexpected loss of transportation; and (3-17-22)~~

~~c. Housing or utility problems requiring immediate attention. (3-17-22)~~

~~**04. Work Site Problems**. Work site problems include: (3-17-22)~~

~~a. Temporary layoff from a regular, full-time job. The person must be able to return to the job within ninety (90) days; (3-17-22)~~

~~b. Work site conditions not meeting legal or local standards of health and safety, hours, pay, or benefits; and (3-17-22)~~

~~c. Alleged discrimination on the job site. (3-17-22)~~

~~**05. Employment or School**. The household member accepts employment, or enrolls at least half (1/2) time in any recognized school, training program, or an institution of higher education. (3-17-22)~~

~~**06. Employment or School in Another Area**. Another household member accepts employment in another area, requiring the household to move. Another household member enrolls at least half (1/2) time in a recognized school, a training program, or an institution of higher education in another area, requiring the household to move. (3-17-22)~~

~~**07.** **Retirement**. Persons under age sixty (60) resign, if the resignation is recognized as retirement. (3-17-22)~~

~~**08.** **Full Time Job Does Not Develop**. A person accepts a bona fide offer of a full time job. The job does not develop. The job results in employment of less than thirty (30) hours a week, or weekly earnings of less than the Federal minimum wage multiplied by thirty (30) hours. (3-17-22)~~

~~**09.** **Temporary Pattern of Employment**. Person leaves a job where workers move from one (1) employer to another, such as migrant farm labor or construction work. Households may apply for benefits between jobs, when work is not yet available at the new site. Even though the new employment has not actually begun, the previous quit is with good cause if it is the pattern of that type of employment. (3-17-22)~~

268. PROOF OF JOB QUIT OR REDUCTION OF WORK HOURS.

~~Request proof~~Verification from the household is required if the household's job quit or reduction of work hours is questionable.~~ The household is responsible for providing proof. If the household cannot get timely proof, offer assistance. Proof includes, but is not limited to, contacts with the previous employer or union organizations. If the employer cannot be contacted or the employer will not provide the information try to get the proof from a third party. In some cases, the household and the Department cannot prove the circumstances of the quit. This may occur because the employer cannot be located or refused to cooperate. This may include quits due to employer discrimination or unreasonable employer demands. In cases where~~ When proof of the voluntary quit cannot be obtained, the household must not be denied Food Stamps~~ on the basis of a voluntary quit or reduction of work hours~~. If a household member refuses, without good cause, to provide enough information to determine voluntary quit or work reduction, a penalty must be imposed.~~ Impose the appropriate quit or reduction penalty.~~ ~~(3-17-22)~~(   )

269. (RESERVED)

270. PENALTY FOR APPLICANT QUITTING A JOB OR REDUCING WORK HOURS.

If the Department determines a voluntary quit or reduction of work hours was not for good cause, the member who quit is not eligible for a ninety (90) day penalty period. The penalty period begins the date the household member quit. The applicant household must be told the job quit and work reduction penalty information listed below: (   )

01. **Denial Reason**. The household must be informed of the reason for the Food Stamp denial for the member. (   )

02. **Sanction Period**. The household must be informed of the proposed voluntary quit or work reduction sanction period. (   )

03. **Fair Hearing**. The household must be informed of the right to a fair hearing. (   )

04. **Right to Reapply**. The household must be informed of the right to reapply after the ninety (90) day penalty period. (   )

271. PENALTY FOR RECIPIENT QUITTING A JOB OR REDUCING WORK HOURS.

If the Department determines a member of the household voluntarily quit a job or reduced work hours, the penalty listed in Subsection 271.01 of this rule must be imposed. Food Stamps must be reduced, beginning the first month after timely notice. The household must be told the information listed in~~ Subsections 271.02 through 271.06~~ this rule within ten (10) calendar days of the voluntary quit or reduction in work ruling. When determining the sanction to impose, previous sanctions for noncompliance with JSAP and work registration requirements as described in Section 237 of these rules must be considered. Previous sanctions for recipient voluntary quit or work reduction must also be considered. If the sanctioned household member becomes exempt from JSAP requirements, the Department will end the sanction. The voluntary quit sanction does not end if the sanctioned household member becomes exempt due to application or receipt of Unemployment Insurance. ~~(3-17-22)~~(   )

01. **Non-Complying Household Member**. The participant who commits the work program violation is excluded as a household member when determining the Food Stamp allotment. The person cannot receive Food

Stamps, but ~~his~~ their income and resources are counted in the Food Stamp computation for the household. The person must serve a minimum sanction period plus take corrective action to become eligible for Food Stamps again. Corrective action includes: returning to work, increasing work hours to meet the work exemption, or completing required activities with ~~EWS~~ JSAP. ~~(3-17-22)~~( )

a. First work program violation. A minimum sanction period of one (1) month is imposed. ( )

b. Second work program violation. A minimum sanction period of three (3) months is imposed. ( )

c. Third and subsequent work program violation. A minimum sanction period of six (6) months is imposed. ( )

02. Joins Another Household. If a sanctioned household member leaves the original household and joins another Food Stamp household, the Department will treat the sanctioned member as an excluded household member. The person cannot receive Food Stamps, but ~~his~~ their income and resources are counted in the Food Stamp computation for the other household. The person is excluded for the rest of the sanction and until corrective actions are taken. ~~(3-17-22)~~( )

03. Closure Reason. The household must be informed of the reason for the closure. ( )

04. Sanction Notice. The household must be informed of the proposed sanction period. ( )

05. Sanction Start. The household must be informed the sanction will begin the first month after timely notice. ( )

06. Actions to End Sanction. The household must be informed of the actions the household can take to end the sanction. ( )

07. Fair Hearing. The household must be informed of the right to a fair hearing. ( )

272. ~~VOLUNTARY QUIT OR REDUCTION OF WORK HOURS DURING THE LAST MONTH OF THE CERTIFICATION PERIOD~~PARTICIPANT VOLUNTARY QUIT OR REDUCTION OF WORK HOURS.

~~If the Department determines a member of the household voluntarily quit a job or reduced work hours, without good cause, in the last month of the six-month or twelve-month contact or certification period the voluntary quit or work reduction penalty is imposed.~~If it is discovered a household member voluntarily quit a job or reduced work hours without good cause during the certification period the Department must provide the individual with a notice of adverse action within ten (10) days after the determination of a quit or reduction in work effort. The individual will be disqualified according to the minimum mandatory sanction schedule under Subsection 271.01 of these rules. ~~(3-17-22)~~( )

~~**01. No Reapplication**. If the household does not apply for recertification in the last month of the six-month or twelve-month contact or certification, the appropriate penalty is imposed. Begin the penalty the first month after the last month of the certification. The penalty is in effect should the household apply during the penalty period. (3-17-22)~~

~~**02. Reapplication**. If the household does apply for recertification in the last month of the six-month or twelve-month contact or certification period, the person quitting work or reducing hours is ineligible. The penalty is imposed, beginning the first month after the last month of the six-month or twelve-month contact or certification period. (3-17-22)~~

~~**273. VOLUNTARY QUIT OR REDUCTION OF WORK HOURS NOT FOUND UNTIL THE LAST MONTH OF THE CERTIFICATION PERIOD.**~~

~~The Department may find a household member voluntarily quit a job or reduced work hours, without good cause, before the last month of the certification period. If the voluntary quit or reduction is not found until the last month of the certification, the voluntary quit or reduction penalty must be determined. (3-17-22)~~

273 – 274. (RESERVED)

275. ENDING VOLUNTARY QUIT WORK PROGRAM PENALTIES.
Eligibility may be reestablished before the end of the penalty period for an otherwise eligible household member when they meet~~s~~ the conditions in Subsection 275.01 of this rule. Eligibility may be reestablished after a voluntary quit or work reduction penalty period has elapsed for an otherwise eligible household member when they meet~~s~~ a condition in Subsection 275.02 of this rule. ~~(3-17-22)~~( )

01. Ending Voluntary Quit or Reduction Penalty Before the End of the Penalty Period. If the sanctioned household member becomes exempt from JSAP requirements, ~~his~~ their eligibility for Food Stamps may be reestablished. The voluntary quit penalty does not end if the sanctioned household member becomes exempt due to application or receipt of Unemployment Insurance. ~~(3-17-22)~~( )

02. Ending Voluntary Quit or Reduction Penalty After Penalty Period. ( )

a. If the sanctioned household member gets a new job comparable in salary or hours to the job they quit, ~~his~~ their eligibility for Food Stamps may be reestablished. A comparable job may entail fewer hours or a lower net salary than the job which was quit. To be comparable, the hours for the new job cannot be less than thirty (30) hours per week and the salary or earnings for the new job cannot be less than ~~F~~federal minimum wage multiplied by thirty (30) hours per week. ~~(3-17-22)~~( )

b. If the sanctioned household member's hours of work are restored to more than thirty (30) hours per week before reduction, ~~his~~ their eligibility for Food Stamps may be reestablished. ~~(3-17-22)~~( )

c. A sanctioned household member can requalify for Food Stamps after serving the minimum sanction period and completing corrective action. The participant must contact the Department and request an opportunity to correct the sanction. ~~The Department may require the participant to attend an assigned EWS activity for up to two (2) weeks to show his willingness to comply with work program requirements.~~ ~~(3-17-22)~~( )

276. FAILURE TO COMPLY WITH A REQUIREMENT OF ANOTHER MEANS - TESTED PROGRAM.
Food Stamps must not increase when a failure to comply causes other means-tested benefits to decrease. Benefits from means-tested programs like TAFI may decrease due to failure to comply with a program requirement. Food Stamp benefits must not increase because of this income loss. If a reduction in benefits from another means-tested program occurs, the Department will verify the reason for the reduction. If the reason for the reduction cannot be verified, the Department will document the case record to reflect the good faith effort to verify the information. ~~(3-17-22)~~( )

277. PENALTY FOR FAILURE TO COMPLY WITH A REQUIREMENT OF ANOTHER MEANS - TESTED PROGRAM.
To prevent an increase in Food Stamp benefits, penalties will be applied to a Food Stamp case for failure to comply with a requirement of another means-tested program such as TAFI. When a Food Stamp recipient fails to comply with a requirement of the TAFI program, the Department will count that portion of the benefit decrease attributed to the TAFI penalty. Conditions for ending the penalty are listed ~~in Subsections 277.01 through 277.03 of this rule~~ below. ~~(3-17-22)~~( )

01. Time-Limited TAFI Penalty. If the TAFI penalty is time-limited, the Department will end the Food Stamp penalty when the TAFI penalty is ended. ~~(3-17-22)~~( )

02. Lifetime TAFI Penalty. If the TAFI penalty is a lifetime penalty, apply the Food Stamp penalty for a length of time to match the remaining months of TAFI eligibility for the household. The Department will ~~E~~end the Food Stamp penalty if the household subsequently reapplies for TAFI and is denied for a reason other than the noncompliance that caused the TAFI penalty. ~~(3-17-22)~~( )

03. Member Who Caused the TAFI Penalty Leaves the Household. The Department will ~~E~~end the Food Stamp penalty when the member who caused the TAFI penalty leaves the household. ~~(3-17-22)~~( )

278. COOPERATION IN ESTABLISHMENT OF PATERNITY AND OBTAINING SUPPORT.
A natural or adoptive parent or other individual living with and exercising parental control over a minor child who has an absent parent must cooperate in establishing paternity for the child and obtaining support for the child~~ and themselves~~. ~~(3-17-22)~~( )

279. FAILURE TO COOPERATE.
When a parent or individual fails to cooperate in establishing paternity and obtaining support, they are not eligible to participate in the Food Stamp Program. ( )

280. EXEMPTIONS FROM THE COOPERATION REQUIREMENT.
The parent or individual will not be required to provide information about the absent or alleged parent or otherwise cooperate in establishing paternity or obtaining support if good cause for not cooperating exists. Good cause for failure to cooperate in obtaining support is listed below: ( )

01. Rape or Incest. Proof the child was conceived~~ as a result~~ because of incest or forcible rape. ~~(3-17-22)~~( )

02. Physical or Emotional Harm. Proof the absent parent may inflict physical or emotional harm to the children, the participant, or individual exercising parental control. This must be supported by medical evidence, police reports, or as a last resort, an affidavit from a knowledgeable source. ( )

03. Minimum Information Cannot be Provided. Substantial and credible proof is provided indicating the participant cannot provide the minimum information regarding the non-custodial parent. ( )

281 – 282. (RESERVED)

~~**282. STUDENT DEFINED.**~~
~~A student must be between the ages of eighteen (18) and fifty (50). A student must be physically and intellectually fit. A student must be enrolled, at least half-time, in an institution of higher education. An institution of higher education usually requires a high school or general equivalency diploma for enrollment. This includes colleges, universities, and vocational or technical schools at the post-high school level. (3-17-22)~~

283. STUDENT ENROLLMENT.
A student is considered enrolled in an institution of higher education if participating in a regular curriculum there. Enrollment status of a student begins the first day of the school term for the institution of higher education~~ school term~~. The enrollment continues through normal periods of class attendance, vacation, and recess. Enrollment stops if the student graduates, is suspended or expelled, drops out, or does not intend to register for the next normal school term. Summer school terms are not normal school terms. ~~(3-17-22)~~( )

284. DETERMINING STUDENT ELIGIBILITY.
To be eligible for Food Stamps, a student must meet at least one (1) of the~~ criteria listed below~~ following: ~~(3-17-22)~~( )

01. Employment. The student: ~~(3-17-22)~~( )

a. ~~The student i~~Is employed a minimum of eighty (80) hours per month and is paid for such employment; or ~~(3-17-22)~~( )

b. ~~The student i~~Is self-employed a minimum of eighty (80) hours per month; and ~~(3-17-22)~~( )

c. ~~The student m~~Must earn at least the ~~F~~federal minimum wage times eighty (80) hours. ~~(3-17-22)~~( )

02. Work Study Program. The student is in a ~~S~~state or ~~F~~federally financed work study program during the regular school year. The student exemption begins the month the school term begins, or the month the work study is approved, whichever is later. The exemption continues until the end of the month the school term ends,

or it becomes known the student has refused an assignment. The student work study exemption stops when there are breaks of a full calendar month or longer between terms, without approved work study. The exemption only applies to months the student is approved for work study. ~~(3-17-22)~~( )

03. Caring for Dependent Child. The student is:~~. responsible for the care of a dependent household member under age six (6). There must not be another adult in the household available to care for the child. Availability of adequate child care is not a factor. The student is responsible for the care of a dependent household member at least age six (6) but under age twelve (12). The Department must determine adequate child care is not available to enable the student to attend class and satisfy the twenty (20) hour work requirement. The student must be a single parent responsible for the care of a dependent child under the age of twelve (12). The student is enrolled full-time in an institution of higher education. Full-time enrollment is determined by the institution. Availability of adequate child care is not a factor.~~ ~~(3-17-22)~~( )

a. Responsible for the care of a dependent household member under the age of six (6). ( )

b. Responsible for the care of a dependent household member who has reached the age of six (6), but is under age twelve (12) when the state agency has determined that adequate child care is not available to enable the student to attend class and comply with the eighty (80) hour work requirement. ( )

c. A single parent enrolled in an institution of higher education on a full-time basis, as determined by the institution, and be responsible for the care of a dependent child under age twelve (12). ( )

04. TAFI Participant. The student gets cash benefits from the TAFI program. ( )

05. Training. The student is assigned to or placed in an institution of higher education through, or complying with, the following programs: WIOA~~ program~~, ~~the~~ JOBS~~ program~~, ~~the~~ JSAP~~ program~~, a program under Section 236 of the Trade Act of 1974, or a program for employment and training operated by a ~~S~~state or local government. ~~(3-17-22)~~( )

285. INELIGIBILITY OF FUGITIVE FELONS AND PROBATION AND PAROLE VIOLATORS.

~~A person is ineligible to receive Food Stamps for any month during which he meets a condition listed below.~~Individuals who are fleeing to avoid prosecution or custody for a crime, or an attempt to commit a crime, classified as a felony (or in the state of New Jersey, a high misdemeanor), or who are violating a condition of probation or parole under a federal or state law, cannot be considered eligible household members. ~~(3-17-22)~~( )

~~**01. Fleeing to Avoid Prosecution**. The person is fleeing to avoid prosecution for a crime which is a felony (or in New Jersey, a high misdemeanor) under the laws of the state he is fleeing. (3-17-22)~~

~~**02. Fleeing to Avoid Custody or Confinement After Conviction**. The person is fleeing to avoid custody or confinement after conviction for a crime which is a felony (or in New Jersey, a high misdemeanor) under the laws of the state he is fleeing. (3-17-22)~~

~~**03. Violating a Condition of Probation or Parole**. The person is violating a condition or probation or parole imposed under Federal or State law. (3-17-22)~~

286. EFFECTIVE DATE OF INELIGIBILITY.

~~Ineligibility of fugitive felons and probation and parole violators begins the earlier of the month a warrant, court order or decision, or decision by a parole board is issued finding the person is fleeing (or fled) to avoid prosecution, or custody or confinement after conviction or is violating (or violated) parole; or the first month the person fled to avoid prosecution, custody or conviction or violated a condition of probation or parole.~~The effective date of disqualification for Food Stamps is the month following the date the Department has documented evidence the individual is fleeing or violating parole/probation. ~~(3-17-22)~~( )

287. INELIGIBILITY FOR A FELONY CONVICTION FOR POSSESSION, USE, OR DISTRIBUTION OF A CONTROLLED SUBSTANCE.

Individuals convicted under federal or state law~~ of any offense classified as a felony involving the possession, use, or distribution of a controlled substance can receive Food Stamps when they comply with the terms of a withheld~~

~~judgment, probation, or parole. The felony must have occurred after August 22, 1996. Controlled substance felons not complying with the terms of a withheld judgment, probation, or parole are not eligible for Food Stamps. Count the income and resources of the disqualified individual in full~~ of a felony involving the possession, use, or distribution of a controlled substance can receive Food Stamps when they comply with the terms of a withheld judgment, probation, or parole. Controlled substance felons who are not complying with the terms of a withheld judgment, probation, or parole are not eligible for Food Stamps. ~~(3-17-22)~~( )

288. -- 299. (RESERVED)

300. RESOURCES DEFINED.
Resources include, but are not limited to, cash, bank accounts, stocks, bonds, personal property, and real property. A household must have the right, authority, or power to change the resource to cash for the resource to be counted. The household must have the legal right to use the resource for support and maintenance for the resource to be counted. ( )

301. DETERMINING RESOURCES.
The resources of all household members are counted unless the resource is excluded. ( )

302. -- 304. (RESERVED)

305. RESOURCE LIMIT.
The Food Stamp resource limit is five thousand dollars ($5,000) for Broad-Based Categorically Eligible households. Households that do not meet the requirements for Broad-Based Categorical Eligibility are subject to resource limits published by the ~~USDA~~ F~~ood and~~ N~~utrition~~ ~~Service~~. ~~(3-17-22)~~( )

306. -- 307. (RESERVED)

308. EQUITY VALUE OF RESOURCES.
Equity value is the current market value of a resource, minus any encumbrance. The current market value is the price the resource is expected to sell for, on the open market, in the geographic area involved. An encumbrance is a legally binding debt against property. The encumbrance on the property does not prevent the property owner from selling to a third party. ( )

309. LIQUID RESOURCES.
All liquid resources are counted, unless excluded. Liquid resources are listed below~~. Liquid resources~~ and can be easily converted to cash. ~~(3-17-22)~~( )

01. Cash on Hand. ~~Cash on hand.~~ ~~(3-17-22)~~( )

02. All Bank and Credit Union Accounts. ~~Checking, savings and credit union accounts.~~ ~~(3-17-22)~~( )

03. Lump Sum Payments. ~~Lump sum payments s~~Such as insurance, SSI, retirement, and income tax refund. ~~(3-17-22)~~( )

04. Trusts. Unrestricted trust accounts and any available amounts from restricted trust accounts. ( )

05. Stocks, less Fees for Transfer and Penalty for Early Sale. ~~Stocks, less fees for transfer and penalty for early sale.~~ ~~(3-17-22)~~( )

06. Savings Bonds, Treasury Bonds, Commercial Bonds at Current Market Value. ~~Savings bonds, treasury bonds, commercial bonds at current market value.~~ ~~(3-17-22)~~( )

07. Savings Certificates or Certificates of Deposit. ~~Saving certificates or certificates of deposit i~~Issued by banks, credit unions, or other financial concerns, less the penalty for early withdrawal. ~~(3-17-22)~~( )

310. NONLIQUID RESOURCES.
Countable nonliquid resources are~~ listed below. Nonliquid resources are~~ resources not easily converted to cash and are listed below. ~~(3-17-22)~~(   )

01. Real Property. Equity value of real property (land and buildings, including mobile homes) unless specifically excluded. Property may be excluded if the property is: ~~(3-17-22)~~(   )

a. ~~The property is u~~Used as a home. ~~(3-17-22)~~(   )

b. ~~The property is i~~Income-producing, and the income is consistent with the property's fair market value. ~~(3-17-22)~~(   )

c. ~~The property is e~~Essential to employment or self-employment. ~~(3-17-22)~~(   )

d. ~~The property is u~~Used in connection with an excluded vehicle. ~~(3-17-22)~~(   )

02. Vehicles. Licensed and unlicensed automobiles, trucks, vans, motorcycles, self-propelled motor homes, snowmobiles, boats, aircraft, all-terrain vehicles, and mopeds. (   )

03. Personal Property. Personal property not otherwise excluded. Personal property includes trailers pulled by another means or campers placed on the bed of a truck or pickup. (   )

311. FACTORS MAKING PROPERTY A RESOURCE.
Property of any kind, including cash, can be a resource~~. The property~~ and must meet all criteria listed below: ~~(3-17-22)~~(   )

01. Ownership Interest. A~~ client~~ participant must have ownership interest in property for it to be counted as a resource. Property is not a resource if the~~ client~~ participant does not own all or part of the property. ~~(3-17-22)~~(   )

02. Legal Right to Spend or Convert Property. A~~ client~~ participant must have a legal right to spend or convert property to cash.~~ Property is not a resource if the owner lacks the legal right to spend or convert property into cash.~~ Physical possession of property is not needed if the owner has the legal ability to spend or convert the property to cash. ~~(3-17-22)~~(   )

03. Legal Ability to Use for Support and Maintenance. Property is not a resource if it cannot legally be used for the owner's support and maintenance. (   )

312. -- 313. (RESERVED)

314. JOINTLY OWNED RESOURCES.
A resource owned jointly by members of two (2) or more households is counted in its entirety for each household, unless the household proves the resource is not available. If the household shows it has access to only a portion of a resource, that portion of the resource is counted. (   )

315. JOINTLY OWNED RESOURCES EXCLUDED.
A jointly owned resource is excluded, if the household shows it cannot sell or divide the resource without consent of the other owner, and the other owner will not sell or divide the resource. A jointly owned resource is excluded, if owned by a resident in a shelter for battered women and children and access to the resource requires agreement of a joint owner living in the former household. A vehicle, jointly owned by a household member and a person not living in the household, may be excluded. The household member must not have possession of the vehicle. The household member must not be able to sell the vehicle. (   )

316. -- 32~~0~~2. (RESERVED)

~~**321. RESOURCES OF DISQUALIFIED HOUSEHOLD MEMBERS.**~~
~~The household must report the resources of members disqualified for Food Stamps. The household must verify any~~

~~questionable information. The resources of the disqualified person are included in determining the resource limit. Disqualified household members with resources counted toward the household limit are listed below: (3-17-22)~~

~~**01. Member Disqualified for IPV**. Resources of a household member disqualified for an intentional program violation are counted. (3-17-22)~~

~~**02. Member Disqualified for Failure to Comply with Work Requirements**. Resources of a household member disqualified for failing to comply with a work requirement are counted. (3-17-22)~~

~~**03. Member Ineligible Due to SSN**. Resources of a household member ineligible for refusing to get an SSN are counted. (3-17-22)~~

~~**04. Ineligible Legal Non-Citizen**. Resources of an ineligible legal non-citizen household member are counted. (3-17-22)~~

~~**05. Member Disqualified for Failure to Meet the ABAWD Work Requirement**. Resources of a household member disqualified for failure to meet the ABAWD work requirement are counted. (3-17-22)~~

~~**06. Member Disqualified for a Voluntary Quit or Reduction in Hours of Work**. Resources of a member disqualified for a voluntary quit or reduction of work are counted. (3-17-22)~~

~~**07. Member Disqualified as a Fugitive Felon or Probation or Parole Violator**. Resources of a member disqualified as a fugitive felon or probation or parole violator are counted. (3-17-22)~~

~~**08. Member Disqualified for Failure to Cooperate in Establishing Paternity and Obtaining Support**. Resources of a member disqualified for failure to cooperate in establishing paternity and obtaining support are counted. (3-17-22)~~

~~**09. Member Disqualified for Conviction of a Controlled Substance Felony**. Resources of individuals convicted under federal or state law of any offense classified as a felony involving the possession, distribution, or use of a controlled substance when they do not comply with the terms of a withheld judgment, probation, or parole are counted. The felony must have occurred after August 22, 1996. (3-17-22)~~

~~**322. RESOURCES OF NONHOUSEHOLD MEMBERS.**~~
~~Resources of nonhousehold members are not included when determining household resources. Resources of nonhousehold members are listed below: (3-17-22)~~

~~**01. Ineligible Student**. Resources of an ineligible student are not counted. (3-17-22)~~

~~**02. Boarder or Roomer**. Resources of a boarder or roomer are not counted. (3-17-22)~~

~~**03. Foster Child**. Resources of a foster child are not counted, if the child is not a member of the Food Stamp household. (3-17-22)~~

~~**04. Foster Adult**. Resources of a foster adult are not counted, if the adult is not a member of the Food Stamp household. (3-17-22)~~

323. LUMP SUM RESOURCES.
Nonrecurring lump sum payments are considered a resource in the month received, unless excluded under these rules. A household is not required to report changes in resources during a certification period. Some lump sum payments are listed below: ( )

01. Retroactive Payments. ~~Retroactive payments from:~~ ~~(3-17-22)~~( )

a. Social Security. ( )

b. SSI. ( )

c. Public Assistance. ( )

d. Railroad Retirement Benefits. ( )

e. Unemployment Compensation Benefits. ( )

f. Child Support. ( )

02. **Insurance Settlements**.~~Insurance settlements.~~ ~~(3-17-22)~~( )

03. **Income Tax Refunds, Rebates, or Credits**.~~Income tax refunds, rebates, or credits.~~ ~~(3-17-22)~~( )

04. **Property Payments**. Lump sum payments and contract payments from sale of property~~. Contract payments from the sale of property~~ are counted as income. ~~(3-17-22)~~( )

05. **Security Deposits**. Refunds of security deposits on rental property or utilities. ( )

06. **Disability Pension**. Annual adjustment payments in VA disability pensions. ( )

07. **Vacation Pay**. Vacation pay, withdrawn in one (1) lump sum by a terminated employee. ( )

08. **Military Reenlistment Bonuses**.~~Military re-enlistment bonuses.~~ ~~(3-17-22)~~( )

09. **Job Corps Readjustment Pay**.~~Job Corps readjustment pay.~~ ~~(3-17-22)~~( )

10. **Severance Pay**. ~~Severance pay, p~~Paid in one (1) lump sum to a former employee. ~~(3-17-22)~~( )

11. **TAFI One-Time Cash Diversion Payment**.~~The one-time TAFI cash diversion payment.~~ ~~(3-17-22)~~( )

324. -- 333. (RESERVED)

334. VEHICLES.

~~Treat any vehicle that is used primarily for transportation and not for recreational use, as described in Subsections 334.01 and 334.02 of this rule.~~ The value of any vehicle that is primarily for recreational use counts toward the household's resource limit. All other vehicles in the household will have their values counted as provided in 7 CFR 273. ~~(3-17-22)~~( )

~~**01.**~~ ~~**Exclude One Vehicle Per Adult**. The value of one (1) vehicle per adult in the Food Stamp household is excluded beginning with the highest valued vehicle.~~ ~~(3-17-22)~~

~~**02.**~~ ~~**All Other Vehicles Are Subject To Federal Regulations**. All other vehicles in the household will have their values counted as provided in 7 CFR 273.~~ ~~(3-17-22)~~

335. -- 350. (RESERVED)

351. EXCLUDED RESOURCES.

Some resources do not count against the limit because they are excluded. Resources excluded by federal law are also excluded for Food Stamps. Exclusions from resources are ~~listed in~~ under Sections 352 through 382 of these rules. ~~(3-17-22)~~( )

352. HOUSEHOLD GOODS EXCLUDED.

Household goods are items of personal property normally found in the home. The items must be used for maintenance, use, and occupancy of the home. Household goods include, but are not limited to, furniture, appliances, television sets, carpets, and utensils for cooking and eating.~~Household goods are excluded as resources.~~

~~(3-17-22)~~( )

353. PERSONAL EFFECTS EXCLUDED.
Personal effects are items worn or carried by a~~ client~~ participant, or items having an intimate relation to the~~ client~~ participant. They include, but are not limited to, clothing, jewelry, personal care items, and prosthetic devices. Personal effects include items for education or recreation, such as books, musical instruments, or hobby materials. ~~Personal effects are excluded as resources.~~ ~~(3-17-22)~~( )

354. HOME AND LOT EXCLUDED.
The home and surrounding land and buildings not separated by property owned by others, are excluded as a resource. A public road or right of way that separates any plot from the home will not affect the exclusion. The ~~H~~home may be a house,~~ a~~ trailer, or~~ a~~ vehicle. ~~(3-17-22)~~( )

01. Unoccupied Home Exclusion. A temporarily unoccupied home is excluded if the household members intend to return. The household members must be absent because of employment, training for future employment,~~ or~~ illness, or the home must be temporarily uninhabitable from casualty or natural disaster. ~~(3-17-22)~~( )

02. Building Lot Exclusion. The following are excluded as a resource: ( )

a. A lot where a household is building a permanent home~~ is excluded as a resource.~~ ( )

b. A lot where a household intends to build a permanent home~~ is excluded as a resource.~~ ; and ( )

c. ~~The~~A lot and partly completed home~~ are excluded.~~ ( )

d. The household can only have one (1) home and lot excluded. The household cannot own a home and lot and have a building lot exclusion for another property. ~~(3-17-22)~~( )

355. LIFE INSURANCE EXCLUDED AS A RESOURCE.
The cash surrender value of life insurance policies is excluded as a resource. ( )

356. BURIAL SPACE OR PLOT AND FUNERAL AGREEMENT EXCLUSIONS.
Burial spaces or plots and funeral agreements are excluded from resources as listed~~ in Subsections 356.01 through 356.02~~ below. ~~(3-17-22)~~( )

01. Burial Space or Plot Exclusion. ~~Exclude o~~One (1) burial space or plot, for each household member, from resources. The value of the burial space or plot does not affect this exclusion. ~~(3-17-22)~~( )

02. Funeral Agreement Exclusion. ~~Exclude u~~Up to~~ one thousand, five hundred dollars ($1,500) of~~ the equity value of one (1) bona fide funeral agreement, for each household member, from resources.~~ The equity value over one thousand, five hundred dollars ($1,500) is counted as a resource.~~ ~~(3-17-22)~~( )

357. PENSION PLANS OR FUNDS EXCLUDED AS A RESOURCE.
The cash value of any funds in a plan, contract, or account, ~~described in~~ under Sections 401(a), 403(a), 403(b), 408, 408A, 457(b), and 501(c) of the Internal Revenue Code of 1986. and the value of funds in a Federal ~~t~~Thrift Savings Plan ~~a~~Account~~ as provided for in~~ under 5 U.S.C. 8439 are excluded as a resource. This exclusion includes any current or future tax preferred retirement accounts~~ which are~~ approved under federal or state law. ~~(3-17-22)~~( )

358. INCOME-PRODUCING PROPERTY EXCLUDED.
Property~~ which~~ that annually produces income consistent with its fair market value is excluded as a resource. Real property, not used as a home, is excluded as a resource if it produces income consistent with it~~'~~s fair market value. This exclusion includes land and buildings. Annual income is consistent with the property's fair market value when consistent with area market trends. ~~(3-17-22)~~( )

359. LIVESTOCK EXCLUDED.
Livestock includes cows, pigs, sheep, llamas, and horses. Farm animals kept for food are excluded. ( )

360. PROPERTY USED FOR SELF-SUPPORT EXCLUDED.
Property essential to the employment or self-employment of a household member, such as tools of a trade or the farm land and machinery of a farmer, is excluded as a resource. Essential work-related equipment of an ineligible legal non-citizen or disqualified person is excluded as a resource. Self-support property is excluded during employment and temporary periods of unemployment. For a household member engaged in farming, property essential to self-employment continues to be excluded for one (1) year from the date the household member ends self-employment from farming. ( )

361. PROPERTY USED WITH EXCLUDED VEHICLE.
Portions of real or personal property are excluded as a resource if used in connection with an excluded vehicle. The vehicle must be used to produce income or be necessary for transporting a physically disabled household member. ( )

362. SALABLE ITEM WITHOUT SIGNIFICANT RETURN EXCLUDED.
Resources that cannot be sold for a significant return are excluded. ~~A significant return is one-half (1/2) the household resource limit. One-half (1/2) the household resource limit is one thousand dollars ($1,000) or one thousand five hundred dollars ($1,500), depending on household composition. The Department requires the household to give proof of the value of a resource only if it questions the resource data provided. Vehicles are not included under this rule. A single resource cannot be divided to get an exclusion under this rule. A resource meeting the conditions described in Subsections 362.01 through 362.03 is not counted.~~ "Significant return" means any return, after estimating costs of sale or disposition, and taking into account the ownership interest of the household, is more than one thousand five hundred dollars ($1,500). ~~(3-17-22)~~( )

~~**01. No Profit from Sale**. The sale, or other disposal, of the resource is not likely to produce one-half (1/2) the resource limit for the household. (3-17-22)~~

~~**02. No Interest in Resource**. The household's interest in a resource is slight. The sale of the resource is not likely to bring one-half (1/2) the household resource limit. (3-17-22)~~

~~**03. Cost of Sale Too Great**. The cost of selling the household's interest in a resource is excessive. The household is not likely to sell the resource for one-half (1/2) the resource limit. (3-17-22)~~

363. HUD FAMILY SELF-SUFFICIENCY (FSS) ESCROW ACCOUNT.
Escrow accounts and the interest earned on an escrow account established by HUD for families participating in the ~~Family Self-Sufficiency (~~FSS~~)~~ Program ~~established by~~ under Section 544 of the National Affordable Housing Act, are excluded as a resource when determining eligibility for food stamps. The federal exclusion for the funds in this program and other similar type escrow funds are only excluded while the funds are still in the escrow account or being used for a HUD approved purpose. Participants in the FSS program may withdraw funds from the escrow account before completing the program, with permission from the public housing authority, but only for purposes related to the goal of the F~~amily Self-~~S~~ufficiency~~ contract, such as completion of higher education, job training, or to meet start-up expenses involved in creation of a small business. ~~(3-17-22)~~( )

364. EDUCATIONAL ACCOUNTS EXCLUDED AS A RESOURCE.
The cash value of any funds in a qualified tuition program ~~described in~~ under Section 529 of the Internal Revenue Code of 1986, or in a Coverdell education savings account under Section 530 of the Internal Revenue Code, are excluded as ~~a~~ resources. ~~(3-17-22)~~( )

365. INDIVIDUAL DEVELOPMENT ACCOUNT EXCLUDED AS A RESOURCE.
The cash value of an Individual Development Account (IDA) ~~established in compliance with~~ under Section 56-1101(5), Idaho Code, is excluded as a resource. ~~(3-17-22)~~( )

366. -- 372. (RESERVED)

373. GOVERNMENT PAYMENTS EXCLUDED.
Government payments for the restoration of a home damaged in a disaster are excluded as a resource. The household must be subject to legal sanction if the funds are not used as intended. ( )

374. EXCLUDED INACCESSIBLE RESOURCES.
The cash value of resources not legally available to the household is excluded as a resource. The household must provide proof resources are not available. ( )

375. FROZEN OR SECURED ACCOUNTS EXCLUDED.
Frozen bank accounts used as security for a loan or due to bankruptcy proceedings are excluded as resources. ( )

376. REAL PROPERTY EXCLUDED IF ATTEMPT TO SELL.
Real property is excluded as a resource if the household is making a good faith effort to sell it at a reasonable price. The Department will Vverify the property is for sale and the household has not refused a reasonable offer. Document in the case record the reason for excluding the property and the household's efforts to sell. (3-17-22)( )

377. TRUST FUNDS EXCLUDED.
Trust funds are excluded if all conditions listed below are met: ( )

01. Trust Irrevocable or Not Changeable by Household. The household must be unable to revoke the trust agreement or change the name of the beneficiary during the certification period. ( )

02. Trust Unlikely to End During Certification. The trust arrangement must be unlikely to end during the certification period. ( )

03. Trustee Independent from Household Control. The trustee of the fund is either a court, institution, corporation, or organization not under the direction or ownership of a household member, or a court-appointed person who has court-imposed limits placed on the use of funds. ( )

04. Trust Not Under Control of Household-Directed Business. The trust investments do not directly involve or help any business or corporation under the control, direction, or influence of a household member. ( )

05. Origin and Use of Trust. The funds held in an irrevocable trust are: ( )

a. Set up from the household's own funds. The trustee uses the funds only to make investments for the trust, or to pay education or medical expenses of the beneficiary; or ( )

b. Set up from nonhousehold funds by a nonhousehold member. ( )

378. INSTALLMENT CONTRACTS EXCLUDED.
An installment contract for the sale of land and buildings is excluded as a resource. The purchase price must be consistent with the property's fair market value. The contract or agreement must produce income consistent with the property's fair market value. Income is consistent with the property's fair market value when consistent with area market trends. The actual property sold under an excluded installment contract is excluded as a resource. Property held as security for the fulfillment of an excluded installment contract is excluded as a resource. ( )

379. TREATMENT OF EXCLUDED RESOURCES.
An excluded resource kept in a separate account is excluded for an unlimited period. If an excluded resource is combined with countable resources, the resource is not counted for six (6) months from the date the funds are combined. After six (6) months, the total combined resources are counted. ( )

380. (RESERVED)

381. NONLIQUID RESOURCES WITH LIENS EXCLUDED.
A nonliquid resource, with a lien placed against it, is excluded. The lien must result from a business loan. The lien agreement must forbid the household to sell the resource. ( )

382. (RESERVED)

383. EXCLUDED RESOURCE CHANGES TO COUNTED RESOURCE.
Resource value increases when a client participant replaces an excluded resource with a counted resource. (3-17-22)( )

384. -- 385. (RESERVED)

386. TRANSFER OF RESOURCES.
If a household transfers a resource within three (3) calendar months before the date of application for Food Stamps, determine if the transfer was made with the intent to qualify for the Food Stamp Program. Disqualify a household if the transfer was made with the intent to qualify for the Food Stamp Program. After a household is certified for Food Stamps, the transfer of a resource to remain eligible for Food Stamps will result in disqualification.Households that knowingly transfer resources for the purpose of qualifying or attempting to qualify for Food Stamps benefits are disqualified from participation in the program for up to one (1) year from the date of the discovery of the transfer. (3-17-22)( )

387. TRANSFER OF RESOURCE NOT COUNTED FOR DISQUALIFICATION.
A transferred resource is not counted for disqualification, if under the conditions below: (3-17-22)( )

01. Three Months Before Application. The transfer of a resource was more than three (3) months before the date of Food Stamp application is not counted. (3-17-22)( )

02. Resources Less Than Limit. The transfer of a resource is not counted if the resource, when added to the other countable resources, does not exceed the resource limit. (3-17-22)( )

03. Transfer at Fair Market Value. The sale or trade of a resource, made at or near the fair market value, is not counted. ( )

04. Transfer Between Household Members. A resource transferred between members of the same household, including ineligible legal non-citizens or disqualified persons whose resources are considered available to the household, is not counted. ( )

05. Transfer for Reasons Other Than Food Stamps. A resource transferred for reasons other than trying to qualify for Food Stamps is not counted. ( )

388. DISQUALIFICATION FOR TRANSFERRING RESOURCES.
Disqualify a household from Food Stamps for up to one (1) year from the discovery date of the transfer.The Department will Bbase the disqualification period on the amount the transferred resource exceeds the resource limit, when added to other countable resources. Disqualification periods are listed in Table 388. The disqualification period begins in the first month of application or recertification unless the household is already certified when the transfer is discovered. If the household is already certified, the disqualification period starts with the first allotment after timely notice to end benefits.

Amount in Excess of the Resource Limit	Months of Disqualification
$0 - 249.99	1
$250 - 999.99	3
$1,000 - 2999.99	6
$3,000 - 4,999.99	9
$5,000 or more	12

(3-17-22)( )

389. -- 399. (RESERVED)

400. INCOME.
All household income is counted in the Food Stamp budget unless excluded under these rules. Income can be earned or unearned. ~~Income must be verified and documented.~~ ~~(3-17-22)~~( )

401. EARNED INCOME.
Earned income includes, but is not limited to~~, income listed in Section 401~~ the following. ~~(3-17-22)~~( )

01. Wages or Salary. Wages and salaries of an employee, advances, tips, commissions, meals, and military pay are earned income. Garnishments from wages are earned income. ( )

02. Self-Employment Income. Income from self-employment, including capital gains, is earned income. Rental property is~~ a~~ self-employment~~ enterprise. The~~ income~~ is earned~~ if a household member manages the property an average of twenty (20) or more hours per week. Payment from a roomer or boarder is self-employment income. ~~(3-17-22)~~( )

03. Training Allowances. ~~Training allowances f~~From programs such as Vocational Rehabilitation~~ are earned income~~. ~~(3-17-22)~~( )

04. Payments Under Title I. ~~Payments under Title I, s~~Such as VISTA and University Year for Action under P.L. 93-113~~ are earned income~~. ~~(3-17-22)~~( )

05. On-the-Job Training Programs. WIOA income includes monies paid by WIOA or the employer. Income from WIOA on-the-job training programs is earned income, unless paid to a household member under age nineteen (19). The household member under age nineteen (19) must be under the control of another household member. ~~(3-17-22)~~( )

06. Basic Allowance for Housing (BAH). ~~BAH is a~~An Armed Services housing allowance.~~ BAH is counted as earned income.~~ ~~(3-17-22)~~( )

402. UNEARNED INCOME.
Unearned income includes, but is not limited to~~ income listed below~~ the following: ~~(3-17-22)~~( )

01. Public Assistance (PA). Payments from SSI, TAFI, AABD, GA, or other Public~~ Assistance~~ programs~~ are unearned income~~. ~~(3-17-22)~~( )

02. Retirement Income. Payments from annuities, pensions, and retirement~~ are unearned income. Old age, survivors, or Social Security benefits are unearned income~~. ~~(3-17-22)~~( )

03. Strike Benefits.~~ Strike benefits are unearned income.~~ ~~(3-17-22)~~( )

04. Veteran's Benefits.~~ Veteran's benefits are unearned income.~~ ~~(3-17-22)~~( )

05. Disability Income.~~ Disability benefits are unearned income.~~ ~~(3-17-22)~~( )

06. Workers' Compensation.~~ Workers' Compensation is unearned income.~~ ~~(3-17-22)~~( )

07. Unemployment Insurance.~~ Unemployment Insurance is unearned income.~~ ~~(3-17-22)~~( )

08. Contributions.~~ Contributions are unearned income.~~ ~~(3-17-22)~~( )

09. Rental Property Income. ~~Rental property income, m~~Minus the cost of doing business,~~ is unearned income~~ if a household member is not managing the property at least twenty (20) hours per week. ~~(3-17-22)~~( )

10. Support Payments. ~~Support payments, i~~Includ~~ing~~es child support payments~~, are unearned income~~. ~~(3-17-22)~~( )

11. Alimony.~~ Alimony payments are unearned income.~~ ~~(3-17-22)~~( )

12. Education~~al~~ Benefits Unless Excluded.~~ Educational scholarships, grants, fellowships, deferred payment loans, and veteran's educational benefits are excluded unearned income.~~ ~~(3-17-22)~~( )

13. ~~Government Sponsored Program Payments~~Regular Payments from a Government Source. Payments~~ from government sponsored programs are unearned income~~ or allowances a household receives that are funded from a government source. ~~(3-17-22)~~( )

14. Dividends, Interest, and Royalties.~~ Dividends, interest, and royalties are unearned income. Interest income is excluded unearned income.~~ ~~(3-17-22)~~( )

15. Contract Income From the Sale of Property.~~ Contract income from the sale of property is counted as unearned income.~~ ~~(3-17-22)~~( )

16. Funds From Trusts. Monies withdrawn from trusts exempt as a resource~~ are unearned income~~. Dividends paid or dividends that could be paid from trusts exempt as a resource~~ are unearned income~~. ~~(3-17-22)~~( )

17. Recurring Lump Sum Payments.~~ Recurring lump sum payments are unearned income.~~ ~~(3-17-22)~~( )

18. Cash Prizes, Gifts, and Lottery Winnings.~~ Cash prizes, gifts and lottery winnings are unearned income.~~ ~~(3-17-22)~~( )

19. Diverted Support or Alimony. Child support or alimony payments~~,~~ diverted by the provider to a third party~~,~~ to pay a household expense~~ are unearned income~~. ~~(3-17-22)~~( )

20. Agent Orange Payments. Payments made under the Agent Orange Act of 1991 and disbursed by the U~~.~~S~~.~~ Treasury~~ are unearned income~~. ~~(3-17-22)~~( )

21. Garnishments.~~ Garnishments from unearned income are unearned income.~~ ~~(3-17-22)~~( )

22. Tribal Gaming Income.~~ Tribal gaming income is unearned income.~~ The participant can choose to count the income in the month received, or prorate the income over~~ a twelve (12) month~~ the period it is intended to cover. ~~(3-17-22)~~( )

23. Other Monetary Benefits Not Otherwise Counted or Excluded.~~ Any monetary benefit, not otherwise counted or excluded, is unearned income.~~ ~~(3-17-22)~~( )

403. -- 404. (RESERVED)

405. EXCLUDED INCOME.

Income excluded when computing Food Stamp eligibility is listed below: ( )

01. Money Withheld. Money withheld voluntarily or involuntarily, from an assistance payment, earned income, or other income source, to repay an overpayment from that income source~~, is excluded. If an intentional noncompliance penalty results in a decrease of benefits under a means tested program such as SSI or GA, count that portion of the benefit decrease attributed to the repayment as income~~. ~~(3-17-22)~~( )

02. Child Support Payments. Child support payments received by TAFI recipients~~ which must be given to CSS are excluded as income~~ that are withheld by the state. ~~(3-17-22)~~( )

03. Earnings of~~ Child~~ Household Member Under Age Eighteen Attending School.~~ Earned income of a household member under age eighteen (18) is excluded.~~ The member must be under parental control of another household member and attending elementary or secondary school.~~ For the purposes of this provision~~ In this rule, a~~n elementary or secondary~~ student is someone who attends elementary or secondary school, or who attends GED or

home-school classes that are recognized, operated, or supervised by the school district. This exclusion applies during semester and summer vacations if enrollment will resume after the break. If the earnings of the child and other household members cannot be differentiated, the Department will prorate equally among the working members and exclude the child's share. ~~(3-17-22)~~(   )

04. **~~Retirement Benefits Paid to Former Spouse or Third Party~~Educational Income**.~~ Social Security retirement benefits based on the household member's former employment, but paid directly to an ex-spouse, are excluded as the household member's income. Military retirement pay diverted by court order to a household member's former spouse is excluded as the household member's income. Any retirement paid directly to a third party from a household member's income by a court order is excluded as the household member's income.~~ Includes grants, scholarships, fellowships, work study, educational loans on which payment is deferred, and veterans' educational benefits. To be excluded, education benefits must meet requirements under 7 CFR 273.9(c)(3). ~~(3-17-22)~~(   )

05. **Infrequent or Irregular Income**. ~~Income received occasionally is excluded as income i~~If it does not exceed thirty dollars ($30) total in a three (3) month period. ~~(3-17-22)~~(   )

06. **Cash Donations**. ~~Cash donations b~~Based on need and received from one (1) or more private nonprofit charitable organizations~~ are excluded as income~~. The donations must not exceed three hundred dollars ($300) in a calendar quarter of an ~~federal fiscal year (~~FFY~~)~~. ~~(3-17-22)~~(   )

07. **Income in Kind**. Any gain or benefit, such as meals, garden produce, clothing, or shelter, not paid in money~~, is excluded as income~~. ~~(3-17-22)~~(   )

08. **Vendor Payments**. ~~A vendor payment is a money p~~Payment made on behalf of a household by a person or organization outside of the household directly to either the household's creditors or to a person or organization providing a service to the household. ~~(3-17-22)~~(   )

09. **Third Party Payments**. ~~If a person or organization makes a p~~Payment~~ to~~ by a third party on behalf of a household using funds that are not owed to the household~~, the payment will be excluded from income~~. ~~(3-17-22)~~(   )

10. **Loans**. ~~Loans are m~~Money received~~ which~~ that is to be repaid.~~ Loans are excluded as income.~~ ~~(3-17-22)~~(   )

11. **Money for Third Party Care**. Money received and used for the care and maintenance of a third party who is not in the household. If a single payment is for both household members and nonhousehold members, the identifiable portion of the payment for nonhousehold members is excluded. If a single payment is for both household members and nonhousehold members, the Department will exclude the lesser of: ~~(3-17-22)~~(   )

a. The prorated share of the nonhousehold members if the portion cannot be identified. (   )

b. The amount~~ actually~~ used for the care and maintenance of the nonhousehold members. ~~(3-17-22)~~(   )

12. **Reimbursements**. ~~Reimbursements f~~For past or future expenses not exceeding actual costs. Payments must not represent a gain or benefit~~. Payments must~~, be used for the purpose intended, and be for other than normal living expenses. Excluded reimbursements are not limited to: ~~(3-17-22)~~(   )

a. Travel, per diem, and uniforms for job or training. (   )

b. Out-of-pocket expenses of volunteer workers. (   )

c. Medical and dependent care expenses. (   )

d. Pay for services provided by Title XX of the Social Security Act. (   )

e. Repayment of loans made by the household from their personal property limit. The repayment must

not exceed the amount of the loan. ( )

f. Work-related and dependent care expenses paid by the JSAP program. ( )

g. Transitional child care payments. ( )

h. Child care payments under the Child Care and Dependent Block Grant Act of 1990. ( )

13. Federal Earned Income Tax Credit (EITC).~~ Federal EITC payments are excluded as income.~~ ~~(3-17-22)~~( )

14. Work Study. Work Study income received while attending post-secondary school~~ is excluded as income~~. ~~(3-17-22)~~( )

15. HUD ~~Family Self-Sufficiency (~~FSS~~)~~ Escrow Account. The federal exclusion for these funds~~ are~~ is only excluded while the funds are in the escrow account or being used for a HUD-approved purpose. See Section 363 of these rules for further clarification. ~~(3-17-22)~~( )

16. Temporary Census Earnings. Wages earned for temporary employment related to U~~.~~S~~.~~ Census activities~~ are excluded as income~~ during the regularly scheduled ten (10) year U~~.~~S~~.~~ Census. ~~(3-17-22)~~( )

17. Income Excluded by Federal Law.~~ If income is excluded by federal law, it is excluded for Food Stamps.~~ ~~(3-17-22)~~( )

406. (RESERVED)

407. INCOME AND ELIGIBILITY VERIFICATION SYSTEM (IEVS).

Income must be verified with the IEVS system for all households applying for or getting Food Stamps~~. Income must be verified~~ and for disqualified members with income counted toward the household Food Stamp benefits. ~~(3-17-22)~~( )

408. (RESERVED)

409. USE OF IEVS INFORMATION FOR APPLICANT HOUSEHOLDS.

IEVS data must be used to compute eligibility and benefits if IEVS data is received before the application is processed. IEVS data on applicant households must be used as soon as possible, even if the applicant household was approved before the IEVS data was received. Action on applications must not be delayed pending receipt of IEVS data. If IEVS data requiring further proof is received before application approval the proof must be obtained and resolved before approving the application. If an applicant household cannot provide an SSN at application, IEVS data must be used as soon as possible after the SSN is known. IEVS data must be used for all household members, eligible, excluded or disqualified. ( )

410. (RESERVED)

411. VERIFIED UPON RECEIPT IEVS DATA.

The IEVS data listed below is considered verified upon receipt, unless it is questionable: ( )

01. Benefit Data Exchange (BENDEX). BENDEX Social Security retirement and disability income data. ( )

02. State Data Exchange (SDX). Benefit and eligibility data from SSA under Titles II and XVI of the Social Security Act accessed through the ~~State Data Exchange (~~SDX~~)~~. ~~(3-17-22)~~( )

03. TAFI.~~ Temporary Assistance for Families in Idaho.~~ ~~(3-17-22)~~( )

04. AABD.~~ Aid to the Aged, Blind, or Disabled.~~ ~~(3-17-22)~~( )

05. **Medicaid**. The Federally aided program for medical care (Title XIX, Social Security Act). ( )

412. UNVERIFIED IEVS DATA.
The IEVS data listed below is considered unverified: ( )

01. **IRS Reported Unearned Income**. ~~Unearned income d~~Data from IRS, including any unreported assets producing income. ~~(3-17-22)~~( )

02. **Wage~~s~~ File**. ~~Wage file data. Wage d~~Data from Department of Commerce and Labor or its counterpart in another state. Wage data from Beneficiary Earning Exchange Record (BEER). ~~(3-17-22)~~( )

03. **Self-Employment Earnings**. ~~Self-employment earnings d~~Data from BEER. ~~(3-17-22)~~( )

04. **~~Questionable~~Income Information the Department Deems Questionable**. ~~Income information the Department feels is doubtful.~~ ~~(3-17-22)~~( )

413. -- 4~~14~~27. (RESERVED)

~~**415. EDUCATIONAL INCOME.**~~
~~Educational income includes deferred repayment educational loans, grants, scholarships, fellowships, and veterans' educational benefits. The school attended must be a recognized institution of post secondary education, a school for the handicapped, a vocational education program, or a program providing completion of a secondary school diploma, or equivalent. Educational income is excluded. (3-17-22)~~

~~**416. -- 426. (RESERVED)**~~

~~**427. AVERAGING SELF-EMPLOYMENT INCOME.**~~

~~**01.** **Annual Self-Employment Income**. When self-employment income is considered annual support by the household, the Department averages the self-employment income over a twelve-month (12) period, even if: (3-17-22)~~

~~**a.** The income is received over a shorter period of time than twelve (12) months; and (3-17-22)~~

~~**b.** The household receives income from other sources in addition to self-employment. (3-17-22)~~

~~**02.** **Seasonal Self-Employment Income**. A seasonally self-employed individual receives income from self-employment during part of the year. When self-employment income is considered seasonal, the Department averages self-employment income for only the part of the year the income is intended to cover. (3-17-22)~~

428. CALCULATION OF SELF-EMPLOYMENT INCOME.
~~The Department calculates self-employment income by adding monthly income to capital gains and subtracting a deduction for expenses as determined in Subsection 428.03 of this rule.~~Self-employment is generally considered annual or seasonal. The Department will add all gross self-employment income, either actual or anticipated, and capital gains and exclude the costs of producing the self-employment income and divide the remaining amount of self-employment income by the number of months over which the income will be averaged. This amount is the monthly self-employment income. ~~(3-17-22)~~( )

01. **~~How Monthly Income Is Determined~~Self-Employment Expense Deduction**. ~~If no income fluctuations are expected, the average monthly income amount is projected for the certification period. If past income does not reflect expected future income, a proportionate adjustment is made to the expected monthly income.~~The Department will use a standard fifty percent (50%) self-employment deduction unless the applicant claims the actual allowable expenses exceed the standard deduction and provides proof of the expenses. ~~(3-17-22)~~( )

02. **~~Capital Gains Income~~Allowable Costs of Producing Self-Employment Income**. ~~Capital gains include profit from the sale or transfer of capital assets used in self-employment. The Department calculates capital~~

~~gains using the federal income tax method. If the household expects to receive any capital gains income from self-employment assets during the certification period, this amount is added to the monthly income, as determined in Subsection 428.01 of this rule, to determine the gross monthly income.~~ Costs of labor, stock, raw material, seed and fertilizer, payments on the principal of the purchase price of income-producing real estate and capital assets, equipment, machinery, and other durable goods, interest paid to purchase income-producing property, insurance premium, and taxes paid on income-producing property. ~~(3-17-22)~~( )

03. **~~Self-Employment Expense Deduction~~Costs Not Allowable**. ~~The Department uses the standard self-employment deduction in Subsection 428.03.a. of this rule, unless the applicant claims that his actual allowable expenses exceed the standard deduction and provides proof of the expenses as described in Subsection 428.03.b. of this rule.~~ Net losses from previous periods, federal, state, and local income taxes, money set aside for retirement, work-related personal expenses (such as transportation to and from work), depreciation, amount that exceeds the payment a household receives from a boarder for lodging and meals, net losses from previous periods, and federal, state, and local income taxes. ~~(3-17-22)~~( )

~~**a.** The self-employment standard deduction is determined by subtracting fifty percent (50%) of the gross monthly self-employment income as determined in Subsections 428.01 and 428.02 of this rule; or (3-17-22)~~

~~**b.** The self-employment actual expense deduction is determined by subtracting the actual allowable expenses from the gross monthly self-employment income. The following items are not allowable expenses and may not be subtracted from gross monthly self-employment income. (3-17-22)~~

~~i. Net losses from previous tax years; (3-17-22)~~

~~ii. Federal, state, and local income taxes; (3-17-22)~~

~~iii. Money set aside for retirement; (3-17-22)~~

~~iv. Work-related personal expenses such as transportation to and from work; and (3-17-22)~~

~~v. Depreciation. (3-17-22)~~

429. SELF-EMPLOYED FARMER.
To be considered a self-employed farmer, a person must receive, or expect to receive, an annual gross income of one thousand dollars ($1,000) or more earned from farming activities. If a farmer's cost of producing self-employment income results in a loss, the Department subtracts the loss from other countable income in the household ~~in accordance with~~ under 7 CFR 273.11(a)(2)(ii)(A) and (B). ~~(3-17-22)~~( )

430. -- 500. (RESERVED)

501. INITIAL CHANGES IN FOOD STAMP CASE.
The Department will ~~A~~act on changes in household circumstances found during the application or the initial interview. ~~(3-17-22)~~( )

01. Food Stamp Issuance Changes. The Department will make changes to the household's Food Stamp issuance when it is required to act on a change. ( )

02. Change Before Certification. If a household reports a change in household circumstances before certification, the Department will include the reported information in determining Food Stamp eligibility and amount. ~~(3-17-22)~~( )

03. Change After Certification. If a household reports a change after the initial Food Stamp benefit has been paid, the Department must act on the change as required by policy for acting on changes within a certification period. Notice of the change must be given to the Food Stamp household. ( )

502. EARNED INCOME WHEN A HOUSEHOLD MEMBER TURNS AGE EIGHTEEN.
When a child attending elementary or secondary school turns age eighteen (18), ~~do~~ the Department will not count

earned income received or expected by that person until the next six-month or twelve-month contact, or recertification. ~~(3-17-22)~~( )

503. -- 507. (RESERVED)

508. PROJECTING MONTHLY INCOME.

Income is projected for each month. Past income may be used to project future income. Changes expected during the certification period must be considered. Criteria for projecting monthly income is listed below: ( )

01. Income Already Received. The Department will ~~C~~count income already received by the household during the month. If the actual amount of income from any pay period is known, use the actual pay period amounts to determine the total month's income. The Department will ~~C~~convert the actual income to a monthly amount if a full month's income has been received or is expected to be received. ~~If no changes are expected, use the known actual pay period amounts for the past thirty (30) days to project future income.~~ ~~(3-17-22)~~( )

02. Anticipated Income. The Department will ~~C~~count income that the household and the Department ~~believe~~ anticipate the household will get during the remainder of the certification period. If the exact income amount is uncertain or unknown, that portion must not be counted. If the date of receipt of income cannot be anticipated for the month of the eligibility determination, that portion must not be counted. If the income has not changed and no changes are anticipated, the Department will use the income received in the past thirty (30) days as one (1) indicator of anticipated income. If changes in income have occurred or are anticipated, past income cannot be used as an indicator of anticipated income. If income changes and income received in the past thirty (30) days do~~es~~ not reflect anticipated income, the Department can use the household income received over a longer period to anticipate income. If income changes seasonally, the Department can use the household income from the last season, comparable to the certification period, to anticipate income. ~~(3-17-22)~~( )

509. TYPES OF INCOME TO BE AVERAGED.

Types of income to be averaged are listed below. Income for a destitute migrant or seasonal farm worker household is not averaged. ( )

01. Self-Employment Income. ~~Average self-employment income.~~ ~~(3-17-22)~~( )

02. Contract Income. ~~Average contract i~~Income over the period of the contract, if not received on an hourly or piecework basis. Households with averaged contract income include school employees, share croppers, and farmers. These households do not include migrants or seasonal farm workers. ~~(3-17-22)~~( )

03. Income Received Less Often Than Monthly. When receipt of income is less often than monthly, the anticipated income can be averaged over the period intended to cover to determine the average monthly income. ( )

04. Child Support Income. ~~Child support income c~~Can be averaged to make a valid projection for ongoing income. ~~(3-17-22)~~( )

510. -- 511. (RESERVED)

512. SPECIAL CASES FOR COUNTING INCOME.

Special cases for counting income are listed below: ( )

01. Wages Held at the Request of Employee. ~~Wages held at the request of the employee are i~~Income in the month the wages would have been paid by the employer. ~~(3-17-22)~~( )

02. Garnishments Held by Employer. ~~Garnishments withheld by an employer are i~~Income in the month the wages would have been paid. ~~(3-17-22)~~( )

03. Wages Held by Employer, Other Than Garnishment and Employee Request. ~~Wages held by the employer, e~~Even if in violation of law, are not counted as income. ~~(3-17-22)~~( )

04. Advances on Wages. ~~Advances on wages will c~~Count as income if the household reasonably expects the advance to be paid. ~~(3-17-22)~~(   )

05. Varying Payment Cycles. Households getting unearned or earned income on a recurring monthly or semi-monthly basis do not have varying income merely because mailing or payment cycles cause additional payments to be received in a month. The income is counted for the month it is intended. (   )

06. Nonrecurring Lump Sum Payments and Capital Gains. Nonrecurring lump sum payments must not be counted as income~~. Nonrecurring lump sum payments~~, but are counted as a resource starting in the month received. Nonrecurring lump sum payments include capital gains from the sale or transfer of securities, real estate, or other real property held as an investment for a set period~~ of time~~. The capital gains are income only if the assets were used in self-employment. ~~(3-17-22)~~(   )

~~**07. PA Entitlement**. If a household intentionally fails to comply with a means-tested program, a penalty may be imposed and benefits reduced to collect the means-tested program overpayment. Means-tested programs include PA. Count the full amount of means-tested benefits the household is entitled to, not the reduced amount caused by the failure to comply. (3-17-22)~~

513. -- 531. (RESERVED)

532. GROSS INCOME LIMIT.

Households exceeding the gross income limit for the household size are not eligible unless they are categorically eligible or have an elderly or disabled member. A household with an elderly or disabled household member is exempt from the gross income limit.~~ If all household members receive or are authorized to receive monthly payments through TAFI, AABD, or SSI, the household is categorically eligible. The gross income limit is raised each federal fiscal year by FNS, based on the federal cost of living (COLA) adjustment.~~ ~~(3-17-22)~~(   )

533. HOUSEHOLD ELIGIBILITY AND BENEFIT LEVEL.

A household's eligibility and benefit level is calculated~~ in accordance with~~ under 7 CFR 273.10, except as indicated below~~ in Subsections 533.01 through 533.07. of this rule~~. The deductions in~~ Subsections 533.01 through 533.07 of~~ this rule are subtracted from non-excluded income. ~~(3-17-22)~~(   )

01. Standard Deductions. ~~The standard deductions a~~Are~~ controlled~~ determined by ~~F~~federal law.~~ The monthly amounts are specified in Title 7 United States Code Section 2014.~~ ~~(3-17-22)~~(   )

02. Earned Income Deduction. ~~The earned income deduction i~~Is twenty percent (20%) of gross earned income. ~~(3-17-22)~~(   )

03. Homeless Shelter Deduction. ~~The homeless shelter deduction i~~Is established by FNS. ~~(3-17-22)~~(   )

04. Excess Medical Deduction. Excess medical expense is nonreimbursed medical expense of more than thirty-five dollars ($35) per household per month. The household member must be either age sixty (60) or older or disabled to get this expense deduction. Special diets are not deductible. For allowable medical expenses, see Section 535 of these rules. (   )

05. Dependent Care Expense Deduction. ~~The dependent care expense deduction i~~Is for monthly dependent care expenses. The dependent care may be needed for children or adults. ~~(3-17-22)~~(   )

06. Child Support Expense Deduction. ~~The child support expense deduction i~~Is the legally obligated child support and arrearage the household pays, or expects to pay, to or for a non-household member. ~~(3-17-22)~~(   )

07. Excess Shelter Expense Deduction. Excess shelter expense is the monthly shelter cost over fifty percent (50%) of the household's income after all other deductions~~. The excess shelter expense~~, and is not deducted if the household has received the homeless shelter deduction. For allowable shelter expenses, see Section 542 of these rules. ~~(3-17-22)~~(   )

534. AVERAGING INFREQUENT, FLUCTUATING, OR ONE-TIME ONLY EXPENSES.
Infrequent, fluctuating, or one-time only expenses for medical, child support, shelter, or child care~~ are~~ may be averaged. ~~(3-17-22)~~(   )

535. MEDICAL EXPENSES.
Elderly or disabled household members that incur medical expenses over thirty-five dollars ($35) per month are allowed a Standard Medical Expense (SME) deduction. Eligible households must verify monthly medical expenses of more than thirty-five dollars ($35) at initial application. Households with medical expenses that exceed the monthly S~~tandard~~ M~~edical~~ ~~Expense~~ may either verify the minimum amount to receive the SME or request and verify excess costs to receive an actual expense deduction at application and recertification. The household must provide proof of the incurred or anticipated cost before a deduction is allowed. ~~(3-17-22)~~(   )

536. DEPENDENT CARE EXPENSES.
The care of a dependent must be necessary to maintain employment, conduct job search, or attend school or training. The dependent care expenses must be deducted from income. (   )

537. DEPENDENT CARE RESTRICTIONS.
~~Dependent care restrictions are listed below~~The following types of dependent care cannot be deducted:
~~(3-17-22)~~(   )

01. Care by Household Member. ~~Dependent care cannot be deducted i~~If the care is provided by another household member. ~~(3-17-22)~~(   )

02. In-Kind Payment. ~~Dependent care cannot be deducted if the payment is in-kind, s~~Such as food or exchanges for shelter. ~~(3-17-22)~~(   )

03. Vendor Payment.~~ Dependent care cannot be deducted if paid by vendor payment.~~ ~~(3-17-22)~~(   )

04. Spouse Can Give Care. ~~Dependent care cannot be deducted i~~If the spouse in the home is physically capable of the dependent care and is not working, seeking work, or registered for work. ~~(3-17-22)~~(   )

05. ~~Paid or Reimbursed~~ Dependent Care. ~~Dependent care cannot be deducted i~~If paid or reimbursed under a federal child care program. ~~(3-17-22)~~(   )

538. CHILD SUPPORT EXPENSES.
Child support expense may be deducted for a household paying or expecting to pay legally obligated child support to or for a person living outside the household. The child support expense deducted must reflect the child support the household pays or expects to pay during the certification period, rather than the obligated amount. (   )

539. -- 541. (RESERVED)

542. COSTS ALLOWED FOR SHELTER DEDUCTION.
Shelter costs are current charges for the shelter occupied by the household~~. Shelter costs~~ and include costs for the home temporarily not occupied because of employment or training away from home or illness. ~~(3-17-22)~~(   )

543. UTILITY ALLOWANCES.
The shelter deduction is computed using one (1) of four (4) utility allowances: ~~Standard Utility Allowance (~~SUA~~).~~, ~~Limited Utility Allowance (~~LUA~~)~~, ~~the Minimum Utility Allowance (~~MUA~~)~~, or ~~the Telephone Utility Allowance (~~TUA~~)~~. Utility allowances are not prorated. ~~(3-17-22)~~(   )

01. Standard Utility Allowance (SUA). (   )

a. The household must have a primary heating or cooling cost to qualify for~~ the~~ SUA. The heating or cooling costs must be separate from rent or mortgage payments. ~~(3-17-22)~~(   )

b. ~~Occupied and unoccupied homes are h~~Households~~ with both an occupied home and an unoccupied home, that~~ are limited to one (1) SUA. ~~(3-17-22)~~(   )

02. Limited Utility Allowance (LUA). The household must be billed for more than one (1) utility that is not for heating or cooling. ( )

03. Minimum Utility Allowance (MUA). The household must be billed for one (1) utility that is not for heating, cooling, or telephone service. ( )

04. Telephone Utility Allowance (TUA). The household must be billed for telephone service and have no other verified utility expenses. ( )

544. -- 546. (RESERVED)

547. COSTS NOT ALLOWED FOR THE SHELTER DEDUCTION.
The costs listed below are not allowed in computing the shelter deduction. ( )

01. Fees for a One-Time Utility Deposit. Fees for a one (1) time utility deposit. (3-17-22)( )

02. Damage or Advance Rental Deposits on Rentals. Damage or advance deposits on rentals. (3-17-22)( )

03. Payments Made to Pay Past Due Rent. Payments made to pay past due rent. (3-17-22)( )

04. Cost to Cut the Household's Own Wood Cutting for Heating. The cost to cut the household's own wood for heating. (3-17-22)( )

05. Furniture Rental Fees. Rental furniture fees. (3-17-22)( )

06. Personal Insurance on Furniture or Personal Belongings. Insurance on furniture or personal belongings. (3-17-22)( )

07. Vehicle Not Used as Residence. Payments or gasoline costs on vehicles used only for recreation. ( )

08. Repairs Not Paid by Household. Costs for repairing or replacing shelter paid by private or public agencies, insurance companies, or any other source. ( )

09. Shelter Not Paid by Household but Paid by a Vendor or Employer. Shelter paid by a vendor or employer. (3-17-22)( )

10. Utility Costs Paid by Utility Payment HUD or FmHA Negative Utility Payment. Utility costs paid entirely by HUD or FmHA negative utility payment. (3-17-22)( )

548. COMPUTING THE SHELTER DEDUCTION.
The shelter deduction is computed as listed below: ( )

01. If Household with has Elderly or Disabled Member. If the household has an elderly or disabled member, The Department will deduct the monthly shelter cost exceeding fifty percent (50%) of the household's income after all other deductions. (3-17-22)( )

02. If Household with has No Elderly or Disabled Member. If the household does not have an elderly or disabled member, The Department will deduct the excess of fifty percent (50%) of the household's income, after all other deductions, up to the maximum limit as specified in under Title 7 USC Section 2014. (3-17-22)( )

549. NET INCOME LIMIT TEST.
Categorically eligible households do not have to meet the net income limit. All other households, including those with an elderly or disabled household member, must not exceed the net income limit to be eligible for Food Stamps. ( )

550. DETERMINATION OF FOOD STAMP BENEFIT.
The Food Stamp benefit is computed ~~in accordance with~~ under 7 CFR 273.9 and 273.10. ~~(3-17-22)~~( )

551. ROUNDING FOOD STAMP PAYMENT.
Income and deductions are not rounded in determining gross or net income. Only the final Food Stamp amount is rounded. ( )

552. -- 561. (RESERVED)

562. PRORATING INITIAL MONTH'S BENEFITS.
Prorating is based on a thirty (30) day calendar month. Benefits are prorated from the application date to the end of the month. ( )

563. FOOD STAMP PRORATING FORMULA.
The prorated Food Stamp amount is determined ~~per~~ under 7 CFR 273.10(a)(1)(iii)(B). If the amount for the initial month is less than ten dollars ($10), benefits must not be issued. ~~(3-17-22)~~( )

564. BENEFITS AFTER THE INITIAL MONTH.
After the initial month, benefits must be issued as described below. ( )

01. All Eligible One and Two Person Households. ~~All eligible one (1) and two (2) person households must r~~Receive a minimum allotment equal to eight percent (8%) of the maximum one (1) person allotment. ~~(3-17-22)~~( )

02. All Eligible Three or More Person Households. When the calculation of benefits would yield a zero benefit, the Department will deny the household's application on the grounds that its net income exceeds the level at which benefits are issued. ~~(3-17-22)~~( )

~~**a.** All eligible households with three (3) or more members entitled to one dollar ($1), must receive two dollars ($2). (3-17-22)~~

~~**b.** All eligible households with three (3) or more members entitled to three dollars ($3), must receive four dollars ($4). (3-17-22)~~

~~**c.** All eligible households with three (3) or more members entitled to five dollars ($5), must receive six dollars ($6). (3-17-22)~~

03. Not Categorically Eligible. All households, except categorically eligible households, must be denied if the household's net income exceeds the level at which benefits are issued. ( )

~~**565. FOOD STAMP BENEFITS FOR CATEGORICALLY ELIGIBLE HOUSEHOLD.**~~
~~Categorically eligible households with one (1) or two (2) household members are eligible to get an allotment amount of Food Stamps that is equal to at least eight percent (8%) of the maximum monthly one (1) person allotment, regardless of net income. Categorically eligible households with three (3) or more household members are eligible for Food Stamps, but do not get Food Stamps if the net income is too high. (3-17-22)~~

56~~6~~5. -- 572. (RESERVED)

573. ACTING ON HOUSEHOLD COMPOSITION CHANGES.
Changes in household composition are not required to be reported. If a household does report a change in household composition, the Department will act on the change ~~as required by~~ using options ~~allowed~~ under 7 CFR 273.12(c). ~~(3-17-22)~~( )

574. ~~ADDING PREVIOUSLY DISQUALIFIED HOUSEHOLD MEMBERS.~~(RESERVED)
~~The resources, income, and deductions of a previously disqualified household member must be determined. Change the previously disqualified household member's participation the month following the last month in the sanction or if~~

~~the person becomes exempt. The disqualification must have been due to an intentional program violation (IPV), work registration or Job Search Assistance Program (JSAP) sanction, voluntary quit or reduction of work hours, failure to comply with the SSN requirement, or ineligible legal non-citizen status. The person's resources, income, and deductions that were previously prorated are counted in full the month after the disqualification ends. Prorate benefits from the date the ABAWD becomes Food Stamp eligible by reaching eighty (80) hours by working, participating in a work program, or combining work and work programs. (3-17-22)~~

575. HOUSEHOLD COMPOSITION CHANGES FOR STUDENT.
Ineligible students are defined as nonhousehold members. When a student's status changes, the change is treated as a new person entering or leaving the Food Stamp household. ( )

576. -- 587. (RESERVED)

588. NOTICE OF DECISION TO HOUSEHOLDS.
The Department must send the household a written notice as soon as Food Stamps are approved or denied. The household must get the notice no later than thirty (30) days after the application date. ( )

589. -- 600. (RESERVED)

601. REPORTING REQUIREMENTS AND RESPONSIBILITIES.
Changes may be reported by phone, mail,~~ or e-mail~~ other electronic interfaces, or~~ directly~~ in person to the Department. Households must report~~ as follows~~ when: ~~(3-17-22)~~( )

01. Household's Total Gross Income Exceeds One Hundred Thirty Percent (130%) of FPG for the Household Size.~~ When the household's total gross income exceeds one hundred thirty percent (130%) of the Federal Poverty Guideline (FPG) for the household size.~~ ~~(3-17-22)~~( )

02. There is a Decrease in the Household's ABAWD Hours to Less Than Eighty (80) Hours Per Month.~~ When there is a decrease in the household's ABAWD hours to less than eighty (80) hours per month.~~ ~~(3-17-22)~~( )

03. There are Substantial Lottery Winnings. Defined as equal to or greater than the financial resource limit for elderly or disabled households not subject to the Broad-Based Categorical Eligibility (BBCE) resource limit. ( )

602. (RESERVED)

603. PERSON OUTSIDE HOUSEHOLD FAILS TO PROVIDE PROOF -- CHANGES.
Food Stamps cannot be closed solely because a person outside the household fails to provide requested proof. The Department will attempt to get another source of proof if a person outside the household does not provide requested proof. Disqualified household members are not persons outside the household. ( )

604. -- 610. (RESERVED)

611. TIME FRAMES FOR REPORTING CHANGES IN HOUSEHOLD CIRCUMSTANCES.
~~Households must report changes in circumstances as required in Section 601 of these rules.~~ Households reporting required changes to the Department must do so by the tenth day of the month following the month in which the change occurred. If Food Stamps are over-issued because a household fails to report required changes, a claim determination must be prepared. A person can be disqualified for failure to report a change if they commit an IPV. ~~(3-17-22)~~( )

~~**01. Reporting Methods**. Changes can be reported by telephone, personal contact, mail, or e-mail. Changes can be reported by a household member or authorized representative. (3-17-22)~~

~~**02. Failure to Report**. If Food Stamps are over-issued because a household fails to report required changes, a Claim Determination must be prepared. A person can be disqualified for failure to report a change if he commits an Intentional Program Violation. (3-17-22)~~

612. (RESERVED)

613. CHANGES ON WHICH THE DEPARTMENT MUST ACT.
The Department must follow the procedures for acting on reported changes~~ as described in~~ under 7 CFR 273.12.
~~(3-17-22)~~( )

614 -- 616. (RESERVED)

617. INCREASES IN FOOD STAMP BENEFITS.

01. Household Reports a Change. If a household reports a change that results in an increase in Food Stamps and the proof cannot be obtained through interfaces or data brokers, the Department must allow the household ten (10) days to provide proof. ( )

02. Failure to Provide Proof of Change. If the household fails to provide proof of a change that would increase the benefit level, the Food Stamp benefit remains at the amount already established. ( )

03. Proof Provided Within Ten Days. If the household provides proof within ten (10) days of reporting the change, the Department will increase the Food Stamp benefits beginning the month immediately following the month in which the change was reported. For changes reported after the 20th of the month, a supplement is issued for the next month no later than the 10th of the next month. If the change is reported and verified after the final date to adjust Food Stamp benefits for the following month in the Department's automated eligibility system, the change to the Food Stamp benefits must be made by the following month, even if a supplement must be issued. ( )

04. Proof Not Provided Within Ten Days. If the household fails to provide proof within ten (10) days of reporting the change, but provides proof later, benefits are increased the month after the proof of the change is provided. ( )

618. DECREASES IN FOOD STAMP BENEFITS.
If the Department acts on a change that results in a decrease in Food Stamp benefits, the Department must give timely notice, if required. The notice must explain the reason for the action. ( )

619 -- 620. (RESERVED)

621. TAFI OR AABD HOUSEHOLD REPORTING CHANGES.
If a change in the AABD or TAFI grant results in a change in the household's Food Stamp benefits, the Department must count the new grant amount, regardless of whether the Food Stamps increase or decrease. If a change requires a reduction or ending of TAFI or AABD and Food Stamp benefits, the Department will issue a Notice of Decision for both programs. If the household makes a timely request for a fair hearing and continued benefits, Food Stamp benefits continue pending the hearing. The household must reapply if certification expires before the hearing is complete. ( )

622. CHANGE ENDS TAFI OR AABD INCOME.
~~A change ending a household's income from a TAFI or AABD grant during the certification period may affect Food Stamp eligibility. A household's Food Stamp benefits must not be closed just because of a TAFI or AABD closure.~~ Food Stamp benefits will be closed only if there is a change on which the Department is required to act.~~ change requires the Department to take action under Section 613 of these rules and the action would close Food Stamps. If the household appeals and TAFI or AABD is continued, continue Food Stamps at the same level. If a TAFI or AABD notice is not required or the household does not appeal, the Department must send a notice explaining that the household's benefits will end. A notice must be sent to the household when Food Stamp benefits change because of a TAFI or AABD change.~~ If TAFI or AABD ends and the household remains Food Stamp eligible, the Department must advise the household of~~ the~~ any applicable work registration requirements. ~~(3-17-22)~~( )

623. FAILURE TO TAKE REQUIRED ACTION.
If the Department is unable to make a change in Food Stamp eligibility or issuance and an overissuance results, the

Department will collect the overpayment. If the Department fails to act on a change that increases household benefits, the Department will restore lost benefits. ~~(3-17-22)~~(   )

624. -- 628. (RESERVED)

629. NOTICE OF LOWERING OR ENDING BENEFITS.
Households must be sent a Notice of Decision when Food Stamps are ended or reduced unless notice is not required under these rules. (   )

630. ADEQUATE NOTICE.
Adequate notice is a written statement telling the household the action the Department is taking. The notice must tell the reasons for the action~~. The notice must~~ and advise the household of the right to a hearing. All notices must be adequate. If Food Stamps are reduced, the household must receive the notice on or before the first day of the month the action is effective. ~~(3-17-22)~~(   )

631. TIMELY NOTICE.
~~Notices must be sent within the time limits listed in these rules.~~ Timely notice must be mailed at least ten (10) days before the effective date of the action. ~~(3-17-22)~~(   )

632. TIMELY NOTICE NOT REQUIRED.
Timely notice is not required when the conditions listed below are met. Adequate notice must be given. (   )

01. Statement of Household. The Department gets a clear, written, signed statement from the household. Food Stamps can be ended or reduced from the facts given in the household statement. (   )

02. Food Stamps Reduced After Closure Notice. The household is sent a notice of closure because it did not provide requested proof. The household provides the proof before the first day of the month of closure. If the proof results in reduced Food Stamps, the reduced benefits are issued. ~~Timely notice of the reduction is not required.~~ ~~(3-17-22)~~(   )

03. Food Stamps Closed or Reduced Because of ~~Intentional Program Violation (~~IPV~~)~~ Penalty. The Department must impose the IPV penalty the first of the month after the month it gives written notice to the ~~client~~ participant. ~~Timely notice is not required.~~ ~~(3-17-22)~~(   )

633. NOTICE OF CHANGES NOT REQUIRED.
Notice to individual Food Stamp households is not required when the conditions ~~listed in~~ under Subsection 633.01 ~~below~~ in this rule are met. Mass notice must be given in some situations~~, as listed in~~ under Subsection 633.02 ~~below~~ in this rule: ~~(3-17-22)~~(   )

01. Waiver by the Household. A household member or authorized representative provides a written statement requesting closure. The person gives information causing reduction or an end to benefits and states, in writing, they know adverse action will be taken. The person acknowledges in writing continuation of benefits is waived if a fair hearing is requested. (   )

02. Mass Changes. ~~Mass changes i~~Include changes: ~~(3-17-22)~~(   )

a. ~~Changes i~~In the income limit tables. ~~(3-17-22)~~(   )

b. ~~Changes i~~In the issuance tables. ~~(3-17-22)~~(   )

c. ~~Changes i~~In Social Security benefits. ~~(3-17-22)~~(   )

d. ~~Changes i~~In SSI payments. ~~(3-17-22)~~(   )

e. ~~Changes i~~In TAFI or AABD grants. ~~(3-17-22)~~(   )

f. ~~Changes c~~Caused by a reduction, suspension, or cancellation of Food Stamps ordered by the

Secretary of USDA. ~~(3-17-22)~~(   )

g. When ~~it performs mass changes,~~ the Department performs mass changes, it notifies Food Stamp households of the mass change by one (1) of the following methods: ~~(3-17-22)~~(   )

i. Media notices. (   )

ii. Posters in the Food Stamp offices and issuance locations. (   )

iii. A general notice mailed to households. (   )

03. Mass Changes in TAFI or AABD. When a mass change to TAFI or AABD causes a Food Stamp change, the Department will use the following criteria: ~~(3-17-22)~~(   )

a. If the Department has thirty (30) days advance notice of the TAFI or AABD mass change, Food Stamps must be adjusted the same month as the change. (   )

b. If the Department does not have advance notice, Food Stamp benefits must be changed no later than the month after the TAFI or AABD mass change. (   )

c. Ten (10) day advance notice to Food Stamp households is not required. Adequate notice must be sent to Food Stamp households. (   )

d. If a household requests a fair hearing because of an issue other than mass change, the Department will continue Food Stamps. ~~(3-17-22)~~(   )

04. Notice of Death. Notice is not required when the Department learns of the death of all household members. (   )

05. Completion of Restored Benefits. Notice is not required when an increased allotment, due to restored benefits, ends. The household must have been notified in writing when the increase would end. (   )

06. Joint Public Assistance and Food Stamp Applications. Notice is not required if the household jointly applies for TAFI or AABD and Food Stamps and gets Food Stamps pending TAFI or AABD approval. The household must be notified at certification that Food Stamps will be reduced upon TAFI or AABD approval. (   )

07. Converting From Repayment to Benefit Reduction. Notice is not required if a household with an IHE or IPV claim fails to repay under the repayment schedule. An allotment reduction is enforced. (   )

08. Households Receiving Expedited Service. Notice is not required if all the following conditions are met: (   )

a. The applicant received expedited services. (   )

b. Proof was postponed. (   )

c. A regular certification period was assigned. (   )

d. Written notice, stating future Food Stamps depend on postponed proof, was given at approval. (   )

09. Residents of a ~~Drug or Alcoholic~~ Substance Use Disorder Treatment Center or a Group Living Arrangement Center. Notice is not required when the Department ends Food Stamps to residents of a ~~drug or alcoholic~~ substance use disorder treatment center or group living arrangement center if: ~~(3-17-22)~~(   )

a. The Department revokes the center's certification. (   )

b. FNS disqualifies the center as a retailer. ( )

634. VERBAL REQUEST FOR END OF FOOD STAMPS.
If a household makes a verbal request for closure, the Department will end the benefits, and notify the household with a ten (10) day advance Notice of Decision. ~~(3-17-22)~~( )

635. -- 638. (RESERVED)

639. CONTINUATION OF BENEFITS PENDING A HEARING.
The household retains the right to continued benefits when the household requests a fair hearing within the ten (10) day notice period. The household must request this continuation of Food Stamps. If certification has not expired, Food Stamps can continue at the former level. Benefits must be continued within five (5) working days of the household's request for a fair hearing. ( )

640. (RESERVED)

641. REDUCING OR ENDING BENEFITS BEFORE HEARING DECISION.
Benefits may be ended or reduced before the hearing decision, if~~ a condition listed below~~ any of the following is met: ~~(3-17-22)~~( )

01. Appeal of Federal Law. The hearing official states, in writing, the sole issue being appealed is one of federal law, regulation, or policy. ( )

02. Food Stamp Issuance Changes. Food Stamp eligibility or benefit level changes occur before the hearing decision and a new hearing is not requested. ( )

03. Food Stamp~~s Expire~~ Certification Period Expires.~~ The Food Stamp certification period expires.~~ ~~(3-17-22)~~( )

04. Mass Change Occurs Before the Hearing Decision.~~ A mass change occurs before the hearing decision.~~ ~~(3-17-22)~~( )

642. -- 643. (RESERVED)

644. EXPIRATION OF CERTIFICATION PERIOD.
Household eligibility ends when the certification period expires. ( )

645. RECERTIFICATION PROCESS.
The Department must follow the recertification procedures~~ described in~~ under 7 CFR 273.14. ~~(3-17-22)~~( )

646. NOTICE OF DECISION FOR TIMELY RECERTIFICATION.
A Notice of Decision must be sent to households that reapply for Food Stamps. To receive Food Stamps with no break in issuance, households must complete a six-month or twelve-month contact or recertification before the fifteenth day of the last month of certification or six-month or twelve-month contact period. If the household applies before the fifteenth day of the month, the Department will notify the household of eligibility or denial by the end of the current certification period. ( )

647. -- 649. (RESERVED)

650. RESTORATION OF LOST BENEFITS.
Lost benefits must be restored. The Department may find Food Stamps have been incorrectly denied, ended, or underissued to an eligible household. The Department may learn of lost benefits from case reviews, Quality Control reviews, or other sources. Benefits are restored when caused by a Department error, when a fair hearing is reversed, or an IPV disqualification is reversed. The Department will ~~R~~restore benefits to eligible and previously eligible households~~. Restore benefits~~ and to households who have moved out of state. The Department will ~~R~~restore benefits for SSA joint processing errors. ~~(3-17-22)~~( )

651. TIME FRAMES FOR RESTORATION OF BENEFITS.
Benefits must not be restored if lost more than twelve (12) months before notification or discovery. ( )

01. Lost Benefits Reported by Household. ~~Lost benefits a~~Are restored when the Department learns of lost benefits reported by the household, a person outside the household, or by another agency. Twelve (12) months are counted from the month the Department is notified of the lost benefits. ~~(3-17-22)~~( )

02. Lost Benefits Discovered by Department. ~~Lost benefits a~~Are restored when the Department discovers lost benefits during the course of business. Twelve (12) months are counted from the month the Department discovers the benefits were lost. ~~(3-17-22)~~( )

03. Lost Benefits From Fair Hearing. ~~Lost benefits a~~Are restored to a household that requests a fair hearing and the decision is in the household's favor. Twelve (12) months are counted from the effective date of the adverse action causing the fair hearing. ~~(3-17-22)~~( )

652. -- 655. (RESERVED)

656. REPLACING FOOD DESTROYED BY A DISASTER.
Conditions and procedures for replacing food destroyed by a disaster are listed below. The food must have been purchased with Food Stamps. ( )

01. Food Destroyed in a Disaster. The actual value of loss, not to exceed one (1) month's allotment, can be replaced. The food bought with Food Stamps must have been destroyed in a disaster. The disaster may involve only the household, such as a house fire, or a larger scope, such as a flood. There is no limit on the number of times food destroyed in a disaster may be replaced. ( )

02. Replacement Time Limit for Disaster Loss. The Department must provide either disaster Food Stamps or replacement Food Stamps, but not both, within ten (10) days of the reported loss, if: ( )

a. The household reports the disaster within ten (10) days of the incident. ( )

b. The disaster is verified by collateral contact, an organization such as the Fire Department or Red Cross, or by home visit. ( )

657. -- 674. (RESERVED)

675. IPV, IHE, AND AE FOOD STAMP CLAIMS.
An overissuance exists when the amount of Food Stamps issued exceeds the Food Stamps a household is eligible to receive. The Department must establish a claim against the household, to recover the value of Food Stamps overissued or misused. The types of Food Stamp claims are listed~~ in Subsections 675.01 through 675.03 of this rule~~ below. ~~(3-17-22)~~( )

01. Intentional Program Violation (IPV) Claim. A~~n IPV claim is an~~ overissuance caused by an intentional, knowing, and willful program violation. ~~(3-17-22)~~( )

02. Inadvertent Household Error (IHE) Claims. An~~ IHE is a household~~ error, without intent to cause an overissuance, which results in a Food Stamp over-issuance. Causes of IHE claims are: ~~(3-17-22)~~( )

a. Failure to give information. A household, without intent to cause an overissuance, fails to give correct or complete information. ( )

b. Failure to report change that was required to be reported. A household, without intent to cause an overissuance, fails to report changes or to report at all. ( )

c. Failure to comply. A household, without intent to cause an overissuance, fails to comply due to language barrier, educational level, or not understanding written or verbal instructions. ( )

d. Pending IPV. An IHE claim occurs between the time of an IPV referral and the IPV decision. ( )

03. Agency Error Claim (AE). A~~n agency error~~ claim that results from an overissuance caused by a Department action~~,~~ or a failure to act. ~~(3-17-22)~~( )

676. PERSONS LIABLE FOR FOOD STAMP CLAIMS.
The persons listed ~~in Subsections 676.01 through 676.03~~ below are responsible for paying a claim. ~~(3-17-22)~~( )

01. Adult Household Members. Adult members of the household at the time of the overissuance or trafficking are liable. They are individually and jointly liable, whether residing in the household where the claim arose, or in any other household. ( )

02. Sponsor of an Alien. The sponsor of an alien household member if the sponsor is at fault for the claim. ( )

03. Person Connected to the Household. A person connected to the household, such as an authorized representative, who ~~actually~~ trafficks~~,~~ or causes an overissuance or trafficking. ~~(3-17-22)~~( )

677. COMPUTING FOOD STAMP CLAIMS.
The Department computes Food Stamp claims as described ~~in Subsections 677.01 and 677.02 of this rule~~ below. ~~(3-17-22)~~( )

01. Claims Not Related to Trafficking. The Department computes claims~~,~~ not related to trafficking~~,~~ back to a minimum of twelve (12) months before it became aware of the overissuance. The Department does not compute these claims~~, not related to trafficking,~~ back more than six (6) years. For an IPV claim, the Department computes back to the month the first ~~act of~~ IPV occurred. The Department continues to compute back a minimum of twelve (12) months before the first ~~act of~~ IPV. The Department does not compute IPV claims back more than six (6) years before the first ~~act of~~ IPV. ~~(3-17-22)~~( )

02. Trafficking-Related Claims. ~~Claims arising from trafficking-related offenses a~~Are the value of the trafficked Food Stamps as determined by: ~~(3-17-22)~~( )

a. The individual's admission. ( )

b. Adjudication. ( )

c. The documentation forming the basis for the trafficking determination. ( )

678. -- 691. (RESERVED)

692. DETERMINING DELINQUENT CLAIMS.
The Department determines if a claim is delinquent ~~by~~ using ~~Subsections 692.01 through 692.05 of this rule~~ the following. ~~(3-17-22)~~( )

01. Claim Not Paid by Due Date. ~~The claim i~~Is delinquent if ~~not paid by the due date, and~~ there is not a satisfactory payment arrangement. The claim remains delinquent until paid in full, a satisfactory repayment agreement is negotiated, or allotment reduction is invoked. ~~(3-17-22)~~( )

02. Payment Arrangement Not Followed. The claim is delinquent if a payment arrangement is established, but scheduled payment is not made by the due date. The claim remains delinquent until paid in full, allotment reduction is invoked, or the Department agrees to resume or renegotiate the repayment schedule. ( )

03. Previous Claim. A claim is not delinquent if another claim for the same household is being paid through an installment agreement or allotment reduction. The Department begins collection on the new claim after

the first claim is settled. ( )

04. Collection Coordinated Through Court. A claim is not delinquent if the Department is unable to determine delinquency status because collection is coordinated through the court system. ( )

05. Claim Awaiting Hearing Decision. ~~A claim awaiting a hearing decision i~~Is not delinquent. If later, the hearing officer affirms a claim does exist against the household, the Department notifies the household. ~~(3-17-22)~~( )

693. (RESERVED)

694. COLLECTING CLAIMS.

The Department collects payment for claims using the methods listed ~~in Subsections 695.01 through 695.05 of these rules~~ below. ~~(3-17-22)~~( )

01. Allotment Reduction. The Department reduces the Food Stamp allotment to collect the claim. ( )

a. For an IPV claim, the allotment reduction limit is the greater of twenty dollars ($20) per month or twenty percent (20%) of the household's monthly allotment. ( )

b. For an IHE or AE claim, the allotment reduction limit is the greater of ten dollars ($10) per month or ten percent (10%) of the household's monthly allotment. The household can agree to a higher amount. ( )

c. The Department does not reduce the initial month's Food Stamps unless the household agrees to this reduction. ( )

02. Household Repay~~ment~~s the Claim from its EBT Account. ~~The household pays the claim from its Electronic Benefit Transfer (EBT) account.~~ ~~(3-17-22)~~( )

03. Payment by Cash, Check, or Money Order. ~~Payment by cash, check, or money order.~~ ~~(3-17-22)~~( )

04. Household Performing Public Service. Payment by public service as ordered by a court, specifically as payment of a claim. ( )

05. Collection by Treasury Offset Program (TOP). The Department submits claims delinquent for one hundred and eighty (180) days, or more, for collection through TOP. ( )

695. TOP NOTICES.

The Department will provide the household with a notice of intent to collect via Treasury offset. The notice must inform the household of the right to request a Department review of the intended collection action. The Department must receive the request for review within sixty (60) days of the notice of intent to collect. The notice of review determination must inform the household of the right to request that FNS review the Department's decision. The notice must include instructions for requesting a review by FNS and the address of the FNS regional office. ( )

696. EFFECTS OF TOP ON THE FOOD STAMP HOUSEHOLD.

When a claim is referred to TOP, any eligible federal payment owed to the household may be intercepted and applied to the claim to reduce the debt. The household may be required to pay collection or processing fees charged by the federal government to intercept the payment. ( )

697. REMOVING A CLAIM FROM TOP.

The Department removes a claim from TOP under the conditions listed ~~in Subsections 697.01 through 697.05 of this rule~~ below. ~~(3-17-22)~~( )

01. Instructed by FNS or Treasury. ~~FNS or Treasury instructs the Department to remove the debt~~

~~from TOP.~~ ~~(3-17-22)~~( )

02. Household Undergoing Allotment Reduction.~~ The person is a member of a Food Stamp household undergoing allotment reduction.~~ ~~(3-17-22)~~( )

03. Claim Is Paid in Full.~~The claim is paid in full.~~ ~~(3-17-22)~~( )

04. Claim Is Satisfied Through a Hearing, Termination, Compromise, or Other Means.~~ The claim is satisfied through a hearing, termination, compromise, or other means.~~ ~~(3-17-22)~~( )

05. Household Arranges to Resume Payments~~ Resumed~~.~~ The household makes arrangements to resume payments.~~ ~~(3-17-22)~~( )

698. INTENTIONAL PROGRAM VIOLATION (IPV).

An IPV includes the actions listed~~ in Subsections 698.01 through 698.06 of this rule~~ below. The~~ client~~ participant must intentionally, knowingly, and willfully commit a program violation. ~~(3-17-22)~~( )

01. False Statement. A person makes a false statement to the Department, either orally or in writing, to get Food Stamps. ( )

02. Misleading Statement. A person makes a misleading statement to the Department, either orally or in writing, to get Food Stamps. ( )

03. Misrepresenting. A person misrepresents facts to the Department, either orally or in writing, to get Food Stamps. ( )

04. Concealing. A person conceals or withholds facts to get Food Stamps. ( )

05. Violation of Regulations. A person commits any act violating the Food Stamp Act, federal regulations, or state Food Stamp regulations. The violation may relate to use, presentation, transfer, acquisition, receipt, or possession of Food Stamps. ( )

06. Trafficking in Food Stamps. ~~Trafficking in Food Stamps m~~Means any of the following: ~~(3-17-22)~~( )

a. The buying, selling, stealing, or otherwise effecting an exchange of food stamp benefits issued and accessed via ~~Electronic Benefit Transfer (~~EBT~~)~~ cards, card numbers, and personal identification numbers (PINs), or by manual voucher and signature, for cash or consideration other than eligible food, either directly, indirectly, in complicity or collusion with others, or acting alone; ~~(3-17-22)~~( )

b. Attempting to buy, sell, steal, or otherwise affect an exchange of food stamp benefits issued and accessed via ~~Electronic Benefit Transfer (~~EBT~~)~~ cards, card numbers, and ~~personal identification numbers (~~PINs~~)~~, or by manual voucher and signatures, for cash or consideration other than eligible food, either directly, indirectly, in complicity or collusion with others, or acting alone; ~~(3-17-22)~~( )

c. The exchange of firearms, ammunition, explosives, or controlled substances,~~ as~~ defined~~ in~~ under Section 802 of Title 21, U~~.~~S~~.~~C~~.~~, for food stamp benefits; ~~(3-17-22)~~( )

d. Purchasing a product with food stamp benefits that has a container requiring a return deposit with the intent of obtaining cash by discarding the product and returning the container for the deposit amount, intentionally discarding the product, and intentionally returning the container for the deposit amount; ( )

e. Purchasing a product with food stamp benefits with the intent of obtaining cash or consideration other than eligible food by reselling the product, and subsequently intentionally reselling the product purchased with food stamp benefits in exchange for cash or consideration other than eligible food; or ( )

f. Intentionally purchasing products originally purchased with food stamp benefits in exchange for

cash or consideration other than eligible food. ( )

699. ESTABLISHING AN INTENTIONAL PROGRAM VIOLATION (IPV).
The Department establishes an IPV by the actions listed~~ in Subsections 699.01 through 699.03 of this rule~~ below. ~~(3-17-22)~~( )

01. Waiver. The~~ client~~ participant signs a waiver to a disqualification hearing. ~~(3-17-22)~~( )

02. Hearing. An administrative disqualification hearing determines an IPV. ( )

03. Judgement. A court judgement determines an IPV. ( )

700. ADMINISTRATIVE RESPONSIBILITY FOR ESTABLISHING IPV.
The Department must investigate and refer cases for an IPV determination. If there is enough recorded evidence to establish an IPV, the Department must take the actions listed below: ( )

01. Act to Collect. The Department must act to collect overissuances. The Department must set up IHE overissuance claims when a suspected IPV claim is not pursued under administrative or prosecution procedures. ( )

02. Obtain Administrative Disqualification. The Department pursues administrative disqualification when: ( )

a. The case facts do not warrant civil or criminal prosecution. ( )

b. The case referred for prosecution was declined. ( )

c. The case was referred for prosecution and no action was taken in a reasonable time. ( )

d. The case was referred for prosecution, but the case was withdrawn by the Department. ( )

03. Do Not Obtain Administrative Disqualification. The Department must not pursue an administrative disqualification in cases: ( )

a. Being referred for prosecution. ( )

b. After any prosecutor action against the accused if the case issues are the same or related circumstances. ( )

701. PENALTIES FOR AN IPV.
IPV persons are ineligible for Food Stamps for twelve (12) months for the first violation~~. IPV persons are ineligible for Food Stamps~~, for twenty-four (24) months for the second violation~~. IPV persons are ineligible for Food Stamps~~, and permanently for the third violation. The Department will disqualify only the person(s)~~ or persons~~ who committed the IPV. The Department will notify the person in writing of the disqualification penalty. The penalty continues without interruption until completed, regardless of the eligibility of the disqualified person. An IPV penalty can be imposed~~,~~ even if no overissuance claim exists. ~~(3-17-22)~~( )

01. Administrative Disqualification Hearings. The disqualification begins no later than the first day of the second month following the date the person gets written notice of the disqualification. ( )

02. Waivers. The disqualification begins the first day of the month following the date the person gets the written notice of disqualification. ( )

03. Court Decisions. The disqualification begins on the date imposed by the court (to start the beginning of the following month) or, if no date is specified, within forty-five (45) days of the date the disqualification was ordered, beginning the first day of the month. ( )

702. PENALTIES FOR IPV TRAFFICKING.
IPV persons are ineligible for Food Stamps for two (2) years for the first finding by a court the recipient purchased illegal drugs with Food Stamps~~. IPV persons~~, are permanently ineligible for Food Stamps for a second finding by the court the recipient purchased illegal drugs with Food Stamps~~. IPV persons~~, and are permanently ineligible for Food Stamps for a first finding by a court the recipient purchased firearms, ammunition, or explosives with Food Stamps. A person convicted of trafficking in Food Stamp benefits of five hundred dollars ($500) or more is permanently disqualified from the Food Stamp program. ~~(3-17-22)~~(   )

703. PENALTIES FOR IPV RECEIPT OF MULTIPLE BENEFITS.
A person found making a fraudulent statement or representation about identity or residence to get multiple benefits is ineligible for Food Stamps for ten (10) years for the first and second offenses and permanently for the third offense. (   )

704. -- 714. (RESERVED)

715. WAIVED HEARINGS.
Persons accused of an IPV may waive their right to an administrative disqualification hearing by completing and signing a Waiver of Disqualification Hearing.~~ The steps needed to waive the hearing are listed below:~~ If the reviewers determine a waiver is proper, each household member suspected of IPV must be mailed or given a Waiver of Disqualification Hearing. ~~(3-17-22)~~(   )

~~**01. Review of Evidence**. The Department must be sure the evidence warrants scheduling a disqualification hearing before giving household members, suspected of an IPV, the waiver option. Household circumstances must be reviewed by the Examiner assigned the case and a program supervisor or designee. (3-17-22)~~

~~**02. Advance Notice**. If the reviewers determine a waiver is proper, each household member suspected of IPV must be mailed or given a Waiver of Disqualification Hearing. (3-17-22)~~

716. DISQUALIFICATION AFTER WAIVED HEARING.
Persons waiving their right to an IPV administrative disqualification hearing must have penalties imposed. (   )

717. COURT REFERRALS.
Procedures for court referrals are listed below: (   )

01. Referred Cases. The Department may refer persons to law enforcement or county prosecutor who are suspected of getting or receiving Food Stamps by committing an IPV~~. The Department may refer~~, or persons suspected of committing an IPV. ~~(3-17-22)~~(   )

02. Impose Court Penalties. The Department must disqualify a person found guilty of IPV by a court for the length of time specified by the court. The disqualified member's household will remain responsible for the overissuance, resulting from the disqualified member's IPV, regardless of the household's eligibility. If the court fails to specify a period, the Department will use the IPV penalty periods~~ specified in~~ under Section 701 of these rules unless they are contrary to the court order. ~~(3-17-22)~~(   )

718. DEFERRED ADJUDICATION.
Deferred Adjudication is an out-of-court settlement between the accused IPV member and the prosecutor. Terms of the settlement are listed below: (   )

01. Deferred Judgement Conditions. Guilt is not decided by the court because the accused person has met the terms of a court order or an agreement with the prosecutor. (   )

02. Agreement with Prosecutor. If the Department has an agreement with the prosecutor, the prosecutor may defer adjudication. The prosecutor must agree to give advance written notice to the member stating the consequences of consenting to disqualification. (   )

03. Notice to Food Stamp Member. If the prosecutor decides deferred adjudication is fitting, the household member suspected of IPV must be mailed or presented with a Deferred Adjudication Disqualification

Consent Agreement. ( )

04. Disqualification Period. The period of disqualification must begin within forty-five (45) days of the date the member signed the Deferred Adjudication Disqualification Consent Agreement~~ (HW 0546)~~. The period of disqualification must begin as agreed upon with the ~~P~~prosecutor. Once a disqualification penalty is imposed against a member, the period continues uninterrupted regardless of the household's eligibility. The disqualified member's household continues to be responsible for overissuance repayment resulting from the disqualified member's IPV regardless of the household's eligibility. ~~(3-17-22)~~( )

05. Notice of Disqualification. The Department must provide a completed Notice of Disqualification ~~(HW 0541)~~ before the disqualification to the disqualified member and remaining household members. The Department must provide a Demand Letter for Overissuance and Repayment Agreement~~ (HW 0544)~~.~~(3-17-22)~~( )

719. (RESERVED)

720. CLAIMS DISCHARGED BY BANKRUPTCY.

The Department will act for FNS in bankruptcy proceedings against households owing claims. The Department may file proofs of claims, objections to discharge, exceptions, petitions, and any other documents, motions, or objectives FNS might have filed. ( )

721. (RESERVED)

722. INTERSTATE CLAIMS COLLECTION.

~~If a household owes a claim and moves from one State to another, the first State should start or continue collection action. The first State has the initial opportunity to collect. The receiving State should take collection action if the first State fails to act. The receiving State should contact the first State to be sure the first State does not intend to pursue collection. The State share of claims collected is kept by the State making the collection.~~Idaho is responsible for initiating and continuing collection action on any Food Stamp recipient claim regardless of whether the household remains in Idaho. ~~(3-17-22)~~( )

723. -- 727. (RESERVED)

728. FOOD STAMP REDUCTION, SUSPENSION, OR CANCELLATION.

Food Stamps for all Food Stamp households must be reduced suspended, or cancelled, if ordered by the USDA Secretary to comply with Section 18 of the Food Stamp Act of 1977. Reduced Food Stamps are computed using the thrifty food plan amounts and are reduced by a percentage defined by FNS. Food Stamp reduction, suspension, and cancellation rules are described below: ( )

01. Reducing Food Stamps. FNS will notify the Department of the effective date of reduction and of the thrifty food plan reduction percentage. The Department must: ( )

a. Act immediately to carry out the reduction. ( )

b. Guarantee one (1) and two (2) person households a minimum benefit of equal to eight percent (8%) of the maximum one (1) person allotment unless the reduction is ninety percent (90%) or more of total projected monthly benefits. ( )

02. Restoring Lost Benefits. Households whose Food Stamps are reduced or cancelled under this ~~section~~ rule are not entitled to restoration of benefits. Reductions or cancellations of Food Stamps may be ordered restored by the USDA Secretary. ~~(3-17-22)~~( )

03. Suspension or Cancellation. If a suspension or cancellation is in effect, no Food Stamps are to be issued to the applicant. ( )

04. Hearings. Any household whose allotment was reduced, suspended, or cancelled under this~~ section~~ rule can request a fair hearing. ~~(3-17-22)~~( )

729. -- 750. (RESERVED)

751. BOARDERS.
Rules for Food Stamp boarders are listed below: ( )

01. Boarder Included with Food Stamp Household. Boarders may be included in the Food Stamp household providing board. The Food Stamp household must request the boarder be included. The household must be otherwise eligible. ( )

02. Foster Children and Foster Adults. Foster children and foster adults are boarders. Foster care payments and guardianship payments are not income for Food Stamps if the foster child and adult do~~es~~ not get Food Stamps as part of the household. If the household requests the foster child and adult be included in the Food Stamp household, foster care payments and guardianship payments are counted. ~~(3-17-22)~~( )

03. ~~Foster Adults~~Certified Family Home (CFH). ~~Foster adults are boarders. Foster care payments are not income for Food Stamps if the foster adult does not get Food Stamps as part of the household. If the household requests the foster adult be included in the Food Stamp household, the foster care payments are counted.~~ CFH residents are considered boarders and may be included in the CFH providers household. ~~(3-17-22)~~( )

04. Meal Compensation. Boarder status must be given to persons paying a reasonable monthly amount for meals. ( )

a. Payments for more than two (2) meals a day must equal or exceed the thrifty food plan for the boarder household size. ( )

b. Payments for two (2) meals or less per day must equal or exceed two-thirds (2/3) of the thrifty food plan for the boarder household size. ( )

05. Nonboarder Status. A person paying less than a reasonable amount for meals is a member of the household providing board. ( )

06. Income from Boarders. If the boarder is not a Food Stamp household member: ( )

a. The meals and lodging payment is self-employment income for the Food Stamp household. ( )

b. The boarder's income and resources are not counted for the Food Stamp household. ( )

752. STRIKERS.
Households with strikers are not eligible to get Food Stamps unless the household was eligible the day before the strike. ( )

753. SPONSORED LEGAL NON-CITIZENS.
Sponsored legal non-citizens are lawfully admitted for permanent United States residence~~, as defined in Sections 101(a)(15) and 101(a)(20) of the Immigration and Nationality Act~~. A sponsor executes an I-864 affidavit of support on behalf of legal non-citizen~~, as a condition of the legal non-citizen's entry or admission into the United States as a permanent resident~~. The income and resources of the sponsor will be deemed until the legal non-citizen becomes a naturalized citizen or until ~~he has~~ they have worked forty (40) qualifying quarters of coverage under Title II of the Social Security Act, or the sponsor dies. A qualifying quarter includes a quarter worked by the legal non-citizen's parent while the legal non-citizen was under eighteen (18) and a quarter worked by the legal noncitizen's spouse during marriage if the legal non-citizen remains married to the spouse or the spouse is deceased. Any quarter after January 1, 1997, in which a legal non-citizen received any federal means-tested benefit is not counted as a qualifying quarter. ~~(3-17-22)~~( )

754. DEEMING INCOME AND RESOURCES TO SPONSORED LEGAL NON-CITIZEN.
Income and resources of the sponsor are deemed available to the legal non-citizen. If the sponsor lives with ~~his~~ their spouse, the spouse's income and resources are also deemed available to the legal non-citizen. The income and

resources are deemed, even if the sponsor and spouse were married after the sponsor signed the sponsorship agreement. The Department counts income and resources deemed to the legal non-citizen toward Food Stamp eligibility and issuance level of the legal non-citizen's household. ~~(3-17-22)~~(   )

01. Battered Legal Non-Citizen Whose Sponsor Signed an Affidavit of Support. For sponsor deeming, a battered legal non-citizen includes the non-citizen and the child of the non-citizen. The non-citizen or child must be battered in the US by a spouse, parent, or member of the family in the same household. The non-citizen must not participate in, or acquiesce to, the battering of the child. (   )

a. A battered legal non-citizen whose sponsor signed an affidavit of support is exempt from the sponsor deeming requirement for one (1) year if the need for Food Stamps is connected to the battery and the legal non-citizen no longer lives with the batterer. (   )

b. The exemption from the sponsor deeming requirement can exceed more than one (1) year if the legal non-citizen demonstrates the battery has been recognized in an order of a judge or by the INS and the need for Food Stamps is connected to the battery. (   )

02. Indigent Legal Non-Citizen Whose Sponsor Signed an Affidavit of Support. A non-citizen is indigent if the household income does not exceed one-hundred thirty percent (130%) of the poverty income guideline (gross income limit) for the household size. (   )

a. For an indigent non-citizen, the Department counts the noncitizen's own income and the cash or in-kind income and resources ~~actually~~ provided by the sponsor and spouse who signed an affidavit of support. ~~(3-17-22)~~(   )

b. A legal non-citizen that satisfies the indigent exemption criteria is exempt from deeming for twelve (12) months. The exemption can be renewed for additional twelve-month periods. (   )

c. If a legal non-citizen is granted an indigence exemption, the Department must provide written notification to the Statistics Branch of the INS on an annual basis. Required information includes written notice of the determination, the sponsored legal non-citizen's name, and the sponsor's name. (   )

d. A legal non-citizen can elect to decline the indigent exemption to avoid sponsor liability and notification to the INS. (   )

e. If the legal non-citizen declines the indigent exemption, the household is subject to sponsored deeming. (   )

755. – 756. (RESERVED)

757. SPONSORED LEGAL NON-CITIZEN'S RESPONSIBILITY.

The legal non-citizen and ~~legal non-citizen's~~ their spouse are responsible for getting the sponsor to cooperate with the Department in determining Food Stamp eligibility. The legal non-citizen and ~~legal non-citizen's~~ their spouse are responsible for providing the information and proof to determine the income and resources of the sponsor and sponsor's spouse. The legal non-citizen and ~~legal non-citizen's~~ their spouse are responsible for providing information and proof to determine if the sponsor sponsors other legal non-citizens and how many. ~~(3-17-22)~~(   )

758. – 760. (RESERVED)

761. COLLECTING CLAIMS AGAINST SPONSORS WHO SIGNED AN I-864 AFFIDAVIT OF SUPPORT ON OR AFTER DECEMBER 19, 1997.

~~The Department must send a demand letter to the sponsor. The demand letter must include the amount owed, the reason for the claim, and the repayment options. The demand letter must tell the sponsor he will not have to repay, if he can show he did not give false statements or withhold information about his circumstances. Collection action may be stopped if documentation is obtained showing the sponsor cannot be located. Collection action may be stopped if the cost of collection exceeds the amount to be recovered. If the sponsor responds to the demand letter, a lump sum cash payment may be collected if the sponsor can pay the claim at one (1) time. If the sponsor cannot pay by lump~~

~~sum, a monthly repayment schedule may be negotiated. Sponsor repayments must be recorded in the case file and identified as either an IHE or IPV claim.~~Claims may be collected against a sponsor who signed an I-864 affidavit of support on or after December 19, 1997, and is found to have provided false statements or withheld information. ~~(3-17-22)~~( )

762. COLLECTING CLAIMS AGAINST SPONSORED LEGAL NON-CITIZENS.
Claims may be collected against sponsored legal non-citizens with a sponsor who signed an I-864 affidavit of support on or after December 19, 1997. Action may be taken to collect by submitting an IHE or IPV. ( )

763. REIMBURSEMENT FOR BENEFITS RECEIVED.
A sponsor who signed an affidavit on or after December 19, 1997~~,~~ must reimburse the Department for the amount of Food Stamps received by the sponsored legal non-citizen if false information is provided or information is withheld. At the time of application for a sponsored legal non-citizen, the legal non-citizen's sponsor must be notified that he will be required to reimburse the Department for the entire amount of Food Stamps received by the sponsored legal non-citizen. ~~(3-17-22)~~( )

764. -- 7~~74~~90. (RESERVED)

~~**775. FOOD STAMPS FOR HOUSEHOLDS WITH IPV MEMBERS, INELIGIBLE FUGITIVE FELON, PROBATION/PAROLE VIOLATOR, WORK REQUIREMENT SANCTIONS, OR A MEMBER CONVICTED OF A CONTROLLED SUBSTANCE-RELATED FELONY.**~~
~~The Department calculates Food Stamp eligibility and benefit level for households containing members disqualified for an IPV, ineligible fugitive felon, probation/parole violator, members ineligible because of work requirement sanctions including JSAP, and Voluntary Quit, or a member ineligible because of a controlled substance-related felony. The household's Food Stamps must not increase because a household member is disqualified for IPV.~~ ~~(3-17-22)~~

~~**776. -- 790. (RESERVED)**~~

791. RESIDENT OF AN INSTITUTION.
A resident of an institution is not eligible for Food Stamps unless the resident meets one (1) of the requirements listed below. A person is a resident of an institution if the institution provides over fifty percent (50%) of the person's meals as a part of normal services. Residents must be otherwise Food Stamp eligible. ( )

01. Resident Under Housing Act. The resident is in federally subsidized housing for the elderly, under Section 202 of the Housing Act or 236 of the National Housing Act. ( )

02. ~~Narcotic Addict or Alcoholic~~Person with Substance Use Disorder. The resident is a~~ narcotic addict or an alcoholic~~ person with a substance use disorder living and taking part in a treatment and rehabilitation program. ~~(3-17-22)~~( )

03. Blind or Disabled. The person is a disabled or blind resident of a group living arrangement. ( )

04. Battered Wom~~e~~an and Child(ren). The resident is a woman or a woman and her child(ren), temporarily living in a shelter for battered women and children. ~~(3-17-22)~~( )

a. The woman is a separate household from other shelter residents for Food Stamps. ( )

b. The woman and her children are a separate household from other shelter residents for Food Stamps. ( )

05. Homeless Person~~s~~. The resident is a person living in a public or private nonprofit shelter for homeless persons. ~~(3-17-22)~~( )

792. PRERELEASE APPLICANTS FROM PUBLIC INSTITUTIONS.
Residents of public institutions who apply for prerelease program SSI may apply for Food Stamps before their release

from public institutions. The application date is the date the person is released from the institution. Eligibility is based on the best estimate of a household's circumstances for the release month and the month after. Eligibility and Food Stamp amount are based on income and resources. Food Stamps for the initial month are prorated from the date the person is released from the institution to the end of the calendar month. ( )

793. NARCOTIC ADDICT AND ALCOHOLICSUBSTANCE USE DISORDER TREATMENT CENTERS.

01. Center Provides Certification List. Each month, each center must give the Ffield Ooffice a list of current client participant residents. The list's accuracy must be certified in writing by the center manager or designee. The Department must conduct random on-site visits to assure list accuracy. If the list is not accurate, or the Department fails to act on the change, the Department may transfer the Food Stamp amount from the center's account to the household's Food Stamp account, for the months the household was not living in the center. (3-17-22)( )

02. Center Misusing Food Stamps. The Department must promptly notify FNS if it believes a center is misusing Food Stamps. The Department must not take action act before FNS takes action against the center. (3-17-22)( )

794. TREATMENT CENTER RESPONSIBILITIES.
Each treatment center must follow SNAP Food Stamp application standards, with the exception of except for: (3-17-22)( )

01. Return Food Stamps. ( )

a. The center must return to the Department all issue documents and Food Stamps, not given to a departing resident, to the Department. (3-17-22)( )

b. Food Stamps must be returned to the Department if the client participant left before the sixteenth of the month and the center was unable to give him them the Food Stamps. (3-17-22)( )

c. Food Stamps must be returned to the Department if they were left over for a resident who left on or after the sixteenth of the month. ( )

02. Give Food Stamps to Departing Client Participant. (3-17-22)( )

a. The center must give the departing client participant the ID card and any unredeemed Food Stamps. (3-17-22)( )

b. The center must give the client participant a full month's Food Stamps if they have been issued, but none have been spent on behalf of the client participant. (3-17-22)( )

c. The center must give the departing client participant one-half (1/2) of the monthly Food Stamps if the client participant leaves before the sixteenth of the month and a portion of the Food Stamps have been spent on behalf of the client participant. (3-17-22)( )

d. If the client participant leaves the center on or after the sixteenth, and Food Stamps were issued and used, the center is not required to give Food Stamps to the client participant. (3-17-22)( )

03. Food Stamp Misuse. The center must be disqualified if it is administratively or judicially found the center misappropriated or used Food Stamps for purchases not contributing to a certified client's participant's meals. (3-17-22)( )

04. FNS Disqualifies Center. If FNS disqualifies a center as a retailer, the Department must close residents' cases. Individual notice of adverse action is not required. ( )

795. RESIDENTS OF GROUP LIVING ARRANGEMENTS.
Disabled or blind residents of public or private non-profit group living arrangements, serving no more than sixteen

(16) residents, may get Food Stamps. Residents get Food Stamps under the same standards as other households. Group living arrangements rules are listed below: ( )

01. FNS-Authorized Retailer or Department Certified. The center must be an FNS-authorized retailer or be certified by the Department as a non-profit group living center. Center status must comply with Section 1616(e) of the Social Security Act or comparable standards of the Secretary of USDA. ( )

02. Application Option. Residents may apply on their own~~. Residents may apply~~, as a group~~. Residents may apply~~, or through an authorized representative employed and designated by the center. Residents may apply through an authorized representative of the resident's choice. ~~(3-17-22)~~( )

03. Residents Apply on Their Own Behalf. A person or a group of residents making up a household can apply on their own behalf. The center must determine the resident is physically and intellectually capable of handling ~~his~~ their own affairs. If the resident is eligible, the center does not act as the authorized representative. The resident or group is responsible for reporting any changes affecting eligibility or benefit level. The resident is responsible for overissuances. ~~(3-17-22)~~( )

04. Certification. Residents of a center applying through the center's authorized representative must be certified as a one (1) person household. Residents of a center applying on their own behalf must be certified according to household size. ( )

05. Residents Are Exempt From Work Registration. ~~Residents are exempt from work registration.~~ ~~(3-17-22)~~( )

06. Residents Are Entitled to Notices of Adverse Action. ~~Residents are entitled to notices of adverse action.~~ If a group living arrangement center loses its authorization or certification, notice is not required. ~~(3-17-22)~~( )

07. Using Food Stamps. The Food Stamps may be used by the resident, a group of residents, or by the center to purchase food for the resident. The center may accept Food Stamps as payment for meals. If residents purchase or prepare food for home consumption, the center must ~~i~~ensure each resident's Food Stamps are used for meals intended for that resident. ~~(3-17-22)~~( )

796. SHELTERS FOR BATTERED WOMEN AND CHILDREN.

The Department must determine if the shelter for battered women and children is a public or private non-profit residential facility. The Department must determine if the shelter serves only battered women and their children. If the facility serves other persons, the Department must determine if a portion of the facility is set aside to serve only battered women and children. Shelters having FNS authorization to redeem Food Stamps on a wholesale basis meet the shelter definition. Battered women and children shelter rules are listed below: ( )

01. Food Stamp Eligibility. Women and children who recently left a household containing a person who abused them may get Food Stamps, even if the household they left was getting Food Stamps. Shelter residents may apply for and get separate Food Stamps only once in a month. The original Food Stamp certification must have included the person who subjected them to abuse. The resident household must meet eligibility criteria for income, resources, and expenses. ( )

02. Income, Resources, and Expenses of the Household Are Counted. ~~Income, resources, and expenses of the household are counted.~~ Income, resources, and expenses of their former household, containing the person who subjected them to abuse, are not counted. Jointly held resources are inaccessible if the resources are jointly owned by the shelter resident and members of the abusive household. Jointly held resources are inaccessible if the shelter residents' access to the resource is dependent on the agreement of the joint owner still living in the former household. Room payments to the shelter are shelter expenses. ~~(3-17-22)~~( )

03. Food Stamps for Former Household. The Department must take prompt action to correct the former household's eligibility and allotment. The Department must issue a ten (10) day advance notice of adverse action. ( )

797. -- 815. (RESERVED)

816. PURCHASE OF PREPARED MEALS.
Persons listed below may purchase prepared meals with their Food Stamps at sites authorized to accept Food Stamps. ( )

01. Older Persons Eating at Communal Dining Facility. Persons sixty (60) or older and their spouses, or persons who receive SSI and their spouses, can use Food Stamps to buy meals made for them at communal dining facilities authorized to accept Food Stamps. ( )

02. Persons Unable to Prepare Meals Getting Meal Delivery Service. A person sixty (60) years of age or over, and a spouse, can elect to use Food Stamps to purchase meals from a nonprofit meal delivery service. A housebound, physically handicapped, or otherwise disabled person, unable to adequately prepare all meals, and a spouse, can elect to use Food Stamps to purchase meals from a nonprofit meal delivery service. ( )

03. Resident Center. A resident of a ~~drug addiction or alcoholic~~ residential treatment center for substance use disorders can use Food Stamps at the center. The person must be enrolled in a treatment and rehabilitation program operated by a nonprofit organization or institution. ~~(3-17-22)~~( )

04. Battered Women and Children. A resident of a shelter for battered women and children can use Food Stamps to purchase meals prepared by the shelter. ( )

05. Homeless. A homeless Food Stamp ~~client~~ participant can use Food Stamps to buy meals prepared by a homeless meal provider. ~~(3-17-22)~~( )

817. -- 849. (RESERVED)

850. FOOD STAMP HOUSEHOLD RIGHTS.
The Food Stamp household has rights protected by ~~F~~federal and ~~S~~state laws and Department rules. The Department must inform ~~clients~~ participants of their rights during the application process and eligibility reviews. Food Stamp rights are listed below: ~~(3-17-22)~~( )

01. Application. The right to get an application on the date requested. ( )

02. Application Registered. The right to have the signed application accepted right away. ( )

03. Representative. The right to have an authorized representative if the applicant cannot get to the Food Stamp office. The authorized representative must have knowledge of the applicant's situation. ( )

04. Thirty Day Processing. The right to have the application processed and Food Stamps issued within thirty (30) days. ( )

05. Notification. The right to be told in writing of: ( )

a. The reasons for the Department's action if the application is rejected. ( )

b. The reasons for the Department's action if Food Stamps are reduced or stopped. ( )

06. Fair Hearing. The right to request a fair hearing about the Department's decision. The right to request a fair hearing if the household feels discrimination has taken place in any way. Food Stamp fair hearings must be requested within ninety (90) days from the day notice is mailed. In certain situations, Food Stamps may continue if a fair hearing is requested. ( )

851. (RESERVED)

852. FOOD STAMP HOUSEHOLD RESPONSIBILITIES.
The Food Stamp household must provide correct and complete information so the Department can make accurate

eligibility and benefit decisions. The responsibilities of the Food Stamp household are listed below: ( )

01. Provide Information. The Food Stamp household must provide information to determine Food stamp eligibility. This includes, but is not limited to, all information about household income, work, and housing cost. ( )

02. Quality Control. The Food Stamp household must cooperate with Quality Control if the case is selected for review. ( )

853. DEPARTMENT INFORMING RESPONSIBILITIES.

The Department must inform the Food Stamp household of what is expected of the household in the eligibility determination process~~. The Department must~~ and advise the household of the information listed below: ~~(3-17-22)~~( )

01. Households Rights and Responsibilities.~~ The Department must inform the household of the household's rights and responsibilities.~~ ~~(3-17-22)~~( )

02. Eligibility Factors That Must be Met and Proven.~~ The Department must inform the household of the eligibility factors that must be met.~~ ~~(3-17-22)~~( )

~~**03. Eligibility Factor Proof**. The Department must inform the household all eligibility factors must be proven. (3-17-22)~~

0~~4~~3. Consequences~~ of~~ for Failure to~~ Cooperate~~ Provide Proof of Eligibility Factors.~~ The Department must inform the household of the consequences for failure to provide proof of eligibility factors.~~ ~~(3-17-22)~~( )

0~~5~~4. Alternate Methods~~ for Getting Proof~~ to Prove Eligibility When Household is Unable to Provide Proof.~~ The Department must inform the household of the alternate methods to prove eligibility when the household is unable to provide proof.~~ ~~(3-17-22)~~( )

0~~6~~5. ~~Department~~ Methods~~ for Getting Proof~~ the Department Uses to Prove Eligibility When Household is Unable to Provide Proof.~~ The Department must inform the household of the methods it uses to prove eligibility when the household is unable to provide proof.~~ ~~(3-17-22)~~( )

0~~7~~6. Social Security Numbers the Department Will Use to Get Wage, Income, and Employment Information.~~ The Department must inform the household Social Security Numbers will be used to get wage, income and employment information. Information is obtained from the Department of Employment (DOE), the Social Security Administration (SSA) and the Internal Revenue Service (IRS).~~ ~~(3-17-22)~~( )

854. DEPARTMENT WILL DOCUMENT ELIGIBILITY DECISIONS.

The Department will document eligibility, ineligibility, and Food Stamp issuance in the case record. The Department must record enough detail to support the Food Stamp determination. ( )

855. -- 860. (RESERVED)

861. NO DISCRIMINATION IN FOOD STAMP PROGRAM.

The Department must not allow human rights discrimination in the Food Stamp Program. The Department will administer the Food Stamp program so no applicant or recipient in Idaho is discriminated for or against due to race, color, gender, or age. The Department will administer the Food Stamp program so no applicant or recipient in Idaho is discriminated for or against, due to political or religious belief or affiliation, national origin, handicap, or disability. ( )

862. PUBLIC NOTICE FOR NO DISCRIMINATION.

The Department~~ must~~ will inform the public via the application form that the Food Stamp Program is conducted without discrimination. The Department must display the U~~.~~S~~.~~D~~.~~A~~.~~ poster "~~...~~And Justice for All" in all ~~F~~field ~~O~~offices. The application form must inform the public the Food Stamp Program is conducted without discrimination.

~~Department Food Stamp publications must inform the public the Food Stamp Program is conducted without discrimination.~~ ~~(3-17-22)~~(   )

863. ~~DISCRIMINATION COMPLAINT INFORMATION.~~(RESERVED)

~~Field Offices must maintain copies of notices informing the public the Food Stamp Program is conducted without discrimination. These files must be available for inspection during reviews and audits.~~ ~~(3-17-22)~~

864. DISCRIMINATION COMPLAINT PROCEDURE.

Any person can file a discrimination complaint. The person may use the Department's complaint procedure. The person may file a complaint directly to FNS, to the Department, or both. The ~~F~~field ~~O~~office must explain both procedures orally or in writing. ~~The Field Office must explain the one hundred eighty (180) day filing time limit, extensions and where to submit complaints. The Department must submit a written report describing the discrimination complaint and the action taken. This report is submitted to the Department's Civil Rights Coordinator. The Department must keep all complaints and complaint records for three (3) years.~~ ~~(3-17-22)~~(   )

865. DISCLOSURE OF INFORMATION.

~~Department programs include the Food Stamp Act, Federal regulations, Federal or Federally-aided means-tested assistance programs and general assistance programs with a means test and formal application procedures.~~ The Department will make available to any ~~F~~federal, ~~S~~state, or local law enforcement officer the address, SSN, and (if available) photograph of a Food Stamp recipient. The officer must furnish the recipient's name and ~~notify~~ provide the Department the federally required evidence the person is fleeing to avoid prosecution, custody, or confinement for a felony~~;~~, violating a condition of parole or probation~~;~~, or has information necessary for the officer to conduct an official duty related to a felony~~/~~ or parole violation. ~~(3-17-22)~~(   )

866. AVAILABILITY OF PUBLIC INFORMATION.

Rules, state plans of operation, procedures, handbooks, manuals, and instructions used to certify households must be available to the public. These materials must be available for public examination during regular office hours and workdays. ~~Copies of audits or investigations, conducted by USDA, are for official use only and are not for public examination~~ See 7 CFR 272.1(d). ~~(3-17-22)~~(   )

867. FOOD STAMP INFORMATION REQUIREMENTS.

Federal regulations and procedures in FNS notices and policy memos must be available for examination by the public. State plans of operation must be available for examination by the public. Examination may take place during office hours at Department headquarters. Handbooks must be available for examination upon request at each ~~F~~field ~~O~~office. The Department must provide information about Food Stamps through mass media, posters, fliers, pamphlets, and face-to-face contacts. Minimum requirements are listed below: ~~(3-17-22)~~(   )

01. Rights and Responsibilities. Households must be informed of Food Stamp program rights and responsibilities. (   )

02. Bilingual Information. All program information must be available in Spanish. ~~Spanish information must say the program is available without regard to race, color, sex, age, handicap, religious creed, national origin or political belief.~~ ~~(3-17-22)~~(   )

868. -- 871. (RESERVED)

872. PROGRAM TRANSFER DURING CERTIFICATION PERIOD.

Households changing from Food Stamps to Food Distribution Program on Indian Reservations (FDPIR) must end their participation the last day of the month they choose to change programs. ~~one (1) program to the other program within a certification period can do so only by ending participation. The household must tell the proper agency of its intent to switch programs. Households certified in either program on the first day of the month can only get that program's benefits during that month. A household, wanting to switch from one (1) program to the other program, must have its eligibility stopped for the currently certified program. Eligibility must end as of the last day of the month it chooses to change programs. The household must file an application for the program in which it wishes to take part.~~ ~~(3-17-22)~~(   )

873. -- 87~~5~~8. (RESERVED)

876. PERSONNEL REQUIREMENTS.
The Department must provide the qualified employees needed to assure prompt action on applications and issuance of benefits. Department employees certifying households for Food Stamps must be hired under Idaho Personnel Commission standards. Only qualified Department employees can interview households and determine eligibility and benefit amount. Only authorized employees or contractors of the Department may have access to Food Stamp cards or other issuance documents. (3-17-22)

877. VOLUNTEERS.
Volunteers, or other persons not employed by the Department, can engage in certification-related activities. Volunteers, or other persons not employed by the Department, must not conduct interviews or certify households. Volunteers and other persons can teach nutrition education and provide transportation to the Field Offices. Volunteers and other persons can help households complete the application forms. Volunteers and other persons can help get proof for information reported on the application. (3-17-22)

878. PERSONNEL AND FACILITIES OF PARTIES TO A STRIKE.
Persons or organizations, who are parties to a strike or lockout, cannot be used in any activity related to certification. These persons must not certify applicant households, interview households or help get proof for the households. These persons can give proof of information provided by households, if they are in the best position to confirm a household's circumstances. Facilities of persons or organizations who are parties to a strike or lockout cannot be used in the certification process or as an interview site. (3-17-22)

879. REVIEW OF CASE FILE.
The client participant or his their representative is allowed to can review his their case file under Department Rules, IDAPA 16.05.01, "Use and Disclosure of Department Records." (3-17-22)( )

880. -- 882. (RESERVED)

883. QUALITY CONTROL AND FOOD STAMP ELIGIBILITYREFUSAL TO COOPERATE WITH QUALITY CONTROL REVIEWS.
State Quality Control (SQC) is the Department's case review system. SQC determines rates of correct Food Stamp issuances and Department and recipient caused errors. Quality control reviews open Food Stamp cases, denials and closures. The quality control review period extends from October 1st to September 30th of the next year. Households selected for quality control review by State Quality Control (SQC) and Federal Quality Control (FQC) must cooperate with both reviews.The Department is required to conduct monthly random quality control reviews of food stamp cases, denials of food stamp applications, and issuance amounts. If a household is selected and refuses to cooperate in a quality control review, it is not eligible for food stamp benefits. (3-17-22)( )

01. Refusal to Cooperate with SQC or FQC. If a household refuses to cooperate in a SQC or FQC review, it is not eligible. (3-17-22)

a01. Advance Notice to End Food Stamps. The Department must send the household advance notice to end Food Stamps. The notice must list the reason for the proposed action, the right to a hearing, the right to schedule a conference or to continue the SQC or FQC review. (3-17-22)( )

b. The Department will close the Food Stamp case. (3-17-22)

02. Food Stamp Eligibility During Quality Control Review Period, After Refusal to Cooperate. The household is not eligible for Food Stamps during the Quality Control review period until it cooperates with the SQC or FQC review. (3-17-22)( )

884. -- 999. (RESERVED)

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.03.05 – ELIGIBILITY FOR AID TO THE AGED, BLIND, AND DISABLED (AABD)

DOCKET NO. 16-0305-2301 (ZBR CHAPTER REWRITE)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo and Incorporation By Reference Synopsis (IBRS)

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2024 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. The pending rule will become final and effective upon the adjournment, *sine die*, of the Second Regular Session of the Sixty-seventh Idaho Legislature after approval.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 56-202, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

Under Executive Order 2020-01: Zero-Based Regulation, the Department is striving to prevent the accumulation of costly, ineffective, and outdated regulations and reduce regulatory burden to achieve a more efficient operation of government. The rule changes are intended to perform a comprehensive review of this chapter by collaborating with the public to streamline or simplify this rule language. The change made in this Pending Rulemaking is to correct a citation to CFR.

The text of the pending rule has been amended in accordance with Section 67-5227, Idaho Code. Only those sections that have changes that differ from the proposed text are printed in this bulletin. The complete text of the proposed rule was published in the October 4, 2023, Idaho Administrative Bulletin, Vol. 23-10, pages 344 through 429.

FEE SUMMARY: Pursuant to Section 67-5224(2)(d), Idaho Code, this pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature. The following is a description of the fee or charge imposed or increased in this rulemaking: Does not apply to this rulemaking.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state General Fund greater than ten thousand dollars ($10,000) during the fiscal year:

This rulemaking is not anticipated to have any fiscal impact on state funds, including the General Fund, or any other known funds.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Laura Schumaker at 208-799-4335.

DATED this 30th of November, 2023.

Trinette Middlebrook and Frank Powell
DHW – Administrative Rules Unit
450 W. State Street – 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
phone: (208) 334-5500
fax: (208) 334-6558
e-mail:dhwrules@dhw.idaho.gov

THE FOLLOWING NOTICE PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section 56-202, Idaho Code.

PUBLIC HEARING SCHEDULE: A public hearing concerning this rulemaking will be held as follows:

VIRTUAL TELECONFERENCE Via WebEx
Thursday, October 12, 2023 12:00 p.m. to 2:00 p.m. (MT)
Join from the meeting link: **https://idhw.webex.com/idhw/j.php?MTID=me93accfca5d5122469c484b34cf4bee3** ***Join by meeting number:*** **Meeting number (access code): 2760 708 2319** **Meeting password: pyPP8FHEz58 (79778343 from phones and video systems)** ***Join by phone:*** **+1-415-527-5035 United States Toll** **+1-303-498-7536 United States Toll (Denver)**

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below. Each meeting will conclude after 30 minutes if no participants sign in or wish to comment in the meeting.

DESCRIPTIVE SUMMARY: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

Under Executive Order 2020-01: Zero-Based Regulation, the Department is striving to prevent the accumulation of costly, ineffective, and outdated regulations and reduce regulatory burden to achieve a more efficient operation of government. The rule changes are intended to perform a comprehensive review of this chapter by collaborating with the public to streamline or simplify this rule language.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased:

This chapter contains no fees or charges.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year as a result of this rulemaking:

This rulemaking is not anticipated to have any fiscal impact on the State General Fund, or any other known funds.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the April 5, 2023, Idaho Administrative Bulletin, Vol. 23-4, pages 33 and 34.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into this rule:

This chapter of rule has incorporated by reference the following references:

1. "Medicare Modernization Act - Prescription Drug Program Guidance to States for the Low Income Subsidy (LIS)," dated May 25, 2005.
2. Social Security Administration Program Operations Manual System (POMS) SI 01320.00, Deeming Resources, effective 10/17/2022.
3. Social Security Administration Program Operations Manual System (POMS) SI 01330.00, Deeming Resources, effective 02/24/2010.
4. Social Security Administration Programs Operations Manual System (POMS) SI 02302.200, Charted Threshold Amounts for Calendar Year 2023, effective 01/24/2023.

These documents are incorporated by reference to save space in the chapter and ensure that it continues to have the force and effect of law.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Laura Schumaker at 208-799-4335.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 25, 2023.

DATED this 1st day of September, 2023.

THE FOLLOWING IS THE TEXT OF ZBR DOCKET NO. 16-0305-2301

16.03.05 – ELIGIBILITY FOR AID TO THE AGED, BLIND, AND DISABLED (AABD)

000. LEGAL AUTHORITY.
Section 56-202, Idaho Code, authorizes the Department to adopt rules for the administration of public assistance programs. ( )

001. (RESERVED)

002. INCORPORATION BY REFERENCE.
The following are incorporated by reference ( )

01. "Medicare Modernization Act - Prescription Drug Program Guidance to States for the Low Income Subsidy (LIS)," dated May 25, 2005. The guidelines may be viewed at the main office of the Department. It is also available online at https://www.cms.gov/Medicare/Eligibility-and-Enrollment/LowIncSubMedicarePresCov/Downloads/StateLISGuidance021009.pdf. ( )

02. Social Security Administration Program Operations Manual System (POMS) SI 01320.00, Deeming Resources, effective date: 10/17/2022. This Deeming of Income section is available at: https://secure.ssa.gov/apps10/poms.nsf/lnx/0501320000. ( )

03. Social Security Administration Program Operations Manual System (POMS) SI 01330.00, Deeming Resources, effective date: 02/24/2010. This Deeming of Resources section is available at: https://secure.ssa.gov/apps10/poms.nsf/lnx/0501330000. ( )

04. Social Security Administration Program Operations Manual System (POMS) SI 02302.200

Charted Threshold Amounts for Calendar Year 2023, effective date: 01/24/2023. This Charted Threshold Amounts table is available at: https://secure.ssa.gov/apps10/poms.nsf/lnx/0502302200. ( )

003. -- 009. (RESERVED)

010. DEFINITIONS.

01. AABD Cash. An EBT payment to a participant, a participant's guardian, or a holder of a limited power of attorney for EBT payments. AABD Cash is a payment of a supplemental cash amount to an individual who meets the program requirements. This payment may be made through direct deposit or an electronic benefits card. ( )

02. Applicant. A person applying for public assistance from the Department, including individuals referred to the Department from a health insurance exchange or marketplace. ( )

03. Annuity. A right to receive periodic payments, either for life, a term of years, or other interval of time, whether or not the initial payment or investment has been annuitized. It includes contracts for single payments where the single payment represents an initial payment or investment together with increases or deductions for interest or fees rather than an actuarially based payment from an insurance pool. ( )

04. Asset. Includes all income and resources of the individual and the individual's spouse, including any income or resources that the individual or their spouse is entitled to, but does not receive because of action by: ( )

a. The individual or their spouse; ( )

b. A person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or their spouse; or ( )

c. A person, including any court or administrative body, acting at the direction or upon the request of the individual or their spouse. ( )

05. Asset Transfer for Sole Benefit. An asset transfer is considered to be for the sole benefit of a spouse, blind or disabled child, or disabled individual if the transfer is arranged in such a way 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 transfer or at any time in the future. ( )

06. Child. Any individual from birth through the end of the month of their nineteenth birthday. ( )

07. Citizen. A person having status as a "national of the United States" defined in 8 USC 1101(a)(22) that includes both citizens of the United States and non-citizen nationals of the United States. ( )

08. Department. The Department of Health and Welfare. ( )

09. Direct Deposit. The electronic deposit of a participant's AABD cash to the participant's personal account with a financial institution. ( )

10. Electronic Benefits Transfer (EBT). A method of issuing AABD cash to a participant, a participant's guardian, or a holder of a limited power of attorney for EBT payments for a participant. ( )

11. Essential Person. A person of the participant's choice whose presence in the household is essential to the participant's well-being. The essential person provides the services a participant needs to live at home. ( )

12. Fair Market Value. The price for which an asset can be reasonably expected to sell on the open market, in the geographic area involved. ( )

13. Long-Term Care. Services provided to an institutionalized individual as defined in 42 USC

1396p(c)(1)(C). ( )

14. **Medicaid**. Idaho's Medical Assistance Program administered by the Department. See Title XIX. ( )

15. **Needy**. A person is considered needy for AABD cash payments if the person meets the non-financial requirements of Title XVI of the Social Security Act and the criteria in Section 514 of these rules. Title XVI of the Social Security Act, known as "Grants to States for Aid to the Aged, Blind, or Disabled," is a program for financial assistance to needy individuals who are sixty-five (65) years of age or over, are blind, or are eighteen (18) years of age or over and permanently and totally disabled. ( )

16. **Non-Citizen**. Same as "alien" defined in Section 101(a)(3) of the Immigration and Nationality Act (INA) (8 USC 1101 (a)(3)), and includes any individual who is not a citizen or national of the United States. ( )

17. **Participant**. An individual who is eligible for, and enrolled in, a Health Care Assistance Program or Medicaid. ( )

18. **Partnership Policy**. A qualified long-term care insurance policy under Section 7702B(b) of the Internal Revenue Code of 1986, which meets the requirements of the long-term care insurance model regulation and Long-term Care Insurance Model Act promulgated by the National Association of Insurance Commissioners (NAIC), as incorporated in 42 USC 1396p(b)(5)(A). ( )

19. **Premium**. A regular, periodic charge or payment for health coverage. ( )

20. **Reasonable Opportunity Period**. A period allowed for an individual to provide requested proof of citizenship or identity. A reasonable opportunity period extends for ninety (90) days beginning on the 5th day after the notice requesting the proof has been mailed to the applicant. This period may be extended if the Department determines that the individual is making a good faith effort to obtain necessary documentation. ( )

21. **Pension Funds**. Retirement funds held in individual retirement accounts (IRAs), as described by the Internal Revenue Code, or in work-related pension plans, including plans for self-employed individuals sometimes referred to as Keogh plans. ( )

22. **Sole Beneficiary**. The only beneficiary of a trust, including a beneficiary during the grantor's life, a beneficiary with a future interest, and a beneficiary by the grantor's will. ( )

23. **Title XIX**. Of the Social Security Act, known as Medicaid, is a medical benefits program jointly financed by the federal and state governments and administered by the states that provides medical care for eligible individuals. Please see https://www.ssa.gov/OP_Home/ssact/title19/1900.htm. ( )

24. **Title XXI**. Of the Social Security Act, known as the Children's Health Insurance Program (CHIP), is a federal and state partnership that provides health insurance to targeted, low-income children. Please see https://www.ssa.gov/OP_Home/ssact/title21/2101.htm. ( )

25. **Treasury Rate**. The five (5) year security note rate listed in the "Daily Treasury Yield Curve Rate" by the US Treasury on January 1 of each year, and is used for the entire calendar year. ( )

26. **Working Day**. A calendar day when regular office hours are observed by the state of Idaho. Weekends and state holidays are not considered working days. ( )

011. -- 019. (RESERVED)

020. ABBREVIATIONS.

01. **AABD**. Aid to the Aged, Blind, and Disabled. ( )

02. **COLA**. Cost of Living Adjustment. ( )

03. **CSA**. Community Spouse Allowance. ( )

04. **CSNS**. Community Spouse Need Standard. ( )

05. **CSRA**. Community Spouse Resource Allowance. ( )

06. **EBT**. Electronic Benefits Transfer. ( )

07. **EITC**. Earned Income Tax Credit. ( )

08. **FSI**. Federal Spousal Impoverishment. ( )

09. **HCBS**. Home and Community Based Services. ( )

10. **ICF/IID**. Intermediate Care Facility for Individuals with Intellectual Disabilities. ( )

11. **INA**. Immigration and Nationality Act. ( )

12. **PASS**. Plan for Achieving Self-Support. ( )

13. **RSDI**. Retirement, Survivors, and Disability Insurance. ( )

14. **SSA**. Social Security Administration. ( )

15. **SSI**. Supplemental Security Income. ( )

16. **SSN**. Social Security Number. ( )

17. **TAFI**. Temporary Assistance for Families in Idaho. ( )

18. **VA**. Veterans Administration. ( )

021. -- 048. (RESERVED)

049. SIGNATURES.
An individual applying for benefits, receiving benefits, or providing additional information as required by these rules, may do so with the depiction of the individual's name either handwritten, electronic, or recorded telephonically. Such signature serves as intention to execute or adopt the sound, symbol, or process for the purpose of signing the related record. ( )

050. APPLICATION FOR ASSISTANCE.

01. **Application Submitted by Participant**. The participant must submit an application form to the Department. An adult participant, a legal guardian, or a representative must sign the application form. ( )

02. **Application Submitted Through SSA Low-Income Subsidy Data Transmission**. For low-income subsidy applicants identified on the SSA data transmission, the protected Medicare Savings Program application date is the day they applied for the low-income subsidy. ( )

051. EFFECTIVE DATE.
The effective date for aid is the first day of the month of application. Medicaid eligibility begins as described in this rule. ( )

01. **AABD Cash**. AABD cash aid is effective on the application date. ( )

02. **Normal Medicaid Eligibility**. Medicaid coverage begins on the first day of the application month.

( )

03. Retroactive (Backdated) Medicaid Eligibility. Medicaid benefits must be backdated to the first day of the calendar month, for each of the three (3) months before the month of application, if the participant was Medicaid-eligible during that month. If the participant is not eligible for Medicaid when they apply, retroactive eligibility is evaluated. ( )

04. Ineligible Non-Citizen Medicaid. Ineligible legal or illegal non-citizen coverage is restricted to emergency services. Coverage begins when the emergency treatment is required. Coverage ends with the last day emergency treatment is required. ( )

052. -- 069. (RESERVED)

070. TIME LIMITS.
The application must be processed within forty-five (45) days for an applicant sixty-five (65) years of age or older. The application must be processed within ninety (90) days for a disabled applicant. The time limit can be extended by events beyond the Department's control. ( )

071. DEATH OF APPLICANT.
An application may be filed for a deceased person. The application must be filed within the backdated eligibility period. Medicaid can be approved, through the date of death, if an AABD applicant dies before eligibility is determined. ( )

072. REQUIRED VERIFICATION.
Applicants must prove their eligibility for aid. The participant is allowed ten (10) calendar days to provide requested proof. The application is denied if the applicant does not provide proof in ten (10) calendar days of the written request and does not have good cause for not providing proof. The Department may also use electronic verification sources when they are available. ( )

073. -- 090. (RESERVED)

091. OUT-OF-STATE APPLICANTS.
A participant receiving AABD cash from another state must not receive AABD cash in Idaho until they are living in Idaho and the cash benefit has ended in the other state. A participant may receive Medicaid in Idaho before AABD cash or Medicaid stops in another state. AABD cash from another state is unearned income for Medicaid. Out-of-state medical coverage is a Medicaid third-party resource. Idaho residents temporarily out of the state, and not receiving aid, may apply for aid in Idaho. ( )

092. CONCURRENT BENEFIT PROHIBITION.
If a person is potentially eligible for AABD cash, TAFI, or foster care, only one (1) program may be chosen. ( )

093. -- 099. (RESERVED)

100. RESIDENCY.
The participant must be living in Idaho and have no immediate intention of leaving. For Medicaid, other persons are Idaho residents if they meet any of the following criteria. ( )

01. Foster Child. A participant living in Idaho and receiving child foster care payments from another state. ( )

02. Incapable Participant. A participant who is incapable of indicating their state of residency after age twenty-one (21) is considered a resident of Idaho when: ( )

a. Their parent or guardian lives in Idaho; or ( )

b. They reside in an Idaho institution. ( )

03. Placed in Another State by Idaho. A participant placed by the state of Idaho in an institution in another state. ( )

04. Homeless. A participant not maintaining a permanent home or having a fixed address who intends to remain in Idaho. ( )

05. Migrant. A migrant working and living in Idaho. ( )

101. TEMPORARY ABSENCE.

A participant may be temporarily absent from their home and still receive AABD cash and Medicaid. A participant is temporarily absent if they intend to return home within one (1) month. Temporary absence may exceed one (1) month for a child attending school or vocational training or a participant in a medical institution, hospital, or nursing home. ( )

102. US CITIZENSHIP VERIFICATION REQUIREMENTS.

Any individual who participates in AABD cash, Health Care Assistance, or Medicaid benefits must provide proof of US citizenship unless they have otherwise met the requirements under 42 CFR 435.406, Citizenship and Non-Citizen Eligibility. ( )

103. SOCIAL SECURITY NUMBER (SSN) REQUIREMENT.

01. SSN Required. The applicant must provide their SSN, or proof they have applied for an SSN, to the Department before approval of eligibility. If the applicant has more than one (1) SSN, all numbers must be provided. ( )

a. The SSN must be verified by the SSA electronically. An applicant with an unverified SSN is not eligible for AABD cash, Health Care Assistance, or Medicaid benefits. ( )

b. The Department must notify the applicant in writing if eligibility is denied or lost for failure to meet the SSN requirement. ( )

02. Application for SSN. To be eligible, the applicant must apply for an SSN, or a duplicate SSN when they cannot provide their SSN to the Department. If the SSN has been applied for but not issued by the SSA, the Department cannot deny, delay, or stop benefits. The Department will help an applicant with required documentation when the applicant applies for an SSN. ( )

03. Failure to Apply for SSN. The applicant may be granted a good cause exception for failure to apply for an SSN if they have a well-established religious objection to applying for an SSN. A well-established religious objection means the applicant: ( )

a. Is a member of a recognized religious sect or division of the sect; and ( )

b. Adheres to the tenets or teachings of the sect or division of the sect and for that reason is conscientiously opposed to applying for or using a national identification number. ( )

04. SSN Requirement Waived. An applicant may have the SSN requirement waived when they are: ( )

a. Only eligible for emergency medical services under 42 CFR 440.255, Emergency and Poststabilization Services; or ( )

b. A newborn child deemed eligible under 42 CFR 435.117, Deemed Newborn Children. ( )

104. – 105. U.S. CITIZENSHIP AND IDENTITY DOCUMENTATION REQUIREMENTS.

(RESERVED)

106. EMERGENCY MEDICAL CONDITION.
An individual who meets eligibility criteria for a category of assistance but does not meet US citizenship requirements or eligible non-citizen requirements may receive medical assistance under a Title XIX or Title XXI coverage group as follows: ( )

01. Emergency Medical Conditions. An individual not meeting the US citizenship requirement may receive medical services necessary to treat an emergency medical condition, including labor and delivery. Emergency medical conditions have acute symptoms of severity, including severe pain. ( )

02. Determination of Emergency Medical Conditions. The Department determines if a condition meets criteria of an emergency medical condition. ( )

03. Limitation on Medical Assistance. Medical assistance is limited to the period established for the emergency medical condition. ( )

04. Documentation Waived. For undocumented individuals with emergency medical conditions, the SSN requirement is waived because an SSN cannot be issued. Individuals must be otherwise eligible for Title XIX or XXI. ( )

107. INSTITUTIONAL STATUS.
An institution provides treatment, services, food, and shelter to four (4) or more people, not related to the owner. A participant living in an ineligible institution an entire calendar month is not eligible for AABD cash, unless they qualify for the institution payment exception. ( )

01. Eligible Institutions for AABD and Medicaid. Are listed below. ( )

a. Medical institution. A public or private medical institution, including a hospital, nursing care facility, or an ICF/IID is an eligible institution. A participant is not eligible for AABD cash if they are a resident of a medical institution the full month. ( )

b. Child care institution. A non-profit private child care institution is an eligible institution. A public child care institution with no more than twenty-five (25) beds is an eligible institution. A child care institution must be licensed or approved by the Department. A detention facility for delinquent children is not a child care institution. A child care institution for mental diseases is an eligible institution if it has sixteen (16) beds or less. A participant is not eligible for AABD cash if they are a resident of a child care institution for the full month. ( )

c. Community residence. A community residence is a facility providing food, shelter, and services to residents. A privately operated community residence is an eligible institution. A publicly operated community residence serving no more than sixteen (16) residents is an eligible institution. The Community Restorium in Bonners Ferry, Idaho, is an eligible institution even though more than sixteen (16) residents are served. ( )

02. Ineligible Institutions for AABD and Medicaid. Are listed below. ( )

a. Public institutions, unless listed in Subsection 108.01 of these rules. ( )

b. Institution for mental diseases, a facility maintained primarily for the care and treatment of persons with mental diseases. ( )

c. Institution for tuberculosis, a facility maintained primarily for the care and treatment of persons with tuberculosis. ( )

d. Correctional institution, a facility for prisoners, persons detained pending disposition of charges, or held under court order as material witnesses or juveniles. ( )

03. Medicaid Exception for Inmates. An inmate can receive Medicaid while they are an inpatient in a medical facility. The inmate must meet all Medicaid eligibility requirements. ( )

108. AABD ELIGIBILITY IN INELIGIBLE INSTITUTIONS.
A participant may get AABD cash in an ineligible institution or a medical institution if they meet one (1) of the conditions listed below. ( )

01. First Month in Institution. An AABD participant can get AABD cash for the month they entered the institution. Eligibility for the entry month applies to these residents: ( )

a. Resident of a public institution. The person is a resident if they, or anyone, pays for their food, shelter, and other services in the institution. ( )

b. Patient in a medical institution. A person receiving room, board, and professional services in a medical institution, including an institution for tuberculosis or mental diseases. ( )

02. Temporary Institution Stay. An AABD participant can get up to three (3) months' AABD payment during a temporary stay in an institution. A participant entering a public medical or psychiatric institution, a hospital, a nursing facility, or an ICF/IID may continue to get AABD payments. The Department must receive the temporary stay data no later than the ninetieth full day of confinement, or the release date, whichever is first. The payments may continue up to three (3) months if these conditions are met: ( )

a. The Department is informed of the institutional stay. ( )

b. A physician certifies the participant's stay is not likely to exceed three (3) full months. ( )

c. A signed statement from the participant or a responsible party showing the participant's need to continue to maintain and pay for the place they intend to return to live. ( )

109. CONDITIONS FOR TEMPORARY AABD IN INSTITUTIONS.
Special conditions for AABD when a participant is in an institution are listed below: ( )

01. Living Arrangement. AABD cash is paid based on the participant's living arrangement the month before the first month in the institution. Changes in living arrangement costs are used to determine AABD cash eligibility and benefit amount. ( )

02. Participant Becomes Ineligible. If the participant becomes ineligible for AABD during their temporary institutional stay, their AABD payment must be ended after proper notice. ( )

03. AABD Status. A participant must get AABD for the month they enter the institution to receive continued AABD payments. ( )

04. Counting Three Full Months. A full month is a month the participant is in the institution every day of the month. If the participant enters after the first day of a month, the month of entry is not included in the three (3) full months. If the participant is discharged before the last day of the month, the month of discharge is not included in the three (3) full months. ( )

05. SSI Benefits. If SSA decides a participant's SSI benefit will continue while the participant is in the institution, AABD payments can also continue. ( )

110. -- 129. (RESERVED)

130. ESTATE NOT IN PROBATE.
An administrator for public aid for a deceased participant's AABD cash can be court-appointed. The administrator must spend AABD cash, accessible through EBT before the participant's death, for the estate. The AABD cash can only be spent to meet the needs of the participant, or their dependents, for the month it was paid. If a participant had no debts for themself, or their dependents, the administrator must return the AABD cash to the Department. AABD benefits paid by direct deposit or posted to the participant's EBT account, after the participant's death, are the property of the State of Idaho. ( )

131. ESTATE IN PROBATE.
AABD cash received by a participant before their death is disbursed as part of the participant's estate if it is probated. The probate administrator spends the AABD cash under their oath of administration. ( )

132. -- 154. (RESERVED)

155. AABD FOR THE AGED.
To qualify for AABD for the aged, a person must be age sixty-five (65) or older. ( )

156. AABD FOR THE BLIND OR DISABLED.
To qualify for AABD for the blind or disabled, a person must meet the definition of blindness or disability used by the SSA for RSDI and SSI benefits. ( )

01. SSA Decision for Disabled. SSA's disability decision is binding on the Department unless: ( )

a. The participant states their disabling condition is different from, or in addition to, their condition considered by SSA, and the participant has not reapplied for SSI; or ( )

b. More than twelve (12) months have passed since the SSA made a final determination the participant was not disabled, and the participant states their condition has changed or become worse since that final determination, and the participant has not reapplied for SSI. ( )

02. Medicaid Pending SSA Appeal. When SSA decides a participant is no longer disabled, they meet the AABD disability requirement and can continue receiving Medicaid if they appeal SSA's decision. Medicaid ends if the SSA decision is upheld. ( )

03. Grandfathered Participant for Aid to the Permanently and Totally Disabled or Aid to the Blind. A participant is disabled if they were eligible as disabled in December 1973, and continues to meet the disability requirement in effect in December 1, 1973. They must also meet the other current eligibility requirements. ( )

157. -- 165. (RESERVED)

166. FUGITIVE FELON OR PROBATION OR PAROLE VIOLATOR.
A participant is ineligible to receive AABD for any month during which they are fleeing to avoid prosecution for a felony, fleeing to avoid custody or confinement after a felony conviction, or violating a federal or state condition of probation or parole. ( )

167. FRAUDULENT MISREPRESENTATION OF RESIDENCY.
A participant is ineligible for AABD for ten (10) years if they were convicted in a federal or state court of having fraudulently misrepresented residence to get AABD, SSI, TAFI, Food Stamps, or Medicaid from two (2) or more states at the same time. ( )

168. -- 199. (RESERVED)

200. RESOURCES DEFINED.
Resources are cash, personal property, real property, and notes receivable. A participant, or spouse, must have the right, authority, or power to convert the resource to cash. The participant must have the legal right to use the resource for support and maintenance. Liquid resources are resources in cash or resources convertible to cash within twenty (20) workdays. Nonliquid resources are any resources, not in the form of cash, which cannot be converted to cash within twenty (20) workdays. ( )

201. RESOURCE LIMIT.
The value of countable resources must be two thousand dollars ($2,000) or less, for a single person to be AABD eligible. A married person must have countable resources of three thousand dollars ($3,000) or less to be eligible for AABD cash. Resources are counted the first moment of each calendar month and apply to the entire month. ( )

202. CHANGE IN VALUE OF RESOURCES.
A change in the value of resources is counted the first moment of the next month. ( )

203. RESOURCES AND CHANGE IN MARITAL STATUS.
A change in marital status changes the resource limit. The resource limit change is effective the month after individual participants are married, divorced, separated, or one (1) spouse dies. ( )

204. FACTORS MAKING PROPERTY A RESOURCE.
Property of any kind is a resource if the participant has an ownership interest in the property and the legal right to spend or convert the property to cash. ( )

205. COUNTING RESOURCES AND INCOME.
An asset cannot be counted as income and resources in the same month. Assets received in cash or in-kind during a month are income. Income held past the month received is a resource. ( )

206. – 207. (RESERVED)

208. SHARED OWNERSHIP RULE.
Except for checking and savings accounts and time deposits, each owner of shared property owns only their fractional interest in the property. The total value of the property is divided among the owners, in direct proportion to each owner's share. ( )

209. CONVERSION OR SALE OF A RESOURCE NOT INCOME.
Payment from the sale, exchange, or replacement of a resource is not income. The payment is a resource. ( )

210. RESOURCES EXCLUDED BY FEDERAL LAW.
A resource excluded by federal law is not counted in determining the resource amount available to the participant. ( )

211. -- 214. (RESERVED)

215. DEEMING RESOURCES.
Resource deeming is determined by the SSA Program Operations Manual System (POMS) SI 01330.00, Deeming Resources, incorporated by reference under Section 002 of these rules. The participant's circumstances are assessed the first moment of the month. Deeming starts the first full calendar month the participant is in a deeming situation. Deeming ends the first full calendar month the participant is not in a deeming situation. Deeming to a child ends the month after the child's eighteenth birthday. ( )

216. HOUSEHOLD FOR RESOURCE COMPUTATIONS.
A participant living in an institution is not a household for resource computations. ( )

217. UNKNOWN RESOURCES.
An asset is not a resource if the participant is unaware of their ownership. The asset is a resource the month after discovery. ( )

218. -- 221. (RESERVED)

222. VEHICLES AS A RESOURCE.
If more than one (1) vehicle is owned, the exclusion applies in the best way for the participant. ( )

01. One Vehicle Excluded. One (1) vehicle is excluded, regardless of value. ( )

02. Other Vehicles Not Excluded. The equity value of a vehicle not excluded under Subsection 222.01 of this rule is a resource. ( )

223. BURIAL FUNDS EXCLUDED FROM RESOURCE LIMIT.
Burial funds up to one thousand five hundred dollars ($1,500) per person, set aside for the burial expenses of the

participant or spouse, are excluded from resources. To be excluded, burial funds must be kept separate from assets not burial-related. A burial contract that can be revoked or sold, without significant hardship, is a resource. Any portion of the contract for the purchase of burial spaces is excluded from resources. A burial contract that cannot be revoked, and cannot be sold without significant hardship, is not a resource. The burial fund portion of the contract counts against the one thousand five hundred dollar ($1,500) burial funds exclusion. The burial space portion of the contract does not count against the burial funds exclusion. Interest earned on excluded burial funds is also excluded. ( )

01. Life Insurance Policy as Burial Funds. The participant can designate a countable life insurance policy as a burial fund. The face value of excluded life insurance policies on the participant counts against the burial funds exclusion. ( )

02. Face Value of Burial Insurance Policies Not Counted. The face value of burial insurance policies does not count toward the one thousand five hundred dollar ($1,500) life insurance limit, when computing the total face value of life insurance policies owned by a participant. Interest on excluded burial funds does not count toward the one thousand five hundred dollar ($1,500) burial funds exclusion. ( )

03. Effective Date of Burial Funds Exclusion. The exclusion is effective the month after the month the funds were set aside. Burial funds can be designated retroactively, back to the first day of the month the participant intended the funds to be set aside. The participant must confirm the designation in writing. ( )

04. Penalty for Misusing Burial Funds. If the participant does not get SSI, burial funds used for another purpose lose the exclusion. An overpayment must be recovered. If the participant gets SSI, and is penalized by SSA because they used excluded burial funds for another purpose, their AABD payment must not be increased to compensate the SSA penalty. ( )

224. BURIAL SPACE OR PLOT EXCLUSION.

A burial space is a burial plot, grave site, crypt, mausoleum, casket, urn, niche, or other repository normally used for the deceased's remains. A burial space, or burial space purchase agreement, held for the burial of the participant, spouse, or other member of their immediate family, is an excluded resource. ( )

01. Burial Space Contract. Must list all burial spaces and include a value for each space or the total value of all the spaces. The contract must not require further payment after the contract is signed. ( )

02. Space Held by Ineligibles Excluded. A space held by an ineligible spouse or parent, for the burial of a participant, spouse, and any member of the participant's immediate family, is excluded. A space held by a legal non-citizen sponsor, or essential person, for their own burial is excluded only if the sponsor is a member of the participant's immediate family. ( )

225. -- 234. (RESERVED)

235. EXCLUDED HOUSEHOLD GOODS AND PERSONAL EFFECTS.

Household goods and personal effects are excluded from resources, regardless of their dollar value. ( )

236. (RESERVED)

237. REAL PROPERTY DEFINITION.

Real property is land, including buildings or immovable objects attached permanently to the land. Real property is a resource unless excluded. ( )

238. HOME AS RESOURCE.

An individual's home is property they own, and serves as their principal place of residence. Their principal place of residence is the place they consider their principal home. If the individual is absent from their home, it is still their principal place of residence if they intend to return. ( )

01. AABD Cash, and Medicaid With the Exception of Long-Term Care. For AABD Cash and Medicaid except for long-term care, the value of an individual's home is an excluded resource. ( )

02. Long-Term Care Services. For long-term care services, when the value of a participant's equity in the home is seven hundred fifty thousand dollars ($750,000) or less, the home is excluded as a resource. When the equity value exceeds seven hundred fifty thousand dollars ($750,000), the individual is ineligible for long-term care services. The equity value, regardless of the amount, is an excluded resource when one (1) of the following applies: ( )

a. The spouse of the individual lives in the home; or ( )

b. The individual's child, who is under age twenty-one (21), or is blind, or meets the disability requirements for AABD cash, lives in the home. ( )

239. SALE OF EXCLUDED HOME AND REPLACEMENT.
If the participant plans to buy another excluded home, proceeds from the sale of a participant's excluded home are excluded resources. Proceeds from the sale of an excluded home must be used to replace the home within three (3) calendar months. Proceeds retained beyond three (3) calendar months are a countable resource. ( )

240. REPLACEMENT OF EXCLUDED RESOURCES.
Cash and in-kind payments for replacement or repair of lost, damaged, or stolen excluded resources, are excluded resources for nine (9) months from the date received. This exclusion can be extended for cash payments, up to an additional nine (9) months. The extension can be made if, for the first nine (9) months, circumstances beyond the participant's control prevent repair or replacement of the lost, damaged, or stolen property and keep the participant from contracting for repair or replacement. This exclusion can be extended for twelve (12) more months for a catastrophe the President declares a major disaster. Interest earned by funds excluded under this provision is excluded from resources. ( )

241. UNDUE HARDSHIP EXCLUSION FROM SALE OF JOINTLY OWNED REAL PROPERTY.
A participant's ownership interest, in jointly owned real property, is an excluded resource as long as sale of the property will cause undue hardship to a co-owner. Undue hardship results if a coowner uses the property as their principal place of residence, would have to move if the property were sold, and has no other readily available housing. ( )

242. AMERICAN INDIAN PROPERTY EXCLUDED.
For the purposes of determining eligibility for an individual who is an American Indian, the following property is excluded: ( )

01. Property. Real property and improvements located on a reservation, including any federally recognized Indian Tribe's reservation, pueblo, or colony, and Indian allotments on or near a reservation as designated and approved by the Bureau of Indian Affairs. ( )

02. Natural Resources. Ownership interest in rents, leases, royalties, or usage rights related to natural resources resulting from the exercise of federally protected rights. ( )

03. Other Ownership Interests or Usage Rights. Ownership interests in or usage rights to property not covered by Subsections 242.01 or 242.02 of this rule that have a unique religious, spiritual, traditional, or cultural significance or rights that support subsistence or traditional lifestyle under applicable tribal law or custom. ( )

243. RESOURCES ASSOCIATED WITH PROPERTY.
Resources associated with real property are mineral rights, timber rights, easements, leaseholds, water rights, remainder interests, and sale of natural resources. These resources are counted as real property. ( )

244. RESOURCES ESSENTIAL FOR SELF-SUPPORT EXCLUDED.
Resources are excluded as essential to self-support, if they fall into one (1) of the categories described below. ( )

01. Essential Property in Current Use. Property in current use in the type of activity that qualifies it as essential to self-support is excluded, regardless of value or rate of return. Trade or business property, government permits, and personal property used by an employee for work are excluded regardless of value or rate of return. If the

property is not in current use, for reasons beyond the participant's control, there must be a reasonable expectation the required use will resume. If the participant does not intend to resume the self-support activity, the property is a countable resource for the month after the month of last use. ( )

02. Nonbusiness Property Producing Goods or Services. Up to six thousand dollars ($6,000) of the equity value of nonbusiness property, used to produce goods or services essential to daily activities, is excluded regardless of rate of return. Equity value over six thousand dollars ($6,000) is not excluded. This exclusion is not used for income-producing property. ( )

03. Nonbusiness Income-Producing Property. Up to six thousand dollars ($6,000) equity in nonbusiness income-producing property is excluded if the property produces a net annual return equal to at least six percent (6%) of the excluded equity. If a participant owns more than one (1) piece of income-producing property, the six percent (6%) return requirement applies to each. The six thousand dollars ($6,000) equity value limit applies to the total equity value of all the properties meeting the six percent (6%) return requirement. If the earnings decline is for reasons beyond the participant's control, up to twenty-four (24) months can be allowed for the property to resume producing a six percent (6%) return. If the property still is not producing a six percent (6%) return at the end of the twenty-four (24) month extension, the resource exclusion must end the month after the month the twenty-four (24) month period ends. ( )

245. RESOURCES SET ASIDE AS PART OF A PLAN FOR ACHIEVING SELF-SUPPORT (PASS) EXCLUDED.

PASS allows blind and disabled participants to set aside income and resources necessary for the achievement of its goals. Resources set aside as part of an approved PASS are excluded. The PASS disregard must not be applied to resources unless the participant would be ineligible due to excess resources. To disregard resources, the PASS must show how resources the participant has or will receive under the plan, will be used to obtain the PASS goal. The PASS must show how the disregarded resources will be identified separately from the participant's other resources, list items or activities requiring savings or purchases and the amounts the participant anticipates saving or spending, and show a specific target date to achieve the objective. ( )

246. LIFE ESTATE INTEREST IN ANOTHER'S HOME.

The purchase of a life estate interest in another individual's home is a resource unless the purchaser resides in the home for a period of at least twelve (12) consecutive months after the date of purchase. ( )

247. -- 255. (RESERVED)

256. RETROACTIVE SSI AND RSDI BENEFITS.

Retroactive SSI and RSDI benefits are issued after the calendar month for which they are paid. Retroactive SSI and RSDI benefits are excluded from resources for nine (9) calendar months after the month they are received. Interest earned by excluded funds is counted as income. ( )

257. DISASTER ASSISTANCE.

Assistance received because of a major disaster declared by the President is excluded from resources. Interest earned on excluded funds is excluded from income and resources. ( )

258. CASH TO PURCHASE MEDICAL OR SOCIAL SERVICES.

Cash paid by a recognized medical or social services program, for the participant to purchase medical or social services, is not a resource for one (1) calendar month after receipt. The cash must not be repayment for a bill already paid. ( )

259. (RESERVED)

260. ALASKA NATIVE CLAIMS SETTLEMENT ACT.

Payments to Alaska Natives and their descendants from the Alaska Native Claims Settlement Act, under PL 100-241, are excluded from resources. ( )

261. STOCK IN ALASKA REGIONAL OR VILLAGE CORPORATIONS.

Stock held by Alaska natives in regional or village corporations is inalienable for a twenty (20) year period under

Sections 7(h) and 8(c) of the Alaska Native Claims Settlement Act. ( )

262. VICTIMS' COMPENSATION PAYMENTS.
Payments, from a fund set up by a State to aid victims of crime, are excluded from resources for nine (9) months. Interest earned on unspent victims' compensation payments is counted for income and resources. ( )

263. -- 264. (RESERVED)

265. TAX ADVANCES AND REFUNDS RELATED TO EARNED INCOME TAX CREDITS.
A federal tax refund or payment made by an employer, related to Earned Income Tax Credits (EITC), is excluded from resources for the month after the month the refund or payment is received. Interest earned on unspent tax refunds related to EITC is counted for income and resources. ( )

266. IDENTIFYING EXCLUDED FUNDS COMMINGLED WITH FUNDS NOT EXCLUDED.
Excluded funds must be separately identifiable to remain excluded. ( )

267. DEDICATED ACCOUNT FOR SSI PARTICIPANT.
A dedicated account for past-due SSI benefits, set up in a financial institution for an SSI participant under age eighteen (18) is an excluded resource. The account must be set up by the child's SSI representative payee, and excluded by SSA. ( )

268. SUPPORT AND MAINTENANCE ASSISTANCE.
Support and Maintenance Assistance (SMA) is in-kind support and maintenance, or cash paid for food or shelter needs. It includes Home Maintenance Assistance aid to cover costs of heating or cooling a home. SMA is an excluded resource. ( )

269. -- 271. (RESERVED)

272. WALKER V. BAYER PAYMENTS.
Class action settlement payments in Susan Walker v. Bayer Corporation, et al., are excluded from resources for Medicaid by PL 105-33. These payments are not excluded for AABD cash. ( )

273. -- 275. (RESERVED)

276. EXCLUDED REAL ESTATE CONTRACT.
The principal balance of a real estate contract is excluded from resources of a participant in long-term care when the Department determines it is in the Department's best interest to exclude the contract. The determination by the Department of its best interest is final. ( )

277. FEES PAID TO A CONTINUING CARE RETIREMENT COMMUNITY (CCRC) OR LIFE CARE COMMUNITY.
An entrance fee to a CCRC or a life care community is a resource if the participant or applicant for long-term care has discretion to spend the fee or if the fee may be used to pay for care in a contingency. A CCRC or life care community is a type of long-term care facility that offers varying levels of care and in which a resident contracts with the facility to obtain care that is intended to endure for the remainder of the resident's life in exchange for valuable consideration. ( )

278. TRUSTS.
A trust is a resource to a participant with the legal right to revoke the trust, and use the principal for their own support and maintenance. See Sections 838 through 873 in these rules for treatment of trusts for Medicaid. ( )

279. RETIREMENT FUNDS.
Retirement funds are work-related plans for providing income or pensions when employment ends. A retirement fund, owned by a participant, is a resource if they have the option of withdrawing a lump sum, even though they are not yet eligible for periodic retirement payments. If the participant is eligible for periodic retirement payments, the fund is not a countable resource. The value of a retirement fund is the amount of money a participant can currently withdraw from the fund. ( )

280. INHERITANCE.
An inheritance is cash, a right, including probate allowances, trust payments and annuities, or noncash items received as the result of someone's death. Cash or noncash items in an inheritance are income the month received and a resource the next month. Participants are required to make claims and take all reasonable action necessary to obtain any inheritance to which they may be entitled. Failure to make such claims or take reasonable steps to obtain an inheritance is an asset transfer. A contested inheritance is not counted as a resource until the contest is settled and money is distributed. ( )

281. LIFE INSURANCE.
A life insurance policy is an excluded resource if its face value, plus the face value of all other life insurance policies the participant owns on the same insured person, totals one thousand five hundred dollars ($1,500) or less. If the face values exceed one thousand five hundred dollars ($1,500) the policies are a resource in the amount of the cash surrender value. ( )

282. CONSERVATORSHIP.
Funds required to be made available for the care and maintenance of a participant, under a court order, are the participant's resource. This is true even if the participant or their agent is required to petition the court to withdraw funds for the participant's care. ( )

283. CONDITIONAL BENEFITS.
A participant ineligible due solely to excess nonliquid resources, can receive AABD cash and related Medicaid. The participant must meet two (2) conditions. First, their countable liquid resources must not exceed three (3) times the participant's AABD cash budgeted needs. Second, the participant agrees, in writing, to sell excess nonliquid resources at their fair market value, within three (3) months. The value of excess real property is not counted as a resource, if the participant makes reasonable efforts to sell the property at its fair market value, and their reasonable efforts to sell are not successful. This exclusion is also used to compute deemed resources. ( )

01. Conditional Benefits Payments Disposal/Exclusion Period. The disposal and exclusion period for excess nonliquid resources begins on the date the participant signs the Agreement to Sell Property. The disposal and exclusion periods can begin earlier for a participant who met all requirements to receive conditional benefits before their first opportunity to sign the Agreement to Sell Property. The participant must sign the Agreement to Sell Property before their application is approved. ( )

02. Period for Disposal of Excess Resources. The disposal period for excess nonliquid personal property is three (3) months. One (1) three (3) month extension, for sale of personal property, is allowed when good cause exists. ( )

03. Good Cause for Not Making Efforts to Sell Excess Property. The participant has good cause for not making efforts to sell property, when circumstances beyond their control prevent their taking the required actions. Without good cause, the participant's countable resources include the value of the excess property, retroactive to the beginning of the conditional benefits period. ( )

284. RESOURCE TRANSFER FOR LESS THAN FAIR MARKET VALUE.
AABD cash participants are subject to a period of ineligibility if they transfer resources for less than fair market value. The participant is not subject to a period of ineligibility if their total countable resources in the transfer month were under two thousand dollars ($2,000), even if they have kept the transferred resources. Excluded resources, except for the excluded home and associated property, are not subject to the resource transfer period of ineligibility. The exceptions to the period of ineligibility for transfer of resources are listed in Section 292 of these rules. ( )

01. Transfer of Resources. Includes reducing or eliminating the participant's ownership or control of the resource. Transfer of resources includes giving away cash resources without receiving fair market value. ( )

02. Transfer of Participant's Resources by a Spouse of Either Spouse's Resources. Subjects the participant to the resource transfer period of ineligibility. ( )

03. Transfer of Participant's Resources by a Co-Owner. Subjects the participant to a period of

ineligibility based on their share of the co-owed resources. ( )

04. Transfer of Participant's Resources by a Legal Representative Such as a Legal Guardian or Parent of Minor Child. Subjects the participant to a period of ineligibility. ( )

285. AABD PERIOD OF INELIGIBILITY FOR RESOURCE TRANSFERS.
The resource transfer period of ineligibility is a period of AABD ineligibility for up to sixty (60) months. The period of ineligibility begins the first day of the month after the transfer month. The participant must be notified in writing at least ten (10) days before a resource transfer period of ineligibility is imposed. ( )

286. RESOURCE TRANSFER LOOK-BACK PERIOD.
The resource transfer penalty applies to any transfer for less than fair market value made during a period preceding a request for cash assistance. Any resource transferred, regardless of type, is subject to a look-back period of sixty (60) months. The look-back period is counted from the date of the application for cash, or the date of the transfer, whichever is later in time. ( )

287. CALCULATING THE PERIOD OF INELIGIBILITY FOR RESOURCE TRANSFERS.
The period of ineligibility is the number of months computed by dividing the difference between the fair market value of the resource and the amount the participant received for the resource by the full AABD allowances for the participant's living arrangement. For an applicant, the Department will use the full AABD allowance for the application month. For a participant, the Department will use the full AABD allowances for the transfer month. For an AABD couple, the period of ineligibility is computed by dividing the difference between the fair market value of the resource and the amount the participant received for the resource by the full AABD allowances for the couple's living arrangement. The number of months of ineligibility is computed to two (2) decimal places and rounded down to the nearest whole number. If the amount transferred is less than the participant's AABD allowances for one (1) month, the participant is not subject to a period of ineligibility. ( )

288. LENGTH OF PERIOD OF INELIGIBILITY.
The period of ineligibility begins with the month after the month the transfer took place. The period of ineligibility continues whether or not the participant receives AABD. Ineligibility continues until all the resources are returned to the participant or spouse, adequate consideration for all the resources is received, sixty (60) months passes, or the penalty period ends. ( )

289. SPOUSE APPLIES AFTER PERIOD OF INELIGIBILITY IS COMPUTED.
If the spouse applies after the period of ineligibility is computed, the Department will compute the spouse's period of ineligibility by multiplying the number of months in the period of ineligibility already expired by the full AABD allowances for the couple's living arrangement. The Department will subtract the total from the original difference between the fair market value of the resource and the amount the participant received for the resource. The Department will divide the remaining difference between the fair market value of the resource and the amount the participant received for the resource by the full AABD allowances for the couple's living arrangement for the first month of ineligibility. ( )

290. MULTIPLE RESOURCE TRANSFERS.
If the participant makes more than one (1) resource transfer, the difference between the fair market value of all the transferred resources and the amount the participant received for all the transferred resources is used to determine the length of the period of ineligibility. The period of ineligibility begins with the month after the month of the first transfer. ( )

291. TRANSFERS TO TRUSTS.
A trust established from the participant's resources is a resource transfer for less than fair market value, unless it meets an exception in Section 292 of these rules. If the trust includes resources of another person, the resource transfer period of ineligibility applies to the participant's share of the trust. ( )

01. Payment from Trust Not for Participant. If a payment is made to another individual from a trust counted as a resource, and the payment is not for the benefit of the participant, the payment is a resource transfer for less than fair market value. ( )

02. Payment from Trust Restricted. If the participant acts so no payment from a trust counted as a resource can be made for any reason, the trust is a resource transfer for less than fair market value. By taking the action, the participant causes the trust to be no longer counted as a resource and the participant is subject to the period of ineligibility. The date of the action restricting payment is the date of the transfer. ( )

292. PERIOD OF INELIGIBILITY EXCEPTIONS.
A participant or spouse is not subject to the resource transfer period of ineligibility if one (1) of the following conditions is satisfied. ( )

01. Home to Spouse. Title to the home is transferred solely to the spouse. ( )

02. Home to Minor Child or Disabled Adult Child. Title to the home is transferred to the child of the participant or spouse. The child must be under age twenty-one (21), blind or totally disabled under Social Security and SSI rules in 20 CFR Part 416. ( )

03. Home to Sibling. Title to the home is transferred to a sibling of the participant or spouse who must have had an equity interest or life estate in the transferred home and was residing in that home for at least one (1) year immediately before the month the home was transferred. ( )

04. Home to Adult Child. Title to the home was transferred to a child of the participant or spouse, other than a child under the age of twenty-one (21). The child must have resided in that home for at least two (2) years immediately before the month the participant entered a medical facility or long-term care. The child must have provided care to the participant, which permitted them to live at home rather than enter a medical facility or long-term care. ( )

05. Benefit of Spouse. Resources, other than the home, were transferred to the participant's spouse or to another person for the sole benefit of the spouse. ( )

06. Transfer from Spouse. The resources were transferred from the participant's spouse to another person for the sole benefit of the participant's spouse. ( )

07. Transfer to Child. The resources were transferred to the participant's child or to a trust established solely for the benefit of the participant's child. The child must be blind or totally disabled under Social Security and SSI rules in 20 CFR Part 416. The child may be any age. ( )

08. Transfer to Trust for Person Under Sixty-Five. The resources were transferred to a trust for the sole benefit of a person under age sixty-five (65) who is blind or totally disabled under Social Security and SSI rules in 20 CFR Part 416. ( )

09. Transfer to a Trust That Is a Countable Resource. The resources were transferred to a trust and the trust is a countable resource for AABD in the amount of the transfer. ( )

10. Intent to Receive Fair Market Value. The participant or spouse proves they intended to dispose of the resources at fair market value or for other adequate consideration, but can prove good cause for not doing so. ( )

11. Resources Returned. All resources transferred for less than fair market value have been returned to the participant. ( )

12. No AABD Purpose. The participant or spouse proves the resources were transferred exclusively for a purpose other than qualifying for AABD. Purposes other than qualifying for AABD include: ( )

a. After the resource transfer the participant has a traumatic onset of disability. ( )

b. After the resource transfer a previously unknown disabling condition is diagnosed. ( )

c. After the resource transfer the participant has an unexpected loss of income or resources resulting

in eligibility for AABD. ( )

d. The resource was excludable in the transfer month. ( )

e. The transfer of resources was court-ordered, provided the participant did not petition the court to order the transfer. ( )

f. The participant took a vow of poverty and gave the resources to a religious order. ( )

13. Undue Hardship. The participant proves failure to receive AABD would deprive them of food or shelter and their total available funds, including income and liquid resources, are less than their AABD allowances for the month they claim undue hardship. Undue hardship must be proven for each month of the period of ineligibility. When determining total available funds for a child, the Department will count any income and resources deemed from their parents. ( )

14. Exception to Fair Market Value. The amount received is reasonable, even if less than fair market value if a forced sale was done under reasonable circumstances, and little or no market demand exists for the type of resource transferred, or the resource was transferred to settle a legal debt approximately equal to the fair market value of the transferred resource. ( )

15. No Benefit to Participant. The participant received no benefit from the resource because they or their spouse held title to the property only as a trustee for another person, or the transfer was done to clear title to property and the participant or spouse had no interest in the property that would benefit them. ( )

16. Fraud Victim. The resource was transferred because the participant or spouse was the victim of fraud, misrepresentation, or coercion. The participant or spouse must take all possible steps to recover the resources or property or its equivalent in damages. The participant must assign recovery rights to the State of Idaho. ( )

293. EFFECT ON MEDICAID ELIGIBILITY.

Ineligibility for AABD cash because of property transfer does not make the participant ineligible for Medicaid. ( )

294. -- 299. (RESERVED)

300. INCOME DEFINITION.

Income is anything that can be used to meet needs for food, or shelter. Income is cash, wages, pensions, in-kind payments, inheritances, gifts, awards, rent, dividends, interest, or royalties the participant receives during a month. ( )

01. Cash Income. Is currency, checks, money orders, or electronic funds transfers. Cash income includes Social Security checks, unemployment checks, and payroll checks. ( )

02. In-Kind Income. Is not cash. In-kind income is food or shelter. Wages paid as in-kind earnings, such as food or shelter, are counted as unearned income. Other in-kind income is not counted. ( )

03. Inheritances. Is cash, a right, or noncash items received as the result of someone's death. Cash or noncash items in an inheritance are income the month received and a resource the next month. A contested inheritance is not counted as income until the contest is settled and money is distributed. ( )

301. APPLICATION FOR POTENTIAL BENEFITS.

The participant must apply for benefits, including RSDI, VA, pensions, Workman's Compensation, or Unemployment Insurance, when there is potential eligibility. The participant must apply when they reach the earliest age to qualify for the benefit. ( )

01. SSI. To get AABD cash, the participant must apply for SSI benefits, if they are potentially eligible. To get AABD-Medicaid, the participant does not have to apply for SSI benefits. ( )

02. VAIP. Participants entitled to a VA pension as of December 31, 1978, are not required to file for Veterans Administration Improved Pension Plan (VAIP), to get AABD cash or AABD-related Medicaid. ( )

03. Other Benefits. EITC, TAFI, BIA General Assistance, and victim's compensation benefits are exempt from the filing requirement. ( )

302. RELATIONSHIP OF INCOME TO RESOURCES.
Income is counted as income in the current month. If the participant keeps countable income after the month received, it is counted as a resource. ( )

303. WHEN INCOME IS COUNTED.
Income is counted the earliest of when received, when credited to a participant's account, or when set aside for the participant's use. Income from SSA, SSI, or VA is counted for the month it is intended to cover. ( )

304. PROSPECTIVE ELIGIBILITY.
Eligibility for AABD cash and Medicaid is prospective. Expected income for the month is compared to the participant's income limit that month. ( )

305. PROJECTING MONTHLY INCOME.
Income is projected for each month to determine AABD cash amount. Past income may be used to project future income. Expected changes must be considered. Income received less often than monthly and patient liability income are not prorated or converted. ( )

306. CRITERIA FOR PROJECTING MONTHLY INCOME.
Monthly income is projected as described below. ( )

01. Converting Income to a Monthly Amount. If a full month's income is expected, but is received on other than a monthly basis, the Department will convert the income to a monthly amount using one (1) of the formulas in the table below.

TABLE 306.01 MONTHLY CONVERSION OF INCOME		
	Conversion	Procedure
a.	Weekly to Monthly	Multiply weekly amounts by 4.3.
b.	Biweekly to Monthly	Multiplying bi-weekly amounts by 2.15.
c.	Semimonthly to Monthly	Multiplying semi-monthly amounts by 2.
d.	Exact Amount	Use the exact monthly income if it is expected for each month.

( )

02. Income Already Received. The Department will count income already received during the month and will convert the actual income to a monthly amount if a full month's income has been received or is expected to be received as described below. ( )

a. If the actual amount of income from any pay period a month is known, the Department will use the actual pay period amounts to determine the total month's income and will convert the actual income to a monthly amount if a full month's income has been received or is expected. ( )

b. If no pay changes are expected, the Department will use the known actual pay period amounts for the past thirty (30) days to project future income and will convert the actual income to a monthly amount if a full month's income has been received or is expected. ( )

03. Expected Income. The Department will count income that the participant and the Department believe the participant will get. The Department will convert expected income to a monthly amount as described below. ( )

a. If the exact income amount is uncertain or unknown, the uncertain or unknown portion must not be counted. The certain or known amount is counted. ( )

b. If the income has not changed and no changes are expected, past income can be used to project future income. ( )

c. If income changes, and income received in the past thirty (30) days does not reflect expected income, income received over a longer period is used to project future income. ( )

d. If income changes seasonally, income from the last comparable season is used to project future income. ( )

04. Ongoing Income. Comes from an ongoing source. It was received in the past and is expected to be received in the future. The Department will convert ongoing income to a monthly amount as described below. ( )

a. If a full month's income is not expected from an ongoing source, the Department will count the amount of income expected for the month. If actual income is known, the Department will use actual income. If actual income is unknown, the Department will project expected income and will convert income to a monthly amount. The Department will use zero (0) income for any pay period in which income was not received that month. ( )

b. If a full month's income from a new source is not expected, the Department will count the actual income expected for the month. The Department will not convert the income to a monthly amount. ( )

c. If income stops and no additional income is expected from the terminated source, the Department will count the actual income received during the month. The Department will not convert the terminated source of income. ( )

d. If a full month's income is not expected from a new or terminated source, the Department will count the income expected for the month. If the actual income is known, the Department will use the known income. If the actual income is unknown, the Department will project the income and will not convert the income to a monthly amount if a full month's income from a new or terminated source is not expected. ( )

05. Income Paid on Salary. Income paid on salary, rather than an hourly wage, is counted at the expected monthly salary rate. ( )

06. Income Paid at Hourly Rate. The Department will compute expected income paid on an hourly basis by multiplying the hourly pay by the expected number of hours the participant will work in the pay period. The Department will convert the pay period amount to a monthly basis. ( )

07. Monthly Income Varies. When monthly income varies each pay period and the rate of pay remains the same, the Department will average the income from the past thirty (30) days to determine the average pay period amount and will convert the average pay period amount to a monthly amount. When income changes and income from the past thirty (30) days is not a valid indicator of future income, a longer period of income history is used to project income. ( )

08. Income Received Less Often Than Monthly. Recurring income, such as quarterly payments or annual income, is counted in the month received, even if the payment is for multiple months. The income is not prorated or converted. If the amount is known, the Department will use the actual. If the amount is unknown, the Department will use the best information available to project income. ( )

307. COUNTING RESOURCES AND INCOME.

An asset cannot be counted as income and resources in the same month. Assets received in cash or in-kind during a month are income. Income held past the month received is a resource. ( )

308. -- 309. (RESERVED)

310. ADOPTION ASSISTANCE UNDER TITLE IV-B OR TITLE XX.
Adoption assistance payments, provided under Title IV-B or Title XX of the Social Security Act, are excluded income. Adoption assistance payments using funds provided under Title IV-E are income. The twenty dollar ($20) standard disregard is not subtracted. ( )

311. -- 312. (RESERVED)

313. ASSISTANCE BASED ON NEED (ABON).
ABON is aid paid under a program using income as a factor of eligibility. ABON is funded wholly by a State, or a political subdivision of a State, or an Indian tribe, or a combination of these sources. Federal funds are not used. ABON is excluded income. ( )

314. (RESERVED)

315. BUREAU OF INDIAN AFFAIRS (BIA) FOSTER CARE.
BIA foster care payments are social services. They are excluded income for the foster child and foster family. ( )

316. BLIND OR DISABLED STUDENT EARNED INCOME.
To qualify for this exclusion, the student must be blind or disabled and be under age twenty-two (22). The student must be regularly attending high school, college, university, or a course of vocational or technical training designed to prepare them for gainful employment. The maximum monthly and annual exclusions cannot exceed the limits set by SSI for the current year. ( )

317. "BUY-IN" REIMBURSEMENT.
The SSA reimbursement for self-paid Medicare Part B "Buy-In" premiums is excluded. ( )

318. – 319. (RESERVED)

320. CONVERSION OR SALE OF A RESOURCE NOT INCOME.
Payment from the sale, exchange, or replacement of a resource is excluded. The payment is a resource that changed form. ( )

321. CREDIT LIFE OR DISABILITY INSURANCE PAYMENTS.
Credit life or credit disability insurance covers payments on loans and mortgages, in case of death or disability. Insurance payments are made directly to loan or mortgage companies and are not available to the participant. These payments are excluded. ( )

322. DEPARTMENT OF EDUCATION SCHOLARSHIPS.
Any grant, scholarship, or loan to an undergraduate for educational purposes, made or insured under any program administered by the Commissioner of Education, is excluded. ( )

323. (RESERVED)

324. GRANTS, SCHOLARSHIPS, AND FELLOWSHIPS.
Any grant, scholarship, or fellowship, not administered by the Commissioner of Education, and used for paying tuition, fees, or required educational expenses is excluded. This exclusion does not apply to any portion set aside or used for food or shelter. ( )

325. DISASTER ASSISTANCE.
Payments received because of a major disaster, declared by the President, are excluded. This includes payments to repair or replace the person's own home or other property and disaster unemployment aid. ( )

326. DOMESTIC VOLUNTEER SERVICE ACT PAYMENTS.
Compensation, other than wages, provided to volunteers in the Foster Grandparents Program, RSVP, and similar National Senior Volunteer Corps programs under Sections 404(g) and 418 of the Domestic Volunteer Service Act is excluded. ( )

327. EARNED INCOME TAX CREDITS.
Earned Income Tax Credits advance payments and refunds are excluded. ( )

328. FEDERAL HOUSING ASSISTANCE.
Federal housing assistance is excluded. ( )

329. FOSTER CARE PAYMENTS.
Foster care payments using funds provided under Title IV-B or Title XX of the Social Security Act are excluded. Payments for foster care of a non-SSI child placed by a public or private non-profit child placement or child care agency are excluded. Foster care payments using funds provided under Title IV-E are income. The twenty dollar ($20) standard disregard is not subtracted. ( )

330. EXPENSE OF OBTAINING INCOME.
Essential expenses of obtaining unearned income are subtracted from the income. An expense is essential if the participant would not receive the income unless they paid the expense. Expenses of receiving income, such as withheld taxes, are not subtracted. ( )

331. GARNISHMENTS.
Garnishments of unearned income are counted as unearned income. Garnishments of earned income are counted as earned income. ( )

332. (RESERVED)

333. GOVERNMENT MEDICAL OR SOCIAL SERVICES.
Governmental payments authorized by federal, state, or local law, for medical or social services, are excluded. Any cash provided by a nongovernmental medical or social services organization (including medical and liability insurers) for medical or social services already received is excluded. ( )

01. Medical Services. Are diagnostic, preventive, therapeutic, or palliative treatment. Treatment must be performed, directed, or supervised by a state-licensed health professional. Medical services include room and board provided during a medical confinement and in-kind medical items. ( )

02. Social Service. Any service, other than medical. Housebound and Aid and Attendance Allowances, including Unusual Medical Expense Allowances, received from the Veterans Administration are excluded. ( )

334. HOME ENERGY ASSISTANCE (HEA) AND SUPPORT AND MAINTENANCE ASSISTANCE (SMA).
HEA and SMA are excluded. ( )

335. (RESERVED)

336. IN-HOME SUPPORTIVE SERVICES.
Payments made by Title XX or other governmental programs to pay an ineligible spouse or ineligible parent for in-home supportive services provided to a participant are excluded. In-home supportive services include attendant care, chore services, and homemaker services. ( )

337. INCOME EXCLUDED BY LAW.
Any income excluded by federal statute is excluded. ( )

338. INFREQUENT OR IRREGULAR INCOME.
The first thirty dollars ($30) of earned income and the first sixty dollars ($60) of unearned income per calendar quarter are excluded when they are infrequent or irregular payments. Income is infrequent if the participant receives it once in a calendar quarter from a single source. Income is irregular if the participant could not reasonably expect to receive it. ( )

339. (RESERVED)

340. LOANS.
Loans are excluded if the participant has signed a written repayment agreement. The signed agreement must state how the loan will be repaid. The signed written agreement can be obtained after the loan is received. Items bought on credit are paid with a loan and are not income. Money repaid to a participant on the principal of a loan is not income, it is a resource. Interest received by a participant on money loaned by them is countable income. ( )

341. (RESERVED)

342. NATIVE AMERICAN PAYMENTS.
Payments authorized by law made to people of Native American ancestry are excluded. ( )

343. (RESERVED)

344. NUTRITION PROGRAMS FOR OLDER AMERICANS.
Payments, other than a wage or salary, made under Chapter 35, Title 42, USC, Programs for Older Americans, are excluded. ( )

345. PERSONAL SERVICES.
A personal service performed for a participant is excluded. Personal services include lawn mowing, house cleaning, grocery shopping, and babysitting. ( )

346. (RESERVED)

347. REBATES, REFUNDS, AABD UNDERPAYMENTS, AND REPLACEMENT CHECKS.
Rebates, refunds, AABD underpayments, and returns of money already paid are excluded. A replacement check is excluded. ( )

348. RELOCATION ASSISTANCE.
Relocation payments under Title II of the Uniform Relocation Assistance and Real Property Acquisitions Policies Act of 1970, Subchapter II, Chapter 61, Title 42, USC, are excluded. Relocation payments paid to civilians of World War II per PL 100-383, are excluded. ( )

349. REPLACEMENT OF INCOME ALREADY RECEIVED.
Replacement of a participant’s lost, stolen, or destroyed income is excluded. ( )

350. RETURN OF MISTAKEN PAYMENTS.
A returned mistaken payment is excluded. If the participant keeps the mistaken payment, it is income. ( )

351. TAX REFUNDS.
Refunds of federal, State, or local taxes paid on income, real property, or food bought by the participant and their family, are excluded. ( )

352. UTILITY PAYMENTS.
Payments for utility costs made to low-income housing tenants by a local housing authority are excluded when paid directly to the tenant or jointly to the tenant and the utility company. ( )

353. (RESERVED)

354. VICTIMS' COMPENSATION PAYMENTS.
Any payment made from a State-sponsored fund to aid victims of crime is excluded. ( )

355. VOCATIONAL REHABILITATION SERVICES PAYMENTS.
Payments other than wages made to an eligible handicapped individual employed in a Vocational Rehabilitation Services project under Title VI of the Rehabilitation Act of 1973, are excluded. ( )

356. VOLUNTEER SERVICES INCOME.

Payments to volunteers under Chapter 66, Title 42, USC Domestic Volunteer Services (ACTION programs) are excluded. Payments are not excluded if the Director of the ACTION agency determines the value, adjusted for hours served, is equal to or greater than the federal or state minimum wage. ( )

357. WALKER V. BAYER PAYMENTS.
Class action settlement payments in Susan Walker v. Bayer Corporation, et al., are excluded for Medicaid but not for AABD cash. ( )

358. WEATHERIZATION ASSISTANCE.
Weatherization assistance is excluded. ( )

359. TEMPORARY CENSUS INCOME.
For Medicaid only, all wages paid by the Census Bureau for temporary employment related to US Census activities are excluded. ( )

360. -- 399. (RESERVED)

400. EARNED INCOME.
Earned income remaining after disregards and exclusions are subtracted, is counted in computing AABD cash. Wages are counted the month they become available to the participant. ( )

401. COMPUTING SELF-EMPLOYMENT INCOME.
Countable self-employment income is the difference between the gross receipts and the allowable costs of producing the income, if the amount is expected to continue. Self-employment income is computed using one (1) of the methods listed in Subsections 401.01 through 401.03 of this rule. Subsection 401.04 of this rule can be used as an income deduction, if applicable. ( )

01. Self-Employed at Least One Year. For individuals who are self-employed for at least one (1) year, income and expenses are averaged over the past twelve (12) months. ( )

02. Self-Employed Less Than One Year. For individuals who are self-employed for less than one (1) year, income and expenses are averaged over the months the business has been in operation. ( )

03. Monthly Increase or Decrease. If a monthly average does not reflect actual monthly income because of an increase or decrease in business, the self-employment income is counted monthly. This method is not used for businesses with seasonal or unusual income peaks at certain times of the year. ( )

04. Net Self-Employment Income Seven and Sixty-Five Hundredths Percent Deduction. If net self-employment income is over four hundred dollars ($400) per year, seven and sixty-five hundredths percent (7.65%) is deducted. This deduction compensates for Social Security taxes paid. If self-employment Social Security tax is not paid, this deduction is not allowed. ( )

402. SELF-EMPLOYMENT ALLOWABLE EXPENSES.
Allowable operating expenses subtracted from self-employment income are the allowable Internal Revenue Service self-employment expenses, except for those listed under Section 403 of these rules. ( )

403. SELF-EMPLOYMENT EXPENSES NOT ALLOWED.
Self-employment expenses not allowed are as follows: ( )

01. Payments on the Principal of Real Estate. Payments on the principal of real estate mortgages on income-producing property. ( )

02. Purchase of Capital Assets or Durable Goods. Purchases of capital assets, equipment, machinery, and other durable goods. Payments on the principal of loans for these items. ( )

03. Federal, State, and Local Income Taxes. ( )

04. **Savings**. Monies set aside for future use such as retirement or work-related expenses. ( )

05. **Labor Paid to Any Family Member**. ( )

06. **Loss of Farm Income Subtracted From Other Income**. ( )

07. **Personal Transportation**. ( )

08. **Net Losses from Previous Periods**. ( )

404. ROYALTIES.
Royalties received as part of a trade or business, or for publication of the participant's work, are earned income. Other royalties are unearned income. ( )

405. HONORARIA.
An honorarium for services rendered is earned income. An honorarium for travel expenses and lodging for a guest speaker is unearned income in the amount it exceeds the expenses. The portion that equals the expenses is excluded as an expense of obtaining the income. ( )

406. SHELTERED WORKSHOP OR WORK ACTIVITIES CENTER PAYMENTS.
Payments for services performed in a sheltered workshop or work activities center are earned income. ( )

407. JOB TRAINING PARTNERSHIP ACT (JTPA).
JTPA payments are earned income. JTPA payments for child care, transportation, medical care, meals, and other reasonable expenses, provided in cash or in-kind, are not income. ( )

408. PROGRAMS FOR OLDER AMERICANS.
Wages or salary paid under Chapter 35, Title 42, USC, Programs for Older Americans, is earned income. ( )

409. UNIFORMED SERVICES PAY AND ALLOWANCES.
Basic pay is earned income. All other pay and allowances are unearned income. ( )

410. RENTAL INCOME.
Net rental income is unearned income, unless from the business of renting real property. Net unearned rental income is gross rent less the expenses on the rental property as listed below. Net rental income from the business of renting properties is self-employment earned income. ( )

01. **Interest**. Interest and escrow portions of a mortgage payment. ( )

02. **Real Estate Insurance**. ( )

03. **Repairs**. Minor repairs to an existing rental structure. ( )

04. **Property Taxes**. ( )

05. **Yard Care**. Lawn care, including tree and shrub care and snow removal. ( )

06. **Advertising Costs for Tenants**. ( )

411. OVERPAYMENT WITHHOLDING OF UNEARNED INCOME.
Money withheld by any benefit program to recover an overpayment is counted as income. Money withheld is not income if the overpaid benefit amount was used to compute AABD cash. ( )

412. RETIREMENT, SURVIVORS, AND DISABILITY INSURANCE (RSDI).
RSDI monthly benefits are unearned income. The income is the amount reported by SSA, regardless of penalties to recover an SSI overpayment. ( )

413. SSI PAYMENTS.
SSI monthly payments are unearned income. The income is the amount reported by SSA, regardless of penalties to recover an SSI overpayment. An advance SSI payment to an applicant appearing SSI-eligible with a financial emergency, is not income the month received. When SSA reduces ongoing SSI to recover the advance, the SSI payment before the reduction continues to be counted as income. ( )

414. BLACK LUNG BENEFITS.
Black Lung payments are unearned income. ( )

415. RAILROAD RETIREMENT PAYMENTS.
Railroad Retirement Board payments are unearned income. ( )

416. UNEMPLOYMENT INSURANCE BENEFITS.
Unemployment insurance benefits received under state and federal unemployment laws are unearned income. ( )

417. UNIFORM GIFTS TO MINORS ACT (UGMA).
UGMA payments from the custodian to the minor are income to the minor. UGMA property, including earnings or additions, are not income to the minor until the month the minor becomes eighteen (18) years old. ( )

418. WORKERS' COMPENSATION.
Workers' compensation, less expenses required to get the payment, is unearned income. ( )

419. MILITARY PENSIONS.
Military pensions are unearned income. ( )

420. VA PENSION PAYMENTS.
VA pension payments are unearned income. The twenty dollar ($20) standard disregard is not subtracted, except by a special act of Congress. ( )

421. VA COMPENSATION PAYMENTS.
VA compensation payments to a veteran, spouse, child, or widow(er) are unearned income. ( )

422. VA EDUCATIONAL BENEFITS.
VA educational payments funded by the government are excluded. ( )

423. ALIMONY, SPOUSAL, AND ADULT SUPPORT.
Alimony, spousal, and other adult support payments are unearned income. ( )

424. CHILD SUPPORT PAYMENTS.
Child support payments are unearned income. One-third (1/3) of a child support payment is excluded for the child receiving support. Child support collected by a State and retained for TAFI payments is not income. ( )

425. DIVIDENDS AND INTEREST.
Dividends and interest are unearned income. ( )

426. AWARDS, GIFTS, PRIZES.
Awards, gifts, and prizes are unearned income. ( )

427. WORK-RELATED UNEARNED INCOME.
Work-related payments that are not salary or wages are unearned income. ( )

428 – 430. (RESERVED)

431. FEDERAL EMERGENCY MANAGEMENT AGENCY (FEMA) EMERGENCY FOOD DISTRIBUTION AND SHELTER PROGRAMS.
FEMA funds are unearned income, unless excluded by the type of aid, such as medical services or Support and Maintenance Assistance. ( )

432. BUREAU OF INDIAN AFFAIRS GENERAL ASSISTANCE (BIA GA).
BIA GA payments are unearned income and are federally funded income based on need. They are paid in cash or in-kind. The twenty dollar ($20) standard disregard is not subtracted. ( )

433. BIA ADULT CUSTODIAL CARE (ACC) AND CHILD WELFARE ASSISTANCE (CWA) PAYMENTS.
BIA ACC and CWA payments, other than foster care made to participants out of an institution, are unearned income. ( )

434. INDIVIDUAL INDIAN MONEY (IIM) ACCOUNTS.
Deposits to an unrestricted IIM account are income in the month deposited. ( )

435. ACCELERATED LIFE INSURANCE INCOME.
Accelerated life insurance payments are unearned income in the month received. ( )

436. REAL ESTATE CONTRACT INCOME.
Payments received on the interest of a negotiable real estate contract are unearned income for Medicaid eligibility. Payments received on the principal of a negotiable real estate contract are a resource for Medicaid eligibility. Payments received on a nonnegotiable real estate contract are unearned income. Principal and interest payments received on an excluded real estate contract of a long-term care participant are unearned income for patient liability. ( )

437. LIMITED AWARD TO CHILD WITH LIFE-THREATENING CONDITION.
Any gift from a tax-exempt nonprofit organization to a child under age eighteen (18), who has a life-threatening condition, is excluded from income under the conditions below. ( )

01. **In-Kind Gift**. Is excluded if the gift is not converted to cash. ( )

02. **Cash Gifts**. Are excluded up to two thousand dollars ($2,000) for the calendar year the cash gifts are made. ( )

438. -- 450. (RESERVED)

451. DEEMING INCOME.
Income deeming counts the income of another person as available to an AABD participant, for eligibility and the amount of AABD cash. Income is deemed to the participant from their ineligible spouse, and to the child participant from their ineligible parent. Income deeming starts the first full calendar month the participant is in a deeming situation. Deeming ends the first full calendar month the participant is not in a deeming situation. Deeming to a child ends the month after the child's eighteenth birthday. ( )

01. **Ineligible Parent**. A natural or adoptive parent or stepparent, who does not receive AABD and lives in the same household as a child. ( )

02. **Ineligible Spouse**. A participant's spouse living with the participant and not receiving AABD is an ineligible spouse. The ineligible spouse of the parent of a child participant, living with the child participant and their parent, is an ineligible spouse. ( )

03. **Ineligible Child**. A child under age twenty-one (21) who does not receive AABD, and lives with the AABD participant. ( )

04. **Income Deeming Exclusions**. Income excluded from deeming is listed in POMS Chapter SI 01320.000, incorporated by reference under Subsection 002.02 of these rules. ( )

452. DEEMING INCOME FROM INELIGIBLE SPOUSE TO PARTICIPANT.
Income is deemed from an ineligible spouse to the participant, if they live together. Income is deemed as described in Subsections 452.01 through 452.08 POMS Chapter SI 01320.000, incorporated by reference under Subsection 002.02

of these rules. ( )

453. DEEMING INCOME FROM INELIGIBLE PARENT TO AABD CHILD.
Income is deemed from an ineligible parent, or their ineligible spouse, to a child participant under age eighteen (18) living in the same household. A stepparent's income is deemed to the child for AABD cash, but not Medicaid. The income is deemed as described in POMS Chapter SI 01320.000, incorporated by reference under Subsection 002.02 of these rules. ( )

454. DEEMING INCOME FROM ESSENTIAL PERSON TO PARTICIPANT.
If a participant and an essential person live in the same household, the essential person's income is deemed to the participant. If essential person deeming makes the participant ineligible, the Department will not use essential person deeming. The income is deemed as described in Subsections 454.01 through 454.06 POMS Chapter SI 01320.000, incorporated by reference under Subsection 002.02 of these rules. ( )

455. DEEMING INCOME FROM INELIGIBLE SPOUSE TO PARTICIPANT AND CHILD PARTICIPANT.
If a participant, their ineligible spouse, and their child participant live in the same household, income is deemed from the participant to the child participant. The income is deemed as described in POMS Chapter SI 01320.000, incorporated by reference under Subsection 002.02 of these rules. ( )

456. DEEMING INCOME FROM SPONSOR TO LEGAL NON-CITIZEN PARTICIPANT -- NO I-864 AFFIDAVIT OF SUPPORT.
The Department will deem income as described in this rule, if the legal non-citizen's sponsor signed an affidavit of support other than the I-864. The deemed income is counted, even if the participant does not live in the sponsor's household. The sponsor's income is not deemed to the participant for Medicaid. ( )

01. Three-Year Limit. The deeming period, regardless of admission date, is three (3) years after the date the legal non-citizen is lawfully admitted. Deeming stops the end of the month, three (3) years from the date the sponsored participant lawfully entered the US for permanent residence. ( )

02. Sponsored Legal Non-Citizen Exempt from Deeming. A lawfully admitted legal non-citizen participant is exempt from sponsor deeming if one (1) or more of the following conditions applies. ( )

a. The legal non-citizen was admitted to the US as a refugee, asylee, or parolee. ( )

b. The legal non-citizen first applied for AABD before October 1, 1980. ( )

c. The legal non-citizen is a lawful permanent resident. ( )

d. The legal non-citizen's entry into the US was sponsored by a church, other social service organization, or an employer who has offered them a job. ( )

e. The legal non-citizen becomes blind or disabled after they are admitted to the US. ( )

f. The legal non-citizen was sponsored by and resides in the same household with their ineligible spouse or ineligible parent. The Department will use ineligible spouse and ineligible parent deeming, not sponsor deeming. ( )

g. The legal non-citizen's sponsor dies. ( )

h. The legal non-citizen was legalized under the Immigration Reform and Control Act of 1986. ( )

i. The legal non-citizen has lived in the US for thirty-six (36) months beginning with the month they were admitted for permanent residence or granted permanent residence status. ( )

j. The legal non-citizen was admitted under Section 249 of the INA as a registry legal non-citizen.

( )

k. The legal non-citizen is an applicant for permanent residence who is an Amerasian or a specified relative of an Amerasian. The Amerasian must be born in Vietnam between January 1, 1962, and January 1, 1976. A specified relative is a spouse, child, parent, or stepparent of the Amerasian, or someone who has acted in the place of a parent of an Amerasian and/or their spouse or child. ( )

l. The legal non-citizen is an applicant for adjustment under the Cuban/Haitian provisions of Section 202 of the Immigration Reform and Control Act of 1986. ( )

03. Sponsor/Legal Non-Citizen Relationships. Sponsor/legal non-citizen relationships and deeming rules are listed in POMS Chapter SI 01320.000, incorporated by reference under Subsection 002.02 of these rules. ( )

04. Sponsor to Legal Non-Citizen Deeming Procedures. The Department will budget the legal non-citizen's actual needs, as if they are a single person living alone. The Department will subtract the legal non-citizen's own income, less exclusions and disregards. The Department will subtract the couple's income, less exclusions, from their needs. If there is no budget deficit, the participant is not eligible. If there is a budget deficit, the Department will follow the procedures in POMS Chapter SI 01320.000, incorporated by reference under Subsection 002.02 of these rules, to compute sponsor deemed income. ( )

457. DEEMING INCOME FROM SPONSOR TO LEGAL NON-CITIZEN -- SPONSOR SIGNED INS FORM I-864 AFFIDAVIT OF SUPPORT.

If the legal non-citizen's sponsor has signed an INS form I-864 Affidavit of Support, all income of the sponsor and the sponsor's spouse is deemed to the legal non-citizen for AABD cash and Medicaid eligibility. Deeming continues until the legal non-citizen becomes a naturalized citizen or has forty (40) quarters of work. Exceptions are listed below: ( )

01. Battery Exception. The legal non-citizen or the legal non-citizen child's parent was battered or subjected to extreme cruelty in the US. There is a substantial connection between the battery and the participant's need for assistance. The person subjected to the battery or cruelty no longer lives with the person responsible for the battery or cruelty. ( )

02. Indigence. Alien sponsor deeming is suspended for twelve (12) months, if the legal non-citizen is not able to get food and shelter without AABD cash. ( )

458. -- 499. (RESERVED)

500. FINANCIAL NEED.

The participant has financial need if their allowances, as described in Sections 501 through 513 of these rules, are more than their income. ( )

501. BASIC ALLOWANCE.

Each participant receives a basic allowance unless they live in a nursing facility. The basic allowance for each living arrangement is listed in this rule. The Semi-Independent Group Residential Facility, Room and Board, Residential and Assisted Living Facility, and Certified Family Home basic allowances do not change with the annual cost-of-living increase in the federal SSI benefit amount. ( )

01. Single Participant. A participant is budgeted five hundred forty-five dollars ($545) monthly as a basic allowance when living in a situation listed below. Beginning January 1, 2001, the basic allowance increase for a single participant is the dollar amount of the annual cost-of-living increase in the federal SSI benefit rate for a single person. ( )

a. Living alone. ( )

b. Living with their ineligible spouse. ( )

c. Living with another participant who is not their spouse. ( )

d. Living in another's household. This includes a living arrangement where the participant purchases lodging (room) and meals (board) from their parent, child, or sibling. ( )

e. Living with their TAFI child. ( )

02. Couple or Participant Living with Essential Person. A participant living with their participant spouse or their essential person is budgeted seven hundred sixty-eight dollars ($768) monthly as a basic allowance. Beginning January 1, 2001, the basic allowance increase for a couple is the dollar amount of the annual cost-of-living increase in the federal SSI benefit rate for a couple. The increase may be rounded up. ( )

03. SIGRIF. A participant living in a semi-independent group residential facility (SIGRIF) is budgeted three hundred forty-nine dollars ($349) monthly as a basic allowance. ( )

502. SPECIAL NEEDS ALLOWANCES.

Special needs allowances are a restaurant meals allowance and a service animal food allowance. ( )

01. Restaurant Meals Allowance. Is fifty dollars ($50) monthly. A physician must state the participant is physically unable to prepare food in their home. A participant able to prepare their food, but living in a place where cooking is not permitted, may be budgeted the restaurant meals allowance for up to three (3) months. ( )

02. Service Animal Food Allowance. Is seventeen dollars ($17) monthly. The allowance is budgeted for a blind or disabled participant using a trained service animal. ( )

503. -- 511. (RESERVED)

512. ROOM AND BOARD HOME ALLOWANCE.

Room and board is a living arrangement where the participant purchases lodging (room) and meals (board) from a person they live with who is not their parent, child, or sibling. ( )

01. Budgeted Room and Board Allowance. Beginning January 1, 2006, a participant living in a room and board home is budgeted six hundred ninety-three dollars ($693). Beginning July 1, 2013, the Room and Board allowance will be adjusted annually by the percentage of the annual cost-of-living increase in the federal SSI benefit rate for a single person. This adjustment will be effective on January 1st of each year. The room and board allowance increase will be rounded to the next dollar. ( )

02. Basic Allowance for Participant in Room and Board Home. A participant living in a room and board home is budgeted seventy-seven dollars ($77) monthly as a basic allowance. Beginning July 1, 2013, this basic allowance will be adjusted annually by the percentage of the annual cost-of-living increase in the federal SSI benefit rate for a single person. This adjustment will be effective on January 1st of each year. The basic allowance increase will be rounded to the nearest dollar. ( )

513. RESIDENTIAL ASSISTED LIVING FACILITY (RALF) AND CERTIFIED FAMILY HOME (CFH) ALLOWANCES.

A participant living in a RALF under IDAPA 16.03.22, "Residential Assisted Living Facilities," or a CFH, under IDAPA 16.03.19, "Certified Family Homes," is budgeted a basic allowance of ninety-six dollars ($96) monthly. Beginning July 1, 2013, this basic allowance will be adjusted annually by the percentage of the annual cost-of-living increase in the federal SSI benefit rate for a single person. This adjustment will be effective on January 1st of each year. The basic allowance increase will be rounded to the nearest dollar. ( )

01. Budgeted Monthly Allowance Based on Level of Care. A participant is budgeted a monthly allowance for care based on the level of care received as described in Section 515 of these rules. If the participant does not require State Plan Personal Care Services (PCS), their eligibility and allowances are based on the Room and Board rate in Section 512 of these rules. ( )

02. Care Levels and Monthly Allowances. Beginning January 1, 2006, care levels and monthly allowances are those listed in Table 513.02 below. Beginning July 1, 2013, the RALF and CFH allowances for participants living in a RALF or CFH on State Plan PCS will be adjusted annually by the percentage of the annual cost-of-living increase in the federal SSI benefit rate for a single person. This adjustment will be effective on January 1st of each year. This increase will be rounded to the next dollar.

TABLE 513.02 - STATE PLAN PCS CARE LEVELS AND ALLOWANCES AS OF 1-1-06		
	Level of Care	Monthly Allowance
a.	Level I	Eight hundred and thirty-five dollars ($835)
b.	Level II	Nine hundred and two dollars ($902)
c.	Level III	Nine hundred and sixty-nine dollars ($969)

( )

03. CFH Operated by Relative. A participant living in a CFH operated by their parent, child, or sibling is not entitled to the CFH State Plan PCS allowances. They may receive the allowance for a person living with a relative as described in Section 501 of these rules. A relative for this purpose is the participant's parent, child, sibling, aunt, uncle, cousin, niece, nephew, grandparent, or grandchild by birth, marriage, or adoption. ( )

514. AABD CASH PAYMENTS.

Only a participant who receives an SSI payment for the month is eligible for an AABD cash payment in the same month. The AABD cash payment amount is based on the participant's living arrangement described in Subsections 514.01 through 514.04 of this rule. An AABD cash payment is the difference between a participant's financial need and their countable income. If the difference is not an even dollar amount, AABD cash is paid at the next higher dollar. ( )

01. Single Participant Maximum Payment. For a single participant described in Subsection 501.01 of these rules, the maximum monthly AABD cash payment amount is fifty-three dollars ($53). ( )

02. Couple or Participant Living with Essential Person Maximum Amount. For participants described in Subsection 501.02 of these rules, the maximum monthly AABD cash payment amounts are: ( )

a. A couple receives twenty dollars ($20); or ( )

b. A participant living with essential person receives eighteen dollars ($18). ( )

03. Semi-Independent Group Maximum Payment. For a participant described in Subsection 501.03 of these rules, the maximum monthly AABD cash payment amount is one hundred sixty-nine dollars ($169). ( )

04. Room and Board Maximum Payment. For a participant described in Section 512 of these rules, the maximum monthly AABD cash payment is one hundred ninety-eight dollars ($198). ( )

05. RALF and CFH. A participant residing in a RALF or CFH is not eligible for an AABD cash payment. ( )

515. RALF CARE AND CFH ASSESSMENT AND LEVEL OF CARE.

The participant's need for care, level of care, plan of care, and the RALF's or CFH's ability to provide care is assessed by the Bureau of Long-Term Care (BLTC) when a participant is admitted. The BLTC must approve the placement before Medicaid can be approved. ( )

516. CHANGE IN LEVEL OF CARE.

A change in the participant's level of care affects eligibility as listed below. ( )

01. Increase in Level of Care. Is effective the month the BLTC reassesses the level of care. ( )

02. Decrease in Level of Care. When the BLTC verifies the participant has a decrease in their level of care, and their income exceeds their new level of care, their Medicaid must be stopped after timely notice. When the BLTC determines the participant no longer meets any level of care, their eligibility and allowances are based on the Room and Board rate in Section 512 of these rules. ( )

517. -- 523. (RESERVED)

524. MOVE FROM NURSING HOME OR HOSPITAL.

If a participant moves from a nursing home or hospital to a different living situation, other than a RALF or CFH, their AABD cash for the month is determined as if they lived in their new situation the entire month. Their AABD cash is their AABD allowances less their countable income. ( )

525. -- 530. (RESERVED)

531. COUPLE BUDGETING.

Income of an AABD participant and their participant spouse living in the same household is combined. The twenty dollar ($20) standard income disregard and the sixty-five dollar ($65) earned income disregard are subtracted once a month, per couple. Each member of a couple living in an institution must have income budgeted as a single person. A couple living together as of the first day of a month, is counted as living together throughout that month. Budgeting as a couple continues through the month the couple stops living together. For couple budgeting, a household is a home, a rental, another's household, or room and board. ( )

532. -- 539. (RESERVED)

540. STANDARD DISREGARD.

The standard disregard is twenty dollars ($20), and is first subtracted from unearned income. If the unearned income is less than the standard disregard, the remainder of the standard disregard is subtracted from earned income. The participant retains the standard disregard for their personal use. ( )

01. Standard Disregard and a Couple. The Department will subtract the standard disregard only once a month from the combined income of a couple in the same household. ( )

02. Standard Disregard Exception. The standard disregard must not be subtracted from nonservice-connected VA payments, Title IV-E foster care payments, or BIA General Assistance. ( )

541. SUBTRACTION OF EARNED INCOME DISREGARDS.

Earned income disregards are subtracted from AABD earned income in the order listed in Sections 542 through 547. They are subtracted the month the income is paid. ( )

542. SIXTY-FIVE DOLLAR EARNED INCOME DISREGARD.

Sixty-five dollars ($65) of earned income in a month are not counted. The Department will subtract the sixty-five dollar ($65) disregard only once a month from the combined income of a couple in the same household. The sixty-five dollar ($65) disregard is a work incentive. The participant retains the sixty-five dollar ($65) disregard for their personal use. ( )

543. IMPAIRMENT-RELATED WORK EXPENSE (IRWE) DISREGARD.

IRWEs are items and services needed and used by a disabled AABD participant to work. The items must be needed because of the participant's impairment, and may be bought or rented. The cost for IRWEs is subtracted from the participant's earned income, for eligibility and AABD cash amount. An item disregarded as a blindness work expense, or as part of a PASS, cannot be disregarded as an IRWE. ( )

544. ONE-HALF REMAINING EARNED INCOME DISREGARD.

One-half (1/2) of remaining earned income, after the IRWE is subtracted, is not counted. The one-half (1/2) of remaining earned income is a work incentive. The participant retains the one-half (1/2) of remaining earned income

for their personal use. ( )

545. BLINDNESS WORK EXPENSE DISREGARD.
The cost of earning income is subtracted from the earned income of a blind person. The blind person must be under age sixty-five (65). If the blind person is age sixty-five (65) or older, they must receive SSI for blindness, or have received AABD the month before they became sixty-five (65). ( )

01. Blind Work Expense Limit. Blindness work expenses are subtracted from earned income. The amount subtracted must not exceed the participant's monthly earnings. ( )

02. No Duplication for Blind Work Expenses. Expenses, subtracted under the IRWE disregard, cannot be subtracted again under this disregard. ( )

546. PLAN TO ACHIEVE SELF-SUPPORT (PASS).
A blind or disabled participant, with an approved PASS, must have income and resources disregarded. Conditions for this disregard are listed below. ( )

01. Under Age Sixty-Five. The participant must be under sixty-five (65), or receive AABD for the blind or disabled during the month of their sixty-fifth birthday. ( )

02. Approved PASS. A participant receiving SSI must have a PASS approved by SSA. A participant not receiving SSI must have a PASS approved by the Department. ( )

03. Income Necessary for Self-Support. The income and resources disregarded under the PASS must be necessary for the participant to achieve self-support. ( )

547. PASS APPROVED BY DEPARTMENT.
A PASS approved by the Department must be in writing, and contain all the following items: ( )

01. Occupational Objective. The PASS must have a specific occupational objective. ( )

02. Specific Goals. The PASS must have specific goals for using the disregarded income and resources to achieve self-support. ( )

03. Time Limit. The PASS must show a specific target date to achieve the goal. An approved PASS is limited to an initial period of eighteen (18) months. Extensions may be granted if needed. ( )

a. The first extension period lasts up to eighteen (18) months. ( )

b. A second eighteen (18) month extension period can be granted. ( )

c. A final extension, up to twelve (12) months can be granted. The PASS can be extended a total of forty-eight (48) months, when the original PASS goal required extensive education or vocational training. ( )

04. No Duplication of Disregards. An item disregarded as an IRWE or under the blindness exception cannot be disregarded under the PASS. ( )

05. Resource Limitation. The PASS disregard must not be used for resources, unless the resources cause the participant to be ineligible without the PASS disregard. ( )

06. Disregard of Resources. The PASS must list the participant's resources. The PASS must list any resources the participant will receive under the plan, and show how the resources will be used toward the occupational goal. The PASS must list goal-related items or activities requiring savings or purchases and the amounts the participant plans to save or spend, and list resources disregarded under the plan. The PASS must show resources disregarded under the plan can be identified separate from the participant's other resources. ( )

548. -- 599. (RESERVED)

600. DEPARTMENT NOTICE RESPONSIBILITY.
The participant must be notified of changes in eligibility or AABD cash amount. The notice must give the effective date, the reason for the action, the rule that supports the action, and appeal rights. See 42 CFR 435.917. ( )

601. ADVANCE NOTICE RESPONSIBILITY.
When a reported change results in closure or decrease, the participant must be notified at least ten (10) calendar days before the effective date of the action. ( )

602. ADVANCE NOTICE NOT REQUIRED.
Advance notice is not required when a condition listed below exists. The participant must be notified by the date of the action. ( )

01. The Department has Proof of the Participant's Death. ( )

02. Participant Requests Closure in Writing. ( )

03. Participant in Institution. The participant is admitted or committed to an institution. Further payments to the participant do not qualify for federal financial participation under the State Plan. ( )

04. Nursing Care. The participant is placed in a nursing facility or an ICF/IID. ( )

05. Participant Address Unknown. The participant's whereabouts are unknown. Department mail is returned with no forwarding address. ( )

06. Participant is Approved for Aid in Another State. ( )

07. Eligible One Month. The participant is eligible for aid only during the calendar month of their application for aid. ( )

08. Non-Citizen With Emergency. The participant is an illegal or legal non-citizen whose Medicaid eligibility ends the day their emergency medical condition stops. ( )

09. Retroactive Medicaid. The participant's Medicaid eligibility is for a prior period. ( )

10. Special Allowance. A special allowance granted for a specific period is stopped. ( )

11. Patient Liability or Participant Participation Changes. ( )

12. Participant's Level of Care Changes. ( )

603. (RESERVED)

604. PARTICIPANT DETERMINED SSI ELIGIBLE AFTER APPEAL.
If the SSA finds a participant is blind or disabled, based on an appeal of an SSA decision, the participant meets the disability requirements for AABD cash and related Medicaid on the effective date determined by SSA. AABD cash payments are effective no earlier than the month SSA issues the favorable decision for SSI payments. ( )

605. REPORTING REQUIREMENTS.
The participant must report changes in circumstances verbally or in writing, by the tenth of the month following the month in which the change occurred. The participant must show good cause for not reporting changes. If failure to report a change results in an overpayment, the overpayment must be recovered. ( )

606. REQUIRED PROOF.
The participant must prove continuing eligibility for aid when a change could affect eligibility, and is allowed ten (10) calendar days to provide requested proof. The case is closed if the participant does not provide proof within ten (10) days and does not have good cause for not providing proof. ( )

607. CHANGES AFFECTING ELIGIBILITY OR AABD CASH AMOUNT.
If a participant reports a change that results in an increase, AABD cash is increased effective the month of report. If a participant reports a change that results in a decrease, AABD cash is decreased or ended effective the first month after proper notice. ( )

608. AABD CASH UNDERPAYMENT.
If the Department is at fault for issuing a payment less than the participant should have received, the Department will issue a supplemental payment for the difference. ( )

609. AABD CASH OVERPAYMENT.
If the participant is paid more AABD cash than they are eligible for, the Department must collect the overpayment. The Department must notify the participant of the right to a hearing, the method for repayment, and the need for a repayment interview. ( )

610. OFFSET OF OVERPAYMENT AND UNDERPAYMENT.
When an underpayment is computed, any overpayment for that month is subtracted from the underpayment. When an overpayment is computed, any underpayment for the month is subtracted. ( )

611. -- 616. (RESERVED)

617. HEARING REQUEST.
A participant may request a hearing to contest a Department decision. The participant must make the request within ninety (90) days of the date the Department mailed the notice of decision. Hearings will be conducted according to IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings." ( )

618. CONTINUED BENEFITS PENDING A HEARING DECISION.
The participant may continue to receive benefits upon request, pending the hearing decision. The Department must receive the participant's request for continued benefits before the effective date of the Department's action stated in the notice of decision. An applicant cannot receive continued benefits when appealing a denial for failure to provide citizenship and identity verification after the expiration of a reasonable opportunity period. ( )

01. Amount of Assistance. The Department will continue the participant's assistance at the current month's level while the hearing decision is pending, unless another change affecting assistance occurs. ( )

02. Continued Eligibility. The participant must continue to meet all eligibility requirements not related to the hearing issue. ( )

03. Overpayment. When the hearing decision is in the Department's favor, the participant must repay assistance received while the hearing decision was pending. ( )

619. (RESERVED)

620. MEDICAID OVERPAYMENT.
If the participant receives Medicaid services during a month they are not eligible, the Department must collect the overpayment. If too little patient liability or participant participation is computed, the Department must collect the overpayment. The participant must be notified of the overpayment. ( )

621. CHANGES IN PATIENT LIABILITY.

01. Increase in Patient Liability. If the patient liability is increased for the current or a past month, the Department will collect the patient liability directly from the participant. ( )

02. Decrease in Patient Liability. If the patient liability is decreased for a current or past month, the funds will be paid to the provider and the provider must reimburse the participant for the portion of the costs the participant paid more than their patient liability. ( )

622. (RESERVED)

623. ELIGIBILITY REDETERMINATION.
An eligibility redetermination is completed at least once every year and when a change affecting eligibility occurs. ( )

624. -- 649. (RESERVED)

650. COOPERATION WITH THE QUALITY CONTROL PROCESS.
When the Department or federal government selects a case for review in the quality control process, the participant must cooperate in the review of the case. Benefits must be stopped, following advance notice, when a participant is unwilling to take part in the quality control process. If the participant reapplies for benefits, they must fully cooperate with the quality control process before the application can be approved. ( )

651. -- 699. (RESERVED)

700. MEDICAID ELIGIBILITY.
A participant must meet the eligibility requirements for at least one (1) Medicaid coverage group to be eligible for Medicaid benefits. Income and circumstances in the current month are used for eligibility for the current month. Resources are counted as of the first moment of the month. ( )

701. MEDICAID APPLICATION.
An adult participant, a legal guardian, or a representative of the participant must sign the application. The participant must submit the application to the Department. A Medicaid application may be made for a deceased person. ( )

702. MEDICAL SUPPORT COOPERATION.
Medical support rights are assigned to the Department by signature on the application. The participant must cooperate with the Department to secure medical support and payments to be eligible for Medicaid. The participant must cooperate on behalf of themself and any participant for whom they can legally assign rights. A participant who cannot legally assign their own rights must not be denied Medicaid if the legally responsible person does not cooperate. ( )

703. CHILD SUPPORT COOPERATION.
The participant must cooperate to identify and locate the noncustodial parent, establish paternity, and establish, modify, and enforce a child medical support order to be eligible for Medicaid. This includes support payments received directly from the noncustodial parent. The cooperation requirement is waived for poverty level pregnant women exempt from cooperating in establishing paternity and obtaining medical support from, or derived from, the father of a child born out of wedlock. A participant who cannot legally assign their own rights must not be denied Medicaid if the legally responsible person does not cooperate. ( )

704. COOPERATION DEFINED.
Cooperation includes providing all information to identify and locate the noncustodial parent. Cooperation for Medicaid includes identifying other liable third-party payers. ( )

01. Name of Noncustodial Parent. The participant must provide the first and last name of the noncustodial parent. ( )

02. Information About Noncustodial Parent. The participant must also provide at least two (2) pieces of information, about the noncustodial parent, listed below: ( )

a. Birth Date. ( )

b. SSN. ( )

c. Current address. ( )

d. Current phone number. ( )

e. Current employer. ( )

f. Make, model, and license number of any motor vehicle owned by the noncustodial parent. ( )

g. Names, phone numbers, and addresses of the parents of the noncustodial parent. ( )

705. GOOD CAUSE FOR NOT COOPERATING IN SECURING MEDICAL AND CHILD SUPPORT.
The participant may claim good cause for failure to cooperate in securing medical and child support for themself or a minor child. Good cause is limited to the following: ( )

01. Rape or Incest. There is proof the child was conceived because of incest or rape. ( )

02. Physical or Emotional Harm. There is proof the child's non-custodial parent may inflict physical or emotional harm to the participant, the child, the custodial parent, or the caretaker relative. There is proof another person may inflict physical or emotional harm to an AABD-related participant if the participant cooperates in securing medical and child support. ( )

03. Minimum Information Cannot Be Provided. Substantial and credible proof is provided indicating the participant cannot provide the minimum information regarding the non-custodial parent. ( )

706. CLOSURE AFTER REVIEW OF GOOD CAUSE REQUEST.
If the participant claims good cause for not cooperating, but the Department determines there is not good cause, the participant must be given the opportunity to withdraw the application or have their Medicaid closed. ( )

707. APPLICATION REQUIREMENTS FOR POTENTIAL MEDICAL COVERAGE.

01. Group Health Plan Enrollment Requirement. Each participant must apply for and enroll in a cost-effective employer group health plan as a condition of eligibility for Medicaid. Medicaid coverage must not be denied, delayed, or stopped pending the start of a participant's group health insurance coverage. A child entitled to enroll in a group health plan must not be denied Medicaid coverage solely because their caretaker fails to apply for the child's enrollment. ( )

02. Medicare Enrollment Requirement. Each participant who may be eligible for Medicare must apply for all parts of Medicare parts A, B, and D for which they are likely to be eligible, as a condition of eligibility for Medicaid. ( )

708. MEDICAID QUALIFYING TRUST PAYMENTS.
For Medicaid Qualifying Trusts established before August 11, 1993, the maximum payment permitted to be made to a participant from the trust must be counted for Medicaid eligibility. The maximum is counted whether or not the trustee actually distributes payments. ( )

709. MEDICAID ELIGIBILITY FOR AABD PARTICIPANT.
A participant eligible for AABD cash is eligible for Medicaid, unless they are in an ineligible institution, receive excess payment from a Medicaid Qualifying Trust, or have an irrevocable trust that is not exempt. ( )

710. -- 719. (RESERVED)

720. LONG-TERM CARE RESIDENT AND MEDICAID.
A resident of a long-term care facility must meet the AABD eligibility criteria to be eligible for Medicaid. A long-term care facility is a nursing facility or an ICF/IID. The need for long-term care is determined using IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." ( )

01. Resources of Resident. The resident's resource limit is two thousand dollars ($2,000). Resources of a married person in long-term care are computed using Federal Spousal Impoverishment rules. Under the SSI method, spouses can use the three thousand dollar ($3,000) couple resource limit if more advantageous. The couple must have lived in the nursing home, in the same room, for six (6) months. ( )

02. Medicaid Income Limit of Long-Term Care Resident Thirty Days or More. The monthly income limit for a long-term care facility resident is three (3) times the federal SSI benefit for a single person. To qualify for this income limit, the participant must be, or be likely to remain, in long-term care at least thirty (30) consecutive days. ( )

03. Medicaid Income Limit of Long-Term Care Resident Less Than Thirty Days. The monthly income limit, for the resident of a long-term care facility for less than thirty (30) consecutive days, is the AABD income limit for the participant's living situation before long-term care. Living situations before long-term care do not include hospital stays. ( )

04. Income Not Counted. The income listed in Subsections 720.04.a. through 720.04.e. of this rule is not counted to compute Medicaid eligibility for a long-term care facility resident. This income is counted in determining participation in the cost of long-term care. ( )

a. Income excluded or disregarded in determining eligibility for AABD cash is not counted. ( )

b. The September 1972 RSDI increase is not counted. ( )

c. Any VA Aid and Attendance allowance, including any increment that is the result of a VA Unusual Medical Expense allowance, is not counted. These allowances are not counted for patient liability, unless the veteran lives in a state-operated veterans' home. ( )

d. RSDI benefit increases from cost-of-living adjustments (COLA) after April 1977 are not counted if they made the participant lose SSI or AABD cash. The COLA increases after SSI or AABD cash stopped are not counted. ( )

e. Income paid into an income trust exempt from counting for Medicaid eligibility under Subsection 872.02 of these rules is used for patient liability. Income paid to the trust and not used for patient liability is subject to the asset transfer penalty. ( )

05. Medicaid Participant Residing in a Skilled Nursing Facility. When a Medicaid participant who is a resident of a skilled nursing facility and meets that level of care as evidenced by the PAARR defined in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," the resident is determined to be disabled for the duration of their residency in the skilled nursing facility. ( )

721. QUALIFIED LONG-TERM CARE PARTNERSHIP POLICY.

Participants who have received, or are entitled to receive, benefits under a Qualified Long-Term Care Partnership policy issued in Idaho after November 1, 2006, will have certain resources disregarded as described below. ( )

01. Value of the Participant's Resources. The total dollar amount of the insurance benefits paid out for a policy holder of a Qualified Long-Term Care Partnership policy is disregarded in calculating the value of the participant's resources for long-term care Medicaid eligibility. The amount that is disregarded is determined on the effective date of an initial application approval for long-term care Medicaid benefits. ( )

02. Resource Disregard Excluded from Estate Recovery. The amount of the resources disregarded from a Qualified Long-Term Care Partnership policy under Subsection 721.01 of this rule, is deducted from the assets of the estate for Medicaid estate recovery. ( )

722. PATIENT LIABILITY.

Patient liability is the participant's income counted toward the cost of long-term care. Patient liability begins the month after the first full calendar month the patient is receiving benefits in a long-term care facility. ( )

723. PATIENT LIABILITY FOR PERSON WITH NO COMMUNITY SPOUSE.

For a participant with no community spouse, patient liability is computed as described below. ( )

01. Income of Participants in Long-Term Care. For a single participant, or participant whose spouse

is also in long-term care and chooses the SSI method of calculating the amount of income and resources, the patient liability is their total income less the deductions in Subsection 723.03 of this rule. ( )

02. Community Property Income of Long-Term Care Participant with Long-Term Care Spouse. Patient liability income for a participant, whose spouse is also in long-term care, choosing the community property method, is one-half (1/2) their share of the couple's community income, plus their own separate income. The deductions under Subsection 723.03 of this rule are subtracted from their income. ( )

03. Income of Participant in Facility. A participant residing in the long-term care facility at least one (1) full calendar month, beginning with their most recent admission, must have the deductions in below subtracted from their income, after the AABD exclusions are subtracted from the income. Total monthly income includes income paid into an income (Miller) trust that month. The income deductions must be subtracted in the order listed. Remaining income is patient liability. ( )

a. AABD Income Exclusions. Income excluded in determining eligibility for AABD cash is subtracted. ( )

b. Aid and Attendance and UME Allowances. VA Aid and Attendance allowance and Unusual Medical Expense (UME) allowance for a veteran or surviving spouse is subtracted, unless the veteran lives in a state operated veterans' home. ( )

c. SSI Payment Two (2) Months. The SSI payment for a participant entitled to receive SSI at their at-home rate for up to two (2) months is subtracted, while temporarily in a long-term care facility. ( )

d. AABD Payment. The AABD payment, and income used to compute the AABD payment, for a participant paid continued AABD payments up to three (3) months in long-term care is subtracted. ( )

e. First Ninety ($90) Dollars of VA Pension. The first ninety ($90) dollars of a VA pension for a veteran in a private long-term care facility or a State Veterans Nursing Home is subtracted. ( )

f. Personal Needs. Forty dollars ($40) is subtracted for the participant's personal needs. For a veteran or surviving spouse in a private long-term care facility or a State Veterans Nursing Home the first ninety ($90) dollars of VA pension substitutes for the forty dollar ($40) personal needs deduction. ( )

g. Employed and Sheltered Workshop Activity Personal Needs. For an employed participant or participant engaged in sheltered workshop or work activity center activities, the lower of the personal needs deduction of two hundred dollars ($200) or their gross earned income is subtracted. The participant's total personal needs allowance must not exceed two hundred and thirty dollars ($230). For a veteran or surviving spouse with sheltered workshop or earned income, and a protected VA pension, the total must not exceed two hundred dollars ($200). This is a deduction only. No actual payment can be made to provide for personal needs. ( )

h. Home Maintenance. Two hundred and twelve dollars ($212) is subtracted for home maintenance cost if the participant had an independent living situation, before their admission for long-term care. Their physician must certify in writing the participant is likely to return home within six (6) months, after the month of admission to a long-term care facility. This is a deduction only. No actual payment can be made to maintain the participant's home. ( )

i. Maintenance Need. A maintenance need deduction for a family member living in the long-term care participant's home is subtracted. A family member is claimed, or could be claimed, as a dependent on the Federal Income Tax return of the long-term care participant. The family member must be a minor or dependent child, dependent parent, or dependent sibling of the long-term care participant. The maintenance need deduction is the AFDC payment standard for the dependents, computed according to the AFDC State Plan in effect before July 16, 1996. ( )

j. Medicare and Health Insurance Premiums. Expenses for Medicare and other health insurance premiums, and deductibles or coinsurance charges are subtracted, and not subject to payment by a third party. Deduction of Medicare Part B premiums is limited to the first two (2) months of Medicaid eligibility. Medicare Part B

premiums must not be subtracted, if the participant got SSI or AABD cash the month prior to the month for which patient liability is being computed. ( )

k. Mandatory Income Taxes. Taxes mandatorily withheld from unearned income for income tax purposes are subtracted. To qualify for deduction of mandatory taxes, the tax must be withheld from income before the participant receives the income. ( )

l. Guardian Fees. Court-ordered guardianship fees of the lesser of ten percent (10%) of the monthly benefit handled by the guardian, or twenty-five dollars ($25) are subtracted. Where the guardian and trustee is the same person, the total deduction for guardian and trust fees must not exceed twenty-five dollars ($25) monthly. ( )

m. Trust Fees. Up to twenty-five dollars ($25) monthly paid to the trustee for administering the participant's trust is subtracted. ( )

n. Impairment-Related Work Expenses (IRWE). IRWEs for an employed participant who is blind or disabled under AABD criteria are subtracted. IRWEs are purchased or rented items and services that are purchased or rented to perform work. The items must be needed because of the participant's impairment. The actual monthly expense of the impairment-related items is subtracted. Expenses must not be averaged. ( )

o. Income Garnished for Child Support. Income garnished for child support to the extent the expense is not already accounted for in computing the maintenance need standard is subtracted. ( )

p. Incurred Medical Expenses. Amounts for certain limited medical or remedial care expenses that have current balances owed and are deemed medically necessary as defined in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," are subtracted. Current medical expenses that are not covered by the Idaho Medicaid Plan, or by a third party, may be deducted from the base participation amount. ( )

q. Pre-existing Medical Expenses. Amounts for medical and remedial care expenses incurred within the three (3) months prior to the month of application are subtracted. The deductions for medical and remedial care expenses are limited to those medically necessary expenses incurred by the participant for the participant's care. These deductions are limited to the amount of liability owed by the participant, and if applicable, after any third-party insurance has been applied. The deduction for medical and remedial care expenses that were incurred as the result of imposition of a transfer of assets penalty period is limited to zero. ( )

724. INCOME OWNERSHIP OF PARTICIPANT WITH COMMUNITY SPOUSE.
Income ownership of a long-term care participant with a community spouse is determined before patient liability is computed. The participant's income ownership is counted as shown below. ( )

01. Income Paid in the Name of Spouse. Income paid solely in the name of a spouse, and not paid from a trust, is the separate income of the spouse. ( )

02. Payment in Name of Both Spouses. Income paid in the names of both the long-term care participant and the community spouse is divided evenly between each spouse. ( )

03. Payment in Name of Spouse or Spouses and Another Person. Income paid in the names of the participant and/or the community spouse and another person is counted as available to each spouse, in proportion to the spouse's ownership. If payment is made to both spouses, and no proportion of ownership is specified, one-half of the income is counted to each spouse. ( )

04. Payment of Aid and Attendance. In the case of VA Aid and Attendance Allowance paid in the veteran's name, with an increment for the veteran's spouse, the increment is counted to the veteran. ( )

725. PATIENT LIABILITY FOR PARTICIPANT WITH COMMUNITY SPOUSE.
For a participant with a community spouse, patient liability is computed as described in Subsection 723.03 of these rules with the addition of the following steps for Community Spouse Allowance (CSA): ( )

01. Shelter Adjustment. The Department will add the current Food Stamp Program Standard Utility Allowance to the community spouse's shelter costs. Shelter costs include rent, mortgage principal and interest, homeowner's taxes, insurance, and condominium or cooperative maintenance charges. The Standard Utility Allowance must be reduced by the value of any utilities included in maintenance charges for a condominium or cooperative. The Department will subtract the Shelter Standard from the shelter and utilities. The Shelter Standard is thirty percent (30%) of one hundred fifty percent (150%) of one-twelfth (1/12) of the income official poverty line defined by the federal Office of Management and Budget (OMB) for a family of two (2) persons. The Shelter Adjustment is the positive balance remaining. ( )

02. Community Spouse Need Standard (CSNS). The Department will add the Shelter Adjustment to the minimum CSNS. The minimum CSNS equals one hundred fifty percent (150%) of one-twelfth (1/12) of the income official poverty line defined by the OMB for a family unit of two (2) members. The minimum CSNS is revised annually in July. The total CSNS may not exceed the maximum CSNS. The maximum CSNS is computed by multiplying one thousand five hundred dollars ($1,500) by the percentage increase in the consumer price index for all urban consumers (all items, US city average) between September 1988 and the September before the current calendar year. The maximum CSNS is revised annually in January. ( )

03. Community Spouse Allowance (CSA). The Department will subtract the community spouse's gross income from the CSNS. The community spouse's income includes income produced by their resources. The Department will round any remaining cents to the next higher dollar. Any positive balance remaining is the CSA. The CSA is subtracted as actually paid to the community spouse, up to the computed maximum. A larger spouse support amount must be used as the CSA, if court-ordered. The CSA ordered by a court is not subject to the CSA limit. ( )

726. PERSONAL NEEDS SUPPLEMENT (PNS).

A nursing home participant may receive a PNS to bring their gross income up to forty dollars ($40). Gross income is income after exclusions and before disregards, and includes money withheld to recover an AABD overpayment. The PNS is the difference between the participant's gross income and forty dollars ($40). If not in an even dollar amount, the PNS is rounded up to the next dollar. The participant's income including the PNS must not exceed forty dollars ($40). ( )

727. FAIR HEARING ON CSA DECISION.

Either spouse may ask for a fair hearing to show the community spouse needs a higher CSA. The hearing officer must consider if, due to unusual conditions, using the computed CSA causes significant financial hardship for the community spouse. If the fair hearing decision finds the community spouse needs more income than the CSA, the CSA must include the additional income. ( )

728. -- 730. (RESERVED)

731. MEDICAID ELIGIBILITY OF MARRIED PERSONS.

There are three (3) methods for Medicaid eligibility of an aged, blind, or disabled married person: (1) the SSI method, (2) the Community Property (CP) method, and (3) the Federal Spousal Impoverishment (FSI) method. The FSI method takes precedence. If the participant is not subject to the FSI method, the CP or SSI methods can be used. ( )

732. CHOOSING FSI, SSI, OR CP RESOURCE COUNTING METHOD.

Table 732 is used to determine the resource counting method for a married person. If an HCBS participant with a spouse at home is not eligible using the FSI method, resources are computed using the SSI/CP method.

TABLE 732 - CHOOSING FSI, SSI, OR CP RESOURCE COUNTING METHOD					
	SPOUSE ONE (1) IN NURSING HOME BEFORE 9/30/89	SPOUSE ONE (1) IN NURSING HOME ON OR AFTER 9/30/89	SPOUSE ONE (1) AT HOME NO HCBS	SPOUSE ONE (1) AT HOME WITH HCBS BEFORE 9/30/89	SPOUSE ONE (1) AT HOME WITH HCBS ON OR AFTER 9/30/89

TABLE 732 - CHOOSING FSI, SSI, OR CP RESOURCE COUNTING METHOD					
SPOUSE TWO (2) IN NURSING HOME BEFORE 9/30/89	SSI/CP	SSI/CP	SSI/CP	SSI/CP	SSI/CP
SPOUSE TWO (2) IN NURSING HOME ON OR AFTER 9/30/89	SSI/CP	SSI/CP	FSI	SSI/CP	SSI/CP
SPOUSE TWO (2) AT HOME NO HCBS	SSI/CP	FSI	SSI/CP	SSI/CP	FSI
SPOUSE TWO (2) AT HOME WITH HCBS BEFORE 9/30/89	SSI/CP	SSI/CP	SSI/CP	SSI/CP	SSI/CP
SPOUSE TWO (2) AT HOME WITH HCBS ON OR AFTER 9/30/89	SSI/CP	SSI/CP	FSI	SSI/CP	SSI/CP

( )

733. CHOOSING FSI, SSI, OR CP INCOME COUNTING METHOD.
Table 733 is used to determine the income counting method for a married person. If a participant subject to the FSI method is not eligible using FSI, income is computed using the SSI/CP method.

TABLE 733 - CHOOSING FSI, SSI, OR CP INCOME COUNTING METHOD					
	SPOUSE ONE (1) IN NURSING HOME BEFORE 9/30/89	SPOUSE ONE (1) IN NURSING HOME ON OR AFTER 9/30/89	SPOUSE ONE (1) AT HOME NO HCBS	SPOUSE ONE (1) AT HOME WITH HCBS BEFORE 9/30/89	SPOUSE ONE (1) AT HOME WITH HCBS ON OR AFTER 9/30/89
SPOUSE TWO (2) IN NURSING HOME BEFORE 9/30/89	SSI/CP	SSI/CP	FSI	SSI/CP	SSI/CP
SPOUSE TWO (2) IN NURSING HOME ON OR AFTER 9/30/89	SSI/CP	SSI/CP	FSI	SSI/CP	SSI/CP
SPOUSE TWO (2) AT HOME NO HCBS	FSI	FSI	SSI/CP	FSI	FSI

TABLE 733 - CHOOSING FSI, SSI, OR CP INCOME COUNTING METHOD					
SPOUSE TWO (2) AT HOME WITH HCBS BEFORE 9/30/89	SSI/CP	SSI/CP	FSI	SSI/CP	SSI/CP
SPOUSE TWO (2) AT HOME WITH HCBS ON OR AFTER 9/30/89	SSI/CP	SSI/CP	FSI	SSI/CP	SSI/CP

( )

734. CHOOSING FSI, SSI, OR CP PATIENT LIABILITY OR PARTICIPATION METHOD.
Table 734 is used to determine the patient liability or participant participation method for a married participant in long-term care or receiving HCBS.

TABLE 734 - PATIENT LIABILITY OR PARTICIPATION METHOD					
	SPOUSE ONE IN NURSING HOME BEFORE 9/30/89	SPOUSE ONE IN NURSING HOME ON OR AFTER 9/30/89	SPOUSE ONE AT HOME NO HCBS	SPOUSE ONE AT HOME WITH HCBS BEFORE 9/30/89	SPOUSE ONE AT HOME WITH HCBS ON OR AFTER 9/30/89
SPOUSE TWO IN NURSING HOME BEFORE 9/30/89	SSI/CP	SSI/CP	FSI	SSI/CP	SSI/CP
SPOUSE TWO IN NURSING HOME ON OR AFTER 9/30/89	SSI/CP	SSI/CP	FSI	SSI/CP	SSI/CP
SPOUSE TWO AT HOME NO HCBS	FSI	FSI	N/A	FSI	FSI
SPOUSE TWO AT HOME WITH HCBS BEFORE 9/30/89	SSI/CP	SSI/CP	FSI	SSI/CP	SSI/CP
SPOUSE TWO AT HOME WITH HCBS ON OR AFTER 9/30/89	SSI/CP	SSI/CP	FSI	SSI/CP	SSI/CP

( )

735. FEDERAL SPOUSAL IMPOVERISHMENT (FSI) METHOD OF COUNTING INCOME AND RESOURCES OF A COUPLE.

The FSI method must be used to compute income and resources of a married participant who requires long-term care as defined in Section 010 of these rules, and who has a community spouse. The participant must have entered long-term care on or after September 30, 1989. Terms used in the FSI method are listed below. ( )

01. Long-Term Care Spouse. Must be in a medical institution or nursing facility, or be an HCBS participant, for thirty (30) consecutive days, or appear likely to meet the thirty (30) days requirement. ( )

02. Community Spouse. The spouse of the long-term care participant. A community spouse is not in long-term care and is not an HCBS participant. ( )

03. Continuous Period of Long-Term Care. A period of residence either in a medical institution with nursing facility services, or at home with HCBS. A continuous period of long-term care is also a combination of institution and personal care services likely to last at least thirty (30) consecutive days. Absence from the institution, or a lapse in HCBS eligibility of thirty (30) consecutive days breaks continuity. The thirty (30) consecutive days of long-term care must not begin on a day the participant is hospitalized. If the participant is hospitalized after the first day of the thirty (30) consecutive days, the hospital stay does not interrupt the thirty (30) consecutive days. ( )

04. Start of Continuous Period of Long-Term Care. The first month of long-term care or HCBS. ( )

05. Nursing Facility Services. Services at the nursing facility level or the ICF/IID level provided in a medical institution. ( )

736. ASSESSMENT DATE AND COUNTING FSI RESOURCES.

The assessment date is the start date of the first continuous period of long-term care. The Department does a one-time assessment to determine the value of the couple’s community and separate resources as of the date of the first continuous period of long-term care. The resource assessment is done at the request of either spouse, after one (1) spouse is in long-term care or meets the level of care for HCBS, whether or not the couple has applied for Medicaid. State laws relating to community property or the division of marital property are not applied in determining the FSI total combined resources of the couple. ( )

737. TREATMENT OF RESOURCES FOR ASSESSMENT.

The resource rules used in determining eligibility for AABD cash and Medicaid are also used in determining the couple's total combined resources for the FSI resource assessment with the following exceptions: ( )

01. Resources for Sale. Excess resources offered for sale, are not excluded from the couple’s total combined resources for the FSI resource assessment. ( )

02. Jointly Owned Real Property. Jointly owned real property that is not the principal residence of the participant is not excluded if the community spouse is the joint owner. ( )

03. Long-term Care Partnership Policy. Resources excluded because of a participant’s qualified long-term care policy are not excluded for the FSI resource assessment. ( )

04. Excluded Home. As defined in 42 USC 1396r-5(c)(5), an excluded home placed in trust retains its exclusion for purposes of the resource assessment. ( )

738. ONE-HALF SPOUSAL SHARE.

The spousal share is one-half (1/2) of the couple’s total combined resources on the assessment date. The spousal share does not change, even if the participant leaves long-term care and then enters long-term care again. The Department must inform the couple of the resources counted in the assessment and the value assigned. The couple must sign the assessment form under penalty of perjury. The signature requirement may be waived for the long-term care spouse if they or their representative says they are unable to sign the resources assessment. A copy of the assessment form must be provided to each spouse when eligibility is determined or when either spouse requests an assessment prior to application. ( )

739. -- 741. (RESERVED)

742. COMMUNITY SPOUSE RESOURCE ALLOWANCE.
The CSRA protects resources for the community spouse. The CSRA is determined by subtracting the greater of the minimum resource allowance or the spousal share from the couple's total combined resources as of the first day of the application month. The deduction must not be more than the maximum resource allowance at the time eligibility is determined. ( )

743. RESOURCE ALLOWANCE LIMITS.
The maximum resource allowance is computed by multiplying sixty thousand dollars ($60,000) by the percentage increase in the consumer price index for all urban consumers (all items, US city average) between September 1988 and the September before the current calendar year. The minimum resource allowance is computed by multiplying twelve thousand dollars ($12,000) by the percentage increase in the consumer price index for all urban consumers (all items, US city average) between September 1988 and the September before the current calendar year. If the result is not an even one hundred dollar ($100) amount, the Department will round up to the next one hundred dollars ($100). The couple's resources exceeding the CSRA are counted for the long-term care spouse. ( )

744. INCOME COUNTED FIRST FOR CSRA REVISION.
Income is determined prior to determining resources. If the couple's income is more than the minimum CSNS, the CSRA cannot be increased. If the community spouse has less income than the minimum CSNS, the CSRA may be increased as provided in Section 745 of these rules. Couple income is the community spouse's gross income plus the long-term care spouse's income. The long-term care spouse's income is their gross income less the AABD cash income exclusions and their patient liability income deductions, but not the CSA deduction. ( )

745. UPWARD REVISION OF CSRA.
If the community spouse's income, including income from their CSA and income-producing resources in their CSRA, is less than the minimum CSNS, the CSRA may be increased. The CSRA is increased by enough resources transferred from the long-term care spouse to raise the community spouse's income to the minimum CSNS Resources included in the transfer are presumed to produce income at the treasury rate, whether or not the resources produce income. If the community spouse shows they are making reasonable use of their income and resources to generate income, the Department may waive the treasury rate requirement. Actual income produced by the resources transferred to the community spouse is used to compute the CSA. A higher CSA can be requested under Section 727 of these rules. If the transferred resources produce more than the treasury rate, the actual income produced is used to determine the additional resources that can be transferred to the community spouse in the CSRA. The long-term care spouse must transfer the resources to the community spouse, or the CSRA is not revised. ( )

746. RESOURCE TRANSFER ALLOWANCE (RTA).
The RTA is computed by subtracting the community spouse's resources at the time of application from the CSRA. The community spouse must own less than the CSRA to get an RTA. The long-term care spouse may transfer the RTA to the community spouse without an asset transfer penalty. If the institutional spouse transfers more than the RTA, the amount of the couple's resources over the CSRA counts as the institutional spouse's resources. After the month, a long-term care spouse is determined Medicaid-eligible under FSI, resources of the community spouse are not considered available to them while they remain in long-term care. ( )

747. PROTECTED PERIOD FOR RTA TRANSFER.
The long-term care spouse has sixty (60) days, from the date their application is approved, to transfer their ownership of the RTA resources to the community spouse. The long-term care spouse must state, in writing, their intent to transfer the RTA resources to the community spouse within the protected period before they can be Medicaid-eligible. Resources not transferred within the sixty (60) day protected period are available to the long-term care spouse, effective the day they entered the facility. ( )

748. EXTENSION FOR RTA TRANSFER.
The protected period can be extended beyond sixty (60) days, if necessary, because of the participant's circumstances. ( )

749. RESOURCE ELIGIBILITY FOR COMMUNITY SPOUSE.
When the community spouse is a Medicaid participant, the spouse's resources are counted using Medicaid rules. The FSI rules apply only to the long-term care spouse. For the month the couple stopped living together, resources of the

community spouse available for their Medicaid eligibility are the resources owned by the couple. ( )

750. INCOME ELIGIBILITY FOR COMMUNITY SPOUSE.
When the community spouse is a Medicaid participant, the spouse's income is counted using Medicaid rules. The FSI rules apply only to the long-term care spouse. The community spouse may choose between the SSI and CP methods for determining income for Medicaid eligibility. ( )

751. CHANGE IN CIRCUMSTANCES.
The FSI method of calculating income and resources stops the first full calendar month after a change in circumstances resulting in a couple no longer having a community spouse and a long-term care spouse. ( )

752. NOTICE AND HEARING.
The Department must tell the participant about the CSA, the family member allowance, the CSRA and how it was computed, and the RTA. Any hearing requested about the CSRA or the RTA must be held within thirty (30) days of the date of the request for hearing. ( )

753. -- 760. (RESERVED)

761. CHOICE OF SSI OR CP METHODS.
A married participant, not using FSI, must be furnished a written explanation of SSI and CP income and resource counting methods. The couple chooses the most useful method, based on their circumstances. The same method must be used for both spouses. ( )

762. SSI METHOD OF COUNTING INCOME AND RESOURCES OF A COUPLE.
The SSI method is the same method used to count income and resources for AABD cash. Income and resources of the participant and spouse are counted as mutually available. This method must be used for months either spouse gets SSI or AABD cash, or an SSI and/or AABD application is filed and approved. This method must be used for Medicaid eligibility, and liability for the cost of long-term care, whether or not one (1) or both spouses apply for Medicaid. For long-term care, the couple's income and resources are mutually available when one (1) or both spouses apply during the month they separated, because one (1) or both left their mutual home to enter a long-term care facility. ( )

763. COMMUNITY PROPERTY (CP) METHOD OF COUNTING INCOME AND RESOURCES OF A COUPLE.
A married participant in long-term care, whose spouse is not in the community, can use the CP method. A married participant using the FSI method, but not income-eligible using FSI, may choose the CP method for income eligibility. The CP method must not be used for the FSI participant's resource eligibility or patient liability. ( )

764. CP METHOD.
The CP method gives each spouse an equal one-half (1/2) share of the couple's community income and resources. Each spouse also has their own separate income and resources. Whether the spouses live together or, if not living together, the length of time they have lived apart, does not change the way income and resources are counted. A spouse's property includes income, personal property, and real property. The income and resources of a married couple acquired during the marriage are presumed to be community property of the couple. The couple can give evidence to rebut the presumption that property acquired during the marriage is community property. ( )

765. TRANSFER OF RIGHTS TO FUTURE INCOME NOT VALID.
An agreement between spouses, transferring or assigning rights to future income from one (1) spouse to the other, is not valid for eligibility for Medicaid. ( )

766. CP METHOD NEED STANDARD.
The participant is budgeted as a single person if their spouse is not a Medicaid applicant, is not living with them, or was not living with them on the first day of the month. The participant and spouse are budgeted as a couple if they both apply and live together, or if they were living together on the first day of the month. ( )

767. CP METHOD RESOURCE LIMIT.
The participant's resource limit is two thousand dollars ($2,000) if their spouse is not a Medicaid applicant, is not living with them, or was not living with them on the first day of the month. The participant and spouse have a

resource limit of three thousand dollars ($3,000) if they both apply and live together, or if they were living together on the first day of the month. ( )

768. CP METHOD INCOME DISREGARDS.
The participant gets the twenty dollar ($20) standard disregard if their spouse is not a Medicaid applicant, is not living with them, or was not living with them on the first day of the month. If the participant has earned income, they get the sixty-five dollar plus one-half ($65 + 1/2) of the remainder earned income disregard. The participant and spouse get the standard disregard on their combined unearned income if they both apply, and live together, or if they were living together on the first day of the month. If either spouse has earned income, they get the earned income disregard from their combined earned income. ( )

769. -- 776. (RESERVED)

777. ELIGIBLE SSI RECIPIENT.
An SSI recipient, or an individual who would be SSI eligible if they applied, is eligible for Medicaid if they meet any of the conditions below. ( )

01. Receives SSI. Gets SSI payments, even if eligibility is based on presumptive disability or presumptive blindness. ( )

02. Conditionally Eligible for SSI. Based on an agreement to dispose of excess resources. ( )

03. Eligible Spouse. Has their SSI payments combined with their spouse's SSI payments. ( )

778. INELIGIBLE SSI RECIPIENT.
An SSI recipient is not eligible for Medicaid if they meet any of the conditions below. ( )

01. Medicaid Qualifying Trust. Has excess income from a Medicaid Qualifying Trust, created and funded before August 11, 1993. ( )

02. Noncooperation. Fails to cooperate in establishing paternity or securing support. ( )

03. Is in an Ineligible Institution. ( )

04. Trust. Has a trust that makes them ineligible for Medicaid. ( )

779. PSYCHIATRIC FACILITY RESIDENT.
A resident of a long-term care psychiatric medical facility is eligible for Medicaid if they are age sixty-five (65) or older. They must meet all the requirements of a long-term care resident. ( )

780. (RESERVED)

781. RSDI RECIPIENT ENTITLED TO COLA DISREGARD.
A participant receiving RSDI is eligible for Medicaid if they became and remain ineligible for SSI payments as of April 2011, or for AABD cash or SSI payments from May 1977 through March 2011. The participant must still be entitled to AABD cash or SSI, except for a COLA in RSDI benefits. All RSDI COLAs received by the participant, and any person whose income and resources are counted in determining the participant's eligibility, are disregarded for Medicaid. ( )

782. MEDICAID BENEFITS UNDER SECTION 1619(B) OF THE SOCIAL SECURITY ACT.
A participant may be eligible for Medicaid under Section 1619(b) of the Social Security Act either under federal or state criteria, depending on their circumstances. ( )

01. Federally Qualified Under SSA Section 1619(b). An SSI recipient with a disability, previously eligible for SSI cash, who, because of earnings from employment, no longer meets the financial eligibility requirements for SSI cash, is eligible for Medicaid. SSA determines the qualification for eligibility under Section 1619(b). ( )

02. State-Only Qualified Under SSA Section 1619(b). An AABD cash participant with a disability, who, because of earnings from employment, no longer meets the financial eligibility requirements for AABD cash, may be eligible for Medicaid. The Department determines eligibility for State-only Section 1619(b) Medicaid. State-only Section 1619(b) Medicaid is authorized under Section 1905(q) of the Social Security Act. ( )

a. A participant must meet all the following requirements to be eligible for State-only 1619(b) Medicaid. The participant: ( )

i. Received AABD cash in the month prior to the first month of their eligibility under this rule. ( )

ii. Is under age sixty-five (65). ( )

iii. Continues to have a disability. ( )

iv. Must depend on Medicaid coverage to continue working. An individual depends on Medicaid coverage if they: ( )

(1) Used Medicaid coverage within the past twelve (12) months; ( )

(2) Expect to use Medicaid coverage in the next twelve (12) months; or ( )

(3) Would be unable to pay unexpected medical bills in the next twelve (12) months without Medicaid coverage. ( )

v. Is not able to afford medical insurance equivalent to Medicaid, including attendant care. The participant meets this requirement if their earnings are under the limit referred to in Subsection 782.02.a.vii. of this rule. ( )

vi. Continues to meet all the non-disability eligibility requirements in these rules. ( )

vii. Has annual gross earned income less than the current calendar year's charted threshold for Idaho as developed by SSA for federal qualification for Section 1619(b) Medicaid. The charted threshold for Idaho is SI 02302.200 Charted Threshold Amounts, incorporated by reference in Subsection 002.04. ( )

b. State-only Section 1619(b) Medicaid ends when the participant meets one (1) of the following criteria. The participant: ( )

i. Is no longer eligible for AABD cash for a reason other than excess earned income; ( )

ii. Has gross earned income equal to or more than the current calendar year's annual earnings threshold for Idaho developed by the SSA for federal Section 1619(b) Medicaid; ( )

iii. Is age sixty-five (65) or older; or ( )

iv. Regains eligibility for AABD cash. ( )

783. APPEAL OF SSA DECISION - APPLICANT DETERMINED SSI ELIGIBLE AFTER APPEAL.
An applicant denied Medicaid, because they do not meet SSI eligibility or RSDI disability requirements, can appeal the SSA denial with SSA. They can get Medicaid, if found eligible for SSI or Social Security disability because of their appeal. The effective date for Medicaid is the first day of the month that the Medicaid application was denied, by SSA. The participant’s eligibility for backdated Medicaid coverage must be determined. ( )

784. APPEAL OF SSA DECISION AND CONTINUED MEDICAID.
A Medicaid participant, denied RSDI or SSI because they are not disabled, can continue to get Medicaid if they appeal the SSA decision. The appeal must be filed within sixty (60) days of the SSA decision. If the final

administrative decision rules against the participant's appeal, Medicaid benefits must end. Medicaid benefits paid during the appeal are not an overpayment. ( )

785. CERTAIN DISABLED CHILDREN.
A disabled child, not eligible for Medicaid outside a medical institution, is eligible for Medicaid if they meet the conditions below. ( )

01. Age. Is under nineteen (19) years old. ( )

02. AABD Criteria. Meets the AABD blindness or disability criteria. ( )

03. AABD Resource Limit. Meets the AABD single person resource limit. ( )

04. Income Limit. Has monthly income not exceeding three (3) times the federal SSI benefit payable monthly to a single person. ( )

05. Eligible for Long-Term Care. Meets the medical conditions for long-term care in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." ( )

06. Appropriate Care. Is appropriately cared for outside a medical institution, under a physician's plan of care. ( )

07. Cost of Care. Can be cared for cost effectively outside a medical institution. The estimated cost of caring for the child must not exceed the cost of the child's care in a hospital, nursing facility, or ICF/IID. ( )

08. Share of Cost. The financially responsible adult of a certain disabled child, who has family income above one hundred fifty percent (150%) of the federal poverty guidelines, is required to share in the cost of the child's Medicaid benefits under IDAPA 16.03.18, "Medicaid Cost-Sharing." ( )

786. (RESERVED)

787. HOME AND COMMUNITY BASED SERVICES (HCBS).
An aged, blind, or disabled participant, who is not income eligible for SSI or AABD cash, in their own home or community setting, is eligible for Medicaid if they meet the conditions below and meets all requirements in one (1) of the waiver Sections 788 through 789 of these rules. ( )

01. Resource Limit. Meets the AABD single person resource limit. ( )

02. Income Limit. Income of the participant must not exceed three (3) times the federal SSI monthly benefit for a single person. A married participant living at home with their spouse who is not an HCBS participant, may choose between the SSI, CP, and FSI methods. If their spouse is also an HCBS participant or lives in a nursing home, the couple may choose between the SSI and CP methods. ( )

03. Maintained in the Community. The applicant must be able to be maintained safely and effectively in their own home or in the community with the waiver services. ( )

04. Cost of Care. The cost of the participant's care must be cost effective as provided in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." ( )

05. Waiver Services Needed. The participant must need and receive, or be likely to need and receive, waiver services for thirty (30) consecutive days. The participant is ineligible when there is a break in need for, or receipt of, waiver services for thirty (30) consecutive days. ( )

06. Effective Date. Waiver services are effective the first day the participant is likely to need and receive waiver services. Medicaid begins the first day of the month in which the first day of approved waiver services are received. ( )

07. Annual Limit. The Department limits the number of participants approved for waiver services each year. A participant who applies for waiver services after the annual limit is reached, must be denied waiver services. ( )

788. AGED AND DISABLED (A&D) WAIVER.
To be eligible for the Aged and Disabled (A&D) Waiver the participant must: ( )

01. Age Eighteen Through Sixty-Four. Be eighteen (18) through sixty-four (64) years old and meet the disability criteria, as provided in Section 156 of these rules, and need nursing facility level of care under IDAPA 16.03.10 "Medicaid Enhanced Plan Benefits"; or ( )

02. Age Sixty-Five or Older. Be age sixty-five (65) or older and need nursing facility level of care under IDAPA 16.03.10 "Medicaid Enhanced Plan Benefits." ( )

789. DEVELOPMENTALLY DISABLED (DD) WAIVER.
To be eligible, the participant must be at least eighteen (18) years of age and need the level of care provided by an ICF/IID under IDAPA 16.03.10 "Medicaid Enhanced Plan Benefits." ( )

790. -- 798. (RESERVED)

799. MEDICAID FOR WORKERS WITH DISABILITIES.
An individual is eligible to participate in the Medicaid for Workers with Disabilities coverage group if the individual meets the requirements below. ( )

01. Non-Financial Requirements. An individual must: ( )

a. Be at least sixteen (16) but less than sixty-five (65) years of age; ( )

b. Meet the Medicaid residency requirement under Section 100 of these rules; ( )

c. Meet the citizenship requirements under 42 CFR 435.406, Citizenship and Non-citizen Eligibility; ( )

d. Meet the SSN requirements under Section 10 3of these rules; and ( )

e. Meet the child support cooperation requirements under Sections 703 through 706 of these rules. ( )

02. Disability. An individual must meet the medical definition for having a disability or blindness used by the SSA for Social Security Disability Insurance (SSDI) and SSI benefits. ( )

03. Employment. An individual must be employed which may include self-employment. Proof of employment must be provided to the Department. Hourly wage or hours worked will not be used to determine employment. ( )

04. Countable Resources. Cannot exceed ten thousand dollars ($10,000) for an individual or fifteen thousand dollars ($15,000) for a couple. When calculating resources, the following items will be excluded: ( )

a. Any resources excluded under Section 210 and Sections 222 through 299 of these rules; ( )

b. A second vehicle as described in Section 222 of these rules; ( )

c. Life insurance policies; ( )

d. Retirement accounts; and ( )

e. Exempt trusts as described in Section 872 of these rules. ( )

05. Countable Income. Is calculated using exclusions and disregards as described in Sections 300 through 547 of these rules. The countable income for: ( )

a. An individual cannot exceed five hundred percent (500%) of the current federal poverty guideline for a household of one (1). ( )

b. A couple cannot exceed five hundred percent (500%) of the current federal poverty guideline for a household of two (2). ( )

06. Earned Income Test. Gross income is the total of earned and unearned income before exclusions or disregards. Each individual's gross earned income must be at least fifteen percent (15%) of their total gross income to qualify. ( )

07. Cost-Sharing. A participant in the Medicaid for Workers with Disabilities coverage group may be required to cost-share; the costs are determined under the provisions in IDAPA 16.03.18, "Medicaid Cost-Sharing." ( )

800. – 801. (RESERVED)

802. WOMAN DIAGNOSED WITH BREAST OR CERVICAL CANCER.
A woman not otherwise eligible for Medicaid and meeting the conditions in Subsections 802.01 through 802.06 of this rule is eligible for Medicaid for the duration of her cancer treatment. Medicaid income and resource limits do not apply to this coverage group. ( )

01. Diagnosis. The participant is diagnosed with breast or cervical cancer through the CDC's National Breast and Cervical Cancer Early Detection Program. ( )

02. Age. The participant is under age sixty-five (65). ( )

03. Creditable Health Insurance. The participant is uninsured or, if insured, the plan does not cover her type of cancer. ( )

04. Non-Financial Eligibility. The participant meets the Medicaid non-financial eligibility requirements in Sections 100 through 108 and Sections 166 and 167 of these rules. ( )

05. Medical Support Cooperation. The participant meets the medical support cooperation requirement in Sections 702 through 706 of these rules. ( )

06. Group Health Plan Enrollment. The participant meets the requirement to enroll in available cost-effective employer group health insurance. ( )

07. Presumptive Eligibility. The Department can presume the participant is eligible for Medicaid, before a formal Medicaid eligibility determination is made. A clinic authorized to screen for breast or cervical cancer by the National Breast and Cervical Cancer Early Detection Program makes the presumptive eligibility determination. The clinic tells the participant how to complete the formal Medicaid determination process. The Medicaid notice and hearing rights do not apply to presumptive eligibility. No overpayment occurs if the formal Medicaid determination finds the participant is not eligible. ( )

08. End of Treatment. The Department determines the end of treatment date under IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." ( )

803. -- 805. (RESERVED)

806. DISABLED ADULT CHILD.
A participant age eighteen (18) or older is eligible for Medicaid if they received SSI or AABD cash based on blindness or a disability which began before they reached age twenty-two (22), and becomes ineligible for and

remains ineligible for AABD cash or SSI because their disabled child RSDI benefit started or increased July 1, 1987, or later. ( )

01. RSDI Benefits Disregarded for Disabled Adult Child. If the participant became ineligible because they began receiving a disabled child benefit on or after July 1, 1987, the benefit amount and any later increases are disregarded. ( )

02. RSDI Increase Disregarded for Disabled Adult Child. If the participant became ineligible because their disabled child benefit increased on or after July 1, 1987, the increase and any later increases are disregarded. ( )

807. (RESERVED)

808. EARLY WIDOWS AND WIDOWERS BEGINNING JANUARY 1, 1991.

A participant who meets the conditions below is considered an SSI recipient for Medicaid. ( )

01. Age. The participant, age fifty (50) to age sixty four and one-half (64-1/2), began receiving early widows or widowers Social Security benefits. ( )

02. Lost SSI or AABD. The participant lost SSI or AABD cash because they began receiving early widows or widowers Social Security benefits. ( )

03. Received SSI or AABD. The participant received SSI or AABD cash in the month, before the month, they became ineligible because they began receiving early widows or widowers Social Security benefits. ( )

04. Widows or Widowers Benefits. The participant would still be eligible for SSI or AABD cash if their Social Security early widows or widowers benefits were not counted as income. ( )

05. No "Part A" Insurance. The participant is not entitled to Medicare Part A hospital insurance. ( )

06. Applied On or After January 1, 1991. The participant's Medicaid application was filed, or pending, on or after January 1, 1991. ( )

809. (RESERVED)

810. QUALIFIED MEDICARE BENEFICIARY (QMB).

A person meeting all requirements below is eligible for QMB, which pays Medicare premiums, coinsurance, and deductibles. ( )

01. Medicare Part A. The participant must be entitled to hospital insurance under Part A of Medicare at the time of their application. ( )

02. Nonfinancial Requirements. The participant must meet the Medicaid residence, citizenship, support cooperation, and SSN requirements. ( )

03. Income. Monthly income must not exceed one hundred percent (100%) of the Federal Poverty Guidelines (FPG). The single person income limit is the poverty line for a family of one (1) person. The couple income limit is the poverty line for a family of two (2) persons. The annual Social Security cost of living increase is disregarded from income, until the month after the month the annual FPG revision is published. AABD cash is not counted as income. The income exclusions and disregards used for AABD are used for QMB. ( )

04. Dependent Income. Income of the dependent child, parent, or sibling is not counted. ( )

05. QMB Dependent Family Member Disregard. A dependent family member is a minor child, adult child meeting SSA disability criteria, parent or sibling of the participant or spouse living with the participant. The

family member is or could be claimed on the federal tax return of the participant or spouse. A participant with a dependent family member has an income disregard based on family size. The spouse is included in family size, whether or not the spouse is also participant. The disregard is based on the official poverty line income as defined by the OMB. The disregard is the difference between the poverty line for one (1) person, or two (2) persons if the participant has a spouse, and the poverty line for the family size including the participant, spouse, and dependent. ( )

06. Resource Limit. The resource limit is equal to the amount defined under 42 USC 1396d(p)(1)(C). The resource exclusions used for AABD are used for QMB. ( )

07. Effective Dates. The effective date of QMB coverage is no earlier than the first day of the month after the approval month. A QMB participant is not entitled to backdated Medicaid. ( )

811. SPECIFIED LOW INCOME MEDICARE BENEFICIARY (SLMB).

A person meeting all requirements below is eligible for SLMB. Medicaid pays the Medicare Part B premiums for a SLMB. The income and resource exclusions and disregards used for AABD are used for SLMB. ( )

01. Other Medicaid. The SLMB may be eligible for other Medicaid. ( )

02. Medicare Part A. The SLMB must be entitled to hospital insurance under Part A of Medicare at the time of their application. ( )

03. Nonfinancial Requirements. The SLMB must meet the Medicaid eligibility requirements of residence, citizenship, support cooperation, and SSN. ( )

04. Income. The annual Social Security cost of living increase is disregarded from income, until the month after the month the annual FPG revision is published. The single person limit is based on a family of one (1). The couple limit is based on a family of two (2). The monthly income limit is up to one hundred twenty percent (120%) of the FPG. ( )

05. Resource Limit. The resource limit is equal to the amount defined under 42 USC 1396d(p)(1)(C). The resource exclusions used for AABD are used for SLMB. ( )

06. Effective Dates. SLMB coverage begins on the first day of the application month, which may be backdated up to three (3) calendar months before the application month. ( )

812. QUALIFIED INDIVIDUAL (QI).

A person meeting all requirements below is eligible for QI. Medicaid pays the Medicare Part B premiums for a QI. The income and resource exclusions and disregards used for AABD are used for QI. ( )

01. Other Medicaid. The QI cannot be eligible for any other type of Medicaid. ( )

02. Medicare Part A. The QI must be entitled to hospital insurance under Part A of Medicare at the time of their application. ( )

03. Nonfinancial Requirements. The QI must meet the Medicaid eligibility requirements of residence, citizenship, support cooperation, and SSN. ( )

04. Income. The annual Social Security cost of living increase is disregarded from income, until the month after the month the annual FPG revision is published. The single person limit is based on a family of one (1). The couple limit is based on a family of two (2). The monthly income limit is up to one hundred thirty-five percent (135%) of the FPG. ( )

05. Resource Limit. The resource limit is equal to the amount defined under 42 USC 1396d(p)(1)(C). The resource exclusions used for AABD are used for SLMB. ( )

06. Coverage Limits. There is an annual limit on participants served based on availability of federal

funds. New applications are denied when the annual limit is reached. ( )

07. Effective Dates. QI coverage begins on the first day of the application month, which may be backdated up to three (3) calendar months before the application month. ( )

813. QUALIFIED DISABLED AND WORKING INDIVIDUAL (QDWI).
A person meeting all requirements below is eligible for QDWI. The person must not be eligible for any other type of Medicaid. A QDWI is eligible only for Medicaid payment of their Medicare Part A premium. ( )

01. Age and Disability. The participant must be a disabled worker under age sixty-five (65). ( )

02. Nonfinancial Requirements. The participant must meet the Medicaid eligibility requirements of residence, citizenship, support cooperation and SSN. ( )

03. Section 1818A Medicare. SSA determined the participant meets the conditions of Section 1818A of the Social Security Act. ( )

04. Income. Monthly income must not exceed two hundred percent (200%) of the one (1) person official poverty line defined by the OMB. ( )

05. Resource Limit. The resource limit is equal to the amount defined under 42 USC 1396d(s). The resource exclusions used for AABD are used for QDWI. ( )

814. SPONSORED LEGAL NON-CITIZEN.
All income and resources of a legal non-citizen's sponsor are deemed for Medicaid eligibility if the sponsor has signed an I-864 affidavit of support. ( )

815. CHILD SUBJECT TO DEEMING.
Income and resources of a child's stepparent are not deemed to the child in determining their Medicaid eligibility. ( )

816. FUGITIVE FELON OR PROBATION OR PAROLE VIOLATOR.
A person denied SSI or AABD cash because of the prohibition against payment to fugitive felons and probation and parole violators is not disqualified from Medicaid. ( )

817. -- 830. (RESERVED)

831. ASSET TRANSFER RESULTING IN PENALTY.
Starting August 11, 1993, the participant is subject to a penalty if they transfer their income or resources for less than fair market value. The asset transfer penalty applies to Medicaid services received October 1, 1993 and later. Excluded resources, other than the home and associated property, are not subject to the asset transfer penalty. Asset transfers subject to penalty under these rules may be voided and set aside by court action as provided in Section 56-218, Idaho Code. The asset transfer penalty applies to a Medicaid participant in long-term care or HCBS. A participant in long-term care is a patient in a nursing facility or a patient in a medical institution, requiring and receiving the level of care provided in a nursing facility. ( )

01. Rebuttable Presumption. Unless a transfer meets the requirements of Section 841 of these rules, it is presumed that the transfer was made for the purpose of qualifying for Medicaid. The asset transfer penalty is applied unless the participant shows that the asset transfer would not have affected their eligibility for Medicaid, or the transfer was made for another purpose than qualifying for Medicaid. ( )

02. Contract for Services Provided by a Relative. A contract for personal services to be furnished to the participant by a relative is presumed to be made for the purpose of qualifying for Medicaid. The asset transfer penalty applies unless the participant shows that: ( )

a. A written contract for personal services was signed before services were delivered. The contract must require that payment be made after services are rendered. The contract must be dated, and the signatures

notarized. Either party must be able to terminate the contract; and ( )

b. The contract must be signed by the participant or a legally authorized representative through a power of attorney, legal guardianship, or conservatorship. A representative who signs the contract must not be the provider of the personal care services under the contract; and ( )

c. Compensation for services rendered must be comparable to rates paid in the open market. ( )

03. Transfer of Income or Resources. Transfer of income or resources includes reducing or eliminating the participant's ownership or control of the asset. ( )

04. Transfer of Income or Resources by a Spouse. A transfer by the participant's spouse of either spouse's income or resources, before eligibility is established, subjects the participant to the asset transfer penalty. After the participant's eligibility is established, a transfer by the spouse of the spouse's own income or resources does not subject the participant to the asset transfer penalty. ( )

05. Transfer of Certain Notes and Loans. Funds used to purchase a promissory note, loan, or mortgage are considered a transferred asset which subjects the participant to a period of ineligibility. The amount of the asset transfer of such note, loan, or mortgage is the outstanding balance due on the date of the Medicaid application, unless the note, loan, or mortgage meets the following: ( )

a. Has a repayment term that is actuarially sound; ( )

b. Provides for payments to be made in equal amounts during the term of the loan with no deferral and no balloon payments; and ( )

c. Prohibits the cancellation of the balance upon the death of the lender. ( )

832. MEDICAID PENALTY FOR ASSET TRANSFERS.
The asset transfer penalty is restricted Medicaid coverage. ( )

01. Restricted Coverage. Means Medicaid will not participate in the cost of nursing facility services or in a level of care in a medical institution equal to nursing facility services. The penalty for a person receiving PCS or community services under the HCBS waiver is ineligibility. ( )

02. Notice and Exemption. The participant must be notified in writing, at least ten (10) days before an asset transfer penalty is imposed. ( )

833. ASSET TRANSFER LOOK-BACK PERIOD.
The asset transfer penalty applies to any transfer for less than fair market value made during a period preceding or following a request for long-term care services. Any asset transferred, regardless of type, is subject to a look-back period of sixty (60) months. The look-back period is counted from the date of the application for long-term care or HCBS services or the date of the transfer, whichever is later in time. ( )

834. PERIOD OF RESTRICTED COVERAGE FOR ASSET TRANSFERS.
The period of restricted coverage is the number of months computed by dividing the net uncompensated value of the transferred asset by the statewide average cost of nursing facility services to private patients. The cost is computed for the time of the participant's most recent request for Medicaid. If the spouse becomes eligible for long-term care Medicaid, the rest of the period of restricted coverage is divided between the participant and spouse. ( )

835. APPLYING THE PENALTY PERIOD OF RESTRICTED COVERAGE.
Restricted coverage continues until the participant or spouse recovers all the assets, receives fair market value at the time of the transfer for all assets, or the period of restricted coverage ends. The penalty continues whether or not the participant is in long-term care. For assets transferred, the penalty period begins running the first day of the month after the month the transfer took place or was discovered to have taken place, or the date the individual would have been eligible for long-term care services or HCBS, if not for the transfer, whichever date is later in time. The value of all asset transfers made during the look-back period is accumulated for the purpose of calculating the penalty. If an

additional transfer is discovered after the penalty has been served, a new penalty period begins the month following timely notice of closure of benefits. When a penalty period ends after the first day of the month, eligibility for long-term care services begins the day after the penalty period ends. ( )

836. MULTIPLE PENALTY PERIODS APPLIED CONSECUTIVELY.
A penalty period is computed for each transfer. One (1) penalty period must expire before the next begins. ( )

837. LIFE ESTATE AS ASSET TRANSFER.

01. Transfer of a Remainder Interest. When a life estate in real property is retained by an individual, and a remainder interest in the property is transferred during the look-back period for less than the fair market value of the remainder interest transferred, the value of the uncompensated remainder is subject to the asset transfer penalty as described in Sections 831 through 835 of these rules. To compute the value of the life estate remainder, multiply the fair market value of the real property at the time of transfer by the remainder factor for the participant's age at the time of transfer listed in the following table:

TABLE 837.01 - REMAINDER TABLE

Age	Remainder	Age	Remainder	Age	Remainder	Age	Remainder
0	.02812	**28**	.03938	**56**	.20994	**84**	.63002
1	.01012	**29**	.04187	**57**	.22069	**85**	.64641
2	.00983	**30**	.04457	**58**	.23178	**86**	.66236
3	.00992	**31**	.04746	**59**	.24325	**87**	.67738
4	.01019	**32**	.05058	**60**	.25509	**88**	.69141
5	.01062	**33**	.05392	**61**	.26733	**89**	.70474
6	.01116	**34**	.05750	**62**	.27998	**90**	.71779
7	.01178	**35**	.06132	**63**	.29304	**91**	.73045
8	.01252	**36**	.06540	**64**	.30648	**92**	.74229
9	.01337	**37**	.06974	**65**	.32030	**93**	.75308
10	.01435	**38**	.07433	**66**	.33449	**94**	.76272
11	.01547	**39**	.07917	**67**	.34902	**95**	.77113
12	.01671	**40**	.08429	**68**	.36390	**96**	.77819
13	.01802	**41**	.08970	**69**	.37914	**97**	.78450
14	.01934	**42**	.09543	**70**	.39478	**98**	.79000
15	.02063	**43**	.10145	**71**	.41086	**99**	.79514
16	.02185	**44**	.10779	**72**	.42739	**100**	.80025
17	.02300	**45**	.11442	**73**	.44429	**101**	.80468
18	.02410	**46**	.12137	**74**	.46138	**102**	.80946
19	.02520	**47**	.12863	**75**	.47851	**103**	.81563
20	.02635	**48**	.13626	**76**	.49559	**104**	.82144
21	.02755	**49**	.14422	**77**	.51258	**105**	.83038
22	.02880	**50**	.15257	**78**	.52951	**106**	.84512

TABLE 837.01 - REMAINDER TABLE							
Age	**Remainder**	**Age**	**Remainder**	**Age**	**Remainder**	**Age**	**Remainder**
23	.03014	**51**	.16126	**79**	.54643	**107**	.86591
24	.03159	**52**	.17031	**80**	.56341	108	.89932
25	.03322	**53**	.17972	**81**	.58033	109	.95455
26	.03505	**54**	.18946	**82**	.59705		
27	.03710	**55**	.19954	**83**	.61358		

( )

02. Transfer of a Life Estate. When a life estate in real property is transferred by an individual during the look-back period for less than fair market value, the value of the life estate is subject to the asset transfer penalty as described in Sections 831 and 835 of these rules. To compute the value of the life estate, multiply the fair market value of the real property at the time of transfer by the life estate factor for the participant's age at the time of transfer listed in the following table:

TABLE 837.02 - LIFE ESTATE TABLE							
Age	**Life Estate**	**Age**	**Life Estate**	**Age**	**Life Estate**	**Age**	**Life Estate**
0	.97188	**28**	.96062	**56**	.79006	**84**	.36998
1	.98988	**29**	.95813	**57**	.77391	**85**	.35359
2	.99017	**30**	.95543	**58**	.76822	**86**	.33764
3	.99008	**31**	.95254	**59**	.75675	**87**	.32262
4	.98981	**32**	.94942	**60**	.74491	**88**	.30859
5	.98938	**33**	.94608	**61**	.73267	**89**	.29526
6	.98884	**34**	.94250	**62**	.72002	**90**	.28221
7	.98822	**35**	.93868	**63**	.70696	**91**	.26955
8	.98748	**36**	.93460	**64**	.69352	**92**	.25771
9	.98663	**37**	.93026	**65**	67970	**93**	.24692
10	.98565	**38**	.92567	**66**	.66551	**94**	.23728
11	.98453	**39**	.92083	**67**	.65098	**95**	.22887
12	.98359	**40**	.91571	**68**	.63610	**96**	.22181
13	.98198	**41**	.91030	**69**	.62086	**97**	.21550
14	.98066	**42**	.90457	**70**	.60522	**98**	.21000
15	.97937	**43**	.89855	**71**	.58914	**99**	.20486
16	.97815	**44**	.89221	**72**	.57261	**100**	.19975
17	.97700	**45**	.88558	**73**	.55571	**101**	.19532
18	.97590	**46**	.87863	**74**	.53862	**102**	.19054
19	.97480	**47**	.87137	**75**	.52149	**103**	.18437
20	.97365	**48**	.86374	**76**	.50441	**104**	.17856

TABLE 837.02 - LIFE ESTATE TABLE

Age	Life Estate	Age	Life Estate	Age	Life Estate	Age	Life Estate
21	.97425	**49**	.85578	**77**	.48742	**105**	.16962
22	.97120	**50**	.83743	**78**	.47049	**106**	.15488
23	.96986	**51**	.83674	**79**	.45357	**107**	.13409
24	.96841	**52**	.82969	**80**	.43659	108	.10068
25	.96678	**53**	.82028	**81**	.41967	109	.04545
26	.96495	**54**	.81054	**82**	.40295		
27	.96290	**55**	.80046	**83**	.38642		

( )

838. ANNUITY AS ASSET TRANSFER.
Except as provided in this rule, when assets are used to purchase an annuity during the look-back period, it is an asset transfer presumed to be made for the purpose of qualifying for Medicaid. To rebut this presumption, the participant must provide proof that clearly establishes the annuity was not purchased to make the participant eligible for Medicaid or avoid recovery from the estate following death. Proof is met if the participant shows the annuity meets the requirements Subsections 838.02 through 838.05 of this rule. ( )

01. Revocable Annuity. Is an annuity that can be assigned. The surrender amount of a revocable annuity is a countable resource. ( )

02. Irrevocable Annuity. The purchase price of an irrevocable, non-assignable annuity is treated as an asset transfer, unless the requirements of Subsections 838.03 through 838.05 of this rule are met. ( )

03. Irrevocable Annuity Life Expectancy Test. The participant's life expectancy, as shown in the Social Security Actuarial - Period Life Table (2020), must equal or exceed the term of the annuity. Using the Table, compare the face value of the annuity to the participant's life expectancy at the purchase time. The annuity meets the life expectancy test if the participant's life expectancy equals or exceeds the term of the annuity. If the exact age is not in the Table, use the next lower age. See https://www.ssa.gov/oact/STATS/table4c6.html. ( )

04. State Named as Beneficiary. The purchase of an annuity is treated as an asset transfer unless the State of Idaho, Medicaid Estate Recovery is named as: ( )

a. The remainder beneficiary in the first position for at least the total amount of medical assistance paid on behalf of the institutionalized individual under this title; or ( )

b. The remainder beneficiary in the second position after the community spouse or minor or disabled child and is named in the first position if the community spouse or a representative of the minor or disabled child disposes of any remainder for less than fair market value. ( )

05. Equal Payment Test. The annuity must provide for payments in equal amounts during the term of the annuity with no deferral and no balloon payments made. ( )

06. Permitted Annuity. The purchase of an annuity is not treated as an asset transfer if the annuity meets any of the descriptions in Sections 408(b), or 408(q), Internal Revenue Code; or is purchased with proceeds from an account or trust described in Sections 408(a), 408(c), or 408(p), Internal Revenue Code, or is a simplified employee pension as described in Section 408(k), Internal Revenue Code, or is a Roth IRA described in Section 408A, Internal Revenue Code. ( )

839. TRUSTS AS ASSET TRANSFERS.
A trust established wholly or partly from the participant's assets is an asset transfer. Assets transferred to a trust on or

after August 11, 1993 are subject to the asset transfer penalty, regardless of when the trust was established. If the trust includes assets of another person, the asset transfer penalty applies to the participant's share of the trust. ( )

840. TRANSFER OF JOINTLY OWNED ASSET.
Transfer of an asset owned jointly by the participant and another person is considered a transfer by the participant. The participant's share of the asset is used to compute the penalty. If the participant and their spouse are joint owners of the transferred asset, the couple's combined ownership is used to compute the penalty. If the spouse becomes eligible for long-term care Medicaid, the rest of the period of restricted coverage is divided between the participant and spouse. ( )

841. PENALTY EXCEPTIONS FOR ASSET TRANSFERS.
A participant is not subject to the asset transfer penalty for taking any action described in Subsections 841.01 through 841.15 of this rule. ( )

01. Home to Spouse. The asset transferred was a home. Title to the home was transferred to the spouse. ( )

02. Home to Minor Child or Disabled Adult Child. The asset transferred was a home. Title to the home was transferred to the child of the participant or spouse. The child must be under age twenty-one (21) or blind or totally disabled under Social Security and SSI rules in 20 CFR Part 416. ( )

03. Home to Brother or Sister. The asset transferred was a home. Title to the home was transferred to a sibling of the participant or spouse. The sibling must have an equity interest in the transferred home and reside in that home for at least one (1) year immediately before the month the participant starts long-term care. ( )

04. Home to Adult Child. The asset transferred was a home. Title to the home was transferred to a child of the participant or spouse, other than a child under the age of twenty-one (21). The child must reside in that home for at least two (2) years immediately before the month the participant started long-term care. The adult child must prove they provided nursing facility level medical care to the participant which permitted them to live at home rather than enter long-term care. The child must not have received payment from Medicaid for home and community-based services provided to the participant. ( )

05. Benefit of Spouse. The assets were transferred to the participant's spouse or to another person for the sole benefit of the spouse. ( )

06. Transfer From Spouse. The assets were transferred from the participant's spouse to another person for the sole benefit of the participant's spouse. ( )

07. Transfer to Child. The assets were transferred to the participant's child, or to a trust established solely for the benefit of the participant's child. The child must be blind or totally disabled under Social Security and SSI rules in 20 CFR Part 416. The child may be any age. ( )

08. Intent to Get Fair Market Value. The participant or spouse proves they intended to dispose of the assets at fair market value or for other adequate consideration. ( )

09. Assets Returned. All assets transferred for less than fair market value have been returned to the participant. ( )

10. Medicaid Qualification Not the Intent. The participant or spouse proves the assets were transferred exclusively for a purpose other than to qualify for Medicaid or to avoid recovery. ( )

11. Undue Hardship. The participant, their representative, or the facility in which they reside may request the hardship waiver. The hardship waiver must be requested in writing within ten (10) days of the date of the asset transfer penalty notice. Undue hardship exists if any of the conditions below apply. ( )

a. The participant proves they are not able to pay for their nursing facility services or their waiver services by any means. ( )

b. The participant proves that they have made reasonable efforts, consistent with their physical and financial ability, to recover the transferred asset. The participant must fully cooperate with the State of Idaho in efforts to recover the transferred asset and, upon request, must assign their rights to recover the asset to the State of Idaho. ( )

c. The participant proves they did not knowingly transfer the asset. ( )

d. The participant proves they would be deprived of food, clothing, shelter, or other necessities of life if the asset transfer penalty is imposed and they assign their rights to recover the asset to the State of Idaho. ( )

12. **Exception to Fair Market Value**. The amount received is adequate, even if not fair market value. This exception must meet one (1) of the conditions below. ( )

a. A forced sale was done under reasonable circumstances. ( )

b. Little or no market demand exists for the type of asset transferred and the lack of market demand was not created by a voluntary act of the participant to qualify for assistance or to avoid recovery. ( )

c. The asset was transferred to settle a legal debt approximately equal to the fair market value of the transferred asset. ( )

13. **No Benefit to Participant**. The participant received no benefit from the asset. This exception must meet one (1) of the conditions below. ( )

a. The participant or spouse held title to the property only as a trustee for another person and had no beneficial interest in the property. ( )

b. The transfer was done to clear title to property. The participant or spouse had no beneficial interest in the property. The defect in the title was not created to transfer assets to qualify for assistance or avoid recovery. ( )

14. **Fraud Victim**. The asset was transferred because the participant or spouse was the victim of fraud, misrepresentation, or coercion. The participant or spouse must take all possible steps to recover the assets or property, or its equivalent in damages and assign recovery rights to the State of Idaho. ( )

15. **Transfer to Trust of Disabled Person**. The assets were transferred to a trust established solely for the benefit of an individual under sixty-five (65) years of age who is disabled. ( )

842. -- 870. (RESERVED)

871. TREATMENT OF TRUSTS.

This trust treatment rule applies to all Medicaid participants. This rules applies to trusts established with the participant's assets on August 11, 1993, or later, and to amounts placed in trusts on or after August 11, 1993. This rule does not apply to an irrevocable trust if the participant meets the undue hardship exemption in Subsection 841.11 of these rules. Assets transferred to a trust are subject to the asset transfer penalty. This rule does not apply to a trust created with assets other than those of the individual, including a trust established by a will. ( )

01. **Revocable Trust**. Is treated as listed below. A revocable burial trust is not a trust for the purposes of Subsection 871.01 of this rule. ( )

a. The body (corpus) of a revocable trust is a resource. ( )

b. Payments from the trust to or for the participant are income. ( )

c. Any other payments from the trust are an asset transfer, triggering an asset transfer penalty period. ( )

d. Under 42 USC 1396p(e)(5), the home and adjoining property loses its exclusion for eligibility purposes when transferred to a revocable trust, unless the participant or spouse is the sole beneficiary of the trust. The home is excluded again if removed from the trust. The exclusion restarts the month following the month the home was removed from the trust. ( )

02. Irrevocable Trust. Is treated as listed below. ( )

a. The part of the body of an irrevocable trust, from which corpus or income payments could be made to or for the participant, is a resource. ( )

b. Payments made to or for the participant are income. ( )

c. Payments from the trust for any other reason are asset transfers, triggering the asset transfer penalty. ( )

d. Any part of the trust from which payment cannot be made to, or for the benefit of the participant under any circumstances, is an asset transfer. ( )

e. The effective date of the transfer is the date the trust was established, or the date payments to the participant were foreclosed. ( )

f. The value of the trust, for calculating the transfer penalty, includes any payments made from that portion of the trust after the date the trust was established, or payments were foreclosed. ( )

g. An irrevocable burial trust is not subject to treatment under Subsection 871.02 of this rule, unless funds in the trust can be paid for a purpose other than the participant's funeral and related expenses. The trust can provide that funds not needed for the participant's funeral expenses are available to reimburse Medicaid, or to go to the participant's estate. ( )

872. EXEMPT TRUSTS.

A trust, created or funded on or after August 11, 1993, is exempt from trust treatment and not subject to the asset transfer penalty if it meets a condition below. ( )

01. Trust for Disabled Person. To be exempt, a trust for a disabled person must meet all the conditions below. ( )

a. The trust contains the assets of a person under age sixty-five (65). ( )

b. The person is blind or totally disabled under the Social Security and SSI rules in 20 CFR Part 416. ( )

c. The trust is established for the person's benefit by their parent, grandparent, legal guardian, or a court. ( )

d. The trust is irrevocable. ( )

e. The trust is exempt until the person reaches age sixty-five (65). After the person reaches age sixty-five (65), additions or augmentations are not exempt from trust treatment. ( )

f. Upon the person's death, the amount not distributed by the trust must first be paid to the State of Idaho, up to the amount Medicaid has paid on the person's behalf. ( )

02. Income Trust. To be exempt, an income trust must meet all the conditions below. ( )

a. The trust is established for the sole benefit of a person who would be eligible for Medicaid in long-term care, or eligible for HCBS except for excess income. ( )

b. Any income, placed directly into an income trust in the same calendar month in which received by the recipient, is not considered income to the individual for determining long-term care Medicaid eligibility. Money paid into the trust is income for patient liability or participant participation. ( )

c. The trust is irrevocable. The trust document may include a clause allowing the trust to be revoked if the participant leaves the nursing facility or HCBS for a reason other than death, and is no longer eligible for Medicaid because of excess income, if Medicaid is reimbursed up to the amount Medicaid has paid on the person's behalf. ( )

d. Income transferred to the trust must be used to pay patient liability or participant participation. If income is not used to pay allowable expenses, it is subject to the asset transfer penalty, unless one (1) of the following exceptions applies. ( )

i. Benefit of the spouse in Subsection 841.05 of these rules; ( )

ii. Transfer from the spouse in Subsection 841.06 of these rules; or ( )

iii. Undue hardship in Subsection 841.11 of these rules. ( )

e. Upon the person’s death, the amount not distributed by the trust must first be paid to the State of Idaho, up to the amount Medicaid has paid on the person’s behalf. ( )

03. Trust Managed by Non-Profit Association for Disabled Person. To be exempt, a trust managed by non-profit association for a disabled person must meet all the conditions below. ( )

a. The trust is established and managed by a nonprofit association. The nonprofit association must not be the participant, their parent, or grandparent. ( )

b. The trust contains the assets of a disabled person. The person must be blind or totally disabled under Social Security and SSI rules in 20 CFR Part 416. ( )

c. Accounts in the trust are established only for the benefit of disabled persons. An account can be established by the disabled person, their parent, grandparent, legal guardian, or a court. A separate account must be maintained for each beneficiary of the trust. For purposes of investment and management, the trust may pool the funds in the accounts. ( )

d. The trust is irrevocable. ( )

e. Upon the person’s death, the amount not distributed by the trust must first be paid to the State of Idaho, up to the amount Medicaid has paid on the person’s behalf. ( )

873. PAYMENTS FROM AN EXEMPT TRUST FOR DISABLED PERSON OR POOLED TRUST.
Cash payments from an exempt trust for a disabled person or a pooled trust must be treated as described below. ( )

01. Cash Payments from Exempt Trust. For a disabled person are income in the month received. ( )

02. Cash Payments from Pooled Trust. Are made directly to the participant are income in the month received. ( )

03. Payments for the Participant’s Food or Shelter. Are income in the month paid. The payments for food or shelter are valued at one-third (1/3) of the AABD budgeted needs for the participant’s living arrangement. ( )

04. Payments Not Made to Participant. Payments from the exempt trust not made to, or on behalf of,

the participant are an asset transfer. ( )

874. -- 914. (RESERVED)

915. MEDICAID REDETERMINATION.
Medicaid eligibility is redetermined each year. The redetermination for AABD cash is the Medicaid redetermination for participants receiving both programs. ( )

916. -- 999. (RESERVED)

[Agency redlined courtesy copy]

Italicized text **indicates changes between the text of the proposed rule as adopted in the pending rule.**

16.03.05 – ELIGIBILITY FOR AID TO THE AGED, BLIND, AND DISABLED (AABD)

000. LEGAL AUTHORITY.
~~The Idaho Department of Health and Welfare, according to~~ Section 56-202, Idaho Code, authorizes the Department to adopt~~s these~~ rules for the administration of public assistance programs. ~~(3-17-22)~~( )

001. ~~TITLE AND SCOPE.~~(RESERVED)

~~**01. Title**. These rules are titled IDAPA 16.03.05, "Eligibility for Aid to the Aged, Blind, and Disabled (AABD)." (3-17-22)~~

~~**02. Scope**. These rules provide standards for issuing AABD cash benefits and related Medicaid benefits. (3-17-22)~~

002. INCORPORATION BY REFERENCE.
The ~~Department is adopting~~ following are incorporated by reference ~~the~~ ( )

01. "Medicare Modernization Act - Prescription Drug Program Guidance to States for the Low Income Subsidy (LIS)," dated May 25, 2005. The guidelines may be viewed at the main office of the Department ~~of Health and Welfare~~. It is also available online at https://www.cms.gov/Medicare/Eligibility-and-Enrollment/LowIncSubMedicarePresCov/Downloads/StateLISGuidance021009.pdf. ~~(3-17-22)~~( )

02. Social Security Administration Program Operations Manual System (POMS) SI 01320.00, Deeming Resources, effective date: 10/17/2022. This Deeming of Income section is available at: https://secure.ssa.gov/apps10/poms.nsf/lnx/0501320000. ( )

03. Social Security Administration Program Operations Manual System (POMS) SI 01330.00, Deeming Resources, effective date: 02/24/2010. This Deeming of Resources section is available at: https://secure.ssa.gov/apps10/poms.nsf/lnx/0501330000. ( )

04. Social Security Administration Program Operations Manual System (POMS) SI 02302.200 Charted Threshold Amounts for Calendar Year 2023, effective date: 01/24/2023. This Charted Threshold Amounts table is available at: https://secure.ssa.gov/apps10/poms.nsf/lnx/0502302200. ( )

003. -- 009. (RESERVED)

010. DEFINITIONS.
~~For purposes of this chapter, the following terms apply. (3-17-22)~~

01. AABD Cash. An EBT payment to a participant, a participant's guardian, or a holder of a limited power of attorney for EBT payments. AABD Cash is a payment of a supplemental cash amount to an individual who meets the program requirements. This payment may be made through direct deposit or an electronic benefits card. ( )

02. Applicant. A person applying for public assistance from the Department, including individuals referred to the Department from a health insurance exchange or marketplace. ( )

03. Annuity. A right to receive periodic payments, either for life, a term of years, or other interval of time, whether or not the initial payment or investment has been annuitized. It includes contracts for single payments where the single payment represents an initial payment or investment together with increases or deductions for interest or fees rather than an actuarially based payment from an insurance pool. ( )

04. Asset. Includes all income and resources of the individual and the individual's spouse, including any income or resources ~~which~~ that the individual or ~~such individual's~~ their spouse is entitled to, but does not receive because of action by: ~~(3-17-22)~~( )

a. The individual or ~~such individual's~~ their spouse; ~~(3-17-22)~~( )

b. A person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or ~~such individual's~~ their spouse; or ~~(3-17-22)~~( )

c. A person, including any court or administrative body, acting at the direction or upon the request of the individual or ~~such individual's~~ their spouse. ~~(3-17-22)~~( )

05. Asset Transfer for Sole Benefit. An asset transfer is considered to be for the sole benefit of a spouse, blind or disabled child, or disabled individual if the transfer is arranged in such a way 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 transfer or at any time in the future. ( )

06. Child. Any individual from birth through the end of the month of ~~his~~ their nineteenth birthday. ~~(3-17-22)~~( )

07. Citizen. A person having status as a "national of the United States" defined in 8 USC 1101(a)(22) that includes both citizens of the United States and non-citizen nationals of the United States. ( )

08. Department. The Department of Health and Welfare. ( )

09. Direct Deposit. The electronic deposit of a participant's AABD cash to the participant's personal account with a financial institution. ( )

10. Electronic Benefits Transfer (EBT). A method of issuing AABD cash to a participant, a participant's guardian, or a holder of a limited power of attorney for EBT payments for a participant. ( )

11. Essential Person. A person of the participant's choice whose presence in the household is essential to the participant's well-being. The essential person provides the services a participant needs to live at home. ( )

12. Fair Market Value. The ~~fair market value of an asset is the~~ price for which ~~the~~ an asset can be reasonably expected to sell on the open market, in the geographic area involved. ~~(3-17-22)~~( )

13. Long-Term Care. ~~Long-term care services are s~~Services provided to an institutionalized individual as defined in 42 U~~.~~S~~.~~C~~.~~ 1396p(c)(1)(C). ~~(3-17-22)~~( )

14. Medicaid. Idaho's Medical Assistance Program administered by the Department. ~~and funded with federal and state funds according to~~ See Title XIX~~, Social Security Act that provides medical care for eligible~~

~~individuals~~. ~~(3-17-22)~~( )

~~**15. Medical Assistance Rules**. Idaho Department of Health and Welfare Rules, IDAPA 16.03.09, "Medicaid Basic Plan Benefits," IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," and IDAPA 16.03.17, "Medicare/Medicaid Coordinated Plan Benefits." (3-17-22)~~

~~**16. Medicaid for Families With Children Rules**. Idaho Department of Health and Welfare Rules, IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children." (3-17-22)~~

1~~7~~5. Needy. A person is considered needy for AABD cash payments if the person meets the non-financial requirements of Title XVI of the Social Security Act and the criteria in Section 514 of these rules. Title XVI of the Social Security Act, known as "Grants to States for Aid to the Aged, Blind, or Disabled," is a program for financial assistance to needy individuals who are sixty-five (65) years of age or over, are blind, or are eighteen (18) years of age or over and permanently and totally disabled. ~~(3-17-22)~~( )

1~~8~~6. Non-Citizen. Same as "alien" defined in Section 101(a)(3) of the Immigration and Nationality Act (INA) (8 USC 1101 (a)(3)), and includes any individual who is not a citizen or national of the United States. ( )

1~~9~~7. Participant. An individual who is eligible for, and enrolled in, a Health Care Assistance Program or Medicaid. ( )

~~20~~18. Partnership Policy. A~~ partnership policy is a~~ qualified long-term care insurance policy~~ as defined in~~ under Section 7702B(b) of the Internal Revenue Code of 1986, which meets the requirements of the long-term care insurance model regulation and ~~l~~Long-term ~~c~~Care ~~i~~Insurance ~~m~~Model ~~a~~Act promulgated by the National Association of Insurance Commissioners (NAIC), as incorporated in 42 USC 1396p(b)(5)(A). ~~(3-17-22)~~( )

~~2~~1~~1~~9. Premium. A regular, periodic charge or payment for health coverage. ( )

2~~2~~0. Reasonable Opportunity Period. A period~~ of time~~ allowed for an individual to provide requested proof of citizenship or identity. A reasonable opportunity period extends for ninety (90) days beginning on the 5th day after the notice requesting the proof has been mailed to the applicant. This period may be extended if the Department determines that the individual is making a ~~"~~good faith~~"~~ effort to obtain necessary documentation. ~~(3-17-22)~~( )

2~~3~~1. Pension Funds. ~~Pension funds are r~~Retirement funds held in individual retirement accounts (IRAs), as described by the Internal Revenue Code, or in work-related pension plans, including plans for self-employed individuals sometimes referred to as Keogh plans. ~~(3-17-22)~~( )

2~~4~~2. Sole Beneficiary. The only beneficiary of a trust, including a beneficiary during the grantor's life, a beneficiary with a future interest, and a beneficiary by the grantor's will. ( )

~~**25. TAFI Rules**. Idaho Department of Health and Welfare Rules, IDAPA 16.03.08, "Temporary Assistance for Families in Idaho." (3-17-22)~~

~~**26. Title XVI**. Title XVI of the Social Security Act, known as "Grants to States for Aid to the Aged, Blind, or Disabled," is a program for financial assistance to needy individuals who are sixty-five (65) years of age or over, are blind, or are eighteen (18) years of age or over and permanently and totally disabled. (3-17-22)~~

2~~7~~3. Title XIX. ~~Title XIX o~~Of the Social Security Act, known as Medicaid, is a medical benefits program jointly financed by the federal and state governments and administered by the states that provides medical care for eligible individuals. Please see https://www.ssa.gov/OP_Home/ssact/title19/1900.htm. ~~(3-17-22)~~( )

2~~8~~4. Title XXI. ~~Title XXI o~~Of the Social Security Act, known as the Children's Health Insurance Program (CHIP), is a federal and state partnership that provides health insurance to targeted, low-income children. Please see https://www.ssa.gov/OP_Home/ssact/title21/2101.htm. ~~(3-17-22)~~( )

2~~9~~5. **Treasury Rate**. The five (5) year security note rate listed in the "Daily Treasury Yield Curve Rate" by the U~~.~~S~~.~~ Treasury on January 1 of each year~~. The January 1 rate~~, and is used for the entire calendar year. ~~(3-17-22)~~(   )

~~30~~26. **Working Day**. A calendar day when regular office hours are observed by the state of Idaho. Weekends and state holidays are not considered working days. (   )

011. -- 019. (RESERVED)

020. ABBREVIATIONS.

01. **AABD**. Aid to the Aged, Blind, and Disabled. (   )

~~**02.** **AB**. Aid to the Blind. (3-17-22)~~

~~**03.** **AFA**. Application for Assistance. (3-17-22)~~

~~**04.** **APTD**. Aid to the Permanently and Totally Disabled. (3-17-22)~~

~~**05.** **ASVI**. Alien Status Verification Index. (3-17-22)~~

0~~6~~2. **COLA**. Cost of Living Adjustment. (   )

0~~7~~3. **CSA**. Community Spouse Allowance. (   )

0~~8~~4. **CSNS**. Community Spouse Need Standard. (   )

0~~9~~5. **CSRA**. Community Spouse Resource Allowance. (   )

~~**10.** **DHW**. Department of Health and Welfare. (3-17-22)~~

~~11~~06. **EBT**. Electronic Benefits Transfer. (   )

~~12~~07. **EITC**. Earned Income Tax Credit. (   )

~~**13.** **FMA**. Family Member Allowance. (3-17-22)~~

~~14~~08. **FSI**. Federal Spousal Impoverishment. (   )

~~15~~09. **HCBS**. Home and Community Based Services. (   )

~~**16.** **HUD**. The U.S. Department of Housing and Urban Development. (3-17-22)~~

~~**17.** **IEVS**. Income and Eligibility Verification System. (3-17-22)~~

10. **ICF/IID**. Intermediate Care Facility for Individuals with Intellectual Disabilities. (   )

1~~8~~1. **INA**. Immigration and Nationality Act. (   )

~~**19.** **IRS**. The U.S. Internal Revenue Service. (3-17-22)~~

~~**20.** **MA**. Medical Assistance. (3-17-22)~~

~~**21.** **OAA**. Old Age Assistance. (3-17-22)~~

~~22~~12. **PASS**. Plan for Achieving Self-Support. (   )

~~23~~13. **RSDI**. Retirement, Survivors, and Disability Insurance. ( )

~~**24.** **SAVE**. Systematic Alien Verification for Entitlements. (3-17-22)~~

~~25~~14. **SSA**. Social Security Administration. ( )

~~26~~15. **SSI**. Supplemental Security Income. ( )

~~27~~16. **SSN**. Social Security Number. ( )

~~28~~17. **TAFI**. Temporary Assistance for Families in Idaho. ( )

~~**29.** **UIB**. Unemployment Insurance Benefits. (3-17-22)~~

~~30~~18. **VA**. Veterans Administration. ( )

021. -- 048. (RESERVED)

049. SIGNATURES.
An individual applying for benefits, receiving benefits, or providing additional information as required by~~ this chapter~~ these rules, may do so with the depiction of the individual's name either handwritten, electronic, or recorded telephonically. Such signature serves as intention to execute or adopt the sound, symbol, or process for the purpose of signing the related record. ~~(3-17-22)~~( )

050. APPLICATION FOR ASSISTANCE.

01. Application Submitted by Participant. The participant must submit an application form to the Department. An adult participant, a legal guardian, or a representative must sign the application form. ( )

02. Application Submitted Through~~ Social Security Administration (~~SSA~~)~~ Low-Income Subsidy Data Transmission. For low-income subsidy applicants identified on the SSA data transmission, the protected Medicare Savings Program application date is the day they applied for the low-income subsidy~~ (LIS)~~. ~~(3-17-22)~~( )

051. EFFECTIVE DATE.
The effective date for aid is the first day of the month of application. Medicaid eligibility begins as described in ~~Subsections 051.01 through 051.04~~ this rule. ~~(3-17-22)~~( )

01. AABD Cash. AABD cash aid is effective on the application date. ( )

02. Normal Medicaid Eligibility. Medicaid coverage begins on the first day of the application month. ( )

03. Retroactive (Backdated) Medicaid Eligibility. Medicaid benefits must be backdated to the first day of the calendar month, for each of the three (3) months before the month of application, if the participant was Medicaid~~ -~~-eligible during that month. If the participant is not eligible for Medicaid when they appl~~ies~~y, retroactive eligibility is evaluated. ~~(3-17-22)~~( )

04. Ineligible Non-Citizen Medicaid. Ineligible legal or illegal non-citizen coverage is restricted to emergency services. Coverage begins when the emergency treatment is required. Coverage ends with the last day emergency treatment is required. ( )

~~**052. PERSONAL INTERVIEW.**~~
~~Each applicant for AABD must participate in a telephone interview unless good cause exists. Upon request, the Department may require a face-to-face interview. (3-17-22)~~

05~~3~~2. -- 069. (RESERVED)

070. TIME LIMITS.
The application must be processed within forty-five (45) days for an applicant sixty-five (65) years of age or older. The application must be processed within ninety (90) days for a disabled applicant. The time limit can be extended by events beyond the Department's control. ( )

071. DEATH OF APPLICANT.
An application may be filed for a deceased person. The application must be filed within the backdated eligibility period. Medicaid can be approved, through the date of death, if an AABD applicant dies before eligibility is determined. ( )

072. REQUIRED VERIFICATION.
Applicants must prove their eligibility for aid. The participant is allowed ten (10) calendar days to provide requested proof. The application is denied if the applicant does not provide proof in ten (10) calendar days of the written request and does not have good cause for not providing proof. The Department may also use electronic verification sources when they are available. ( )

073. -- 0~~8~~90. (RESERVED)

~~**090. APPLICATIONS FOR MEDICAID.**~~
~~The Department must examine the potential eligibility of the participant for all Medicaid coverage groups when a participant applies for Medicaid. (3-17-22)~~

091. OUT-OF-STATE APPLICANTS.
A participant receiving AABD cash from another state must not receive AABD cash in Idaho until they ~~is~~ are living in Idaho and the cash benefit has ended in the other state. A participant may receive Medicaid in Idaho before AABD cash or Medicaid stops in another state. AABD cash from another state is unearned income for Medicaid. Out-of-state medical coverage is a Medicaid third~~-~~-party resource. Idaho residents temporarily out of the state, and not receiving aid, may apply for aid in Idaho. ~~(3-17-22)~~( )

092. CONCURRENT BENEFIT PROHIBITION.
If a person is potentially eligible for AABD cash, TAFI, or foster care, only one (1) program may be chosen. ( )

093. -- 099. (RESERVED)

100. RESIDENCY.
The participant must be living in Idaho and have no immediate intention of leaving. For Medicaid, other persons are Idaho residents if they meet any of the following criteria~~ in Subsections 100.01 through 100.05 of this rule~~. ~~(3-17-22)~~( )

01. Foster Child. A participant living in Idaho and receiving child foster care payments from another state. ( )

02. Incapable Participant. A participant~~,~~ who is incapable of indicating ~~his~~ their state of residency after age twenty-one (21)~~,~~ is considered a resident of Idaho when: ~~(3-17-22)~~( )

a. ~~His~~Their parent or guardian lives in Idaho; or ~~(3-17-22)~~( )

b. ~~He~~They reside~~s~~ in an Idaho institution. ~~(3-17-22)~~( )

03. Placed in Another State by Idaho. A participant placed by the state of Idaho in an institution in another state. ( )

04. Homeless. A participant not maintaining a permanent home or having a fixed address who intends to remain in Idaho. ( )

05. Migrant. A migrant working and living in Idaho. ( )

101. TEMPORARY ABSENCE.

A participant may be temporarily absent from ~~his~~ their home and still receive AABD cash and Medicaid. A participant is temporarily absent if they intend~~s~~ to return home within one (1) month. Temporary absence may exceed one (1) month for a child attending school or vocational training or a participant in a medical institution, hospital, or nursing home. ~~(3-17-22)~~( )

102. US CITIZENSHIP VERIFICATION REQUIREMENTS.

Any individual who participates in AABD cash, Health Care Assistance, or Medicaid benefits must provide proof of U~~.~~S~~.~~ citizenship unless they ha~~s~~ve otherwise met the requirements under ~~Subsection 104.06 of these rules~~ 42 CFR 435.406, Citizenship and Non-Citizen Eligibility. ~~(3-17-22)~~( )

~~**01. Citizenship Verified**. Citizenship must be verified by electronic means when available. If an electronic verification is not immediately obtainable, the Department may request documentation from the applicant The Department will not deny the application until the applicant has had a reasonable opportunity period to obtain and provide the necessary proof of U.S. citizenship. (3-17-22)~~

~~**02. Benefits During Reasonable Opportunity Period**. Benefits are provided during the reasonable opportunity period that is provided to allow the applicant time to obtain and provide documentation to verify U.S. citizenship. No overpayment will exist for the reasonable opportunity period if the applicant does not provide necessary documentation during the reasonable opportunity period so that the application results in denial. (3-17-22)~~

~~**03. Electronic Verification**. Electronic interfaces initiated by the Department with agencies that maintain citizenship and identity information are the primary sources of verification of U.S. Citizenship and Identity. (3-17-22)~~

~~**04. Documents**. When verification is not available through an electronic interface, the individual must provide the Department with the most reliable document that is available. Documents can be: (3-17-22)~~

~~**a.** Originals; (3-17-22)~~

~~**b.** Photocopies; (3-17-22)~~

~~**c.** Facsimiles; (3-17-22)~~

~~**d.** Scanned; or (3-17-22)~~

~~**e.** Other type of copy of a document. (3-17-22)~~

~~**05. Accepted Documentation**. Other forms of documentation are accepted to the same extent as an original document, unless information on the submitted document is: (3-17-22)~~

~~**a.** Inconsistent with other information available to the Department; or (3-17-22)~~

~~**b.** The Department has good cause to question the validity of the document or the information on it. (3-17-22)~~

~~**06. Submission of Documents**. The Department accepts documents that are submitted: (3-17-22)~~

~~**a.** In person; (3-17-22)~~

~~**b.** By mail or parcel service; (3-17-22)~~

~~**c.** Through an electronic submission; or (3-17-22)~~

~~**d.** Through a guardian or authorized representative. (3-17-22)~~

103. SOCIAL SECURITY NUMBER (SSN) REQUIREMENT.

01. SSN Required. The applicant must provide his social security number their (SSN), or proof they hasve applied for an SSN, to the Department before approval of eligibility. If the applicant has more than one (1) SSN, all numbers must be provided. (3-17-22)( )

a. The SSN must be verified by the Social Security Administration (SSA) electronically. An applicant with an unverified SSN is not eligible for AABD cash, Health Care Assistance, or Medicaid benefits.(3-17-22)( )

b. The Department must notify the applicant in writing if eligibility is denied or lost for failure to meet the SSN requirement. ( )

02. Application for SSN. To be eligible, the applicant must apply for an SSN, or a duplicate SSN when they cannot provide his their SSN to the Department. If the SSN has been applied for but not issued by the SSA, the Department cannot deny, delay, or stop benefits. The Department will help an applicant with required documentation when the applicant applies for an SSN. (3-17-22)( )

03. Failure to Apply for SSN. The applicant may be granted a good cause exception for failure to apply for an SSN if they have a well-established religious objection to applying for an SSN. A well-established religious objection means the applicant: ( )

a. Is a member of a recognized religious sect or division of the sect; and ( )

b. Adheres to the tenets or teachings of the sect or division of the sect and for that reason is conscientiously opposed to applying for or using a national identification number. ( )

04. SSN Requirement Waived. An applicant may have the SSN requirement waived when they is are: (3-17-22)( )

a. Only eligible for emergency medical services as described in Section 801 of these rules under 42 CFR *440.255*, Emergency and Poststabilization Services; or (3-17-22)( )

b. A newborn child deemed eligible as described in Section 800 of these rules under 42 CFR 435.117, Deemed Newborn Children. (3-17-22)( )

104. – 105. U.S. CITIZENSHIP AND IDENTITY DOCUMENTATION REQUIREMENTS.(RESERVED)
To be eligible for AABD cash and Medicaid, an individual must provide proof of U.S. citizenship and identity unless he has otherwise met the requirements under Subsection 104.06 of this rule. The individual must provide the Department with the most reliable document that is available. The Department will accept documents as described in Section 102 of these rules. (3-17-22)

01. Documents Accepted as Proof of Both U.S. Citizenship and Identity. The following documents are accepted as proof of both U.S. citizenship and identity: (3-17-22)

a. A U.S. passport, including a U.S. Passport card, without regard to expiration date as long as the passport or passport card was issued without limitation; (3-17-22)

b. A Certificate of Naturalization; or (3-17-22)

c. A Certificate of U.S. Citizenship. (3-17-22)

d. Documentary evidence issued by a federally recognized Indian tribe. Such documents include: (3-17-22)

i. A tribal enrollment card; (3-17-22)

~~ii. A certificate of Degree of Indian Blood; (3-17-22)~~

~~iii. A tribal census document; or (3-17-22)~~

~~iv. Documents on tribal letterhead, issued under the signature of the appropriate tribal official. (3-17-22)~~

~~**02. Documents Accepted as Evidence of U.S. Citizenship**. The following documents are accepted as proof of U.S. citizenship if the proof in Subsection 104.01 of this rule is not available. These documents are not proof of identity and must be used in combination with a least one (1) document listed in Subsections 104.03 and 104.04 of this rule to establish both citizenship and identity. If the applicant does not have one (1) of the documents listed below, he may submit an affidavit signed by another individual under penalty of perjury who can reasonably attest to the applicant's citizenship, and that contains the applicant's name, date of birth, and place of U.S. birth. The affidavit does not have to be notarized. (3-17-22)~~

~~**a.** A U.S. birth certificate that shows the individual was born in one (1) of the following: (3-17-22)~~

~~i. United States fifty (50) states; (3-17-22)~~

~~ii. District of Columbia; (3-17-22)~~

~~iii. Puerto Rico, on or after January 13, 1941; (3-17-22)~~

~~iv. Guam; (3-17-22)~~

~~v. U.S. Virgin Islands, on or after January 17, 1917; (3-17-22)~~

~~vi. America Samoa; (3-17-22)~~

~~vii. Swain's Island; or (3-17-22)~~

~~viii. Northern Mariana Islands, after November 4, 1986; (3-17-22)~~

~~**b.** A certification of report of birth issued by the Department of State, Forms DS-1350 or FS-545; (3-17-22)~~

~~**c.** A report of birth abroad of a U.S. Citizen, Form FS-240; (3-17-22)~~

~~**d.** A U.S. Citizen I.D. card, DHS Form I-197; (3-17-22)~~

~~**e.** A Northern Mariana Identification Card; (3-17-22)~~

~~**f.** A final adoption decree showing the child's name and U.S. place of birth, or if the adoption is not final, a statement from the state-approved adoption agency that shows the child's name and U.S. place of birth; (3-17-22)~~

~~**g.** Evidence of U.S. Civil Service employment before June 1, 1976; (3-17-22)~~

~~**h.** An official U.S. Military record showing a U.S. place of birth; (3-17-22)~~

~~**i.** A certification of birth abroad, FS-545; (3-17-22)~~

~~**j.** Verification with the Department of Homeland Security's Systematic Alien Verification for Entitlements (SAVE) database; (3-17-22)~~

~~**k.** Evidence of meeting the automatic criteria for U.S. citizenship outlined in the Child Citizenship~~

~~Act of 2000;~~ ~~(3-17-22)~~

~~**l.** Medical records, including, hospital, clinic, or doctor records, or admission papers from a nursing facility, skilled care facility, or other institution that indicate a U.S. place of birth;~~ ~~(3-17-22)~~

~~**m.** Life, health, or other insurance record that indicates a U.S. place of birth;~~ ~~(3-17-22)~~

~~**n.** Official religious record recorded in the U.S. showing that the birth occurred in the U.S;~~ ~~(3-17-22)~~

~~**o.** School records, including pre-school, Head Start, and daycare, showing the child's name and U.S. place of birth; or~~ ~~(3-17-22)~~

~~**p.** Federal or state census record showing U.S. citizenship or a U.S. place of birth.~~ ~~(3-17-22)~~

~~**03.** **Evidence of Identity**. The following documents are accepted as proof of identity, provided the document has a photograph or other identifying information including: name, age, sex, race, height, weight, eye color, or address.~~ ~~(3-17-22)~~

~~**a.** A state- or territory-issued driver's license. A driver's license issued by a Canadian government authority is not a valid indicator of identity in the U. S.;~~ ~~(3-17-22)~~

~~**b.** A federal, state, or local government-issued identity card;~~ ~~(3-17-22)~~

~~**c.** School identification card;~~ ~~(3-17-22)~~

~~**d.** U.S. Military card or draft record;~~ ~~(3-17-22)~~

~~**e.** Military dependent's identification card;~~ ~~(3-17-22)~~

~~**f.** U. S. Coast guard Merchant Mariner card;~~ ~~(3-17-22)~~

~~**g.** A cross-match with a federal or state governmental, public assistance, law enforcement, or corrections agency's data system;~~ ~~(3-17-22)~~

~~**h.** A finding of identity from a federal or state governmental agency, when the agency has verified and certified the identity of the individual, including public assistance, law enforcement, internal revenue or tax bureau, or corrections agency;~~ ~~(3-17-22)~~

~~**i.** A finding of identity from another state benefits agency or program provided that it obtained verification of identity as a criterion of participation;~~ ~~(3-17-22)~~

~~**j.** Verification of citizenship by a federal agency or another state. If the Department finds that a federal agency or an agency in another state verified citizenship on or after July 1, 2006, no further documentation of citizenship or identity is required;~~ ~~(3-17-22)~~

~~**k.** Two (2) documents containing consistent information that corroborates the applicant's identity including: employer identification cards, high school or high school equivalency diplomas, college diplomas, marriage certificates, divorce decrees, property deeds or titles; or~~ ~~(3-17-22)~~

~~**l.** When the applicant does not have any documentation as specified in Subsections 104.03.a. through k. of this rule, the applicant may submit an affidavit signed by another individual under penalty of perjury, who can reasonably attest to the applicant's identity. The affidavit must contain the applicant's name and other identifying information to establish identity stated in Subsection 104.03 of this rule. The affidavit does not have to be notarized.~~ ~~(3-17-22)~~

~~**04.** **Identity Rules for Children**. For children under age nineteen (19), clinic, doctor, or hospital records, including pre-school or daycare records, may be used as additional sources of documentation of identity.~~

~~(3-17-22)~~

~~**05. Eligibility for Medicaid Applicants Who Do Not Provide U.S. Citizenship and Identity Documentation**. If verification of U.S. citizenship and identity is not obtained through electronic means, or if the applicant is unable to provide documentation at the time of application, the applicant has ninety (90) days to provide proof of U.S. citizenship and identity. The ninety (90) days begins five (5) days after the date the notice is mailed requesting the documentation of citizenship and identity. Medicaid benefits will be approved pending verification if the applicant meets all other eligibility requirements. Medicaid will be denied if the applicant refuses to obtain documentation. (3-17-22)~~

~~**06. Individuals Considered as Meeting the U.S. Citizenship and Identity Documentation Requirements**. The following individuals are considered to have met the U.S. citizenship and identity documentation requirements, regardless of whether documentation required in Subsections 104.01 through 104.05 of this rule is provided: (3-17-22)~~

~~**a.** Supplemental Security Income (SSI) recipients; (3-17-22)~~

~~**b.** Individuals determined by the SSA to be entitled to or enrolled in any part of Medicare; (3-17-22)~~

~~**c.** Social Security Disability Income (SSDI) recipients; (3-17-22)~~

~~**d.** Adoptive or foster care children receiving assistance under Title IV-B or Title IV-E of the Social Security Act; (3-17-22)~~

~~**e.** Individuals deemed eligible for Medicaid as a newborn under Section 800 of these rules; and (3-17-22)~~

~~**f.** Individuals whose name and social security number are validated by the Social Security Administration data match as meeting U.S. citizenship status. (3-17-22)~~

~~**07. Assistance in Obtaining Documentation**. The Department will provide assistance to individuals who need assistance in securing satisfactory documentary evidence of citizenship. (3-17-22)~~

~~**08. Provide Verification of U.S. Citizenship and Identity One Time**. When an individual's U.S. citizenship and identity have been verified, whether through electronic data matches or provision of documentation, changes in eligibility will not require an individual to provide the verification again. If later verification provides the Department with good cause to question the validity of the individual's citizenship or identity, the individual may be requested to provide further verification. (3-17-22)~~

~~**105. CITIZENSHIP AND QUALIFIED NON-CITIZEN REQUIREMENTS.**~~
~~To be eligible for AABD cash and Medicaid, an individual must be a member of one (1) of the groups listed in Subsections 105.01 through 105.16 of this rule. An individual must also provide proof of identity as provided in Section 104 of these rules. (3-17-22)~~

~~**01. U.S. Citizen**. A U.S. Citizen or a "national of the United States." (3-17-22)~~

~~**02. Child Born Outside the U.S.** A child born outside the U.S., as defined in Public Law 106-395, is considered a citizen if all of the following conditions are met: (3-17-22)~~

~~**a.** At least one (1) parent is a U.S. Citizen. The parent can be a citizen by birth or naturalization. This includes an adoptive parent; (3-17-22)~~

~~**b.** The child is residing permanently in the U.S. in the legal and physical custody of a parent who is a U.S. Citizen; (3-17-22)~~

~~**c.** The child is under eighteen (18) years of age; (3-17-22)~~

~~**d.** The child is a lawful permanent resident; and (3-17-22)~~

~~**e.** If the child is an adoptive child, the child was residing in the U.S. at the time the parent was naturalized and was in the legal and physical custody of the adoptive parent. (3-17-22)~~

~~**03. Full-Time Active Duty U.S. Armed Forces Member**. A qualified non-citizen as defined in 8 U.S.C. 1641(b) or (c) currently on full-time active duty with the U.S. Army, U.S. Air Force, U.S. Marine Corps, U.S. Navy or U.S. Coast Guard, or a spouse or unmarried dependent child of the U.S. Armed Forces member. (3-17-22)~~

~~**04. Veteran of the U.S. Armed Forces**. A qualified non-citizen as defined in 8 U.S.C. 1641(b) or (c) honorably discharged from the U.S. Army, U.S. Air Force, U.S. Marine Corps, U.S. Navy or U.S. Coast Guard for a reason other than their citizenship status or a spouse, including a surviving spouse who has not remarried, or an unmarried dependent child of the veteran. (3-17-22)~~

~~**05. Non-Citizen Entering the U.S. Before August 22, 1996**. A non-citizen who entered the U.S. before August 22, 1996, and is currently a qualified non-citizen as defined in 8 U.S.C. 1641(b) or (c) and remained continuously present in the U.S. until they became a qualified alien. (3-17-22)~~

~~**06. Non-Citizen Entering on or After August 22, 1996**. A non-citizen who entered on or after August 22, 1996, and; (3-17-22)~~

~~**a.** Is a refugee admitted into the U.S. under 8 U.S.C. 1157, and can be eligible for seven (7) years from their date of entry; (3-17-22)~~

~~**b.** Is an asylee granted asylum into the U.S. under 8 U.S.C. 1158, and can be eligible for seven (7) years from the date their asylee status is assigned; (3-17-22)~~

~~**c.** Is an individual whose deportation or removal from the U.S. has been withheld under 8 U.S.C. 1253 or 1231(b)(3) as amended by Section 305(a) of Division C of Public Law 104-208, and can be eligible for seven (7) years from the date their deportation or removal was withheld; (3-17-22)~~

~~**d.** Is an Amerasian immigrant admitted into the U.S. under 8 U.S.C. 1612(b)(2)(A)(i)(V), and can be eligible for seven (7) years from the date of entry; (3-17-22)~~

~~**e.** Is a Cuban or Haitian entrant to the U.S. under Section 501(e) of the Refugee Assistance Act, and can be eligible for seven (7) years from their date of entry; (3-17-22)~~

~~**f.** Is an Afghan special immigrant, as defined in Public Law 110-161, who has special immigration status after December 26, 2007; or (3-17-22)~~

~~**g.** Is an Iraqi special immigrant, as defined in Public Law 110-181, who has special immigration status after January 28, 2008. (3-17-22)~~

~~**07. Qualified Non-Citizen Entering on or After August 22, 1996**. A qualified non-citizen under 8 U.S.C. 1641(b) or (c), entering the U.S. on or after August 22, 1996, and who has held a qualified non-citizen status for at least five (5) years. (3-17-22)~~

~~**08. American Indian Born in Canada**. An American Indian born in Canada under 8 U.S.C. 1359. (3-17-22)~~

~~**09. American Indian Born Outside the U.S.** An American Indian born outside of the U.S., and is a member of a U.S. federally recognized tribe under 25 U.S.C. 450 b(e). (3-17-22)~~

~~**10. Qualified Non-Citizen Child Receiving Federal Foster Care**. A qualified non-citizen child as defined in 8 U.S.C. 1641(b) or (c), and receiving federal foster care assistance. (3-17-22)~~

~~**11. Victim of Severe Form of Trafficking**. A victim of a severe form of trafficking in persons, as~~

~~defined in 22 U.S.C. 7102(13); who meets one (1) of the following: (3-17-22)~~

~~**a.** Is under the age of eighteen (18) years; or (3-17-22)~~

~~**b.** Is certified by the U.S. Department of Health and Human Services as willing to assist in the investigation and prosecution of a severe form of trafficking in persons; and (3-17-22)~~

~~i. Has made a bona fide application for a temporary visa under 8 U.S.C. 1104(a)(15)(T), which has not been denied; or (3-17-22)~~

~~ii. Is remaining in the U.S. to assist the U.S. Attorney General in the prosecution of traffickers in persons. (3-17-22)~~

~~**12. Qualified Non-Citizen Receiving Supplement Security Income (SSI)**. A qualified non-citizen under 8 U.S.C. 1641(b) or (c), and is receiving SSI; or (3-17-22)~~

~~**13. Permanent Resident Receiving AABD Cash On August 22, 1996**. A permanent resident receiving AABD cash on August 22, 1996. (3-17-22)~~

~~**14. Individuals Not Meeting the Citizenship or Qualified Non-Citizen Requirements**. An individual who does not meet the citizenship or qualified non-citizen requirements in Subsections 105.01 through 105.13 of this rule, may be eligible for emergency medical services if he meets all other conditions of eligibility. (3-17-22)~~

106. ~~(RESERVED)~~EMERGENCY MEDICAL CONDITION.

An individual who meets eligibility criteria for a category of assistance but does not meet US citizenship requirements or eligible non-citizen requirements may receive medical assistance under a Title XIX or Title XXI coverage group as follows: ( )

01. Emergency Medical Conditions. An individual not meeting the US citizenship requirement may receive medical services necessary to treat an emergency medical condition, including labor and delivery. Emergency medical conditions have acute symptoms of severity, including severe pain. ( )

02. Determination of Emergency Medical Conditions. The Department determines if a condition meets criteria of an emergency medical condition. ( )

03. Limitation on Medical Assistance. Medical assistance is limited to the period established for the emergency medical condition. ( )

04. Documentation Waived. For undocumented individuals with emergency medical conditions, the SSN requirement is waived because an SSN cannot be issued. Individuals must be otherwise eligible for Title XIX or XXI. ( )

107. INSTITUTIONAL STATUS.

An institution provides treatment, services, food, and shelter to four (4) or more people, not related to the owner. A participant living in an ineligible institution an entire calendar month is not eligible for AABD cash, unless they qualif~~ies~~y for the institution payment exception. ~~(3-17-22)~~( )

01. Eligible Institutions for AABD and Medicaid. ~~Eligible institutions for AABD and Medicaid are defined in Subsections 107.01.a. through 107.01.e~~Are listed below. ~~(3-17-22)~~( )

a. Medical institution. A public or private medical institution, including a hospital, nursing care facility, or an ~~intermediate care facility for persons with intellectual disabilities~~ ICF/IID is an eligible institution. A participant is not eligible for AABD cash if they ~~is~~ are a resident of a medical institution the full month. ~~(3-17-22)~~( )

b. Child care institution. A non-profit private child care institution is an eligible institution. A public

child care institution with no more than twenty-five (25) beds is an eligible institution. A child care institution must be licensed or approved by the Department. A detention facility for delinquent children is not a child care institution. A child care institution for mental diseases~~ (IMD)~~ is an eligible institution if it has sixteen (16) beds or less. A participant is not eligible for AABD cash if they~~ is~~ are a resident of a child care institution for the full month. ~~(3-17-22)~~(____)

c. Community residence. A community residence is a facility providing food, shelter, and services to residents. A privately operated community residence is an eligible institution. A publicly operated community residence serving no more than sixteen (16) residents is an eligible institution. The Community Restorium in Bonners Ferry, Idaho, is an eligible institution even though more than sixteen (16) residents are served. (____)

02. Ineligible Institutions for AABD and Medicaid.~~ Ineligible institutions for AABD and Medicaid are defined in Subsections 107.02.a. through 107.02.d.~~ Are listed below. ~~(3-17-22)~~(____)

a. Public institutions~~.~~,~~ Public institutions are ineligible institutions~~ unless listed in Subsection 108.01 of these rules. ~~(3-17-22)~~(____)

b. Institution for mental diseases,~~. An institution for mental diseases for adults is an ineligible institution. A~~ a facility~~ is an institution for mental diseases if it is~~ maintained primarily for the care and treatment of persons with mental diseases. ~~(3-17-22)~~(____)

c. Institution for tuberculosis,~~. An institution for tuberculosis is an ineligible institution. A~~ a facility~~ is an institution for tuberculosis if it is~~ maintained primarily for the care and treatment of persons with tuberculosis. ~~(3-17-22)~~(____)

d. Correctional institution,~~. A correctional institution is an ineligible institution. A correctional institution is~~ a facility for prisoners, persons detained pending disposition of charges, or held under court order as material witnesses or juveniles. ~~(3-17-22)~~(____)

03. Medicaid Exception for Inmates. An inmate can receive Medicaid while they are an inpatient in a medical facility. The inmate must meet all Medicaid eligibility requirements. (____)

108. AABD ELIGIBILITY IN INELIGIBLE INSTITUTIONS.

A participant may get AABD cash in an ineligible institution or a medical institution if they meet~~s~~ one (1) of the conditions listed~~ in Subsections 108.01 and 108.02~~ below. ~~(3-17-22)~~(____)

01. First Month in Institution. An AABD participant can get AABD cash for the month they entered the institution. Eligibility for the entry month applies to these residents: ~~(3-17-22)~~(____)

a. Resident of a public institution. The person is a resident if they, or anyone, pays for~~ his~~ their food, shelter, and other services in the institution. ~~(3-17-22)~~(____)

b. Patient in a medical institution. A~~ patient is a~~ person receiving room, board, and professional services in a medical institution, including an institution for tuberculosis or mental diseases. ~~(3-17-22)~~(____)

02. Temporary Institution Stay. An AABD participant can get up to three (3) months' AABD payment during a temporary stay in an institution. A participant entering a public medical or psychiatric institution, a hospital, a nursing facility, or an ICF/IID may continue to get AABD payments. The Department must receive the temporary stay data no later than the ninetieth full day of confinement, or the release date, whichever is first. The payments may continue up to three (3) months if these conditions are met: (____)

a. The Department is informed of the institutional stay. (____)

b. A physician certifies the participant's stay is not likely to exceed three (3) full months. (____)

c. A signed statement from the participant or a responsible party showing the participant's need to continue to maintain and pay for the place they intend~~s~~ to return to live. ~~(3-17-22)~~(____)

109. CONDITIONS FOR TEMPORARY AABD IN INSTITUTIONS.
Special conditions for AABD when a participant is in an institution are listed ~~in Subsections 109.01 through 109.05.~~ below: ~~(3-17-22)~~( )

01. Living Arrangement. AABD cash is paid based on the participant's living arrangement the month before the first month in the institution. Changes in living arrangement costs are used to determine AABD cash eligibility and benefit amount. ( )

02. Participant Becomes Ineligible. If the participant becomes ineligible for AABD during ~~his~~ their temporary institutional stay, ~~his~~ their AABD payment must be ended after proper notice. ~~(3-17-22)~~( )

03. AABD Status. A participant must get AABD for the month they enter~~s~~ the institution to receive continued AABD payments. ~~(3-17-22)~~( )

04. Counting Three Full Months. A full month is a month the participant is in the institution every day of the month. If the participant enters after the first day of a month, the month of entry is not included in the three (3) full months. If the participant is discharged before the last day of the month, the month of discharge is not included in the three (3) full months. ( )

05. SSI Benefits. If SSA decides a participant's SSI benefit will continue while the participant is in the institution, AABD payments can also continue. ( )

110. -- 12~~8~~9. (RESERVED)

~~**129. PARTICIPANT'S GUARDIAN FOR AABD CASH.**~~
~~A court appointed guardian can manage AABD cash for a participant who is not competent to do so. The Department may petition the District Court to appoint a guardian if one is needed. (3-17-22)~~

130. ESTATE NOT IN PROBATE.
An administrator for public aid for a deceased participant's AABD cash can be court-~~-~~appointed. The administrator must spend AABD cash, accessible through EBT before the participant's death, for the estate. The AABD cash can only be spent to meet the needs of the participant, or ~~his~~ their dependents, for the month it was paid. If a participant had no debts for th~~i~~emself, or ~~his~~ their dependents, the administrator must return the AABD cash to the Department. AABD benefits paid by direct deposit or posted to the participant's EBT account, after the participant's death, are the property of the ~~s~~State of Idaho. ~~(3-17-22)~~( )

131. ESTATE IN PROBATE.
AABD cash received by a participant before ~~his~~ their death is disbursed as part of the participant's estate~~,~~ if it is probated. The probate administrator spends the AABD cash under ~~his~~ their oath of administration. ~~(3-17-22)~~( )

132. -- 154. (RESERVED)

155. AABD FOR THE AGED.
To qualify for AABD for the aged, a person must be age sixty-five (65) or older. ( )

156. AABD FOR THE BLIND OR DISABLED.
To qualify for AABD for the blind or disabled, a person must meet the definition of blindness or disability used by the SSA for RSDI and SSI benefits. ~~(3-17-22)~~( )

01. SSA Decision for Disabled. SSA's disability decision is binding on the Department unless: ( )

a. The participant states ~~his~~ their disabling condition is different from, or in addition to, ~~his~~ their condition considered by SSA, and the participant has not reapplied for SSI; or ~~(3-17-22)~~( )

b. More than twelve (12) months have passed since the SSA made a final determination the

participant was not disabled, and the participant states his their condition has changed or become worse since that final determination, and the participant has not reapplied for SSI. (3-17-22)( )

02. Medicaid Pending SSA Appeal. When SSA decides a participant is no longer disabled, they meets the AABD disability requirement and can continue receiving Medicaid if they appeals SSA's decision. Medicaid ends if the SSA decision is upheld. (3-17-22)( )

03. Grandfathered Participant for Aid to the Permanently and Totally Disabled (APTD) or Aid to the Blind (AB). A participant is disabled if they was were eligible as disabled in December 1973, and continues to meet the disability requirement in effect in December 1, 1973. HeThey must also meet the other current eligibility requirements. (3-17-22)( )

157. -- 165. (RESERVED)

166. FUGITIVE FELON OR PROBATION OR PAROLE VIOLATOR.

A participant is ineligible to receive AABD for any month during which they is are fleeing to avoid prosecution for a felony, fleeing to avoid custody or confinement after a felony conviction, or violating a federal or state condition of probation or parole. (3-17-22)( )

167. FRAUDULENT MISREPRESENTATION OF RESIDENCY.

A participant is ineligible for AABD for ten (10) years if they was were convicted in a federal or state court of having fraudulently misrepresented residence to get AABD, SSI, TAFI, Food Stamps, or Medicaid from two (2) or more states at the same time. (3-17-22)( )

168. -- 199. (RESERVED)

200. RESOURCES DEFINED.

Resources are cash, personal property, real property, and notes receivable. A participant, or spouse, must have the right, authority, or power to convert the resource to cash. The participant must have the legal right to use the resource for support and maintenance. Liquid resources are resources in cash or resources convertible to cash within twenty (20) workdays. Nonliquid resources are any resources, not in the form of cash, which cannot be converted to cash within twenty (20) workdays. (3-17-22)( )

201. RESOURCE LIMIT.

The value of countable resources must be two thousand dollars ($2,000) or less, for a single person to be AABD eligible. A married person must have countable resources of three thousand dollars ($3,000) or less to be eligible for AABD cash. Resources are counted the first moment of each calendar month and apply to the entire month. ( )

202. CHANGE IN VALUE OF RESOURCES.

A change in the value of resources is counted the first moment of the next month. ( )

203. RESOURCES AND CHANGE IN MARITAL STATUS.

A change in marital status changes the resource limit. The resource limit change is effective the month after individual participants are married, divorced, separated, or one (1) spouse dies. ( )

204. FACTORS MAKING PROPERTY A RESOURCE.

Property of any kind is a resource if the participant has an ownership interest in the property and the legal right to spend or convert the property to cash. ( )

205. COUNTING RESOURCES AND INCOME.

An asset cannot be counted as income and resources in the same month. Assets received in cash or in-kind during a month are income. Income held past the month received is a resource. ( )

206. – TYPES OF RESOURCES.

Liquid resources are resources in cash or resources convertible to cash within twenty (20) working days. Nonliquid resources are any resources, not in the form of cash, which cannot be converted to cash within twenty (20) workdays.

~~(3-17-22)~~

207. ~~EQUITY VALUE OF RESOURCES.~~(RESERVED)
~~Equity value is the fair market value of a resource, minus any debts on it.~~ ~~(3-17-22)~~

208. SHARED OWNERSHIP RULE.
Except for checking and savings accounts and time deposits, each owner of shared property owns only ~~his~~ their fractional interest in the property. The total value of the property is divided among the owners, in direct proportion to each owner's share. ~~(3-17-22)~~( )

209. CONVERSION OR SALE OF A RESOURCE NOT INCOME.
Payment from the sale, exchange, or replacement of a resource is not income. The payment is a resource. ( )

210. RESOURCES EXCLUDED BY FEDERAL LAW.
A resource excluded by federal law is not counted in determining the resource amount available to the participant. ( )

211. -- 214. (RESERVED)

215. DEEMING RESOURCES.
~~Resources are deemed from a spouse to a participant, from a parent or spouse of a parent to a child participant, from an essential person to a participant, or from a sponsor to a legal non-citizen participant.~~ Resource deeming is determined by the SSA Program Operations Manual System (POMS) SI 01330.00, Deeming Resources, incorporated by reference under Section 002 of these rules. ~~t~~The participant's circumstances are assessed the first moment of the month. Deeming starts the first full calendar month the participant is in a deeming situation. Deeming ends the first full calendar month the participant is not in a deeming situation. Deeming to a child ends the month after the child's eighteenth birthday. ~~(3-17-22)~~( )

~~**01. Spouse of Adult Participant**. When a participant lives with a spouse, his resources include those of the spouse. The resource limit is for a couple, when the spouse was a member of the household as of the first moment of the benefit month. The AABD resource exclusions are subtracted. Pension funds the ineligible spouse has on deposit are excluded. (3-17-22)~~

~~**02. Resources of Parent(s) of Child Under Age Eighteen**. When a child participant, under age eighteen (18), is living with his parent or the spouse of his parent, their resources are deemed to the child. When there is more than one (1) child participant in the household, deemed parental resources are divided equally among the child AABD cash participants. When the child lives with one (1) parent, resources over the single person resource limit are deemed to the child. When the child lives with both parents, resources over the couple limit are deemed to the child. A stepparent's resources are not deemed to the child for Medicaid eligibility. A stepparent's resources are deemed to the child for AABD cash. Resources and exclusions of the child participant, and the parents, are computed separately. Pension funds owned by an ineligible parent or parent's spouse are excluded from resources for deeming. (3-17-22)~~

~~**03. Resources of Essential Person of Participant**. When a participant lives with an essential person, the resources of the essential person are deemed to the participant. The essential person's countable resources are combined with the participant's countable resources. When the essential person is not the participant's spouse, the single person resource limit is used. When the essential person is the participant's ineligible spouse, the couple resource limit is used. (3-17-22)~~

~~**04. Resources of Legal Non-Citizen's Sponsor -- No INS Form I-864 Signed**. A legal non-citizen's resources include those of his sponsor and of the sponsor's spouse. When the sponsor has not signed an I-864 affidavit of support, the resources deeming period is three (3) years after the legal non-citizen's admission to the U.S. A sponsor's resources are not deemed to the legal non-citizen for Medicaid eligibility. (3-17-22)~~

~~**a.** If the sponsor does not have a spouse living with him, the sponsor's countable resources over the single person resource limit are deemed to the legal non-citizen participant. (3-17-22)~~

~~**b.** If the sponsor's spouse lives with him, the sponsor couple's resources over the couple resource limit are deemed to the legal non-citizen participant. (3-17-22)~~

~~**c.** If a person sponsors two (2) or more legal non-citizen participants, the sponsor's deemed resources are divided and deemed equally to the legal non-citizen participants. (3-17-22)~~

~~**05. Resources of Legal Non-Citizen's Sponsor -- INS Form I-864 Signed**. For a legal non-citizen admitted to the U.S. on or after August 22, 1996, whose sponsor has signed an INS Form I-864 affidavit of support, all resources of the sponsor and sponsor's spouse are deemed to the legal non-citizen for AABD cash and Medicaid eligibility. Exceptions are listed in Subsections 215.05.a. and 215.05.b. of these rules. (3-17-22)~~

~~**a.** The legal non-citizen, or the legal non-citizen child's parent, was battered or subjected to extreme cruelty in the U.S. There is a substantial connection between the battery and the participant's need for assistance. The person subjected to the battery or cruelty no longer lives with the person responsible for the battery or cruelty. (3-17-22)~~

~~**b.** Alien sponsor deeming is suspended for twelve (12) months, if the legal non-citizen is not able to get food and shelter without AABD cash. (3-17-22)~~

216. HOUSEHOLD FOR RESOURCE COMPUTATIONS.
A participant living in an institution is not a household for resource computations. ( )

217. UNKNOWN RESOURCES.
An asset is not a resource if the participant is unaware of ~~his~~ their ownership. The asset is a resource the month after discovery. ~~(3-17-22)~~( )

218. -- 221. (RESERVED)

222. VEHICLES AS A RESOURCE.
~~Vehicles are excluded as resources as described in Subsection 222.01 of these rules.~~ If more than one (1) vehicle is owned, the exclusion applies in the best way for the participant. ~~(3-17-22)~~( )

01. One Vehicle Excluded. One (1) vehicle is excluded, regardless of value. ( )

02. Other Vehicles Not Excluded. The equity value of a vehicle not excluded under Subsection 222.01 of ~~these~~ this rule~~s~~ is a resource. ~~(3-17-22)~~( )

223. BURIAL FUNDS EXCLUDED FROM RESOURCE LIMIT.
Burial funds up to one thousand five hundred dollars ($1,500) per person, set aside for the burial expenses of the participant or spouse, are excluded from resources. To be excluded, burial funds must be kept separate from assets not burial-related. A burial contract that can be revoked or sold, without significant hardship, is a resource. Any portion of the contract for the purchase of burial spaces is excluded from resources. A burial contract that cannot be revoked, and cannot be sold without significant hardship, is not a resource. The burial fund portion of the contract counts against the one thousand five hundred dollar ($1,500) burial funds exclusion. The burial space portion of the contract does not count against the burial funds exclusion. Interest earned on excluded burial funds is also excluded. ( )

01. Life Insurance Policy as Burial Funds. The participant can designate a countable life insurance policy as a burial fund. The face value of excluded life insurance policies on the participant counts against the burial funds exclusion. ( )

02. Face Value of Burial Insurance Policies Not Counted. The face value of burial insurance policies does not count toward the one thousand five hundred dollar ($1,500) life insurance limit, when computing the total face value of life insurance policies owned by a participant. Interest on excluded burial funds does not count toward the one thousand five hundred dollar ($1,500) burial funds exclusion. ( )

03. Effective Date of Burial Funds Exclusion. The exclusion is effective the month after the month

the funds were set aside. Burial funds can be designated retroactively, back to the first day of the month the participant intended the funds to be set aside. The participant must confirm the designation in writing. ( )

04. Penalty for Misusing Burial Funds. If the participant does not get SSI, burial funds used for another purpose lose the exclusion. An overpayment must be recovered. If the participant gets SSI, and is penalized by SSA because they used excluded burial funds for another purpose, ~~his~~ their AABD payment must not be increased to compensate the SSA penalty. ~~(3-17-22)~~( )

224. BURIAL SPACE OR PLOT EXCLUSION.
A burial space is a burial plot, grave site, crypt, mausoleum, casket, urn, niche, or other repository normally used for the deceased's remains. A burial space, or burial space purchase agreement, held for the burial of the participant, spouse, or other member of ~~his~~ their immediate family, is an excluded resource. ~~(3-17-22)~~( )

01. Burial Space Contract. ~~The burial space contract m~~Must list all burial spaces and include a value for each space or the total value of all the spaces. The contract must not require further payment after the contract is signed. ~~(3-17-22)~~( )

02. Space Held by Ineligibles Excluded. A space held by an ineligible spouse or parent, for the burial of a participant, spouse, and any member of the participant's immediate family, is excluded. A space held by a legal non-citizen sponsor, or essential person, for ~~his~~ their own burial is excluded only if the sponsor is a member of the participant's immediate family. ~~(3-17-22)~~( )

225. -- 234. (RESERVED)

235. EXCLUDED HOUSEHOLD GOODS AND PERSONAL EFFECTS.
Household goods and personal effects are excluded from resources, regardless of their dollar value. ( )

236. (RESERVED)

237. REAL PROPERTY DEFINITION.
Real property is land, including buildings or immovable objects attached permanently to the land. Real property is a resource unless excluded. ( )

238. HOME AS RESOURCE.
An individual's home is property they own~~s~~, and serves as ~~his~~ their principal place of residence. ~~His~~ Their principal place of residence is the place they consider~~s~~ ~~his~~ their principal home. If the individual is absent from ~~his~~ their home, it is still ~~his~~ their principal place of residence if they intend~~s~~ to return. ~~(3-17-22)~~( )

01. AABD Cash, and Medicaid With the Exception of Long-Term Care. For AABD Cash and Medicaid ~~with the exception of~~ except for long-term care, the value of an individual's home is an excluded resource. ~~(3-17-22)~~( )

02. Long-Term Care Services. For long-term care services, when the value of a participant's equity in the home is seven hundred fifty thousand dollars ($750,000) or less, the home is excluded as a resource. When the equity value exceeds seven hundred fifty thousand dollars ($750,000), the individual is ineligible for long-term care services. The equity value, regardless of the amount, is an excluded resource when one (1) of the following applies: ( )

a. The spouse of the individual lives in the home; or ( )

b. The individual's child, who is under age twenty-one (21), or is blind, or meets the disability requirements for AABD cash, lives in the home. ( )

239. SALE OF EXCLUDED HOME AND REPLACEMENT.
If the participant plans to buy another excluded home, proceeds from the sale of a participant's excluded home are excluded resources. Proceeds from the sale of an excluded home must be used to replace the home within three (3) calendar months. Proceeds retained beyond three (3) calendar months are a countable resource. ( )

240. REPLACEMENT OF EXCLUDED RESOURCES.
Cash and in-kind payments for replacement or repair of lost, damaged, or stolen excluded resources, are excluded resources for nine (9) months from the date received. This exclusion can be extended for cash payments, up to an additional nine (9) months. The extension can be made if, for the first nine (9) months, circumstances beyond the participant's control prevent repair or replacement of the lost, damaged, or stolen property and keep the participant from contracting for repair or replacement. This exclusion can be extended for twelve (12) more months for a catastrophe the President declares a major disaster. Interest earned by funds excluded under this provision is excluded from resources. ( )

241. UNDUE HARDSHIP EXCLUSION FROM SALE OF JOINTLY OWNED REAL PROPERTY.
A participant's ownership interest, in jointly owned real property, is an excluded resource as long as sale of the property will cause undue hardship to a co-owner. Undue hardship results if a coowner uses the property as~~ his~~ their principal place of residence, would have to move if the property were sold, and has no other readily available housing. ~~(3-17-22)~~( )

242. AMERICAN INDIAN PROPERTY EXCLUDED.
For the purposes of determining eligibility for an individual who is an American Indian, the following property is excluded: ~~(3-17-22)~~( )

01. Property. Real property and improvements located on a reservation, including any federally recognized Indian Tribe's reservation, pueblo, or colony, and Indian allotments on or near a reservation as designated and approved by the Bureau of Indian Affairs. ( )

02. Natural Resources. Ownership interest in rents, leases, royalties, or usage rights related to natural resources resulting from the exercise of federally protected rights. ( )

03. Other Ownership Interests or Usage Rights. Ownership interests in or usage rights to property not covered by Subsections 242.01 or 242.02 of this rule that have a unique religious, spiritual, traditional, or cultural significance or rights that support subsistence or traditional lifestyle~~ according to~~ under applicable tribal law or custom. ~~(3-17-22)~~( )

243. RESOURCES ASSOCIATED WITH PROPERTY.
Resources associated with real property are mineral rights, timber rights, easements, leaseholds, water rights, remainder interests, and sale of natural resources. These resources are counted as real property. ( )

244. RESOURCES ESSENTIAL FOR SELF-SUPPORT EXCLUDED.
Resources are excluded as essential to self-support, if they fall into one (1) of the categories described~~ in Subsections 244.01 through 244.03~~ below. ~~(3-17-22)~~( )

01. Essential Property in Current Use. Property in current use in the type of activity that qualifies it as essential to self-support is excluded, regardless of value or rate of return. Trade or business property, government permits, and personal property used by an employee for work are excluded regardless of value or rate of return. If the property is not in current use, for reasons beyond the participant's control, there must be a reasonable expectation the required use will resume. If the participant does not intend to resume the self-support activity, the property is a countable resource for the month after the month of last use. ( )

02. Nonbusiness Property Producing Goods or Services. Up to six thousand dollars ($6,000) of the equity value of nonbusiness property, used to produce goods or services essential to daily activities, is excluded regardless of rate of return. Equity value over six thousand dollars ($6,000) is not excluded. This exclusion is not used for income-producing property. ( )

03. Nonbusiness Income~~-~~-Producing Property. Up to six thousand dollars ($6,000) equity in nonbusiness income~~ ~~-producing property is excluded if ~~it produces at least a six percent (6%) rate of return. T~~the property~~ must~~ produces a net annual return equal to at least six percent (6%) of the excluded equity. If a participant owns more than one (1) piece of income~~ ~~-producing property, the six percent (6%) return requirement applies to each. The six thousand dollars ($6,000) equity value limit applies to the total equity value of all the properties meeting the

six percent (6%) return requirement. If the earnings decline is for reasons beyond the participant's control, up to twenty-four (24) months can be allowed for the property to resume producing a six percent (6%) return. If the property still is not producing a six percent (6%) return at the end of the twenty-four (24) month extension, the resource exclusion must end the month after the month the twenty-four (24) month period ends. (3-17-22)( )

245. RESOURCES SET ASIDE AS PART OF A PLAN FOR ACHIEVING SELF-SUPPORT (PASS) EXCLUDED.

PASS allows blind and disabled participants to set aside income and resources necessary for the achievement of its goals. Resources set aside as part of an approved PASS are excluded. The PASS disregard must not be applied to resources unless the participant would be ineligible due to excess resources. To disregard resources, the PASS must show how resources the participant has or will receive under the plan, will be used to obtain the PASS goal. The PASS must show how the disregarded resources will be identified separately from the participant's other resources., The PASS must list items or activities requiring savings or purchases and the amounts the participant anticipates saving or spending., The PASS must and show a specific target date to achieve the objective. (3-17-22)( )

246. LIMITED AWARD TO CHILD WITH LIFE-THREATENING CONDITION.

Any gift from a tax exempt nonprofit organization to a child under age eighteen (18), who has a life threatening condition, is excluded from resources under the conditions in Subsections 246.01 through 246.02. (3-17-22)

01. In-Kind. An in-kind gift is excluded if the gift is not converted to cash. (3-17-22)

02. Cash. Cash gifts are excluded up to two thousand dollars ($2,000) for the calendar year the cash gifts are made. (3-17-22)

2476. LIFE ESTATE INTEREST IN ANOTHER'S HOME.

The purchase of a life estate interest in another individual's home is a resource unless the purchaser resides in the home for a period of at least twelve (12) consecutive months after the date of purchase. ( )

2487. -- 2545. (RESERVED)

2556. RETROACTIVE SSI AND RSDI BENEFITS.

Retroactive SSI and RSDI benefits are issued after the calendar month for which they are paid. Retroactive SSI and RSDI benefits are excluded from resources for nine (9) calendar months after the month they are received. Interest earned by excluded funds is counted as income. ( )

256. (RESERVED)

257. DISASTER ASSISTANCE.

Assistance received because of a major disaster declared by the President is excluded from resources. Interest earned on excluded funds is excluded from income and resources. ( )

258. CASH TO PURCHASE MEDICAL OR SOCIAL SERVICES.

Cash paid by a recognized medical or social services program, for the participant to purchase medical or social services, is not a resource for one (1) calendar month after receipt. The cash must not be repayment for a bill already paid. ( )

259. (RESERVED)

260. ALASKA NATIVE CLAIMS SETTLEMENT ACT.

Payments to Alaska Natives and their descendants from the Alaska Native Claims Settlement Act, under public Law PL 100-241, are excluded from resources. (3-17-22)( )

261. STOCK IN ALASKA REGIONAL OR VILLAGE CORPORATIONS.

Stock held by Alaska natives in regional or village corporations is inalienable for a twenty (20) year period under Sections 7(h) and 8(c) of the Alaska Native Claims Settlement Act. ( )

262. VICTIMS' COMPENSATION PAYMENTS.

Payments, from a fund set up by a State to aid victims of crime, are excluded from resources for nine (9) months. Interest earned on unspent victims' compensation payments is counted for income and resources. ( )

263. -- 264. (RESERVED)

265. TAX ADVANCES AND REFUNDS RELATED TO EARNED INCOME TAX CREDITS.
A federal tax refund or payment made by an employer, related to Earned Income Tax Credits (EITC), is excluded from resources for the month after the month the refund or payment is received. Interest earned on unspent tax refunds related to EITC is counted for income and resources. ( )

266. IDENTIFYING EXCLUDED FUNDS COMMINGLED WITH FUNDS NOT EXCLUDED.
Excluded funds must be separately identifiable to remain excluded. ( )

267. DEDICATED ACCOUNT FOR SSI PARTICIPANT.
A dedicated account for past-due SSI benefits, set up in a financial institution for an SSI participant under age eighteen (18) is an excluded resource. The account must be set up by the child's SSI representative payee, and excluded by SSA. ( )

268. SUPPORT AND MAINTENANCE ASSISTANCE~~ (HOME ENERGY ASSISTANCE)~~.
~~Support and Maintenance Assistance (SMA) is in-kind support and maintenance, or cash paid for food or shelter needs. It includes Home Energy Assistance. SMA Home Energy Assistance is aid to meet the costs of heating or cooling a home. SMA and Home Energy Assistance are excluded resources.~~Support and Maintenance Assistance (SMA) is in-kind support and maintenance, or cash paid for food or shelter needs. It includes Home Maintenance Assistance aid to cover costs of heating or cooling a home. SMA is an excluded resource. ~~(3-17-22)~~( )

269. -- 27~~0~~1. (RESERVED)

~~**271. VA MONETARY ALLOWANCES TO A CHILD BORN WITH SPINA BIFIDA.**~~
~~VA monetary allowances to a child born with spina bifida, who is the child of a Vietnam veteran, are excluded resources. (3-17-22)~~

272. WALKER V. BAYER PAYMENTS.
Class action settlement payments in Susan Walker v. Bayer Corporation, et al.,, are excluded from resources for Medicaid by P~~ublic ~~L~~aw~~ 105-33. These payments are not excluded for AABD cash. ~~(3-17-22)~~( )

273. -- 275. (RESERVED)

276. EXCLUDED REAL ESTATE CONTRACT.
The principal balance of a real estate contract is excluded from resources of a participant in long-term care when the Department determines it is in the Department's best interest to exclude the contract. The determination by the Department of its best interest is final. ( )

277. FEES PAID TO A CONTINUING CARE RETIREMENT COMMUNITY (CCRC) OR LIFE CARE COMMUNITY.
An entrance fee to a CCRC or a life care community is a resource if the participant or applicant for long-term care has discretion to spend the fee or if the fee may be used to pay for care in a contingency. A CCRC or life care community is a type of long-term care facility that offers varying levels of care and in which a resident contracts with the facility to obtain care that is intended to endure for the remainder of the resident's life in exchange for valuable consideration. ( )

278. TRUSTS.
A trust is a resource to a participant with the legal right to revoke the trust, and use the principal for~~ his~~ their own support and maintenance. See Sections 838 through 873 in these rules for treatment of trusts for Medicaid. ~~(3-17-22)~~( )

279. RETIREMENT FUNDS.
Retirement funds are work-related plans for providing income or pensions when employment ends. A retirement

fund, owned by a participant, is a resource if they ha~~s~~ve the option of withdrawing a lump sum, even though they ~~is~~ are not yet eligible for periodic retirement payments. If the participant is eligible for periodic retirement payments, the fund is not a countable resource. The value of a retirement fund is the amount of money a participant can currently withdraw from the fund. ~~(3-17-22)~~(   )

280. INHERITANCE.
An inheritance is cash, a right, including probate allowances, trust payments and annuities, or noncash items received as the result of someone's death. Cash or noncash items in an inheritance are income the month received and a resource the next month. Participants are required to make claims and take all reasonable action necessary to obtain any inheritance to which they may be entitled. Failure to make such claims or take reasonable steps to obtain an inheritance is an asset transfer. A contested inheritance is not counted as a resource until the contest is settled and money is distributed. (   )

281. LIFE INSURANCE.
A life insurance policy is an excluded resource if its face value, plus the face value of all other life insurance policies the participant owns on the same insured person, totals one thousand five hundred dollars ($1,500) or less. If the face values exceed one thousand five hundred dollars ($1,500) the policies are a resource in the amount of the cash surrender value. (   )

282. CONSERVATORSHIP.
Funds required to be made available for the care and maintenance of a participant, under a court order, are the participant's resource. This is true even if the participant or ~~his~~ their agent is required to petition the court to withdraw funds for the participant's care. ~~(3-17-22)~~(   )

283. CONDITIONAL BENEFITS.
A participant ineligible due solely to excess nonliquid resources, can receive AABD cash and related Medicaid. The participant must meet two (2) conditions. First, ~~his~~ their countable liquid resources must not exceed three (3) times the participant's AABD cash budgeted needs. Second, the participant agrees, in writing, to sell excess nonliquid resources at their fair market value, within three (3) months. The value of excess real property is not counted as a resource~~, as long as~~ if the participant makes reasonable efforts to sell the property at its fair market value, and ~~his~~ their reasonable efforts to sell are not successful. This exclusion is also used to compute deemed resources.
~~(3-17-22)~~(   )

01. Conditional Benefits Payments Disposal/Exclusion Period. The disposal ~~period~~ and exclusion period for excess nonliquid resources begins on the date the participant signs the Agreement to Sell Property. The disposal and exclusion periods can begin earlier for a participant who met all requirements to receive conditional benefits before ~~his~~ their first opportunity to sign the Agreement to Sell Property. The participant must sign the Agreement to Sell Property before ~~his~~ their application is approved. ~~(3-17-22)~~(   )

02. ~~Time~~ Period for Disposal of Excess Resources. The disposal period for excess nonliquid personal property is three (3) months. One (1) three (3) month extension, for sale of personal property, is allowed when good cause exists. ~~(3-17-22)~~(   )

03. Good Cause for Not Making Efforts to Sell Excess Property. The participant has good cause ~~exists~~ for not making efforts to sell property, when circumstances beyond ~~his~~ their control prevent ~~his~~ their taking the required actions. Without good cause, the participant's countable resources include the value of the excess property, retroactive to the beginning of the conditional benefits period. ~~(3-17-22)~~(   )

284. RESOURCE TRANSFER FOR LESS THAN FAIR MARKET VALUE.
~~Starting November 1, 2000,~~ AABD cash participants are subject to a period of ineligibility if they transfer resources for less than fair market value. The participant is not subject to a period of ineligibility if ~~his~~ their total countable resources in the transfer month were under two thousand dollars ($2,000), even if they ha~~d~~ve kept the transferred resources. Excluded resources, except for the excluded home and associated property, are not subject to the resource transfer period of ineligibility. The exceptions to the period of ineligibility for transfer of resources are listed in Section 292 of these rules. ~~(3-17-22)~~(   )

01. Transfer of Resources. ~~Transfer of resources i~~Includes reducing or eliminating the participant's

ownership or control of the resource. Transfer of resources includes giving away cash resources without receiving fair market value. ~~(3-17-22)~~(____)

02. Transfer of Participant's Resources by a Spouse of Either Spouse's Resources. ~~A transfer by the participant's spouse of either spouse's resources s~~Subjects the participant to the resource transfer period of ineligibility. ~~(3-17-22)~~(____)

03. Transfer of Participant's Resources by a Co-Owner. ~~Transfer of the participant's resources by a co-owner s~~Subjects the participant to a period of ineligibility based on ~~his~~ their share of the co-owed resources. ~~(3-17-22)~~(____)

04. Transfer of Participant's Resources by a Legal Representative Such as a Legal Guardian or Parent of Minor Child. ~~Transfer of the participant's resources by a legal representative such as a legal guardian or parent of a minor child s~~Subjects the participant to a period of ineligibility. ~~(3-17-22)~~(____)

285. AABD PERIOD OF INELIGIBILITY FOR RESOURCE TRANSFERS.

The resource transfer period of ineligibility is a period of AABD ineligibility for up to sixty (60) months. The period of ineligibility begins the first day of the month after the transfer month. The participant must be notified in writing at least ten (10) days before a resource transfer period of ineligibility is imposed. ( )

286. RESOURCE TRANSFER LOOK-BACK PERIOD.

The resource transfer penalty applies to any transfer for less than fair market value made during a period preceding a request for cash assistance. ~~The look-back period is determined as follows:~~ ~~(3-17-22)~~

~~**01. Transfers Prior to February 8, 2006**. For any resource transferred prior to February 8, 2006, the look-back period is thirty-six (36) months. The look-back period is counted from the month prior to the month the application was submitted.~~ ~~(3-17-22)~~

~~**02. Transfers On or After February 8, 2006**.~~ Any resource transferred ~~on or after February 8, 2006~~, regardless of type, is subject to a look-back period of sixty (60) months. The look-back period is counted from the date of the application for cash, or the date of the transfer, whichever is later in time. ~~(3-17-22)~~(____)

287. CALCULATING THE PERIOD OF INELIGIBILITY FOR RESOURCE TRANSFERS.

The period of ineligibility is the number of months computed by dividing the difference between the fair market value of the resource and the amount the participant received for the resource by the full AABD allowances for the participant's living arrangement. For an applicant, the Department will use the full AABD allowance for the application month. For a participant, the Department will use the full AABD allowances for the transfer month. For an AABD couple, the period of ineligibility is computed by dividing the difference between the fair market value of the resource and the amount the participant received for the resource by the full AABD allowances for the couple's living arrangement. The number of months of ineligibility is computed to two (2) decimal places and rounded down to the nearest whole number. If the amount transferred is less than the participant's AABD allowances for one (1) month, the participant is not subject to a period of ineligibility. ~~(3-17-22)~~(____)

288. LENGTH OF PERIOD OF INELIGIBILITY.

The period of ineligibility begins with the month after the month the transfer took place. The period of ineligibility continues whether or not the participant receives AABD. Ineligibility continues until all the resources are returned to the participant or spouse, adequate consideration for all the resources is received, sixty (60) months passes, or the penalty period ends. ( )

289. SPOUSE APPLIES AFTER PERIOD OF INELIGIBILITY IS COMPUTED.

If the spouse applies after the period of ineligibility is computed, the Department will compute the spouse's period of ineligibility by multiplying the number of months in the period of ineligibility already expired by the full AABD allowances for the couple's living arrangement. The Department will ~~S~~subtract the total from the original difference between the fair market value of the resource and the amount the participant received for the resource. The Department will ~~D~~divide the remaining difference between the fair market value of the resource and the amount the participant received for the resource by the full AABD allowances for the couple's living arrangement for the first month of ineligibility. ~~(3-17-22)~~(____)

290. MULTIPLE RESOURCE TRANSFERS.
If the participant makes more than one (1) resource transfer, the difference between the fair market value of all the transferred resources and the amount the participant received for all the transferred resources is used to determine the length of the period of ineligibility. The period of ineligibility begins with the month after the month of the first transfer. ( )

291. TRANSFERS TO TRUSTS.
A trust established from the participant's resources is a resource transfer for less than fair market value, unless it meets an exception in Section 292 of these rules. If the trust includes resources of another person, the resource transfer period of ineligibility applies to the participant's share of the trust. ( )

01. Payment from Trust Not for Participant. If a payment is made to another individual from a trust counted as a resource, and the payment is not for the benefit of the participant, the payment is a resource transfer for less than fair market value. ( )

02. Payment from Trust Restricted. If the participant~~ takes action~~ acts so no payment from a trust counted as a resource can be made for any reason, the trust is a resource transfer for less than fair market value. By taking the action, the participant causes the trust to be no longer counted as a resource and the participant is subject to the period of ineligibility. The date of the action restricting payment is the date of the transfer. ~~(3-17-22)~~( )

292. PERIOD OF INELIGIBILITY EXCEPTIONS.
A participant or spouse is not subject to the resource transfer period of ineligibility if one (1) of the following conditions is satisfied. ( )

01. Home to Spouse. Title to the home is transferred solely to the spouse. ( )

02. Home to Minor Child or Disabled Adult Child. Title to the home is transferred to the child of the participant or spouse. The child must be under age twenty-one (21), blind or totally disabled under Social Security and SSI rules in 20 CFR Part 416. ( )

03. Home to~~ Brother or Sister~~ Sibling. Title to the home is transferred to a~~ brother or sister~~ sibling of the participant or spouse who must have had an equity interest or life estate in the transferred home and was residing in that home for at least one (1) year immediately before the month the home was transferred. ~~(3-17-22)~~( )

04. Home to Adult Child. Title to the home was transferred to a~~ son or daughter~~ child of the participant or spouse, other than a child under the age of twenty-one (21). The~~ son or daughter~~ child must have resided in that home for at least two (2) years immediately before the month the participant entered a medical facility or long-term care. The~~ son or daughter~~ child must have provided care to the participant, which permitted th~~i~~em to live at home rather than enter a medical facility or long-term care. ~~(3-17-22)~~( )

05. Benefit of Spouse. Resources, other than the home, were transferred to the participant's spouse or to another person for the sole benefit of the spouse. ( )

06. Transfer from Spouse. The resources were transferred from the participant's spouse to another person for the sole benefit of the participant's spouse. ( )

07. Transfer to Child. The resources were transferred to the participant's child or to a trust established solely for the benefit of the participant's child. The child must be blind or totally disabled under Social Security and SSI rules in 20 CFR Part 416. The child may be any age. ( )

08. Transfer to Trust for Person Under Sixty-Five. The resources were transferred to a trust for the sole benefit of a person under age sixty-five (65)~~,~~ who is blind or totally disabled under Social Security and SSI rules in 20 CFR Part 416.~~ The person must be blind or totally disabled under Social Security and SSI rules in 20 CFR Part 416.~~ ~~(3-17-22)~~( )

09. Transfer to a Trust That Is a Countable Resource. The resources were transferred to a trust and

the trust is a countable resource for AABD in the amount of the transfer. ( )

10. Intent to Receive Fair Market Value. The participant or spouse proves they intended to dispose of the resources at fair market value or for other adequate consideration, but can prove good cause for not doing so. (3-17-22)( )

11. Resources Returned. All resources transferred for less than fair market value have been returned to the participant. ( )

12. No AABD Purpose. The participant or spouse proves the resources were transferred exclusively for a purpose other than qualifying for AABD. Purposes other than qualifying for AABD include: ( )

a. After the resource transfer the participant has a traumatic onset of disability. ( )

b. After the resource transfer a previously unknown disabling condition is diagnosed. ( )

c. After the resource transfer the participant has an unexpected loss of income or resources resulting in eligibility for AABD. ( )

d. The resource was excludable in the transfer month. ( )

e. The transfer of resources was court-ordered, provided the participant did not petition the court to order the transfer. ( )

f. The participant took a vow of poverty and gave the resources to a religious order. ( )

13. Undue Hardship. The participant proves failure to receive AABD would deprive thiem of food or shelter and his their total available funds, including income and liquid resources, are less than his their AABD allowances for the month they claims undue hardship. Undue hardship must be proven for each month of the period of ineligibility. When determining total available funds for a child, the Department will count any income and resources deemed from his their parents. (3-17-22)( )

14. Exception to Fair Market Value. The amount received is reasonable, even if less than fair market value if a forced sale was done under reasonable circumstances, and little or no market demand exists for the type of resource transferred, or the resource was transferred to settle a legal debt approximately equal to the fair market value of the transferred resource. ( )

15. No Benefit to Participant. The participant received no benefit from the resource because they or their spouse held title to the property only as a trustee for another person, or the transfer was done to clear title to property and the participant or spouse had no interest in the property that would benefit thiem. (3-17-22)( )

16. Fraud Victim. The resource was transferred because the participant or spouse was the victim of fraud, misrepresentation, or coercion. The participant or spouse must take all possible steps to recover the resources or property or its equivalent in damages. The participant must assign recovery rights to the State of Idaho. ( )

293. EFFECT ON MEDICAID ELIGIBILITY.

Ineligibility for AABD cash because of property transfer does not make the participant ineligible for Medicaid. ( )

294. -- 299. (RESERVED)

300. INCOME DEFINITION.

Income is anything that can be used to meet needs for food, or shelter. Income is cash, wages, pensions, in-kind payments, inheritances, gifts, awards, rent, dividends, interest, or royalties the participant receives during a month. ( )

01. Cash Income. Cash income iIs currency, checks, money orders, or electronic funds transfers. Cash

income includes Social Security checks, unemployment checks, and payroll checks. ~~(3-17-22)~~( )

02. In-Kind Income. ~~In-kind income i~~Is not cash. In-kind income is food or shelter. Wages paid as in-kind earnings, such as food or shelter, are counted as unearned income. Other in-kind income is not counted. ~~(3-17-22)~~( )

03. Inheritances. ~~An inheritance i~~Is cash, a right, or noncash items received as the result of someone's death. Cash or noncash items in an inheritance are income the month received and a resource the next month. A contested inheritance is not counted as income until the contest is settled and money is distributed. ~~(3-17-22)~~( )

301. APPLICATION FOR POTENTIAL BENEFITS.

The participant must apply for benefits, including RSDI, VA, pensions, Workman's Compensation, or Unemployment Insurance, when there is potential eligibility. The participant must apply when they reach~~es~~ the earliest age to qualify for the benefit. ~~(3-17-22)~~( )

01. SSI. To get AABD cash, the participant must apply for SSI benefits, if they ~~is~~ are potentially eligible. To get AABD-Medicaid, the participant does not have to apply for SSI benefits. ~~(3-17-22)~~( )

02. VAIP. Participants entitled to a VA pension as of December 31, 1978, are not required to file for Veterans Administration Improved Pension Plan (VAIP), to get AABD cash or AABD-related Medicaid. ( )

03. Other Benefits. EITC, TAFI, BIA General Assistance, and victim's compensation benefits are exempt from the filing requirement. ( )

302. RELATIONSHIP OF INCOME TO RESOURCES.

Income is counted as income in the current month. If the participant keeps countable income after the month received, it is counted as a resource. ( )

303. WHEN INCOME IS COUNTED.

Income is counted the earliest of when received, when credited to a participant's account, or when set aside for the participant's use. Income from SSA, SSI, or VA is counted for the month it is intended to cover. ( )

304. PROSPECTIVE ELIGIBILITY.

Eligibility for AABD cash and Medicaid is prospective. Expected income for the month is compared to the participant's income limit that month. ( )

305. PROJECTING MONTHLY INCOME.

Income is projected for each month to determine AABD cash amount. Past income may be used to project future income. Expected changes must be considered. Income received less often than monthly ~~is~~ and patient liability income are not prorated or converted. ~~Patient liability income is not prorated or converted.~~ ~~(3-17-22)~~( )

306. CRITERIA FOR PROJECTING MONTHLY INCOME.

Monthly income is projected as described ~~in this Subsections 306.01 through 306.08~~ below. ~~(3-17-22)~~( )

01. Converting Income to a Monthly Amount. If a full month's income is expected, but is received on other than a monthly basis, the Department will convert the income to a monthly amount using one (1) of the formulas in ~~Subsections 306.01.a. through 306.01.d~~ the table below.

TABLE 306.01 MONTHLY CONVERSION OF INCOME		
	Conversion	Procedure
a.	Weekly to Monthly	Multiply weekly amounts by 4.3.
b.	Biweekly to Monthly	Multiplying bi-weekly amounts by 2.15.
c.	Semimonthly to Monthly	Multiplying semi-monthly amounts by 2.
d.	Exact Amount	Use the exact monthly income if it is expected for each month.

~~(3-17-22)~~(____)

02. Income Already Received. The Department will ~~C~~Count income already received during the month~~.~~ and will ~~C~~convert the actual income to a monthly amount if a full month's income has been received or is expected to be received as described ~~in Subsections 306.02.a. and 306.02.b~~ below. ~~(3-17-22)~~(____)

a. ~~Actual income.~~ If the actual amount of income from any pay period a month is known, the Department will use the actual pay period amounts to determine the total month's income~~.~~ and will ~~C~~convert the actual income to a monthly amount if a full month's income has been received or is expected. ~~(3-17-22)~~(____)

b. ~~Projecting income.~~ If no pay changes are expected, the Department will use the known actual pay period amounts for the past thirty (30) days to project future income~~.~~ and will ~~C~~convert the actual income to a monthly amount if a full month's income has been received or is expected. ~~(3-17-22)~~(____)

03. Expected Income. The Department will ~~C~~count income that the participant and the Department believe the participant will get. The Department will ~~C~~convert expected income to a monthly amount as described ~~in Subsections 306.03.a. through 306.03.d~~ below. ~~(3-17-22)~~(____)

a. ~~Exact income unknown.~~ If the exact income amount is uncertain or unknown, the uncertain or unknown portion must not be counted. The certain or known amount is counted. ~~(3-17-22)~~(____)

b. ~~Income not changed.~~ If the income has not changed and no changes are expected, past income can be used to project future income. ~~(3-17-22)~~(____)

c. ~~Income changes.~~ If income changes, and income received in the past thirty (30) days does not reflect expected income, income received over a longer period is used to project future income. ~~(3-17-22)~~(____)

d. ~~Seasonal income changes.~~ If income changes seasonally, income from the last comparable season is used to project future income. ~~(3-17-22)~~(____)

04. Ongoing Income. ~~Ongoing income c~~Comes from an ongoing source. It was received in the past and is expected to be received in the future. The Department will ~~C~~convert ongoing income to a monthly amount as described ~~in Subsections 306.04.a. through 306.04.d~~ below. ~~(3-17-22)~~(____)

a. ~~Full month's income not expected from ongoing source.~~ If a full month's income is not expected from an ongoing source, the Department will count the amount of income expected for the month. If actual income is known, the Department will use actual income. If actual income is unknown, the Department will project expected income~~.~~ and will ~~C~~convert income to a monthly amount. The Department will ~~U~~use zero (0) income for any pay period in which income was not received that month. ~~(3-17-22)~~(____)

b. ~~Income from new source.~~ If a full month's income from a new source is not expected, the Department will count the actual income expected for the month. ~~Do~~ The Department will not convert the income to a monthly amount. ~~(3-17-22)~~(____)

c. ~~Income stops.~~ If income stops and no additional income is expected from the terminated source, the Department will count the actual income received during the month. ~~Do~~ The Department will not convert the terminated source of income. ~~(3-17-22)~~(____)

d. ~~Full month's income not expected from new or stopped source.~~ If a full month's income is not expected from a new or terminated source, the Department will count the income expected for the month. If the actual income is known, the Department will use the known income. If the actual income is unknown, the Department will project the income~~. Do~~ and will not convert the income to a monthly amount if a full month's income from a new or terminated source is not expected. ~~(3-17-22)~~(____)

05. Income Paid on Salary. Income paid on salary, rather than an hourly wage, is counted at the expected monthly salary rate. (   )

06. Income Paid at Hourly Rate. The Department will ~~C~~compute expected income paid on an hourly basis by multiplying the hourly pay by the expected number of hours the participant will work in the pay period. The Department will ~~C~~convert the pay period amount to a monthly basis. ~~(3-17-22)~~( )

07. Monthly Income Varies. When monthly income varies each pay period and the rate of pay remains the same, the Department will average the income from the past thirty (30) days to determine the average pay period amount~~.~~ and will ~~C~~convert the average pay period amount to a monthly amount. When income changes and income from the past thirty (30) days is not a valid indicator of future income, a longer period of income history is used to project income. ~~(3-17-22)~~( )

08. Income Received Less Often Than Monthly. Recurring income, such as quarterly payments or annual income, is counted in the month received, even if the payment is for multiple months. The income is not prorated or converted. If the amount is known, the Department will use the actual. If the amount is unknown, the Department will use the best information available to project income. ~~(3-17-22)~~( )

307. COUNTING RESOURCES AND INCOME.

An asset cannot be counted as income and resources in the same month. Assets received in cash or in-kind during a month are income. Income held past the month received is a resource. ( )

308. -- 309. (RESERVED)

310. ADOPTION ASSISTANCE UNDER TITLE IV-B OR TITLE XX.

Adoption assistance payments, provided under Title IV-B or Title XX of the Social Security Act, are excluded income. Adoption assistance payments using funds provided under Title IV-E are income. The twenty dollar ($20) standard disregard is not subtracted. ~~(3-17-22)~~( )

311. -- 312. (RESERVED)

313. ASSISTANCE BASED ON NEED (ABON).

ABON is aid paid under a program using income as a factor of eligibility. ABON is funded wholly by a State, or a political subdivision of a State, or an Indian tribe, or a combination of these sources. Federal funds are not used. ABON is excluded income. ~~(3-17-22)~~( )

314. (RESERVED)

315. BUREAU OF INDIAN AFFAIRS (BIA) FOSTER CARE.

BIA foster care payments are social services. They are excluded income for the foster child and foster family. ~~(3-17-22)~~( )

316. BLIND OR DISABLED STUDENT EARNED INCOME.

To qualify for this exclusion, the student must be blind or disabled~~. The student must~~ and be under age twenty-two (22). The student must be regularly attending high school, college, university, or a course of vocational or technical training designed to prepare th~~i~~em for gainful employment. The maximum monthly and annual exclusions cannot exceed the limits set by SSI for the current year. ~~(3-17-22)~~( )

317. "BUY-IN" REIMBURSEMENT.

The SSA reimbursement for self-paid Medicare Part B "Buy-In" premiums is excluded. ( )

318. – 319. ~~COMMODITIES, FOOD STAMPS, AND FOOD PROGRAMS.~~(RESERVED)

~~Food, under the Federal Food Stamp Program, Donated Commodities Program, School Lunch Program, and Child Nutrition Program, is excluded. This includes free or reduced price food for women and children under the National School Lunch Act and the Child Nutrition Act of 1966. (3-17-22)~~

~~**319. CONTRIBUTIONS FOR RESIDENTIAL AND ASSISTED LIVING FACILITY RESIDENTS.**~~

~~Contributions from a third party, for a participant residing in a Residential and Assisted Living Facility, are excluded. The contribution must be paid directly to the facility. The contribution must pay for items or services provided to the participant by the facility. The items or services must not be included in the participant's State Plan Personal Care~~

~~Services or his Personal Care Supplement or must be charges for rent, utilities, or food exceeding the Personal Care Supplement Allowance. The participant must not be charged a higher rate than other residents of the facility. The person making the contribution must provide a signed statement identifying the item or service the payment covers, the reason the item or service is needed by the participant, and the monthly amount of the payment.~~ ~~(3-17-22)~~

320. CONVERSION OR SALE OF A RESOURCE NOT INCOME.
Payment from the sale, exchange, or replacement of a resource is excluded. The payment is a resource that changed form. ( )

321. CREDIT LIFE OR DISABILITY INSURANCE PAYMENTS.
Credit life or credit disability insurance covers payments on loans and mortgages, in case of death or disability. Insurance payments are made directly to loan or mortgage companies and are not available to the participant. These payments are excluded. ( )

322. DEPARTMENT OF EDUCATION SCHOLARSHIPS.
Any grant, scholarship, or loan to an undergraduate for educational purposes, made or insured under any program administered by the Commissioner of Education, is excluded. ( )

323. ~~GIFTS OF DOMESTIC TRAVEL TICKETS.~~(RESERVED)
~~A ticket for domestic travel received as a gift by a participant or spouse is excluded.~~ ~~(3-17-22)~~

324. GRANTS, SCHOLARSHIPS, AND FELLOWSHIPS.
Any grant, scholarship, or fellowship, not administered by the Commissioner of Education, and used for paying tuition, fees, or required educational expenses is excluded. This exclusion does not apply to any portion set aside or ~~actually~~ used for food or shelter. ~~(3-17-22)~~( )

325. DISASTER ASSISTANCE.
Payments received because of a major disaster, declared by the President, are excluded. This includes payments to repair or replace the person's own home or other property and disaster unemployment aid. ( )

326. DOMESTIC VOLUNTEER SERVICE ACT PAYMENTS.
Compensation, other than wages, provided to volunteers in the Foster Grandparents Program, RSVP, and similar National Senior Volunteer Corps programs under Sections 404(g) and 418 of the Domestic Volunteer Service Act is excluded. ( )

327. EARNED INCOME TAX CREDITS.
Earned Income Tax Credits advance payments and refunds are excluded. ( )

328. FEDERAL HOUSING ASSISTANCE.
Federal housing assistance ~~listed in Subsections 328.01 through 328.05~~ is excluded. ~~(3-17-22)~~( )

~~**01. United States Housing Act of 1937**. United States Housing Act of 1937, Section 1437 et seq. of 42 U.S. Code.~~ ~~(3-17-22)~~

~~**02. The National Housing Act**. The National Housing Act, Section 1701 et seq. of 12 U.S. Code.~~ ~~(3-17-22)~~

~~**03. Housing and Urban Development Act of 1965**. Section 101 of the Housing and Urban Development Act of 1965, Section 1701s of 12 U.S. Code, and Section 1451 of 42 U.S. Code.~~ ~~(3-17-22)~~

~~**04. Housing Act of 1949**. Title V of the Housing Act of 1949, Section 1471 et seq. of 42 U.S. Code.~~ ~~(3-17-22)~~

~~**05. Housing Act of 1959**. Section 202(h) of the Housing Act of 1959.~~ ~~(3-17-22)~~

329. FOSTER CARE PAYMENTS.
Foster care payments using funds provided under Title IV-B or Title XX of the Social Security Act are excluded.

Payments for foster care of a non-SSI child placed by a public or private non-profit child placement or child care agency are excluded. Foster care payments using funds provided under Title IV-E are income. The twenty dollar ($20) standard disregard is not subtracted. ( )

330. EXPENSE OF OBTAINING INCOME.
Essential expenses of obtaining unearned income are subtracted from the income. An expense is essential if the participant would not receive the income unless they paid the expense. Expenses of receiving income, such as withheld taxes, are not subtracted. ~~(3-17-22)~~( )

331. GARNISHMENTS.
Garnishments of unearned income are counted as unearned income. Garnishments of earned income are counted as earned income. ( )

332. ~~GERMAN REPARATIONS.~~(RESERVED)
~~Reparations payments from the Federal Republic of Germany received on or after November 1, 1984 are excluded.~~
~~(3-17-22)~~

333. GOVERNMENT MEDICAL OR SOCIAL SERVICES.
Governmental payments authorized by federal, state, or local law, for medical or social services, are excluded. Any cash provided by a nongovernmental medical or social services organization (including medical and liability insurers) for medical or social services already received is excluded. ( )

01. Medical Services. ~~Medical services a~~Are diagnostic, preventive, therapeutic, or palliative treatment. Treatment must be performed, directed, or supervised by a ~~S~~state~~-~~-licensed health professional. Medical services include room and board provided during a medical confinement~~. Medical services include~~ and in-kind medical items~~ such as prescription drugs, eye glasses, prosthetics, and their maintenance. In-kind medical items include devices intended to bring the physical abilities of a handicapped person to a par with an unaided person who is not handicapped. Electric wheelchairs, modified scooters, and service animals and their food are in-kind medical items~~. ~~(3-17-22)~~( )

02. Social Service. ~~A social service is a~~Any service, other than medical.~~ A social service helps a handicapped or socially disadvantaged person to function in society on a level comparable to a person not handicapped or disadvantaged.~~ Housebound and Aid and Attendance Allowances, including Unusual Medical Expense Allowances, received from the Veterans Administration are excluded. ~~(3-17-22)~~( )

334. HOME ENERGY ASSISTANCE (HEA) AND SUPPORT AND MAINTENANCE ASSISTANCE (SMA).
~~SMA is in-kind support and maintenance, or cash paid for food or shelter needs. SMA includes HEA. HEA is aid to meet the costs of heating or cooling a home. SMA must be provided in-kind by a nonprofit organization. HEA must be provided in cash or in-kind by suppliers of home heating gas or oil or a municipal utility providing home energy. SMA and~~ HEA and SMA are excluded. ~~(3-17-22)~~( )

335. ~~HOME PRODUCE FOR PERSONAL USE.~~(RESERVED)
~~Home produce is excluded if it is consumed by the participant or his household. Home produce includes livestock grown for personal consumption.~~ ~~(3-17-22)~~

336. IN-HOME SUPPORTIVE SERVICES.
Payments made by Title XX or other governmental programs to pay an ineligible spouse or ineligible parent for in-home supportive services provided to a participant are excluded. In-home supportive services include attendant care, chore services, and homemaker services. ( )

337. INCOME EXCLUDED BY LAW.
Any income excluded by federal statute is excluded. ( )

338. INFREQUENT OR IRREGULAR INCOME.
The first thirty dollars ($30) of earned income and the first sixty dollars ($60) of unearned income per calendar quarter are excluded when they are infrequent or irregular payments. Income is infrequent if the participant receives it

once in a calendar quarter from a single source. Income is irregular if the participant could not reasonably expect to receive it. ( )

339. (RESERVED)

340. LOANS.
Loans are excluded if the participant has signed a written repayment agreement. The signed agreement must state how the loan will be repaid. The signed written agreement can be obtained after the loan is received. Items bought on credit are paid with a loan and are not income. Money repaid to a participant on the principal of a loan is not income, it is a resource. Interest received by a participant on money loaned by them is countable income. ( )

341. ~~MANPOWER DEVELOPMENT AND TRAINING ACT PAYMENTS.~~(RESERVED)
~~Payments made under the Manpower Development and Training Act of 1962, as amended by the Manpower Act of 1965 are excluded.~~ ~~(3-17-22)~~

342. NATIVE AMERICAN PAYMENTS.
Payments authorized by law made to people of Native American ancestry are excluded. ( )

343. (RESERVED)

344. NUTRITION PROGRAMS FOR OLDER AMERICANS.
Payments, other than a wage or salary, made under Chapter 35,~~ of~~ Title 42,~~ of the~~ U~~.~~S~~. ~~C~~ode~~, Programs for Older Americans, are excluded. ~~(3-17-22)~~( )

345. PERSONAL SERVICES.
A personal service performed for a participant is excluded. Personal services include lawn mowing, house cleaning, grocery shopping, and babysitting. ( )

346. (RESERVED)

347. REBATES, REFUNDS, AABD UNDERPAYMENTS, AND REPLACEMENT CHECKS.
Rebates, refunds, AABD underpayments, and returns of money already paid are excluded. A replacement check is excluded. ( )

348. RELOCATION ASSISTANCE.
Relocation payments under Title II of the Uniform Relocation Assistance and Real Property Acquisitions Policies Act of 1970, Subchapter II, Chapter 61, Title 42, USC, are excluded. Relocation payments paid to civilians of World War II per PL 100-383, are excluded. ( )

349. REPLACEMENT OF INCOME ALREADY RECEIVED.
Replacement of a participant's lost, stolen, or destroyed income is excluded. ( )

350. RETURN OF MISTAKEN PAYMENTS.
A returned mistaken payment is excluded. If the participant keeps the mistaken payment, it is income. ( )

351. TAX REFUNDS.
Refunds of ~~F~~federal, ~~S~~State, or local taxes paid on income, real property, or food bought by the participant and~~ his~~ their family, are excluded. ~~(3-17-22)~~( )

352. UTILITY PAYMENTS.
Payments for utility costs made to low-income housing tenants by a local housing authority are excluded when paid directly to the tenant or jointly to the tenant and the utility company. ( )

353. (RESERVED)

354. VICTIMS' COMPENSATION PAYMENTS.
Any payment made from a State-sponsored fund to aid victims of crime is excluded. ( )

355. VOCATIONAL REHABILITATION SERVICES PAYMENTS.
Payments other than wages made to an eligible handicapped individual employed in a Vocational Rehabilitation Services project under Title VI of the Rehabilitation Act of 1973, are excluded. ( )

356. VOLUNTEER SERVICES INCOME.
Payments to volunteers under Chapter 66, Title 42, USC Domestic Volunteer Services (ACTION programs) are excluded. Payments are not excluded if the Director of the ACTION agency determines the value, adjusted for hours served, is equal to or greater than the federal or state minimum wage. ( )

357. WALKER V. BAYER PAYMENTS.
Class action settlement payments in Susan Walker v. Bayer Corporation, et al., are excluded for Medicaid but not for AABD cash. ( )

358. WEATHERIZATION ASSISTANCE.
Weatherization assistance is excluded. ( )

359. TEMPORARY CENSUS INCOME.
For Medicaid only, all wages paid by the Census Bureau for temporary employment related to US Census activities are excluded. ( )

360. -- 399. (RESERVED)

400. EARNED INCOME.
Earned income remaining after disregards and exclusions are subtracted, is counted in computing AABD cash. Wages are counted the month they become available to the participant. ( )

401. COMPUTING SELF-EMPLOYMENT INCOME.
Countable self-employment income is the difference between the gross receipts and the allowable costs of producing the income, if the amount is expected to continue. Self-employment income is computed using one (1) of the methods listed in Subsections 401.01 through 401.03 of this rule. Subsection 401.04 of this rule can be used as an income deduction, if applicable. ~~(3-17-22)~~( )

01. Self-Employed at Least One Year. For individuals who are self-employed for at least one (1) year, income and expenses are averaged over the past twelve (12) months. ( )

02. Self-Employed Less Than One Year. For individuals who are self-employed for less than one (1) year, income and expenses are averaged over the months the business has been in operation. ( )

03. Monthly Increase or Decrease. If a monthly average does not reflect actual monthly income because of an increase or decrease in business, the self-employment income is counted monthly. This method is not used for businesses with seasonal or unusual income peaks at certain times of the year. ( )

04. Net Self-Employment Income Seven and Sixty-Five Hundredths Percent Deduction. If net self-employment income is over four hundred dollars ($400) per year, seven and sixty-five hundredths percent (7.65%) is deducted. This deduction compensates for Social Security taxes paid. If self-employment Social Security tax is not paid, this deduction is not allowed. ( )

402. SELF-EMPLOYMENT ALLOWABLE EXPENSES.
Allowable operating expenses subtracted from self-employment income are the allowable Internal Revenue Service self-employment expenses, except for those listed~~ in~~ under S~~ubs~~ection~~s~~ 40~~2~~3~~.01 through 402.17~~ of~~ this~~ these rules. ~~(3-17-22)~~( )

~~**01. Labor**. Labor paid to individuals not in the family. (3-17-22)~~

~~**02. Materials**. Materials such as stock, seed and fertilizer. (3-17-22)~~

~~**03.** **Rent**. Rent on business property.~~ ~~(3-17-22)~~

~~**04.** **Interest**. Interest paid to purchase income producing property.~~ ~~(3-17-22)~~

~~**05.** **Insurance**. Insurance paid for business property.~~ ~~(3-17-22)~~

~~**06.** **Taxes**. Taxes on income producing property.~~ ~~(3-17-22)~~

~~**07.** **Business Transportation**. Business transportation as defined by the IRS.~~ ~~(3-17-22)~~

~~**08.** **Maintenance**. Landscape and grounds maintenance.~~ ~~(3-17-22)~~

~~**09.** **Lodging**. Lodging for business related travel.~~ ~~(3-17-22)~~

~~**10.** **Meals**. Meals for business related travel.~~ ~~(3-17-22)~~

~~**11.** **Use of Home**. Costs of partial use of home for business.~~ ~~(3-17-22)~~

~~**12.** **Legal**. Business related legal fees.~~ ~~(3-17-22)~~

~~**13.** **Shipping**. Business related shipping costs.~~ ~~(3-17-22)~~

~~**14.** **Uniforms**. Business related uniforms.~~ ~~(3-17-22)~~

~~**15.** **Utilities**. Utilities for business property.~~ ~~(3-17-22)~~

~~**16.** **Advertising**. Business related advertising.~~ ~~(3-17-22)~~

~~**17.** **Depreciation**. Depreciation for equipment, machinery, or other capital investments.~~ ~~(3-17-22)~~

403. SELF-EMPLOYMENT EXPENSES NOT ALLOWED.
Self-employment expenses not allowed are ~~listed in Subsections 403.01 through 403.08.~~ as follows: ~~(3-17-22)~~( )

01. Payments on the Principal of Real Estate. Payments on the principal of real estate mortgages on income-producing property. ( )

02. Purchase of Capital Assets or Durable Goods. Purchases of capital assets, equipment, machinery, and other durable goods. Payments on the principal of loans for these items. ( )

03. Federal, State, and Local Income Taxes. ~~Federal, state, and local income taxes.~~ ~~(3-17-22)~~( )

04. Savings. Monies set aside for future use such as retirement or work-related expenses. ( )

05. Labor Paid to Any Family Member. ~~Labor paid to any family member.~~ ~~(3-17-22)~~( )

06. Loss of Farm Income Subtracted From Other Income. ~~Loss of farm income subtracted from other income.~~ ~~(3-17-22)~~( )

07. Personal Transportation. ~~Personal transportation.~~ ~~(3-17-22)~~( )

08. Net Losses from Previous Periods. ~~Net losses from previous periods.~~ ~~(3-17-22)~~( )

404. ROYALTIES.
Royalties received as part of a trade or business, or for publication of the participant's work, are earned income. Other royalties are unearned income. ( )

405. HONORARIA.
An honorarium for services rendered is earned income. An honorarium for travel expenses and lodging for a guest speaker is unearned income in the amount it exceeds the expenses. The portion that equals the expenses is excluded as an expense of obtaining the income. ( )

406. SHELTERED WORKSHOP OR WORK ACTIVITIES CENTER PAYMENTS.
Payments for services performed in a sheltered workshop or work activities center are earned income. ( )

407. JOB TRAINING PARTNERSHIP ACT (JTPA).
JTPA payments are earned income. JTPA payments for child care, transportation, medical care, meals, and other reasonable expenses, provided in cash or in-kind, are not income. ( )

408. PROGRAMS FOR OLDER AMERICANS.
Wages or salary paid under Chapter 35, Title 42, USC, Programs for Older Americans, is earned income. ( )

409. UNIFORMED SERVICES PAY AND ALLOWANCES.
Basic pay is earned income. All other pay and allowances are unearned income. ( )

410. RENTAL INCOME.
Net rental income is unearned income, unless from the business of renting real property. Net unearned rental income is gross rent less the expenses on the rental property as listed in Subsections 410.01 through 410.06 below. Net rental income from the business of renting properties is self-employment earned income. (3-17-22)( )

01. Interest. Interest and escrow portions of a mortgage payment. ( )

02. Real Estate Insurance. Real estate insurance. (3-17-22)( )

03. Repairs. Minor repairs to an existing rental structure. ( )

04. Property Taxes. Property taxes. (3-17-22)( )

05. Yard Care. Lawn care, including tree and shrub care and snow removal. ( )

06. Advertising Costs for Tenants. Advertising costs for tenants. (3-17-22)( )

411. OVERPAYMENT WITHHOLDING OF UNEARNED INCOME.
Money withheld by any benefit program to recover an overpayment is counted as income. Money withheld is not income if the overpaid benefit amount was used to compute AABD cash. ( )

412. RETIREMENT, SURVIVORS, AND DISABILITY INSURANCE (RSDI).
RSDI monthly benefits are unearned income. The income is the amount reported by SSA, regardless of penalties to recover an SSI overpayment. ( )

413. SSI PAYMENTS.
SSI monthly payments are unearned income. The income is the amount reported by SSA, regardless of penalties to recover an SSI overpayment. An advance SSI payment to an applicant appearing SSI-eligible with a financial emergency, is not income the month received. When SSA reduces ongoing SSI to recover the advance, the SSI payment before the reduction continues to be counted as income. ( )

414. BLACK LUNG BENEFITS.
Black Lung payments are unearned income. ( )

415. RAILROAD RETIREMENT PAYMENTS.
Railroad Retirement Board payments are unearned income. ( )

416. UNEMPLOYMENT INSURANCE BENEFITS.
Unemployment insurance benefits received under state and federal unemployment laws are unearned income.

( )

417. UNIFORM GIFTS TO MINORS ACT (UGMA).
UGMA payments from the custodian to the minor are income to the minor. UGMA property, including earnings or additions, are not income to the minor until the month the minor becomes eighteen (18) years of age old. (3-17-22)( )

418. WORKERS' COMPENSATION.
Workers' compensation, less expenses required to get the payment, is unearned income. ( )

419. MILITARY PENSIONS.
Military pensions are unearned income. ( )

420. VA PENSION PAYMENTS.
VA pension payments are unearned income. The twenty dollar ($20) standard disregard is not subtracted, except by a special act of Congress. ( )

421. VA COMPENSATION PAYMENTS.
VA compensation payments to a veteran, spouse, child, or widow(er) are unearned income. ( )

422. VA EDUCATIONAL BENEFITS.
VA educational payments funded by the government are excluded. ( )

423. ALIMONY, SPOUSAL, AND ADULT SUPPORT.
Alimony, spousal, and other adult support payments are unearned income. ( )

424. CHILD SUPPORT PAYMENTS.
Child support payments are unearned income. One-third (1/3) of a child support payment is excluded for the child receiving support. Child support collected by a State and retained for TAFI payments is not income. ( )

425. DIVIDENDS AND INTEREST.
Dividends and interest are unearned income. ( )

426. AWARDS, GIFTS, PRIZES.
Awards, gifts, and prizes are unearned income. (3-17-22)( )

427. GIFTS.
Gifts are unearned income. (3-17-22)

428. PRIZES.
Prizes are unearned income. (3-17-22)

4297. WORK-RELATED UNEARNED INCOME.
Work-related payments that are not salary or wages are unearned income. ( )

428 – 430. COMMUNITY SERVICE BLOCK GRANTS.(RESERVED)
Community service block grant distributions are unearned income, unless excluded by the type of aid, such as medical services or Support and Maintenance Assistance. (3-17-22)

431. FEDERAL EMERGENCY MANAGEMENT AGENCY (FEMA) EMERGENCY FOOD DISTRIBUTION AND SHELTER PROGRAMS.
FEMA funds are unearned income, unless excluded by the type of aid, such as medical services or Support and Maintenance Assistance. ( )

432. BUREAU OF INDIAN AFFAIRS GENERAL ASSISTANCE (BIA GA).
BIA GA payments are unearned income. BIA GA payments and are Ffederally- funded income based on need. They are paid in cash or in-kind. The twenty dollar ($20) standard disregard is not subtracted. (3-17-22)( )

433. BIA ADULT CUSTODIAL CARE (ACC) AND CHILD WELFARE ASSISTANCE (CWA) PAYMENTS.
BIA ACC and CWA payments, other than foster care made to participants out of an institution, are unearned income. ( )

434. INDIVIDUAL INDIAN MONEY (IIM) ACCOUNTS.
Deposits to an unrestricted IIM account are income in the month deposited. ( )

435. ACCELERATED LIFE INSURANCE INCOME.
Accelerated life insurance payments are unearned income in the month received. ( )

436. REAL ESTATE CONTRACT INCOME.
Payments received on the interest of a negotiable real estate contract are unearned income for Medicaid eligibility. Payments received on the principal of a negotiable real estate contract are a resource for Medicaid eligibility. Payments received on a nonnegotiable real estate contract are unearned income. Principal and interest payments received on an excluded real estate contract of a long-term care participant are unearned income for patient liability. ( )

437. LIMITED AWARD TO CHILD WITH LIFE-THREATENING CONDITION.
Any gift from a tax~~-~~-exempt nonprofit organization to a child under age eighteen (18), who has a life~~-~~-threatening condition, is excluded from income under the conditions~~ in Subsections 437.01 through 437.02~~ below. ~~(3-17-22)~~( )

01. In-Kind Gift. ~~An in-kind gift i~~Is excluded if the gift is not converted to cash. ~~(3-17-22)~~( )

02. Cash Gifts. ~~Cash gifts a~~Are excluded up to two thousand dollars ($2,000) for the calendar year the cash gifts are made. ~~(3-17-22)~~( )

438. -- 450. (RESERVED)

451. DEEMING INCOME.
Income deeming counts the income of another person as available to an AABD participant, for eligibility and the amount of AABD cash. Income is deemed to the participant from~~ his~~ their ineligible spouse~~. Income is deemed~~, and to the child participant from~~ his~~ their ineligible parent. Income deeming starts the first full calendar month the participant is in a deeming situation. Deeming ends the first full calendar month the participant is not in a deeming situation. Deeming to a child ends the month after the child's eighteenth birthday. ~~(3-17-22)~~( )

01. Ineligible Parent. A natural or adoptive~~ father or mother,~~ parent or~~ a~~ stepparent, who does not receive AABD and lives in the same household as a child. ~~(3-17-22)~~( )

02. Ineligible Spouse. A participant's~~ husband or wife,~~ spouse living with the participant~~,~~ and not receiving AABD is an ineligible spouse. The ineligible~~ husband or wife,~~ spouse of the parent of a child participant, living with the child participant and~~ his~~ their parent, is an ineligible spouse. ~~(3-17-22)~~( )

03. Ineligible Child. A child under age twenty-one (21) who does not receive AABD, and lives with the AABD participant. ( )

04. Income Deeming Exclusions. Income excluded from deeming is listed in~~ Table 451.04~~ POMS Chapter SI 01320.000, incorporated by reference under Subsection 002.02 of these rules.

TABLE 451.04 - INCOME DEEMING EXCLUSIONS			
Type of Income	Ineligible Spouse or Parent, Ineligible Child, Eligible Legal Non-citizen	Essential Person	Sponsor of Legal Non-citizen
Income excluded by Federal laws other than the Social Security Act.	Excluded	Excluded	Excluded
Public Income Maintenance Payments (PIM). Public income maintenance payments include TAFI, AABD, SSI, refugee cash assistance, BIA-GA, VA payments based on need, local, county and state payments based on need, and payments under the 1974 Disaster Relief Act.	Excluded	Not Excluded	Not Excluded
Income used by a PIM program for amount of payment to someone other than an SSI recipient.	Excluded	Not Excluded	Not Excluded
Grants, scholarships, fellowships.	Excluded	Not Excluded (unless excluded by Federal laws)	Not Excluded (unless excluded by Federal laws)
Foster care payments.	Excluded	Not Excluded	Not Excluded
Food Stamps and Dept. of Agriculture donated foods.	Excluded	Not Excluded	Not Excluded
Home grown produce.	Excluded	Not Excluded	Not Excluded
Tax refunds on real property or food.	Excluded	Not Excluded	Not Excluded
Income used in an approved plan for achieving self support (PASS).	Excluded	Not Excluded	Not Excluded
Income used to pay court ordered or Title IV-D support payments.	Excluded	Not Excluded	Not Excluded
Payments based to Alaskans based on age and residence.	Excluded (not applicable to children)	Not Excluded	Not Excluded
Disaster Assistance.	Excluded	Excluded	Excluded
Infrequent or irregular income.	Excluded	Not Excluded	Not Excluded
Blind Work Expenses (BWE).	Excluded	Not Excluded	Not Excluded
Payments to provide in-home support.	Excluded	Not Excluded	Not Excluded
Home energy assistance and support and maintenance assistance.	Excluded	Excluded	Excluded
Child's earned income, up to one thousand two hundred and ninety dollars ($1,290) per month and five thousand two hundred dollars ($5,200) per year.	Excluded (not applicable to spouses or parents)	Does Not Apply	Does Not Apply
Impairment-related work expenses (IRWE).	Excluded	Not Excluded	Not Excluded

~~TABLE 451.04 – INCOME DEEMING EXCLUSIONS~~			
~~Type of Income~~	~~Ineligible Spouse or Parent, Ineligible Child, Eligible Legal Non-citizen~~	~~Essential Person~~	~~Sponsor of Legal Non-citizen~~
~~Interest on burial funds, appreciation in the value of burial space purchase agreements excluded from resources and interest on the value of burial space purchase agreements.~~	~~Excluded~~	~~Not Excluded~~	~~Not Excluded~~

~~(3-17-22)~~(____)

452. DEEMING INCOME FROM INELIGIBLE SPOUSE TO PARTICIPANT.
Income is deemed from an ineligible spouse to the participant, if they live together. Income is deemed as described in ~~Subsections 452.01 through 452.08~~ POMS Chapter SI 01320.000, incorporated by reference under Subsection 002.02 of these rules.

~~TABLE 452 – INCOME DEEMED FROM INELIGIBLE SPOUSE~~		
~~Step~~		~~Procedure~~
~~01.~~	~~Compute Child's Living Allowance.~~	~~Compute the living allowance for each ineligible child in the household. The living allowance is the difference between the basic allowance for a person living alone and the basic allowance for a couple. Round up cents to the next dollar. A child receiving public income maintenance payments does not get a living allowance.~~ ~~Subtract the child's unearned income from his living allowance. Subtract the child's earned income from any living allowance remaining.~~
~~02.~~	~~Adjust Spouse Income with Child's Living Allowance~~	~~Subtract the remaining living allowance, for each ineligible child in the household, from the ineligible spouse's gross unearned income, then from gross earned income.~~
~~03.~~	~~Add Adjusted Earned and Unearned Incomes~~	~~Add adjusted earned and unearned income. This is the deemed income of the ineligible spouse.~~
~~04.~~	~~Compute Participant's Needs as a Single Person~~	~~Compute the participant's budgeted AABD needs as if he was a single person, living alone.~~
~~05.~~	~~Deemed Income Equal to or Less Than One-Half of Participant's Needs~~	~~If the deemed income is equal to, or less than, one-half of the participant's budgeted needs, computed as if he was a single person living alone, no income is deemed from the ineligible spouse.~~
~~06.~~	~~Deemed Income More Than One-Half Participant's Needs~~	~~If the deemed income is more than one-half of the participant's budgeted needs, computed as if he was a single person living alone, continue the deeming process.~~

TABLE 452 - INCOME DEEMED FROM INELIGIBLE SPOUSE		
Step		**Procedure**
07.	Compute Participant's Income	Add the remaining earned and unearned ineligible spouse deemed income (after the ineligible child deduction) to the gross earned and unearned incomes of the participant. This is the total earned and unearned income. Subtract the standard disregard of twenty dollars ($20) from the total unearned income. If the total unearned income is less than twenty dollars ($20), subtract the remainder from the total earned income. Subtract the earned income disregard of sixty-five dollars ($65) from the earned income. Subtract one half of the remaining earned income. Combine the remaining unearned income and the remaining earned income to compute the participant's total countable income. Determine the couple's budgeted needs as if they were an eligible couple. If the participant's countable income, including deemed income, is more than the couple's budgeted needs, the participant is ineligible. If the participant's countable income, including deemed income, is less than the couple's budgeted needs compute the participant's AABD cash.
08.	Determine AABD Cash	Subtract the participant's countable and deemed incomes from the couple's budgeted needs, to compute the budget deficit. Compute a second budget deficit, using the participant's income, and the single person budgeted needs. AABD cash is the smaller of the two (2) budget deficits.

(3-17-22)(   )

453. DEEMING INCOME FROM INELIGIBLE PARENT TO AABD CHILD.
Income is deemed from an ineligible parent, or his their ineligible spouse, to a child participant under age eighteen (18) living in the same household. A stepparent's income is deemed to the child for AABD cash, but not Medicaid. The income is deemed as described in Subsections 453.01 through 453.11 POMS Chapter SI 01320.000, incorporated by reference under Subsection 002.02 of these rules.

TABLE 453 - INCOME DEEMED FROM INELIGIBLE PARENT		
Step		Procedure
01.	Compute Child's Living Allowance	Compute the living allowance for each ineligible child in the household. The living allowance is the difference between the basic allowance for a person living alone and the basic allowance for a couple. Round up cents to the next dollar. A child receiving public income maintenance payments does not get a living allowance. Subtract the child's unearned income from his living allowance. Subtract the child's earned income from any living allowance remaining. Subtract the remaining living allowance, for each ineligible child in the household, from the ineligible parents unearned income. If any living allowance remains subtract it from the parent's earned income.
02.	Remaining Parental Income	The parent may have remaining income. Go to Subsection 453.03.
03.	Subtract Income Disregard	Subtract one (1) standard twenty dollar ($20) disregard from the unearned income of the parents. If unearned income is less than twenty dollars ($20) subtract the balance of the twenty dollars ($20) from the earned income of the parents.
04.	Subtract Earned Income Disregard	Subtract one (1) sixty-five dollar ($65) earned income disregard from the earned income of the parents. Subtract one-half (1/2) of the remaining balance of the earned income of the parents.
05.	Combine Income	Combine any remaining parental earned income with any remaining parental unearned income.
06.	Compute Living Allowance for Parent	Compute a living allowance for the ineligible parent. For one (1) parent, the living allowance is the basic allowance for a person living alone. For two (2) parents, the living allowance is the basic allowance for a couple. A parent receiving public income maintenance payments does not get a living allowance.
07.	Subtract Living Allowance	Subtract the parent living allowance from the remaining balance of the parent's income. This is the deemed parental income.
08.	Divide Deemed Income	If there is more than one (1) child participant in the household, the deemed parental income is divided equally between those children. Each child's share of parental income must only reduce the amount of his AABD cash to zero, when combined with the child's own countable income. Excess deemed parental income, remaining after a child participant's AABD cash is reduced to zero, is divided equally between the other child participants in the household. The excess deemed income is combined with their share of the parental income available for deeming.

TABLE 453 - INCOME DEEMED FROM INELIGIBLE PARENT		
Step		**Procedure**
09.	Subtract Disregard	Subtract the standard twenty dollar ($20) disregard from each child participant's unearned income, including deemed income. If a child's total unearned income is less than twenty dollars ($20), subtract the balance of the standard disregard from the child's earned income.
10.	Subtract Disregard	Subtract the sixty five dollar ($65) earned income disregard and one-half of the balance from each child's own earned income.
11.	Combine Income	Combine each child's unearned income with his earned income. If the child's remaining countable income is less than his actual budgeted needs, the child has a budget deficit. If the child is otherwise eligible, his AABD cash is the budget deficit.

(3-17-22)(   )

454. DEEMING INCOME FROM ESSENTIAL PERSON TO PARTICIPANT.
If a participant and an essential person live in the same household, the essential person's income is deemed to the participant. If essential person deeming makes the participant ineligible, do the Department will not use essential person deeming. The income is deemed as described in Subsections 454.01 through 454.06 POMS Chapter SI 01320.000, incorporated by reference under Subsection 002.02 of these rules.

TABLE 454 - DEEMING FROM ESSENTIAL PERSON TO PARTICIPANTS		
Step		**Procedure**
01.	Compute Income	Compute the total earned and unearned income of the essential person. Subtract income exclusions.
02.	Subtract Disregard	Subtract income exclusions and disregards from the participant's income.
03.	Add Unearned Income	Add the income from Subsection 454.01 to the participant's unearned income.
04.	Add Earned Income	Add the participant's remaining earned income from Subsection 454.02 to the income in Subsection 454.03. This is the participant's countable income.
05.	Compute Needs	Compute the participant's budgeted needs, as though the participant and the essential person were an AABD couple.
06.	Subtract Income	Subtract participant's income in Subsection 454.04 from his budgeted needs. The difference is the participant's AABD cash.

(3-17-22)(   )

455. DEEMING INCOME FROM INELIGIBLE SPOUSE TO PARTICIPANT AND CHILD PARTICIPANT.
If a participant, his their ineligible spouse, and their child participant live in the same household, income is deemed from the participant to the child participant. The income is deemed as described in Subsections 455.01 through 455.03 POMS Chapter SI 01320.000, incorporated by reference under Subsection 002.02 of these rules.

TABLE 455 - DEEMING FROM INELIGIBLE SPOUSE TO PARTICIPANT AND CHILD PARTICIPANT		
Step		**Procedure**
01.	Compute AABD cash	Use the procedures in Table 452, to determine if the participant is eligible for AABD cash. If the participant is eligible, no income is deemed to the child participant.

TABLE 455 - DEEMING FROM INELIGIBLE SPOUSE TO PARTICIPANT AND CHILD PARTICIPANT		
Step		Procedure
02.	Participant Not Eligible	If the participant has too much income, including deemed income, to be eligible for AABD cash, all income over the amount needed to reduce the participant's AABD cash to zero is deemed to the child participant.
03.	Divide Deemed Income	If there is more than one (1) child participant in the household, the deemed parental income is divided equally between those children. Each child's share of parental income must only reduce the amount of his AABD cash to zero, when combined with the child's own countable income. Excess deemed parental income, remaining after a child participant's AABD cash is reduced to zero, is divided equally between the other child participants in the household. The excess deemed income is combined with their share of the parental income available for deeming.

(3-17-22)(____)

456. DEEMING INCOME FROM SPONSOR TO LEGAL NON-CITIZEN PARTICIPANT -- NO I-864 AFFIDAVIT OF SUPPORT.

The Department will Ddeem income as described in this Section rule, if the legal non-citizen's sponsor signed an affidavit of support other than the I-864. The deemed income is counted, even if the participant does not live in the sponsor's household. The sponsor's income is not deemed to the participant for Medicaid. (3-17-22)(____)

01. Three--Year Limit. Effective October 1, 1996 tThe deeming period, regardless of admission date, is three (3) years after the date the legal non-citizen is lawfully admitted. Deeming stops the end of the month, three (3) years from the date the sponsored participant lawfully entered the U.S. for permanent residence. (3-17-22)(____)

02. Sponsored Legal Non-Citizen Exempt from Deeming. A lawfully admitted legal non-citizen participant is exempt from sponsor deeming if one (1) or more of the following conditions in Subsections 456.02.a. through 456.02.m. applies. (3-17-22)(____)

a. Refugee. The legal non-citizen was admitted to the U.S. as a refugee, asylee, or parolee. (3-17-22)(____)

b. Applied before October 1, 1980. The legal non-citizen first applied for AABD before October 1, 1980. (3-17-22)(____)

c. Permanent resident. The legal non-citizen is a lawful permanent resident under color of law. (3-17-22)(____)

d. Sponsored with job. The legal non-citizen's entry into the U.S. was sponsored by a church, other social service organization, or an employer who has offered him them a job. (3-17-22)(____)

e. Blind or disabled. The legal non-citizen becomes blind or disabled after they is are admitted to the U.S. (3-17-22)(____)

f. Legal non-citizen lives with spouse. The legal non-citizen was sponsored by and resides in the same household with his their ineligible spouse or ineligible parent. The Department will Uuse ineligible spouse and ineligible parent deeming, not sponsor deeming. (3-17-22)(____)

g. Sponsor dies. The legal non-citizen's sponsor dies. (3-17-22)(____)

h. Legalized legal non-citizen. The legal non-citizen was legalized under the Immigration Reform and Control Act of 1986. (3-17-22)(____)

i. ~~Resided for thirty-six (36) months.~~ The legal non-citizen has lived in the U~~.~~S~~.~~ for thirty-six (36) months beginning with the month ~~t~~they~~y~~ ~~was~~ were admitted for permanent residence or granted permanent residence status. ~~(3-17-22)~~(____)

j. ~~Registry legal non-citizen.~~ The legal non-citizen was admitted under Section 249 of the INA as a registry legal non-citizen. ~~(3-17-22)~~(____)

k. ~~Amerasian legal non-citizen.~~ The legal non-citizen is an applicant for permanent residence who is an Amerasian or a specified relative of an Amerasian. The Amerasian must be born in Vietnam between January 1, 1962, and January 1, 1976. A specified relative is a spouse, child, parent, or stepparent of the Amerasian, or someone who has acted in the place of a parent of an Amerasian and/or ~~his~~ their spouse or child. ~~(3-17-22)~~(____)

l. ~~Cuban/Haitian.~~ The legal non-citizen is an applicant for adjustment under the Cuban/Haitian provisions of Section 202 of the Immigration Reform and Control Act of 1986. ~~(3-17-22)~~(____)

03. Sponsor/Legal Non-Citizen Relationships. Sponsor/legal non-citizen relationships and deeming rules are listed in ~~Subsections 456.03.a. through 456.03.f~~ POMS Chapter SI 01320.000, incorporated by reference under Subsection 002.02 of these rules.~~.~~

~~TABLE 456.03 – SPONSOR/LEGAL NON-CITIZEN RELATIONSHIPS AND DEEMING~~		
~~Step~~		~~Procedure~~
~~a.~~	~~Sponsor is Spouse~~	~~If the legal non-citizen's sponsor is his ineligible spouse, and the couple does not live together, sponsor to legal non-citizen deeming is used.~~
~~b.~~	~~Legal Non-Citizen is a Child~~	~~If the legal non-citizen is a child, and does not live with his sponsor parent(s), sponsor to legal non-citizen deeming is used.~~
~~c.~~	~~Child With Ineligible Parent~~	~~If the participant is a child whose ineligible parent(s) and sponsor both have income available for deeming to him, the income of the ineligible parent(s) is deemed as in Section 376.~~
~~d.~~	~~Child Eligible After Parent Deeming~~	~~If the child remains eligible after income is deemed from his ineligible parent(s), the sponsor's income is deemed to him under the sponsor to legal non-citizen deeming procedures.~~
~~e.~~	~~Participant Couple With Sponsors~~	~~If each member of a participant couple has his own sponsor, separate deeming computations are used. The couple's countable income includes the combined deemed incomes.~~
~~f.~~	~~Member of Couple Not Eligible~~	~~If one (1) member of a couple with separate sponsors is not eligible, the ineligible spouse's income is deemed to the participant as in Section 379. This is in addition to income deemed from the sponsor.~~

~~(3-17-22)~~(____)

04. Sponsor to Legal Non-Citizen Deeming Procedures. The Department will ~~B~~budget the legal non-citizen's actual needs, as if they~~y~~ ~~is~~ are a single person living alone. The Department will ~~S~~subtract the legal non-citizen's own income, less exclusions and disregards. The Department will ~~S~~subtract the couple's income, less exclusions, from their needs. If there is no budget deficit, the participant is not eligible. If there is a budget deficit, the Department will follow the procedures in ~~Subsections 456.04.a. through 456.04.d.~~ POMS Chapter SI 01320.000, incorporated by reference under Subsection 002.02 of these rules, to compute sponsor deemed income.

~~TABLE 456.04 - SPONSOR TO LEGAL NON-CITIZEN DEEMING PROCEDURES~~		
~~Step~~		~~Procedure~~
~~a.~~	~~Compute Income~~	~~Compute the gross monthly earned and unearned income of the sponsor, and the sponsor's spouse, if living with him.~~
~~b.~~	~~Subtract Living Allowance~~	~~Subtract a living allowance for the sponsor the sponsor's spouse, if living with him.~~ ~~The sponsor's living allowance is the basic allowance for a single person living alone.~~ ~~The living allowance for the sponsor's spouse is one-half the basic allowance for a single person living alone. Round up cents to the next dollar.~~
~~c.~~	~~Subtract Dependent Living Allowance~~	~~Subtract a living allowance for each dependent claimed by the sponsor on his most recent Federal tax return. Do not subtract an allowance for the sponsor's spouse in this step. The living allowance is one-half the basic allowance for a single person living alone. Round up cents to the next dollar. Do not reduce the living allowance by the dependent's income.~~
~~d.~~	~~Deem Income~~	~~Income remaining is deemed to the participant from the sponsor.~~

~~(3-17-22)~~(   )

457. DEEMING INCOME FROM SPONSOR TO LEGAL NON-CITIZEN -- SPONSOR SIGNED INS FORM I-864 AFFIDAVIT OF SUPPORT.
If the legal non-citizen's sponsor has signed an INS form I-864 ~~a~~Affidavit of ~~s~~Support, all income of the sponsor and the sponsor's spouse is deemed to the legal non-citizen for AABD cash and Medicaid eligibility. Deeming continues until the legal non-citizen becomes a naturalized citizen or has forty (40) quarters of work. Exceptions are listed ~~in Subsections 457.01 and 457.02.~~ below: ~~(3-17-22)~~(   )

01. Battery Exception. The legal non-citizen or the legal non-citizen child's parent was battered or subjected to extreme cruelty in the US. There is a substantial connection between the battery and the participant's need for assistance. The person subjected to the battery or cruelty no longer lives with the person responsible for the battery or cruelty. (   )

02. Indigence. Alien sponsor deeming is suspended for twelve (12) months, if the legal non-citizen is not able to get food and shelter without AABD cash. (   )

458. -- 499. (RESERVED)

500. FINANCIAL NEED.
The participant has financial need if ~~his~~ their allowances, as described in Sections 501 through 513 of these rules, are more than ~~his~~ their income. ~~(3-17-22)~~(   )

501. BASIC ALLOWANCE.
Each participant receives a basic allowance unless they live~~s~~ in a nursing facility. The basic allowance for each living arrangement is listed in ~~Subsections 501.01 through 501.03 of~~ this rule. The Semi-Independent Group Residential Facility, Room and Board, Residential and Assisted Living Facility, and Certified Family Home basic allowances ~~are those in effect January 1, 2001. They~~ do not change with the annual cost-of-living increase in the federal SSI benefit amount. ~~(3-17-22)~~(   )

01. Single Participant. ~~Through December 31, 2000, a~~A participant is budgeted five hundred forty-five dollars ($545) monthly as a basic allowance when living in a situation ~~described in Subsections 501.01.a. through 501.01.e. of these rules~~ listed below. Beginning January 1, 2001, the basic allowance increase for a single participant is the dollar amount of the annual cost-of-living increase in the federal SSI benefit rate for a single person. ~~(3-17-22)~~(   )

a. Living alone. ( )

b. Living with ~~his~~ their ineligible spouse. ~~(3-17-22)~~( )

c. Living with another participant who is not ~~his~~ their spouse. ~~(3-17-22)~~( )

d. Living in another's household. This includes a living arrangement where the participant purchases lodging (room) and meals (board) from ~~his~~ their parent, child, or sibling. ~~(3-17-22)~~( )

e. Living with ~~his~~ their TAFI child. ~~(3-17-22)~~( )

02. Couple or Participant Living with Essential Person. ~~Through December 31, 2000, a~~A participant living with ~~his~~ their participant spouse or ~~his~~ their essential person is budgeted seven hundred sixty-eight dollars ($768) monthly as a basic allowance. Beginning January 1, 2001, the basic allowance increase for a couple is the dollar amount of the annual cost-of-living increase in the federal SSI benefit rate for a couple. The increase may be rounded up. ~~(3-17-22)~~( )

03. SIGRIF. A participant living in a semi-independent group residential facility (SIGRIF) is budgeted three hundred forty-nine dollars ($349) monthly as a basic allowance. ( )

502. SPECIAL NEEDS ALLOWANCES.
Special needs allowances are a restaurant meals allowance and a service animal food allowance. ( )

01. Restaurant Meals Allowance. ~~The restaurant meals allowance i~~Is fifty dollars ($50) monthly. A physician must state the participant is physically unable to prepare food in ~~his~~ their home. A participant able to prepare ~~his~~ their food, but living in a place where cooking is not permitted, may be budgeted the restaurant meals allowance for up to three (3) months. ~~(3-17-22)~~( )

02. Service Animal Food Allowance. ~~The service animal food allowance i~~Is seventeen dollars ($17) monthly. The allowance is budgeted for a blind or disabled participant~~,~~ using a trained service animal. ~~(3-17-22)~~( )

503. -- 511. (RESERVED)

512. ROOM AND BOARD HOME ALLOWANCE.
Room and board is a living arrangement where the participant purchases lodging (room) and meals (board) from a person they live~~s~~ with who is not ~~his~~ their parent, child, or sibling. ~~(3-17-22)~~( )

01. Budgeted Room and Board Allowance. Beginning January 1, 2006, a participant living in a room and board home is budgeted six hundred ninety-three dollars ($693). Beginning July 1, 2013, the Room and Board allowance will be adjusted annually by the percentage of the annual cost-of-living increase in the federal SSI benefit rate for a single person. This adjustment will be effective on January 1st of each year. The room and board allowance increase will be rounded to the next dollar. ( )

02. Basic Allowance for Participant in Room and Board Home. A participant living in a room and board home is budgeted seventy-seven dollars ($77) monthly as a basic allowance. Beginning July 1, 2013, this basic allowance will be adjusted annually by the percentage of the annual cost-of-living increase in the federal SSI benefit rate for a single person. This adjustment will be effective on January 1st of each year. The basic allowance increase will be rounded to the nearest dollar. ( )

513. RESIDENTIAL ASSISTED LIVING FACILITY (RALF) AND CERTIFIED FAMILY HOME (CFH) ALLOWANCES.
A participant living in a ~~Residential Assisted Living Facility (~~RALF~~), in accordance with~~ under IDAPA 16.03.22, "Residential Assisted Living Facilities," or a ~~Certified Family Home (~~CFH~~), in accordance with~~ under IDAPA 16.03.19, "Certified Family Homes," is budgeted a basic allowance of ninety-six dollars ($96) monthly. Beginning July 1, 2013, this basic allowance will be adjusted annually by the percentage of the annual cost-of-living increase in

the federal SSI benefit rate for a single person. This adjustment will be effective on January 1st of each year. The basic allowance increase will be rounded to the nearest dollar. (3-17-22)( )

01. Budgeted Monthly Allowance Based Oon Level of Care. A participant is budgeted a monthly allowance for care based on the level of care received as described in Section 515 of these rules. If the participant does not require State Plan Personal Care Services (PCS), his their eligibility and allowances are based on the Room and Board rate in Section 512 of these rules. (3-17-22)( )

02. Care Levels and Monthly Allowances. Beginning January 1, 2006, care levels and monthly allowances are those listed in Table 513.02 of these rules below. Beginning July 1, 2013, the RALF and CFH allowances for participants living in a RALF or CFH on State Plan PCS will be adjusted annually by the percentage of the annual cost-of-living increase in the federal SSI benefit rate for a single person. This adjustment will be effective on January 1st of each year. This increase will be rounded to the next dollar.

TABLE 513.02 - STATE PLAN PCS CARE LEVELS AND ALLOWANCES AS OF 1-1-06		
	Level of Care	Monthly Allowance
a.	Level I	Eight hundred and thirty-five dollars ($835)
b.	Level II	Nine hundred and two dollars ($902)
c.	Level III	Nine hundred and sixty-nine dollars ($969)

(3-17-22)( )

03. CFH Operated by Relative. A participant living in a Certified Family Home (CFH) operated by his their parent, child, or sibling is not entitled to the CFH State Plan PCS allowances. He They may receive the allowance for a person living with a relative as described in Section 501 of these rules. A relative for this purpose is the participant's parent, child, sibling, aunt, uncle, cousin, niece, nephew, grandparent, or grandchild by birth, marriage, or adoption. (3-17-22)( )

514. AABD CASH PAYMENTS.

Only a participant who receives an SSI payment for the month is eligible for an AABD cash payment in the same month. The AABD cash payment amount is based on the participant's living arrangement described in Subsections 514.01 through 514.04 of this rule. An AABD cash payment is the difference between a participant's financial need and his their countable income. If the difference is not an even dollar amount, AABD cash is paid at the next higher dollar. AABD cash is paid electronically as provided in IDAPA 16.03.20, "Electronic Payments of Public Assistance, Food Stamps, and Child Support." (3-17-22)( )

01. Single Participant Maximum Payment. For a single participant described in Subsection 501.01 of these rules, the maximum monthly AABD cash payment amount is fifty-three dollars ($53). ( )

02. Couple or Participant Living with Essential Person Maximum Amount. For participants described in Subsection 501.02 of these rules, the maximum monthly AABD cash payment amounts are: ( )

a. A couple receives twenty dollars ($20); or ( )

b. A participant living with essential person receives eighteen dollars ($18). ( )

03. Semi-Independent Group Maximum Payment. For a participant described in Subsection 501.03 and Section 511 of these rules, the maximum monthly AABD cash payment amount is one hundred sixty-nine dollars ($169). (3-17-22)( )

04. Room and Board Maximum Payment. For a participant described in Section 512 of these rules, the maximum monthly AABD cash payment is one hundred ninety-eight dollars ($198). ( )

05. RALF and CFH. A participant residing in a RALF or CFH is not eligible for an AABD cash payment. ( )

515. ~~RESIDENTIAL AND ASSISTED LIVING FACILITY~~RALF CARE AND ~~CERTIFIED FAMILY HOME~~ CFH ASSESSMENT AND LEVEL OF CARE.
The participant's need for care, level of care, plan of care, and the ~~licensed facility's~~ RALF's or CFH's ability to provide care is assessed by the Bureau of Long-Term Care (BLTC) when a participant is admitted. The BLTC must approve the placement before Medicaid can be approved. ~~(3-17-22)~~( )

516. CHANGE IN LEVEL OF CARE.
A change in the participant's level of care affects eligibility as ~~described in Subsections 516.01 and 516.02 of this rule~~ listed below. ~~(3-17-22)~~( )

01. Increase in Level of Care. ~~An increase in level of care i~~Is effective the month the BLTC reassesses the level of care. ~~(3-17-22)~~( )

02. Decrease in Level of Care. When the BLTC verifies the participant has a decrease in ~~his~~ their level of care, and ~~his~~ their income exceeds ~~his~~ their new level of care, ~~his~~ their Medicaid must be stopped after timely notice. When the BLTC determines the participant no longer meets any level of care, ~~his~~ their eligibility and allowances are based on the Room and Board rate in Section 512 of these rules. ~~(3-17-22)~~( )

517. -- ~~520.~~ ~~(RESERVED)~~

~~**521. MOVE FROM RESIDENTIAL ASSISTED LIVING FACILITY OR CERTIFIED FAMILY HOME TO LIVING SITUATION OTHER THAN A NURSING HOME OR HOSPITAL.**~~
~~A participant may move from a licensed facility to a living situation, other than a nursing home or hospital. No change to his Medicaid income limit is made, based on the move, until the next month. (3-17-22)~~

~~522. --~~523. (RESERVED)

524. MOVE FROM NURSING HOME OR HOSPITAL.
If a participant moves from a nursing home or hospital to a different living situation, other than a ~~residential and assisted living facility~~ RALF or ~~certified family home~~ CFH, ~~his~~ their AABD cash for the month is determined as if they lived in ~~his~~ their new situation the entire month. ~~His~~ Their AABD cash is ~~his~~ their AABD allowances less ~~his~~ their countable income. ~~(3-17-22)~~( )

525. -- 530. (RESERVED)

531. COUPLE BUDGETING.
Income of an AABD participant and ~~his~~ their participant spouse living in the same household is combined. The twenty dollar ($20) standard income disregard and the sixty-five dollar ($65) earned income disregard are subtracted once a month, per couple. Each member of a couple living in an institution must have income budgeted as a single person. A couple living together as of the first day of a month, is counted as living together throughout that month. Budgeting as a couple continues through the month the couple stops living together. For couple budgeting, a household is a home, a rental, another's household, or room and board. ~~(3-17-22)~~( )

532. -- 539. (RESERVED)

540. STANDARD DISREGARD.
The standard disregard is twenty dollars ($20)~~. The standard disregard~~, and is first subtracted from unearned income. If the unearned income is less than the standard disregard, the remainder of the standard disregard is subtracted from earned income. The participant retains the standard disregard for ~~his~~ their personal use. ~~(3-17-22)~~( )

01. Standard Disregard and a Couple. The Department will ~~S~~subtract the standard disregard only once a month from the combined income of a couple in the same household. ~~(3-17-22)~~( )

02. Standard Disregard Exception. The standard disregard must not be subtracted from nonservice-

connected VA payments, Title IV-E foster care payments, or BIA General Assistance. ( )

541. SUBTRACTION OF EARNED INCOME DISREGARDS.
Earned income disregards are subtracted from AABD earned income in the order listed in Sections 542 through 547. They are subtracted the month the income is paid. ( )

542. SIXTY-FIVE DOLLAR EARNED INCOME DISREGARD.
Sixty-five dollars ($65) of earned income in a month are not counted. The Department will ~~S~~subtract the sixty-five dollar ($65) disregard only once a month from the combined income of a couple in the same household. The sixty-five dollar ($65) disregard is a work incentive. The participant retains the sixty-five dollar ($65) disregard for ~~his~~ their personal use. ~~(3-17-22)~~( )

543. IMPAIRMENT-RELATED WORK EXPENSE (IRWE) DISREGARD.
~~Impairment-related work expenses~~IRWEs are items and services needed and used by a disabled AABD participant to work. The items must be needed because of the participant's impairment~~. The items~~, and may be bought or rented. The cost for ~~impairment-related work expenses~~ IRWEs is subtracted from the participant's earned income, for eligibility and AABD cash amount. An item disregarded as a blindness work expense, or as part of a PASS, cannot be disregarded as an ~~impairment-related work expense~~ IRWE. ~~(3-17-22)~~( )

544. ONE-HALF REMAINING EARNED INCOME DISREGARD.
One-half (1/2) of remaining earned income, after the IRWE is subtracted, is not counted. The one-half (1/2) of remaining earned income is a work incentive. The participant retains the one-half (1/2) of remaining earned income for ~~his~~ their personal use. ~~(3-17-22)~~( )

545. BLINDNESS WORK EXPENSE DISREGARD.
The cost of earning income is subtracted from the earned income of a blind person. The blind person must be under age sixty-five (65). If the blind person is age sixty-five (65) or older, they must receive SSI for blindness, or have received AABD the month before they became sixty-five (65). ~~(3-17-22)~~( )

01. Blind Work Expense Limit. Blindness work expenses are subtracted from earned income. The amount subtracted must not exceed the participant's monthly earnings. ( )

02. No Duplication for Blind Work Expenses. Expenses, subtracted under the ~~impairment-related work expense~~ IRWE disregard, cannot be subtracted again under this disregard. ~~(3-17-22)~~( )

546. PLAN TO ACHIEVE SELF-SUPPORT (PASS).
A blind or disabled participant, with an approved ~~plan to achieve self-support (~~PASS~~)~~, must have income and resources disregarded. Conditions for this disregard are listed ~~in Subsections 546.01 through 546.03~~ below. ~~(3-17-22)~~( )

01. Under Age Sixty-Five. The participant must be under sixty-five (65), or receive AABD for the blind or disabled during the month of ~~his~~ their sixty-fifth birthday. ~~(3-17-22)~~( )

02. Approved PASS. A participant receiving SSI must have a PASS approved by SSA. A participant not receiving SSI must have a PASS approved by the Department. ( )

03. Income Necessary for Self-Support. The income and resources disregarded under the PASS must be necessary for the participant to achieve self-support. ( )

547. PASS APPROVED BY DEPARTMENT.
A PASS approved by the Department must be in writing~~. The PASS must~~, and contain all the following items ~~in Subsections 547.01 through 547.06.~~: ~~(3-17-22)~~( )

01. Occupational Objective. The PASS must have a specific occupational objective. ( )

02. Specific Goals. The PASS must have specific goals for using the disregarded income and resources to achieve self-support. ( )

03. Time Limit. The PASS must show a specific target date to achieve the goal. An approved PASS is limited to an initial period of eighteen (18) months. Extensions may be granted if needed. ( )

a. The first extension period lasts up to eighteen (18) months. ( )

b. A second eighteen (18) month extension period can be granted. ( )

c. A final extension, up to twelve (12) months can be granted. The PASS can be extended a total of forty-eight (48) months, when the original PASS goal required extensive education or vocational training. ( )

04. No Duplication of Disregards. An item disregarded as an ~~impairment-related work expense~~ IRWE or under the blindness exception cannot be disregarded under the PASS. ~~(3-17-22)~~( )

05. Resource Limitation. The PASS disregard must not be used for resources, unless the resources cause the participant to be ineligible without the PASS disregard. ( )

06. Disregard of Resources. The PASS must list the participant's resources. The PASS must list any resources the participant will receive under the plan~~. The PASS must~~, and show how the resources will be used toward the occupational goal. The PASS must list goal-related items or activities requiring savings or purchases and the amounts the participant plans to save or spend~~. The PASS must~~, and list resources disregarded under the plan. The PASS must show resources disregarded under the plan can be identified separate from the participant's other resources. ~~(3-17-22)~~( )

548. -- 599. (RESERVED)

600. DEPARTMENT NOTICE RESPONSIBILITY.

The participant must be notified of changes in eligibility or AABD cash amount. The notice must give the effective date, the reason for the action, the rule that supports the action, and appeal rights. See 42 CFR 435.917. ~~(3-17-22)~~( )

601. ADVANCE NOTICE RESPONSIBILITY.

When a reported change results in closure or decrease, the participant must be notified at least ten (10) calendar days before the effective date of the action. ( )

602. ADVANCE NOTICE NOT REQUIRED.

Advance notice is not required when a condition listed ~~in Subsections 602.01 through 602.12~~ below exists. The participant must be notified by the date of the action. ~~(3-17-22)~~( )

01. The Department has Proof of the Participant's Death ~~of Participant~~. ~~The Department has proof of the participant's death.~~ ~~(3-17-22)~~( )

02. Participant Requests Closure in Writing. ~~The participant requests closure in writing.~~ ~~(3-17-22)~~( )

03. Participant in Institution. The participant is admitted or committed to an institution. Further payments to the participant do not qualify for federal financial participation under the State Plan. ( )

04. Nursing Care. The participant is placed in a nursing facility~~,~~ or ~~Intermediate Care for Persons with Intellectual Disabilities~~ an ICF/IID. ~~(3-17-22)~~( )

05. Participant Address Unknown. The participant's whereabouts are unknown. Department mail is returned with no forwarding address. ( )

06. Participant is Approved for Aid in Another State. ~~A participant is approved for aid in another state.~~ ~~(3-17-22)~~( )

07. Eligible One Month. The participant is eligible for aid only during the calendar month of ~~his~~ their application for aid. ~~(3-17-22)~~(____)

08. Non-Citizen With Emergency. The participant is an illegal or legal non-citizen whose Medicaid eligibility ends the day ~~his~~ their emergency medical condition stops. ~~(3-17-22)~~(____)

09. Retroactive Medicaid. The participant's Medicaid eligibility is for a prior period. ( )

10. Special Allowance. A special allowance granted for a specific period is stopped. ( )

11. Patient Liability or Participant Participation Changes. ~~Patient liability or client participation changes.~~ ~~(3-17-22)~~(____)

12. Participant's Level of Care Changes. ~~The participant's level of care changes.~~ ~~(3-17-22)~~(____)

603. (RESERVED)

604. PARTICIPANT DETERMINED SSI ELIGIBLE AFTER APPEAL.
If the SSA finds a participant is blind or disabled, based on an appeal of an SSA decision, the participant meets the disability requirements for AABD cash and related Medicaid on the effective date determined by SSA. AABD cash payments are effective no earlier than the month SSA issues the favorable decision for SSI payments. ( )

605. REPORTING REQUIREMENTS.
The participant must report changes in circumstances verbally or in writing, by the tenth of the month following the month in which the change occurred. The participant must show good cause for not reporting changes. If failure to report a change results in an overpayment, the overpayment must be recovered. ( )

606. REQUIRED PROOF.
The participant must prove continuing eligibility for aid when a change could affect eligibility~~. The participant~~, and is allowed ten (10) calendar days to provide requested proof. The case is closed if the participant does not provide proof within ten (10) days and does not have good cause for not providing proof. ~~(3-17-22)~~(____)

607. CHANGES AFFECTING ELIGIBILITY OR AABD CASH AMOUNT.
If a participant reports a change that results in an increase, AABD cash is increased effective the month of report. If a participant reports a change that results in a decrease, AABD cash is decreased or ended effective the first month after proper notice. ( )

608. AABD CASH UNDERPAYMENT.
If the Department is at fault for issuing a payment less than the participant should have received, the Department will issue~~s~~ a supplemental payment for the difference. ~~(3-17-22)~~(____)

609. AABD CASH OVERPAYMENT.
If the participant is paid more AABD cash than they ~~is~~ are eligible for, the Department must collect the overpayment. The Department must notify the participant of the right to a hearing, the method for repayment, and the need for a repayment interview. ~~(3-17-22)~~(____)

610. OFFSET OF OVERPAYMENT AND UNDERPAYMENT.
When an underpayment is computed, any overpayment for that month is subtracted from the underpayment. When an overpayment is computed, any underpayment for the month is subtracted. ( )

611. -- 616. (RESERVED)

617. HEARING REQUEST.
A participant may request a hearing to contest a Department decision. The participant must make the request within ~~thirty~~ ninety (~~3~~90) days of the date the Department mailed the notice of decision. Hearings will be conducted according to IDAPA 16.05.03, "~~Rules Governing~~ Contested Case Proceedings and Declaratory Rulings."
~~(3-17-22)~~(____)

618. CONTINUED BENEFITS PENDING A HEARING DECISION.
The participant may continue to receive benefits upon request, pending the hearing decision. The Department must receive the participant's request for continued benefits before the effective date of the Department's action stated in the notice of decision. An applicant cannot receive continued benefits when appealing a denial for failure to provide citizenship and identity verification after the expiration of a reasonable opportunity period. ( )

01. Amount of Assistance. The Department will continue the participant's assistance at the current month's level while the hearing decision is pending, unless another change affecting assistance occurs. ( )

02. Continued Eligibility. The participant must continue to meet all eligibility requirements not related to the hearing issue. ( )

03. Overpayment. When the hearing decision is in the Department's favor, the participant must repay assistance received while the hearing decision was pending. ( )

619. (RESERVED)

620. MEDICAID OVERPAYMENT.
If the participant receives Medicaid services during a month the~~y~~ ~~is~~ are not eligible, the Department must collect the overpayment. If too little patient liability or ~~client~~ participant participation is computed, the Department must collect the overpayment. The participant must be notified of the overpayment. ~~(3-17-22)~~( )

621. CHANGES IN PATIENT LIABILITY.

01. Increase in Patient Liability. If the patient liability is increased for the current or a past month, the Department will collect the patient liability directly from the ~~client~~ participant. ~~(3-17-22)~~( )

02. Decrease in Patient Liability. If the patient liability is decreased for a current or past month, the funds will be paid to the provider and the provider must reimburse the ~~client~~ participant for the portion of the costs the ~~client~~ participant paid ~~in excess of~~ more than their patient liability. ~~(3-17-22)~~( )

622. (RESERVED)

623. ELIGIBILITY REDETERMINATION.
An eligibility redetermination is completed at least once every year and when a change affecting eligibility occurs. ( )

624. -- 649. (RESERVED)

650. COOPERATION WITH THE QUALITY CONTROL PROCESS.
When the Department or federal government selects a case for review in the quality control process, the participant must cooperate in the review of the case. Benefits must be stopped, following advance notice, when a participant is unwilling to take part in the quality control process. If the participant reapplies for benefits, they must fully cooperate with the quality control process before the application can be approved. ( )

651. -- 699. (RESERVED)

700. MEDICAID ELIGIBILITY.
A participant must meet the eligibility requirements for at least one (1) Medicaid coverage group to be eligible for Medicaid benefits. Income and circumstances in the current month are used for eligibility for the current month. Resources are counted as of the first moment of the month. ( )

701. MEDICAID APPLICATION.
An adult participant, a legal guardian, or a representative of the participant must sign the application. The participant must submit the application to the Department. A Medicaid application may be made for a deceased person. ( )

702. MEDICAL SUPPORT COOPERATION.
Medical support rights are assigned to the Department by signature on the application. The participant must cooperate with the Department to secure medical support and payments~~,~~ to be eligible for Medicaid. The participant must cooperate on behalf of th~~i~~emself and any participant for whom they can legally assign rights. A participant who cannot legally assign~~ his~~ their own rights must not be denied Medicaid if the legally responsible person does not cooperate. ~~(3-17-22)~~(   )

703. CHILD SUPPORT COOPERATION.
The participant must cooperate to identify and locate the noncustodial parent, establish paternity, and establish, modify, and enforce a child medical support order~~,~~ to be eligible for Medicaid. This includes support payments received directly from the noncustodial parent. The cooperation requirement is waived for poverty level pregnant women exempt from cooperating in establishing paternity and obtaining medical support from, or derived from, the father of a child born out of wedlock. A participant who cannot legally assign~~ his~~ their own rights must not be denied Medicaid if the legally responsible person does not cooperate. ~~(3-17-22)~~(   )

704. COOPERATION DEFINED.
Cooperation includes~~, but is not limited to,~~ providing all information to identify and locate the noncustodial parent. Cooperation for Medicaid includes identifying other liable third~~ ~~-party payers. ~~(3-17-22)~~(   )

01. Name of Noncustodial Parent. The participant must provide the first and last name of the noncustodial parent. (   )

02. Information About Noncustodial Parent. The participant must also provide at least two (2) pieces of information, about the noncustodial parent, listed~~ in Subsections 703.02.a. through 703.02.g.~~ below: ~~(3-17-22)~~(   )

a. Birth Date. (   )

b. S~~ocial ~~S~~ecurity ~~N~~umber~~. ~~(3-17-22)~~(   )

c. Current address. (   )

d. Current phone number. (   )

e. Current employer. (   )

f. Make, model, and license number of any motor vehicle owned by the noncustodial parent. (   )

g. Names, phone numbers, and addresses of the parents of the noncustodial parent. (   )

705. GOOD CAUSE FOR NOT COOPERATING IN SECURING MEDICAL AND CHILD SUPPORT.
The participant may claim good cause for failure to cooperate in securing medical and child support for th~~i~~emself or a minor child. Good cause is limited to the~~ reasons listed in Subsections 705.01 through 705.03.~~ following: ~~(3-17-22)~~(   )

01. Rape or Incest. There is proof the child was conceived~~ as a result~~ because of incest or rape. ~~(3-17-22)~~(   )

02. Physical or Emotional Harm. There is proof the child's non-custodial parent may inflict physical or emotional harm to the participant, the child, the custodial parent, or the caretaker relative. There is proof another person may inflict physical or emotional harm to an AABD-related participant if the participant cooperates in securing medical and child support. (   )

03. Minimum Information Cannot Be Provided. Substantial and credible proof is provided indicating the participant cannot provide the minimum information regarding the non-custodial parent. (   )

706. CLOSURE AFTER REVIEW OF GOOD CAUSE REQUEST.
If the participant claims good cause for not cooperating, but the Department determines there is not good cause, the participant must be given the opportunity to withdraw the application or have their Medicaid closed. ( )

707. APPLICATION REQUIREMENTS FOR POTENTIAL MEDICAL COVERAGE.

01. Group Health Plan Enrollment Requirement. Each participant must apply for and enroll in a cost-effective employer group health plan as a condition of eligibility for Medicaid. Medicaid coverage must not be denied, delayed, or stopped pending the start of a participant's group health insurance coverage. A child entitled to enroll in a group health plan must not be denied Medicaid coverage solely because ~~his~~ their caretaker fails to apply for the child's enrollment. ~~(3-17-22)~~( )

02. Medicare Enrollment Requirement. Each participant who may be eligible for Medicare must apply for all parts of Medicare parts A, B, and D for which they ~~is~~ are likely to be eligible, as a condition of eligibility for Medicaid. ~~(3-17-22)~~( )

708. MEDICAID QUALIFYING TRUST PAYMENTS.
For Medicaid Qualifying Trusts established before August 11, 1993, the maximum payment permitted to be made to a participant from the trust must be counted for Medicaid eligibility. The maximum is counted whether or not the trustee actually distributes payments. ( )

709. MEDICAID ELIGIBILITY FOR AABD PARTICIPANT.
A participant eligible for AABD cash is eligible for Medicaid, unless they ~~is~~ are in an ineligible institution, receive~~s~~ excess payment from a Medicaid Qualifying Trust, or ha~~s~~ve an irrevocable trust that is not exempt. ~~(3-17-22)~~( )

710. -- 719. (RESERVED)

720. LONG-TERM CARE RESIDENT AND MEDICAID.
A resident of a long-term care facility must meet the AABD eligibility criteria to be eligible for Medicaid. A long-term care facility is a nursing facility or an ~~intermediate care facility for persons with intellectual disabilities~~ ICF/IID. The need for long-term care is determined using IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits."
~~(3-17-22)~~( )

01. Resources of Resident. The resident's resource limit is two thousand dollars ($2,000). Resources of a married person in long-term care are computed using Federal Spousal Impoverishment rules. Under the SSI method, spouses can use the three thousand dollar ($3,000) couple resource limit if more advantageous. The couple must have lived in the nursing home, in the same room, for six (6) months. ( )

02. Medicaid Income Limit of Long-Term Care Resident Thirty Days or More. The monthly income limit for a long-term care facility resident is three (3) times the federal SSI benefit for a single person. To qualify for this income limit, the participant must be, or be likely to remain, in long-term care at least thirty (30) consecutive days. ( )

03. Medicaid Income Limit of Long-Term Care Resident Less Than Thirty Days. The monthly income limit, for the resident of a long-term care facility for less than thirty (30) consecutive days, is the AABD income limit for the participant's living situation before long-term care. Living situations before long-term care do not include hospital stays. ( )

04. Income Not Counted. The income listed in Subsections 720.04.a. through 720.04.e. of this rule is not counted to compute Medicaid eligibility for a long-term care facility resident. This income is counted in determining participation in the cost of long-term care. ( )

a. Income excluded or disregarded in determining eligibility for AABD cash is not counted.
( )

b. The September 1972 RSDI increase is not counted. ( )

c. Any VA Aid and Attendance allowance, including any increment that is the result of a VA Unusual Medical Expense allowance, is not counted. These allowances are not counted for patient liability, unless the veteran lives in a state-operated veterans' home. ( )

d. RSDI benefit increases from cost-of-living adjustments (COLA) after April 1977 are not counted if they made the participant lose SSI or AABD cash. The COLA increases after SSI or AABD cash stopped are not counted. ( )

e. Income paid into an income trust exempt from counting for Medicaid eligibility under Subsection 872.02 of these rules is used for patient liability. Income paid to the trust and not used for patient liability is subject to the asset transfer penalty. ( )

05. Medicaid Participant Residing in a Skilled Nursing Facility. When a Medicaid participant who is a resident of a skilled nursing facility and meets that level of care as evidenced by the PA~~S~~ARR defined in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits,"~~ Section 227,~~ the resident is determined to be disabled for the duration of~~ his~~ their residency in the skilled nursing facility. ~~(3-17-22)~~( )

721. QUALIFIED LONG-TERM CARE PARTNERSHIP POLICY.

Participants who have received, or are entitled to receive, benefits under a Qualified Long-Term Care Partnership policy issued in Idaho after November 1, 2006, will have certain resources disregarded as described~~ in Subsections 721.01 and 721.02 of these rules~~ below. ~~(3-17-22)~~( )

01. Value of the Participant's Resources. The total dollar amount of the insurance benefits paid out for a policy holder of a Qualified Long-Term Care Partnership policy is disregarded in calculating the value of the participant's resources for long-term care Medicaid eligibility. The amount that is disregarded is determined on the effective date of an initial application approval for long-term care Medicaid benefits. ( )

02. Resource Disregard Excluded from Estate Recovery. The amount of the resources disregarded from a Qualified Long-Term Care Partnership policy under Subsection 721.01 of this rule, is deducted from the assets of the estate for Medicaid estate recovery. ( )

722. PATIENT LIABILITY.

Patient liability is the participant's income counted toward the cost of long-term care. Patient liability begins the month after the first full calendar month the patient is receiving benefits in a long-term care facility. ( )

723. PATIENT LIABILITY FOR PERSON WITH NO COMMUNITY SPOUSE.

For a participant with no community spouse, patient liability is computed as described~~ in Subsections 723.01 through 723.03 of this rule~~ below. ~~(3-17-22)~~( )

01. Income of Participants in Long-Term Care. For a single participant, or participant whose spouse is also in long-term care and chooses the SSI method of calculating the amount of income and resources, the patient liability is~~ his~~ their total income less the deductions in Subsection 723.03 of this rule. ~~(3-17-22)~~( )

02. Community Property Income of Long-Term Care Participant with Long-Term Care Spouse. Patient liability income for a participant, whose spouse is also in long-term care, choosing the community property method, is one-half (1/2)~~ his~~ their share of the couple's community income, plus~~ his~~ their own separate income. The deductions~~ in Table~~ under Subsection 723.03 of this rule are subtracted from~~ his~~ their income. ~~(3-17-22)~~( )

03. Income of Participant in Facility. A participant residing in the long-term care facility at least one (1) full calendar month, beginning with~~ his~~ their most recent admission, must have the deductions in~~ Subsection 723.03~~ below subtracted from~~ his~~ their income, after the AABD exclusions are subtracted from the income. Total monthly income includes income paid into an income (Miller) trust that month. The income deductions must be subtracted in the order listed. Remaining income is patient liability. ~~(3-17-22)~~( )

a. AABD Income Exclusions. ~~Subtract i~~Income excluded in determining eligibility for AABD cash is subtracted. ~~(3-17-22)~~( )

b. Aid and Attendance and UME Allowances. ~~Subtract a~~ VA Aid and Attendance allowance and Unusual Medical Expense (UME) allowance for a veteran or surviving spouse is subtracted, unless the veteran lives in a state operated veterans' home. ~~(3-17-22)~~( )

c. SSI Payment Two (2) Months. ~~Subtract t~~The SSI payment for a participant entitled to receive SSI at ~~his~~ their at-home rate for up to two (2) months is subtracted, while temporarily in a long-term care facility. ~~(3-17-22)~~( )

d. AABD Payment. ~~Subtract t~~The AABD payment, and income used to compute the AABD payment, for a participant paid continued AABD payments up to three (3) months in long-term care is subtracted. ~~(3-17-22)~~( )

e. First Ninety ($90) Dollars of VA Pension. ~~Subtract t~~The first ninety ($90) dollars of a VA pension for a veteran in a private long-term care facility or a State Veterans Nursing Home is subtracted. ~~(3-17-22)~~( )

f. Personal Needs. ~~Subtract f~~Forty dollars ($40) is subtracted for the participant's personal needs. For a veteran or surviving spouse in a private long-term care facility or a State Veterans Nursing Home the first ninety ($90) dollars of VA pension substitutes for the forty dollar ($40) personal needs deduction. ~~(3-17-22)~~( )

g. Employed and Sheltered Workshop Activity Personal Needs. For an employed participant or participant engaged in sheltered workshop or work activity center activities~~, subtract~~ the lower of the personal needs deduction of two hundred dollars ($200) or ~~his~~ their gross earned income is subtracted. The participant's total personal needs allowance must not exceed two hundred and thirty dollars ($230). For a veteran or surviving spouse with sheltered workshop or earned income, and a protected VA pension, the total must not exceed two hundred dollars ($200). This is a deduction only. No actual payment can be made to provide for personal needs. ~~(3-17-22)~~( )

h. Home Maintenance. ~~Subtract t~~Two hundred and twelve dollars ($212) is subtracted for home maintenance cost if the participant had an independent living situation, before ~~his~~ their admission for long-term care. ~~His~~ Their physician must certify in writing the participant is likely to return home within six (6) months, after the month of admission to a long-term care facility. This is a deduction only. No actual payment can be made to maintain the participant's home. ~~(3-17-22)~~( )

i. Maintenance Need. ~~Subtract a~~A maintenance need deduction for a family member~~,~~ living in the long-term care participant's home is subtracted. A family member is claimed, or could be claimed, as a dependent on the Federal Income Tax return of the long-term care participant. The family member must be a minor or dependent child, dependent parent, or dependent sibling of the long-term care participant. The maintenance need deduction is the AFDC payment standard for the dependents, computed according to the AFDC State Plan in effect before July 16, 1996. ~~(3-17-22)~~( )

j. Medicare and Health Insurance Premiums. ~~Subtract e~~Expenses for Medicare and other health insurance premiums, and deductibles or coinsurance charges are subtracted, and not subject to payment by a third party. Deduction of Medicare Part B premiums is limited to the first two (2) months of Medicaid eligibility. Medicare Part B premiums must not be subtracted, if the participant got SSI or AABD cash the month prior to the month for which patient liability is being computed. ~~(3-17-22)~~( )

k. Mandatory Income Taxes. ~~Subtract t~~Taxes mandatorily withheld from unearned income for income tax purposes are subtracted. To qualify for deduction of mandatory taxes, the tax must be withheld from income before the participant receives the income. ~~(3-17-22)~~( )

l. Guardian Fees. ~~Subtract c~~Court-ordered guardianship fees of the lesser of ten percent (10%) of the monthly benefit handled by the guardian, or twenty-five dollars ($25) are subtracted. Where the guardian and trustee is the same person, the total deduction for guardian and trust fees must not exceed twenty-five dollars ($25) monthly. ~~(3-17-22)~~( )

m. Trust Fees. ~~Subtract u~~Up to twenty-five dollars ($25) monthly paid to the trustee for administering

the participant's trust is subtracted. (3-17-22)( )

n. Impairment--Related Work Expenses (IRWE). Subtract impairment-related work expenses IRWEs for an employed participant who is blind or disabled under AABD criteria are subtracted. Impairment-related work expenses IRWEs are purchased or rented items and services that are purchased or rented to perform work. The items must be needed because of the participant's impairment. The actual monthly expense of the impairment-related items is subtracted. Expenses must not be averaged. (3-17-22)( )

o. Income Garnished for Child Support. Subtract iIncome garnisheed for child support to the extent the expense is not already accounted for in computing the maintenance need standard is subtracted. (3-17-22)( )

p. Incurred Medical Expenses. Subtract aAmounts for certain limited medical or remedial care expenses that have current balances owed and are deemed medically necessary as defined in IDAPA 16.03.09, "Medicaid Basic Plan Benefits.," are subtracted. Current medical expenses that are not covered by the Idaho Medicaid Plan, or by a third party, may be deducted from the base participation amount. (3-17-22)( )

q. Pre-existing Medical Expenses. Subtract aAmounts for medical and remedial care expenses incurred within the three (3) months prior to the month of application are subtracted. The deductions for medical and remedial care expenses are limited to those medically necessary expenses incurred by the participant for the participant's care. These deductions for medical and remedial care expenses is are limited to the amount of liability owed by the participant, and if applicable, after any third-party insurance has been applied. The deduction for medical and remedial care expenses that were incurred as the result of imposition of a transfer of assets penalty period is limited to zero. (3-17-22)( )

724. INCOME OWNERSHIP OF PARTICIPANT WITH COMMUNITY SPOUSE.

Income ownership of a long-term care participant with a community spouse is determined before patient liability is computed. The participant's income ownership is counted as shown in Subsections 724.01 through 724.04 below. (3-17-22)( )

01. Income Paid in the Name of Spouse. Income paid solely in the name of a spouse, and not paid from a trust, is the separate income of the spouse. ( )

02. Payment in Name of Both Spouses. Income paid in the names of both the long-term care participant and the community spouse is divided evenly between each spouse. ( )

03. Payment in Name of Spouse or Spouses and Another Person. Income paid in the names of the participant and/or the community spouse and another person is counted as available to each spouse, in proportion to the spouse's ownership. If payment is made to both spouses, and no proportion of ownership is specified, one-half of the income is counted to each spouse. ( )

04. Payment of Aid and Attendance. In the case of VA Aid and Attendance Allowance paid in the veteran's name, with an increment for the veteran's spouse, the increment is counted to the veteran. ( )

725. PATIENT LIABILITY FOR PARTICIPANT WITH COMMUNITY SPOUSE.

After income ownership is decided, patient liability is determined using steps in Table 725.For a participant with a community spouse, patient liability is computed as described in Subsection 723.03 of these rules with the addition of the following steps for Community Spouse Allowance (CSA):

TABLE 725 - INCOME DEDUCTIONS FOR PARTICIPANT IN FACILITY		
Step		**Procedure**
01.	AABD Income Exclusions	Subtract income excluded in determining eligibility for AABD cash.
02.	Aid and Attendance and UME Allowances	Subtract a VA Aid and Attendance allowance and Unusual Medical Expense (UME) allowance for a veteran or surviving spouse, unless the veteran lives in a state operated veterans' home.

TABLE 725 - INCOME DEDUCTIONS FOR PARTICIPANT IN FACILITY		
Step		**Procedure**
03.	SSI Payment Two (2) Months	Subtract the SSI payment for a participant entitled to receive SSI at his at-home rate for up to two (2) months, while temporarily in a long term care facility.
04.	AABD Cash	Subtract the AABD cash payment and income used to compute AABD cash, for a participant eligible to have his AABD cash continued up to three (3) months, while he is in long-term care.
05.	VA Pension	Subtract the first ninety (90$) of the VA pension for a veteran.
06.	Personal Needs	Subtract forty dollars ($40) for the participant's personal needs. Do not allow this deduction for a veteran.
07.	Employed and Sheltered Workshop Activity Needs	For an employed participant or participant engaged in sheltered workshop or work activity center activities subtract the lower of two hundred dollars ($200) or his earned income.
08.	Community Spouse Allowance: Step a.	Compute the Community Spouse Allowance (CSA) using Step a. through Step c. Compute the Shelter Adjustment. Add the current Food Stamp Program Standard Utility Allowance to the community spouse's shelter costs. Shelter costs include rent, mortgage principal and interest, homeowner's taxes, insurance, and condominium or cooperative maintenance charges. The Standard Utility Allowance must be reduced by the value of any utilities included in maintenance charges for a condominium or cooperative. Subtract the Shelter Standard from the shelter and utilities. The Shelter Standard is thirty percent (30%) of one hundred fifty percent (150%) of one-twelfth (1/12) of the income official poverty line defined by the Federal Office of Management and Budget (OMB) for a family of two (2) persons. The Shelter Adjustment is the positive balance remaining.
09.	Community Spouse Allowance: Step b.	Compute the Community Spouse Need Standard (CSNS). Add the Shelter Adjustment to the minimum CSNS. The minimum CSNS equals one hundred fifty percent (150%) of one-twelfth (1/12) of the income official poverty line defined by the OMB for a family unit of two (2) members. The minimum CSNS is revised annually in July. The total CSNS may not exceed the maximum CSNS. The maximum CSNS is computed by multiplying one thousand five hundred dollars ($1,500) by the percentage increase in the consumer price index for all urban Consumers (all items; U.S. city average) between September 1988 and the September before the current calendar year. The maximum CSNS is revised annually in January.

TABLE 725 - INCOME DEDUCTIONS FOR PARTICIPANT IN FACILITY		
Step		Procedure
10.	Community Spouse Allowance: Step c.	Compute the Community Spouse Allowance. Subtract the community spouse's gross income from the CSNS. The community spouse's income includes income produced by his resources. Round any remaining cents to the next higher dollar. Any positive balance remaining is the CSA. The CSA is subtracted as actually paid to the community spouse, up to the computed maximum. A larger spouse support amount must be used as the CSA, if court ordered. The CSA ordered by a court is not subject to the CSA limit.
11.	Family Member Allowance (FMA)	Compute the family member's gross income. Subtract the family member's gross income from the minimum CSNS. Divide the difference by three (3). Round cents to the next higher dollar. Any remainder is the FMA for that family member. The FMA is allowed, whether or not it is actually paid by the participant. A family member is, or could be claimed, as a dependent on the Federal income tax return of either spouse. The family member must be a minor or dependent child, dependent parent or dependent sibling of either spouse. The family member must live in the community spouse's home.
12.	Medicare and Health Insurance Premiums	Subtract expenses for Medicare and other health insurance premiums, and deductibles or coinsurance charges, not subject to payment by a third party. Deduction of Medicare Part B premiums is limited to the first two (2) months of Medicaid eligibility. Do not subtract the Medicare Part B premiums if the participant got SSI or AABD cash the month prior to the month for which patient liability is being computed.
13.	Mandatory Income Taxes	Subtract taxes mandatorily withheld from unearned income for income tax purposes. To qualify for deduction of mandatory taxes, the tax must be withheld from income before the participant receives the income.
14.	Guardian Fees	Subtract court-ordered guardianship fees of the lesser of ten percent (10%) of the monthly benefit handled by the guardian, or twenty-five dollars ($25). Where the guardian and trustee are the same person, the total deduction for guardian and trust fees must not exceed twenty-five dollars ($25) monthly.
15.	Trust Fees	Subtract up to twenty-five dollars ($25) monthly paid to the trustee for administering the participant's trust.
16.	Impairment Related Work Expenses	Subtract impairment-related work expenses for an employed participant who is blind or disabled under AABD criteria. Impairment-related work expenses are purchased or rented items and services, purchased or rented to perform work. The items must be needed because of the participant's impairment. The actual monthly expense of the impairment-related items is subtracted. Expenses must not be averaged.

TABLE 725 - INCOME DEDUCTIONS FOR PARTICIPANT IN FACILITY		
Step		Procedure
17.	Income Garnished for Child Support	Subtract income garnished for child support to the extent the expense is not already accounted for in computing the Family Member Allowance.
18.	Incurred Medical Expenses	Subtract amounts for certain limited medical or remedial care expenses that have current balances owed and are deemed medically necessary as defined in IDAPA 16.03.09, "Medicaid Basic Plan Benefits." Current medical expenses that are not covered by the Idaho Medicaid Plan, or by a third party, may be deducted from the base participation amount.
19.	Pre-existing Medical Expenses	Subtract amounts for medical and remedial care expenses incurred within the three (3) months prior to the month of application. The deductions for medical and remedial care expenses are limited to those medically necessary expenses incurred by the participant for the participant's care. The deduction for medical and remedial care expenses is limited to the amount of liability owed by the participant, and if applicable, after any third-party insurance has been applied. The deduction for medical and remedial care expenses that were incurred as the result of imposition of a transfer of assets penalty period is limited to zero.

(3-17-22)(   )

01. Shelter Adjustment. The Department will add the current Food Stamp Program Standard Utility Allowance to the community spouse's shelter costs. Shelter costs include rent, mortgage principal and interest, homeowner's taxes, insurance, and condominium or cooperative maintenance charges. The Standard Utility Allowance must be reduced by the value of any utilities included in maintenance charges for a condominium or cooperative. The Department will subtract the Shelter Standard from the shelter and utilities. The Shelter Standard is thirty percent (30%) of one hundred fifty percent (150%) of one-twelfth (1/12) of the income official poverty line defined by the federal Office of Management and Budget (OMB) for a family of two (2) persons. The Shelter Adjustment is the positive balance remaining. (   )

02. Community Spouse Need Standard (CSNS). The Department will add the Shelter Adjustment to the minimum CSNS. The minimum CSNS equals one hundred fifty percent (150%) of one-twelfth (1/12) of the income official poverty line defined by the OMB for a family unit of two (2) members. The minimum CSNS is revised annually in July. The total CSNS may not exceed the maximum CSNS. The maximum CSNS is computed by multiplying one thousand five hundred dollars ($1,500) by the percentage increase in the consumer price index for all urban consumers (all items, US city average) between September 1988 and the September before the current calendar year. The maximum CSNS is revised annually in January. (   )

03. Community Spouse Allowance (CSA). The Department will subtract the community spouse's gross income from the CSNS. The community spouse's income includes income produced by their resources. The Department will round any remaining cents to the next higher dollar. Any positive balance remaining is the CSA. The CSA is subtracted as actually paid to the community spouse, up to the computed maximum. A larger spouse support amount must be used as the CSA, if court-ordered. The CSA ordered by a court is not subject to the CSA limit. (   )

726. PERSONAL NEEDS SUPPLEMENT (PNS).

A nursing home participant may receive a PNS to bring his their gross income up to forty dollars ($40). Gross income is income after exclusions and before disregards. Gross income, and includes money withheld to recover an AABD overpayment. The PNS is the difference between the participant's gross income and forty dollars ($40). If not in an even dollar amount, the PNS is rounded up to the next dollar. The participant's income including the PNS must not exceed forty dollars ($40). (3-17-22)(   )

727. FAIR HEARING ON CSA DECISION.

Either spouse may ask for a fair hearing to show the community spouse needs a higher CSA. The hearing officer must

consider if, due to unusual conditions, using the computed CSA causes significant financial hardship for the community spouse. If the fair hearing decision finds the community spouse needs more income than the CSA, the CSA must include the additional income. ( )

728. -- 730. (RESERVED)

731. MEDICAID ELIGIBILITY OF MARRIED PERSONS.
There are three (3) methods for Medicaid eligibility of an aged, blind, or disabled married person: (1) Tthe SSI method, (2) the Community Property (CP) method, and (3) the Federal Spousal Impoverishment (FSI) method. The FSI method takes precedence. If the participant is not subject to the FSI method, the CP or SSI methods can be used. (3-17-22)( )

732. CHOOSING FSI, SSI, OR CP RESOURCE COUNTING METHOD.
Table 732 is used to determine the resource counting method for a married person. If an HCBS participant with a spouse at home is not eligible using the FSI method, resources are computed using the SSI/CP method.

TABLE 732 - CHOOSING FSI, SSI, OR CP RESOURCE COUNTING METHOD

	SPOUSE ONE (1) IN NURSING HOME BEFORE 9/30/89	SPOUSE ONE (1) IN NURSING HOME ON OR AFTER 9/30/89	SPOUSE ONE (1) AT HOME NO HCBS	SPOUSE ONE (1) AT HOME WITH HCBS BEFORE 9/30/89	SPOUSE ONE (1) AT HOME WITH HCBS ON OR AFTER 9/30/89
SPOUSE TWO (2) IN NURSING HOME BEFORE 9/30/89	SSI/CP	SSI/CP	SSI/CP	SSI/CP	SSI/CP
SPOUSE TWO (2) IN NURSING HOME ON OR AFTER 9/30/89	SSI/CP	SSI/CP	FSI	SSI/CP	SSI/CP
SPOUSE TWO (2) AT HOME NO HCBS	SSI/CP	FSI	SSI/CP	SSI/CP	FSI
SPOUSE TWO (2) AT HOME WITH HCBS BEFORE 9/30/89	SSI/CP	SSI/CP	SSI/CP	SSI/CP	SSI/CP
SPOUSE TWO (2) AT HOME WITH HCBS ON OR AFTER 9/30/89	SSI/CP	SSI/CP	FSI	SSI/CP	SSI/CP

( )

733. CHOOSING FSI, SSI, OR CP INCOME COUNTING METHOD.
Table 733 is used to determine the income counting method for a married person. If a participant subject to the FSI method is not eligible using FSI, income is computed using the SSI/CP method.

TABLE 733 - CHOOSING FSI, SSI, OR CP INCOME COUNTING METHOD					
	SPOUSE ONE (1) IN NURSING HOME BEFORE 9/30/89	SPOUSE ONE (1) IN NURSING HOME ON OR AFTER 9/30/89	SPOUSE ONE (1) AT HOME NO HCBS	SPOUSE ONE (1) AT HOME WITH HCBS BEFORE 9/30/89	SPOUSE ONE (1) AT HOME WITH HCBS ON OR AFTER 9/30/89
SPOUSE TWO (2) IN NURSING HOME BEFORE 9/30/89	SSI/CP	SSI/CP	FSI	SSI/CP	SSI/CP
SPOUSE TWO (2) IN NURSING HOME ON OR AFTER 9/30/89	SSI/CP	SSI/CP	FSI	SSI/CP	SSI/CP
SPOUSE TWO (2) AT HOME NO HCBS	FSI	FSI	SSI/CP	FSI	FSI
SPOUSE TWO (2) AT HOME WITH HCBS BEFORE 9/30/89	SSI/CP	SSI/CP	FSI	SSI/CP	SSI/CP
SPOUSE TWO (2) AT HOME WITH HCBS ON OR AFTER 9/30/89	SSI/CP	SSI/CP	FSI	SSI/CP	SSI/CP

( )

734. CHOOSING FSI, SSI, OR CP PATIENT LIABILITY OR ~~CLIENT~~ PARTICIPATION METHOD.
Table 734 is used to determine the patient liability or ~~client~~ participant participation method for a married participant in long-~~-~~term care or receiving HCBS.

TABLE 734 - PATIENT LIABILITY OR ~~CLIENT~~ PARTICIPATION METHOD					
	SPOUSE ONE IN NURSING HOME BEFORE 9/30/89	SPOUSE ONE IN NURSING HOME ON OR AFTER 9/30/89	SPOUSE ONE AT HOME NO HCBS	SPOUSE ONE AT HOME WITH HCBS BEFORE 9/30/89	SPOUSE ONE AT HOME WITH HCBS ON OR AFTER 9/30/89
SPOUSE TWO IN NURSING HOME BEFORE 9/30/89	SSI/CP	SSI/CP	FSI	SSI/CP	SSI/CP
SPOUSE TWO IN NURSING HOME ON OR AFTER 9/30/89	SSI/CP	SSI/CP	FSI	SSI/CP	SSI/CP

TABLE 734 - PATIENT LIABILITY OR ~~CLIENT~~ PARTICIPATION METHOD					
SPOUSE TWO AT HOME NO HCBS	FSI	FSI	N/A	FSI	FSI
SPOUSE TWO AT HOME WITH HCBS BEFORE 9/30/89	SSI/CP	SSI/CP	FSI	SSI/CP	SSI/CP
SPOUSE TWO AT HOME WITH HCBS ON OR AFTER 9/30/89	SSI/CP	SSI/CP	FSI	SSI/CP	SSI/CP

~~(3-17-22)~~(   )

735. FEDERAL SPOUSAL IMPOVERISHMENT (FSI) METHOD OF COUNTING INCOME AND RESOURCES OF A COUPLE.

The FSI method must be used to compute income and resources of a married participant~~,~~ who requires long-term care as defined in Section 010 of these rules, and who has a community spouse. The participant must have entered long-term care on or after September 30, 1989. Terms used in the FSI method are listed ~~in Subsections 735.01 through 735.05 of this rule~~ below. ~~(3-17-22)~~(   )

01. Long-Term Care Spouse. ~~The long-term care spouse m~~Must be in a medical institution or nursing facility, or be an HCBS participant, for thirty (30) consecutive days, or appear likely to meet the thirty (30) days requirement. ~~(3-17-22)~~(   )

02. Community Spouse. ~~The community spouse is t~~The ~~husband or wife~~ spouse of the long-term care participant. A community spouse is not in long-term care and is not an HCBS participant. ~~(3-17-22)~~(   )

03. Continuous Period of Long-Term Care. A ~~continuous period of long-term care is a~~ period of residence either in a medical institution with nursing facility services, or at home with HCBS. A continuous period of long-term care is also a combination of institution and personal care services likely to last at least thirty (30) consecutive days. Absence from the institution, or a lapse in HCBS eligibility~~,~~ of thirty (30) consecutive days breaks continuity. The thirty (30) consecutive days of long-term care must not begin on a day the participant is hospitalized. If the participant is hospitalized after the first day of the thirty (30) consecutive days, the hospital stay does not interrupt the thirty (30) consecutive days. ~~(3-17-22)~~(   )

04. Start of Continuous Period of Long-Term Care. The ~~start of a continuous period of long-term care is the~~ first month of long-term care or HCBS. ~~(3-17-22)~~(   )

05. Nursing Facility Services. ~~Nursing facility services are s~~Services at the nursing facility level or the ~~intermediate care for persons with intellectual disabilities~~ ICF/IID level provided in a medical institution. ~~(3-17-22)~~(   )

736. ASSESSMENT DATE AND COUNTING FSI RESOURCES.

The assessment date is the start date of the first continuous period of long-term care. The Department does a one-time assessment to determine the value of the couple's community and separate resources as of the date of the first continuous period of long-term care. The resource assessment is done at the request of either spouse, after one (1) spouse is in long-term care or meets the level of care for HCBS, whether or not the couple has applied for Medicaid. State laws relating to community property or the division of marital property are not applied in determining the FSI total combined resources of the couple. (   )

737. TREATMENT OF RESOURCES FOR ASSESSMENT.
The resource rules used in determining eligibility for AABD cash and Medicaid are also used in determining the couple's total combined resources for the FSI resource assessment with the following exceptions: ( )

01. Resources for Sale. Excess resources offered for sale, are not excluded from the couple's total combined resources for the FSI resource assessment. ( )

02. Jointly Owned Real Property. Jointly owned real property that is not the principal residence of the participant is not excluded if the community spouse is the joint owner. ( )

03. Long-term Care Partnership Policy. Resources excluded because of a participant's qualified long-term care policy are not excluded for the FSI resource assessment. ( )

04. Excluded Home. As defined in 42 USC 1396r-5(c)(5), an excluded home placed in trust retains its exclusion for purposes of the resource assessment. ( )

738. ONE-HALF SPOUSAL SHARE.
The spousal share is one-half (1/2) of the couple's total combined resources on the assessment date. The spousal share does not change, even if the participant leaves long-term care and then enters long-term care again. The Department must inform the couple of the resources counted in the assessment and the value assigned. The couple must sign the assessment form under penalty of perjury. The signature requirement may be waived for the long-term care spouse if they or their representative says they are unable to sign the resources assessment. A copy of the assessment form must be provided to each spouse when eligibility is determined or when either spouse requests an assessment prior to application. ( )

739. -- 741. (RESERVED)

742. COMMUNITY SPOUSE RESOURCE ALLOWANCE.
The CSRA protects resources for the community spouse. The CSRA is determined by subtracting the greater of the minimum resource allowance or the spousal share from the couple's total combined resources as of the first day of the application month. The deduction must not be more than the maximum resource allowance at the time eligibility is determined. ( )

743. RESOURCE ALLOWANCE LIMITS.
The maximum resource allowance is computed by multiplying sixty thousand dollars ($60,000) by the percentage increase in the consumer price index for all urban consumers (all items~~;~~, U~~.~~S~~.~~ city average) between September 1988 and the September before the current calendar year. The minimum resource allowance is computed by multiplying twelve thousand dollars ($12,000) by the percentage increase in the consumer price index for all urban consumers (all items~~;~~, U~~.~~S~~.~~ city average) between September 1988 and the September before the current calendar year. If the result is not an even one hundred dollar ($100) amount, the Department will round up to the next one hundred dollars ($100). The couple's resources exceeding the CSRA are counted for the long-term care spouse. ~~(3-17-22)~~( )

744. INCOME COUNTED FIRST FOR CSRA REVISION.
Income is determined prior to determining resources. If the couple's income is more than the minimum CSNS, the CSRA cannot be increased. If the community spouse has less income than the minimum CSNS, the CSRA may be increased as provided in Section 745 of these rules. Couple income is the community spouse's gross income plus the long-term care spouse's income. The long-term care spouse's income is ~~his~~ their gross income less the AABD cash income exclusions and ~~his~~ their patient liability income deductions, but not the CSA deduction. ~~(3-17-22)~~( )

745. UPWARD REVISION OF CSRA.
If the community spouse's income, including income from ~~his~~ their CSA and income-producing resources in ~~his~~ their CSRA, is less than the minimum CSNS, the CSRA may be increased. The CSRA is increased by enough resources~~,~~ transferred from the long-term care spouse~~,~~ to raise the community spouse's income to the minimum CSNS Resources included in the transfer are presumed to produce income at the treasury rate, whether or not the resources produce income. If the community spouse shows they ~~is~~ are making reasonable use of ~~his~~ their income and resources~~,~~ to generate income, the Department may waive the treasury rate requirement. Actual income produced by the resources transferred to the community spouse is used to compute the CSA. A higher CSA can be requested under

Section 727 of these rules. If the transferred resources produce more than the treasury rate, the actual income produced is used to determine the additional resources that can be transferred to the community spouse in the CSRA. The long-term care spouse must transfer the resources to the community spouse, or the CSRA is not revised. ~~(3-17-22)~~(   )

746. RESOURCE TRANSFER ALLOWANCE (RTA).
The ~~resource transfer allowance (~~RTA~~)~~ is computed by subtracting the community spouse's resources~~,~~ at the time of application~~,~~ from the CSRA. The community spouse must own less than the CSRA to get an RTA. The long~~-~~-term care spouse may transfer the RTA to the community spouse without an asset transfer penalty. If the institutional spouse transfers more than the RTA, the amount of the couple's resources over the CSRA counts as the institutional spouse's resources. After the month, a long-term care spouse is determined Medicaid~~-~~-eligible under FSI, resources of the community spouse are not considered available to them ~~him~~ while they remain~~s~~ in long-term care. ~~(3-17-22)~~(   )

747. PROTECTED PERIOD FOR RTA TRANSFER.
The long-term care spouse has sixty (60) days, from the date ~~his~~ their application is approved, to transfer ~~his~~ their ownership of the RTA resources to the community spouse. The long-term care spouse must state, in writing, ~~his~~ their intent to transfer the RTA resources to the community spouse~~,~~ within the protected period~~,~~ before they can be Medicaid~~-~~-eligible. Resources not transferred within the sixty (60) day protected period are available to the long-term care spouse, effective the day they entered the facility. ~~(3-17-22)~~(   )

748. EXTENSION FOR RTA TRANSFER.
The protected period can be extended beyond sixty (60) days, if necessary, because of the participant's circumstances. (   )

749. RESOURCE ELIGIBILITY FOR COMMUNITY SPOUSE.
When the community spouse is a Medicaid participant, the spouse's resources are counted using Medicaid rules. The FSI rules apply only to the long-term care spouse. For the month the couple stopped living together, resources of the community spouse available for their Medicaid eligibility are the resources owned by the couple. (   )

750. INCOME ELIGIBILITY FOR COMMUNITY SPOUSE.
When the community spouse is a Medicaid participant, the spouse's income is counted using Medicaid rules. The FSI rules apply only to the long-term care spouse. The community spouse may choose between the SSI and CP methods for determining income for Medicaid eligibility. (   )

751. CHANGE IN CIRCUMSTANCES.
The FSI method of calculating income and resources stops the first full calendar month after a change in circumstances resulting in a couple no longer having a community spouse and a long-term care spouse. (   )

752. NOTICE AND HEARING.
The Department must tell the participant about the CSA, the family member allowance, the CSRA and how it was computed, and the RTA. Any hearing requested about the CSRA or the RTA must be held within thirty (30) days of the date of the request for hearing. ~~(3-17-22)~~(   )

753. -- 760. (RESERVED)

761. CHOICE OF SSI OR CP METHODS.
A married participant, not using FSI, must be furnished a written explanation of SSI and CP income and resource counting methods. The couple chooses the most useful method, based on their circumstances. The same method must be used for both spouses. (   )

762. SSI METHOD OF COUNTING INCOME AND RESOURCES OF A COUPLE.
The SSI method is the same method used to count income and resources for AABD cash. Income and resources of the participant and spouse are counted as mutually available. This method must be used for months either spouse gets SSI or AABD cash, or an SSI and/or AABD application is filed and approved. This method must be used for Medicaid eligibility, and liability for the cost of long-term care, whether or not one (1) or both spouses apply for Medicaid. For

long-term care, the couple's income and resources are mutually available when one (1) or both spouses apply during the month they separated, because one (1) or both left their mutual home to enter a long-term care facility. ~~(3-17-22)~~(   )

763. COMMUNITY PROPERTY (CP) METHOD OF COUNTING INCOME AND RESOURCES OF A COUPLE.

A married participant in long-term care, whose spouse is not in the community, can use the CP method. A married participant using the FSI method, but not income-eligible using FSI, may choose the CP method for income eligibility. The CP method must not be used for the FSI participant's resource eligibility or patient liability. (   )

764. CP METHOD.

The CP method gives each spouse ~~has~~ an equal one-half (1/2) share of the couple's community income and resources. Each spouse also has ~~his or her~~ their own separate income and resources. Whether the spouses live together or, if not living together, the length of time they have lived apart, does not change the way income and resources are counted. A spouse's property includes income, personal property, and real property. The income and resources of a married couple acquired during the marriage are presumed to be community property of the couple. The couple can give evidence to rebut the presumption that property acquired during the marriage is community property. ~~(3-17-22)~~(   )

765. TRANSFER OF RIGHTS TO FUTURE INCOME NOT VALID.

An agreement between spouses, transferring or assigning rights to future income from one (1) spouse to the other, is not valid for eligibility for Medicaid. (   )

766. CP METHOD NEED STANDARD.

The participant is budgeted as a single person if ~~his~~ their spouse is not a Medicaid applicant, is not living with th~~i~~em, or was not living with th~~i~~em on the first day of the month. The participant and spouse are budgeted as a couple if they both apply~~,~~ and live together, or if they were living together on the first day of the month. ~~(3-17-22)~~(   )

767. CP METHOD RESOURCE LIMIT.

The participant's resource limit is two thousand dollars ($2,000) if ~~his~~ their spouse is not a Medicaid applicant, is not living with th~~i~~em, or was not living with th~~i~~em on the first day of the month. The participant and spouse have a resource limit of three thousand dollars ($3,000) if they both apply~~,~~ and live together, or if they were living together on the first day of the month. ~~(3-17-22)~~(   )

768. CP METHOD INCOME DISREGARDS.

The participant gets the twenty dollar ($20) standard disregard if ~~his~~ their spouse is not a Medicaid applicant, is not living with th~~i~~em, or was not living with th~~i~~em on the first day of the month. If the participant has earned income, they get~~s~~ the sixty-five dollar plus one-half ($65 + 1/2) of the remainder earned income disregard. The participant and spouse get the standard disregard on their combined unearned income if they both apply, and live together, or if they were living together on the first day of the month. If either spouse has earned income, they get the earned income disregard from their combined earned income. ~~(3-17-22)~~(   )

769. -- 77~~5~~6. (RESERVED)

~~**776. 1972 RSDI RECIPIENT.**~~

~~A participant remains eligible if he meets any of the conditions in Subsections 776.01 through 776.03 and all other Medicaid eligibility requirements. (3-17-22)~~

~~**01. Money Payment in August 1972**. In August 1972, the participant was eligible for, or received, a state money payment of OAA, AB, APTD or Aid to Families with Dependent Children (AFDC). (3-17-22)~~

~~**02. Eligible If Not in Institution**. The participant would have been eligible for OAA, AB, APTD or Aid to Families with Dependent Children (AFDC) if he were not in a medical institution or intermediate care facility in August 1972. (3-17-22)~~

~~**03. Getting RSDI in August 1972**. The participant received RSDI benefits in August 1972, and became ineligible for a state money payment due to the RSDI benefit increase effective in September 1972. (3-17-22)~~

777. ELIGIBLE SSI RECIPIENT.
An SSI recipient, or an individual who would be SSI eligible if they applied, is eligible for Medicaid if they meet~~s~~ any of the conditions~~ in Subsections 777.01 through 777.03~~ below. ~~(3-17-22)~~(   )

01. Receives SSI. Gets SSI payments, even if eligibility is based on presumptive disability or presumptive blindness. (   )

02. Conditionally Eligible for SSI. ~~Is conditionally eligible for SSI, b~~Based on an agreement to dispose of excess resources. (   )

03. Eligible Spouse. Has~~ his~~ their SSI payments combined with~~ his~~ their spouse's SSI payments. ~~(3-17-22)~~(   )

778. INELIGIBLE SSI RECIPIENT.
An SSI recipient is not eligible for Medicaid if they meet~~s~~ any of the conditions~~ in Subsections 778.01 through 778.04~~ below. ~~(3-17-22)~~(   )

01. Medicaid Qualifying Trust. Has excess income from a Medicaid Qualifying Trust, created and funded before August 11, 1993. (   )

02. Noncooperation. Fails to cooperate in establishing paternity or securing support. (   )

03. Is in an Ineligible Institution.~~ Is in an ineligible institution.~~ ~~(3-17-22)~~(   )

04. Trust. Has a trust that makes th~~i~~em ineligible for Medicaid. ~~(3-17-22)~~(   )

779. PSYCHIATRIC FACILITY RESIDENT.
A resident of a long-term care psychiatric medical facility~~,~~ is eligible for Medicaid if they~~ is~~ are age sixty-five (65) or older.~~ He~~ They must meet all the requirements of a long-term~~-~~ care resident. ~~(3-17-22)~~(   )

780. ~~GRANDFATHERED SSI RECIPIENT.~~(RESERVED)
~~A grandfathered SSI recipient is eligible for Medicaid. A grandfathered SSI recipient received, or was eligible to receive, APTD, APTD-MA, AB or AB-MA or APTD-MA in long-term care on December 31, 1973, or had an application for this assistance on file December 31, 1973.~~ ~~(3-17-22)~~

~~**01. Disability and Blindness Criteria**. The grandfathered SSI recipient must have been eligible under the disability criteria for APTD or the blindness criteria for AB in effect on December 31, 1973. For each consecutive month after December 1973, the grandfathered SSI recipient must continue to meet the criteria for disability or blindness.~~ ~~(3-17-22)~~

~~**02. Eligibility Requirements**. The grandfathered SSI recipient must meet all current Medicaid rules, except the criteria for blindness or disability. A long-term care participant must also remain in long-term care, and continue to need long-term care.~~ ~~(3-17-22)~~

781. RSDI RECIPIENT ENTITLED TO COLA DISREGARD.
A participant receiving RSDI is eligible for Medicaid if they became and remain~~s~~ ineligible for SSI payments as of April 2011, or for AABD cash or SSI payments from May 1977 through March 2011. The participant must still be entitled to AABD cash or SSI, except for a ~~cost-of-living adjustment (~~COLA~~)~~ in RSDI benefits. All RSDI COLAs received by the participant, and any person whose income and resources are counted in determining the participant's eligibility, are disregarded for Medicaid. ~~(3-17-22)~~(   )

782. MEDICAID BENEFITS UNDER SECTION 1619(B) OF THE SOCIAL SECURITY ACT.
A participant may be eligible for Medicaid under Section 1619(b) of the Social Security Act either under federal or state criteria, depending on~~ his~~ their circumstances. ~~(3-17-22)~~(   )

01. Federally Qualified Under SSA Section 1619(b). An SSI recipient with a disability, previously

eligible for SSI cash, who, because of earnings from employment, no longer meets the financial eligibility requirements for SSI cash, is eligible for Medicaid. SSA determines the qualification for eligibility under Section 1619(b). ( )

02. State-Only Qualified Under SSA Section 1619(b). An AABD cash participant with a disability, who, because of earnings from employment, no longer meets the financial eligibility requirements for AABD cash, may be eligible for Medicaid. The Department determines eligibility for State-only Section 1619(b) Medicaid. State-only Section 1619(b) Medicaid is authorized under Section 1905(q) of the Social Security Act. ( )

a. Eligibility Requirements. A participant must meet all of the following requirements to be eligible for State-only 1619(b) Medicaid. The participant: (3-17-22)( )

i. The participant rReceived AABD cash in the month prior to the first month of his their eligibility under this Section of rule. (3-17-22)( )

ii. The participant iIs under age sixty-five (65). (3-17-22)( )

iii. The participant cContinues to have a disability. (3-17-22)( )

iv. The participant mMust depend on Medicaid coverage to continue working. An individual depends on Medicaid coverage if they: (3-17-22)( )

(1) Used Medicaid coverage within the past twelve (12) months; or (3-17-22)( )

(2) Expects to use Medicaid coverage in the next twelve (12) months; or (3-17-22)( )

(3) Would be unable to pay unexpected medical bills in the next twelve (12) months without Medicaid coverage. ( )

v. The participant iIs not able to afford medical insurance equivalent to Medicaid, including attendant care. The participant meets this requirement if his their earnings are under the limit referred to in Subsection 782.02.a.vii. of this rule. (3-17-22)( )

vi. The participant cContinues to meet all of the non-disability eligibility requirements in these rules. (3-17-22)( )

vii. The participant'sHas annual gross earned income is less than the current calendar year's charted threshold for Idaho as developed by SSA for federal qualification for Section 1619(b) Medicaid. The charted threshold for Idaho is online at http://policy.ssa.gov/poms.nsf/lnx/0502302200 SI 02302.200 Charted Threshold Amounts, incorporated by reference in Subsection 002.04. (3-17-22)( )

b. Ending State-Only 1619(b) Medicaid. State-only Section 1619(b) Medicaid ends when the participant meets one (1) of the following criteria. The participant: (3-17-22)( )

i. The participant iIs no longer eligible for AABD cash for a reason other than excess earned income; (3-17-22)( )

ii. The participant'sHas gross earned income is equal to or more than the current calendar year's annual earnings threshold for Idaho developed by the Social Security Administration for Ffederal Section 1619(b) Medicaid; (3-17-22)( )

iii. The participant iIs age sixty-five (65) or older; or (3-17-22)( )

iv. The participant rRegains eligibility for AABD cash. (3-17-22)( )

783. APPEAL OF SSA DECISION - APPLICANT DETERMINED SSI ELIGIBLE AFTER APPEAL.
An applicant denied Medicaid, because they does not meet SSI eligibility or RSDI disability requirements, can appeal

the SSA denial with SSA. ~~He~~ They can get Medicaid, if found eligible for SSI or Social Security disability ~~as a result~~ because of ~~his~~ their appeal. The effective date for Medicaid is the first day of the month ~~of~~ that the Medicaid application ~~that~~ was denied, ~~because of the~~ by SSA ~~denial~~. The participant's eligibility for backdated Medicaid coverage must be determined. ~~(3-17-22)~~(   )

784. APPEAL OF SSA DECISION AND CONTINUED MEDICAID.
A Medicaid participant, denied RSDI or SSI because they ~~is~~ are not disabled, can continue to get Medicaid if they appeal~~s~~ the SSA decision. The appeal must be filed within sixty (60) days of the SSA decision. If the final administrative decision rules against the participant's appeal, Medicaid benefits must end. Medicaid benefits paid during the appeal are not an overpayment. ~~(3-17-22)~~(   )

785. CERTAIN DISABLED CHILDREN.
A disabled child, not eligible for Medicaid outside a medical institution, is eligible for Medicaid if they meet~~s~~ the conditions ~~in Subsections 785.01 through 785.08 of these rules~~ below. ~~(3-17-22)~~(   )

01. Age. Is under nineteen (19) years old. (   )

02. AABD Criteria. Meets the AABD blindness or disability criteria. (   )

03. AABD Resource Limit. Meets the AABD single person resource limit. (   )

04. Income Limit. Has monthly income not exceeding three (3) times the federal SSI benefit payable monthly to a single person. (   )

05. Eligible for Long-Term Care. Meets the medical conditions for long-term care in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." (   )

06. Appropriate Care. Is appropriately cared for outside a medical institution, under a physician's plan of care. (   )

07. Cost of Care. Can be cared for cost effectively outside a medical institution. The estimated cost of caring for the child must not exceed the cost of the child's care in a hospital, nursing facility, or ICF/IID. (   )

08. Share of Cost. The financially responsible adult of a certain disabled child, who has family income above one hundred fifty percent (150%) of the federal poverty guidelines, is required to share in the cost of the child's Medicaid benefits under ~~the provisions in~~ IDAPA 16.03.18, "Medicaid Cost-Sharing." ~~(3-17-22)~~(   )

786. ~~EXTENDED (POSTPARTUM) MEDICAID FOR PREGNANT WOMEN.~~(RESERVED)
~~A woman receiving Medicaid while pregnant continues to be eligible through the last day of the month in which the sixty (60) day post partum period ends.~~ ~~(3-17-22)~~

787. HOME AND COMMUNITY BASED SERVICES (HCBS).
An aged, blind, or disabled participant, who is not income eligible for SSI or AABD cash, in ~~his~~their own home or community setting, is eligible for Medicaid if they meet~~s~~ the conditions ~~in Subsections 787.01 through 787.07 of these rules,~~ below and meets all requirements in one (1) of the waiver Sections 788 through 789 of these rules. ~~(3-17-22)~~(   )

01. Resource Limit. Meets the AABD single person resource limit. (   )

02. Income Limit. Income of the participant must not exceed three (3) times the ~~F~~federal SSI monthly benefit for a single person. A married participant living at home with ~~his~~ their spouse who is not an HCBS participant, may choose between the SSI, CP, and FSI methods. If ~~his~~ their spouse is also an HCBS participant or lives in a nursing home, the couple may choose between the SSI and CP methods. ~~(3-17-22)~~(   )

03. Maintained in the Community. The applicant must be able to be maintained safely and effectively in ~~his~~ their own home or in the community with the waiver services. ~~(3-17-22)~~(   )

04. Cost of Care. The cost of the participant's care must be ~~determined to be~~ cost effective as provided in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." ~~(3-17-22)~~(   )

05. Waiver Services Needed. The participant must need and receive, or be likely to need and receive, waiver services for thirty (30) consecutive days. The participant is ineligible when there is a break in need for, or receipt of, waiver services for thirty (30) consecutive days. (   )

06. Effective Date. Waiver services are effective the first day the participant is likely to need and receive waiver services. Medicaid begins the first day of the month in which the first day of approved waiver services are received. (   )

07. Annual Limit. The Department limits the number of participants approved for waiver services each year. A participant who applies for waiver services after the annual limit is reached, must be denied waiver services. (   )

788. AGED AND DISABLED (A&D) WAIVER.

~~In order t~~To be eligible for the Aged and Disabled (A&D) Waiver~~,~~ the participant must: ~~(3-17-22)~~(   )

01. Age Eighteen Through Sixty-Four. Be eighteen (18) through sixty-four (64) years old and meet ~~both~~ the disability criteria, as provided in Section 156 of these rules, and need nursing facility level of care ~~as provided in~~ under IDAPA 16.03.10 "Medicaid Enhanced Plan Benefits"; or ~~(3-17-22)~~(   )

02. Age Sixty-Five or Older. Be age sixty-five (65) or older and need nursing facility level of care ~~as provided in~~ under IDAPA 16.03.10 "Medicaid Enhanced Plan Benefits." ~~(3-17-22)~~(   )

789. DEVELOPMENTALLY DISABLED (DD) WAIVER.

To be eligible, the participant must be at least eighteen (18) years of age and need the level of care provided by an ~~intermediate care facility for persons with intellectual disabilities (~~ICF/IID~~)~~ under IDAPA 16.03.10 "Medicaid Enhanced Plan Benefits." ~~(3-17-22)~~(   )

790. -- 798. (RESERVED)

799. MEDICAID FOR WORKERS WITH DISABILITIES.

An individual is eligible to participate in the Medicaid for Workers with Disabilities coverage group if the individual meets the requirements ~~in Subsections 799.01 through 799.07 of this rule~~ below. ~~(3-17-22)~~(   )

01. Non-Financial Requirements. An individual must: (   )

a. Be at least sixteen (16) but less than sixty-five (65) years of age; (   )

b. Meet the Medicaid residency requirement ~~as described in~~ under Section 100 of these rules; ~~(3-17-22)~~(   )

c. Meet the citizenship requirements ~~as described in Sections 105 and 106 of these rules~~ under 42 CFR 435.406, Citizenship and Non-citizen Eligibility; ~~(3-17-22)~~(   )

d. Meet the SSN requirements ~~as described in~~ under Section 10~~4~~ 3of these rules; and ~~(3-17-22)~~(   )

e. Meet the child support cooperation requirements ~~as described in~~ under Sections 703 through 706 of these rules. ~~(3-17-22)~~(   )

02. Disability. An individual must meet the medical definition for having a disability or blindness used by the S~~ocial~~ S~~ecurity~~ A~~dministration~~ for Social Security Disability Insurance (SSDI) and ~~Supplemental Security Income (~~SSI~~)~~ benefits. ~~(3-17-22)~~(   )

03. Employment. An individual must be employed which may include self-employment. Proof of employment must be provided to the Department. Hourly wage or hours worked will not be used to determine

employment. ( )

04. Countable Resources. ~~Countable resources c~~Cannot exceed ten thousand dollars ($10,000) for an individual or fifteen thousand dollars ($15,000) for a couple. When calculating resources, the following items will be excluded: ~~(3-17-22)~~( )

a. Any resources excluded under Section 210 and Sections 222 through 299 of these rules; ( )

b. A second vehicle as described in Section 222 of these rules; ( )

c. Life insurance policies; ( )

d. Retirement accounts; and ( )

e. Exempt trusts as described in Section 872 of these rules. ( )

05. Countable Income. ~~Countable income i~~Is calculated using exclusions and disregards as described in Sections 300 through 547 of these rules. The countable income for: ~~(3-17-22)~~( )

a. An individual~~'s countable income~~ cannot exceed five hundred percent (500%) of the current federal poverty guideline for a household of one (1). ~~(3-17-22)~~( )

b. A couple~~'s countable income~~ cannot exceed five hundred percent (500%) of the current federal poverty guideline for a household of two (2). ~~(3-17-22)~~( )

06. Earned Income Test. Gross income is the total of earned and unearned income before exclusions or disregards. Each individual's gross earned income must be at least fifteen percent (15%) of ~~his~~ their total gross income to qualify. ~~(3-17-22)~~( )

07. Cost-Sharing. A participant in the Medicaid for Workers with Disabilities coverage group may be required to cost-share~~. If a participant is required to cost-share for Medicaid,~~; the costs are determined under the provisions in IDAPA 16.03.18, "Medicaid Cost-Sharing." ~~(3-17-22)~~( )

800. – 801. ~~NEWBORN CHILD OF MEDICAID MOTHER.~~(RESERVED)

~~A child is deemed eligible for Medicaid without an application if born to a woman receiving Medicaid on the date of the child's birth, including during a period of retroactive eligibility for the mother. The child remains eligible for Medicaid for up to one (1) year without an application. An application for Medicaid must be filed on behalf of the child no later than his first birthday. He must qualify for Medicaid in his own right after the month of his first birthday.~~ ~~(3-17-22)~~

~~**801. INELIGIBLE NON-CITIZEN WITH EMERGENCY MEDICAL CONDITION.**~~

~~A non-citizen, who is otherwise ineligible only because of his status as a non-citizen, is eligible only for medical services necessary to treat an emergency medical condition.~~ ~~(3-17-22)~~

~~**01. Emergency Medical Condition**. An emergency medical condition can reasonably be expected to seriously harm the patient's health, cause serious impairment to bodily functions, or cause serious dysfunction of any bodily organ or part, without immediate medical attention. The Division of Medicaid determines if the condition is an emergency and the services necessary to treat it.~~ ~~(3-17-22)~~

~~**02. Effective Date of Eligibility**. Medicaid eligibility begins no earlier than the date the participant experienced the medical emergency and ends the date the emergency condition stops. The Division of Medicaid determines the beginning and ending dates.~~ ~~(3-17-22)~~

802. WOMAN DIAGNOSED WITH BREAST OR CERVICAL CANCER.

A woman not otherwise eligible for Medicaid and meeting the conditions in Subsections 802.01 through 802.06 of this rule is eligible for Medicaid for the duration of her cancer treatment. Medicaid income and resource limits do not apply to this coverage group. ( )

01. Diagnosis. The participant is diagnosed with breast or cervical cancer through the C~~enters for~~ D~~isease~~ ~~Control and Prevention~~'s National Breast and Cervical Cancer Early ~~d~~Detection Program. ~~(3-17-22)~~( )

02. Age. The participant is under age sixty-five (65). ( )

03. Creditable Health Insurance. The participant is uninsured or, if insured, the plan does not cover her type of cancer. ( )

04. Non-Financial Eligibility. The participant meets the Medicaid non-financial eligibility requirements in Sections 100 through 108 and Sections 166 and 167 of these rules. ( )

05. Medical Support Cooperation. The participant meets the medical support cooperation requirement in Sections 702 through 706 of these rules. ( )

06. Group Health Plan Enrollment. The participant meets the requirement to enroll in available cost-effective employer group health insurance. ( )

07. Presumptive Eligibility. The Department can presume the participant is eligible for Medicaid, before a formal Medicaid eligibility determination is made. A clinic authorized to screen for breast or cervical cancer by the National Breast and Cervical Cancer Early Detection Program makes the presumptive eligibility determination. The clinic tells the participant how to complete the formal Medicaid determination process. The Medicaid notice and hearing rights do not apply to presumptive eligibility. No overpayment occurs if the formal Medicaid determination finds the participant is not eligible. ( )

08. End of Treatment. The ~~Division of Medicaid~~ Department determines the end of treatment date ~~according to~~ under IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." ~~(3-17-22)~~( )

803. -- 805. (RESERVED)

806. DISABLED ADULT CHILD.

A participant age eighteen (18) or older is eligible for Medicaid if they received SSI or AABD cash based on blindness or a disability which began before they reached age twenty-two (22), and becomes ineligible for and remains ineligible for AABD cash or SSI because ~~his~~ their disabled child RSDI benefit started or increased July 1, 1987, or later. ~~(3-17-22)~~( )

01. RSDI Benefits Disregarded for Disabled Adult Child. If the participant became ineligible because they began receiving a disabled child benefit on or after July 1, 1987, the benefit amount and any later increases are disregarded. ~~(3-17-22)~~( )

02. RSDI Increase Disregarded for Disabled Adult Child. If the participant became ineligible because ~~his~~ their disabled child benefit increased on or after July 1, 1987, the increase and any later increases are disregarded. ~~(3-17-22)~~( )

807. (RESERVED)

808. EARLY WIDOWS AND WIDOWERS BEGINNING JANUARY 1, 1991.

A participant who meets the conditions ~~in Subsections 808.01 through 808.06~~ below is considered an SSI recipient for Medicaid. ( )

01. Age. The participant, age fifty (50) to age sixty four and one-half (64-1/2), began receiving early widows or widowers Social Security benefits. ( )

02. Lost SSI or AABD. The participant lost SSI or AABD cash because they began receiving early widows or widowers Social Security benefits. ~~(3-17-22)~~( )

03. Received SSI or AABD. The participant received SSI or AABD cash in the month, before the

month, they became ineligible because they began receiving early widows or widowers Social Security benefits. ~~(3-17-22)~~( )

04. Widows or Widowers Benefits. The participant would still be eligible for SSI or AABD cash if ~~his~~ their Social Security early widows or widowers benefits were not counted as income. ~~(3-17-22)~~( )

05. No "Part A" Insurance. The participant is not entitled to Medicare Part A hospital insurance. ( )

06. Applied On or After January 1, 1991. The participant's Medicaid application was filed, or pending, on or after January 1, 1991. ( )

809. ~~CERTAIN DISABLED WIDOWS AND WIDOWERS THROUGH JUNE 30, 1988.~~(RESERVED)

~~A participant who meets the conditions in Subsections 809.01 through 809.04 is considered an SSI recipient for Medicaid. (3-17-22)~~

~~**01. Age**. The participant was under age sixty (60) when his disabled widows and widowers benefits began. (3-17-22)~~

~~**02. Lost SSI**. The participant is ineligible for SSI because of an increase in SSA disability benefits starting January, 1984. (3-17-22)~~

~~**03. Continuously Entitled**. The participant is continuously entitled to Social Security benefits for disabled widows and widowers starting January, 1984 or earlier. (3-17-22)~~

~~**04. Applied Before July 1, 1988**. The participant applied for Medicaid before July 1, 1988. (3-17-22)~~

810. QUALIFIED MEDICARE BENEFICIARY (QMB).

A person meeting all requirements ~~in Subsections 810.01 through 810.07~~ below is eligible for QMB~~. QMB Medicaid~~, which pays Medicare premiums, coinsurance, and deductibles. ~~(3-17-22)~~( )

01. Medicare Part A. The participant must be entitled to hospital insurance under Part A of Medicare at the time of ~~his~~ their application. ~~(3-17-22)~~( )

02. Nonfinancial Requirements. The participant must meet the Medicaid residence, citizenship, support cooperation, and SSN requirements. ( )

03. Income. Monthly income must not exceed one hundred percent (100%) of the Federal Poverty Guidelines (FPG). The single person income limit is the poverty line for a family of one (1) person. The couple income limit is the poverty line for a family of two (2) persons. The annual Social Security cost of living increase is disregarded from income, until the month after the month the annual FPG revision is published. AABD cash is not counted as income. The income exclusions and disregards used for AABD are used for QMB. ( )

04. Dependent Income. Income of the dependent child, parent, or sibling is not counted. ( )

05. QMB Dependent Family Member Disregard. A dependent family member is a minor child, adult child meeting SSA disability criteria, parent or sibling of the participant or spouse living with the participant. The family member is or could be claimed on the federal tax return of the participant or spouse. A participant with a dependent family member has an income disregard based on family size. The spouse is included in family size, whether or not the spouse is also participant. The disregard is based on the official poverty line income as defined by the OMB. The disregard is the difference between the poverty line for one (1) person, or two (2) persons if the participant has a spouse, and the poverty line for the family size including the participant, spouse, and dependent. ( )

06. Resource Limit. The resource limit is equal to the amount defined under 42 USC 1396d(p)(1)(C). The resource exclusions used for AABD are used for QMB. ( )

07. Effective Dates. The effective date of QMB coverage is no earlier than the first day of the month after the approval month. A QMB participant is not entitled to backdated Medicaid. ( )

811. SPECIFIED LOW INCOME MEDICARE BENEFICIARY (SLMB).
A person meeting all requirements ~~in Subsections 811.01 through 811.06~~ below is eligible for SLMB. Medicaid pays the Medicare Part B premiums for a SLMB. The income and resource exclusions and disregards used for AABD are used for SLMB. ~~(3-17-22)~~( )

01. Other Medicaid. The SLMB may be eligible for other Medicaid. ( )

02. Medicare Part A. The SLMB must be entitled to hospital insurance under Part A of Medicare at the time of ~~his~~ their application. ~~(3-17-22)~~( )

03. Nonfinancial Requirements. The SLMB must meet the Medicaid eligibility requirements of residence, citizenship, support cooperation, and SSN. ( )

04. Income. The annual Social Security cost of living increase is disregarded from income, until the month after the month the annual FPG revision is published. The single person limit is based on a family of one (1). The couple limit is based on a family of two (2). The monthly income limit is up to one hundred twenty percent (120%) of the FPG. ( )

05. Resource Limit. The resource limit is equal to the amount defined under 42 USC 1396d(p)(1)(C). The resource exclusions used for AABD are used for SLMB. ( )

06. Effective Dates. SLMB coverage begins on the first day of the application month~~. SLMB coverage~~, which may be backdated up to three (3) calendar months before the application month. ~~(3-17-22)~~( )

812. QUALIFIED INDIVIDUAL (QI).
A person meeting all requirements ~~in Subsections 812.01 through 812.07~~ below is eligible for QI. Medicaid pays the Medicare Part B premiums for a QI. The income and resource exclusions and disregards used for AABD are used for QI. ~~(3-17-22)~~( )

01. Other Medicaid. The QI cannot be eligible for any other type of Medicaid. ( )

02. Medicare Part A. The QI must be entitled to hospital insurance under Part A of Medicare at the time of ~~his~~ their application. ~~(3-17-22)~~( )

03. Nonfinancial Requirements. The QI must meet the Medicaid eligibility requirements of residence, citizenship, support cooperation, and SSN. ( )

04. Income. The annual Social Security cost of living increase is disregarded from income, until the month after the month the annual FPG revision is published. The single person limit is based on a family of one (1). The couple limit is based on a family of two (2). The monthly income limit is up to one hundred thirty-five percent (135%) of the FPG. ( )

05. Resource Limit. The resource limit is equal to the amount defined under 42 USC 1396d(p)(1)(C). The resource exclusions used for AABD are used for SLMB. ( )

06. Coverage Limits. There is an annual limit on participants served based on availability of federal funds. New applications are denied when the annual limit is reached. ( )

07. Effective Dates. QI coverage begins on the first day of the application month~~. QI coverage~~, which may be backdated up to three (3) calendar months before the application month. ~~(3-17-22)~~( )

813. QUALIFIED DISABLED AND WORKING INDIVIDUAL (QDWI).
A person meeting all requirements ~~in Subsections 812.01 through 812.05 of these rules~~ below is eligible for QDWI. The person must not be eligible for any other type of Medicaid. A QDWI is eligible only for Medicaid payment of ~~his~~

their Medicare Part A premium. ~~(3-17-22)~~(   )

01. Age and Disability. The participant must be a disabled worker under age sixty-five (65). (   )

02. Nonfinancial Requirements. The participant must meet the Medicaid eligibility requirements of residence, citizenship, support cooperation and SSN. (   )

03. Section 1818A Medicare. SSA determined the participant meets the conditions of Section 1818A of the Social Security Act. (   )

04. Income. Monthly income must not exceed two hundred percent (200%) of the one (1) person official poverty line defined by the OMB. (   )

05. Resource Limit. The resource limit is equal to the amount defined under 42 USC 1396d(s). The resource exclusions used for AABD are used for QDWI. (   )

814. SPONSORED LEGAL NON-CITIZEN.
All income and resources of a legal non-citizen's sponsor are deemed for Medicaid eligibility if the sponsor has signed an I-864 affidavit of support. (   )

815. CHILD SUBJECT TO DEEMING.
Income and resources of a child's stepparent are not deemed to the child in determining ~~his~~ their Medicaid eligibility. ~~(3-17-22)~~(   )

816. FUGITIVE FELON OR PROBATION OR PAROLE VIOLATOR.
A person denied SSI or AABD cash because of the prohibition against payment to fugitive felons and probation and parole violators is not disqualified from Medicaid. (   )

817. -- 830. (RESERVED)

831. ASSET TRANSFER RESULTING IN PENALTY.
Starting August 11, 1993, the participant is subject to a penalty if they transfer~~s his~~ their income or resources for less than fair market value. The asset transfer penalty applies to Medicaid services received October 1, 1993 and later. Excluded resources, other than the home and associated property, are not subject to the asset transfer penalty. Asset transfers subject to penalty under these rules may be voided and set aside by court action as provided in Section 56-218, Idaho Code. The asset transfer penalty applies to a Medicaid participant in long-term care or HCBS. A participant in long-term care is a patient in a nursing facility or a patient in a medical institution, requiring and receiving the level of care provided in a nursing facility. ~~(3-17-22)~~(   )

01. Rebuttable Presumption. Unless a transfer meets the requirements of Section 841 of these rules, it is presumed that the transfer was made for the purpose of qualifying for Medicaid. The asset transfer penalty is applied unless the participant shows that the asset transfer would not have affected ~~his~~ their eligibility for Medicaid, or the transfer was made for another purpose than qualifying for Medicaid. ~~(3-17-22)~~(   )

02. Contract for Services Provided by a Relative. A contract for personal services to be furnished to the participant by a relative is presumed to be made for the purpose of qualifying for Medicaid. The asset transfer penalty applies unless the participant shows that: (   )

a. A written contract for personal services was signed before services were delivered. The contract must require that payment be made after services are rendered. The contract must be dated, and the signatures notarized. Either party must be able to terminate the contract; and (   )

b. The contract must be signed by the participant or a legally authorized representative through a power of attorney, legal guardianship, or conservatorship. A representative who signs the contract must not be the provider of the personal care services under the contract; and (   )

c. Compensation for services rendered must be comparable to rates paid in the open market.

( )

03. Transfer of Income or Resources. Transfer of income or resources includes reducing or eliminating the participant's ownership or control of the asset. ( )

04. Transfer of Income or Resources by a Spouse. A transfer by the participant's spouse of either spouse's income or resources, before eligibility is established, subjects the participant to the asset transfer penalty. After the participant's eligibility is established, a transfer by the spouse of the spouse's own income or resources does not subject the participant to the asset transfer penalty. ( )

05. Transfer of Certain Notes and Loans. Funds used to purchase a promissory note, loan, or mortgage are considered a transferred asset which subjects the participant to a period of ineligibility. The amount of the asset transfer of such note, loan, or mortgage is the outstanding balance due on the date of the Medicaid application, unless the note, loan, or mortgage meets the following: ( )

a. Has a repayment term that is actuarially sound; ( )

b. Provides for payments to be made in equal amounts during the term of the loan with no deferral and no balloon payments; and ( )

c. Prohibits the cancellation of the balance upon the death of the lender. ( )

832. MEDICAID PENALTY FOR ASSET TRANSFERS.
The asset transfer penalty is restricted Medicaid coverage. ( )

01. Restricted Coverage. ~~Restricted coverage m~~Means Medicaid will not participate in the cost of nursing facility services~~. Medicaid will not participate~~ or in a level of care in a medical institution equal to nursing facility services. The penalty for a person receiving PCS or community services under the HCBS waiver is ineligibility. ~~(3-17-22)~~( )

02. Notice and Exemption. The participant must be notified in writing, at least ten (10) days before an asset transfer penalty is imposed. ( )

833. ASSET TRANSFER LOOK-BACK PERIOD.
The asset transfer penalty applies to any transfer for less than fair market value made during a period preceding or following a request for long-term care services.~~ The look-back period is determined as follows:~~ ~~(3-17-22)~~

~~**01. Transfers Prior to February 8, 2006**. For any asset transferred prior to February 8, 2006, the look-back period is thirty-six (36) months, unless the transfer is to or from a trust. If the transfer is to or from a trust, the look-back period is sixty (60) months. If the person is entitled to Medicaid or HCBS services, the look-back period is counted from the month long-term care or HCBS services began, or would have begun, were it not for a penalty. If the person is not entitled to Medicaid, the look-back period is counted from the month prior to the month the application was submitted. (3-17-22)~~

~~**02. Transfers On or After February 8, 2006**.~~ Any asset transferred~~ on or after February 8, 2006~~, regardless of type, is subject to a look-back period of sixty (60) months. The look-back period is counted from the date of the application for long-term care or HCBS services or the date of the transfer, whichever is later in time. ~~(3-17-22)~~( )

834. PERIOD OF RESTRICTED COVERAGE FOR ASSET TRANSFERS.
The period of restricted coverage is the number of months computed by dividing the net uncompensated value of the transferred asset by the statewide average cost of nursing facility services to private patients. The cost is computed for the time of the participant's most recent request for Medicaid. If the spouse becomes eligible for long-term care Medicaid, the rest of the period of restricted coverage is divided between the participant and spouse. ( )

835. APPLYING THE PENALTY PERIOD OF RESTRICTED COVERAGE.
Restricted coverage continues until the participant or spouse recovers all the assets, receives fair market value at the

time of the transfer for all~~ of the~~ assets, or the period of restricted coverage ends. The penalty continues whether or not the participant is in long-term care.~~ The penalty period for asset transfers is applied as follows:~~ ~~(3-17-22)~~

~~**01. Penalty Period for Transfer Prior to February 8, 2006**. For assets transferred prior to February 8, 2006, there is no penalty if the amount transferred is less than the cost of one (1) month's care. The penalty period begins running the month the transfer took place. The month the transfer took place is counted as one (1) of the penalty months. A penalty period is computed for each transfer. A penalty period must expire before the next begins. Each partial month before the end of consecutive penalty periods is a penalty month. A partial month at the end of consecutive penalty periods is dropped. (3-17-22)~~

~~**02. Penalty Period for Transfers On or After February 8, 2006**.~~ For assets transferred~~ on or after February 8, 2006~~, the penalty period begins running the first day of the month after the month the transfer took place or was discovered to have taken place, or the date the individual would have been eligible for long-term care services or HCBS, if not for the transfer, whichever date is later in time. The value of all asset transfers made during the look-back period is accumulated for the purpose of calculating the penalty. If an additional transfer is discovered after the penalty has been served, a new penalty period begins the month following timely notice of closure of benefits. When a penalty period ends after the first day of the month, eligibility for long-term care services begins the day after the penalty period ends. ~~(3-17-22)~~(   )

836. MULTIPLE PENALTY PERIODS APPLIED CONSECUTIVELY.
A penalty period is computed for each transfer. One (1) penalty period must expire before the next begins. (   )

837. LIFE ESTATE AS ASSET TRANSFER.

01. Transfer of a Remainder Interest. When a life estate in real property is retained by an individual, and a remainder interest in the property is transferred during the look-back period for less than the fair market value of the remainder interest transferred, the value of the uncompensated remainder is subject to the asset transfer penalty as described in Sections 831 through 835 of these rules. To compute the value of the life estate remainder, multiply the fair market value of the real property at the time of transfer by the remainder factor for the participant's age at the time of transfer listed in the following table:

TABLE 837.01 - REMAINDER TABLE

Age	Remainder	Age	Remainder	Age	Remainder	Age	Remainder
0	.02812	**28**	.03938	**56**	.20994	**84**	.63002
1	.01012	**29**	.04187	**57**	.22069	**85**	.64641
2	.00983	**30**	.04457	**58**	.23178	**86**	.66236
3	.00992	**31**	.04746	**59**	.24325	**87**	.67738
4	.01019	**32**	.05058	**60**	.25509	**88**	.69141
5	.01062	**33**	.05392	**61**	.26733	**89**	.70474
6	.01116	**34**	.05750	**62**	.27998	**90**	.71779
7	.01178	**35**	.06132	**63**	.29304	**91**	.73045
8	.01252	**36**	.06540	**64**	.30648	**92**	.74229
9	.01337	**37**	.06974	**65**	.32030	**93**	.75308
10	.01435	**38**	.07433	**66**	.33449	**94**	.76272
11	.01547	**39**	.07917	**67**	.34902	**95**	.77113
12	.01671	**40**	.08429	**68**	.36390	**96**	.77819
13	.01802	**41**	.08970	**69**	.37914	**97**	.78450

TABLE 837.01 - REMAINDER TABLE

Age	Remainder	Age	Remainder	Age	Remainder	Age	Remainder
14	.01934	**42**	.09543	**70**	.39478	**98**	.79000
15	.02063	**43**	.10145	**71**	.41086	**99**	.79514
16	.02185	**44**	.10779	**72**	.42739	**100**	.80025
17	.02300	**45**	.11442	**73**	.44429	**101**	.80468
18	.02410	**46**	.12137	**74**	.46138	**102**	.80946
19	.02520	**47**	.12863	**75**	.47851	**103**	.81563
20	.02635	**48**	.13626	**76**	.49559	**104**	.82144
21	.02755	**49**	.14422	**77**	.51258	**105**	.83038
22	.02880	**50**	.15257	**78**	.52951	**106**	.84512
23	.03014	**51**	.16126	**79**	.54643	**107**	.86591
24	.03159	**52**	.17031	**80**	.56341	108	.89932
25	.03322	**53**	.17972	**81**	.58033	109	.95455
26	.03505	**54**	.18946	**82**	.59705		
27	.03710	**55**	.19954	**83**	.61358		

( )

02. Transfer of a Life Estate. When a life estate in real property is transferred by an individual during the look-back period for less than fair market value, the value of the life estate is subject to the asset transfer penalty as described in Sections 831 and 835 of these rules. To compute the value of the life estate, multiply the fair market value of the real property at the time of transfer by the life estate factor for the participant's age at the time of transfer listed in the following table:

TABLE 837.02 - LIFE ESTATE TABLE

Age	Life Estate	Age	Life Estate	Age	Life Estate	Age	Life Estate
0	.97188	**28**	.96062	**56**	.79006	**84**	.36998
1	.98988	**29**	.95813	**57**	.77391	**85**	.35359
2	.99017	**30**	.95543	**58**	.76822	**86**	.33764
3	.99008	**31**	.95254	**59**	.75675	**87**	.32262
4	.98981	**32**	.94942	**60**	.74491	**88**	.30859
5	.98938	**33**	.94608	**61**	.73267	**89**	.29526
6	.98884	**34**	.94250	**62**	.72002	**90**	.28221
7	.98822	**35**	.93868	**63**	.70696	**91**	.26955
8	.98748	**36**	.93460	**64**	.69352	**92**	.25771
9	.98663	**37**	.93026	**65**	67970	**93**	.24692
10	.98565	**38**	.92567	**66**	.66551	**94**	.23728
11	.98453	**39**	.92083	**67**	.65098	**95**	.22887

TABLE 837.02 - LIFE ESTATE TABLE

Age	Life Estate	Age	Life Estate	Age	Life Estate	Age	Life Estate
12	.98359	**40**	.91571	**68**	.63610	**96**	.22181
13	.98198	**41**	.91030	**69**	.62086	**97**	.21550
14	.98066	**42**	.90457	**70**	.60522	**98**	.21000
15	.97937	**43**	.89855	**71**	.58914	**99**	.20486
16	.97815	**44**	.89221	**72**	.57261	**100**	.19975
17	.97700	**45**	.88558	**73**	.55571	**101**	.19532
18	.97590	**46**	.87863	**74**	.53862	**102**	.19054
19	.97480	**47**	.87137	**75**	.52149	**103**	.18437
20	.97365	**48**	.86374	**76**	.50441	**104**	.17856
21	.97425	**49**	.85578	**77**	.48742	**105**	.16962
22	.97120	**50**	.83743	**78**	.47049	**106**	.15488
23	.96986	**51**	.83674	**79**	.45357	**107**	.13409
24	.96841	**52**	.82969	**80**	.43659	108	.10068
25	.96678	**53**	.82028	**81**	.41967	109	.04545
26	.96495	**54**	.81054	**82**	.40295		
27	.96290	**55**	.80046	**83**	.38642		

( )

838. ANNUITY AS ASSET TRANSFER.

Except as provided in this rule, when assets are used to purchase an annuity during the look-back period, it is an asset transfer presumed to be made for the purpose of qualifying for Medicaid. To rebut this presumption, the participant must provide proof that clearly establishes the annuity was not purchased to make the participant eligible for Medicaid or avoid recovery from the estate following death. Proof is met if the participant shows the annuity meets the requirements~~ described in~~ Subsections 838.02 through 838.05 of this rule. ~~(3-17-22)~~( )

01. Revocable Annuity. ~~A revocable annuity i~~Is an annuity that can be assigned. The surrender amount of a revocable annuity is a countable resource. ~~(3-17-22)~~( )

02. Irrevocable Annuity. The purchase price of an irrevocable, non-assignable annuity is treated as an asset transfer, unless the requirements of Subsections 838.03 through 838.05 of this rule are met. ( )

03. Irrevocable Annuity Life Expectancy Test. The participant's life expectancy, as shown in the ~~following~~ Social Security Actuarial - Period Life ~~t~~Table (2020), must equal or exceed the term of the annuity. Using the Table, ~~838.03~~ compare the face value of the annuity to the participant's life expectancy at the purchase time. The annuity meets the life expectancy test if the participant's life expectancy equals or exceeds the term of the annuity. If the exact age is not in the Table, use the next lower age. See https://www.ssa.gov/oact/STATS/table4c6.html.

~~TABLE 838.03 - LIFE EXPECTANCY TABLE~~

~~Age~~	~~Years of Life Remaining Male~~	~~Years of Life Remaining Female~~		~~Age~~	~~Years of Life Remaining Male~~	~~Years of Life Remaining Female~~

~~**0**~~	~~73.26~~	~~79.26~~	~~**74**~~	~~10.12~~	~~12.74~~
~~**10**~~	~~64.03~~	~~69.93~~	~~**75**~~	~~9.58~~	~~12.09~~
~~**20**~~	~~54.41~~	~~60.13~~	~~**76**~~	~~9.06~~	~~11.46~~
~~**30**~~	~~45.14~~	~~50.43~~	~~**77**~~	~~8.56~~	~~10.85~~
~~**40**~~	~~35.94~~	~~40.86~~	~~**78**~~	~~8.07~~	~~10.25~~
~~**50**~~	~~27.13~~	~~31.61~~	~~**79**~~	~~7.61~~	~~9.67~~
~~**60**~~	~~19.07~~	~~22.99~~	~~**80**~~	~~7.16~~	~~9.11~~
~~**61**~~	~~18.33~~	~~22.18~~	~~**81**~~	~~6.72~~	~~8.57~~
~~**62**~~	~~17.60~~	~~21.38~~	~~**82**~~	~~6.31~~	~~8.04~~
~~**63**~~	~~16.89~~	~~20.60~~	~~**83**~~	~~5.92~~	~~7.54~~
~~**64**~~	~~16.19~~	~~19.82~~	~~**84**~~	~~5.55~~	~~7.05~~
~~**65**~~	~~15.52~~	~~19.06~~	~~**85**~~	~~5.20~~	~~6.59~~
~~**66**~~	~~14.86~~	~~18.31~~	~~**86**~~	~~4.86~~	~~6.15~~
~~**67**~~	~~14.23~~	~~17.58~~	~~**87**~~	~~4.55~~	~~5.74~~
~~**68**~~	~~13.61~~	~~16.85~~	~~**88**~~	~~4.26~~	~~5.34~~
~~**69**~~	~~13.00~~	~~16.14~~	~~**89**~~	~~3.98~~	~~4.97~~
~~**70**~~	~~12.41~~	~~15.44~~	~~**90**~~	~~3.73~~	~~4.63~~
~~**71**~~	~~11.82~~	~~14.75~~	~~**95**~~	~~2.71~~	~~3.26~~
~~**72**~~	~~11.24~~	~~14.06~~	~~**100**~~	~~2.05~~	~~2.39~~
~~**73**~~	~~10.67~~	~~13.40~~	~~**110**~~	~~1.14~~	~~1.22~~

~~(3-17-22)~~( )

04. State Named as Beneficiary. The purchase of an annuity is treated as an asset transfer unless the State of Idaho, Medicaid Estate Recovery is named as: ( )

a. The remainder beneficiary in the first position for at least the total amount of medical assistance paid on behalf of the institutionalized individual under this title; or ( )

b. The remainder beneficiary in the second position after the community spouse or minor or disabled child and is named in the first position if the community spouse or a representative of the minor or disabled child disposes of any remainder for less than fair market value. ( )

05. Equal Payment Test. The annuity must provide for payments in equal amounts during the term of the annuity with no deferral and no balloon payments made. ( )

06. Permitted Annuity. The purchase of an annuity is not treated as an asset transfer if the annuity meets any of the descriptions in Sections 408(b), or 408(q), Internal Revenue Code; or is purchased with proceeds from an account or trust described in Sections 408(a), 408(c), or 408(p), Internal Revenue Code, or is a simplified employee pension as described in Section 408(k), Internal Revenue Code, or is a Roth IRA described in Section 408A, Internal Revenue Code. ( )

839. TRUSTS AS ASSET TRANSFERS.

A trust established wholly or partly from the participant's assets is an asset transfer. Assets transferred to a trust on or after August 11, 1993 are subject to the asset transfer penalty, regardless of when the trust was established. If the trust

includes assets of another person, the asset transfer penalty applies to the participant's share of the trust. ( )

840. TRANSFER OF JOINTLY OWNED ASSET.
Transfer of an asset owned jointly by the participant and another person is considered a transfer by the participant. The participant's share of the asset is used to compute the penalty. If the participant and ~~his~~ their spouse are joint owners of the transferred asset, the couple's combined ownership is used to compute the penalty. If the spouse becomes eligible for long-term care Medicaid, the rest of the period of restricted coverage is divided between the participant and spouse. ~~(3-17-22)~~( )

841. PENALTY EXCEPTIONS FOR ASSET TRANSFERS.
A participant is not subject to the asset transfer penalty for taking any action described in Subsections 841.01 through 841.1~~4~~5 of this rule. ~~(3-17-22)~~( )

01. Home to Spouse. The asset transferred was a home. Title to the home was transferred to the spouse. ( )

02. Home to Minor Child or Disabled Adult Child. The asset transferred was a home. Title to the home was transferred to the child of the participant or spouse. The child must be under age twenty-one (21) or blind or totally disabled under Social Security and SSI rules in 20 CFR Part 416. ( )

03. Home to Brother or Sister. The asset transferred was a home. Title to the home was transferred to a ~~brother or sister~~ sibling of the participant or spouse. The ~~brother or sister~~ sibling must have an equity interest in the transferred home~~. The brother or sister must~~ and reside in that home for at least one (1) year immediately before the month the participant starts long-term care. ~~(3-17-22)~~( )

04. Home to Adult Child. The asset transferred was a home. Title to the home was transferred to a ~~son or daughter~~ child of the participant or spouse, other than a child under the age of twenty-one (21). The ~~son or daughter~~ child must reside in that home for at least two (2) years immediately before the month the participant started long-term care. The adult child must prove they provided nursing facility level medical care to the participant which permitted th~~i~~em to live at home rather than enter long-term care. The ~~son or daughter~~ child must not have received payment from Medicaid for home and community~~-~~-based services provided to the participant. ~~(3-17-22)~~( )

05. Benefit of Spouse. The assets were transferred to the participant's spouse or to another person for the sole benefit of the spouse. ( )

06. Transfer From Spouse. The assets were transferred from the participant's spouse to another person for the sole benefit of the participant's spouse. ( )

07. Transfer to Child. The assets were transferred to the participant's child, or to a trust established solely for the benefit of the participant's child. The child must be blind or totally disabled under Social Security and SSI rules in 20 CFR Part 416. The child may be any age. ( )

08. Intent to Get Fair Market Value. The participant or spouse proves they intended to dispose of the assets at fair market value or for other adequate consideration. ~~(3-17-22)~~( )

09. Assets Returned. All assets transferred for less than fair market value have been returned to the participant. ( )

10. Medicaid Qualification Not the Intent. The participant or spouse proves the assets were transferred exclusively for a purpose other than to qualify for Medicaid or to avoid recovery. ( )

11. Undue Hardship. The participant, ~~his~~ their representative, or the facility in which they reside~~s~~ may request the hardship waiver. The hardship waiver must be requested in writing within ten (10) days of the date of the asset transfer penalty notice. Undue hardship exists if any of the conditions ~~in Subsections 841.11.a. through 841.11.d. of this rule~~ below apply. ~~(3-17-22)~~( )

a. The participant proves they ~~is~~ are not able to pay for ~~his~~ their nursing facility services or ~~his~~ their

waiv~~i~~er services by any means. ~~(3-17-22)~~(   )

b. The participant proves that they ha~~s~~ve made reasonable efforts, consistent with~~ his~~ their physical and financial ability, to recover the transferred asset. The participant must fully cooperate with the ~~s~~State of Idaho in efforts to recover the transferred asset and, upon request, must assign~~ his~~ their rights to recover the asset to the State of Idaho. ~~(3-17-22)~~(   )

c. The participant proves they did not knowingly transfer the asset. ~~(3-17-22)~~(   )

d. The participant proves they would be deprived of food, clothing, shelter, or other necessities of life if the asset transfer penalty is imposed and they assign~~s his~~ their rights to recover the asset to the State of Idaho. ~~(3-17-22)~~(   )

12. Exception to Fair Market Value. The amount received is adequate, even if not fair market value. This exception must meet one (1) of the conditions~~ in Subsections 841.12.a. through 841.12.c. of this rule~~ below. ~~(3-17-22)~~(   )

a. A forced sale was done under reasonable circumstances. (   )

b. Little or no market demand exists for the type of asset transferred and the lack of market demand was not created by a voluntary act of the participant to qualify for assistance or to avoid recovery. (   )

c. The asset was transferred to settle a legal debt approximately equal to the fair market value of the transferred asset. (   )

13. No Benefit to Participant. The participant received no benefit from the asset. This exception must meet one (1) of the conditions~~ in Subsections 841.13.a. and 841.13.b. of this rule~~ below. ~~(3-17-22)~~(   )

a. The participant or spouse held title to the property only as a trustee for another person~~. The participant or spouse~~ and had no beneficial interest in the property. ~~(3-17-22)~~(   )

b. The transfer was done to clear title to property. The participant or spouse had no beneficial interest in the property. The defect in the title was not created~~ in an attempt~~ to transfer assets to qualify for assistance or avoid recovery. ~~(3-17-22)~~(   )

14. Fraud Victim. The asset was transferred because the participant or spouse was the victim of fraud, misrepresentation, or coercion. The participant or spouse must take all possible steps to recover the assets or property, or its equivalent in damages and~~ must~~ assign recovery rights to the ~~s~~State of Idaho. ~~(3-17-22)~~(   )

15. Transfer to Trust of Disabled Person. The assets were transferred to a trust established solely for the benefit of an individual under sixty-five (65) years of age who is disabled. (   )

842. -- 870. (RESERVED)

871. TREATMENT OF TRUSTS.

Th~~ese~~is trust treatment rule~~s~~ appl~~y~~ies to all Medicaid participants. Th~~ese~~is rules appl~~y~~ies to trusts established with the participant's assets on August 11, 1993, or later, and to amounts placed in trusts on or after August 11, 1993.~~ Section 871 of these~~ This rule~~s~~ does not apply to an irrevocable trust if the participant meets the undue hardship exemption in Subsection 841.11 of these rules. Assets transferred to a trust are subject to the asset transfer penalty. ~~Section 871~~ This rule does not apply to a trust created with assets other than those of the individual, including a trust established by a will. ~~(3-17-22)~~(   )

01. Revocable Trust.~~ Revocable trusts are~~ Is treated as listed~~ in Subsections 871.01.a. through 871.01.d. of these rules~~ below. A revocable burial trust is not a trust for the purposes of Subsection 871.01 of~~ these~~ this rule~~s~~. ~~(3-17-22)~~(   )

a. The body (corpus) of a revocable trust is a resource. (   )

b. Payments from the trust to or for the participant are income. ( )

c. Any other payments from the trust are an asset transfer, triggering an asset transfer penalty period. ( )

d. ~~As defined in~~Under 42 U~~.~~S~~.~~C~~.~~ 1396p(e)(5), the home and adjoining property loses its exclusion for eligibility purposes when transferred to a revocable trust, unless the participant or spouse is the sole beneficiary of the trust. The home is excluded again if removed from the trust. The exclusion restarts the month following the month the home was removed from the trust. ~~(3-17-22)~~( )

02. Irrevocable Trust.~~ Irrevocable trusts are~~ Is treated as listed~~ in Subsections 871.02.a. through 871.02.g. of these rules~~ below. ~~(3-17-22)~~( )

a. The part of the body of an irrevocable trust, from which corpus or income payments could be made to or for the participant, is a resource. ( )

b. Payments made to or for the participant are income. ( )

c. Payments from the trust for any other reason are asset transfers, triggering the asset transfer penalty. ( )

d. Any part of the trust from which payment cannot be made to, or for the benefit of the participant under any circumstances, is an asset transfer. ( )

e. The effective date of the transfer is the date the trust was established, or the date payments to the participant were foreclosed. ( )

f. The value of the trust, for calculating the transfer penalty, includes any payments made from that portion of the trust after the date the trust was established, or payments were foreclosed. ( )

g. An irrevocable burial trust is not subject to treatment under Subsection 871.02 of~~ these~~ this rule~~s~~, unless funds in the trust can be paid for a purpose other than the participant's funeral and related expenses. The trust can provide that funds not needed for the participant's funeral expenses are available to reimburse Medicaid, or to go to the participant's estate. ~~(3-17-22)~~( )

872. EXEMPT TRUSTS.

A trust, created or funded on or after August 11, 1993, is exempt from trust treatment and not subject to the asset transfer penalty if it meets a condition~~ in Subsections 872.01 through 872.03 of this rule~~ below. ~~(3-17-22)~~( )

01. Trust for Disabled Person. To be exempt, a trust for a disabled person must meet all the conditions~~ in Subsections 872.01.a. through 872.01.f. of this rule~~ below. ~~(3-17-22)~~( )

a. The trust contains the assets of a person under age sixty-five (65). ( )

b. The person is blind or totally disabled under the Social Security and SSI rules in 20 CFR Part 416. ( )

c. The trust is established for the person's benefit by~~ his~~ their parent, grandparent, legal guardian, or a court. ~~(3-17-22)~~( )

d. The trust is irrevocable. ( )

e. The trust is exempt until the person reaches age sixty-five (65). After the person reaches age sixty-five (65), additions or augmentations are not exempt from trust treatment. ( )

f. Upon the person's death, the amount not distributed by the trust must first be paid to the State of

Idaho, up to the amount Medicaid has paid on the person's behalf. ( )

02. Income Trust. To be exempt, an income trust must meet all the conditions ~~in Subsections 872.02.a. through 872.02.e. of this rule~~ below. ~~(3-17-22)~~( )

a. The trust is established for the sole benefit of a person who would be eligible for Medicaid in long-term care, or eligible for HCBS except for excess income. ( )

b. Any income, placed directly into an income trust in the same calendar month in which received by the recipient, is not considered income to the individual for determining long-term care Medicaid eligibility. Money paid into the trust is income for patient liability or ~~client~~ participant participation. ~~(3-17-22)~~( )

c. The trust is irrevocable. The trust document may include a clause allowing the trust to be revoked if the participant leaves the nursing facility or HCBS for a reason other than death, and is no longer eligible for Medicaid because of excess income, if Medicaid is reimbursed up to the amount Medicaid has paid on the person's behalf. ( )

d. Income transferred to the trust must be used to pay patient liability or ~~client~~ participant participation. If income is not used to pay allowable expenses, it is subject to the asset transfer penalty, unless one (1) of the following exceptions ~~in Subsections 872.02.d.i. through 872.02.d.iii. of this rule~~ applies. ~~(3-17-22)~~( )

i. Benefit of the spouse in Subsection 841.05 of these rules; ( )

ii. Transfer from the spouse in Subsection 841.06 of these rules; or ( )

iii. Undue hardship in Subsection 841.11 of these rules. ( )

e. Upon the person's death, the amount not distributed by the trust must first be paid to the State of Idaho, up to the amount Medicaid has paid on the person's behalf. ( )

03. Trust Managed by Non-Profit Association for Disabled Person. To be exempt, a trust managed by non-profit association for a disabled person must meet all the conditions ~~in Subsections 872.03.a. through 872.03.e. of this rule~~ below. ~~(3-17-22)~~( )

a. The trust is established and managed by a nonprofit association. The nonprofit association must not be the participant, ~~his~~ their parent, or ~~his~~ grandparent. ~~(3-17-22)~~( )

b. The trust contains the assets of a disabled person. The person must be blind or totally disabled under Social Security and SSI rules in 20 CFR Part 416. ( )

c. Accounts in the trust are established only for the benefit of disabled persons. An account can be established by the disabled person, ~~his~~ their parent, grandparent, legal guardian, or a court. A separate account must be maintained for each beneficiary of the trust. For purposes of investment and management, the trust may pool the funds in the accounts. ~~(3-17-22)~~( )

d. The trust is irrevocable. ( )

e. Upon the person's death, the amount not distributed by the trust must first be paid to the State of Idaho, up to the amount Medicaid has paid on the person's behalf. ( )

873. PAYMENTS FROM AN EXEMPT TRUST FOR DISABLED PERSON OR POOLED TRUST.

Cash payments from an exempt trust for a disabled person or a pooled trust must be treated as described ~~in Subsections 873.01 through 873.04 of these rules~~ below. ~~(3-17-22)~~( )

01. Cash Payments from Exempt Trust. ~~Cash payments from an exempt trust f~~For a disabled person are income in the month received. ~~(3-17-22)~~( )

02. Cash Payments from Pooled Trust. Cash payments from a pooled trust Are made directly to the participant are income in the month received. (3-17-22)( )

03. Payments for the Participant's Food or Shelter. Payments for the participant's food or shelter aAre income in the month paid. The payments for food or shelter are valued at one-third (1/3) of the AABD budgeted needs for the participant's living arrangement. (3-17-22)( )

04. Payments Not Made to Participant. Payments from the exempt trust not made to, or on behalf of, the participant are an asset transfer. ( )

874. -- 914. (RESERVED)

915. MEDICAID REDETERMINATION.

Medicaid eligibility is redetermined each year. The redetermination for AABD cash is the Medicaid redetermination for participants receiving both programs. ( )

916. -- 999. (RESERVED)

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.03.06 – REFUGEE MEDICAL ASSISTANCE

DOCKET NO. 16-0306-2301

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2024 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. The pending rule will become final and effective upon the adjournment, *sine die*, of the second Regular Session of the Sixty-seventh Idaho Legislature after approval.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 56-202 and 56-203, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

In 2022, the Director of the Office of Refugee Resettlement (ORR), Administration for Children and Families, under the U.S. Department of Health and Human services announced a change of the Refugee Medical Assistance (RMA) eligibility period for participants whose date of eligibility for ORR benefits is on or after October 1, 2021. This change was made under the authority of 45 CFR 400.211(b) and announced in the Federal Register.

There are no changes to the pending rule and it is being adopted as originally proposed. The complete text of the proposed rule was published in the September 6, 2023, Idaho Administrative Bulletin, Vol. 23-9, pages 187 through 189.

FEE SUMMARY: Pursuant to Section 67-5224(2)(d), Idaho Code, this pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature. The following is a description of the fee or charge imposed or increased in this rulemaking: Not Applicable.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state General Fund greater than ten thousand dollars ($10,000) during the fiscal year:

This rulemaking is not anticipated to have any fiscal impact on the state General Fund, or any other known funds.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Laura Schumaker at 208-799-4335.

DATED this 9th day of November, 2023.

Trinette Middlebrook and Frank Powell
DHW – Administrative Rules Unit
450 W. State Street – 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
phone: (208) 334-5500
fax: (208) 334-6558
email: dhwrules@dhw.idaho.gov

THE FOLLOWING NOTICE PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 56-202 and 56-203, Idaho Code.

PUBLIC HEARING SCHEDULE: Two public hearings concerning this rulemaking will be held as follows:

VIRTUAL TELECONFERENCES Via WebEx
Wednesday, September 13, 2023 **9:00 a.m. - 11:00 a.m.**
Join from the meeting link **https://idhw.webex.com/idhw/j.php?MTID=m5dcc0316e6fafb1eb2ed4ab85f174210** **Join by meeting number** **Meeting number (access code): 2760 602 0742** **Meeting password: MDqjmP3cs92 (63756732 from phones and video systems)** **Join by phone** **+1-415-527-5035 United States Toll** **+1-303-498-7536 United States Toll (Denver)**
Thursday, September 14, 2023 **12:00 p.m. - 2:00 p.m. (MT)**
Join from the meeting link **https://idhw.webex.com/idhw/j.php?MTID=madb16385f7bd63c8263c4160e3a925a1** **Join by meeting number** **Meeting number (access code): 2762 839 2540** **Meeting password: muHbrNkz333 (68427659 from phones and video systems)** **Join by phone** **+1-415-527-5035 United States Toll** **+1-303-498-7536 United States Toll (Denver)**

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below. Each meeting will conclude after 30 minutes if no participants sign in or wish to comment in the meeting.

DESCRIPTIVE SUMMARY: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

In 2022, the Director of the Office of Refugee Resettlement (ORR), Administration for Children and Families, under the U.S. Department of Health and Human services announced a change of the Refugee Medical Assistance (RMA) eligibility period for participants whose date of eligibility for ORR benefits is on or after October 1, 2021. This change was made under the authority of 45 CFR 400.211(b) and announced in the Federal Register.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased:

This chapter contains no fees or charges.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the State General Fund greater than ten thousand dollars ($10,000) during the fiscal year as a result of this rulemaking:

This rulemaking is not anticipated to have any fiscal impact on the State General Fund, or any other known funds.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because it was determined to be not feasible. This rule change is being made to reflect the recent expansion of the eligibility period for Refugee Medical Assistance made by the federal Office of Refugee Resettlement.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into this rule:

There are no incorporations by reference in this chapter of rules.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Laura Schumaker at 208-799-4335.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before September 27, 2023.

DATED this 25th day of August, 2023.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0306-2301

150. REFUGEE MEDICAL ASSISTANCE PROGRAM.

01. Time Limitation. Medical assistance under the Refugee Medical Assistance Program will be ~~limited to eight (8) consecutive months beginning with the month the refugee enters the United States~~ determined under 45 CFR 400.211(b). ~~(3-17-22)~~( )

02. Eligibility. Refugees whose countable income does not exceed one hundred fifty percent (150%) of the Federal Poverty Guidelines are eligible for Refugee Medical Assistance. (3-17-22)

03. Refugee Medical Assistance with "Spend Down." An applicant for Refugee Medical Assistance whose countable income exceeds one hundred fifty percent (150%) FPG for their family size may become eligible for Refugee Medical Assistance under certain conditions. A special provision, for refugees only, will allow those refugees whose income exceeds one hundred fifty percent (150%) FPG for their family size to subtract their medical costs from their income and thus "spend down" to the FPG limit for their family size. (3-17-22)

04. Counting Income for Refugee Medical Assistance. (3-17-22)

a. Income is counted or excluded in accordance with IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children." The sole exception is that Refugee Cash Assistance is excluded from income when determining eligibility for Refugee Medical Assistance. (3-17-22)

b. The income of sponsors, and the in-kind services and shelter provided to refugees by their sponsors, will not be considered in determining eligibility for Refugee Medical Assistance. (3-17-22)

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.03.09 – MEDICAID BASIC PLAN BENEFITS

DOCKET NO. 16-0309-2301

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo and Incorporation By Reference Synopsis (IBRS)

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2024 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. The pending rule will become final and effective upon the adjournment, *sine die*, of the second Regular Session of the Sixty-seventh Idaho Legislature after approval.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 56-202(b), 56-264, 56-265, and 56-1610, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

These rule changes will decrease regulatory burdens, make technical corrections, implement operations for the end of the public health emergency, update rules to comply with the latest changes to Idaho statutes (H0153, H0223, H0374, and S1094 from the 2023 legislative session), IDAPA 16.05.06, “Criminal History and Background Checks,” and make changes to the Idaho State Plan for behavioral health services appropriated by the Legislature.

There are no changes to the pending rule and it is being adopted as originally proposed. The complete text of the proposed rule was published in the July 5, 2023, Idaho Administrative Bulletin, Vol. 23-7, pages 42 through 79.

FEE SUMMARY: Pursuant to Section 67-5224(2)(d), Idaho Code, this pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature. The following is a description of the fee or charge imposed or increased in this rulemaking: Not Applicable.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state General Fund greater than ten thousand dollars ($10,000) during the fiscal year:

There is no impact to the state General Fund, grant funds, or any other funds as funding has already been appropriated for the changes to services.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact William Deseron, 208-859-0046.

DATED this 9th day of November, 2023.

Trinette Middlebrook and Frank Powell
DHW – Administrative Rules Unit
450 W. State Street – 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
phone: (208) 334-5500
fax: (208) 334-6558
email: dhwrules@dhw.idaho.gov

**THE FOLLOWING NOTICE PUBLISHED WITH
THE TEMPORARY AND PROPOSED RULE**

EFFECTIVE DATE: The effective date of the temporary rule is July 1, 2023.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule, and proposed rulemaking procedures have been initiated. The action is authorized pursuant to Sections 56-202(b), 56-264, and 56-1610, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearings concerning this rulemaking will be held as follows:

VIRTUAL TELECONFERENCES Via WebEx
Thursday, July 13, 2023 **4:00 p.m. - 5:00 p.m. (MT)**
Join from the meeting link **https://idhw.webex.com/idhw/j.php?MTID=m52baf11a0fdb1fe4179f5791a82980b4** **Join by meeting number** **Meeting number (access code): 2760 060 4198** **Meeting password: PytTUgg5y53 (79888445 from phones and video systems)** **Join by phone** **+1-415-527-5035 United States Toll** **+1-303-498-7536 United States Toll (Denver)**
Monday, July 17, 2023 **10:00 a.m. -11:00 a.m. (MT)**
Join from the meeting link **https://idhw.webex.com/idhw/j.php?MTID=me93b96b1ea479828068a79d89916478c** **Join by meeting number** **Meeting number (access code): 2764 933 3016** **Meeting password: Aty6k6iMQf4 (28965646 from phones and video systems)** **Join by phone** **+1-415-527-5035 United States Toll** **+1-303-498-7536 United States Toll (Denver)**

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below. Each meeting will conclude after 30 minutes if no participants sign into the meeting.

DESCRIPTIVE SUMMARY: The following is the required finding and concise statement of its supporting reasons for adopting a temporary rule and a nontechnical explanation of the substance and purpose of the proposed rulemaking:

These rule changes will decrease regulatory burdens, make technical corrections, implement operations for the end of the public health emergency, update rules to comply with the latest changes to Idaho statutes (H0153, H0223, H0374, and S1094 from the 2023 legislative session), IDAPA 16.05.06, "Criminal History and Background Checks," and make changes to the Idaho State Plan for behavioral health services appropriated by the legislature.

TEMPORARY RULE JUSTIFICATION: Pursuant to Sections 67-5226(1)(b) and (c), Idaho Code, the Governor has found that temporary adoption of the rule of the rule is appropriate for the following reasons:

This rulemaking aligns these rules with laws passed by the 2023 legislature (H0153, H0223, H0374, and S1094), and confers benefits to participants and reduces administrative burdens on providers.

These changes are to comply with deadlines in amendments to governing law or federal programs, and to confer a benefit.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: There are no fees in this chapter of rule.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year:

There is no impact to the state general fund, grant funds, or any other funds as funding has already been appropriated for the changes to services.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2)(b), Idaho Code, negotiated rulemaking was not conducted because this rulemaking was deemed to be not feasible as it aligns with statutes passed by the 2023 Legislative session.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into this rule:

The rulemaking changes in the Incorporation By Reference Section include:

- American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR, 2022); and
- Updated title for Travel Policies and Procedures by the Idaho Office of the State Controller.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into this rule: The rulemaking changes in the Incorporation By Reference Section includes updated title for Travel Policies and Procedures by the Idaho Office of the State Controller.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact William Deseron, 208-859-0046.

Anyone may submit written comments regarding the proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before July 26, 2023.

DATED this 26th day of May, 2023.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0309-2301

004. INCORPORATION BY REFERENCE.
The following are incorporated by reference in this chapter of rules: (3-17-22)

01. American Speech-Language-Hearing Association (ASHA): Medicaid Guidance for Speech-Language Pathology Services. The American Speech-Language-Hearing Association (2004) Medicaid Guidance for Speech-Language Pathology Services: Addressing the "Under the Direction of" Rule technical report is available on the internet at: https://www.asha.org/. The report may also be obtained at the ASHA National Office, 2200 Research Boulevard, Rockville, MD 20850-3289, telephone (301) 296-5700. (3-17-22)

02. DSM-5-TR. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR) Arlington, VA, American Psychiatric Association, 20~~13~~22. A copy of the manual is available for public review at the Department of Health and Welfare, 450 West State Street, Boise, Idaho, 83702. ~~(3-17-22)~~( )

03. Estimated Useful Lives of Depreciable Hospital Assets, 2004 Revised Edition, Guidelines Lives. This document may be obtained from American Hospital Publishing, Inc., 211 East Chicago Avenue, Chicago, IL, 60611. (3-17-22)

04. Medicare Durable Medical Equipment Medicare Administrative Contractor Jurisdiction D Supplier Manual 2016, As Amended (CMS/Medicare DME Coverage Manual). Since the supplier manual is amended on a quarterly basis by CMS, the current year's manual is being incorporated by reference, as amended, to allow for the incorporation of the most recent amendments to the manual. The full text of the CMS/Medicare DME Coverage Manual is available via the Internet at https://med.noridianmedicare.com/web/jddme/education/supplier-manual. (3-17-22)

05. Provider Reimbursement Manual (PRM). The Provider Reimbursement Manual (PRM), Part I and Part II (CMS Publication 15-1 and 15-2), is available on the CMS website at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals.html. (3-17-22)

06. Travel Polic~~ies~~y and Procedures~~ of the Idaho State Board of Examiners~~. The text of "~~Idaho~~ State Travel Polic~~ies~~y and Procedures~~ of the Idaho State Board of Examiners~~," Appendices A and B, ~~June 13, 2000~~January 17, 2023, is available at the Office of the State Controller, 700 W. State St., 5th Fl., Box 83720, Boise, Idaho 83720-0011 or ~~on the Internet~~ at~~ http://www.sco.idaho.gov~~https://www.sco.idaho.gov/LivePages/state-travel-policy-and-procedures.aspx. ~~(3-17-22)~~( )

005. -- 007. (RESERVED)

008. AUDIT, INVESTIGATION, AND ENFORCEMENT.
~~In addition to any actions specified in these rules, t~~The Department may audit, investigate, and take enforcement action under ~~the provisions of~~ IDAPA 16.05.07, "The Investigation and Enforcement of Fraud, Abuse, and Misconduct." ~~(3-17-22)~~( )

009. ~~CRIMINAL HISTORY AND~~ BACKGROUND CHECK REQUIREMENTS.

01. Compliance With ~~Department Criminal History~~Background Checks. ~~Criminal history~~Background checks are required for certain types of providers under these rules. Providers who are required to have a ~~criminal history~~background check must comply with IDAPA 16.05.06, "Criminal History and Background Checks." ~~Except, through the duration of the declared COVID-19 public health emergency, if the individuals working in the area listed in this rule are unable to complete a criminal background check in accordance with the timeframes set forth in IDAPA 16.05.06, then agencies may allow newly hired direct care staff to begin rendering services prior~~

~~to completion of the criminal background check in accordance with the requirements specified by the Department in a COVID-19 information release posted on the Department's website at https://healthandwelfare.idaho.gov/providers/idaho-medicaid-providers/information-medicaid-providers.~~ ~~(3-17-22)~~(____)

02. Department-Issued Variances to Requirements for a ~~Criminal History Check~~ Clearance. ~~(3-17-22)~~(____)

a. Notwithstanding those provider types required to obtain a ~~criminal history check~~ clearance or ~~Department~~ enhanced clearance under these rules or under IDAPA 16.05.06, "Criminal History and Background Checks," the Department ~~at its discretion~~ may allow variances to clearance requirements under certain circumstances. Providers who are subject to a ~~criminal history and~~ background check must still complete and notarize an application for a ~~criminal history and~~ background check. ~~(3-17-22)~~(____)

b. In cases where the application process results in a denial rather than a clearance, and the denial is due to the applicant's prior convictions for disqualifying drug and alcohol-related offenses, the applicant may, with prior written approval of the Department, deliver covered Medicaid Peer Support and Recovery Coaching services. (3-17-22)

c. A variance may be granted on a case-by-case basis upon review by the Department ~~or its designee~~ of any underlying facts and circumstances in each individual case. The Department will establish the process for the administrative review which will be conducted separate from the ~~criminal history~~ background check unit. During the Department's review, the following factors may be considered: ~~(3-17-22)~~(____)

i. The severity or nature of the crimes or other findings; (3-17-22)

ii. The period of time since the incidents occurred; (3-17-22)

iii. The number and pattern of incidents being reviewed; (3-17-22)

iv. Circumstances surrounding the incidents that would help determine the risk of repetition; (3-17-22)

v. The relationship between the incidents and the position sought; (3-17-22)

vi. Activities since the incidents, such as continuous employment, education, participation in treatment, completion of a problem-solving court or other formal offender rehabilitation, payment of restitution, or any other factors that may be evidence of rehabilitation; (3-17-22)

vii. A pardon ~~that was~~ granted by a state governor or the President of the United States; ~~(3-17-22)~~(____)

viii. The falsification or omission of information on the self-declaration form and other supplemental forms submitted; and (3-17-22)

ix. Any other factor deemed relevant to the review. (3-17-22)

d. A variance granted under these rules is not a criminal history and background check clearance and does not set a precedent for subsequent application for variance. The Department may revoke a variance when it identifies a risk to participants' health and safety. Providers who have been granted a variance must still meet all other Department requirements for Medicaid coverage and reimbursement of Peer Support and Recovery Coaching services, and are prohibited from delivering any other covered Medicaid service without the required clearance or Department enhanced clearance. (3-17-22)

03. Availability to Work or Provide Service. (3-17-22)

a. The employer~~, at its discretion,~~ may allow an individual to provide care or services on a provisional basis once the application for a ~~criminal history and~~ background check is completed and notarized, and the employer

has reviewed the application for any disqualifying crimes or relevant records. The employer determines whether the individual could pose a health and safety risk to the vulnerable participants it serves. The individual is not allowed to provide care or services when the employer determines the individual has disclosed a disqualifying crime or relevant records. ~~(3-17-22)~~(____)

b. Those individuals licensed or certified by the Department are not available to provide services or receive licensure or certification until the ~~criminal history and~~ background check is completed and a clearance issued by the Department. ~~(3-17-22)~~(____)

04. Additional Criminal Convictions. Once an individual has received a ~~criminal history~~ clearance, any additional criminal convictions must be reported by the agency to the Department when the agency learns of the conviction. ~~(3-17-22)~~(____)

05. Providers Subject to ~~Criminal History~~ Background Check Requirements. The following providers must receive a ~~criminal history~~ clearance: ~~(3-17-22)~~(____)

a. Contracted Non-Emergency Medical Transportation Providers. All staff of transportation providers having contact with participants ~~must comply with IDAPA 16.05.06, "Criminal History and Background Checks," with the exception of~~ except for individuals contracted as transportation providers defined in Subsection 870.02 of these rules. ~~(3-17-22)~~(____)

b. Provider types deemed by the Department to be at high risk for fraud, waste, and abuse under Subsection 200.02 of these rules ~~must consent to comply with criminal background checks, including fingerprinting, in accordance with~~ and 42 CFR 455.434. ~~(3-17-22)~~(____)

(BREAK IN CONTINUITY OF SECTIONS)

011. DEFINITIONS: I THROUGH O.

~~For the purposes of these rules, the following terms are used as defined below:~~ ~~(3-17-22)~~

01. Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID). An ~~ICF/IID is an~~ entity licensed as an ICF/IID and federally certified to provide care to Medicaid and Medicare participants with developmental disabilities. ~~(3-17-22)~~(____)

02. Idaho Behavioral Health Plan (IBHP). ~~The Idaho Behavioral Health Plan is a~~A prepaid ambulatory health plan (PAHP) that provides outpatient behavioral health coverage for Medicaid-eligible children and adults. Outpatient behavioral health services include mental health and substance use disorder treatment ~~as well as~~and case management services. The coordination and provision of behavioral health services as authorized through the IBHP contract are provided to qualified, enrolled participants by a statewide network of professionally licensed and certified behavioral health providers. ~~(3-17-22)~~(____)

03. Idaho Infant Toddler Program (ITP). ~~The Idaho Infant Toddler Program s~~Serves children from birth through the end of their 36th month of age~~,~~ who meet the requirements and provisions of the Individuals with Disabilities Education Act (IDEA), Part C. ~~(3-17-22)~~(____)

04. In-Patient Hospital Services. Services that are ordinarily furnished in a hospital for the care and treatment of an in-patient under the direction of a physician or dentist except for those services provided in mental hospitals. (3-17-22)

05. Intermediary. Any organization that administers Title XIX or Title XXI; in this case the Department of Health and Welfare. (3-17-22)

06. Intermediate Care Facility Services. ~~Those s~~Services furnished in an intermediate care facility as defined in 42 CFR 440.150, but excluding services provided in a Christian Science Sanatorium. ~~(3-17-22)~~(____)

07. Legal Representative. A parent with custody of a minor child, one who holds a legally-executed and effective power of attorney for health decisions, or a court-appointed guardian whose powers include the power to make health care decisions. (3-17-22)

08. Legend Drug. A drug that requires, by federal regulation or state rule, the order of a licensed medical practitioner before dispensing or administration to the patient. (3-17-22)

09. Level of Care. The classification in which a participant is placed, based on severity of need for institutional care. (3-17-22)

10. Licensed, Qualified Professionals. Individuals licensed, registered, or certified by national certification standards in their respective discipline, or otherwise qualified within the state of Idaho. (3-17-22)

11. Licensed Practitioner of the Healing Arts. The term ~~licensed practitioner of the healing arts comprises~~ includes the following practitioner types: certified registered nurse anesthetists (CRNA), nurse practitioners (NP), nurse midwives (NM), clinical nurse specialists (CNS), and physician assistants (PA), as defined in these rules. ~~(3-17-22)~~(   )

12. Lock-In Program. An administrative sanction, required of a participant found to have misused the services provided by the Medical Assistance Program. The participant is required to select one (1) provider in the identified area(s) of misuse to serve as the primary provider. (3-17-22)

13. Locum Tenens/Reciprocal Billing. The practice of a physician to retain a substitute physician when the regular physician is absent for reasons such as illness, pregnancy, vacation, or continuing medical education. The substitute physician is called the “Locum Tenens” physician. Reimbursement to a Locum Tenens physician will be limited to a period of ninety (90) continuous days. Reciprocal billing occurs when a substitute physician covers the regular physician during an absence or on an on-call basis a period of fourteen (14) continuous days or less. (3-17-22)

14. Medical Assistance. Payments for part or all of the cost of services funded by Titles XIX or XXI of the federal Social Security Act~~, as amended~~. ~~(3-17-22)~~(   )

15. Medicaid. Idaho's Medical Assistance Program. (3-17-22)

16. Medicaid-Related Ancillary Costs. ~~For the purpose of these rules, those s~~Services considered to be ancillary by Medicare cost reporting principles. Medicaid-related ancillary costs will be determined by apportioning direct and indirect costs associated with each ancillary service to Medicaid participants by dividing Medicaid charges into total charges for that service. The resulting percentage, when multiplied by the ancillary service cost, will be considered Medicaid-related ancillaries. ~~(3-17-22)~~(   )

17. Medical Necessity (Medically Necessary). A service is medically necessary if: (3-17-22)

a. It is reasonably calculated to prevent, diagnose, or treat conditions in the participant that endanger life, cause pain, or cause functionally significant deformity or malfunction; and (3-17-22)

b. There is no other equally effective course of treatment available or suitable for the participant requesting the service that is more conservative or substantially less costly. (3-17-22)

c. Medical services must be: (3-17-22)

i. Of a quality that meets professionally-recognized standards of health care; and (3-17-22)

ii. Substantiated by records including evidence of such medical necessity and quality. Those records must be made available to the Department upon request. (3-17-22)

18. Medical Supplies. Healthcare-related items that are consumable, disposable, or cannot withstand repeated use by more than one (1) individual, are suitable for use in any setting in which normal life activities take

place, and are reasonable and medically necessary for the treatment of a disability, illness, or injury for a Medicaid participant. (3-17-22)

19. Medicare Durable Medical Equipment Medicare Administrative Contractor Jurisdiction D Supplier Manual (CMS/Medicare DME Coverage Manual). A publication ~~that is~~ incorporated ~~by reference~~ in Section 004 of these rules ~~and~~ that contains information on DME supplier enrollment, documentation, claim submission, coverage, appeals, and overpayments. ~~(3-17-22)~~( )

20. Nurse Midwife (NM). An advanced practice registered nurse who meets all the applicable requirements to practice as a nurse midwife according to ~~the~~ state regulations ~~in the state~~ where the services are provided. ~~(3-17-22)~~( )

21. Nominal Charges. A public provider's charges are nominal where aggregate charges amount to less than one-half (1/2) of the reasonable cost of the services provided. (3-17-22)

22. Non-Legend Drug. Any drug the distribution of which is not subject to the ordering, dispensing, or administering by a licensed medical practitioner. (3-17-22)

23. Non-Physician Practitioner (NPP). A non-physician practitioner, previously referred to as a midlevel practitioner, comprises the following practitioner types: certified registered nurse anesthetists (CRNA), nurse practitioners (NP), nurse midwives (NM), clinical nurse specialists (CNS), pharmacist (RPh), and physician assistants (PA), as defined in these rules. (3-17-22)

24. Nurse Practitioner (NP). A ~~registered nurse or licensed professional nurse (RN)~~ person who meets all the applicable requirements to practice as a nurse practitioner according to ~~the~~ state regulations ~~in the state~~ where the services are provided. ~~(3-17-22)~~( )

25. Nursing Facility (NF). An institution, or distinct part of an institution, that is primarily engaged in providing skilled nursing care and related services for participants. It is an entity licensed as a nursing facility and federally certified to provide care to Medicaid and Medicare participants. Participants must require medical or nursing care, or rehabilitation services for injuries, disabilities, or sickness. (3-17-22)

26. Ordering, Rendering, Prescribing Providers. Providers who order services, refer for services or prescribe services, products, or prescription drugs for Medicaid participants. (3-17-22)

27. Orthotic. Pertaining to or promoting the support of an impaired joint or limb. (3-17-22)

28. Outpatient Hospital Services. Preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services furnished by or under the direction of a physician or dentist to a patient not in need of inpatient hospital care. (3-17-22)

29. Out-of-State Care. Medical service that is not provided in Idaho or bordering counties is considered out-of-state. Bordering counties outside Idaho are considered out-of-state for the purpose of authorizing long term care. (3-17-22)

012. DEFINITIONS: P THROUGH Z.

~~For the purposes of these rules, the following terms are used as defined below:~~ ~~(3-17-22)~~

01. Participant. A person eligible for and enrolled in the Idaho Medical Assistance Program. (3-17-22)

02. Patient. The person undergoing treatment or receiving services from a provider. (3-17-22)

03. Pharmacist. A person who meets all the applicable requirements to practice as a licensed pharmacist according to ~~the~~ state regulations ~~in the state~~ where the services are provided. ~~(3-17-22)~~( )

04. Physician. A person possessing a Doctor of Medicine (MD) degree or a Doctor of Osteopathy

(DO) degree, and within the State or United States territory services are provided is either licensed to practice medicine, ~~or~~ is a resident enrolled in a postgraduate medical training program, is a licensed international medical graduate, or is a licensed bridge year physician. ~~(3-17-22)~~(____)

05. Physician Assistant (PA). A person who meets all the applicable requirements to practice as a licensed ~~physician assistant~~ PA according to ~~the~~ state regulations ~~in the state~~ where the services are provided. ~~(3-17-22)~~(____)

06. Plan of Care. A written description of medical, remedial, habilitative, or rehabilitative services to be provided to a participant, developed by or under the direction and written approval of a physician. Medications, services, and treatments are identified specifically as to amount, type, and duration of service. ~~(3-17-22)~~(____)

07. Prepaid Ambulatory Health Plan (PAHP). ~~As defined in~~ Under 42 CFR 438.2, ~~a PAHP is~~ an entity that provides medical services to enrollees under contract with the Department on the basis of prepaid capitation payments, or other arrangements that do not use State Plan payment rates. The PAHP does not provide or arrange for, and is not responsible for the provision of any inpatient hospital or institutional services for its enrollees, and does not have a comprehensive risk contract. ~~(3-17-22)~~(____)

08. Private Rate. Rate most frequently charged to private patients for a service or item. (3-17-22)

09. Prosthetic Device. Replacement, corrective, or supportive devices prescribed by a physician or other licensed practitioner of the healing arts profession within the scope of their practice as defined by state law to: (3-17-22)

a. Artificially replace a missing portion of the body; or (3-17-22)

b. Prevent or correct physical deformities or malfunctions; or (3-17-22)

c. Support a weak or deformed portion of the body. (3-17-22)

d. Computerized communication devices are not included in this definition of a prosthetic device. (3-17-22)

10. Provider. Any individual, partnership, association, corporation, or organization, public or private, that furnishes medical goods or services in compliance with these rules and who has applied for and received a Medicaid provider number and who has entered into a written provider agreement with the Department ~~in accordance with~~ under Section 205 of these rules. ~~(3-17-22)~~(____)

11. Provider Agreement. A written agreement between the provider and the Department, entered into ~~in accordance with~~ under Section 205 of these rules. ~~(3-17-22)~~(____)

12. Provider Reimbursement Manual (PRM). A federal publication that specifies accounting treatments and standards for the Medicare program, CMS Publications 15-1 and 15-2, that are incorporated ~~by reference~~ in Section 004 of these rules. ~~(3-17-22)~~(____)

~~**13. Prudent Layperson**. A person who possesses an average knowledge of health and medicine. (3-17-22)~~

1~~4~~3. Psychologist, Licensed. A person licensed to practice psychology according to ~~the~~ state regulations ~~in the state~~ where the services are provided. ~~(3-17-22)~~(____)

1~~5~~4. Psychologist Extender. A person who practices psychology under the supervision of a licensed psychologist who meets ~~the~~ state regulations ~~in the state~~ where the services are provided. ~~(3-17-22)~~(____)

1~~6~~5. Public Provider. A public provider is one operated by a federal, state, county, city, or other local government agency or instrumentality. (3-17-22)

1~~7~~6. **Qualified Interpreter**. A ~~qualified interpreter~~ person who meets the definition of qualified interpreter ~~consistent with~~ under 28 CFR 35.104. ~~(3-17-22)~~(   )

1~~8~~7. **Quality Improvement Organization (QIO)**. An organization that performs utilization and quality control review of health care furnished to Medicare and Medicaid participants. A QIO is formerly known as a Peer Review Organization (PRO). (3-17-22)

1~~9~~8. **Related Entity**. An organization with which the provider is associated or affiliated to a significant extent, or has control of, or is controlled by, that furnishes the services, facilities, or supplies for the provider. (3-17-22)

~~20~~19. **Registered Nurse (RN)**. A person who meets all the applicable requirements and is licensed to practice as an ~~Licensed Registered Nurse~~ RN according to ~~the~~ state regulations ~~in the state~~ where the services are provided. ~~(3-17-22)~~(   )

2~~1~~0. **Rural Health Clinic (RHC)**. An outpatient entity that meets the requirements of 42 USC Section 1395x(aa)(2). It is primarily engaged in furnishing physicians and other medical and health services in rural, federally~~-~~defined, medically underserved areas, or designated health professional shortage areas. ~~(3-17-22)~~(   )

2~~2~~1. **Rural Hospital-Based Nursing Facilities**. Hospital-based nursing facilities not located within a metropolitan statistical area (MSA) as defined by the United States Bureau of Census. (3-17-22)

2~~3~~2. **Social Security Act**. 42 USC 101 et seq., authorizing, in part, federal grants to the states for medical assistance to low-income persons who meet certain criteria. (3-17-22)

2~~4~~3. **State Plan**. The contract between the state and federal government under 42 USC Section 1396a(a). (3-17-22)

2~~5~~4. **Supervision**. Procedural guidance by a qualified person and initial direction and periodic inspection of the actual act, at the site of service delivery. (3-17-22)

2~~6~~5. **Title XVIII**. Title XVIII of the Social Security Act, known as Medicare, for aged, blind, and disabled individuals administered by the federal government. (3-17-22)

2~~7~~6. **Title XIX**. Title XIX of the Social Security Act, known as Medicaid, is a medical benefits program jointly financed by the federal and state governments and administered by the states. This program pays for medical assistance for certain individuals and families with low income and limited resources. (3-17-22)

2~~8~~7. **Title XXI**. Title XXI of the Social Security Act, known as the State Children's Health Insurance Program (SCHIP). This is a program that primarily pays for medical assistance for low-income children. (3-17-22)

2~~9~~8. **Third Party**. Includes a person, institution, corporation, or public or private agency that is liable to pay all or part of the medical cost of injury, disease, or disability of a medical assistance participant. ~~(3-17-22)~~(   )

~~30~~29. **Transportation**. The physical movement of a participant to and from a medical appointment or service by the participant, another person, taxi, or common carrier. ~~(3-17-22)~~(   )

013. MEDICAL CARE ADVISORY COMMITTEE (MCAC).

The Director of the Department will appoint a ~~Medical Care Advisory Committee~~ MCAC to advise ~~and counsel~~ on ~~all aspects of~~ health and medical services. ~~(3-17-22)~~(   )

01. **Membership**. The ~~Medical Care Advisory Committee~~ MCAC will include~~, but not be limited to,~~ the following: ~~(3-17-22)~~(   )

a. Licensed physicians and other ~~representatives of the~~ health professionals ~~who are~~ familiar with the medical needs of low-income ~~population groups~~ individuals and ~~with~~ the resources available and required for their

care; and ~~(3-17-22)~~(   )

b. Members of ~~consumer groups, including medical assistance~~ stakeholder organizations and Medicaid participants~~ and consumer organizations~~. ~~(3-17-22)~~(   )

02. **Organization**. The ~~Medical Care Advisory Committee~~ MCAC will: ~~(3-17-22)~~(   )

a. Consist of not more than twenty-two (22) members;~~ and~~ ~~(3-17-22)~~(   )

b. Be appointed by the Director to the ~~Medical Care Advisory Committee~~ MCAC to serve three (3) year terms, whose terms are to overlap;~~ and~~ ~~(3-17-22)~~(   )

c. Elect a chairman and a vice-chairman to serve a two (2) year term;~~ and~~ ~~(3-17-22)~~(   )

d. Meet at least quarterly; and (3-17-22)

e. Submit an activity report ~~of its activities~~ and recommendations to the Director at least ~~once each year~~ annually. ~~(3-17-22)~~(   )

03. **Policy Function**. The ~~Medical Care Advisory Committee~~ MCAC must be given opportunity to participate in medical assistance policy development and program administration. ~~(3-17-22)~~(   )

04. **Staff Assistance**. The ~~Medical Care Advisory Committee~~ MCAC must be provided staff assistance from within the Department and independent technical assistance as needed to enable them to make effective recommendations, and will be provided with travel and per diem costs, where necessary. ~~(3-17-22)~~(   )

014. -- 099. (RESERVED)

GENERAL PARTICIPANT PROVISIONS
(Sections 100-199)

100. ELIGIBILITY FOR MEDICAL ASSISTANCE.
~~Idaho Department of Health and Welfare Rules,~~ IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children," and ~~Idaho Department of Health and Welfare Rules,~~ IDAPA 16.03.05, "Eligibility for Aid to the Aged, Blind, and Disabled (AABD)," are applicable in determining eligibility for medical assistance. ~~(3-17-22)~~(   )

(BREAK IN CONTINUITY OF SECTIONS)

210. CONDITIONS FOR PAYMENT.

01. **Participant Eligibility**. The Department will reimburse providers for medical care and services, regardless of the current eligibility status of the medical assistance participant in the month of payment, provided a complete and properly submitted claim for payment has been received and each of the following conditions are met: (3-17-22)

a. The participant was found eligible for medical assistance for the month, day, and year during which the medical care and services were rendered; (3-17-22)

b. The participant received such medical care and services no earlier than the third month before the month in which application was made on such participant's behalf;~~ and~~ ~~(3-17-22)~~(   )

c. The provider verified the participant's eligibility on the date the service was rendered and can provide proof of the eligibility verification~~.~~; and ~~(3-17-22)~~(   )

d. Not more than twelve (12) months have elapsed since the month of the latest participant services

for which such payment is being made. Medicare cross-over claims are excluded from the twelve (12) month submittal limitation. (3-17-22)

02. Time Limits. The time limit set forth in Subsection 210.01.d. of this rule does not apply with respect to retroactive eligibility adjustment. When participant eligibility is determined retroactively, the Department will reimburse providers for services within the period of retroactive eligibility if a claim for those services is submitted within twelve (12) months of the date of the participant's eligibility determination. (3-17-22)

03. Acceptance of State Payment. By participating in the Medical Assistance Program, providers agree to accept, as payment in full, the amounts paid by the Department for services to Medicaid participants. Providers also agree to provide all materials and services without unlawfully discriminating on the grounds of race, age, sex, creed, color, national origin, or physical or intellectual disability. (3-17-22)

04. Payment in Full. If a provider accepts Medicaid payment for a covered service, the Medicaid payment must be accepted as full payment for that service, and the participant cannot be billed for the difference between the billed amount and the Medicaid allowed amount. (3-17-22)

05. Medical Care Provided Outside the State of Idaho. Out-of-state medical care is subject to the same utilization review and other Medicaid coverage requirements and restrictions as medical care received within the state of Idaho. (3-17-22)

06. Ordering, Prescribing, and Referring Providers. Any service or supply ordered, prescribed, or referred by a physician or other qualified professional who is not an enrolled Medicaid provider will not be reimbursed by the Department. (3-17-22)

07. Referral From Participant's Assigned Primary Care Provider. Medicaid services may require a referral from the participant's assigned primary care provider. Services requiring a referral are listed in the Idaho Medicaid Provider Handbook. Services provided without a referral, when one is required, are not covered and are subject to sanctions, recoupment, or both. The Department may change the services that require a referral after appropriate notification of Medicaid-eligible individuals and providers as specified in Section 563 of these rules. (3-17-22)

08. Follow-up Communication with Assigned Primary Care Provider. Medicaid services may require timely follow-up communication with the participant's assigned primary care provider. Services requiring post-service communication with the primary care provider and time frames for that communication are listed in the Idaho Medicaid Provider Handbook. Services provided without timely communication of care outcomes, when communication is required, are not covered and are subject to sanctions, recoupment, or both. The Department may change the services that require communication of care outcomes after appropriate notification of Medicaid-eligible individuals and providers as specified in Section 563 of these rules. ~~(3-17-22)~~( )

09. ~~Services Delivered Via Telehealth~~ Virtual Care. Services delivered via ~~telehealth~~virtual care ~~as defined in~~under Title 54, Chapter 57, Idaho Code, must be identified as such ~~in accordance with~~under billing requirements published in the Idaho Medicaid Provider Handbook. ~~Telehealth~~Virtual care services billed without being identified as such are not covered. Virtual care ~~S~~services ~~delivered via telehealth~~ may be reimbursed within limitations defined by the Department in the Idaho Medicaid Provider Handbook. Fee-for-service reimbursement is not available for ~~an electronic mail message (e-mail), or facsimile transmission (fax)~~asynchronous services except remote monitoring. ~~(3-17-22)~~( )

10. Services Subject to Electronic Visit Verification (EVV). Services requiring EVV compliance are subject to quality review. Services billed without the minimum essential EVV elements, ~~as defined by~~under Section 1903(l)(2) of the Social Security Act, may be denied, delayed, or subject to sanctions or recoupment, or both, ~~in accordance with~~under IDAPA 16.05.07, "The Investigation and Enforcement of Fraud, Abuse, and Misconduct." ~~(3-17-22)~~( )

(BREAK IN CONTINUITY OF SECTIONS)

230. GENERAL PAYMENT PROCEDURES.

01. Provided Services. (3-17-22)

a. Each participant may consult a participating physician or provider of their choice for care and receive covered services by presenting their identification card to the provider, subject to restrictions imposed by participation in Healthy Connections or enrollment in a~~ Prepaid Ambulatory Health Plan (~~PAHP~~)~~. ~~(3-17-22)~~(   )

b. The provider must obtain the required information by using the Medicaid number on the identification card from the Electronic Verification System (EVS) and transfer the required information onto the appropriate claim form. Where the ~~Electronic Verification System (~~EVS~~)~~ indicates that a participant is enrolled in Healthy Connections, the provider must comply with referral or follow-up communication requirements ~~defined in~~under Section 210 of these rules. ~~(3-17-22)~~(   )

c. Upon providing the care and services to a participant, the provider or their agent must submit a properly completed claim to the Department. (3-17-22)

d. The Department is to process each claim received and make payment directly to the provider. (3-17-22)

e. The Department will not supply claim forms. Forms needed to comply with the Department's unique billing requirements are included in~~ Appendix D of~~ the Idaho Medicaid Provider Handbook. ~~(3-17-22)~~(   )

02. Individual Provider Reimbursement. The Department will not pay the individual provider more than the lowest of: (3-17-22)

a. The provider's actual charge for service; or (3-17-22)

b. The maximum allowable charge for the service as established by the Department on its pricing file, if the service or item does not have a specific price on file, the provider must submit documentation to the Department and reimbursement will be based on the documentation; or (3-17-22)

c. The Medicaid-allowed amount minus the Medicare payment or the Medicare co-insurance and deductible amounts added together when a participant has both Medicare and Medicaid. (3-17-22)

03. Services Normally Billed Directly to the Patient. If a provider delivers services and it is customary for the provider to bill patients directly for such services, the provider must complete the appropriate claim form and submit it to the Department. (3-17-22)

04. Reimbursement for Other Noninstitutional Services. The Department will reimburse for all noninstitutional services that are not included in other ~~Idaho~~ Department~~ of Health and Welfare R~~rules, but allowed under Idaho's Medical Assistance Program ~~according to the provisions of~~under 42 CFR Section 447.325. ~~(3-17-22)~~(   )

05. Review of Records. (3-17-22)

a. The Department, ~~or its duly authorized agent,~~ the U.S. Department of Health and Human Services, and the Bureau of Compliance have the right to review ~~pertinent~~ records of providers receiving Medicaid reimbursement for covered services. ~~(3-17-22)~~(   )

b. The review of participants' medical and financial records must be conducted for the purposes of determining: (3-17-22)

i. The necessity for the care; or (3-17-22)

ii. That treatment was rendered ~~in accordance with~~under accepted medical standards of practice; or

~~(3-17-22)~~(____)

iii. That charges were not in excess of the provider's usual and customary rates; or (3-17-22)

iv. That fraudulent or abusive treatment and billing practices are not taking place. (3-17-22)

c. Refusal of a provider to permit the Department to review records pertinent to medical assistance will constitute grounds for: (3-17-22)

i. Withholding payments to the provider until access to the requested information is granted; or (3-17-22)

ii. Suspending the provider's number. (3-17-22)

06. Lower of Cost or Charges. Payment to providers, other than public providers furnishing such services free of charge or at nominal charges to the public, is the lesser of the reasonable cost of such services or the customary charges with respect to such services. Public providers that furnish services free of charge, or at a nominal charge, are reimbursed fair compensation that is the same as reasonable cost. (3-17-22)

07. Procedures for Medicare Cross-Over Claims. (3-17-22)

a. If a medical assistance participant is eligible for Medicare, the provider must first bill Medicare for the services rendered to the participant. (3-17-22)

b. If a provider accepts a Medicare assignment, the Department will pay the provider for the services, up to the Medicaid allowable amount minus the Medicare payment, and forward the payment to the provider automatically based upon the Medicare Summary Notice (MSN) information ~~on the computer tape~~ that is received from the Medicare Part B Carrier on a weekly basis. ~~(3-17-22)~~(____)

c. If a provider does not accept a Medicare assignment, an MSN must be attached to the appropriate claim form and submitted to the Department. The Department will pay the provider for the services, up to the Medicaid allowable amount minus the Medicare payment. (3-17-22)

d. For all other services, an MSN must be attached to the appropriate claim form and submitted to the Department. The Department will pay the provider for the services up to the Medicaid allowable amount minus the Medicare payment. (3-17-22)

08. Services Reimbursable After the Appeals Process. Reimbursement for services originally identified by the Department as not medically necessary will be made if such decision is reversed by the appeals process required in IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings." (3-17-22)

(BREAK IN CONTINUITY OF SECTIONS)

235. PATIENT "ADVANCE DIRECTIVES."

01. Provider Participation. Hospitals, nursing facilities, providers of home health care services (home health agencies, federally qualified health clinics, rural health clinics), hospice providers, and personal care R~~.~~N~~.~~ supervisors must: ~~(3-17-22)~~(____)

a. Provide all adults receiving medical care written and oral information (the information provided must contain all material found in the Department's approved ~~advance directive form "Your Rights As A Patient To Make Medical Treatment Decisions"~~Advance Directive Registration Form) which defines their rights under state law to make decisions concerning their medical care. ~~(3-17-22)~~(____)

i. The provider must explain that the participant has the right to make decisions regarding their

medical care which includes the right to accept or refuse treatment. If the participant has any questions regarding treatment, the facility or agency will notify the physician of those concerns. Their physician can answer any questions they may have about the treatment. (3-17-22)

ii. The provider will inform the participant of their rights to formulate advance directives, such as "Living Will" or "Durable Power of Attorney For Health~~C~~care," or both. ~~(3-17-22)~~(   )

iii. The provider must comply with Subsection 235.02 of this rule. (3-17-22)

b. Provide all adults receiving medical care written information on the providers' policies concerning the implementation of the participant's rights regarding "Durable Power of Attorney for Health~~C~~care," "Living Will," and the participant's right to accept or refuse medical and surgical treatment. ~~(3-17-22)~~(   )

c. Document in the participant's medical record whether the participant has executed an advance directive ("Living Will" or "Durable Power of Attorney for Health~~C~~care," or both), or have a copy of the Department's approved ~~a~~Advance ~~d~~Directive Registration ~~f~~Form ~~("Your Rights as a Patient to Make Medical Treatment Decisions")~~ attached to the patient's medical record which has been completed acknowledging whether the patient/resident has executed an advance directive ("Living Will" or "Durable Power of Attorney for Health~~C~~care," or both). ~~(3-17-22)~~(   )

d. The provider cannot condition the provision of care or otherwise discriminate against an individual based on whether that participant has executed an ~~"A~~advance ~~D~~directive.~~"~~ ~~(3-17-22)~~(   )

e. If the provider cannot comply with the patient's "Living Will" or "Durable Power of Attorney for Health~~C~~care," or both, as a matter of conscience, the provider will assist the participant in transferring to a facility or agency that can comply. ~~(3-17-22)~~(   )

f. Provide education to their staff and the community on issues concerning advance directives. (3-17-22)

02. When ~~"~~Advance Directives~~"~~ Must Be Given. Hospitals, nursing facilities, providers of home health care (home health agencies, federally qualified health centers, rural health clinics), hospice agencies, and personal care RN supervisors, must give information concerning "~~A~~advance ~~D~~directives" to adult participants in the following situations: ~~(3-17-22)~~(   )

a. Hospitals must give the information at the time of the participant's admission as an inpatient unless Subsection 235.03 of this rule applies. (3-17-22)

b. Nursing facilities must give the information at the time of the participant's admission as a resident. (3-17-22)

c. Home health providers must give the information to the participant in advance of the participant coming under the care of the provider. (3-17-22)

d. The personal care RN supervisors will inform the participant when the RN completes the RN Assessment and Care Plan. The RN supervisor will inform the Qualified Intellectual Disabilities Professional (QIDP) and the personal care attendant of the participants decision regarding "~~A~~advance ~~D~~directives." ~~(3-17-22)~~(   )

e. A hospice provider must give information at the time of initial receipt of hospice care by the participant. (3-17-22)

03. Information Concerning ~~"~~Advance Directives~~"~~ at the Time an Incapacitated Individual Is Admitted. An individual may be admitted to a facility in a comatose or otherwise incapacitated state and be unable to receive information or articulate whether they have executed an advance directive. In this case, to the extent that a facility issues materials about policies and procedures to the families or to the surrogates or other concerned persons of the incapacitated patient ~~in accordance with~~under state law, it must also include the information concerning advance directives. This does not relieve the facility from its obligation to provide this information to the patient once

they are no longer incapacitated. ~~(3-17-22)~~(____)

04. Provider Agreement. A "Memorandum of Understanding Regarding Advance Directives" is incorporated within the provider agreement. By signing the Medicaid provider agreement, the provider is not excused from its obligation regarding advance directives ~~to the general public per~~under Section 1902(a) of the Social Security Act, as amended by Section 4751 of OBRA 1990. ~~(3-17-22)~~(____)

(BREAK IN CONTINUITY OF SECTIONS)

455. AMBULATORY SURGICAL CENTER SERVICES: PROVIDER REIMBURSEMENT.

01. Payment Methodology. ASC services reimbursement is designed to pay for use of facilities and supplies necessary to safely care for the patient. Such services are reimbursed as follows: (3-17-22)

a. ASC service payments represent reimbursement for the costs of goods and services recognized by the Medicare program ~~as described in~~under 42 CFR, Part 416. Payment ~~levels~~ will be determined by the Department. Any surgical procedure covered by the Department, but which is not covered by Medicare will have a reimbursement rate established by the Department. ~~(3-17-22)~~(____)

b. ASC services include the following: (3-17-22)

i. Nursing, technician, and related services; (3-17-22)

ii. Use of ASC facilities; (3-17-22)

iii. Drugs, biologicals, surgical dressings, supplies, splints, casts, and appliances and equipment directly related to the provision of surgical procedures; (3-17-22)

iv. Diagnostic or therapeutic services or items directly related to the provision of a surgical procedure; (3-17-22)

v. Administration, record~~-~~keeping, and housekeeping items and services; and ~~(3-17-22)~~(____)

vi. Materials for anesthesia. (3-17-22)

c. ASC services do not include the following services: (3-17-22)

i. Physician services; (3-17-22)

ii. Laboratory services, x-ray or diagnostic procedures (other than those directly related to the performance of the surgical procedure); (3-17-22)

iii. Prosthetic and orthotic devices; (3-17-22)

iv. Ambulance services; (3-17-22)

v. ~~Durable medical equipment~~DME typically used in the participant's place of residence, but may be suitable for use in any setting in which normal life activities take place, other than a hospital, nursing facility, or ICF/IID; and ~~(3-17-22)~~(____)

vi. Any other service not specified in Subsection 455.01.b. of this rule. (3-17-22)

02. Payment for Ambulatory Surgical Center Services. Payment is made at a rate established ~~in accordance with~~under Section 230 of these rules. ~~(3-17-22)~~(____)

(BREAK IN CONTINUITY OF SECTIONS)

511. ABORTION PROCEDURES: PARTICIPANT ELIGIBILITY.
The Department will fund abortions ~~under the Medical Assistance Program only~~ under circumstances where the abortion is necessary to save the life of the woman, or in cases of rape or incest as determined by the courts, or, where no court determination has been made, if reported to a law enforcement agency or child protective services. ~~(3-17-22)~~(____)

512. -- 513. (RESERVED)

514. ABORTION PROCEDURES: PROVIDER QUALIFICATIONS AND DUTIES.

01. Required Documentation in the Case of Rape or Incest. In the case of rape or incest, the following documentation must be provided to the Department: (3-17-22)

a. A copy of the court determination of rape or incest; or (3-17-22)

b. Where no court determination has been made, documentation that the rape or incest was reported to a law enforcement agency~~.~~ or child protective services; or ~~(3-17-22)~~(____)

c. Where the rape or incest was not reported to a law enforcement agency or child protective services, a ~~licensed~~ physician must certify in writing ~~that, in the physician's~~their professional opinion~~,~~ that the woman was unable~~, for reasons related~~due to her health, to file a report ~~the rape or incest to a law enforcement agency~~. The certification must contain the name and address of the woman. ~~(3-17-22)~~(____)

02. Required Documentation in the Case ~~Where the Abortion is Necessary~~ to Save ~~the~~a Woman's Life ~~of the Woman~~. In the case where the abortion is necessary to save the life of the woman, a licensed physician must certify in writing that the woman may die if the fetus is carried to term. The certification must contain the name and address of the woman. ~~(3-17-22)~~(____)

(BREAK IN CONTINUITY OF SECTIONS)

524. NON-PHYSICIAN PRACTITIONER SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.

01. Identification of Services. The required services must be covered under the legal scope of practice as identified by the appropriate State rules of the NPP. (3-17-22)

02. Deliverance of Services. The services must be delivered under physician supervision, if required by ~~Idaho Statute~~state regulations where the service is provided. ~~(3-17-22)~~(____)

(BREAK IN CONTINUITY OF SECTIONS)

549. LM SERVICES: COVERAGE AND LIMITATIONS.

01. Maternity and Newborn - Coverage. Antepartem, intrapartum, and up to six (6) weeks of postpartum maternity and newborn care are covered. (3-17-22)

02. Maternity and Newborn - Limitations. Maternal or newborn services provided after the sixth postpartum week are not covered ~~when provided by a CPM~~. ~~(3-17-22)~~(____)

03. Medication - Coverage and Limitations. LM providers may administer medication and bill Medicaid if the medication is a Medicaid-covered service, and is also listed in the LM formulary ~~in~~under IDAPA 24.26.01, "Rules of the Idaho Board of Midwifery." ~~(3-17-22)~~(____)

(BREAK IN CONTINUITY OF SECTIONS)

573. CHIS: COVERAGE AND LIMITATIONS.

01. Excluded for Medicaid Payment. ~~The following are excluded for Medicaid payment:~~ ~~(3-17-22)~~(____)

i. Vocational services; (3-17-22)

ii. Educational services; and (3-17-22)

iii. Recreational services. (3-17-22)

02. Service Delivery. The CHIS allowed under the Medicaid ~~s~~State ~~p~~Plan authority include evaluations, diagnostic and therapeutic treatment services provided on an outpatient basis. These services help improve individualized functional skills, develop replacement behaviors, and promote self-sufficiency of the participant. CHIS may be delivered in the community, the participant's home, or in a DDA ~~in accordance with~~under the requirements of ~~this chapter~~these rules. Duplication of services is not reimbursable. ~~(3-17-22)~~(____)

03. Required Recommendation. CHIS must be recommended by a physician or other licensed practitioner of the healing arts within ~~his or her~~their scope of practice, under state law. (3-17-22)

a. The CHIS provider may not seek reimbursement for services provided more than thirty (30) calendar days prior to the signed and dated recommendation. (3-17-22)

b. The recommendation is only required to be completed once and must be received prior to submitting the initial prior authorization request. If the participant has not accessed CHIS for more than three hundred sixty-five (365) calendar days~~,~~ then a~~nd~~ new recommendation must be received. ~~(3-17-22)~~(____)

04. Required Screening. Needs are determined through the current version of the Vineland Adaptive Behavior Scales or other Department-approved screening tools that are conducted by the family's chosen CHIS provider, and the Department, ~~or its designee,~~ and are administered ~~in accordance with~~under the protocol of the tool. The screening tool is only required to be completed once and must be completed prior to submitting the initial prior authorization request. The following apply: ~~(3-17-22)~~(____)

a. If a screening tool has been completed by the Department~~, or its designee,~~ a new screening is not required. ~~(3-17-22)~~(____)

b. If the participant has been determined eligible by the Department, a new screening tool is not required. (3-17-22)

c. If the participant has not accessed CHIS for more than three hundred sixty-five (365) calendar days, a new screening must be completed. (3-17-22)

d. The screening cannot be billed more than once unless an additional screening is required ~~in accordance with~~under guidelines as outlined in the Medicaid Provider Handbook. ~~(3-17-22)~~(____)

05. Services. All CHIS recommended on a participant's assessment and clinical treatment plan must be prior authorized by the Department~~, or its contractor~~. The following CHIS are available for eligible participants and are reimbursable services when provided ~~in accordance with~~under these rules: ~~(3-17-22)~~(____)

a. Habilitative Skill Building. This direct intervention service includes techniques used to develop, improve, and maintain, to the maximum extent possible, the developmentally appropriate functional abilities and daily living skills needed by a participant. This service may include teaching and coordinating methods of training

with family members or others who regularly participate in caring for the eligible participant. Services include individual or group interventions. (3-17-22)

i. Group services must be provided by one (1) qualified staff providing direct services for ~~up to six (6)~~two (2) or three (3) participants. ~~(3-17-22)~~(   )

ii. As the number and needs of the participants increase, the participant ratio in the group must be adjusted ~~accordingly~~from three (3) to two (2). ~~(3-17-22)~~(   )

iii. Group services will only be reimbursed when the participant's objectives relate to benefiting from group interaction. (3-17-22)

b. Behavioral Intervention. This service utilizes direct intervention techniques used to produce positive meaningful changes in behavior that incorporate functional replacement behaviors and reinforcement-based strategies while also addressing any identified habilitative skill building needs. These services are provided to participants who exhibit interfering behaviors that impact the independence or abilities of the participant, such as impaired social skills and communication or destructive behaviors. Intervention services may include teaching and coordinating methods of training with family members or others who regularly participate in caring for the eligible participant. Evidence-based or evidence-informed practices are used to promote positive behaviors and learning while reducing interfering behaviors and developing behavioral self-regulation. Services include individual or group interventions. (3-17-22)

i. Group services must be provided by one (1) qualified staff providing direct services for ~~up to six (6)~~two (2) or three (3) participants. ~~(3-17-22)~~(   )

ii. As the number and severity of the participants with behavioral issues increase, the participant ratio in the group must be adjusted ~~accordingly~~from three (3) to two (2). ~~(3-17-22)~~(   )

iii. Group services should only be delivered when the participant's objectives relate to benefiting from group interaction. (3-17-22)

c. Interdisciplinary Training. This is a companion service to behavioral intervention and habilitative skill building and is used to assist with implementing a participant's health and medication monitoring, positioning and physical transferring, use of assistive equipment, and intervention techniques in a manner that meets the participant's needs. This service is to be utilized for collaboration, with the participant present, during the provision of services between the intervention specialist or professional and a Speech Language and Hearing Professional (SLP), Physical Therapist (PT), Occupational Therapist (OT), medical professional, behavioral or mental health professional. (3-17-22)

d. Crisis Intervention. This service may include providing training to staff directly involved with the participant, delivering intervention directly with the eligible participant, and developing a crisis plan that directly addresses the behavior occurring and the necessary intervention strategies to minimize the behavior and future occurrences. Crisis intervention is provided in the home or community on a short-term basis typically not to exceed thirty (30) days. Positive behavior interventions must be used prior to, and in conjunction with, the implementation of any restrictive intervention. Crisis intervention is available for participants who have an unanticipated event, circumstance, or life situation that places a participant at risk of at least one (1) of the following: (3-17-22)

i. Hospitalization; (3-17-22)

ii. Out-of-home placement; ~~(3-17-22)~~(   )

iii. Incarceration; or (3-17-22)

iv. Physical harm to self or others, including a family altercation or psychiatric relapse. (3-17-22)

e. Assessment and Clinical Treatment Plan (ACTP). The ACTP is a comprehensive assessment that guides the formation of the implementation plan(s) that include developmentally appropriate objectives and strategies

related to identified needs. The qualified provider conducts an assessment to evaluate the participant's strengths, needs, and functional abilities across environments. This process guides the development of intervention strategies and recommendations for services related to the participant's identified needs. The ACTP must be monitored and adjusted to reflect the current needs of the participant. The CHIS provider must document that a copy of the ACTP was offered to the participant's parent or legal guardian. The ACTP must be completed on a Department-approved form as referenced in the Medicaid Provider Handbook and contain the following minimum standards: ~~(3-17-22)~~(____)

i. Clinical interview(s) must be completed with the parent or legal guardian; (3-17-22)

ii. Administer or obtain an objective and validated comprehensive skills or developmental assessment approved by the Department. The most current version of the assessment must be used and the assessment must have been completed within the last three-hundred and sixty-five (365) days; (3-17-22)

iii. Review of assessments, reports, and relevant history; (3-17-22)

iv. Observations in at least one (1) environment; (3-17-22)

v. A reinforcement inventory or preference assessment; (3-17-22)

vi. A transition plan; and (3-17-22)

vii. Be signed by the individual completing the assessment and the parent or legal guardian. (3-17-22)

(BREAK IN CONTINUITY OF SECTIONS)

602. SCREENING MAMMOGRAPHIES: COVERAGE AND LIMITATIONS.

01. Screening Mammographies. ~~Screening mammographies are limited to one (1) per year for women who are forty (40) or more years of age~~Align with the “A” and “B” recommendations of the United States Preventative Services Taskforce. ~~(3-17-22)~~(____)

02. Diagnostic Mammographies. ~~Diagnostic mammographies a~~Are not subject to the limitations of screening mammographies. Diagnostic mammographies are covered when a physician or licensed practitioner of the healing arts orders the procedure for a participant of any age. ~~(3-17-22)~~(____)

(BREAK IN CONTINUITY OF SECTIONS)

640. DIABETES EDUCATION AND TRAINING SERVICES: DEFINITIONS.
~~For purposes of these rules, a~~A Certified Diabetes Educator is a state-licensed health professional who is certified by the Certification Board for Diabetes Care and Education or the Association of Diabetes Care and Education Specialists (ADCES). ~~(3-17-22)~~(____)

641. DIABETES EDUCATION AND TRAINING SERVICES: PARTICIPANT ELIGIBILITY.
The medical necessity for diabetes education and training are evidenced by the following: (3-17-22)

01. ~~Recent Diagnosis~~Participants with Diabetes. Are eligible for a Diabetes Management Program when: (____)

a. A recent diagnosis of diabetes within ninety (90) days of enrollment with no history of prior diabetes education; or ~~(3-17-22)~~(____)

~~02~~b. ~~Uncontrolled Diabetes.~~ Uncontrolled diabetes manifested by two (2) or more fasting blood sugar

of greater than one hundred forty milligrams per decaliter (140 mg/dL), hemoglobin A1c greater than eight percent (8%), or random blood sugar greater than one hundred eighty milligrams per decaliter (180 mg/dL), in addition to the manifestations; or ~~(3-17-22)~~(____)

~~03~~**c.** ~~**Recent Manifestations**.~~ Recent manifestations ~~resulting~~ from poor diabetes control including neuropathy, retinopathy, recurrent hypoglycemia, repeated infections, or nonhealing wounds. ~~(3-17-22)~~(____)

02. **Participants with Pre-Diabetes**. Are eligible for the National Diabetes Prevention Program when they meet the program's guidance. (____)

642. DIABETES EDUCATION AND TRAINING SERVICES: COVERAGE AND LIMITATIONS.

01. **Concurrent Diagnosis**. Only training and education services that are reasonable and necessary ~~for treatment of a current injury or illness~~ will be covered. Covered professional and educational services will address each participant's medical needs through scheduled outpatient group or individual training or counseling concerning diet and nutrition, exercise, medications, home glucose monitoring, insulin administration, foot care, or the effects of other current illnesses and complications. ~~(3-17-22)~~(____)

02. **No Substitutions**. The physician may not use the formally structured program, or a Certified Diabetes Educator, as a substitute for basic diabetic care and instruction the physician must furnish to the participant, which includes the disease process and pathophysiology of diabetes mellitus, and dosage administration of oral hypoglycemic agents. (3-17-22)

03. **Services Limited**. Diabetes education and training services will be limited to twenty-four (24) hours of group sessions and twelve (12) hours of individual counseling every five (5) calendar years. (3-17-22)

(BREAK IN CONTINUITY OF SECTIONS)

644. DIABETES EDUCATION AND TRAINING SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.

Outpatient diabetes education and training services will be covered under one (1) of the following conditions: ~~(3-17-22)~~(____)

01. ~~**Meets Program Standards**~~**Diabetes Management Program**. The education and training services are provided through a diabetes management program recognized as meeting the program standards of the American Diabetes Association or ~~the National Diabetes Prevention Program~~Association of Diabetes Care and Education Specialists by a certified diabetic educator. ~~(3-17-22)~~(____)

02. ~~**Conducted by a Certified Diabetic Educator**~~**The National Diabetes Prevention Program**. The ~~education and training services are provided by a Certified Diabetic Educator through a formal~~provider meets the requirements for the program. ~~(3-17-22)~~(____)

(BREAK IN CONTINUITY OF SECTIONS)

709. OUTPATIENT BEHAVIORAL HEALTH SERVICES: COVERAGE AND LIMITATIONS.

01. **Community-Based Outpatient Behavioral Health Services**. The Community-Based Outpatient Behavioral Health Services included in the Idaho Behavioral Health Plan (IBHP) or the Idaho State Plan are ~~medically necessary rehabilitation~~covered services that evaluate the need for and provide therapeutic and rehabilitative treatment to minimize symptoms of mental illness and substance use disorders and restore independent functioning. ~~These services include:~~ ~~(3-17-22)~~(____)

~~a.~~ ~~Assessments and Planning;~~ ~~(3-17-22)~~

~~**b.** Psychological and Neurological Testing; (3-17-22)~~

~~**c.** Psychotherapy (Individual, Group, and Family); (3-17-22)~~

~~**d.** Pharmacologic Management; (3-17-22)~~

~~**e.** Partial Care Treatment; (3-17-22)~~

~~**f.** Behavioral Health Nursing; (3-17-22)~~

~~**g.** Drug Screening; (3-17-22)~~

~~**h.** Community-Based Rehabilitation; (3-17-22)~~

~~**i.** Substance Use Disorder Treatment Services; and (3-17-22)~~

~~**j.** Case Management. (3-17-22)~~

02. Prior Authorization. Some behavioral health services may require prior authorization from the IBHP contractor. (3-17-22)

(BREAK IN CONTINUITY OF SECTIONS)

723. HOME HEALTH SERVICES: PROCEDURAL REQUIREMENTS.

01. Orders. (3-17-22)

a. Home health services must be ordered by a physician, or a licensed practitioner of the healing arts. Orders must include ~~at a minimum,~~ the provider's National Provider Identifier (NPI), the services or items to be provided, the frequency, and, where applicable, the expected duration of time for which the home health services will be needed. Orders for medical supplies, equipment, and appliances are detailed in Section 753 of these rules. ~~(3-17-22)~~( )

b. Home health services required for extended periods must be reordered at least every sixty (60) days for services and annually for medical supplies, equipment, and appliances. (3-17-22)

02. Face-to-Face Encounter for Home Health Services, Medical Supplies, Equipment, and Appliances. (3-17-22)

a. To initiate home health services, medical supplies, equipment, and appliances, the participant's physician, or a licensed practitioner of the healing arts ~~as authorized in this rule,~~ must document a face-to-face encounter related to the primary reason the patient requires home health services. Documentation must indicate the practitioner who conducted the encounter, and the date of the encounter as described in the CMS/Medicare DME coverage manual. ~~(3-17-22)~~( )

i. For home health services, the face-to-face encounter must have occurred no more than ninety (90) days before, or thirty (30) days after, the start of the home health services. (3-17-22)

ii. For home health medical supplies, equipment, and appliances, the face-to-face encounter must have occurred no more than six (6) months before the start of services. (3-17-22)

b. The face-to-face encounter may occur ~~via telehealth, as defined in~~virtually under Subsection 210.09 of these rules. ~~(3-17-22)~~( )

c. The face-to-face encounter may be performed by participant's physician, including an attending acute or post-acute physician, or licensed practitioner of the healing arts. (3-17-22)

03. Home Health Plan of Care. (3-17-22)

a. All home health services must be provided under a home health plan of care that is established prior to beginning treatment and must be signed by the licensed, qualified professional who established the plan. (3-17-22)

b. All home health plans of care must be reviewed by the ordering provider at least every sixty (60) days for services, and annually for medical supplies, equipment, and appliances. (3-17-22)

(BREAK IN CONTINUITY OF SECTIONS)

732. THERAPY SERVICES: COVERAGE AND LIMITATIONS.
Therapy services are covered under these rules when delivered by a therapy professional and provided by one (1) of the following providers: outpatient hospitals, outpatient rehabilitation facilities, comprehensive outpatient rehabilitative facilities, nursing facilities, school-based services, independent practitioners, and home health agencies. Therapy services provided by a home health agency under a home health plan of care must meet the requirements ~~found in~~under Sections 730 through 739 of these rules, and the requirements ~~found in~~under Sections 720 through 729 of these rules. ~~(3-17-22)~~( )

01. Service Description: **Occupational Therapy and Physical Therapy**. Modalities, therapeutic procedures, tests, and measurements as described in the Idaho Medicaid Provider Handbook are covered with the following limitations: (3-17-22)

a. Any evaluation or re-evaluation may only be performed by the therapist. Any changes in the participant's condition not consistent with planned progress or treatment goals necessitate a documented re-evaluation by the therapist before further treatment is carried out. (3-17-22)

b. Any CPT procedure code that falls under the heading of either, "Active Wound Care Management," or "Tests and Measurements," requires the therapist to have direct, one-to-one (1:1) patient contact. (3-17-22)

c. The therapist may be reimbursed for the technical component of muscle testing, joint range of motion, electromyography, or nerve velocity determinations as described in the CPT Manual when ordered by a physician, nurse practitioner, or ~~physician assistant~~PA. ~~(3-17-22)~~( )

d. Any assessment provided under the heading "Orthotic Management and Prosthetic Management" must be completed by the therapist. (3-17-22)

e. The services of occupational or physical therapy assistants used when providing covered therapy benefits are included as part of the covered service. These services are billed by the supervising therapist. Therapy assistants may not provide evaluation services, or take responsibility for the service. The therapist has full responsibility for the service provided. (3-17-22)

02. Service Description: Speech-Language Pathology. Speech-language pathology services must be provided as defined in Section 730 of these rules. Services provided by speech-language pathology aides and assistants are considered unskilled services, and will be denied as not medically necessary if they are billed as speech-language pathology services. (3-17-22)

03. Non-Covered Services: Occupational Therapy, Physical Therapy, and Speech-Language Pathology. (3-17-22)

a. Continuing services for participants who do not exhibit the capability to achieve measurable improvement and who do not meet the criteria for a maintenance program. (3-17-22)

b. Services that address developmentally acceptable error patterns. (3-17-22)

c. Services that do not require the skills of a therapy professional. (3-17-22)

d. Massage, work hardening, and conditioning. (3-17-22)

e. Services ~~that are~~ not medically necessary, ~~as defined in~~under Section 011 of these rules. ~~(3-17-22)~~(   )

f. Duplicate services, ~~as defined~~ under Section 730 of these rules. ~~(3-17-22)~~(   )

g. Acupuncture (with or without electrical stimulation). (3-17-22)

h. Biofeedback, unless provided to treat urinary incontinence. (3-17-22)

i. Services that are ~~considered to be~~ experimental or investigational. ~~(3-17-22)~~(   )

j. Vocational Program. (3-17-22)

04. Service Limitations. (3-17-22)

a. Physical therapy (PT) and speech-language pathology (SLP) services are limited to a combined annual dollar amount for all PT and SLP services. The Department will set the total amount based on the annual Medicare caps. The Department may allow additional therapy services, when the services are determined to be medically necessary and supporting documentation is provided upon request of the Department. (3-17-22)

b. Occupational therapy services are limited to an annual dollar amount set by the Department based on the annual Medicare caps. The Department may allow additional therapy services, when the services are determined to be medically necessary and supporting documentation is provided upon request of the Department. (3-17-22)

c. Exceptions to service limitations. (3-17-22)

i. Therapy provided by home health agencies is subject to the limitations on home health services ~~contained in~~under Section 722 of these rules. ~~(3-17-22)~~(   )

ii. Therapy provided through school-based services or the Idaho Infant Toddler Program is not included in the service limitations under Subsection 732.04 of this rule. (3-17-22)

iii. Therapy provided to EPSDT participants under the age of twenty-one (21) ~~in accordance with~~under the EPSDT requirements ~~contained~~ in Sections 881 through 883 of these rules, and ~~in~~ Section 1905(r) of the Social Security Act, will be authorized by the Department when additional therapy services are medically necessary. ~~(3-17-22)~~(   )

d. Feeding therapy services are covered for children with a diagnosed feeding disorder that results in a clinically significant deviation from normal childhood development. The provider of feeding therapy is an occupational therapist or speech therapist with training specific to feeding therapy. (3-17-22)

e. Maintenance therapy is covered when an individualized assessment of the participant's condition demonstrates that skilled care is required to carry out a safe and effective maintenance program. (3-17-22)

f. ~~Telehealth~~Virtual care modalities are covered to the extent they are allowed under the rules of the applicable board of licensing. The Department will define limitations on ~~telehealth~~virtual care in the provider handbook to promote quality services and program integrity. ~~(3-17-22)~~(   )

733. THERAPY SERVICES: PROCEDURAL REQUIREMENTS.

The Department will pay for therapy services rendered by a therapy professional if such services are ordered by a

physician, nurse practitioner, or ~~physician assistant~~PA as part of a plan of care. ~~(3-17-22)~~(____)

01. Orders. (3-17-22)

a. All therapy must be ordered by a physician, nurse practitioner, or ~~physician assistant~~PA. ~~(3-17-22)~~(____)

b. ~~In the event that~~If services are required for extended periods, ~~these services~~they must be reordered as necessary, but at least every ninety (90) days for all participants with the following exceptions: ~~(3-17-22)~~(____)

i. Therapy provided by home health agencies must be included in the home health plan of care and be reordered at least every sixty (60) days. (3-17-22)

ii. Therapy for individuals with long-term medical conditions, as documented by physician, nurse practitioner, or ~~physician assistant~~PA, must be reordered at least every three hundred sixty-five (365) days. ~~(3-17-22)~~(____)

c. Therapy services provided under a home health plan of care must comply with the order requirements in Section 723 of these rules. (3-17-22)

02. Level of Supervision. Supervision of physical therapist assistants and occupational therapist assistants by the physical therapist or occupational therapist must be done ~~according to the~~under rules of the applicable licensure board. ~~(3-17-22)~~(____)

03. Face-to-Face Encounter for Home Health Therapy Services. Therapy services provided under a home health plan of care must comply with ~~the face-to-face encounter~~ requirements in Subsection 723.02 of these rules. ~~(3-17-22)~~(____)

04. Therapy Plan of Care. All therapy services must be provided under a therapy plan of care that is based on an evaluation and is established prior to beginning treatment. (3-17-22)

a. The plan of care must be signed by the person who established the plan, and sent to the ordering provider within thirty (30) days of the evaluation to continue therapy services. ~~(3-17-22)~~(____)

b. The plan of care must be consistent with the therapy evaluation and ~~must~~ contain~~, at a minimum~~: ~~(3-17-22)~~(____)

i. Diagnoses; (3-17-22)

ii. Treatment goals that are measurable and pertain to the identified functional impairment(s); and (3-17-22)

iii. Type, frequency, and duration of therapy services. (3-17-22)

c. Therapy services provided under a home health plan of care must comply with the home health plan of care requirements in Section 723 of these rules. (3-17-22)

(BREAK IN CONTINUITY OF SECTIONS)

753. DURABLE MEDICAL EQUIPMENT AND SUPPLIES: PROCEDURAL REQUIREMENTS.

01. Orders. (3-17-22)

a. All medical supplies, equipment, and appliances must be ordered by a physician or non-physician practitioner acting within the scope of their licensure. Such orders must meet the requirements ~~described~~ in the CMS/

Medicare DME coverage manual. ~~(3-17-22)~~(____)

b. ~~In the event that~~If medical equipment and supplies are required for extended periods, these must be reordered as necessary, but at least annually, for all participants. ~~(3-17-22)~~(____)

c. The following information to support the medical necessity of the item(s) must be included in the order and accompany all requests for prior authorization, or be kept on file with the DME provider for items that do not require prior authorization: (3-17-22)

i. The participant's medical diagnosis, including current information on the medical condition that requires the use of the supplies or medical equipment, or both; (3-17-22)

ii. An estimate of the time period that the medical equipment or supply item will be necessary and frequency of use. As needed (PRN) orders must include the conditions for use and the expected frequency; (3-17-22)

iii. For medical equipment, a full description of the equipment needed. All modifications or attachments to the basic equipment must be supported; (3-17-22)

iv. For medical supplies, the type and quantity of supplies necessary must be identified; and (3-17-22)

v. Documentation of the participant's medical necessity for the item, that meets coverage criteria. (3-17-22)

vi. Additional information may be requested by the Department for specific equipment or supplies. (3-17-22)

02. Face-to-Face Encounter for Home Health Medical Supplies, Equipment, and Appliances. Medical supplies, equipment, and appliances provided under a home health plan of care must comply with ~~the face-to-face encounter~~ requirements in Subsection 723.02 of these rules. ~~(3-17-22)~~(____)

03. Plan of Care Requirements for Home Health Medical Supplies, Equipment, and Appliances. Medical supplies, equipment, and appliances provided under a home health plan of care must comply with ~~the home health plan of care~~ requirements in Subsection 723.03 of these rules. ~~(3-17-22)~~(____)

04. Prior Authorizations. (3-17-22)

a. Prior authorization means a written, faxed, or electronic approval from the Department that permits payment or coverage of a medical item or service that is covered only by such authorization. (3-17-22)

i. Medicaid payment will be denied for the medical item or service or portions thereof that were provided prior to the submission of a valid prior authorization request. An exception may be allowed on a case-by-case basis, when events beyond the provider's control prevented the request's submission. ~~(3-17-22)~~(____)

ii. The provider may not bill the Medicaid participant for services not reimbursed by Medicaid solely because the authorization was not requested or obtained in a timely manner. ~~An exception may be allowed on a case-by-case basis where, despite diligent efforts on the part of the provider to submit a request, or events beyond the provider's control prevented it.~~ ~~(3-17-22)~~(____)

b. An item or service will be deemed prior approved where the individual to whom the service was provided was not eligible for Medicaid ~~at the time~~when the service was provided, but was subsequently found eligible under IDAPA 16.03.05, "Eligibility for Aid to the Aged, Blind, and Disabled," or IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children," and the medical item or service provided is approved by the Department by the same guidance that applies to other prior authorization requests. ~~(3-17-22)~~(____)

c. A valid prior authorization request is a written, faxed, or electronic request from a provider ~~of Medicaid~~ for services that contains all information and documentation as required by these rules to justify the medical

necessity, amount of and duration for the item or service. ~~(3-17-22)~~(____)

05. Notification of Changes to Prior Authorization Requirements. The Department will provide sixty (60) days notice of any substantive ~~and significant~~ changes to requirements for prior authorization in its provider handbook. The Department will provide a method to allow providers to provide input and comment on proposed changes. ~~(3-17-22)~~(____)

06. Equipment Rental -- Purchase Procedures. Unless specified by the Department, all equipment must be rented except when it would be more cost effective to purchase it. Rentals are subject to the following guidelines: (3-17-22)

a. Rental payments, including intermittent payments, are to be automatically applied to the purchase of the equipment. (3-17-22)

b. The Department may choose to continue to rent certain equipment without purchasing it. Such items include apnea monitors, ventilators, and other respiratory equipment. (3-17-22)

c. The total monthly rental cost of a DME item must not exceed one-tenth (1/10) of the total purchase price of the item. (3-17-22)

07. Notice of Decision. A Notice of Decision approving or denying a requested item will be issued to the participant by the Department. The participant has twenty-eight (28) days from the date of the denial to request a fair hearing on the decision. Hearings will be conducted ~~in accordance with~~under IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings." ~~(3-17-22)~~(____)

(BREAK IN CONTINUITY OF SECTIONS)

850. SCHOOL-BASED SERVICE: DEFINITIONS.

01. Activities of Daily Living (ADL). The performance of basic self-care activities in meeting a participant's needs for sustaining ~~him~~them in a daily living environment, including, but not limited to, bathing, washing, dressing, toileting, grooming, eating, communication, continence, mobility, and associated tasks. ~~(3-17-22)~~(____)

02. Children's Habilitation Intervention Services (CHIS). CHIS are medically necessary, evidence-informed or evidence-based therapeutic techniques based on applied behavior analysis principles used to result in positive outcomes. These intervention services are delivered directly to Medicaid-eligible students with identified developmental limitations that impact the student's functional skills and behaviors across an array of developmental domains. CHIS include habilitative skill building, behavioral intervention, behavioral consultation, crisis intervention, and interdisciplinary training services. ~~(3-17-22)~~(____)

03. Educational Services. Services that are provided in buildings, rooms, or areas designated or used as a school or an educational setting, which are provided during the specific hours and time periods in which the educational instruction takes place in the school day and period of time for these students, which are included in the individual educational plan (IEP) for the student. (3-17-22)

04. Evidence-Based Interventions. Interventions that have been scientifically researched and reviewed in peer reviewed journals, replicated successfully by multiple independent investigators, have been shown to produce measurable and substantiated beneficial outcomes, and are delivered with fidelity by certified or credentialed individuals trained in the evidence-based model. (3-17-22)

05. Evidence-Informed Interventions. Interventions that use elements or components of evidence-based techniques and are delivered by a qualified individual who ~~are~~is not certified or credentialed in an evidence-based model. ~~(3-17-22)~~(____)

06. Human Services Field. A diverse field that is focused on improving the quality of life for participants. Areas of academic study include sociology, special education, counseling, and psychology~~.~~, or other areas of academic study ~~as~~ referenced in the Medicaid Provider Handbook. ~~(3-17-22)~~(   )

07. School-Based Services. School-based services are health-related and rehabilitative services provided by Idaho public school districts and charter schools under the Individuals with Disabilities Education Act (IDEA). (3-17-22)

08. The Psychiatric Rehabilitation Association (PRA). An association that works to improve and promote the practice and outcomes of psychiatric rehabilitation and recovery. The PRA also maintains a certification program to promote the use of qualified staff to work ~~for~~with individuals with mental illness. http://www.psychrehabassociation.org. ~~(3-17-22)~~(   )

~~**09. PRA Credential**. Certificate or certification in psychiatric rehabilitation based upon the primary population with whom the individual works in accordance with the requirements set by the PRA. (3-17-22)~~

~~10~~09. Serious Mental Illness (SMI). ~~In accordance with~~Under 42 CFR 483.102(b)(1), a person with SMI: ~~(3-17-22)~~(   )

a. Currently or at any time during the year, must have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet the diagnostic criteria specified in the DSM-~~V~~5-TR; and ~~(3-17-22)~~(   )

b. Must have a functional impairment that substantially interferes with or limits one (1) or more major life activities. Functional impairment is defined as difficulties that substantially interfere with or limit role functioning with an individual's basic daily living skills, instrumental living skills, and functioning in social, family, vocational, or educational contexts. Instrumental living skills include maintaining a household, managing money, getting around the community, and taking prescribed medication. An adult who met the functional impairment criteria during the past year without the benefit of treatment or other support services is considered to have a serious mental illness. ~~(3-17-22)~~(   )

1~~1~~0. Serious and Persistent Mental Illness (SPMI). A participant must meet the criteria for SMI, have at least one (1) additional functional impairment, and have a diagnosis under DSM-~~V~~5-TR with one (1) of the following: Schizophrenia, Schizoaffective Disorder, Bipolar I Disorder, Bipolar II Disorder, Major Depressive Disorder Recurrent Severe, Delusional Disorder, or Borderline Personality Disorder. The only Not Otherwise Specified (NOS) diagnosis included is Psychotic Disorder NOS for a maximum of one hundred twenty (120) days without a conclusive diagnosis. ~~(3-17-22)~~(   )

(BREAK IN CONTINUITY OF SECTIONS)

853. SCHOOL-BASED SERVICE: COVERAGE AND LIMITATIONS.

The Department will pay school districts and charter schools for covered rehabilitative and health-related services. Services include medical or remedial services provided by school districts or other cooperative service agencies, as defined in Section 33-317, Idaho Code. (3-17-22)

01. Excluded Services. The following services are excluded from Medicaid payments to school-based programs: (3-17-22)

a. Vocational Services. (3-17-22)

b. Educational Services. Educational services (other than health-related services) or education-based costs normally incurred to operate a school and provide an education. Evaluations completed for educational services only cannot be billed. ~~(3-17-22)~~(   )

c. Recreational Services. (3-17-22)

d. Payment for school-related services will not be provided to students who are inpatients in nursing homes or hospitals. (3-17-22)

02. Evaluation and Diagnostic Services. Evaluations to determine eligibility or the need for health-related services may be reimbursed even if the student is not found eligible for health-related services. Evaluations completed for educational services only cannot be billed. Evaluations completed must: (3-17-22)

a. Be recommended or referred by a physician or other licensed practitioner of the healing arts. A school district or charter school may not seek reimbursement for services provided more than thirty (30) days prior to the signed and dated recommendation or referral; (3-17-22)

b. Be conducted by qualified professionals for the respective discipline as defined in Section 855 of these rules; (3-17-22)

c. Be directed toward a diagnosis; (3-17-22)

d. Include recommended interventions to address each need; and (3-17-22)

e. Include name, title, and signature of the person conducting the evaluation. (3-17-22)

03. Reimbursable Services. School districts and charter schools can bill for the following health-related services provided to eligible students when the services are provided under the recommendation of a physician or other ~~non-physician~~ practitioner of the healing arts for the Medicaid services for which the school district or charter school is seeking reimbursement. A school district or charter school may not seek reimbursement for services provided more than thirty (30) days prior to the signed and dated recommendation or referral. The recommendations or referrals are valid up to three hundred sixty-five (365) days. ~~(3-17-22)~~(____)

a. Behavioral Intervention. Behavioral Intervention is a direct intervention used to promote positive, meaningful changes in behavior that incorporate functional replacement behaviors and reinforcement-based strategies, while also addressing any identified habilitative skill building needs and the student's ability to participate in educational services, as defined in Section 850 of these rules, through a consistent, assertive, and continuous intervention process to address behavior goals identified on the IEP. Behavioral intervention includes conducting a functional behavior assessment and developing a behavior implementation plan with the purpose of preventing or treating behavioral conditions. This service is provided to students who exhibit maladaptive behaviors. Services include individual or group behavioral interventions. (3-17-22)

i. Group services must be provided by one (1) qualified staff providing direct services for ~~up to six (6)~~two (2) or three (3) students. ~~(3-17-22)~~(____)

ii. As the number and severity of the students with behavioral issues increases, the student ratio in the group must be adjusted ~~accordingly~~from three (3) to two (2). ~~(3-17-22)~~(____)

iii. Group services should only be delivered when the student's goals relate to benefiting from group interaction. (3-17-22)

b. Behavioral Consultation. Behavioral consultation assists other service professionals by consulting with the IEP team during the assessment process, performing advanced assessment, coordinating the implementation of the behavior implementation plan and providing ongoing training to the behavioral interventionist and other team members. (3-17-22)

i. Behavioral consultation cannot be provided as a direct intervention service. (3-17-22)

ii. Behavioral consultation must be limited to thirty-six (36) hours per student per year. (3-17-22)

c. Crisis Intervention. Crisis intervention services may include providing training to staff directly involved with the student, delivering intervention directly with the eligible student, and developing a crisis plan that

directly addresses the behavior occurring and the necessary intervention strategies to minimize the behavior and future occurrences. This service is provided on a short-term basis, typically not ~~to~~ exceeding thirty (30) school days and is available for students who have an unanticipated event, circumstance, or life situation that places a student at risk of at least one (1) of the following: ~~(3-17-22)~~(____)

i. Hospitalization; (3-17-22)

ii. Out-of-home placement; (3-17-22)

iii. Incarceration; or (3-17-22)

iv. Physical harm to self or others, including a family altercation or psychiatric relapse. (3-17-22)

d. Habilitative Skill Building. Habilitative skill building is a direct intervention service that includes techniques used to develop, improve and maintain, to the maximum extent possible, the developmentally appropriate functional abilities and daily living skills needed by a student. This service may include teaching and coordinating methods of training with family members or others who regularly participate in caring for the eligible student. Services include individual or group interventions. (3-17-22)

i. Group services must be provided by one (1) qualified staff providing direct services for ~~up to six (6)~~two (2) or three (3) students. ~~(3-17-22)~~(____)

ii. As the number and needs of the students increase, the student ratio in the group must be adjusted accordingly. (3-17-22)

iii. Group services should only be delivered when the student's goals relate to benefiting from group interaction. (3-17-22)

e. Interdisciplinary Training. Interdisciplinary training is a companion service to behavioral intervention and habilitative skill building and is used to assist with implementing a student's health and medication monitoring, positioning and physical transferring, use of assistive equipment, and intervention techniques in a manner that meets the student's needs. This service is to be utilized for collaboration, with the student present, during the provision of services between the intervention specialist or professional and a Speech Language and Hearing Professional (SLP), Physical Therapist (PT), Occupational Therapist (OT), medical professional, or behavioral or mental health professional. (3-17-22)

f. Medical Equipment and Supplies. Medical equipment and supplies that are covered by Medicaid must be medically necessary, ordered by a physician or non-physician practitioner, and prior authorized. Authorized items must be for use at the school where the service is provided. Equipment that is too large or unsanitary to transport from home to school and back may be covered, if prior authorized. The equipment and supplies must be for the student's exclusive use and must be transferred with the student if the student changes schools. All equipment purchased by Medicaid belongs to the student. (3-17-22)

g. Nursing Services. Skilled nursing services must be provided by a licensed nurse, within the scope of ~~his or her~~their practice. Emergency, first aid, or non-routine medications not identified on the plan as a health-related service are not reimbursed. ~~(3-17-22)~~(____)

h. Occupational Therapy and Evaluation. ~~Occupational therapy and evaluation~~These services for vocational assessment, training or vocational rehabilitation are not reimbursed. ~~(3-17-22)~~(____)

i. Personal Care Services (PCS). School-based ~~personal care services~~PCS include medically oriented tasks having to do with the student's physical or functional requirements. ~~Personal care services~~PCS do not require a goal on the plan of service. The provider must deliver at least one (1) of the following services: ~~(3-17-22)~~(____)

i. Basic personal care and grooming to include bathing, ~~care of the~~ hair care, assistance with clothing, and basic skin care; ~~(3-17-22)~~(____)

ii. Assistance with bladder or bowel requirements that may include helping the student to and from the bathroom or assisting the student with bathroom routines; (3-17-22)

iii. Assistance with food, nutrition, and diet activities including preparation of meals if incidental to medical need; (3-17-22)

iv. Assisting the student with physician-ordered medications that are ordinarily self-administered, ~~in accordance with~~under IDAPA 24.34.01, "Rules of the Idaho Board of Nursing," Subsection 490.05; ~~(3-17-22)~~(____)

v. Non-nasogastric gastrostomy tube feedings, if the task is not complex and can be safely performed in the given student care situation, and meet the requirements ~~are met in accordance with~~under IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Subsection 303.01. ~~(3-17-22)~~(____)

j. Physical Therapy and Evaluation. (3-17-22)

k. Psychological Evaluation. (3-17-22)

l. Psychotherapy. (3-17-22)

m. Skills Building/Community-Based Rehabilitation Services (CBRS). Skills Building/CBRS are interventions to reduce the student's disability by assisting in gaining and utilizing skills necessary to participate in school. They are designed to build competency and confidence while increasing mental health and/or decreasing behavioral symptoms. Skills Building/CBRS provides training in behavior control, social skills, communication skills, appropriate interpersonal behavior, symptom management, activities of daily living, and coping skills. These services are intended to prevent placement of the student into a more restrictive educational situation. ~~(3-17-22)~~(____)

n. Speech/Audiological Therapy and Evaluation. (3-17-22)

o. Social History and Evaluation. (3-17-22)

p. Transportation Services. School districts and charter schools can receive reimbursement for mileage for transporting a student to and from home and school when: (3-17-22)

i. The student requires special transportation assistance, a wheelchair lift, an attendant, or both, when medically necessary for the health and safety of the student; (3-17-22)

ii. The transportation occurs in a vehicle specifically adapted to meet the needs of a student with a disability; (3-17-22)

iii. The student requires and receives another Medicaid-reimbursable service billed by the school-based services provider, other than transportation, on the day that transportation is being provided; ~~(3-17-22)~~(____)

iv. Both the Medicaid-covered service and the need for the special transportation are included on the student's plan; and (3-17-22)

v. The mileage, as well as the services performed by the attendant, are documented. See Section 855 of these rules for documentation requirements. (3-17-22)

q. Interpretive Services. Interpretive services needed by a student who is deaf or does not adequately speak or understand English and requires an interpreter to communicate with the professional or paraprofessional providing the student with a health-related service may be billed with the following limitations: (3-17-22)

i. Payment for interpretive services is limited to the specific time that the student is receiving the health-related service; documentation for interpretive service must include the Medicaid-reimbursable health-related service being provided while the interpretive service is provided. ~~(3-17-22)~~(____)

ii. Both the Medicaid-covered service and the need for interpretive services must be included on the student's plan; and (3-17-22)

iii. Interpretive services are not covered if the professional or paraprofessional providing services is able to communicate in the student's primary language. (3-17-22)

(BREAK IN CONTINUITY OF SECTIONS)

855. SCHOOL-BASED SERVICE: PROVIDER QUALIFICATIONS AND DUTIES.
Medicaid will only reimburse for services provided by qualified staff. The following are the minimum qualifications for providers of covered services: (3-17-22)

01. Behavioral Intervention. ~~Behavioral intervention m~~Must be provided by, or under the supervision of, an intervention specialist or professional. Individuals providing behavioral intervention must be one (1) of the following: ~~(3-17-22)~~(____)

a. Intervention Paraprofessional. ~~Intervention paraprofessionals may p~~Provides direct services. The specialist or professional must observe and review the direct services performed by the paraprofessional monthly, or more often as necessary, to ensure the paraprofessional demonstrates the necessary skills to correctly provide the direct service. An intervention paraprofessional under the direction of a qualified intervention specialist or professional must: ~~(3-17-22)~~(____)

i. Be at least eighteen (18) years of age; (3-17-22)

ii. Demonstrate the knowledge, have the skills needed to support the program to which they are assigned; and (3-17-22)

iii. Meet the paraprofessional requirements ~~as defined in~~under IDAPA 08.02.02, "Rules Governing Uniformity." ~~(3-17-22)~~(____)

b. Intervention Technician. ~~Intervention technician is a~~A provisional position intended to allow an individual to gain the necessary degree, competency, or experience needed to qualify as an intervention specialist or higher. Provisional status is limited to a single eighteen (18) successive month period. The specialist or professional must observe and review the direct services performed by the technician monthly, or more often as necessary, to ensure the technician demonstrates the necessary skills to correctly provide the direct service. An intervention technician under the direction of a qualified intervention specialist or professional, must: ~~(3-17-22)~~(____)

i. Be an individual who is currently enrolled and is within twenty-four (24) semester credits, or equivalent, to complete their bachelor's degree or higher from an accredited institution in a human services field and working towards meeting the experience and competency requirements; or (3-17-22)

ii. Hold a bachelor's degree from an accredited institution in a human services field or ~~a~~ has a bachelor's degree and a minimum of twenty-four (24) semester credits, or equivalent, in a human services field and working towards meeting the experience and competency requirements. ~~(3-17-22)~~(____)

c. Intervention Specialist. ~~Intervention specialists may p~~Provides direct services, completes assessments, and develops implementation plans. Intervention specialists who will complete assessments must have documented training and experience in completing assessments and designing and implementing comprehensive therapies for students with functional or behavioral needs, or both. The qualifications for this provider type can be met by one (1) of the following: ~~(3-17-22)~~(____)

i. An individual who holds an Idaho Standard Instructional Certificate who meets qualifications for an endorsement specific to special education as defined in ~~IDAPA 08.02.02, "Rules Governing Uniformity," Sections 021-024~~in State Board of Education Policy Section IV.B;~~ or~~ ~~(3-17-22)~~(____)

ii. An individual who holds a Habilitative Intervention Certificate of Completion in Idaho with an expiration date of July 1, 2019, or later, and does not have a gap of more than three (3) years of employment as an intervention specialist~~,~~; or ~~(3-17-22)~~(   )

iii. An individual who holds a bachelor's degree from an accredited institution in a human services field or has a bachelor's degree and a minimum of twenty-four (24) semester credits in a human services field, can demonstrate one thousand forty (1,040) hours of supervised experience working with children who demonstrate functional or behavioral needs, and meets the competency requirements by completing one (1) of the following: (3-17-22)

(1) A Department-approved competency checklist referenced in the Medicaid Provider Handbook; (3-17-22)

(2) A minimum of forty (40) hours of applied behavior analysis training delivered by an individual who is certified or credentialed to provide the training; or (3-17-22)

(3) Other Department-approved competencies as defined in the Medicaid Provider Handbook. (3-17-22)

d. Intervention Professional. ~~Intervention professionals may p~~Provides direct services, completes assessments, and develops implementation plans. Intervention professionals who will complete assessments must have documented training and experience in completing assessments and designing and implementing comprehensive therapies for students with functional or behavioral needs, or both. The qualifications for this provider type can be met by one (1) of the following: ~~(3-17-22)~~(   )

i. An individual who holds a master's degree or higher from an accredited institution in psychology, education, applied behavior analysis, or have a related discipline with one thousand five hundred (1,500) hours of relevant coursework or training, or both, in principles of child development, learning theory, positive behavior support techniques, dual diagnosis psychology, education, or behavior analysis which may be documented within the individual's degree program, other coursework, or training; and (3-17-22)

ii. Have one thousand two hundred (1,200) hours of relevant experience in completing and implementing comprehensive behavioral therapies for participants with functional or behavioral needs, which may be documented within the individual's degree program, other coursework, or training. (3-17-22)

e. Evidence-Based Model (EBM) Intervention Paraprofessional. ~~EBM intervention paraprofessionals may p~~Provides direct services~~. EBM intervention paraprofessionals~~and must be supervised ~~in accordance with~~under the evidence-based model in which they are certified or credentialed. The EBM intervention specialist or professional must observe and review the direct services performed by the paraprofessional to ensure the paraprofessional demonstrates the necessary skills to correctly provide the direct service. An EBM intervention paraprofessional must: ~~(3-17-22)~~(   )

i. Hold a high school diploma; and (3-17-22)

ii. Hold a para-level certification or credential in an evidence-based model approved by the Department. (3-17-22)

f. Evidence-Based Model (EBM) Intervention Specialist. ~~EBM intervention specialists may p~~Provides direct services, completes assessments, and develops implementation plans~~. EBM intervention specialists~~and must be supervised ~~in accordance with~~under the evidence-based model in which they are certified or credentialed. The EBM intervention professional must observe and review the direct services performed by the specialist to ensure the specialist demonstrates the necessary skills to correctly provide the direct service. The specialist may supervise the EBM intervention paraprofessional working within the same evidence-based model. An EBM intervention specialist must: ~~(3-17-22)~~(   )

i. Hold a bachelor's degree from an accredited institution in accordance with their certification or credentialing requirements; and (3-17-22)

ii. Hold a bachelors-level certification or credential in an evidence-based model approved by the Department. (3-17-22)

g. Evidence-Based Model (EBM) Intervention Professional. ~~EBM intervention professionals may p~~Provides direct services, completes assessments, ~~and~~ develops implementation plans~~.~~, ~~EBM intervention professionals~~and may supervise EBM intervention paraprofessionals or specialists working within the same evidence-based model in which they are certified or credentialed. An EBM intervention professional must: ~~(3-17-22)~~(____)

i. Hold a master's degree or higher from an accredited institution in accordance with their certification or credentialing requirements; and (3-17-22)

ii. Hold a masters-level certification or credential in an evidence-based model approved by the Department. (3-17-22)

02. Behavioral Consultation. ~~Behavioral consultation m~~Must be provided by a professional who has a Doctoral or Master's degree in psychology, education, applied behavioral analysis, or has a related discipline with one thousand five hundred (1,500) hours of relevant coursework or training, or both, in principles of child development, learning theory, positive behavior support techniques, dual diagnosis psychology, education, or behavior analysis (may be included as part of degree program)~~;~~, and who meets one (1) of the following: ~~(3-17-22)~~(____)

a. An individual who holds an Idaho Standard Instructional Certificate who meets qualifications for an endorsement specific to special education as defined in ~~IDAPA 08.02.02, "Rules Governing Uniformity"~~State Board of Education Policy Section IV.B; ~~(3-17-22)~~(____)

b. An individual with a Pupil Personnel Certificate who meets the qualifications defined under IDAPA 08.02.02, "Rules Governing Uniformity," excluding an ~~licensed registered nurse~~RN or audiologist; ~~(3-17-22)~~(____)

c. An occupational therapist who is qualified and registered to practice in Idaho; (3-17-22)

d. An intervention professional, as defined in Subsection 855.01 of this rule; or (3-17-22)

e. An EBM intervention professional, as defined in Subsection 855.01 of this rule. (3-17-22)

03. Crisis Intervention. ~~Crisis intervention m~~Must be provided by, or under the supervision of, an intervention specialist or professional. Individuals providing crisis intervention must be one (1) of the following: ~~(3-17-22)~~(____)

a. An intervention paraprofessional, ~~as defined in~~under Subsection 855.01 of this rule; ~~(3-17-22)~~(____)

b. An intervention technician, ~~as defined in~~under Subsection 855.01 of this rule; ~~(3-17-22)~~(____)

c. An intervention specialist, ~~as defined in~~under Subsection 855.01 of this rule; ~~(3-17-22)~~(____)

d. An intervention professional, ~~as defined in~~under Subsection 855.01 of this rule; ~~(3-17-22)~~(____)

e. An EBM intervention paraprofessional, ~~as defined in~~under Subsection 855.01 of this rule; ~~(3-17-22)~~(____)

f. An EBM intervention specialist, ~~as defined in~~under Subsection 855.01 of this rule; ~~(3-17-22)~~(____)

g. An EBM intervention professional, ~~as defined in~~under Subsection 855.01 of this rule;

~~(3-17-22)~~(____)

h. A licensed physician, licensed practitioner of the healing arts; (3-17-22)

i. An advanced practice registered nurse; (3-17-22)

j. A licensed psychologist; (3-17-22)

k. A licensed clinical professional counselor or professional counselor; (3-17-22)

l. A licensed marriage and family therapist; (3-17-22)

m. A licensed masters social worker, licensed clinical social worker, or licensed social worker; (3-17-22)

n. A psychologist extender registered with the ~~Bureau~~Division of Occupational and Professional Licenses; ~~(3-17-22)~~(____)

o. An ~~licensed registered nurse (~~RN~~)~~; ~~(3-17-22)~~(____)

p. A licensed occupational therapist; or (3-17-22)

q. An endorsed or certified school psychologist. (3-17-22)

04. Habilitative Skill Building. ~~Habilitative skill building m~~Must be provided by, or under the supervision of, an intervention specialist or professional. Individuals providing habilitative skill building must be one (1) of the following under Subsection 855.01 of this rule: ~~(3-17-22)~~(____)

a. An intervention paraprofessional~~, as defined in Subsection 855.01 of this rule~~; ~~(3-17-22)~~(____)

b. An intervention technician~~, as defined in Subsection 855.01 of this rule~~; ~~(3-17-22)~~(____)

c. An intervention specialist~~, as defined in Subsection 855.01 of this rule~~; ~~(3-17-22)~~(____)

d. An intervention professional~~, as defined in Subsection 855.01 of this rule~~; ~~(3-17-22)~~(____)

e. An EBM intervention paraprofessional~~, as defined in Subsection 855.01 of this rule~~; ~~(3-17-22)~~(____)

f. An EBM intervention specialist~~, as defined in Subsection 855.01 of this rule~~; or ~~(3-17-22)~~(____)

g. An EBM intervention professional~~, as defined in Subsection 855.01 of this rule~~. ~~(3-17-22)~~(____)

05. Interdisciplinary Training. ~~Interdisciplinary Training m~~Must be provided by one (1) of the following under Subsection 855.01 of this rule: ~~(3-17-22)~~(____)

a. An intervention specialist~~, as defined in Subsection 855.01 of this rule~~; ~~(3-17-22)~~(____)

b. An intervention professional~~, as defined in Subsection 855.01 of this rule~~; ~~(3-17-22)~~(____)

c. An EBM intervention specialist~~, as defined in Subsection 855.01 of this rule~~; ~~(3-17-22)~~(____)

d. An EBM intervention professional~~, as defined in Subsection 855.01 of this rule~~. ~~(3-17-22)~~(____)

06. Medical Equipment and Supplies. See Subsection 853.03 of these rules. ~~(3-17-22)~~(____)

07. Nursing Services. ~~Nursing services m~~Must be provided by an ~~licensed registered nurse (~~RN~~)~~ or by

a licensed practical nurse (LPN) licensed to practice in Idaho. ~~(3-17-22)~~(____)

08. Occupational Therapy and Evaluation. For therapy-specific rules, refer to Sections 730 through 739 of these rules. (3-17-22)

09. Personal Care Services (PCS). ~~Personal care services m~~Must be provided by or under the direction of ~~a registered nurse licensed by the State of Idaho~~an RN. ~~(3-17-22)~~(____)

a. Providers of PCS must have at least one (1) of the following qualifications: (3-17-22)

i. Licensed Registered Nurse (RN).~~A person currently licensed by the Idaho State Board of Nursing as a licensed registered nurse;~~ ~~(3-17-22)~~(____)

ii. Licensed Practical Nurse (LPN). A person currently licensed by the Idaho State Board of Nursing as a licensed practical nurse; (3-17-22)

iii. Certified Nursing Assistant (CNA). A person currently certified by the State of Idaho; or (3-17-22)

iv. Personal Assistant. A person who meets the standards of Section 39-5603, Idaho Code, and receives training to ensure the quality of services. The assistant must be at least age eighteen (18) years of age. (3-17-22)

b. The ~~licensed registered nurse (~~RN~~)~~ must review or complete, or both, the PCS assessment and develop or review, or both, the written plan of care annually. Oversight provided by the RN must include all of the following: ~~(3-17-22)~~(____)

i. Development of the written PCS plan of care; (3-17-22)

ii. Review of the treatment given by the personal assistant through a review of the student's PCS service detail reports as maintained by the provider; and (3-17-22)

iii. Reevaluation of the plan of care as necessary, but at least annually. (3-17-22)

c. The RN must conduct supervisory visits on a quarterly basis, or more frequently as determined by the IEP team and defined as part of the PCS plan of care. (3-17-22)

10. Physical Therapy and Evaluation. For therapy-specific rules, refer to Sections 730 through 739 of these rules. (3-17-22)

11. Psychological Evaluation. ~~A psychological evaluation m~~Must be provided by a: ~~(3-17-22)~~(____)

a. Licensed psychiatrist; (3-17-22)

b. Licensed physician; (3-17-22)

c. Licensed psychologist; (3-17-22)

d. Psychologist extender registered with the ~~Bureau~~Division of Occupational and professional Licenses; or ~~(3-17-22)~~(____)

e. Endorsed or certified school psychologist. (3-17-22)

12. Psychotherapy. Provision of psychotherapy services must have~~, at a minimum~~, one (1) or more of the following credentials: ~~(3-17-22)~~(____)

a. Psychiatrist, M~~.~~D~~.~~; ~~(3-17-22)~~(____)

b. Physician, M~~.~~D~~.~~; ~~(3-17-22)~~(____)

c. Licensed psychologist; (3-17-22)

d. Licensed clinical social worker; (3-17-22)

e. Licensed clinical professional counselor; (3-17-22)

f. Licensed marriage and family therapist; (3-17-22)

g. Certified psychiatric nurse (RN), ~~as described in~~under Subsection 707.13 of these rules; ~~(3-17-22)~~(____)

h. Licensed professional counselor whose provision of psychotherapy is supervised ~~in compliance~~under with IDAPA 24.15.01, "Rules of the Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists"; ~~(3-17-22)~~(____)

i. Licensed masters social worker whose provision of psychotherapy is supervised ~~as described in~~under IDAPA 24.14.01, "Rules of the State Board of Social Work Examiners"; ~~(3-17-22)~~(____)

j. Licensed associate marriage and family therapist whose provision of psychotherapy is supervised ~~as described in~~under IDAPA 24.15.01, "Rules of the Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists"; or ~~(3-17-22)~~(____)

k. Psychologist extender, registered with the ~~Bureau~~Division of Occupational and Professional Licenses, whose provision of diagnostic services is supervised ~~in compliance with~~under IDAPA 24.12.01, "Rules of the Idaho State Board of Psychologist Examiners." ~~(3-17-22)~~(____)

13. Skills Building/Community-Based Rehabilitation Services (CBRS). Skills Building/CBRS must be provided by one (1) of the following. Skills Building/Community-Based Rehabilitation Services (CBRS) provider who is not required to have a PRA credential or credential required for CBRS specialists must be one (1) of the following: ~~(3-17-22)~~(____)

a. Licensed physician, licensed practitioner of the healing arts; (3-17-22)

b. Advanced practice registered nurse; (3-17-22)

c. Licensed psychologist; (3-17-22)

d. Licensed clinical professional counselor or professional counselor; (3-17-22)

e. Licensed marriage and family therapist; (3-17-22)

f. Licensed masters social worker, licensed clinical social worker, or licensed social worker; (3-17-22)

g. Psychologist extender registered with the ~~Bureau~~Division of Occupational and professional Licenses; ~~(3-17-22)~~(____)

h. Licensed registered nurse (RN); (3-17-22)

i. Licensed occupational therapist; (3-17-22)

j. Endorsed or certified school psychologist; (3-17-22)

k. Skills Building/Community Based Rehabilitation Services specialist~~. A Skills Building/CBRS specialist~~ who must: ~~(3-17-22)~~(____)

i. Be an individual who has a bachelor's degree and holds a current PRA credential; or (3-17-22)

ii. Be an individual who has a bachelor's degree or higher and is under the supervision of a licensed behavioral health professional, a physician, nurse, or an endorsed or certified school psychologist. The supervising practitioner is required to have regular one-to-one (1:1) supervision of the specialist to review treatment provided to student participants on an ongoing basis. The frequency of the one-to-one (1:1) supervision must occur at least monthly. Supervision can be conducted using ~~telehealth~~synchronous virtual care when it is equally effective as direct on-site supervision; and ~~(3-17-22)~~(____)

iii. Have a credential required for CBRS specialists. (3-17-22)

14. Speech/Audiological Therapy and Evaluation. For therapy-specific rules, refer to Sections 730 through 739 of these rules. (3-17-22)

15. Social History and Evaluation. ~~Social history and evaluation m~~Must be provided by a ~~licensed registered nurse (~~RN~~)~~, psychologist, M.D, school psychologist, certified school social worker, or by a person who is licensed and qualified to provide social work in the state of Idaho. ~~(3-17-22)~~(____)

16. Transportation. ~~Transportation m~~Must be provided by an individual who has a current Idaho driver's license and is covered under vehicle liability insurance that covers passengers for business use. ~~(3-17-22)~~(____)

17. Therapy Paraprofessionals. The schools may use paraprofessionals to provide occupational therapy, physical therapy, and speech therapy if they are under the supervision of the appropriate professional. The services provided by paraprofessionals must be delegated and supervised by a professional therapist ~~as defined by~~under the appropriate licensure and certification rules. The portions of the treatment plan that can be delegated to the paraprofessional must be identified in the IEP or transitional IFSP. ~~(3-17-22)~~(____)

a. Occupational Therapy (OT). Refer to IDAPA 24.06.01, "Rules for the Licensure of Occupational Therapists and Occupational Therapy Assistants," for qualifications, supervision, and service requirements. (3-17-22)

b. Physical Therapy (PT). Refer to IDAPA 24.13.01, "Rules Governing the Physical Therapy Licensure Board," for qualifications, supervision, and service requirements. ~~(3-17-22)~~(____)

c. Speech-Language Pathology (SLP). Refer to IDAPA 24.23.01, "Rules of the Speech, ~~and~~ Hearing and Communication Services Licensure Board," and the American Speech-Language-Hearing Association (ASHA) guidelines for qualifications, supervision, and service requirements for speech-language pathology~~. The guidelines have been~~as incorporated ~~by reference~~ in Section 004 of these rules. ~~(3-17-22)~~(____)

i. Supervision must be provided by an SLP professional ~~as defined~~ in Section 734 ~~of this chapter~~ of these rules. ~~(3-17-22)~~(____)

ii. The professional must observe and review the direct services performed by the paraprofessional monthly, or more often as necessary, to ensure the paraprofessional demonstrates the necessary skills to correctly provide the SLP service. (3-17-22)

(BREAK IN CONTINUITY OF SECTIONS)

892. PREGNANCY-RELATED SERVICES: COVERAGE AND LIMITATIONS.

When ordered by the participant's attending physician or licensed practitioner of the healing arts, payment of the following services is available after confirmation of pregnancy and extending through the end of the month in which the sixtieth day following delivery occurs. (3-17-22)

01. Individual and Family Social Services. Limited to two (2) visits during the covered period. (3-17-22)

02. Maternity Nursing Visit. These services are only available to women unable to obtain a physician or licensed practitioner of the healing arts~~,~~ to provide prenatal care. This service is to end immediately when a primary physician is found. A maximum of nine (9) visits can be authorized. ~~(3-17-22)~~( )

03. Nursing Services. Limited to two (2) visits during the covered period. (3-17-22)

04. Nutrition Services. ~~Nutritional services are~~As described in Sections 630 through 632 of these rules. ~~(3-17-22)~~( )

05. Qualified Provider Risk Assessment and Plan of Care. When prior authorized by the Department, payment is made for qualified provider services in completion of a standard risk assessment and plan of care for women unable to obtain a primary care physician, nurse practitioner, or nurse midwife for the provision of antepartum care. (3-17-22)

06. Risk Reduction Follow-Up. ( )

(BREAK IN CONTINUITY OF SECTIONS)

894. PREGNANCY-RELATED SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.
Services must be: (3-17-22)

01. Risk Reduction Follow-Up. Provided by a licensed social worker~~s~~, ~~licensed registered nurses~~RN, nurse midwife, physician, NP, or PA either in independent practice or as employees of entities that have current provider agreements with the Department. ~~(3-17-22)~~( )

02. Individual and Family Social Services. Provided by a licensed social worker qualified to provide individual counseling~~ in accordance with the provisions of IDAPA 24.14.01, "Rules of the State Board of Social Work Examiners."~~ ~~(3-17-22)~~( )

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.03.10 – MEDICAID ENHANCED PLAN BENEFITS

DOCKET NO. 16-0310-2101

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo and Incorporation By Reference Synopsis (IBRS)

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2024 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. The pending rule will become final and effective upon the adjournment, *sine die*, of the Second Regular Session of the Sixty-seventh Idaho Legislature after approval.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 56-202(b), 56-264, and 56-1610, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

These rule changes will decrease regulatory burdens, make technical corrections, implement operations for the end of the public health emergency, update rules to comply with K.W. Settlement, and align with federal regulations regarding conflicts of interest. These changes are being made in conjunction with companion Docket No. 16-0313-2101, Consumer-Directed Services. Negotiated Rulemaking was conducted for these companion dockets in November 2021.

The text of the pending rule has been amended in accordance with Section 67-5227, Idaho Code. Only those sections that have changes that differ from the proposed text are printed in this bulletin. The complete text of the proposed rule was published in the October 4, 2023, Idaho Administrative Bulletin, Vol. 23-10, pages 430 through 485.

FEE SUMMARY: Pursuant to Section 67-5224(2)(d), Idaho Code, this pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature. The following is a description of the fee or charge imposed or increased in this rulemaking: Does not apply to this rulemaking.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact to the state General Fund greater than ten thousand dollars ($10,000) during the fiscal year:

This rulemaking is not anticipated to have any fiscal impact to state funds, including the General Fund, or any other known funds.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact William Deseron at 208-859-0046.

DATED this 30th of November, 2023.

Trinette Middlebrook and Frank Powell
DHW – Administrative Rules Unit
450 W. State Street – 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
phone: (208) 334-5500
fax: (208) 334-6558
e-mail:dhwrules@dhw.idaho.gov

THE FOLLOWING NOTICE PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is September 1, 2023.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule, and proposed regular rulemaking procedures have been initiated. The action is authorized pursuant to Sections 56-202(b), 56-264, and 56-1610, Idaho Code.

PUBLIC HEARING SCHEDULE: Two public hearings concerning this rulemaking will be held as follows:

VIRTUAL TELECONFERENCE Via WebEx
Wednesday, October 18, 2023 **9:00 a.m. (MT)**
Join from the meeting link: **https://idhw.webex.com/idhw/j.php?MTID=m22d7402b3e4f05b93a795b6ffd75471a** ***Join by meeting number:*** **Meeting number (access code): 2761 907 1160** **Meeting password: fMMMepQE333 (36663773 from phones and video systems)** ***Join by phone:*** **+1-415-527-5035 United States Toll** **+1-303-498-7536 United States Toll (Denver)**

VIRTUAL TELECONFERENCE Via WebEx
Wednesday, October 18, 2023 **2:00 p.m. (MT)**
Join from the meeting link: **https://idhw.webex.com/idhw/j.php?MTID=m24d31b98e8d19db20a8af0d0505f54e6** ***Join by meeting number:*** **Meeting number (access code): 2760 176 3901** **Meeting password: sVaHVstG774 (78248784 from phones and video systems)** ***Join by phone:*** **+1-415-527-5035 United States Toll** **+1-303-498-7536 United States Toll (Denver)**

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is the required finding and concise statement of its supporting reasons for adopting a temporary rule and a nontechnical explanation of the substance and purpose of the proposed rulemaking:

The following changes are made in conjunction with companion Docket No. 16-0313-2101, Consumer-Directed Services.

This rule change will decrease regulatory burdens, make technical corrections, implement operations for the end of the public health emergency, update rules to comply with K.W. Settlement, and align with federal regulations regarding conflicts of interest.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section(s) 67-5226(1), sections (a), (b), and (c), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate for the following reasons:

The changes in this rulemaking qualify for all the following purposes for a Temporary rulemaking:

(a) Protection of the public health, safety, or welfare; or
(b) Compliance with deadlines in amendments to governing law or federal programs; or
(c) Conferring a benefit.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased:

This rulemaking and this chapter of rules do not contain any fees.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year:

There is no anticipated fiscal impact to the General Fund, state funds, or any other known funds.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the November 3, 2021, Idaho Administrative Bulletin, Volume 21-11, pages 42-43.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into this rule:

A document incorporated by reference in these rules is being updated to reflect the current version (January 17, 2023). The title has changed from “Travel Policies and Procedures of the Idaho State Board of Examiners” to “State Travel Policies and Procedures.”

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact William Deseron, 208-859-0046.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 25, 2023.

DATED this 1st day of September, 2023.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0310-2101

Italicized text **indicates changes between the text of the proposed rule as adopted in the pending rule.**

004. INCORPORATION BY REFERENCE.
The Department has incorporated by reference the following~~ document~~: ~~(3-17-22)~~(   )

01. 42 CFR Part 447. 42 CFR Part 447, "Payment for Services," revised as of October 1, 2001, is available from CMS, 7500 Security Blvd, Baltimore, M.D., 21244-1850 or on the Code of Federal Regulations website at http://www.ecfr.gov/cgi-bin/text-idx?SID=3ec1965dbf5044d8f79b25d4d58c4cd1&mc=true&tpl=/ecfrbrowse/Title42/42cfrv4_02.tpl#0. (3-17-22)

02. Estimated Useful Lives of Depreciable Hospital Assets, 2004 Revised Edition, Guidelines Lives. This document may be obtained from American Hospital Publishing, Inc., 211 E. Chicago Ave., Chicago, IL. 60611. (3-17-22)

03. Medicare Region D Durable Medical Equipment Regional Carrier (DMERC) Supplier Manual or Its Successor. The full text of the Medicare Region D DMERC Supplier Manual Chapters IX and X, date April 2001, is available via the Internet at www.cignamedicare.com. A copy is also available at the Idaho State Supreme Court Law Library. (3-17-22)

04. Provider Reimbursement Manual (PRM). The Provider Reimbursement Manual (PRM), Part I and Part II CMS Publication 15-1 and 15-2), is available on the CMS website at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals.html. (3-17-22)

05. Resource Utilization Groups (RUG) Grouper. The RUG III, version 5.12, 34 Grouper, nursing weights only, with index maximization. The RUG Grouper is available from CMS, 7500 Security Blvd., Baltimore, MD, 21244-1850. (3-17-22)

06. State Travel Polic~~ies~~y and Procedures~~ of the Idaho State Board of Examiners~~. The text of "~~Idaho ~~State Travel Polic~~ies~~y and Procedures~~ of the Idaho State Board of Examiners~~," and Appendices A and B,~~ June 13, 2000~~ January 17, 2023, is available at the Office of the State Controller, 700 W. State St., 5th Fl., Box 83720, Boise, Idaho 83720-0011 or~~ on the Internet~~ at~~ http://www.sco.idaho.gov/~~ https://www.sco.idaho.gov/LivePages/state-travel-policy-and-procedures.aspx. ~~(3-17-22)~~(   )

005. -- 007. (RESERVED)

008. AUDIT, INVESTIGATION AND ENFORCEMENT.
In addition to any actions specified in these rules, the Department may audit, investigate, and take enforcement action under~~ the provisions of~~ IDAPA 16.05.07, "The Investigation and Enforcement of Fraud, Abuse,~~ or~~ and Misconduct." ~~(3-17-22)~~(   )

009. ~~CRIMINAL HISTORY AND~~ BACKGROUND CHECK REQUIREMENTS.

01. Compliance With Department~~ Criminal History~~ Background Check. Employees and contractors of ~~A~~agencies~~ must verify that individuals~~ working in the area~~ listed in~~ under Subsection 009.03 of~~ these~~ this rule~~s whom are employed or whom they contract have complied~~ must comply with the provisions in IDAPA 16.05.06, "~~Rules Governing Mandatory ~~Criminal History and Background Checks."~~ Except, through the duration of the declared COVID-19 public health emergency, if the individuals working in the area listed in this rule are unable to complete a criminal background check in accordance with the timeframes set forth in IDAPA 16.05.06, then agencies may allow newly hired direct care staff to begin rendering services prior to completion of the criminal background check in accordance with the requirements specified by the Department in a COVID-19 information release posted on the Department's website at https://healthandwelfare.idaho.gov/providers/idaho-medicaid-providers/information-medicaid-providers.~~ ~~(3-17-22)~~(   )

~~**02. Additional Criminal Convictions**. Once an individual has received a criminal history clearance, any additional criminal convictions must be reported by the agency to the Department when the agency learns of the conviction. (3-17-22)~~

0~~3~~2. Providers Subject to~~ Criminal History and~~ Background Check Requirements. The following providers are required to~~ have a criminal history and~~ follow background check requirements provided in these rules and any other identified rules: ~~(3-17-22)~~(   )

a. Adult Day Health Providers.~~ The criminal history and background check requirements applicable to providers of adult day health as provided in Sections 329 and 705 of these rules.~~ ~~(3-17-22)~~(   )

b. Adult Residential Care Providers.~~ The criminal history and background check requirements applicable to adult residential care providers as provided in Section 329 of these rules.~~ ~~(3-17-22)~~(   )

c. Attendant Care Providers.~~ The criminal history and background check requirements applicable to attendant care providers as provided in Section 329 of these rules.~~ ~~(3-17-22)~~(   )

d. Behavior Consultation or Crisis Management Providers.~~ The criminal history and background check requirements applicable to behavior consultation or crisis management providers as provided in Section 705 of these rules.~~ ~~(3-17-22)~~(   )

e. Certified Family Home Providers and All Adults in the Home.~~ The criminal history and~~ See additional background check requirements~~ applicable to certified family homes are found in Sections 305, 329 and 705 of these rules, and as provided in~~ under IDAPA 16.03.19, "~~Rules Governing~~ Certified Family Homes." ~~(3-17-22)~~(   )

f. Chore Services Providers.~~ The criminal history and background check requirements applicable to chore services providers as provided in Sections 329 and 705 of these rules.~~ ~~(3-17-22)~~(   )

g. Companion Services Providers.~~ The criminal history and background check requirements applicable to companion services providers as provided in Section 329 of these rules.~~ ~~(3-17-22)~~(   )

h. Day Habilitation Providers.~~ The criminal history and background check requirements applicable to day habilitation providers as provided in Section 329 of these rules.~~ ~~(3-17-22)~~(   )

i. Developmental Disabilities Agencies (DDA).~~ The criminal history and~~ See additional background check requirements for DDA and staff~~ as provided in~~ under IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)~~,~~." ~~Section 009.~~ ~~(3-17-22)~~(   )

j. Homemaker Services Providers.~~ The criminal history and background check requirements applicable to homemaker services providers as provided in Section 329 of these rules.~~ ~~(3-17-22)~~(   )

k. Non-Medical Transportation Providers. (   )

~~k~~l. Personal Assistance Agencies Acting ~~A~~as Fiscal Intermediaries. The~~ criminal history and~~ background check requirements applicable to the staff of personal assistance agencies acting as fiscal intermediaries ~~as provided in Subsection 329.02 of these rules~~. ~~(3-17-22)~~(   )

~~l~~m. Personal Care Providers.~~ The criminal history and background check requirements applicable to personal care providers as provided in Subsection 305.06 of these rules~~. ~~(3-17-22)~~(   )

~~m~~n. Residential Habilitation Providers.~~ The criminal history and~~ See additional background check requirements applicable to residential habilitation providers~~ as provided in Sections 329 and 705 of these rules, and~~ under IDAPA 16.04.17 "~~Rules Governing~~ Residential Habilitation Agencies~~,~~." ~~Sections 202 and 301.~~ ~~(3-17-22)~~(   )

~~n~~o. Respite Care Providers.~~ The criminal history and background check requirements applicable to respite care providers as provided in Sections 329, 665, and 705 of these rules.~~ ~~(3-17-22)~~(   )

~~o~~p. Service Coordinators and Paraprofessionals.~~ The criminal history and background check requirements applicable to service coordinators and paraprofessionals working for an agency as provided in Section~~

~~729 of these rules.~~ ~~(3-17-22)~~( )

~~p~~q. Skilled Nursing Providers.~~ The criminal history and background check requirements applicable to skilled nursing providers as provided in Sections 329 and 705 of these rules.~~ ~~(3-17-22)~~( )

~~q~~r. Supported Employment Providers.~~ The criminal history and background check requirements applicable to supported employment providers as provided in Sections 329 and 705 of these rules.~~ ~~(3-17-22)~~( )

~~r~~s. Therapeutic Consultant Providers.~~ The criminal history and background check requirements applicable to therapeutic consultation providers as provided in Section 685 of these rules.~~ ~~(3-17-22)~~( )

010. DEFINITIONS: A THROUGH D.

~~For the purposes of these rules, the following terms are used as defined below:~~ ~~(3-17-22)~~

01. Accrual Basis. An accounting system based on the principle that revenues are recorded when they are earned; expenses are recorded in the period incurred. (3-17-22)

02. Active Treatment. ~~Active treatment is the c~~Continuous participation, during all waking hours, by an individual in an aggressive, consistently implemented program of specialized and generic training, treatment, health and related services, and provided~~ in accordance with~~ under a treatment plan developed by an interdisciplinary team and monitored by a Qualified Intellectual Disabilities Professional (QIDP) directed toward: (1) the acquisition of the behaviors necessary for the resident to function with as much self-determination and independence as possible; or (2) the prevention or deceleration of regression or loss of current functional status. ~~(3-17-22)~~( )

03. Activities of Daily Living (ADL). The performance of basic self-care activities in meeting an individual's needs for sustaining them in a daily living environment, including bathing, washing, dressing, toileting, grooming, eating, communication, continence, mobility, and associated tasks. (3-17-22)

04. Allowable Cost. ~~Costs that are r~~Reimbursable~~,~~ cost~~ and~~ sufficiently documented to meet the requirements of audit. ~~(3-17-22)~~( )

05. Amortization. The systematic recognition of the declining utility value of certain assets, usually not owned by the organization or intangible in nature. (3-17-22)

06. Appraisal. The method of determining the value of property as determined by an Appraisal Institute appraisal. The appraisal must specifically identify the values of land, buildings, equipment, and goodwill. (3-17-22)

07. Assets. Economic resources of the provider recognized and measured in conformity with generally accepted accounting principles. (3-17-22)

08. Attendant Care. Services provided under a Medicaid Home and Community-Based Services waiver that involve personal and medically-oriented tasks dealing with the functional needs of the participants and accommodating the participant's needs for long-term maintenance, supportive care, or ~~activities of daily living (~~ADL~~)~~. These services may include personal assistance and medical tasks that can be done by unlicensed persons or delegated to unlicensed persons by a health care professional or the participant. Services are based on the person's abilities and limitations, regardless of age, medical diagnosis, or other category of disability. This assistance may take the form of hands-on assistance (~~actually ~~performing a task for the person) or cuing to prompt the participant to perform a task. ~~(3-17-22)~~( )

09. Audit. An examination of provider records~~ on the basis of~~ based on which an opinion is expressed representing the compliance of a provider's financial statements and records with Medicaid law, regulations, and rules. ~~(3-17-22)~~( )

10. Auditor. The individual or entity designated by the Department to conduct the audit of a provider's records. (3-17-22)

11. Audit Reports. (3-17-22)

a. Draft Audit Report. A preliminary report of the audit finding sent to the provider for the provider's review and comments. (3-17-22)

b. Final Audit Report. A final written report containing the results, findings, and recommendations, if any, from the audit of the provider, as approved by the Department. (3-17-22)

12. Bad Debts. Amounts due to provider ~~as a result~~ because of services rendered, but ~~that~~ are considered uncollectible. ~~(3-17-22)~~(____)

13. Bed-Weighted Median. A numerical value determined by arraying the average per diem cost per bed of all facilities from high to low and identifying the bed at the point in the array at which half of the beds have equal or higher per diem costs and half have equal or lower per diem costs. The identified bed is the median bed. The per diem cost of the median bed is the bed-weighted median. (3-17-22)

14. Budget Adjustment Factor (BAF). A total budget for nursing facility reimbursement will be established by legislative appropriation and will be effective on July 1 of each year. The budget will be compared to the annual expected Medicaid reimbursement rates for the same rate year. A ~~budget adjustment factor~~ BAF will be established to adjust the expected Medicaid reimbursement rates to meet the approved budget. The BAF may be positive or negative and will apply to all nursing facility rates calculated under the established prospective rate system. The BAF will not be applied to the calculated customary charge for each nursing facility and will not apply to any nursing facility that is retrospectively settled. ~~(3-17-22)~~(____)

15. Capitalize. The practice of accumulating expenditures related to long-lived assets that will benefit later periods. (3-17-22)

16. Case Mix Adjustment Factor. The factor used to adjust a provider's direct care rate component for the difference in the average Medicaid acuity and the average nursing facility-wide acuity. The average Medicaid acuity is from the picture date immediately preceding the rate period. The average nursing facility-wide acuity is the average of the indexes that correspond to the cost reporting period. (3-17-22)

17. Case Mix Index (CMI). A numeric score assigned to each nursing facility resident, based on the resident's physical and mental condition, that projects the amount of relative resources needed to provide care to the resident. (3-17-22)

a. Nursing Facility-Wide Case Mix Index. The average of the entire nursing facility's case mix indexes identified at each picture date during the cost reporting period. If case mix indexes are not available for applicable quarters due to lack of data, case mix indexes from available quarters will be used. (3-17-22)

b. Medicaid Case Mix Index. The average of the weighting factors assigned to each Medicaid resident in the facility on the picture date, based on their RUG classification. Medicaid or non-Medicaid status is based upon information contained in the MDS databases. To the extent that Medicaid identifiers are found to be incorrect, the Department may adjust the Medicaid case mix index and reestablish the reimbursement rate. (3-17-22)

c. State-Wide Average Case Mix Index. The simple average of all nursing facilities "facility-wide" case mix indexes used in establishing the reimbursement limitation July 1st of each year. The state-wide case mix index will be calculated annually during each July 1st rate setting. (3-17-22)

18. Certified Family Home (CFH). ~~A home certified by the Department to provide care to one (1) or two (2)adults, who are unable to reside on their own and require help with activities of daily living, protection and security, and need encouragement toward independence~~ A home that meets the requirements under IDAPA 16.03.19, "Certified Family Homes.". ~~(3-17-22)~~(____)

l9. Chain Organization. A proprietorship, partnership, or corporation that leases, manages, or owns two (2) or more facilities that are separately licensed. (3-17-22)

20. Claim. An itemized bill for services rendered to one (1) participant by a provider and submitted to the Department for payment. (3-17-22)

21. Clinical Nurse Specialist. An~~ licensed registered nurse~~ RN who meets all the applicable requirements to practice as a clinical nurse specialist under Title 54, Chapter 14, Idaho Code, and IDAPA 24.34.01, "Rules of the Idaho Board of Nursing." ~~(3-17-22)~~(   )

22. Common Ownership. An individual(s),~~ individuals,~~ or other entities who have equity or ownership in two (2) or more organizations that conduct business transactions with each other. Common ownership exists if an individual(s)~~ or individuals~~ possesses significant ownership or equity in the provider and the institution or organization serving the provider. ~~(3-17-22)~~(   )

23. Compensation. The total of all remuneration received, including cash, expenses paid, salary advances, etc. (3-17-22)

24. Complaint. The process by which an individual registers dissatisfaction with program operations, quality of services, or other relevant concerns. A complaint is separate from an appeal, and an individual is not required to submit a complaint in order to pursue an appeal under these rules. (   )

2~~4~~5. Control. ~~Control e~~Exists where an individual or an organization has the power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or institution. ~~(3-17-22)~~(   )

2~~5~~6. Cost Center. A "collection point" for expenses incurred in the rendering of services, supplies, or materials that are related or so considered for cost-accounting purposes. (3-17-22)

2~~6~~7. Cost Component. The portion of the nursing facility's rate that is determined from a prior cost report, including property rental rate. The cost component of a nursing facility's rate is established annually~~ at~~ July 1st of each year. ~~(3-17-22)~~(   )

2~~7~~8. Cost Reimbursement System. A method of fiscal administration of Title XIX and Title XXI that compensates the provider based on~~ the basis of~~ expenses incurred. ~~(3-17-22)~~(   )

2~~8~~9. Cost Report. A fiscal year report of provider costs required by the Medicare program and any supplemental schedules required by the Department. (3-17-22)

~~29~~30. Cost Statements. An itemization of costs and revenues, presented on the accrual basis, that is used to determine cost of care for facility services for a specified period~~ of time~~. These statements are commonly called income statements. ~~(3-17-22)~~(   )

3~~0~~1. Costs Related to Patient Care. All necessary and proper costs that are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. Necessary and proper costs related to patient care are usually costs that are common and accepted occurrences in the field of the provider's activity. They include costs such as depreciation, interest expenses, nursing costs, maintenance costs, administrative costs, costs of employee pension plans, and normal standby costs. (3-17-22)

3~~1~~2. Costs Not Related to Patient Care. Costs that are not appropriate or necessary and proper in developing and maintaining the operation of patient care facilities and activities. Such costs are nonallowable in computing reimbursable costs. They include, for example, cost of meals sold to visitors or employees~~;~~, cost of drugs sold to other than patients~~;~~, cost of operation of a gift shop~~;~~, and similar items. Travel and entertainment expenses are nonallowable unless it can be~~ specifically~~ shown that they relate to patient care and for the operation of the nursing facility. ~~(3-17-22)~~(   )

3~~2~~3. Customary Charges. ~~Customary charges are the r~~Rates charged to Medicare participants and to patients liable for such charges, as reflected in the facility's records. Those charges are adjusted downward, when the provider does not impose such charges on most patients liable for payment on a charge basis or~~,~~ when the provider

fails to make reasonable collection efforts. The reasonable effort to collect such charges is the same effort necessary for Medicare reimbursement as is needed for unrecovered costs attributable to certain bad debt under PRM, Chapter 3, Sections 310 and 312. ~~(3-17-22)~~( )

3~~3~~4. Day Treatment Services. ~~Day treatment services are d~~Developmental services provided regularly during normal working hours on weekdays by, or on behalf of, the ~~Intermediate Care Facility for Persons with Intellectual Disabilities (~~ICF/IID~~)~~. ~~However, d~~Day treatment services do not include recreational therapy, speech therapy, physical therapy, occupational therapy, or services paid for, or required to be provided by, a school or other entity. ~~(3-17-22)~~( )

3~~4~~5. Department. The Idaho Department of Health and Welfare or ~~a person authorized to act on behalf of the Department~~ its designee. ~~(3-17-22)~~( )

3~~5~~6. Depreciation. The systematic distribution of the cost or other basis of tangible assets, less salvage, over the estimated life of the assets. (3-17-22)

3~~6~~7. Developmental Disability (DD). ~~A developmental disability, as d~~Defined ~~in~~ under Section 66-402, Idaho Code, means a chronic disability of a person that appears before the age of twenty-two (22) years ~~of age~~; and ~~(3-17-22)~~( )

a. Is attributable to an impairment, such as an intellectual disability, cerebral palsy, epilepsy, autism, or other condition found to be closely related to or similar to one (1) of these impairments, that requires similar treatment or services, or is attributable to dyslexia resulting from such impairments; (3-17-22)

b. Results in substantial functional limitations in three (3) or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency; and (3-17-22)

c. Reflects the need for a combination or sequence of special, interdisciplinary, or generic care, treatment, or other services that are of lifelong or extended duration and individually planned and coordinated. (3-17-22)

3~~7~~8. Direct Care Costs. Costs directly assigned to the nursing facility or allocated to the nursing facility through the Medicare cost-finding principles and consisting of the following: (3-17-22)

a. Direct nursing salaries that include the salaries of ~~licensed registered nurses (~~RNs~~)~~, certified nurse's aides, and unit clerks; ~~(3-17-22)~~( )

b. Routine nursing supplies; (3-17-22)

c. Nursing administration; (3-17-22)

d. Direct portion of Medicaid-related ancillary services; (3-17-22)

e. Social services; (3-17-22)

f. Raw food; (3-17-22)

g. Employee benefits associated with the direct salaries: and (3-17-22)

h. Medical waste disposal, for rates with effective dates beginning July 1, 2005. (3-17-22)

3~~8~~9. Director. The Director of the Department ~~of Health and Welfare~~ or their designee. ~~(3-17-22)~~( )

~~39~~40. Durable Medical Equipment (DME). Equipment other than prosthetics or orthotics that can withstand repeated use by one (1) or more individuals, is primarily and customarily used to serve a medical purpose,

is generally not useful to a person in the absence of an illness or injury, is appropriate for use in the home, and is reasonable and necessary for the treatment of an illness or injury for a Medicaid participant. (3-17-22)

(BREAK IN CONTINUITY OF SECTIONS)

093. ORGAN TRANSPLANTS: COVERAGE AND LIMITATIONS.

01. Coverage Limitations. ~~No organ transplant will be covered by the Medical Assistance Program unless prior authorized by the Department, or its designee.~~ Coverage is limited to organ transplants performed for the treatment of medical conditions ~~in accordance with~~ under evidence-based standards of care. ~~(3-17-22)~~( )

02. Living Donor Costs. The transplant costs for actual or potential living donors are fully covered by Medicaid and include all medically necessary preparatory, operation, and post-operation recovery expenses associated with the donation. Payments for post-operation expenses of a donor will be limited to the period of actual recovery. (3-17-22)

(BREAK IN CONTINUITY OF SECTIONS)

200. PRIVATE DUTY NURSING (PDN) SERVICES.

~~**01. Description of Private Duty Nursing (PDN) Services**. Private Duty Nursing (~~PDN~~)~~ services are nursing services provided by an ~~licensed registered nurse~~ RN or ~~licensed practical nurse~~ LPN to a non-institutionalized child under the age of twenty-one (21) requiring care for conditions of such medical severity or complexity that skilled nursing care is necessary. Sections 200 through 209 of these rules cover requirements for ~~private duty nursing~~ PDN services. ~~(3-17-22)~~( )

~~**02. Temporary Changes to PDN Rules During Declared State of Emergency Related to Novel Coronavirus Disease (COVID-19)**. In response to Idaho's declaration on 3/13/20 of a state of emergency related to COVID-19, the Department reserves the right to temporarily alter requirements and processes related to PDN services in order to mitigate spread of disease and to ensure the health and safety of our participants under the guidance and authority of the provisions in a CMS-approved 1135 waiver through the duration of the emergency state. Guidance for approved flexibilities is posted on the Medicaid Information Releases website at https://www.idmedicaid.com/default.aspx. (3-17-22)~~

(BREAK IN CONTINUITY OF SECTIONS)

300. PERSONAL CARE SERVICES (PCS).

~~**01. Description of Personal Care Services (PCS).**~~ Under Sections 39-5601 through 39-5607, Idaho Code, it is the intent of the Department to provide ~~personal care services (~~PCS~~)~~ to eligible participants in their ~~own homes or~~ personal residences to prevent unnecessary institutional placement, to provide for the greatest degree of independence ~~possible~~, to enhance quality of life, ~~to~~ encourage individual choice, and ~~to~~ maintain community integration. ~~(3-17-22)~~( )

~~**02. Temporary Changes to PCS Rules During Declared State of Emergency Related to Novel Coronavirus Disease (COVID-19)**. In response to Idaho's declaration on 3/13/20 of a state of emergency related to COVID-19, the Department reserves the right to temporarily alter requirements and processes related to PCS services, currently and through the duration of the emergency state, in order to mitigate spread of disease and to ensure the health and safety of our participants under the guidance and authority of the provisions in a CMS approved 1135 waiver. Guidance for approved flexibilities is posted on the Medicaid Information Releases website at https://healthandwelfare.idaho.gov/providers/idaho-medicaid-providers/information-medicaid-providers. (3-17-22)~~

(BREAK IN CONTINUITY OF SECTIONS)

304. PERSONAL CARE SERVICES: PROCEDURAL REQUIREMENTS.

01. Service Delivery Based on Plan of Care or NSA. All PCS services are provided based on a written plan of care or a negotiated service agreement (NSA). The requirements for the NSA for participants in Residential Assisted Living Facilities are~~ described in~~ under IDAPA 16.03.22, "Residential Assisted Living Facilities." The requirements for the NSA for participants in C~~ertified~~ F~~amily~~ H~~omes~~ are described in IDAPA 16.03.19, "Certified Family Homes." The Personal Assistance Agency and the participant who lives in their own home are responsible to prepare the plan of care. ~~(3-17-22)~~(____)

a. The plan of care for participants who live in their own homes or in a PCS Family Alternate Care Home is based on: (3-17-22)

i. The physician's or authorized provider's information, if applicable; (3-17-22)

ii. The results of the UAI for adults, the children's PCS assessment and, if applicable, the QIDP's assessment and observations of the participant; and (3-17-22)

iii. Information obtained from the participant. (3-17-22)

b. The plan of care must include all aspects of medical and non-medical care that the provider needs to perform, including the amount, type, and frequency of necessary services. (3-17-22)

c. The plan of care must be~~ revised and~~ updated based upon treatment results or a change(s) in the participant's needs, or both, but at least annually. ~~(3-17-22)~~(____)

d. The plan of care or NSA must meet the person-centered planning requirements~~ described in Sections 316 and 317 of~~ under these rules. ~~(3-17-22)~~(____)

02. Service Supervision. The delivery of PCS is overseen by an ~~licensed registered nurse (~~RN~~)~~ or Qualified Intellectual Disabilities Professional (QIDP). The~~ BLTC~~ Department will identify the need for supervision. ~~(3-17-22)~~(____)

a. Oversight must include~~ all of~~ the following: ~~(3-17-22)~~(____)

i. Assistance in the development of the written plan of care; (3-17-22)

ii. Review of the treatment given by the personal assistant through a review of the participant's PCS record as maintained by the provider; (3-17-22)

iii. Re-evaluation of the plan of care as necessary; and (3-17-22)

iv. Immediate notification of the guardian, emergency contact, or family members of any significant changes in the participant's physical condition or response to the services delivered. (3-17-22)

b. All participants who are developmentally disabled, other than those with only a physical disability as determined by the~~ BLTC~~ Department, may receive oversight by a QIDP as defined in 42 CFR 483.430. Oversight must include: ~~(3-17-22)~~(____)

i. Assistance in the development of the plan of care for those aspects of active treatment that are provided in the participant's personal residence by the personal assistant; (3-17-22)

ii. Review of the care or training programs given by the personal assistant through a review of the

participant's PCS record as maintained by the provider and through on-site interviews with the participant; (3-17-22)

iii. Re-evaluation of the plan of care as necessary, but at least annually; and (3-17-22)

iv. An on-site visit to the participant to evaluate any change of condition when requested by the personal assistant, the Personal Assistance Agency, the nurse supervisor, the service coordinator, or the participant. (3-17-22)

03. Prior Authorization Requirements. All PCS services must be prior authorized by the Department. Authorizations will be based on the information from: (3-17-22)

a. The children's PCS assessment or ~~Uniform Assessment Instrument (~~UAI~~)~~ for adults; ~~(3-17-22)~~(   )

b. The individual service plan developed by the Personal Assistance Agency; and (3-17-22)

c. Any other medical information that supports the medical need. (3-17-22)

04. ~~PCS~~ Record Requirements for a Participant's ~~in Their Own~~ Home. PCS records must be maintained for all participants receiving PCS in their own homes or in a PCS Family Alternate Care Home. ~~(3-17-22)~~(   )

a. ~~Documentation Requirements.~~ PCS provider must maintain documentation of every visit made to the participant's home and ~~must~~ record the following ~~minimum~~ information: ~~(3-17-22)~~(   )

i. Date and time of visit; (3-17-22)

ii. Length of visit; (3-17-22)

iii. Services provided during the visit; and (3-17-22)

iv. Documentation of any changes noted in the participant's condition or any deviations from the plan of care. (3-17-22)

b. ~~Participant's Signature.~~ The participant or legal guardian must verify services were delivered by signing the documentation. ~~(3-17-22)~~(   )

c. ~~Provider Signature.~~ The Plan of Care must be signed by the provider indicating that they will deliver services according to the authorized service plan and consistent with home and community-based requirements. ~~(3-17-22)~~(   )

d. ~~Copy Requirement.~~ A copy of the information required in Subsection 304.04 of ~~these~~ this rule~~s~~ must be maintained and available in a format accessible to the participant in their home. Failure to maintain this information may result in recovery of funds paid for undocumented services. ~~(3-17-22)~~(   )

e. Electronic Visit Verification (EVV) ~~S~~systems. ~~EVV systems~~ as described in Section 041 of these rules will not take the place of documentation requirements of Subsection 304.04 of ~~these~~ this rule~~s~~ but may be used to generate documentation retained in the participant's home. ~~(3-17-22)~~(   )

05. PCS Record Requirements for a Participant in a Residential Assisted Living Facility (RALF) or C~~ertified~~ F~~amily~~ H~~ome~~. The PCS records must be maintained on all participants who receive PCS in a ~~Residential Assisted Living Facility (~~RALF~~)~~ or ~~Certified Family Home (~~CFH~~)~~. ~~(3-17-22)~~(   )

a. ~~Participant in a RALF. The a~~Additional PCS record requirements for RALF participants ~~in RALF are described in~~ are under IDAPA 16.03.22, "Residential Assisted Living Facilities." ~~(3-17-22)~~(   )

b. ~~Participant in a CFH. The a~~Additional PCS record requirements for CFH participants ~~in CFHs are~~

~~described in~~ are under IDAPA 16.03.19, "Certified Family Homes." ~~(3-17-22)~~(____)

c. ~~Participant's Signature.~~ The participant or legal guardian must sign the NSA agreeing to the delivery of services as specified. ~~(3-17-22)~~(____)

d. ~~Provider Signature.~~ The NSA must be signed by the supervisory nurse or agency personnel responsible for developing the NSA with the participant~~,~~ and must indicate that they will deliver services according to the authorized NSA and consistent with home and community-based requirements. ~~(3-17-22)~~(____)

06. Provider Responsibility for Notification. The Personal Assistance Agency is responsible to notify the ~~BLTC~~ Department and the physician or authorized provider when any significant changes in the participant's condition are noted during service delivery. This notification must be documented in the Personal Assistance Agency record. ~~(3-17-22)~~(____)

~~**07. COVID-19**. The sections of this rule may be subject to amendment by the BLTC for the duration of the COVID-19 state of emergency. Please consult Medicaid Information Release MA20-15 for additional guidance. (3-17-22)~~

305. PERSONAL CARE SERVICES: PROVIDER QUALIFICATIONS.

01. Provider Qualifications for Personal Assistants. All personal assistants must have at least one (1) of the following qualifications: (3-17-22)

a. ~~Licensed Registered Nurse (~~RN~~). A person currently licensed by the Idaho State Board of Nursing as a licensed registered nurse~~; ~~(3-17-22)~~(____)

b. ~~Licensed Practical Nurse (~~LPN~~). A person currently licensed by the Idaho State Board of Nursing as a licensed practical nurse~~; or ~~(3-17-22)~~(____)

c. Personal Assistant. A person who meets the standards of Section 39-5603, Idaho Code, and receives training to ensure the quality of services. The assistant must be at least age eighteen (18) years of age. The ~~BLTC~~ Department may require a certified nursing assistant (CNA) if, in their professional judgment, the participant's medical condition warrants a CNA. ~~(3-17-22)~~(____)

02. Provider Training Requirements. In the case where care is provided in the participant's own home, and the participant has a developmental disability that is not physical only and requires more than physical assistance, all those who provide care must have: (3-17-22)

a. Completed one (1) of the Department-approved developmental disabilities training courses; or (3-17-22)

b. Experience providing direct services to people with developmental disabilities. (3-17-22)

c. ~~BLTC determines~~Department approval of whether developmental disability training is required. Providers who are qualified as QIDPs are exempted from the Department-approved developmental disabilities training course. ~~(3-17-22)~~(____)

d. ~~In order~~Regional approval. ~~t~~To serve a participant with a developmental disability, a region may temporarily approve a PCS provider who meets all qualifications except for the required training course or experience, if all the following conditions are met: ~~(3-17-22)~~(____)

i. The ~~BLTC~~ Department verifies that there are no other qualified providers available; ~~(3-17-22)~~(____)

ii. The provider is enrolled in the next available training course with a graduation date no later than six (6) months from the date of the request for temporary provider status; and (3-17-22)

iii. The supervising QIDP makes monthly visits until the provider graduates from the training program. (3-17-22)

03. Provider Exclusion. If PCS is paid for by Medicaid, except in extraordinary circumstances as defined by the Department, a PCS service provider cannot be the spouse of any participant or be the parent of a participant if the participant is a minor child. ~~(3-17-22)~~(____)

04. Care Delivered in Provider's Home for a Child. When care for a child is delivered in the provider's home, the provider must be licensed or certified for the appropriate level of child foster care or day care. The provider must be licensed for care of individuals under age eighteen (18),~~ as defined in~~ under Section 39-1213, Idaho Code. Noncompliance with these standards is cause for termination of the~~ provider's~~ provider agreement. ~~(3-17-22)~~(____)

05. Care Delivered in Provider's Home for an Adult. When care for an adult is provided in a home owned or leased by the provider, the provider must be certified as a C~~ertified ~~F~~amily ~~H~~ome~~ under IDAPA 16.03.19, "Certified Family Homes." ~~(3-17-22)~~(____)

06. ~~Criminal History~~Background Check. All PCS providers, including service coordinators, RN supervisors, QIDP supervisors, and personal assistants~~,~~ must~~ participate in~~ obtain a~~ criminal history~~ background check as required by Section 39-5604, Idaho Code. The~~ criminal history~~ background check must be conducted~~ in accordance with~~ under IDAPA 16.05.06, "Criminal History and Background Checks." ~~(3-17-22)~~(____)

07. Health Screen. Each Personal Assistance Agency employee who serves as a personal assistant must complete a health questionnaire. Personal Assistance Agencies must retain the health questionnaire in their personnel files. If the personal assistant indicates on the questionnaire that they have a medical problem, they are required to submit a statement from a physician or authorized provider that their medical condition does not prevent them from performing all the duties required of a personal care provider. Misrepresentation of information submitted on the health questionnaire may be cause for termination of employment for the personal assistant and would disqualify the employee to provide services to Medicaid participants. (3-17-22)

(BREAK IN CONTINUITY OF SECTIONS)

308. PERSONAL CARE SERVICES (PCS): QUALITY ASSURANCE.

01. Responsibility for Quality. Personal Assistance Agencies, RALFs, and CFHs furnishing PCS are responsible for~~ assuring that they~~ provideing quality services in compliance with applicable rules. ~~(3-17-22)~~(____)

02. Review Results. Results of quality assurance reviews conducted by the Department must be transmitted to the provider within forty-five (45) days after the review is completed. (3-17-22)

03. Quality Improvement Plan. The provider must respond within forty-five (45) days after the results are received. If problems are identified, the provider must implement a quality improvement plan and report the results to the Department upon request. (3-17-22)

04. HCBS Compliance. Personal Assistance Agencies are responsible for ensuring they meet the setting requirements~~ described in~~ under Section 313 of these rules. RALFs~~,~~ and CFHs are responsible for ensuring that they meet the setting requirements~~ described in~~ under Sections 313 and 314 of these rules. All providers furnishing PCS are responsible for ensuring they meet the person-centered planning requirements~~ described in~~ under Sections 316 through 317 of these rules. PCS providers must comply with associated Department quality assurance activities. The Department may take enforcement actions~~ as described in~~ under IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 205, if the provider fails to comply with any term or provision of the provider agreement, or any applicable state or federal regulation. ~~(3-17-22)~~(____)

~~**05. COVID-19**. The sections of this rule may be subject to amendment by the BLTC for the duration of the COVID-19 state of emergency. Please consult Medicaid Information Release MA20-15 for additional guidance.~~

~~(3-17-22)~~

(BREAK IN CONTINUITY OF SECTIONS)

314. RESIDENTIAL PROVIDER-OWNED OR CONTROLLED SETTING QUALITIES.
In addition to the setting requirements~~ described in~~ under Section 313 of these rules, provider-owned or controlled settings, including R~~esidential~~ A~~ssisted~~ L~~iving~~ F~~acilitie~~s and C~~ertified~~ F~~amily~~ H~~ome~~s that provide services to HCBS participants, must~~ also~~ meet the following conditions: ~~(3-17-22)~~(   )

01. Written Agreement. A lease, residency agreement, admission agreement, or other form of written agreement will be in place for each HCBS participant at the time of occupancy. The lease or residency agreement must provide protections that address eviction processes and appeals comparable to those provided under Idaho landlord tenant law. (3-17-22)

02. Privacy. Participants have the right to privacy within their residence. Each participant must have privacy in their sleeping or living unit to include the following: (3-17-22)

a. The right to entrance doors that are lockable by the individual, with only appropriate staff having keys to doors. (3-17-22)

b. Participants sharing units have a choice of roommates in that setting. (3-17-22)

03. Décor. Participants have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement. (3-17-22)

04. Schedules and Activities. Participants have the freedom and support to control their own schedules and activities. (3-17-22)

05. Access To Food. Participants have access to food at any time. (3-17-22)

06. Visitors. Participants are able to have visitors of their choosing at any time~~ in accordance with the applicable requirements under IDAPA 16.03.19, "Certified Family Homes," and IDAPA 16.03.22, "Residential Assisted Living Facilities." Except, through the duration of the declared COVID-19 public health emergency, CFH providers may restrict visitation to minimize the spread of the COVID-19 infection~~. ~~(3-17-22)~~(   )

07. Accessibility. The setting is physically accessible to the participant. (3-17-22)

(BREAK IN CONTINUITY OF SECTIONS)

317. HOME AND COMMUNITY-BASED PERSON-CENTERED SERVICE PLAN REQUIREMENTS.
All person-centered service plans must reflect the following components: (3-17-22)

01. Services And Supports. Clinical services and supports that are important for the participant's behavioral, functional, and medical needs as identified through an assessment. (3-17-22)

02. Service Delivery Preferences. Indication of what is important to the participant~~ with regard to~~ about the service provider and preferences for the delivery of such services and supports. ~~(3-17-22)~~(   )

03. Setting Selection. HCBS settings selected by the participant or the participant's decision-making authority are chosen from among a variety of setting options, as required in Section 313 of these rules. The person-centered service plan must identify and document the alternative home and community setting options that were considered by the participant, or the participant's decision-making authority. (3-17-22)

04. Participant Strengths and Preferences. (3-17-22)

05. Individually Identified Goals and Desired Outcomes. (3-17-22)

06. Paid and Unpaid Services and Supports. ~~Paid and unpaid services and supports that will a~~Assist the participant to achieve identified goals, and the providers of those services and supports, including natural supports. ~~(3-17-22)~~(   )

07. Risk Factors. Risk factors to the participant as well as people around the participant and measures in place to minimize them, including individualized back-up plans and strategies when needed. (3-17-22)

08. Understandable Language. Be understandable to the participant receiving services and supports, and the individuals important in supporting them. ~~At a minimum, t~~The written plan must be understandable, and written in plain language~~ in a manner~~ that is accessible to participants with disabilities and~~ persons~~ who~~ are~~ have limited English proficien~~t~~cy, consistent with 42 CFR 435.905(b). ~~(3-17-22)~~(   )

09. Plan Monitor. Identify the name of the individual or entity responsible for monitoring the plan. (3-17-22)

10. Plan Signatures. Be finalized and agreed to, by the participant, or the participant's decision-making authority, in writing, indicating informed consent. The plan must also be signed by the plan developer and all individuals and providers responsible for its implementation indicating they will deliver services according to the authorized plan of service and consistent with home and community-based requirements. ~~(3-17-22)~~(   )

a. Children's DD service providers responsible for implementation of the plan include the providers of those services~~ defined in~~ under Section 523 of these rules. ~~(3-17-22)~~(   )

b. Adult DD service providers responsible for implementation of the plan include those required to develop a provider implementation plan~~ as defined in~~ under Sections 513 and 654 of these rules. ~~(3-17-22)~~(   )

c. Consumer-directed service providers responsible for implementation of the plan include the participant, Support Broker, and Fiscal Employment Agency~~ as identified in~~ under IDAPA 16.03.13, "Consumer-Directed Services." ~~(3-17-22)~~(   )

d. Personal Care and Aged and Disabled Waiver service providers responsible for the implementation of the plan include the providers of those services~~ defined in~~ under Sections 303 and 326 of these rules. Alternate format signatures may be used; refer to Medicaid Information Release MA20-15 for guidance. ~~(3-17-22)~~(   )

11. Plan Distribution. Be distributed to the participant and the participant's decision-making authority, if applicable, and other people involved in the implementation of the plan. ~~At a minimum, t~~The following providers will receive a copy of the plan: ~~(3-17-22)~~(   )

a. Children's DD providers of services~~ defined in~~ under Section 523 of these rules as identified on the plan of service developed by the family-centered planning team. ~~(3-17-22)~~(   )

b. Adult DD service providers required to develop a provider implementation plan~~ as defined in~~ under Sections 513 and 654 of these rules. Additionally, the participant will determine during the person-centered planning process whether the service plan, in whole or in part, will be distributed to any other developmental disability service provider. ~~(3-17-22)~~(   )

c. Consumer-Directed service providers~~ as defined in~~ under IDAPA 16.03.13, "Consumer-Directed Services," Section 110. Additionally, the participant, or the participant's decision-making authority will determine during the person-centered planning process whether the service plan, in whole or in part, will be distributed to any other community support worker or vendors. ~~(3-17-22)~~(   )

d. Personal Care and Aged and Disabled Waiver service providers furnishing those services~~ defined in~~ under Sections 303 and 326 of these rules. ~~(3-17-22)~~(   )

12. Residential Requirements. For participants living in residential provider~~-~~-owned or controlled settings~~ as described in~~ under Section 314 of these rules, the following additional requirements apply: ~~(3-17-22)~~(____)

a. Options~~ described in~~ under Subsection 317.03 of this rule must include a residential setting option that allows for private units. Selection of residential settings will be based on the participant's needs, preferences, and resources available for room and board. ~~(3-17-22)~~(____)

b. Any exception to residential provider~~-~~-owned or controlled setting qualities~~ as described in~~ under Section 314 of these rules must be documented in the person-centered plan~~ as described in~~ under Section 315 of these rules. ~~(3-17-22)~~(____)

(BREAK IN CONTINUITY OF SECTIONS)

320. AGED AND DISABLED WAIVER SERVICES.

~~**01. Description of Aged and Disabled Services**.~~ Idaho's elderly and physically disabled citizens should be able to maintain self-sufficiency, individuality, independence, dignity, choice, and privacy in a cost-effective home-like setting. When possible, services should be available in the participant's own home and community regardless of their age, income, or ability and should encourage the involvement of natural supports, such as family, friends, neighbors, volunteers, church, and others. ~~(3-17-22)~~(____)

~~**02. Temporary Changes to Aged and Disabled Rules During Declared State of Emergency Related to Novel Coronavirus Disease (COVID-19)**. In response to Idaho's declaration on 3/13/20 of a state of emergency related to COVID-19, the Department reserves the right to temporarily alter requirements and processes related to Aged and Disabled waiver services, currently and through the duration of the emergency state, in order to mitigate spread of disease and to ensure the health and safety of our participants under the guidance and authority of the provisions in a CMS-approved 1135 waiver or HCBS Attachment K amendment to the existing Aged and Disabled waiver. Guidance for approved flexibilities is posted at https://healthandwelfare.idaho.gov/providers/idaho-medicaid-providers/information-medicaid-providers. (3-17-22)~~

(BREAK IN CONTINUITY OF SECTIONS)

326. AGED AND DISABLED WAIVER SERVICES: COVERAGE AND LIMITATIONS.

01. Adult Day Health. ~~Adult day health is a~~A supervised, structured service generally furnished four (4) or more hours per day on a regularly scheduled basis, for one (1) or more days per week. It is provided outside the home of the participant in a non-institutional, community-based setting, and it encompasses health services, social services, recreation, supervision for safety, and assistance with~~ activities of daily living~~ ADL needed to ensure the optimal functioning of the participant. Adult day health services provided under this waiver will not include room and board payments. ~~(3-17-22)~~(____)

02. Adult Residential Care Services. ~~Adult residential care services c~~Consist of a range of services provided in a homelike, non-institutional setting that includes RALFs and CFHs. Payment is not made for the cost of room and board, including the cost of building maintenance, upkeep, and improvement. ~~(3-17-22)~~(____)

a. ~~Adult residential care services consist of a range of~~These services are provided in a congregate setting licensed under IDAPA 16.03.22, "Residential Assisted Living Facilities," that include: ~~(3-17-22)~~(____)

i. Medication assistance, to the extent permitted under State law; (3-17-22)

ii. Assistance with~~ activities of daily living~~ ADL; ~~(3-17-22)~~(____)

iii. Meals, including special diets; (3-17-22)

iv. Housekeeping; (3-17-22)

v. Laundry; (3-17-22)

vi. Transportation; (3-17-22)

vii. Opportunities for socialization; (3-17-22)

viii. Recreation; and (3-17-22)

ix. Assistance with personal finances. (3-17-22)

x. Administrative oversight must be provided for all services provided or available in this setting. (3-17-22)

xi. A documented individual service plan must be negotiated between the participant or their legal representative, and a facility representative. (3-17-22)

b. ~~Adult residential care services also consist of a range of~~These services are provided in a setting licensed under IDAPA 16.03.19, "Certified Family Homes," that include: ~~(3-17-22)~~(   )

i. Medication assistance, to the extent permitted under State law; (3-17-22)

ii. Assistance with ~~activities of daily living~~ ADL; ~~(3-17-22)~~(   )

iii. Meals, including special diets; (3-17-22)

iv. Housekeeping; (3-17-22)

v. Laundry; (3-17-22)

vi. Transportation; (3-17-22)

vii. Recreation; and (3-17-22)

viii. Assistance with personal finances. (3-17-22)

ix. Administrative oversight must be provided for all services provided or available in this setting. (3-17-22)

x. A documented individual service plan must be negotiated between the participant or their legal representative, and a facility representative. (3-17-22)

03. Specialized Medical Equipment and Supplies. (3-17-22)

~~a. Specialized medical equipment and supplies include: (3-17-22)~~

~~i~~**a**. Devices, controls, or appliances that enable a participant to increase their abilities to perform ~~activities of daily living~~ ADL, or to perceive, control, or communicate with the environment in which they live; and ~~(3-17-22)~~(   )

~~ii~~**b**. Items necessary for life support, ancillary supplies and equipment necessary for the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State Plan. (3-17-22)

~~b~~**c**. Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the Medicaid State Plan and exclude those items that are not of direct medical or remedial benefit to the participant. (3-17-22)

04. Non-Medical Transportation. ~~Non-medical transportation e~~Enables a waiver participant to gain access to waiver and other community services and resources. ~~(3-17-22)~~(   )

a. Non-medical transportation is offered in addition to medical transportation required in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," and will not replace it. (3-17-22)

b. Whenever possible, family, neighbors, friends, or community agencies who can provide this service without charge, or public transit providers will be utilized. (3-17-22)

05. Attendant Care. Services provided under a Medicaid Home and Community-Based Services waiver that involve personal and medically oriented tasks dealing with the functional needs of the participant and accommodating the participant's needs for long-term maintenance, supportive care, or ~~activities of daily living (~~ADL~~)~~. These services may include personal assistance and medical tasks that can be done by unlicensed persons, or delegated to an unlicensed person by a licensed health care professional or the participant. Services are based on the participant's abilities and limitations, regardless of age, medical diagnosis, or other category of disability. This assistance may take the form of hands-on assistance (~~actually~~ performing a task for the person) or cuing to prompt the participant to perform a task. ~~(3-17-22)~~(   )

06. Chore Services. ~~Chore services i~~Include the following~~ services~~ when necessary to maintain the functional use of the home, or to provide a clean, sanitary, and safe environment: ~~(3-17-22)~~(   )

a. Intermittent assistance may include the following: (3-17-22)

i. Yard maintenance; (3-17-22)

ii. Minor home repair; (3-17-22)

iii. Heavy housework; (3-17-22)

iv. Sidewalk maintenance; and (3-17-22)

v. Trash removal to assist the participant to remain in the home. (3-17-22)

b. Chore activities may include the following: (3-17-22)

i. Washing windows; (3-17-22)

ii. Moving heavy furniture; (3-17-22)

iii. Shoveling snow to provide safe access inside and outside the home; (3-17-22)

iv. Chopping wood when wood is the participant's primary source of heat; and (3-17-22)

v. Tacking down loose rugs and flooring. (3-17-22)

c. These services are only available when neither the participant, nor anyone else in the household, is capable of performing or financially providing for them, and where no other relative, caregiver, landlord, community volunteer, agency, or third-party payer is willing to provide them or is responsible for their provision. (3-17-22)

d. In the case of rental property, the landlord's responsibility under the lease agreement will be examined prior to any authorization of service. Chore services are limited to the services provided in a home rented or owned by the participant. (3-17-22)

07. Companion Services. ~~Companion services i~~Include non-medical care, supervision, and socialization provided to a functionally impaired adult. Companion services are in-home services to ensure the safety and well-being of a person who cannot be left alone because of frail health, a tendency to wander, inability to respond to emergency situations, or other conditions that would require a person on-site. The service provider, who may live with the participant, may provide voice cuing and occasional assistance with toileting, personal hygiene, dressing, and other~~ activities of daily living~~ ADL. Providers may also perform light housekeeping tasks that are incidental to the care and supervision of the participant. However, the primary responsibility is to provide companionship and be there in case they are needed. ~~(3-17-22)~~(____)

08. Consultation. ~~Consultation services are s~~Services to a participant or family member~~. Services~~ that are provided by a Personal Assistance Agency to a participant or family member to increase their skills as an employer or manager of their own care. Such services are directed at achieving the highest level of independence and self-reliance possible for the participant and the participant's family. Services include consulting with the participant and family to gain a better understanding of the special needs of the participant and the role of the caregiver. ~~(3-17-22)~~(____)

09. Home~~ ~~-Delivered Meals. ~~Home delivered meals are m~~Meals that are delivered to the participant's home to promote adequate participant nutrition. One (1) to two (2) meals per day may be provided to a participant who: ~~(3-17-22)~~(____)

a. Rents or owns a home; (3-17-22)

b. Is alone for significant parts of the day; (3-17-22)

c. Has no caregiver for extended periods of time; and (3-17-22)

d. Is unable to prepare a meal without assistance. (3-17-22)

10. Homemaker Services. ~~Homemaker services c~~Consist of performing for the participant, or assisting them with, or both, the following tasks: laundry, essential errands, meal preparation, and other routine housekeeping duties if there is no one else in the household capable of performing these tasks. ~~(3-17-22)~~(____)

11. Environmental Accessibility Adaptations. ~~Environmental accessibility adaptations i~~Include minor housing adaptations that are necessary to enable the participant to function with greater independence in the home, or without which, the participant would require institutionalization or have a risk to health, welfare, or safety. Such adaptations may include: ~~(3-17-22)~~(____)

a. The installation of ramps and lifts, widening of doorways, modification of bathroom facilities, or installation of electric and plumbing systems that are necessary to accommodate the medical equipment and supplies necessary for the welfare of the waiver participant, but must exclude those adaptations or improvements to the home that are not of direct medical or remedial benefit to the participant, such as carpeting, roof repair, or central air conditioning. (3-17-22)

b. Unless otherwise authorized by the Department, permanent environmental modifications are limited to a home that is the participant's principal residence and is owned by the participant or the participant's non-paid family. (3-17-22)

c. Portable or non-stationary modifications may be made when such modifications can follow the participant to their next place of residence or be returned to the Department. (3-17-22)

12. Personal Emergency Response System~~ (PERS)~~. ~~PERS is a~~An electronic device that enables a waiver participant to secure help in an emergency. The participant may also wear a portable "help" button to allow for mobility. The system is connected to the participant's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals. This service is limited to participants who: ~~(3-17-22)~~(____)

a. Rent or own a home, or live with unpaid caregivers; (3-17-22)

b. Are alone for significant parts of the day; (3-17-22)

c. Have no caregiver for extended periods~~ of time~~; and ~~(3-17-22)~~( )

d. Would otherwise require extensive, routine supervision. (3-17-22)

13. Respite Care. ~~Respite care i~~Includes short-term breaks from care giving responsibilities to non-paid caregivers. The caregiver or participant is responsible for selecting, training, and directing the provider. While receiving respite care services, the waiver participant cannot receive other services that are duplicative in nature. Respite care services provided under this waiver do not include room and board payments. Respite care services may be provided in the participant's residence, a CFH, a~~ developmental disabilities agency~~ DDA, a RALF, or an adult day health facility. ~~(3-17-22)~~( )

14. Skilled Nursing. ~~Skilled nursing i~~Includes intermittent or continuous oversight, training, or skilled care that is within the scope of the Nurse Practice Act. Such care must be provided by an~~ licensed registered nurse~~ RN, or~~ licensed practical nurse~~ LPN under the supervision of an~~ licensed registered nurse~~ RN, licensed to practice in Idaho. These services are not appropriate if they are less cost~~-~~-effective than a Home Health visit. ~~(3-17-22)~~( )

15. Residential Habilitation. ~~Habilitation services *assist the participant to reside as independently as possible in the community, or maintain family unity.*~~ ~~*(3-17-22)*~~

~~***a.***~~ ~~Residential habilitation. *Residential habilitation s*~~Services consist of an integrated array of individually tailored services and supports furnished to eligible participants. These services and supports are designed to assist the participants to reside successfully in their own homes, with their families~~*, or in* certified family homes~~. The number of residents in a setting will be limited by an amount in the Idaho Medicaid Provider Handbook, unless otherwise authorized by the Department. The services and supports that may be furnished consist of the following: ~~(3-17-22)~~*( )*

~~*i*~~**a.** Self-direction consists of identifying and responding to dangerous or threatening situations, making decisions and choices affecting the individual's life, and initiating changes in living arrangements or life activities; (3-17-22)

~~*ii*~~**b.** Money management consists of training or assistance in handling personal finances, making purchases, and meeting personal financial obligations; (3-17-22)

~~*iii*~~**c.** Daily living skills consist of training in accomplishing routine housekeeping tasks, meal preparation, dressing, personal hygiene, self-administration of medications, and other areas of daily living including proper use of adaptive and assistive devices~~,~~ and appliances, as well as following home safety, first aid, and emergency procedures; ~~(3-17-22)~~( )

~~*iv*~~**d.** Socialization consists of training or assistance in participation in general community activities and establishing relationships with peers with an emphasis on connecting the participant to their community. Socialization training associated with participation in community activities includes assisting the participant to identify activities of interest, working out arrangements to participate in such activities, and identifying specific training activities necessary to assist the participant to continue to participate in such activities on an on-going basis. Socialization training does not include participation in nontherapeutic activities that are merely diversional or recreational in nature; (3-17-22)

~~*v*~~**e.** Mobility consists of training or assistance aimed at enhancing movement within the person's living arrangement, mastering the use of adaptive aids and equipment, accessing and using public transportation, independent travel, or movement within the community;~~ or~~ ~~(3-17-22)~~( )

~~*vi*~~**f.** Behavior shaping and management consist of training and assistance in appropriate expressions of emotions or desires, assertiveness, acquisition of socially appropriate behaviors, or extension of therapeutic services that consist of reinforcing physical, occupational, speech, and other therapeutic programs. (3-17-22)

~~vii~~**g.** Personal assistance services necessary to assist the individual in daily living activities, household tasks, and such other routine activities as the person or the person's primary caregiver(s) ~~are~~ is unable to accomplish on their own behalf. Personal assistance activities include direct assistance with grooming, bathing, and eating, assistance with medications that are ordinarily self-administered, supervision, communication assistance, reporting changes in the waiver participant's condition and needs, household tasks essential to health care at home to include general cleaning of the home, laundry, meal planning and preparation, shopping, and correspondence. ~~(3-17-22)~~(____)

~~*b*~~***16*****.** **Day** ~~*h*~~***H*****abilitation**. ~~*Day habilitation c*~~*C*onsists of assistance with acquisition, retention, or improvement in self-help, socialization, and adaptive skills that take place in a non-residential setting, separate from the home or facility in which the participant resides. Services will normally be furnished four (4) or more hours per day on a regularly scheduled basis, for one (1) or more days per week, unless provided as an adjunct to other day activities included in a participant's plan of care. Day habilitation services will focus on enabling the participant to attain or maintain their maximum functional level and will be coordinated with any physical therapy, occupational therapy, or speech-language pathology services listed in the plan of care. In addition, day habilitation services may serve to reinforce skills or lessons taught in school, therapy, or other settings. ~~(3-17-22)~~*(____)*

1~~*6*~~***7*****.** **Supported Employment**. ~~Supported employment c~~Consists of competitive work in integrated work settings for individuals with the most severe disabilities for whom competitive employment has not traditionally occurred, or for whom competitive employment has been interrupted or intermittent ~~as a result~~ because of a severe disability. Because of the nature and severity of their disability, these individuals need intensive supported employment services or extended services ~~in order~~ to perform such work. ~~(3-17-22)~~(____)

a. Supported employment services rendered under this waiver are not available under a program funded by either the Rehabilitation Act of 1973, as amended, or the Individuals with Disabilities Education Act (IDEA). Documentation must be maintained in the file of each individual receiving this service verifying that the service is not otherwise available or funded under the Rehabilitation Act of 1973, as amended, or the IDEA. (3-17-22)

b. Federal Financial Participation (FFP) cannot be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following: (1) incentive payments made to an employer of waiver participants to encourage or subsidize the employer's participation in a supported employment program, (2) payments that are passed through to beneficiaries of a supported employment program, or (3) payments for vocational training that is not directly related to a waiver participant's supported employment program. ~~(3-17-22)~~(____)

1~~*7*~~***8*****.** **Transition Services**. ~~Transition services i~~Include goods and services that enable a participant residing in a nursing facility, hospital, IMD, or ICF/IID to transition to a community-based setting. A participant is eligible to receive transition services immediately following discharge from a qualified institution after residing within that institution for a minimum of forty-five (45) days. ~~(3-17-22)~~(____)

a. Qualified Institutions include the following: (3-17-22)

i. Skilled, or Intermediate Care Facilities; (3-17-22)

ii. Nursing Facilities; (3-17-22)

iii. ~~Licensed Intermediate Care Facilities for Persons with Intellectual Disabilities (~~ICF/IID~~)~~; ~~(3-17-22)~~(____)

iv. Hospitals; and (3-17-22)

v. Institutions for Mental Diseases (IMDs). (3-17-22)

b. Transition services may include the following goods and services: (3-17-22)

i. Security deposits that are required to obtain a lease on an apartment or home; (3-17-22)

ii. Cost of essential household furnishings, including furniture, window coverings, food preparation items, and bed/bath linens; (3-17-22)

iii. Set-up fees or deposits for utility or service access, including telephone, electricity, heating, and water; (3-17-22)

iv. Services necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy; (3-17-22)

v. Moving expenses; and (3-17-22)

vi. Activities to assess need~~,~~ and arrange for and procure transition services. ~~(3-17-22)~~(____)

c. Excluded goods and services. Transition services do not include ongoing expenses, real property, ongoing utility charges, décor, or diversion/recreational items such as televisions, DVDs, and computers. (3-17-22)

d. ~~Service limitations.~~ Transition services are limited to a total cost of two thousand dollars ($2,000) per participant and can be accessed every two (2) years, contingent upon a qualifying transition from an institutional setting. Transition services are furnished only to the extent that the participant is unable to meet such expense or when the support cannot be obtained from other sources. ~~(3-17-22)~~(____)

(BREAK IN CONTINUITY OF SECTIONS)

328. AGED AND DISABLED WAIVER SERVICES: PROCEDURAL REQUIREMENTS.

01. Role of the Department. The Department~~ or its contractor~~ will provide for the administration of the UAI, and the development of the initial individual service plan.~~ This will be done either by Department staff or a contractor.~~ The Department~~ or its contractor~~ will review and approve all individual service plans, and will authorize Medicaid payment by type, scope, and amount. ~~(3-17-22)~~(____)

a. Services that are not in the individual service plan approved by the Department~~ or its contractor~~ are not eligible for Medicaid payment. ~~(3-17-22)~~(____)

b. Services~~ in excess of~~ more than those in the approved individual service plan are not eligible for Medicaid payment. ~~(3-17-22)~~(____)

c. The earliest date that services may be approved by the Department~~ or its contractor~~ for Medicaid payment is the date that the participant's individual service plan is signed by the participant or their designee. ~~(3-17-22)~~(____)

02. Pre-Authorization Requirements. All waiver services must be pre-authorized by the Department. Authorization will be based on the information from: (3-17-22)

a. The UAI; (3-17-22)

b. The individual service plan developed by the Department~~ or its contractor~~; and ~~(3-17-22)~~(____)

c. Any other medical information that verifies the need for nursing facility services in the absence of the waiver services. (3-17-22)

03. UAI Administration. The UAI will be administered, and the initial individual service plan developed, by the Department~~ or its contractor~~. ~~(3-17-22)~~(____)

04. Individual Service Plan. All waiver services must be authorized by the Department~~ or its~~

~~contractor~~ in the Region where the participant will be residing and services provided based on a documented individual service plan. ~~(3-17-22)~~(____)

a. The initial individual service plan is developed by the Department~~ or its contractor~~, based on the UAI, in conjunction with: ~~(3-17-22)~~(____)

i. The waiver participant, ~~(~~with efforts made by the Department~~ or its contractor~~ to maximize the participant's involvement in the planning process by providing them with information and education regarding their rights~~)~~; ~~(3-17-22)~~(____)

ii. The guardian, when appropriate; (3-17-22)

iii. The supervising nurse or case manager, when appropriate; and (3-17-22)

iv. Others identified by the waiver participant. (3-17-22)

b. The individual service plan must include the following: (3-17-22)

i. The specific type, amount, frequency, and duration of Medicaid-reimbursed waiver services to be provided; (3-17-22)

ii. Supports and service needs that are to be met by the participant's family, friends, neighbors, volunteers, church, and other community services; (3-17-22)

iii. The providers of waiver services when known; (3-17-22)

iv. Documentation that the participant has been given a choice between waiver services and institutional placement; and (3-17-22)

v. The signature of the participant or their legal representative, agreeing to the plan. (3-17-22)

c. The individual service plan must be revised and updated at least annually, based upon treatment results or a change in the participant's needs. (3-17-22)

d. All services reimbursed under the Aged and Disabled Waiver must be authorized by the Department~~ or its contractor~~ prior to the payment of services. ~~(3-17-22)~~(____)

e. The individual service plan, which includes all waiver services, is monitored by the Personal Assistance Agency, participant, family, and the Department~~ or its contractor~~. ~~(3-17-22)~~(____)

05. Service Delivered Following a Documented Plan of Care. All services that are provided must be based on a documented plan of care. (3-17-22)

a. The plan of care is developed by the plan of care team that includes: (3-17-22)

i. The waiver participant with efforts made to maximize their participation on the team by providing them with information and education regarding their rights; (3-17-22)

ii. The guardian when appropriate; (3-17-22)

iii. Service provider identified by the participant or guardian; and (3-17-22)

iv. May include others identified by the waiver participant. (3-17-22)

b. The plan of care must be based on an assessment process approved by the Department. (3-17-22)

c. The plan of care must include the following: (3-17-22)

i. The specific types, amounts, frequency, and duration of Medicaid-reimbursed waiver services to be provided; (3-17-22)

ii. Supports and service needs that are to be met by the participant's family, friends, and other community services; (3-17-22)

iii. The providers of waiver services; (3-17-22)

iv. Goals to be addressed within the plan year; (3-17-22)

v. Activities to promote progress, maintain functional skills, or delay or prevent regression;~~ and~~ ~~(3-17-22)~~(____)

vi. The signature of the participant or their legal representative~~.~~; and ~~(3-17-22)~~(____)

vii. The signature of the agency or provider indicating that they will deliver services according to the authorized service plan and consistent with home and community-based requirements. (3-17-22)

d. The plan must be revised and updated by the plan of care team based upon treatment results or a change in the participant's needs. A new plan must be developed and approved annually. (3-17-22)

e. The Department's Nurse Reviewer monitors the plan of care and all waiver services. (3-17-22)

f. The plan of care may be adjusted during the year with an addendum to the plan. These adjustments must be based on changes in a participant's need or demonstrated outcomes. Additional assessments or information may be clinically necessary. Adjustment of the plan of care is subject to prior authorization by the Department. (3-17-22)

06. Individual Service Plan and Plan of Care. The development and documentation of the individual service plan and plan of care must meet the person-centered planning requirements described in Sections 316 and 317 of these rules. (3-17-22)

07. Provider Records. Records will be maintained on each waiver participant. (3-17-22)

a. Each service provider must document each visit made or service provided to the participant, and will record~~ at a minimum~~ the following~~ information~~: ~~(3-17-22)~~(____)

i. Date and time of visit; (3-17-22)

ii. Services provided during the visit; (3-17-22)

iii. Provider observation of the participant's response to the service if appropriate to the service provided, including any changes in the participant's condition; and (3-17-22)

iv. Length of visit, including time in and time out~~,~~ if appropriate to the service provided. Unless the Department~~ or its contractor~~ determines that the participant is unable to do so, the service delivery will be verified by the participant as evidenced by their signature on the service record. ~~(3-17-22)~~(____)

b. The provider is required to keep the original service delivery record. A copy of the service delivery record will be maintained and available in a format accessible to the participant. Failure to maintain documentation according to these rules will result in the recoupment of funds paid for undocumented services. (3-17-22)

c. The individual service plan initiated by the Department~~ or its contractor~~ must specify which waiver services are required by the participant. The plan will contain all elements required by Subsection 328.04.a. of ~~these~~ this rule~~s~~ and a copy of the most current individual service plan will be maintained in the participant's home and will be available to all service providers and the Department. A copy of the current individual service plan and UAI will

be available from the Department~~ or its contractor~~ to each individual service provider with a release of information signed by the participant or legal representative. ~~(3-17-22)~~(____)

d. Record requirements for participants in RALFs are~~ described in~~ under IDAPA 16.03.22, “Residential Assisted Living Facilities.” ~~(3-17-22)~~(____)

e. Record requirements for participants in CFHs are~~ described in~~ under IDAPA 16.03.19, “Certified Family Homes.” ~~(3-17-22)~~(____)

f. EVV Systems as described in Section 041 of these rules will not take the place of documentation requirements of Subsection 328.07 of this rule, but maybe used to generate documentation retained in the participant’s home. (3-17-22)

08. Provider Responsibility for Notification. The service provider is responsible to notify the Department~~ or its contractor~~, physician or authorized provider, or case manager, and family if applicable, when any significant changes in the participant's condition are noted during service delivery. Such notification will be documented in the service record. ~~(3-17-22)~~(____)

09. Records Retention. Personal Assistance Agencies, and other providers are responsible to retain their records for five (5) years following the date of service. (3-17-22)

10. Requirements for a~~n~~ Fiscal Intermediary (FI). Participants of PCS will have one (1) year from the date that services begin in their geographic region to obtain the services of an FI and become an employee in fact or to use the services of an agency. Provider qualifications are~~ in accordance with~~ under Section 329 of these rules. ~~(3-17-22)~~(____)

~~**11. COVID-19**. The sections of this rule may be subject to amendment by the BLTC for the duration of the COVID-19 state of emergency. Please consult Medicaid Information Release MA20-15 for additional guidance. (3-17-22)~~

329. AGED AND DISABLED WAIVER SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.
Each provider must have a signed provider agreement with the Department for each of the services it provides. (3-17-22)

01. Employment Status. Unless otherwise specified by the Department, each individual service provider must be an employee of record or fact of an agency. The Department may enter into provider agreements with individuals in situations in which no agency exists, or no fiscal intermediary agency is willing to provide services. Such agreements will be reviewed annually to verify whether coverage by a personal assistance agency or fiscal intermediary agency is still not available. (3-17-22)

02. Fiscal Intermediary Services. An agency that has responsibility for the following: (3-17-22)

a. ~~To d~~Directly assure compliance with legal requirements related to employment of waiver service providers; ~~(3-17-22)~~(____)

b. ~~To o~~Offer supportive services to enable participants or their families to perform the required employer tasks themselves; ~~(3-17-22)~~(____)

c. ~~To b~~Bill the Medicaid program for services approved and authorized by the Department; ~~(3-17-22)~~(____)

d. ~~To c~~Collect any participant participation due; ~~(3-17-22)~~(____)

e. ~~To p~~Pay personal assistants and other waiver service providers for service; ~~(3-17-22)~~(____)

f. ~~To p~~Perform all necessary withholding as required by state and federal labor and tax laws, rules, and regulations; ~~(3-17-22)~~(____)

g. ~~To a~~Assure that personal assistants providing services meet the standards and qualifications under in this rule; ~~(3-17-22)~~(____)

h. ~~To m~~Maintain liability insurance coverage; ~~(3-17-22)~~(____)

i. ~~To c~~Conduct, at least annually, participant satisfaction or quality control reviews that are available to the Department and the ~~general~~ public; and ~~(3-17-22)~~(____)

j. ~~To o~~Obtain such ~~criminal~~ background checks and health screens on new and existing employees of record and fact as required. ~~(3-17-22)~~(____)

03. Provider Qualifications. All providers of homemaker services, respite care, adult day health, transportation, chore services, companion services, attendant care, adult residential care, and home-delivered meals must meet, either by formal training or demonstrated competency, the training requirements contained in the provider training matrix and the standards for direct care staff and allowable tasks or activities in the Department's Aged and Disabled waiver as approved by CMS. (3-17-22)

a. A waiver provider cannot be a relative of any participant to whom the provider is supplying services except for extraordinary circumstances as defined by the Department. ~~(3-17-22)~~(____)

b. For the purposes of Section 329 of ~~these~~ this rule~~s~~, a relative is defined as a spouse or parent of a minor child. ~~(3-17-22)~~(____)

c. Individuals who provide direct care or services must ~~satisfactorily~~ complete a ~~criminal history and~~ background check ~~in accordance with~~ and receive a clearance under IDAPA 16.05.06, "Criminal History and Background Checks." ~~(3-17-22)~~(____)

04. Quality Assurance. Providers of Aged and Disabled waiver services are responsible for ensuring that they provide quality services in compliance with applicable rules. (3-17-22)

a. The results of a quality assurance review conducted by the Department must be transmitted to the provider within forty-five (45) days after the review is completed. (3-17-22)

b. The provider must respond to the quality assurance review within forty-five (45) days after the results are received from the Department. If problems are identified, the provider must implement a quality improvement plan and report the results to the Department upon request. (3-17-22)

c. The Department may take enforcement actions as described in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 205, if the provider fails to comply with any term or provision of the provider agreement, or any applicable state or federal regulation. (3-17-22)

05. HCBS Setting Compliance. Providers of Aged and Disabled waiver services are responsible for ensuring that they meet the person-centered planning and setting quality requirements ~~described in~~ under Sections 311 through 318 of these rules, as applicable, and must comply with associated Department quality assurance activities. ~~(3-17-22)~~(____)

06. Specialized Medical Equipment and Supplies. Providers of specialized medical equipment and supplies must be enrolled in the Medicaid program as participating medical vendor providers. Providers must ensure all items meet applicable standards of manufacture, design, and installation. Preference will be given to equipment and supplies that are the most cost-effective option to meet the participant's needs. (3-17-22)

07. Skilled Nursing Service Providers. ~~Skilled nursing service providers m~~Must be licensed in Idaho as an ~~licensed registered nurse~~ RN or ~~licensed practical nurse~~ LPN in good standing, or must be practicing on a federal reservation and be licensed in another state. Skilled nursing providers who provide direct care and services must ~~satisfactorily~~ complete a ~~criminal history and~~ background check ~~in accordance with~~ and receive a clearance under IDAPA 16.05.06, "Criminal History and Background Checks." ~~(3-17-22)~~(____)

08. Consultation Services. Consultation services mMust be provided through a Personal Assistance Agency by a person who has demonstrated skills in training participants/family members in hiring, firing, training, and supervising their own care providers. (3-17-22)(____)

09. Adult Residential Care Providers. Adult residential care providers wWill meet all applicable state laws and regulations. In addition, the provider must ensure that adequate staff are provided to meet the needs of the participants accepted for admission. Adult residential care providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with and receive a clearance appropriate to the setting under IDAPA 16.03.19, "Certified Family Homes," or IDAPA 16.03.22, "Residential Assisted Living Facilities." (3-17-22)(____)

10. Providers of Home-Delivered Meals. Providers of home delivered meals mMust be a public agency or private business, and must exercise supervision to ensure that: (3-17-22)(____)

a. Each meal meets one-third (1/3) of the Recommended Daily Allowance, as defined by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences; (3-17-22)

b. Meals are delivered in accordance with under the service plan, in a sanitary manner, and at the correct temperature for the specific type of food; (3-17-22)(____)

c. Documentation is maintained demonstrating that the meals served are made from the highest USDA grade for each specific food served; (3-17-22)

d. The agency or business is inspected and licensed as a food establishment under IDAPA 16.02.19, "Idaho Food Code"; (3-17-22)

e. A Registered Dietitian documents the review and approval of menus, menu cycles, and any changes or substitutions; and (3-17-22)

f. Either by formal training or demonstrated competency, the training requirements contained in the Idaho provider training matrix and the standards for direct care staff in accordance with under Subsection 329.03 of this rule have been met. (3-17-22)(____)

11. Personal Emergency Response Systems. Personal emergency response system providers mMust demonstrate that the devices installed in a waiver participant's home meet Federal Communications Standards, or Underwriter's Laboratory Standards, or equivalent standards. (3-17-22)(____)

12. Adult Day Health Providers. Providers of adult day health mMust meet the following requirements: (3-17-22)(____)

a. Services provided in a facility must be provided in a facility that meets the building and health standards identified in IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)." (3-17-22)

b. Services provided in a home must be provided in a home that meets the standards of home certification identified in IDAPA 16.03.19, "Certified Family Homes." (3-17-22)

c. Services provided in a RALF must be provided in a facility that meets the standards identified in IDAPA 16.03.22, "Residential Assisted Living Facilities." (3-17-22)

d. Adult day health providers who provide direct care or services must satisfactorily complete a criminal history background check in accordance with and receive a clearance under IDAPA 16.05.06, "Criminal History and Background Checks." (3-17-22)(____)

e. Providers of adult day health must notify the Department on behalf of the participant, if the adult day health is provided in a CFH other than the participant's primary residence. The adult day health provider must provide care and supervision appropriate to the participant's needs as identified on the plan. (3-17-22)

f. Adult day health providers who provide direct care or services must be free from communicable disease. (3-17-22)

g. All providers of adult day health services must meet, either by formal training or demonstrated competency, the training requirements contained in the Idaho provider training matrix and the standards for direct care staff~~ in accordance with~~ under Subsection 329.03 of this rule. ~~(3-17-22)~~(____)

13. Non-Medical Transportation Services. Providers of non-medical transportation services must: (3-17-22)

a. Possess a valid driver's license; (3-17-22)

b. Complete a background check and receive a clearance under IDAPA 16.05.06, "Criminal History and Background Checks." (____)

~~b~~c. Possess valid vehicle insurance; and (3-17-22)

~~c~~d. Meet, either by formal training or demonstrated competency, the training requirements contained in the Idaho provider training matrix and the standards for direct care staff~~ in accordance with~~ under Subsection 329.03 of this rule. ~~(3-17-22)~~(____)

14. Attendant Care Providers. ~~Attendant care providers who p~~Provide direct care and services and must~~ satisfactorily~~ complete a~~ criminal history and~~ background check~~ in accordance with~~ and receive a clearance under IDAPA 16.05.06, "Criminal History and Background Checks." All providers of attendant care must meet, either by formal training or demonstrated competency, the training requirements contained in the Idaho provider training matrix and the standards for direct care staff~~ in accordance with~~ under Subsection 329.03 of this rule. ~~(3-17-22)~~(____)

15. Homemaker Services Providers. ~~The homemaker m~~Must be~~ an~~ employees of record or fact of an agency. Homemaker service providers who provide direct care or services must~~ satisfactorily~~ complete a~~ criminal history and~~ background check~~ in accordance with~~ and receive a clearance under IDAPA 16.05.06, "Criminal History and Background Checks." All~~ providers of~~ homemaker services providers must meet, either by formal training or demonstrated competency, the training requirements contained in the Idaho provider training matrix and the standards for direct care staff~~ in accordance with~~ under Subsection 329.03 of this rule. ~~(3-17-22)~~(____)

16. Environmental Accessibility Adaptations. All services must be provided~~ in accordance with~~ under applicable state or local building codes and meet state or local building, plumbing, and electrical requirements for certification. ~~(3-17-22)~~(____)

17. Residential Habilitation Supported Living. When residential habilitation services are provided by an agency, the agency must be certified by the Department as a residential habilitation agency under IDAPA 16.04.17, "Residential Habilitation Agencies," and supervise the direct services provided. Individuals who provide residential habilitation services in the home of the participant (supported living) must be employed by a residential habilitation agency. Providers of residential habilitation services must meet the following requirements: (3-17-22)

a. ~~Direct service s~~Staff who provide direct care or services must~~ meet the following minimum qualifications~~: ~~(3-17-22)~~(____)

i. Be at least eighteen (18) years of age; (3-17-22)

ii. Be a high school graduate, or have a GED, or demonstrate the ability to provide services according to a plan of service; (3-17-22)

iii. Have current CPR and First Aid certifications; (3-17-22)

iv. Be free from communicable disease; (3-17-22)

v. Each staff person assisting with participant medications must successfully complete and follow the "Assistance with Medications" course available through the Idaho Professional Technical Education Program approved by the Idaho State Board of Nursing or other Department-approved training. (3-17-22)

vi. ~~Residential habilitation service providers who provide direct care or services must satisfactorily c~~Complete a~~ criminal history and~~ background check~~ in accordance with~~ and receive a clearance under IDAPA 16.05.06, "Criminal History and Background Checks;" ~~(3-17-22)~~(   )

vii. Have appropriate certification or licensure if required to perform tasks that require certification or licensure. Direct service staff must also have taken a traumatic brain injury training course approved by the Department. (3-17-22)

b. The provider agency is responsible for providing direct service staff with a traumatic brain injury training course approved by the Department, and training specific to the needs of the participant. (3-17-22)

c. Prior to delivering services to a participant, agency direct service staff must complete an orientation program~~. The orientation program must~~ that includes the following subjects: ~~(3-17-22)~~(   )

i. Purpose and philosophy of services; (3-17-22)

ii. Service rules; (3-17-22)

iii. Policies and procedures; (3-17-22)

iv. Proper conduct in relating to waiver participants; (3-17-22)

v. Handling of confidential and emergency situations that involve the waiver participant; (3-17-22)

vi. Participant rights; (3-17-22)

vii. Methods of supervising participants; (3-17-22)

viii. Working with individuals with traumatic brain injuries; and (3-17-22)

ix. Training specific to the needs of the participant. (3-17-22)

d. Additional training requirements must be completed within six (6) months of employment with the residential habilitation agency and include~~ at a minimum~~: ~~(3-17-22)~~(   )

i. ~~Instructional techniques: ~~Methodologies for training in a systematic and effective manner; ~~(3-17-22)~~(   )

ii. ~~Managing behaviors: ~~Techniques and strategies for teaching adaptive behaviors; ~~(3-17-22)~~(   )

iii. Feeding; (3-17-22)

iv. Communication; (3-17-22)

v. Mobility; (3-17-22)

vi. ~~Activities of daily living~~ADL; ~~(3-17-22)~~(   )

vii. Body mechanics and lifting techniques; (3-17-22)

viii. Housekeeping techniques; and (3-17-22)

ix. Maintenance of a clean, safe, and healthy environment. (3-17-22)

e. The provider agency will be responsible for providing on-going training specific to the needs of the participant as needed. (3-17-22)

18. Day Habilitation Providers. ~~Providers of day habilitation services m~~Must have a minimum of two (2) years of experience working directly with persons with a traumatic brain injury,~~ must~~ provide documentation of standard licensing specific to their discipline, and~~ must~~ have taken a traumatic brain injury course approved by the Department. Day habilitation providers who provide direct care and services must~~ satisfactorily~~ complete a~~ criminal history and~~ background check~~ in accordance with~~ and receive a clearance under IDAPA 16.05.06, "Criminal History and Background Checks." ~~(3-17-22)~~(_____)

19. Respite Care Providers. ~~Providers of respite care services m~~Must meet the following~~ minimum qualifications~~: ~~(3-17-22)~~(_____)

a. Have received care-giving instructions in the needs of the person who will be provided the service; (3-17-22)

b. Demonstrate the ability to provide services according to a plan of service; (3-17-22)

c. Be free of communicable disease; and (3-17-22)

d. Respite care service providers who provide direct care and services must~~ satisfactorily~~ complete a ~~criminal history and~~ background check~~ in accordance with~~ and receive a clearance under IDAPA 16.05.06, "Criminal History and Background Checks." ~~(3-17-22)~~(_____)

20. Supported Employment Services. ~~Supported employment services m~~Must be provided by an agency that supervises the direct service and is accredited by the Commission on Accreditation of Rehabilitation Facilities, other comparable standards, or meet State requirements to be a State-approved provider. Supported employment service providers who provide direct care or services must~~ satisfactorily~~ complete a~~ criminal history and~~ background check~~ in accordance with~~ and receive a clearance under IDAPA 16.05.06, "Criminal History and Background Checks." ~~(3-17-22)~~(_____)

21. Chore Services Providers. ~~Providers of chore services m~~Must meet the following~~ minimum qualifications~~: ~~(3-17-22)~~(_____)

a. Be skilled in the type of service to be provided~~; and~~. ~~(3-17-22)~~(_____)

b. Demonstrate the ability to provide services according to a plan of service. (3-17-22)

c. Chore service providers who provide direct care and services must~~ satisfactorily~~ complete a ~~criminal history and~~ background check~~ in accordance with~~ and receive a clearance under IDAPA 16.05.06, "Criminal History and Background Checks." ~~(3-17-22)~~(_____)

d. Meet, either by formal training or demonstrated competency, the training requirements in the Idaho provider training matrix and the standards for direct care staff~~ in accordance with~~ under Subsection 329.03 of this rule. ~~(3-17-22)~~(_____)

22. Transition Services. Transition managers as described in Section 350.01 of these rules are responsible for administering transition services. (3-17-22)

~~**23. COVID-19**. The sections of this rule may be subject to amendment by the BLTC for the duration of the COVID-19 state of emergency. Please consult Medicaid Information Release MA20-15 for additional guidance. (3-17-22)~~

(BREAK IN CONTINUITY OF SECTIONS)

350. TRANSITION MANAGEMENT.

Transition management provides relocation assistance and intensive service coordination activities to assist nursing facility, hospital, IMD, and ICF/IID residents to transition to community settings of their choice. Transition managers provide oversight and coordination activities for participants during a transitional period up to twelve (12) months following a return to the community. This provider type will function as a liaison between the participant, institutional or facility discharge staff, and other individuals as designated by the participant and the Department to support a successful and sustainable transition to the community. A participant is eligible to receive transition management when planning to discharge from a qualifying institution after residing within that institution for a minimum of forty-five (45) days. (3-17-22)

01. Provider Qualifications. Transition managers must: (3-17-22)

a. ~~Satisfactorily c~~Complete a~~ criminal history and~~ background check~~ in accordance with~~ and receive a clearance under IDAPA 16.05.06, “Criminal History and Background Checks”; ~~(3-17-22)~~( )

b. Have documented successful completion of the Department-approved Transition Manager training prior to providing any transition management and transition services; (3-17-22)

c. Have a Bachelor's Degree in a human services field from a nationally accredited university or college, or three (3) years' supervised work experience with the population being served; and (3-17-22)

d. Be employed with a provider type approved by the Department. (3-17-22)

02. Service Description. Transition management includes the following activities: (3-17-22)

a. A comprehensive assessment of health, social, and housing needs; (3-17-22)

b. Development of housing options with each participant, including assistance with housing choices, applications, waitlist follow-up, roommate selection, and introductory visits; (3-17-22)

c. Assistance with tasks necessary to accomplish a move from the institutional setting; (3-17-22)

d. Securing Transition Services~~ in accordance with~~ under Subsection 326.17 or Subsection 703.15 of these rules~~ in order~~ to make arrangements necessary to move, including: ~~(3-17-22)~~( )

i. Obtaining durable medical equipment, assistive technology, and medical supplies, if needed; (3-17-22)

ii. Arranging for home modifications, if needed; (3-17-22)

iii. Applying for public assistance, if needed; (3-17-22)

iv. Arranging household preparations including scheduling moving and/or cleaning services, utility set-up, purchasing furniture, and household supplies, if needed. (3-17-22)

e. Coordinating with others involved in plan development for the participant to ensure successful transition and establishment in a community setting; (3-17-22)

f. Providing post-transition support, including assistance with problem solving, dependency and isolation concerns, consumer-directed services and supports, post-secondary educational institutions and proprietary schools when applicable, and community inclusion. ~~(3-17-22)~~( )

03. Service Limitations. Transition management is limited to seventy-two (72) hours per participant per qualifying transition. (3-17-22)

~~**04. Temporary Changes to Transition Management Rules During Declared State of Emergency**~~

~~**Related to Novel Coronavirus Disease (COVID-19)**. In response to Idaho's declaration on 3/13/20 of a state of emergency related to COVID-19, the Department reserves the right to temporarily alter requirements and processes related to Transition Management services, currently and through the duration of the emergency state, in order to mitigate spread of disease and to ensure the health and safety of our participants under the guidance and authority of the provisions in a CMS approved 1135 waiver. Guidance for approved flexibilities is posted at https://healthandwelfare.idaho.gov/providers/idaho-medicaid-providers/information-medicaid-providers. (3-17-22)~~

(BREAK IN CONTINUITY OF SECTIONS)

504. -- 50~~6~~5. (RESERVED)

506. ADULT DEVELOPMENTAL DISABILITY SERVICES: ADMINISTRATIVE APPEALS.

01. Appealable Decisions. Applicants to or participants in the Adult DD Services Program may file an administrative appeal if they disagree with a Department decision affecting individual rights, including final decisions made under the following: ( )

a. Program eligibility determinations under these rules; ( )

b. Program assessment results under these rules; ( )

c. Budget assignments under these rules; ( )

d. Exception review decisions under these rules; and ( )

e. Authorization of services, plans of service, or both, under these rules. ( )

02. Appeals Process. Administrative appeal processes are under IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings." ( )

(BREAK IN CONTINUITY OF SECTIONS)

508. ADULT DEVELOPMENTAL DISABILITY SERVICES PRIOR AUTHORIZATION: DEFINITIONS.
~~For the purposes of these rules the following terms are used as defined below. (3-17-22)~~

01. Adult. A person~~ who is~~ eighteen (18) years~~ of age~~ old or older. ~~(3-17-22)~~( )

02. Assessment. A process~~ that is described in~~ under Section 509 of these rules for program eligibility and~~ in~~ Section 512 of these rules for plan of service. ~~(3-17-22)~~( )

03. Clinical Review. A process of professional review that validates the need for continued services. (3-17-22)

04. Community Crisis Support. Intervention for participants who are at risk of losing housing, employment, or income, or who are at risk of incarceration, physical harm, family altercations, or other emergencies. (3-17-22)

05. Concurrent Review. A clinical review to determine the need for continued prior authorization of services. (3-17-22)

06. Department-Approved Assessment Tool. Any standardized assessment tool approved by the Department for use in determining~~ developmental disability~~ DD eligibility, waiver eligibility, skill level to identify

the participant's needs for the plan of service, and for determining the participant's budget. ~~(3-17-22)~~(____)

07. Duplication of Services. When goals are not separate and unique to each service provided, or when more than one (1) service is provided at the same time, unless otherwise authorized. (____)

0~~7~~8. Exception Review. A clinical review of a plan that falls outside the established standards due to a health or safety risk. ~~(3-17-22)~~(____)

09. Health. The prevention of deterioration of one's physical or mental health condition, cognitive functioning, or an increase in maladaptive behavior, and is related to the effects of one's disability. (____)

10. Health Risks. Must be established through written documentation and current treatment recommendations from a licensed practitioner of the healing arts under these rules, or other professional licensed by the State of Idaho whose recommendation is within the scope of their license. Such documentation must establish: (____)

a. The current physical or mental condition, or cognitive functioning that will likely deteriorate, or the current maladaptive behavior(s) that will likely increase; and (____)

b. The specific supports or services being requested, including type and frequency if applicable, that will address the identified need. (____)

c. To comply with the documentation requirement, the Department may require the participant to obtain additional consultation or assessment, available to the participant and covered by Medicaid, from a professional licensed by the State of Idaho acting within the scope of their license. If the Department requires additional consultation or assessment, the Department will specify the nature of the consultation or assessment and the necessary documentation. (____)

~~08~~11. Interdisciplinary Team. ~~For purposes of these rules, the interdisciplinary team is a~~A team of professionals, determined by the Department, that reviews requests for reconsideration. ~~(3-17-22)~~(____)

~~09~~12. Level of Support. An assessment score derived from a Department-approved assessment tool that indicates types and amounts of services and supports necessary to allow the individual to live independently and safely in the community. (3-17-22)

~~10~~13. Person-Centered Planning Process. A meeting facilitated by the participant or plan developer, comprised of family and individuals significant to the participant who collaborate with the participant to develop the plan of service. (3-17-22)

~~11~~14. Person-Centered Planning Team. The group who develops the plan of service. This group includes~~, at a minimum,~~ the participant and the service coordinator or plan developer chosen by the participant. The person-centered planning team may include others identified by the participant or agreed upon by the participant and the Department as important to the process. ~~(3-17-22)~~(____)

~~12~~15. Plan Developer. A paid or non-paid person identified by the participant~~ who is~~ responsible for developing one (1) plan of service and subsequent addenda that cover all services and supports, based on a person-centered planning process. ~~(3-17-22)~~(____)

~~13~~16. Plan Monitor. A person who oversees the provision of services on a paid or non-paid basis. (3-17-22)

~~14~~17. Plan of Service. An initial or annual plan that identifies all services and supports based on a person-centered planning process. Plans are authorized~~ annually~~ every three hundred sixty-five (365) days. ~~(3-17-22)~~(____)

~~15~~18. Prior Authorization (PA). A process for determining a participant's eligibility for services and medical necessity prior to the delivery or payment of services as provided by these rules. (3-17-22)

~~16~~19. **Provider Status Review**. The written documentation that identifies the participant's progress toward goals defined in the plan of service. (3-17-22)

~~17~~20. **Right Care**. Accepted treatment for defined diagnosis, functional needs, and abilities to achieve the desired outcome. The right care is consistent with best practice and continuous quality improvement. (3-17-22)

~~18~~21. **Right Place**. Services delivered in the most integrated setting in which they normally occur, based on the participant's choice to promote independence. (3-17-22)

~~19~~22. **Right Price**. The most integrated and least expensive services that are sufficiently intensive to address the participant's needs. The amount is based on the individual's needs for services and supports as identified in the assessment. (3-17-22)

~~20~~23. **Right Outcomes**. Services based on assessed need that ensure the health and safety of the participant and result in progress, maintenance, or delay or prevention of regression for the participant. (3-17-22)

24. **Safety**. Prevention of criminal activity, destruction of property, or injury or harm to self or others. (   )

25. **Safety Risks**. Must be documented by the following: (   )

a. Current incident reports; (   )

b. Police reports; (   )

c. Assessments from a licensed practitioner of the healing arts under these rules or a professional licensed in Idaho and whose assessment is within the scope of their license; or (   )

d. Status reports and implementation plans that reflect the type and frequency of intervention(s) in place to prevent the risk and the participant's progress under such intervention(s). (   )

e. Such documentation must establish: (   )

i. An imminent or likely safety risk; and (   )

ii. The specific supports or services that are being requested, including the type and frequency if applicable, that are likely to prevent that risk. (   )

~~21~~26. **Service Coordination**. ~~Service coordination is a~~An activity ~~which~~ that assists individuals eligible for Medicaid in gaining and coordinating access to necessary care and services appropriate to the needs of an individual. ~~(3-17-22)~~(   )

~~22~~27. **Service Coordinator**. An individual who provides service coordination to a Medicaid-eligible participant, is employed by a service coordination agency, and meets the training, experience, and other requirements under Sections 729 through 732 of these rules. (3-17-22)

~~23~~28. **Services**. Services paid for by the Department that enable the individual to reside safely and effectively in the community. (3-17-22)

~~24~~29. **Supports**. Formal or informal services and activities, not paid for by the Department, that enable the individual to reside safely and effectively in the setting of their choice. (3-17-22)

(BREAK IN CONTINUITY OF SECTIONS)

511. ADULT DEVELOPMENTAL DISABILITY SERVICES PRIOR AUTHORIZATION: COVERAGE AND LIMITATIONS.
The~~e~~is~~ scope of these~~ rule~~s~~ defines prior authorization for the following Medicaid~~ developmental disability~~ DD services for adults: ~~(3-17-22)~~( )

01. DD Waiver Services. ~~DD Waiver s~~Services~~ as~~ described in Sections 700 through 719 of these rules~~; and~~. ~~(3-17-22)~~( )

02. Developmental Therapy. ~~Developmental t~~Therapy~~ as~~ described in Sections 649 through 657 of these rules and IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)."~~; and~~ ~~(3-17-22)~~( )

03. Service Coordination. Service~~ Coordination~~ for persons with developmental disabilities as described in Sections 720 through 779 of these rules. ~~(3-17-22)~~( )

04. Residential Habilitation - Supported Living. The number of residents in a setting is limited by an amount in the Idaho Medicaid Provider Handbook, unless otherwise authorized by the Department. ( )

(BREAK IN CONTINUITY OF SECTIONS)

513. ADULT DEVELOPMENTAL DISABILITY SERVICES PRIOR AUTHORIZATION: PLAN OF SERVICE.
In collaboration with the participant, the Department will assure that the participant has one (1) plan of service~~. This plan of service~~ that is based on the individualized participant budget referred to in Section 514 of these rules and must identify all services and supports. Participants may develop their own plan or designate a paid or non-paid plan developer. In developing the plan of service, the plan developer and the participant must identify services and supports available outside of Medicaid-funded services that can help the participant meet desired goals. Authorized services must be delivered by providers who are selected by the participant. ~~(3-17-22)~~( )

01. Qualifications of a Paid Plan Developer. Neither a provider of direct service to the participant nor the assessor may be chosen to be the paid plan developer. Family members and all others who wish to be paid for plan development must be employed as a service coordinator as defined in Sections 729 through 732 of these rules. (3-17-22)

02. Plan Development. All participants must direct the development of their service plan through a person-centered planning process. Individuals invited to participate in the person-centered planning process will be identified by the participant and may include family members, guardian, or individuals who are significant to the participant. In developing the plan of service, the plan developer and participant must identify any services and supports available outside of Medicaid-funded services that can help the participant meet desired goals and outcomes. (3-17-22)

a. The plan of service must be submitted within forty-five (45) days prior to the expiration of the existing plan of service unless delayed because of participant unavailability due to extenuating circumstances. If the plan is not submitted within this~~ time~~ period, authorization for provider payments may be terminated. ~~(3-17-22)~~( )

b. The plan development process must meet the person-centered planning requirements described in Section 316 of these rules. (3-17-22)

c. The participant may facilitate their own person-centered planning meeting or designate a paid or non-paid plan developer to facilitate the meeting. Individuals responsible for facilitating the person-centered planning meeting cannot be providers of direct services to the participant. (3-17-22)

03. Prior Authorization Outside of These Rules. The plan developer must ensure that all services that require prior authorization outside of these rules are submitted to the appropriate unit of the Department. These services include: (3-17-22)

a. Durable Medical Equipment (DME); (3-17-22)

b. Transportation; and (3-17-22)

c. Physical therapy, occupational therapy, and speech-language pathology services. (3-17-22)

04. No Duplication of Services. The plan developer will ensure that there is no duplication of services. Duplicate services will not be authorized. (3-17-22)

05. Plan Monitoring. The participant, service coordinator, or plan monitor must monitor the plan. The plan developer is the plan monitor unless there is a service coordinator, in which case the service coordinator assumes the roles of both service coordinator and plan monitor. The planning team must identify the frequency of monitoring, which must be at least every ninety (90) days. Plan monitoring must include the following: (3-17-22)

a. Review of the plan of service in a face-to-face contact with the participant to identify the~~ current~~ status of programs and changes if needed. The face-to-face encounter may occur via synchronous interaction ~~telehealth~~ virtual care, as defined in Title 54, Chapter 57, Idaho Code; ~~(3-17-22)~~(   )

b. Contact with service providers to identify barriers to service provision; (3-17-22)

c. Discuss with participant satisfaction regarding quality and quantity of services; and (3-17-22)

d. Review of provider status reviews. (3-17-22)

e. The provider will immediately report all allegations or suspicions of mistreatment, abuse, neglect, or exploitation,~~ as well as~~ and injuries of unknown origin to the agency administrator, the Department, the adult protection authority, and any other entity identified under Section 39-5303, Idaho Code, or federal law. ~~(3-17-22)~~(   )

06. Provider Status Reviews. Service providers, with exceptions identified in Subsection 513.09 of ~~these~~ this rule~~s~~, must report the participant's progress toward goals to the plan monitor on the provider status review when the plan has been in effect for six (6) months and at the annual person-centered planning meeting. The semi-annual review is due fifteen (15) days *after* the end of the six (6) month period. The annual review is due thirty (30) days *after* plan's end. The semi-annual and annual reviews must include: ~~(3-17-22)~~(   )

a. The status of supports and services to identify progress; (3-17-22)

b. Maintenance; or (3-17-22)

c. Delay or prevention of regression. (3-17-22)

07. Content of the Plan of Service. The plan of service must identify the type of service to be delivered, goals to be addressed within the plan year, frequency of supports and services, and identified service providers. The plan of service must include activities to promote progress, maintain functional skills, or delay or prevent regression. (3-17-22)

a. The written plan of service must meet the person-centered planning requirements described in Section 317 of these rules. (3-17-22)

b. The written plan of service must be finalized and agreed to~~ according to~~ under procedural requirements described in Section 704 of these rules. ~~(3-17-22)~~(   )

c. The Department will distribute a copy of the plan of service to adult DD service providers defined in Section 317 of these rules. Additionally, the plan developer will be responsible to distribute a copy of the plan of service, in whole or part, to any other~~ developmental disability~~ DD service provider identified by the participant during the person-centered planning process. ~~(3-17-22)~~(   )

08. Informed Consent. Unless the participant has a guardian who retains full decision-making authority, the participant must make decisions regarding the type and amount of services required. Prior to plan development, the plan developer must document that they have provided information and support to the participant to maximize their ability to make informed choices regarding the services and supports they receive and from whom. During plan development and amendment, planning team members must each indicate whether they believe the plan meets the needs of the participant and represents the participant's choice. If there is a conflict that cannot be resolved among person-centered planning members or if a member does not believe the plan meets the participant's needs or represents the participant's choice, the plan or amendment may be referred to the Bureau of Developmental Disability Services to negotiate a resolution with members of the planning team. (3-17-22)

09. Provider Implementation Plan. Each provider of Medicaid services must develop an implementation plan that complies with home and community-based setting requirements and identifies specific objectives that relate to goals finalized and agreed to in the participant's authorized plan of service. These objectives must demonstrate how the provider will assist the participant to meet the participant's goals, desired outcomes, and needs identified in the plan of service. (3-17-22)

a. Exceptions. An implementation plan is not required for waiver providers of: (3-17-22)

i. Specialized medical equipment; (3-17-22)

ii. Home-delivered meals; (3-17-22)

iii. Environmental accessibility adaptations; (3-17-22)

iv. Non-medical transportation; (3-17-22)

v. Personal emergency response systems~~ (PERS)~~; ~~(3-17-22)~~(____)

vi. Respite care;~~ and~~ ~~(3-17-22)~~(____)

vii. Chore services~~.~~; ~~(3-17-22)~~(____)

viii. Community crisis support services; and (____)

ix. Adult DD service coordination. (____)

b. Time for Completion. Implementation plans must be completed within fourteen (14) days of receipt of the authorized plan of service or the service start date, whichever is later. (3-17-22)

i. If the authorized plan of service is received after the service start date, service providers must support billing by documenting service provision as agreed to by the participant and consistent with Section 704 of these rules. (3-17-22)

ii. Implementation plan revision must be based on changes to the needs of the participant. (3-17-22)

c. Documentation of Changes. Documentation of Implementation Plan changes will be included in the participant's record~~. This documentation~~, and must include~~, at a minimum,~~ the reason for the change, documentation of coordination with other service providers (where applicable), the date the change was made, and the signature of the person making the change complete with the date and title. ~~(3-17-22)~~(____)

10. H~~ome and~~ C~~ommunity-~~B~~ased~~ S~~ervices~~ Plan of Service Signature. Upon receipt of the authorized plan of service, HCBS providers responsible for the implementation of the plan~~ as identified in~~ under Section 317 of these rules must sign the plan indicating they will deliver services according to the finalized and authorized plan of service, and consistent with home and community-based requirements. Each HCBS provider responsible for the implementation of the plan must maintain their signed plan in the participant's record. Documentation of signature must include the signature of the professional responsible for service provision complete

with their title and the date signed. Provider signature~~ will~~ is to be completed each time an initial or annual plan of service is implemented. ~~(3-17-22)~~(____)

11. Addendum to the Plan of Service. (3-17-22)

a. A plan of service may be adjusted during the year with an addendum to the plan. These adjustments must be based on a change to a cost, addition or increase of a service~~ or increase to a service~~, or a change of provider, addition of a restrictive intervention, or addition of alone time. Additional assessments or information may be clinically necessary. Adjustment of the plan of service is subject to prior authorization by the Department. ~~(3-17-22)~~(____)

b. When a service plan has been adjusted, the Department will distribute a copy of the addendum to HCBS providers responsible for the implementation of the plan of service~~ as identified in~~ under Section 317 of these rules. ~~(3-17-22)~~(____)

c. Upon receipt of the addendum, the HCBS provider must sign the addendum indicating they have reviewed the plan adjustment and will deliver services accordingly. Documentation must include the signature of the professional responsible for service provision complete with their title and the date signed, and must be maintained in the participant's record. Provider signature~~ will~~ is to be completed each time an addendum is authorized. ~~(3-17-22)~~(____)

12. Annual Reauthorization of Services. A participant's plan of service must be reauthorized annually. The Department will review and authorize the new plan of service prior to the expiration of the current plan. (3-17-22)

a. ~~Plan Developer Responsibilities for Annual Reauthorization.~~ A new plan of service must be provided to the Department by the plan developer at least forty-five (45) days prior to the expiration date of the current plan unless delayed because of participant unavailability due to extenuating circumstances. If the plan is not submitted within the period, authorization for provider payments may be terminated. Prior to~~ this~~ submission, the plan developer must: ~~(3-17-22)~~(____)

i. Notify the providers who appear on the plan of service of the annual review date. (3-17-22)

ii. Obtain a copy of the current annual provider status review from each provider for use by the person-centered planning team. Each provider status review must meet the requirements in Subsection 513.06 of th~~ese~~is rule~~s~~. ~~(3-17-22)~~(____)

iii. Convene the person-centered planning team to develop a new plan of service inviting individuals to participate that have been identified by the participant. (3-17-22)

b. ~~Evaluation and Prior Authorization of the Plan of Service.~~ The plan of service will be evaluated and prior authorized~~ in accordance with~~ under the requirements in Sections 507 and 513 of these rules. ~~(3-17-22)~~(____)

c. ~~Adjustments to the Annual Budget and Services.~~ The annual budget and services may be adjusted by the Department based on demonstrated outcomes, progress toward goals and objectives, and benefit of services. ~~(3-17-22)~~(____)

d. ~~Annual Status Reviews Requirement.~~ If the provider's annual status reviews are not submitted to the plan developer with the annual plan, services~~ will~~ may not be authorized at the time of the annual reauthorization. These services may be added to the plan of service only by means of an addendum to the plan~~ in accordance with~~ under Subsection 513.10 of th~~ese~~is rule~~s~~. ~~(3-17-22)~~(____)

e. ~~Reapplication After a Lapse in Service.~~ For participants who are re-applying for service after a lapse in service, the assessor will evaluate whether assessments are current and accurately describe the status of the participant. ~~(3-17-22)~~(____)

f. ~~Annual Assessment Results.~~ An annual assessment will be completed~~ in accordance with~~ under

Section 512 of these rules. ~~(3-17-22)~~(____)

13. ~~**Complaints and Administrative Appeals**~~**Participant Plan of Service Notifications**. The Department will notify each participant whether their plan of service was approved in whole, in part, or denied. The notification will include an individualized explanation of the decision and how the participant may appeal the service plan decision. ~~(3-17-22)~~(____)

~~**a.** Participant complaints about the assessment process, eligibility determination, plan development, quality of service, and other relevant concerns may be referred to the Division of Medicaid. (3-17-22)~~

~~**b.** A participant who disagrees with a Department decision regarding program eligibility and authorization of services under these rules may file an appeal. Administrative appeals are governed by provisions of IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings." (3-17-22)~~

514. ADULT DEVELOPMENTAL DISABILITY SERVICES PRIOR AUTHORIZATION: PROVIDER REIMBURSEMENT.

Providers are reimbursed on a fee-for-service basis based on a participant budget. (3-17-22)

01. Individualized Budget Beginning on October 1, 2006. Beginning October 1, 2006, for DD waiver participants, and beginning January 1, 2007, for all other adult DD participants, the Department sets an individualized budget for each participant according to an individualized measurement of the participant's functional abilities, behavioral limitations, and medical needs related to the participant's disability. Using these specific participant factors, the budget-setting methodology will correlate a participant's characteristics with the participant's individualized budget amount, so participants with higher needs will be assigned a higher individualized budget amount. (3-17-22)

a. The Department notifies each participant of their set budget amount as part of the eligibility determination process or annual redetermination process. The notification will include how the participant may appeal the set budget amount. (3-17-22)

b. Individualized budgets will be re-evaluated annually. At the request of the participant, the Department will also re-evaluate the set budget amount when there are documented changes in the participant's condition resulting in a need for services that meet medical necessity criteria, and this is not reflected on the current inventory of individual needs. (3-17-22)

02. Residential Habilitation - Supported Living Acuity-Based Levels of Support. Reimbursement for residential habilitation - supported living is based on the participant's assessed level of support need. All plans of service that include supported living must include community integration goals that provide for maintained or enhanced independence, quality of life, and self-determination. The number of residents in a setting will be limited by an amount in the Idaho Medicaid Provider Handbook, unless otherwise authorized by the Department. As a participant's independence increases and they are less dependent on supports, they must transition to less intense supports. ~~(3-17-22)~~(____)

a. High support is for those participants who require twenty-four (24) hour per day supports and supervision as determined by a Department-approved assessment tool. High support allows for a blend of one-to-one and group staffing. Participants authorized at the high support daily rate will not be authorized to receive developmental therapy services, adult day care, or non-medical transportation. These services are included in the high support daily rate. (3-17-22)

b. Intense support is for those exceptional participants who require intense, twenty-four (24) hour per day supports and supervision. This support level typically requires one-on-one staffing, but requests for a blend of one-on-one and group staffing will be reviewed on a case-by-case basis. Participants authorized at the intense support daily rate will not be authorized to receive developmental therapy services, adult day care, or non-medical transportation. These services are included in the intense support daily rate. To qualify for this level of support, participants must be evaluated to meet one (1) or more of the following criteria: (3-17-22)

i. Recent felony convictions or charges for offenses related to the serious injury or harm of another

person. These participants must have been placed in a supported living setting directly from incarceration or directly after being diverted from incarceration. (3-17-22)

ii. History of predatory sexual offenses and are at high risk to re-offend based on a sexual offender risk assessment completed by an appropriate professional. (3-17-22)

iii. Documented, sustained history of serious aggressive behavior showing a pattern of causing harm to themselves or others. The serious aggressive behavior must be such that the threat or use of force on another person makes that person reasonably fear bodily harm. The participant must also have the capability to carry out such a threat. The frequency and intensity of this type of aggressive behavior must require continuous monitoring to prevent injury to themselves or others. (3-17-22)

iv. Chronic or acute medical conditions that are so complex or unstable that one-to-one staffing is required to provide frequent interventions and constant monitoring. Without this intervention and monitoring the participant would require placement in a nursing facility, hospital, or ICF/IID with twenty-four (24) hour on-site nursing. Verification of the complex medical condition and the need for this level of service requires medical documentation. (3-17-22)

c. Hourly support is for those individuals ~~that~~ who do not meet criteria for either high or intense supports or those individuals who qualify for a daily rate but whose needs can be met with less than twenty-four (24) hour per day support. The combination of hourly supported living, developmental therapy, community~~-~~-supported employment, and adult day care will not be authorized to exceed the maximum set daily amount established by the Department, except when all of the following ~~conditions~~ are met: ~~(3-17-22)~~(   )

i. The participant is eligible to receive the high support daily rate; (3-17-22)

ii. Community-supported employment is included in the plan and is causing the combination to exceed the daily limit; (3-17-22)

iii. There is documentation that the Person-Centered Planning team has explored other options including using lower-cost services and natural supports; and (3-17-22)

iv. The participant's health and safety needs will be met using hourly services despite having been assessed to qualify for twenty-four (24) hour care. (3-17-22)

515. ADULT DEVELOPMENTAL DISABILITY SERVICES: QUALITY ASSURANCE AND IMPROVEMENT.

01. Quality Assurance. ~~Quality Assurance c~~Consists of audits and reviews to assure compliance with the Department's rules and regulations. If problems are identified during the review or audit, the provider must implement a corrective action plan within forty-five (45) days after the results are received. ~~The Department may take enforcement actions as described in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 205, if the provider fails to comply with the corrective action plan, any term or provision of the provider agreement, or any applicable state or federal regulation.~~ ~~(3-17-22)~~(   )

02. Quality Improvement. The Department may gather and utilize information from providers to evaluate customer satisfaction, participant satisfaction, participant experience related to home and community-based setting qualities, outcomes monitoring, care management, quality assurance, quality improvement activities, and health and safety. These findings may lead to quality improvement activities to improve provider processes and outcomes for participants. (3-17-22)

03. Exception Review. The Department will complete an exception review of plans or addend~~ums~~a requesting services that exceed the assigned budget authorized by the assessor. Requests for these services will be authorized when one (1) of the following ~~conditions are~~ is met: ~~(3-17-22)~~(   )

a. Services are needed to assure the health or safety of participants and the services requested on the plan or addendum are ~~required based on medical necessity as defined in Section 012 of these rules~~ needed to mitigate

a documented health risk or safety risk. ~~(3-17-22)~~(   )

b. Supported employment services as defined in Section 703 of these rules are needed for the participant to obtain or maintain employment. The request must be submitted on the Department-approved Exception Review Form and is reviewed and approved based on the following: (3-17-22)

i. A supported employment service recommendation must be submitted that includes: recommended amount of service, level of support needed, employment goals, and a transition plan. When the participant is transitioned from the Idaho Division of Vocational Rehabilitation (IDVR) services, the recommendation must be completed by IDVR. When a participant is in an established job, the recommendation must be completed by the supported employment agency identified on the plan of service or addendum; (3-17-22)

ii. The participant's plan of service was developed by the participant and their person-centered planning team and includes a goal for supported employment services. Prior to the submission of an exception review with an addendum, a comprehensive review of all services on the participant's plan must occur. The participant's combination of services must support the increase or addition of supported employment services; and (3-17-22)

iii. An acknowledgment signed by the participant and their legal guardian, if one exists, that additional budget dollars approved to purchase supported employment services must not be reallocated to purchase any other Medicaid service. (3-17-22)

04. Concurrent Review. The Department will obtain the necessary information to determine that participants continue to meet eligibility criteria, participant rights are maintained, services continue to be clinically necessary, services continue to be the choice of the participant, services support participant integration, and services constitute appropriate care to warrant continued authorization or need for the service. (3-17-22)

05. Participant Complaints. Participant complaints about program operations, quality of services, or other relevant concerns may be referred to the Division of Medicaid and will be tracked and routed for follow-up as warranted. (   )

0~~5~~6. Abuse, Fraud, or Substandard Care. Reviewers finding suspected abuse, fraud, or substandard care must refer their findings for investigation to the Department and other regulatory or law enforcement agencies for investigation. (3-17-22)

(BREAK IN CONTINUITY OF SECTIONS)

645. HOME AND COMMUNITY-BASED SERVICES (HCBS) STATE PLAN OPTION.

~~Home and community-based services~~HCBS are provided through the HCBS State Plan option as allowed in Section 1915(i) of the Social Security Act for adults with ~~developmental disabilities~~ DD who do not meet the ICF/IID level of care. HCBS ~~s~~State ~~p~~Plan option services must comply with Sections 310 through 319, and Sections 645 through 657 of these rules. ~~Through the duration of the COVID-19 public health emergency, the Department reserves the right to temporarily alter requirements and processes related to the Adult Developmental Disabilities HCBS State Plan Option program to mitigate spread of disease and to ensure the health and safety of our participants under the guidance and authority of the provisions in a CMS approved 1135 waiver or a state plan amendment to the existing Adult Developmental Disabilities HCBS State Plan Option benefit. In the event additional changes are required in the future, guidance will be posted on the Medicaid Information Releases webpage.~~ ~~(3-17-22)~~(   )

(BREAK IN CONTINUITY OF SECTIONS)

648. COMMUNITY CRISIS SUPPORTS COVERAGE AND LIMITATIONS.

Community crisis support may be authorized the following business day after the intervention if there is a documented need for immediate intervention, no other means of support are available, and the services are appropriate to rectify the crisis. Community crisis support is limited to a maximum of twenty (20) hours during any

consecutive five (5) day period. (3-17-22)

01. Emergency Room. Crisis services may be provided in an emergency room during the ER evaluation process if the goal is to prevent hospitalization and return the participant to the community. (3-17-22)

02. Before Plan Development. Community crisis support may be provided before or after the completion of the assessment and plan of service. If community crisis support is provided before the completion of the assessment and plan of service, the plan of service must include an identification of the factors contributing to the crisis and a strategy for addressing those factors in the future. (3-17-22)

03. Crisis Resolution Plan. After community crisis support has been provided, the provider of the community crisis support service must complete a crisis resolution plan and submit it to the Department for approval within ~~seventy-two (72) hours~~ five (5) business days of providing the service. ~~(3-17-22)~~(   )

(BREAK IN CONTINUITY OF SECTIONS)

651. DEVELOPMENTAL THERAPY: COVERAGE REQUIREMENTS AND LIMITATIONS.
Developmental therapy must be recommended by a physician or other practitioner of the healing arts. (3-17-22)

01. Requirements to Deliver Developmental Therapy. Developmental therapy may be delivered in a ~~developmental disabilities agency~~ DDA center-based program, the community, or the home of the participant. Developmental therapy includes individual developmental therapy and group developmental therapy. Developmental therapy must be delivered by Developmental Specialists or paraprofessionals qualified ~~in accordance with~~ under these rules, based on an assessment completed prior to the delivery of developmental therapy. ~~(3-17-22)~~(   )

a. ~~Areas of Service.~~ These services must be directed toward the rehabilitation or habilitation of physical or developmental disabilities in the areas of self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency. ~~(3-17-22)~~(   )

b. ~~Age-Appropriate.~~ Developmental therapy includes instruction in daily living skills the participant has not gained at the normal developmental stages in their life~~,~~ or is not likely to develop without training or therapy. Developmental therapy must be age-appropriate. ~~(3-17-22)~~(   )

c. ~~Tutorial Activities and Educational Tasks are Excluded.~~ Developmental therapy does not include tutorial activities or assistance with educational tasks associated with educational needs that result from the participant's disability. ~~(3-17-22)~~(   )

d. ~~Settings for Developmental Therapy.~~ Developmental Therapy may be provided in home and community-based settings as described in Section 312 of these rules. Developmental therapy, in both individual and group formats, must be available in both community-based and home-based settings, and be based on participant needs, interests, or choices. ~~(3-17-22)~~(   )

e. ~~Staff-to-Participant Ratio.~~ When group developmental therapy is center-based, there must be a minimum of one (1) qualified staff~~,~~ who may be a paraprofessional or a Developmental Specialist~~,~~ providing direct services for every twelve (12) participants. The community-based services must occur in integrated, inclusive settings and with no more than three (3) participants per qualified staff at each session. Additional staff must be added, as necessary, to meet the needs of each individual served. ~~(3-17-22)~~(   )

02. Excluded Services. The following services are excluded for Medicaid payments: (3-17-22)

a. Vocational services; (3-17-22)

b. Educational services; and (3-17-22)

c. Recreational services. (3-17-22)

03. Limitations on Developmental Therapy. Developmental therapy may not exceed the limitations as~~ follows~~ specified below:~~ only one (1) type of therapy will be reimbursed during a single time period by the Medicaid program. Developmental therapy will not be reimbursed during periods when the participant is being transported to and from the agency.~~ ~~(3-17-22)~~(____)

a. Developmental therapy must not exceed twenty-two (22) hours per week. (____)

b. Developmental therapy provided in combination with supported employment services under these rules must not exceed forty (40) hours per week. (____)

c. When a participant receives adult day health as provided in these rules, the combination of adult day health and developmental therapy must not exceed thirty (30) hours per week. (____)

d. Only one (1) type of therapy will be reimbursed during a single period by the Medicaid program. Developmental therapy will not be reimbursed during periods when the participant is being transported to and from the agency. (____)

(BREAK IN CONTINUITY OF SECTIONS)

655. DEVELOPMENTAL THERAPY: PROVIDER QUALIFICATIONS AND DUTIES.

01. Developmental Specialist for Adults. To be qualified as a Developmental Specialist for adults, a person must have a minimum of two hundred forty (240) hours of professionally supervised experience with individuals who have developmental disabilities and either: (3-17-22)

a. Possess a bachelor's or master's degree in special education, early childhood special education, speech and language pathology, applied behavioral analysis, psychology, physical therapy, occupational therapy, social work, or therapeutic recreation; or (3-17-22)

b. Possess a bachelor's or master's degree in an area not listed~~ above~~ in Subsection 65~~7~~5.0~~5~~1.a. of this rule and have: ~~(3-17-22)~~(____)

i. Completed a competency course jointly approved by the Department and the Idaho Association of Developmental Disabilities Agencies that relates to the job requirements of a Developmental Specialist; and (3-17-22)

ii. Passed a competency examination approved by the Department. (3-17-22)

c. Any person employed as a Developmental Specialist in Idaho prior to May 30, 1997, unless previously disallowed by the Department, will be allowed to continue providing services as a Developmental Specialist as long as there is not a gap of more than three (3) years of employment as a Developmental Specialist. (3-17-22)

~~**d.** Through the duration of the COVID-19 public health emergency, Development Specialists for adults may begin rendering services prior to completing the training requirements provided that they complete the training requirements within thirty (30) days of first rendering services, advise the participant or legal guardian that the individual has not yet completed the applicable trainings, and comply with any other requirements specified by the Department in a COVID-19 information release posted on the Department's website at https://healthandwelfare.idaho.gov/Providers/Providers-Medicaid/InformationReleases/tabid/264/Default.aspx. (3-17-22)~~

02. Developmental Therapy Paraprofessionals. Paraprofessionals, such as aides or therapy technicians, may be used by an agency to provide developmental therapy if they are under the supervision of a Developmental Specialist. A developmental therapy paraprofessional must be at least seventeen (17) years~~ of age~~ old. ~~(3-17-22)~~(____)

03. Requirements for Collaboration with Other Providers. When participants are receiving rehabilitative or habilitative services from other providers, each DDA must coordinate each participant's DDA program with these providers to maximize skill acquisition and generalization of skills across environments, and to avoid duplication of services. The DDA must maintain documentation of this collaboration~~. This documentation~~ that includes other plans of services such as the Individual Education Plan (IEP), Personal Care Services (PCS) plan, Residential Habilitation plan, and the outpatient behavioral health service plan. The participant's file must also reflect how these plans have been integrated into the DDA's plan of service for each participant. ~~(3-17-22)~~(   )

(BREAK IN CONTINUITY OF SECTIONS)

~~**658. COVID-19 PUBLIC HEALTH EMERGENCY RESIDENTIAL HABILITATION.**~~
~~Through the duration of the COVID-19 public health emergency, the Department will pay for residential habilitation services, as described in Subsection 703.01 of these rules, provided by facilities that have entered into a provider agreement with the Department and are certified as developmental disabilities agencies by the Department. Prior to receiving residential habilitation services from a DDA, an individual must be determined by the Department, or its contractor, to have a developmental disability under Sections 500 through 506 of these rules and Section 66-402, Idaho Code, be eighteen (18) years of age or older, and live in the community. DDA's providing residential habilitation services must comply with any additional requirements specified by the Department in a COVID-19 information release posted on the Department's website at https://healthandwelfare.idaho.gov/Providers/Providers-Medicaid/InformationReleases/tabid/264/Default.aspx. (3-17-22)~~

65~~9~~8. -- 699. (RESERVED)

ADULTS WITH DEVELOPMENTAL DISABILITIES WAIVER SERVICES
(Sections 700-719)

700. ADULTS WITH D~~EVELOPMENTAL~~ D~~ISABILITIES~~ WAIVER SERVICES.
Under 42 CFR Section 440.180, it is the intention of the Department to provide waiver services to eligible adult participants to prevent unnecessary institutional placement, provide for the greatest degree of independence possible, enhance the quality of life, encourage individual choice, and achieve and maintain community integration. For an adult participant to be eligible, the Department must find that the participant requires services due to a developmental disability that impairs their mental or physical function or independence, is capable of being maintained safely and effectively in a non-institutional setting, and would, in the absence of such services, need to reside in an ICF/IID. ~~Through the duration of the COVID-19 public health emergency, the Department reserves the right to temporarily alter requirements and processes related to the Adult DD waiver program to mitigate spread of disease and to ensure the health and safety of our participants under the guidance and authority of the provisions in a CMS approved 1135 waiver or HCBS Attachment K amendment to the existing Adult Developmental Disability waiver. In the event additional changes are required in the future, guidance will be posted on the Medicaid Information Releases webpage.~~ ~~(3-17-22)~~(   )

701. (RESERVED)

702. ADULT DD WAIVER SERVICES: ELIGIBILITY.
Waiver eligibility will be determined by the Department as described in Section 509 of these rules. The participant must be financially eligible for Medical Assistance ~~as described in~~ under IDAPA 16.03.05, "Eligibility for Aid for the Aged, Blind, and Disabled (AABD)," Section 787. The cited chapter implements ~~and is in accordance with~~ the Financial Eligibility Section of the Idaho State Plan. In addition, waiver participants must meet the following ~~requirements~~: ~~(3-17-22)~~(   )

01. Age of Participants. DD waiver participants must be eighteen (18) years ~~of age~~ old or older. ~~(3-17-22)~~(   )

02. Eligibility Determinations. The Department must determine that: (3-17-22)

a. The participant would qualify for ICF/IID level of care~~ as set forth in~~ under Section 584 of these rules, if the waiver services listed in Section 703 of these rules were not made available; and ~~(3-17-22)~~(   )

b. The participant could be safely and effectively maintained in the requested or chosen community residence with appropriate waiver services. This determination must: (1) be made by a team of individuals with input from the person-centered planning team~~;~~, and (2) prior to any denial of services on this basis, be determined by the plan developer that services to correct the concerns of the team are not available. ~~(3-17-22)~~(   )

c. The average annual cost of waiver services and other medical services to the participant would not exceed the average annual cost to Medicaid~~ of~~ for ICF/IID care and other medical costs. ~~(3-17-22)~~(   )

03. H~~ome and~~ C~~ommunity-~~B~~ased~~ S~~ervices~~ Waiver~~-~~-Eligible Participants. A participant who is determined by the Department to be eligible for services under the H~~ome and~~ C~~ommunity-~~B~~ased~~ S~~ervices~~ ~~W~~waivers for DD may elect not to utilize waiver services but may choose admission to an ICF/IID. ~~(3-17-22)~~(   )

04. Processing Applications. The participant's self-reliance staff will process the application~~ in accordance with~~ under IDAPA 16.03.05, "Eligibility for Aid to the Aged, Blind, and Disabled (AABD)," as if the application was for admission to an ICF/IID, except that the self-reliance staff will forward potentially eligible applications immediately to the Department for review. The Medicaid application process cited above conforms to all statutory and regulatory requirements relating to the Medicaid application process. ~~(3-17-22)~~(   )

05. Transmitted Decisions to Self-Reliance Staff. The decisions of the Department regarding the acceptance of the participants into the waiver program will be transmitted to the self-reliance staff. (3-17-22)

06. Case Redetermination. (3-17-22)

a. Financial redetermination will be conducted~~ pursuant to~~ under IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children," and IDAPA 16.03.05, "Eligibility for Aid to the Aged, Blind, and Disabled (AABD)." Medical redetermination will be made at least annually or sooner by the Department~~, or sooner~~ at the request of the participant, the self-reliance staff, provider agency, or physician. The~~ sections~~ chapters cited implement~~ and are in accordance with~~ Idaho's approved State Plan~~ with the exception of~~ except for deeming of income provisions. ~~(3-17-22)~~(   )

b. The redetermination process will assess the following factors: (3-17-22)

i. The participant's continued need and eligibility for waiver services; and (3-17-22)

ii. Discharge from the waiver services program. (3-17-22)

07. Participant Eligibility Notifications. The Department will notify each participant of their eligibility decision as part of the initial eligibility determination, annual redetermination, or other reassessment process. The notification includes an individualized explanation of the decision and how the participant may appeal the eligibility decision. (   )

07. H~~ome and~~ C~~ommunity-~~B~~ased~~S Waiver Participant Limitations. The number of Medicaid participants to receive waiver services under the~~ home and community-based~~ HCBS waiver for~~ developmentally disabled~~ DD participants will be limited to the projected number of users contained in the Department's approved waiver. Individuals who apply for waiver services after the waiver maximum has been reached will be placed on a waiting list and will have their applications processed after September 30th for the DD waiver of each new waiver year. ~~(3-17-22)~~(   )

(BREAK IN CONTINUITY OF SECTIONS)

704. ADULT DD WAIVER SERVICES: PROCEDURAL REQUIREMENTS.

01. Authorization of Services on a Written Plan. All waiver services must be identified on the plan of service and authorized by the process~~ described in~~ under Sections 507 through 520 of these rules. The plan of service must be reviewed by a plan monitor or targeted service coordinator at a frequency determined by the person-centered planning team, but at least every ninety (90) days. ~~(3-17-22)~~(____)

02. Provider Records.~~ Three (3) types of record~~ The following information will be maintained on all participants receiving waiver services: ~~(3-17-22)~~(____)

a. Direct ~~S~~service ~~P~~provider ~~I~~information that includes written documentation of each visit made or service provided to the participant, and will record~~ at a minimum~~ the following information: ~~(3-17-22)~~(____)

i. Date and time of visit;~~ and~~ ~~(3-17-22)~~(____)

ii. Services provided during the visit;~~ and~~ ~~(3-17-22)~~(____)

iii. A statement of the participant's response to the service, if appropriate to the service provided, including any changes in the participant's condition; and (3-17-22)

iv. Length of visit, including time in and time out, if appropriate to the service provided. Unless the participant is determined by the Service Coordinator to be unable to do so, the delivery will be verified by the participant as evidenced by their signature on the service record. (3-17-22)

v. A copy of the above information will be maintained in the participant's home unless authorized to be kept elsewhere by the Department. Failure to maintain such documentation will result in the recoupment of funds paid for undocumented services. (3-17-22)

b. The plan of service developed by the plan developer and the person-centered planning team must specify which services are required by the participant. The plan of service must contain all elements required by Subsection 704.01 of this rule and a copy of the most current plan of service must be maintained in the participant's home and must be available to all service providers and the Department. (3-17-22)

c. The provider implementation plan if required by these rules. (____)

~~c~~d. In addition to the plan of service, all providers~~, with the exception of chore, non-medical transportation, and enrolled Medicaid vendors,~~ that are required to develop an implementation plan must submit a provider status review six (6) months after the start date of the plan of service and annually to the plan monitor as described in Sections 507 through 520 of these rules. ~~(3-17-22)~~(____)

03. Provider Responsibility for Notification. ~~It is the responsibility of t~~The service provider is responsible to notify the service coordinator or plan developer when any significant changes in the participant's condition are noted during service delivery. Such notification will be documented in the service record. ~~(3-17-22)~~(____)

04. Records Maintenance. ~~In order t~~To provide continuity of services, when a participant changes service providers, plan developers, or service coordinators, all of the foregoing participant records will be delivered to and held by the Department until a replacement service provider, plan developer, or service coordinator is selected by the participant. When a participant leaves the waiver services program, the records will be retained by the Department as part of the participant's closed case record. Provider agencies will be responsible to retain their participant's records for five (5) years following the date of service. ~~(3-17-22)~~(____)

705. ADULT DD WAIVER SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.
All providers of waiver services must have a valid provider agreement with the Department. Performance under this agreement will be monitored by the Department. (3-17-22)

01. Residential Habilitation -- Supported Living. When residential habilitation services are provided by an agency, the agency must be certified by the Department as a Residential Habilitation Agency under IDAPA 16.04.17, "Residential Habilitation Agencies," and must supervise the direct services provided. Individuals who

provide residential habilitation services in the home of the participant (supported living) must be employed by a Residential Habilitation Agency. Providers of residential habilitation services must meet the following requirements: (3-17-22)

a. Direct service staff must meet the following ~~minimum qualifications~~: ~~(3-17-22)~~(   )

i. Be at least eighteen (18) years ~~of age~~ old; ~~(3-17-22)~~(   )

ii. Be a high school graduate, ~~or~~ have a GED, or demonstrate the ability to provide services according to a plan of service; ~~(3-17-22)~~(   )

iii. Have current CPR and First Aid certifications; (3-17-22)

iv. Be free from communicable disease; (3-17-22)

v. If transporting participants, have a valid driver's license and vehicle insurance; (   )

vi. Each staff person assisting with participant medications has ~~successfully completed~~ passed the "Assistance with Medications" course available through the Idaho ~~Professional~~ Division of Career-Technical Education ~~Program approved by the Idaho State Board of Nursing~~ or other Department-approved training. ~~(3-17-22)~~(   )

vii. Residential habilitation service providers who provide direct care or services ~~satisfactorily~~ complete~~d~~ a ~~criminal~~ background check ~~in accordance with~~ and receive a clearance under Section 009 of these rules and IDAPA 16.05.06, "Criminal History and Background Checks." ~~(3-17-22)~~(   )

viii. Have appropriate certification or licensure if required to perform tasks that require certification or licensure. (3-17-22)

b. All skill training for agency direct service staff must be provided by a Qualified Intellectual Disabilities Professional (QIDP) who has demonstrated experience in writing skill training programs. (3-17-22)

c. Prior to delivering services to a participant, agency direct service staff must complete an orientation program~~. The orientation program must~~ that includes the following ~~subjects~~: ~~(3-17-22)~~(   )

i. Purpose and philosophy of services; (3-17-22)

ii. Service rules; (3-17-22)

iii. Policies and procedures; (3-17-22)

iv. Proper conduct in relating to waiver participants; (3-17-22)

v. Handling of confidential and emergency situations that involve the waiver participant; (3-17-22)

vi. Participant rights; (3-17-22)

vii. Methods of supervising participants; (3-17-22)

viii. Working with individuals with developmental disabilities; and (3-17-22)

ix. Training specific to the needs of the participant. (3-17-22)

d. Additional training requirements must be completed within six (6) months of employment with the residential habilitation agency and include ~~at a minimum~~: ~~(3-17-22)~~(   )

i. ~~Instructional techniques:~~ Methodologies for training in a systematic and effective manner;

~~(3-17-22)~~( )

ii. ~~Managing behaviors:~~ Techniques and strategies for teaching adaptive behaviors; ~~(3-17-22)~~( )

iii. Feeding; (3-17-22)

iv. Communication; (3-17-22)

v. Mobility; (3-17-22)

vi. Activities of daily living; (3-17-22)

vii. Body mechanics and lifting techniques; (3-17-22)

viii. Housekeeping techniques; and (3-17-22)

ix. Maintenance of a clean, safe, and healthy environment. (3-17-22)

e. The provider agency will be responsible for providing ongoing training specific to the needs of the participant as needed. (3-17-22)

~~**f.** Through the duration of the COVID-19 public health emergency, agency direct service staff may begin rendering services prior to completing the training requirements, provided that they complete the training requirements within thirty (30) days of first rendering services, advise the participant or legal guardian that the individual has not yet completed the applicable trainings, and comply with any other requirements specified by the Department in a COVID-19 information release posted on the Department's website at https://healthandwelfare.idaho.gov/Providers/Providers-Medicaid/InformationReleases/tabid/264/Default.aspx. (3-17-22)~~

02. Residential Habilitation -- ~~Certified Family Home (~~CFH~~)~~. ~~(3-17-22)~~( )

a. An individual who provides direct residential habilitation services in their own home must be certified ~~by the Department~~ to operate a ~~certified family home~~ CFH under IDAPA 16.03.19, "Certified Family Homes," and ~~must~~ receive residential habilitation program coordination services provided through the Department~~, or its contractor,~~ for the residential habilitation services they provide. ~~(3-17-22)~~( )

b. CFH providers providing residential habilitation services as a DD Waiver provider must meet the following ~~minimum qualifications~~: ~~(3-17-22)~~( )

i. Be at least eighteen (18) years ~~of age~~ old; ~~(3-17-22)~~( )

ii. Be a high school graduate, have a GED, or demonstrate the ability to provide services according to a plan of service; (3-17-22)

iii. Have current CPR and First Aid certifications; (3-17-22)

iv. Be free from communicable disease; (3-17-22)

v. If transporting participants, have a valid driver's license and vehicle insurance; ( )

vi. Each CFH provider of residential habilitation services assisting with participant medications has ~~successfully completed the "Assistance with Medications" course available through the Idaho Professional Technical Education Program approved by the Idaho State Board of Nursing, or other Department-approved training~~ met the requirements of IDAPA 16.03.19, "Certified Family Homes. ~~(3-17-22)~~( )

vii. CFH providers of residential habilitation services who provide direct care and services ~~have satisfactorily~~ must complete~~d~~ a ~~criminal history~~ background check ~~in accordance with~~ and receive a clearance under Section 009 of these rules and IDAPA 16.05.06, "Criminal History and Background Checks;" and ~~(3-17-22)~~( )

viii. Have appropriate certification or licensure if required to perform tasks that require certification or licensure. (3-17-22)

c. All skill training for CFH providers who are providing residential habilitation services must be provided through the Department ~~or its contractor~~ by qualified intellectual disabilities professional (QIDP) who has demonstrated experience in writing skill training programs. ~~(3-17-22)~~(____)

d. Prior to delivering residential habilitation services to a participant, the CFH provider must complete an orientation training in the following areas as provided by ~~either~~ the Department~~, or its contractor or both, and include the following areas~~: ~~(3-17-22)~~(____)

i. Purpose and philosophy of services; (3-17-22)

ii. Service rules; (3-17-22)

iii. Policies and procedures; (3-17-22)

iv. Proper conduct in relating to waiver participants; (3-17-22)

v. Handling of confidential and emergency situation that involve the waiver participant; (3-17-22)

vi. Participant rights; (3-17-22)

vii. Methods of supervising participants; (3-17-22)

viii. Working with individuals with developmental disabilities; and (3-17-22)

ix. Training specific to the needs of the participant. (3-17-22)

e. Additional training requirements for CFH providers providing residential habilitation waiver services must be completed by the CFH provider within six (6) months of certification date and include ~~a minimum of~~ the following: ~~(3-17-22)~~(____)

i. ~~Instructional Techniques:~~ Methodologies for training in a systematic and effective manner; ~~(3-17-22)~~(____)

ii. ~~Managing behaviors: t~~Techniques and strategies for teaching adaptive behaviors; ~~(3-17-22)~~(____)

iii. Feeding; (3-17-22)

iv. Communication; (3-17-22)

v. Mobility; (3-17-22)

vi. Activities of daily living; (3-17-22)

vii. Body mechanics and lifting techniques; (3-17-22)

viii. Housekeeping techniques; and (3-17-22)

ix. Maintenance of a clean, safe, and healthy environment. (3-17-22)

f. The Department ~~or its contractor~~ will be responsible for providing on-going training to the CFH provider of residential habilitation specific to the needs of the participant as needed. ~~(3-17-22)~~(____)

~~**g.**~~ ~~Through the duration of the COVID-19 public health emergency, CFH providers may begin~~

rendering services prior to completing the training requirements, provided that they complete the training requirements within thirty (30) days of first rendering services, advise the participant or legal guardian that the individual has not yet completed the applicable trainings, and comply with any other requirements specified by the Department in a COVID-19 information release posted on the Department's website at https://healthandwelfare.idaho.gov/Providers/Providers-Medicaid/InformationReleases/tabid/264/Default.aspx. (3-17-22)

03. Chore Services. Providers. of chore services mMust meet the following minimum qualifications: (3-17-22)( )

a. Be skilled in the type of service to be provided; and (3-17-22)

b. Demonstrate the ability to provide services according to a plan of service. (3-17-22)

c. Chore service providers who provide direct care and services have satisfactorily must completed a criminal history and background check in accordance with and receive a clearance under Section 009 of these rules and IDAPA 16.05.06, "Criminal History and Background Checks." (3-17-22)( )

04. Respite Care. Providers. of respite care services mMust meet the following minimum qualifications: (3-17-22)( )

a. Have received care giving instructions in the needs of the person who will be provided receive the service; (3-17-22)( )

b. Demonstrate the ability to provide services according to a plan of service; (3-17-22)

c. Be free of communicable disease; and (3-17-22)

d. Respite care service providers who provide direct care and services have satisfactorily must completed a criminal history and background check in accordance with and receive a clearance under Section 009 of these rules and IDAPA 16.05.06, "Criminal History and Background Checks." (3-17-22)( )

05. Supported Employment. Supported employment s**Services**. mMust be provided by an agency that supervises the direct service and is accredited by the Commission on Accreditation of Rehabilitation Facilities or other comparable standards, or meets State requirements to be a State-approved provider. Supported employment service providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with and receive a clearance under Section 009 of these rules and IDAPA 16.05.06, "Criminal History and Background Checks." (3-17-22)( )

06. Non-Medical Transportation. Providers. of non-medical transportation services mMust: (3-17-22)( )

a. Possess a valid driver's license; and vehicle insurance. (3-17-22)( )

b. Possess valid vehicle insurance. (3-17-22)

b. Complete a background check and receive a clearance under Section 009 of these rules and IDAPA 16.05.06, "Criminal History and Background Checks." ( )

07. Environmental Accessibility Adaptations. All services must be provided in accordance with under applicable state or local building codes and meet state or local building, plumbing, and electrical requirements for certification. (3-17-22)( )

08. Specialized Medical Equipment and Supplies. Providers. of specialized medical equipment and supplies mMust be enrolled in the Medicaid program as participating medical vendor providers. Providers must ensure all items meet applicable standards of manufacture, design, and installation. Preference will be given to equipment and supplies that are the most cost-effective option to meet the participant's needs. (3-17-22)( )

09. Personal Emergency Response System~~.~~ ~~Personal emergency response system p~~**Providers**. ~~m~~Must demonstrate that the devices installed in a waiver participant's home meet Federal Communications Standards, or Underwriter's Laboratory standards, or equivalent standards. ~~(3-17-22)~~(   )

10. Home~~-~~-**Delivered Meal**~~s.~~ **Providers**. ~~of home-delivered meals m~~Must be a public agency or private business~~,~~ and ~~must~~ exercise supervision to ensure that: ~~(3-17-22)~~(   )

a. Each meal meets one-third (1/3) of the Recommended Daily Allowance, as defined by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences; (3-17-22)

b. Meals are delivered ~~in accordance with~~ under the service plan, in a sanitary manner, and at the correct temperature for the specific type of food; ~~(3-17-22)~~(   )

c. A Registered Dietitian documents the review and approval of menus, menu cycles, and any changes or substitutions; and (3-17-22)

d. The agency or business is inspected and licensed as a food establishment under IDAPA 16.02.19, "Idaho Food Code." (3-17-22)

11. Skilled Nursing~~.~~ ~~Skilled nursing service p~~**Providers**. ~~m~~Must be licensed in Idaho as an ~~licensed registered nurse~~ RN or ~~licensed practical nurse~~ LPN in good standing~~,~~ or ~~must~~ be practicing on a federal reservation and be licensed in another state. Skilled nursing providers who provide direct care and services must ~~satisfactorily~~ complete a ~~criminal history and~~ background check ~~in accordance with~~ and receive a clearance under Section 009 of these rules and IDAPA 16.05.06, "Criminal History and Background Checks." ~~(3-17-22)~~(   )

12. Behavior Consultation or Crisis Management~~.~~ ~~Behavior Consultation or Crisis Management~~ **Providers**. ~~m~~Must meet the following: ~~(3-17-22)~~(   )

a. Work under the direct supervision of a licensed psychologist or Ph~~.~~D~~.~~ in Special Education~~,~~ with training and experience in treating severe behavior problems and ~~training and experience~~ in applied behavior analysis; and ~~(3-17-22)~~(   )

b. Have a Master's Degree in a behavioral science such as social work, psychology, psychosocial rehabilitation counseling, psychiatric nursing, special education, or a closely related course of study; or (3-17-22)

c. Be a licensed pharmacist; or (3-17-22)

d. Be a Qualified Intellectual Disabilities Professional (QIDP). (3-17-22)

e. Emergency back-up providers must meet the ~~minimum~~ residential habilitation provider qualifications ~~described~~ under IDAPA 16.04.17, "Residential Habilitation Agencies." ~~(3-17-22)~~(   )

f. Behavior consultation or crisis management providers who provide direct care or services must ~~satisfactorily~~ complete a ~~criminal history and~~ background check ~~in accordance with~~ and receive a clearance under Section 009 of these rules and IDAPA 16.05.06, "Criminal History and Background Checks." ~~(3-17-22)~~(   )

13. Adult Day Health~~.~~ **Providers**. ~~of adult day health m~~Must meet the following requirements: ~~(3-17-22)~~(   )

a. Services provided in a facility must be provided in a facility that meets the building and health standards ~~identified in~~ under IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)"; ~~(3-17-22)~~(   )

b. Services provided in a home must be provided in a home that meets the standards ~~of home certification identified in~~ under IDAPA 16.03.19, "Certified Family Homes"; ~~(3-17-22)~~(   )

c. Adult day health providers who provide direct care or services must ~~satisfactorily~~ complete a ~~criminal history~~ background check ~~in accordance with~~ and receive a clearance under Section 009 of these rules and

IDAPA 16.05.06, "Criminal History and Background Checks"; ~~(3-17-22)~~( )

d. ~~Providers of a~~Adult day health providers must notify the Department on behalf of the participant, if the adult day health is provided in a ~~certified family home~~ CFH other than the participant's primary residence. The adult day health provider must provide care and supervision appropriate to the participant's needs as identified on the plan. ~~(3-17-22)~~( )

e. Adult day health providers who provide direct care or services must be free from communicable disease. (3-17-22)

14. Service Supervision. The plan of service that includes all waiver services is monitored by the plan monitor or targeted service coordinator. (3-17-22)

15. Transition Services. Transition managers as described in Subsection 350.01 of these rules are responsible for administering transition services. ~~(3-17-22)~~( )

(BREAK IN CONTINUITY OF SECTIONS)

727. SERVICE COORDINATION: COVERAGE AND LIMITATIONS.

Service coordination consists of services provided to assist individuals in gaining access to needed services~~. Service coordination~~, and includes the following~~ activities described in Subsections 727.01 through 727.10 of this rule~~. ~~(3-17-22)~~( )

01. Plan Assessment and Periodic Reassessment. Activities that are required to determine the participant's needs by development of a plan assessment and periodic reassessment as described in Section 730 of these rules. These activities include: (3-17-22)

a. Taking a participant's history; (3-17-22)

b. Identifying the participant's needs and completing related documentation; and (3-17-22)

c. Gathering information from other sources such as family members, medical providers, social workers, and educators to form a complete assessment of the participant. (3-17-22)

02. Development of the Plan. Development and revision of a specific plan, described in Section 731 of these rules that includes information collected through the assessment and specifies goals and actions needed by the participant. The plan must be updated at least annually~~ (or extended through the duration of the declared COVID-19 public health emergency)~~ and as needed to meet the needs of the participant. ~~(3-17-22)~~( )

03. Referral and Related Activities. Activities that help link the participant with service providers ~~that are capable of providing needed~~ able to provide services to address identified needs and achieve goals specified in the service coordination plan. ~~(3-17-22)~~( )

04. Monitoring and Follow-Up Activities. Monitoring and follow-up contacts that are necessary to ensure the plan is implemented and adequately address~~es~~ the participant's needs. These activities may be with the participant, family members, providers, or other entities or individuals and conducted as frequently as necessary. These activities must include at least one (1) face-to-face contact with the participant at least every ninety (90) days. ~~(t~~The face-to-face encounter may occur via synchronous interaction~~ telehealth~~ virtual *care*, as defined in Title 54, Chapter 57, Idaho Code~~)~~, to determine whether the following conditions are met: ~~(3-17-22)~~*( )*

a. Services are being provided according to the participant's plan; (3-17-22)

b. Services in the plan are adequate; and (3-17-22)

c. Whether there are changes in the needs or status of the participant, and if so, making necessary

adjustments in the plan and service arrangements with providers. (3-17-22)

05. Crisis Assistance. Crisis~~ assistance is~~ service coordination used to assist a participant to access community resources~~ in order~~ to resolve a crisis~~. Crisis service coordination~~; it does not include crisis counseling, transportation to emergency service providers, or direct skill-building services. The need for all crisis assistance hours must meet the definition of "crisis" in Section 721 of these rules. ~~(3-17-22)~~(   )

a. Crisis Assistance for Children's Service Coordination. Crisis hours are~~ not~~ unavailable until~~ four and a half (4.5)~~ all available hours of service coordination have already been provided in the month. Crisis hours for children's service coordination must be authorized by the Department. ~~(3-17-22)~~(   )

b. Crisis Assistance for Adults With a Developmental Disability. Crisis hours are~~ not~~ unavailable until ~~four and a half (4.5)~~ all available hours of service coordination have already been provided in the month. Crisis assistance for adults with a developmental disability must be authorized by the Department and is based on community crisis supports~~ as found in~~ under Section 646 through 648 of these rules. ~~(3-17-22)~~(   )

c. Authorization for crisis assistance hours may be requested retroactively~~ as a result~~ because of a crisis~~, defined in~~ under Section 721 of these rules~~,~~ when a participant's service coordination benefits have been exhausted and no other means of support is available to the participant. In retroactive authorizations, the service coordinator must complete a crisis resolution plan and submit a request for crisis services to the Department within ~~seventy-two (72) hours~~ five (5) business days of the last day of providing the service. ~~(3-17-22)~~(   )

06. Contacts for Assistance. Service coordination may include contacts with non-eligible individuals only when the contact is directly related to identifying the needs and supports to help the participant access services. (3-17-22)

07. Exclusions. Service coordination does not include activities that are: (3-17-22)

a. An integral component of another covered Medicaid service; (3-17-22)

b. Integral to the administration of foster care programs; (3-17-22)

c. Integral to the administration of another non-medical program for which a participant may be eligible. This exclusion does not apply to case management provided as part of the individualized education program or individualized family service plan required by the Individuals with Disabilities Education Act. (3-17-22)

08. Limitations on the Provision of Direct Services. Providers of service coordination services may only provide both service coordination and direct services to the same Medicaid participant when the participant is receiving children's service coordination. The service coordination provider must document that the participant has made a free choice of service coordinators and direct service providers. (3-17-22)

09. Limitations on Service Coordination. Service coordination is limited to four and a half (4.5) hours per month, except when utilizing unused hours in the individual's current plan of service from previous months. ~~(3-17-22)~~(   )

10. Limitations on Service Coordination Plan Assessment and Plan Development. Reimbursement for the annual assessment and plan development cannot exceed~~ six~~ twelve (~~6~~12) hours per year. ~~(3-17-22)~~(   )

728. SERVICE COORDINATION: PROCEDURAL REQUIREMENTS.

01. Prior Authorization for Service Coordination Services. Services must be prior authorized by the Department~~ according to the direction~~ as provided in the Medicaid Provider Handbook available at www.idmedicaid.com. ~~(3-17-22)~~(   )

02. Service Coordination Plan Development. (3-17-22)

a. A written plan~~, described in~~ under Section 731 of these rules~~,~~ must be developed and implemented

within sixty (60) days after the participant chooses a service coordinator. ~~(3-17-22)~~(____)

b. The plan must be updated at least annually ~~(or extended through the duration of the declared COVID-19 public health emergency)~~ and amended as necessary. ~~(3-17-22)~~(____)

c. The plan must address the service coordination needs of the participant as identified in the assessment ~~described in~~ under Section 730 of these rules. ~~(3-17-22)~~(____)

d. The plan must be developed prior to ongoing service coordination being provided. (3-17-22)

03. Documentation of Service Coordination. Agencies must maintain records that contain documentation describing the services provided, review of the continued need for service coordination, and progress toward each service coordination goal. Documentation must be completed as ~~required~~ described in Section 56-209(h), Idaho Code. All active records must be immediately available. Documentation must include ~~all of~~ the following: ~~(3-17-22)~~(____)

a. The name of the eligible participant. (3-17-22)

b. The name of the provider agency and the person providing the services. (3-17-22)

c. The date, time, duration, and place the service was provided. (3-17-22)

d. The nature, content, units of the service coordination received, and whether goals specified in the plan have been achieved. (3-17-22)

e. Whether the participant declined any services in the plan. (3-17-22)

f. The need for and occurrences of coordination with any non-Medicaid case managers. (3-17-22)

g. The timeline for obtaining needed services. (3-17-22)

h. The timeline for re-evaluation of the plan. (3-17-22)

i. A copy of the assessment or prior authorization from the Department that documents eligibility for service coordination services, and a dated and signed plan. (3-17-22)

j. Agency records must contain documentation describing details of the service provided, signed by the person who delivered the service. (3-17-22)

k. Documented review of participant's continued need for service coordination and progress toward each service coordination goal. A review must be completed at least every one hundred eighty (180) days after the plan development or update. Progress reviews must include the date of the review, and the signature of the service coordinator completing the review. (3-17-22)

l. Documentation of the participant's, family's, or legal guardian's satisfaction with service. (3-17-22)

m. A copy of the informed consent form signed by the participant, parent, or legal guardian that documents that the participant has been informed of the purposes of service coordination, their rights to refuse service coordination, and their right to choose their service coordinator and other service providers. (3-17-22)

n. A plan that is signed by the participant, parent, or legal guardian, and the service coordinator. The plan must reflect person-centered planning principles and document the participant's inclusion in the development of the plan. The service coordinator must also document that a copy of the plan was given to the participant or their legal representative. The plan must be updated and authorized when required, but at least annually. Children's service coordination plans cannot be effective before the date that the child's parent or legal guardian has signed the plan. (3-17-22)

04. Documentation Completed by a Paraprofessional. Each entry completed by a paraprofessional must be reviewed by the participant's service coordinator and include the date of review and the service coordinator's signature on the documentation. (3-17-22)

05. Participant Freedom of Choice. A participant must have freedom of choice when selecting from the service coordinators available to them. The service coordinator cannot restrict the participant's choice of other health care or HCBS providers. ~~(3-17-22)~~(   )

06. Service Coordinator Contact and Availability. The frequency of contact, mode of contact, and person or entity to be contacted must be identified in the plan and ~~must~~ meet the needs of the participant. The contacts must verify the participant's well being and whether services are being provided according to the written plan. At least every ninety (90) days, service coordinators must have face-to-face contact with each participant. The face-to-face encounter may occur via synchronous interaction ~~telehealth~~ virtual care, as defined in Title 54, Chapter 57, Idaho Code. ~~(3-17-22)~~(   )

a. When it is necessary for the children's service coordinator to conduct a face-to-face contact with a child participant without the parent or legal guardian present, the service coordinator must notify the parent or legal guardian prior to the face-to-face contact with the participant. Notification must be documented in the participant's file. (3-17-22)

b. Service coordinators do not have to be available on a twenty-four (24) hour basis, but must include an individualized objective on the plan describing what the participant, families, and providers should do in an emergency situation. The individualized objective must include how the service coordinator will coordinate needed services after an emergency situation. (3-17-22)

07. ~~Service Coordinator Responsibility Related to~~ Conflict of Interest. ~~Service coordinators have a primary responsibility to the participant whom they serve, to respect and promote the right of the participant to self-determination, and preserve the participant's freedom to choose services and providers. In order to assure that participant rights are being addressed, service coordinators must~~ Individuals and agency employees or contractors who develop a participant's plan of service under these rules cannot: ~~(3-17-22)~~(   )

a. ~~Be alert to and avoid conflicts of interest that interfere with the exercise of professional discretion and impartial judgment.~~Be related by blood or marriage to the participant or to any paid caregiver or the participant; ~~(3-17-22)~~(   )

b. ~~Inform the participant parent, or legal guardian when a real or potential conflict of interest arises and take reasonable steps to resolve the issue in a manner that makes the participant's interests primary and protects the participant's interests to the greatest extent possible.~~Be financially responsible for the participant; ~~(3-17-22)~~(   )

c. Be empowered to make financial or health-related decisions on behalf of the participant; (   )

d. Hold financial interests in any entity that is paid to provide care for the participant; or (   )

e. Be a provider of the State Plan HCBS or waiver services for the participant or have an interest in or are employed by a provider of State Plan HCBS or waiver services. (   )

08. Service Coordinator Responsibilities Related to Conflict of Interest. The service coordinator will: (   )

a. Be alert to, and avoid, conflicts of interest that interfere with the exercise of professional discretion and impartial judgment. (   )

b. Inform the participant, parent, or legal guardian when a real or potential conflict of interest arises and take reasonable steps to resolve the issue in a manner that makes the participant's interests primary and protects their interests to the greatest extent possible. (   )

0~~8~~9. Agency Responsibilit~~y~~ies Related to Conflict of Interest.~~ To assure that participants are protected from restrictions to their self-determination rights because of conflict of interest, the agency must guard against conflict of interest, and inform all participants and guardians of the risk. Each agency must have a document in each participant's file that contains the following information:~~ The agency must guard against conflicts of interest and inform all participants and guardians of any risks. The agency must: ~~(3-17-22)~~(   )

a. Ensure its employees and contractors meet the conflict of interest standards as defined in these rules; and (   )

b. Have a document in each participant's file that contains: (   )

~~a~~i. The definition of "conflict of interest" as defined in Section 721 of these rules; ~~(3-17-22)~~(   )

~~b~~ii. A signed statement by the agency representative verifying that the concept of conflict of interest was reviewed and explained to the participant's parent~~,~~ or legal guardian; and ~~(3-17-22)~~(   )

~~c~~iii. The participant's, parent's, or legal guardian's signature on the document. (3-17-22)

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.03.13 – CONSUMER-DIRECTED SERVICES

DOCKET NO. 16-0313-2101

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2024 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. The pending rule will become final and effective upon the adjournment, *sine die*, of the Second Regular Session of the Sixty-seventh Idaho Legislature after approval.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 56-202, 56-203, 56-250 through 257, and 56-260 through 266, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

This rule change will decrease regulatory burdens, make technical corrections, implement operations for the end of the public health emergency, and align with federal regulations regarding conflicts of interest. These changes are being made in conjunction with companion Docket No. 16-0310-2101, Medicaid Enhanced Plan Benefits. Negotiated Rulemaking was conducted for these companion dockets in November 2021.

There are no changes to the pending rule and it is being adopted as originally proposed. The complete text of the proposed rule was published in the October 4, 2023, Idaho Administrative Bulletin, Vol. 23-10, pages 486 through 492.

FEE SUMMARY: Pursuant to Section 67-5224(2)(d), Idaho Code, this pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature. The following is a description of the fee or charge imposed or increased in this rulemaking: Does not apply to this rulemaking.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state General Fund greater than ten thousand dollars ($10,000) during the fiscal year:

This rulemaking is not anticipated to have any fiscal impact on state funds, including the General Fund, or any other known funds.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact William Deseron at 208-859-0046.

DATED this 30th of November, 2023.

Trinette Middlebrook and Frank Powell
DHW – Administrative Rules Unit
450 W. State Street – 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
phone: (208) 334-5500
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e-mail:dhwrules@dhw.idaho.gov

THE FOLLOWING NOTICE PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is September 1, 2023.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule, and proposed regular rulemaking procedures have been initiated. The action is authorized pursuant to Sections 56-202(b), 56-203, 56-253, and 56-264, Idaho Code.

PUBLIC HEARING SCHEDULE: Two public hearings concerning this rulemaking will be held as follows:

VIRTUAL TELECONFERENCE Via WebEx
Wednesday, October 18, 2023 **9:00 a.m. (MT)**
Join from the meeting link: **https://idhw.webex.com/idhw/j.php?MTID=m22d7402b3e4f05b93a795b6ffd75471a** ***Join by meeting number:*** **Meeting number (access code): 2761 907 1160** **Meeting password: fMMMepQE333 (36663773 from phones and video systems)** ***Join by phone:*** **+1-415-527-5035 United States Toll** **+1-303-498-7536 United States Toll (Denver)**

VIRTUAL TELECONFERENCE Via WebEx
Wednesday, October 18, 2023 **2:00 p.m. (MT)**
Join from the meeting link: **https://idhw.webex.com/idhw/j.php?MTID=m24d31b98e8d19db20a8af0d0505f54e6** ***Join by meeting number:*** **Meeting number (access code): 2760 176 3901** **Meeting password: sVaHVstG774 (78248784 from phones and video systems)** ***Join by phone:*** **+1-415-527-5035 United States Toll** **+1-303-498-7536 United States Toll (Denver)**

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is the required finding and concise statement of its supporting reasons for adopting a temporary rule and a nontechnical explanation of the substance and purpose of the proposed rulemaking:

The following changes are made in conjunction with companion Docket No. 16-0310-2101, Medicaid Enhanced Plan Benefits.

This rule change will decrease regulatory burdens, make technical corrections, implement operations for the end of the public health emergency, update rules to comply with K.W. Settlement, and align with federal regulations regarding conflicts of interest.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section(s) 67-5226(1) (a), (b), and (c), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate for the following reasons:

The changes in this rulemaking qualify for all the following purposes for a Temporary rulemaking:

(a) Protection of the public health, safety, or welfare; or
(b) Compliance with deadlines in amendments to governing law or federal programs; or
(c) Conferring a benefit.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased:

This rulemaking and this chapter of rules do not contain any fees.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year:

There is no anticipated fiscal impact to the General Fund, state funds, or any other known funds.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the November 3, 2021, Idaho Administrative Bulletin, Volume 21-11, pages 44-45.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into this rule:

The documents incorporated by reference in these rules are not being changed in this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact William Deseron at 208-859-0046.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 25, 2023.

DATED this 1st day of September, 2023.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0313-2101

009. ~~CRIMINAL HISTORY AND~~ BACKGROUND CHECK REQUIREMENTS.

01. Compliance With Department ~~Criminal History~~ Background Check. The fiscal employer agent must verify that each support broker and community support worker, whose ~~criminal history~~ background check has not been waived by the participant, has complied with IDAPA 16.05.06, "Criminal History and Background Checks." When a participant chooses to waive the ~~criminal history~~ background check requirement for a community support worker, the waiver must be completed in accordance with Section 150 of these rules. ~~Except, through the duration of the declared COVID-19 public health emergency, if each support broker and community support worker, whose criminal history check has not been waived by the participant is unable to complete a criminal background check in accordance with the timeframes set forth in IDAPA 16.05.06, then provider may allow newly hired direct care staff to begin rendering services prior to completion of the criminal background check in accordance with the requirements specified by the Department in a COVID-19 information release posted on the Department's website at https://healthandwelfare.idaho.gov/Providers/Providers-Medicaid/InformationReleases/tabid/264/Default.aspx.~~ ~~(3-17-22)~~(____)

02. Availability to Work or Provide Service. Participants~~, at their discretion,~~ may review the completed application and allow the community support worker to provide services on a provisional basis if no disqualifying offenses ~~listed in~~ under IDAPA 16.05.06, "Criminal History and Background Checks," are disclosed. ~~(3-17-22)~~(____)

03. Additional Criminal Convictions. Once ~~criminal history~~ clearances have been received, any additional criminal convictions must be immediately reported by the worker to the participant and by the participant to the Department. ~~(3-17-22)~~(____)

04. Notice of Pending Investigations or Charges. Once ~~criminal history~~ clearances have been received, any charges or investigations for abuse, neglect or exploitation of any vulnerable adult or child, criminal charges, or substantiated adult protection or child protection complaints, must be immediately reported by the worker to the participant and by the participant to the Department. ~~(3-17-22)~~(____)

05. Providers Subject to ~~Criminal History~~ Background Check Requirements. A community support worker, who has not had the requirement waived by the participant, and a support broker as defined in Section 010 of these rules. ~~(3-17-22)~~(____)

(BREAK IN CONTINUITY OF SECTIONS)

135. SUPPORT BROKER REQUIREMENTS AND LIMITATIONS.

01. Initial Application to Become a Support Broker. Individuals interested in becoming a support broker must complete the Department-approved application to document that they: (3-17-22)

a. ~~Is~~Are eighteen (18) years of age or older; ~~(3-17-22)~~(____)

b. ~~Has~~Have skills and knowledge typically gained by completing college courses or community classes or workshops that count toward a degree in the human services field; and ~~(3-17-22)~~(____)

c. ~~Has~~Have at least two (2) years verifiable experience with the target population and knowledge of services and resources in the developmental disabilities field. ~~(3-17-22)~~(____)

02. Application Exam. Applicants that meet the minimum requirements ~~outlined in~~ under this ~~section~~ rule will receive training materials and resources to prepare for the application exam. Under Family-Directed Community Supports (FDCS), children's support brokers must attend the initial training. Applicants must earn a score of seventy percent (70%) or higher to pass. Applicants may take the exam up to three (3) times. After the third time, the applicant will not be allowed to retest for twelve (12) months from the date of the last exam. Applicants who

pass the exam, and meet all other requirements~~ outlined in~~ under these rules, will be eligible to enter into a provider agreement with the Department.~~ Through the duration of the COVID-19 public health emergency, support brokers may begin rendering services prior to completing the training requirements, provided that they complete the training requirements within thirty (30) days of first rendering services, advise the participant or legal guardian that the individual has not yet completed the applicable trainings, and comply with any other requirements specified by the Department in a COVID-19 information release posted on the Department's website at https://healthandwelfare.idaho.gov/Providers/Providers-Medicaid/InformationReleases/tabid/264/Default.aspx.~~ ~~(3-17-22)~~(   )

03. Required Ongoing Training. All support brokers must document a minimum of twelve (12) hours per year of ongoing, relevant training in the provision of support broker services. Up to six (6) hours of the required twelve (12) hours may be obtained through independent self-study. The remaining hours must consist of classroom training. (3-17-22)

04. Termination. The Department may terminate the provider agreement when the support broker: (3-17-22)

a. Is no longer able to pass a~~ criminal history~~ background check~~ as outlined in~~ under Section 009 of these rules. ~~(3-17-22)~~(   )

b. Puts the health or safety of the participant at risk by failing to perform job duties~~ as outlined in~~ under the employment agreement. ~~(3-17-22)~~(   )

c. Does not receive and document the required ongoing training. (3-17-22)

05. Limitations. The support broker must~~ not~~: ~~(3-17-22)~~(   )

a. Not ~~P~~provide, or be employed by an agency that provides paid community supports under Section 150 of these rules to the same participant; and ~~(3-17-22)~~(   )

b. For Self-Directed Community Supports (SDCS),~~ be the guardian, parent, spouse, payee, or conservator of the participant, or have direct control over the participant's choices. Additionally, the support broker must not be in a position to both influence a participant's decision making and receive undue financial benefit from the participant's decisions~~ meet the conflict of interest standards under IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." ~~(3-17-22)~~(   )

(BREAK IN CONTINUITY OF SECTIONS)

190. INDIVIDUALIZED BUDGET.

The Department~~ sets an individualized budget for each participant according to an individualized measurement of the participant's functional abilities, behavioral limitations, medical needs, and other individual factors related to the participant's assessed needs. Using these specific participant factors, the budget-setting methodology will correlate a participant's characteristics with the participant's individualized budget amount, so participants with higher needs will be assigned a higher individualized budget amount. The participant must work within the identified budget and acknowledge that they understand the budget figure is a fixed amount.~~ will assign budgets based on the criteria under IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." ~~(3-17-22)~~(   )

01. Budget Amount Notification. The Department notifies each participant of their set budget amount as part of the eligibility determination or annual redetermination process. The notification will include how the participant may appeal the set budget amount. (3-17-22)

02. Annual Re-Evaluation of Adult Individualized Budgets. Individualized budgets will be re-evaluated annually. At the request of the participant, the Department will also re-evaluate the set budget amount when there are documented changes in the participant's condition that results in a need for services that meet medical necessity criteria, and that is not reflected on the current inventory of individual needs. (3-17-22)

03. Annual Re-Evaluation of Children's Individualized Budgets. Individualized budgets will be re-evaluated annually. At the request of the participant, the Department will also re-evaluate the set budget amount when there are documented changes that may support placement in a different budget category~~ as identified in~~ under IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Section 527. ~~(3-17-22)~~(   )

(BREAK IN CONTINUITY OF SECTIONS)

302. FISCAL EMPLOYER AGENT DUTIES AND RESPONSIBILITIES: CUSTOMER SERVICE.

01. Customer Service System. The provider must provide a customer service system to respond to all inquiries from participants, employees, agencies, and vendors. The provider must: (3-17-22)

a. Provide staff with customer service training with an emphasis on consumer-direction. (3-17-22)

b. Ensure staff are trained and have the skills to assist participants with enrollment and to help them understand their account statements. (3-17-22)

c. Ensure that fiscal employer agent personnel are available during regular business hours~~, 8 a.m. to 5 p.m. Mountain Time, Monday through Friday, excluding state holidays~~. ~~(3-17-22)~~(   )

d. Provide translation and interpreter services (i.e., American Sign Language and services for persons with limited English proficiency). (3-17-22)

e. Provide prompt and consistent response to verbal and written communication. Specifically: (3-17-22)

i. All calls and voice mails~~ messages~~ must be responded to within one (1) business day; and ~~(3-17-22)~~(   )

ii. All written and electronic correspondence must be responded to within five (5) business days. (3-17-22)

f. Maintain a toll-free phone line where callers speak to a live person during business hours and are provided the option to leave voice mail at any time, all day, every day. (3-17-22)

g. Maintain a toll-free fax line that is available all day, every day, exclusively for participants and their employees. (3-17-22)

02. Complaint Resolution and Tracking System. The provider is responsible for receiving, responding to, and tracking all complaints from any source under this agreement. A complaint is defined as a verbal or written expression of dissatisfaction about fiscal employer agent services. The provider must: (3-17-22)

a. Respond to all written and electronic correspondence within five business (5) days. ~~(3-17-22)~~(   )

b. Respond to~~ verbal complaints~~ all calls and voicemails within one (1) business day. ~~(3-17-22)~~(   )

c. Maintain an electronic tracking system and log of complaints and resolutions. The electronic log of complaints and resolutions must be accessible for Department review through the SFTP site. (3-17-22)

d. Log and track complaints received from the Department pertaining to fiscal employer agent services. (3-17-22)

e. Compile a summary report and analyze complaints received on a quarterly basis to determine the quality of services to participants and to identify any corrective action necessary. (3-17-22)

f. Post the complaint to the SFTP site within twenty-four (24) hours any day a complaint is received Monday through Friday. Saturday and Sunday complaints must be posted to the SFTP site by close of business the following Monday. Failure to comply will result in a fifty dollar ($50) penalty payable to Medicaid within ninety (90) days of incident. (3-17-22)

(BREAK IN CONTINUITY OF SECTIONS)

310. FISCAL EMPLOYER AGENT DUTIES AND RESPONSIBILITIES: PERFORMANCE METRICS.
The provider must do the following: (____)

01. Readiness Review. ~~The provider must c~~Complete a readiness review conducted by the Department with the provider prior to providing fiscal employer agent services. ~~(3-17-22)~~(____)

a. ~~Required Level of Expectation:~~ The provider must complete one hundred percent (100%) of the readiness review. ~~(3-17-22)~~(____)

b. ~~Method of Monitoring:~~ The Department will access SFTP site for review of provider documents and conduct an onsite review. ~~(3-17-22)~~(____)

02. Compliance with Tax Regulations and Labor Laws. ~~The provider must e~~Ensure each participant's compliance with regulations for both federal ~~taxes~~ and state taxes, ~~as well as~~ and all applicable labor laws. ~~(3-17-22)~~(____)

03. Fiscal Support and Financial Consultation. (3-17-22)

a. The provider must provide each participant with fiscal support and financial consultation. (3-17-22)

b. ~~Required Level of Expectation:~~ The provider must respond to ninety-five percent (95%) of ~~participant~~ calls and voicemails within two (2) business days and to ~~e-mails~~ written and electronic correspondence within five business (5) days. ~~(3-17-22)~~(____)

04. Federal and State Forms Submitted. ~~The provider must e~~Ensure each participant's compliance with regulations for both federal ~~taxes~~ and state taxes, including preparation and submission of all federal and state forms for each participant and their employees. ~~(3-17-22)~~(____)

05. Mandatory Reporting, Withholding, and Payment. ~~The provider must p~~Perform all mandatory reporting, withholding, and payment actions according to the compliance requirements of the state and federal agencies. ~~(3-17-22)~~(____)

06. Payroll Checks. ~~The provider must i~~Issue payroll checks within the two (2) week or semi-monthly payroll cycle, after receipt of completed, approved time sheets. ~~(3-17-22)~~(____)

07. Adherence to Support and Spending Plan. ~~The provider must d~~Distribute payments to each participant employee ~~in accordance with~~ under the participant's support and spending plan. ~~(3-17-22)~~(____)

08. Record Activities. ~~The provider must r~~Record all activities in an individual file for each participant and their employees. ~~(3-17-22)~~(____)

09. Records in Participant File. ~~The provider must m~~Maintain complete records in each participant's file. ~~(3-17-22)~~(____)

10. Manage Phone, Fax, and E-Mail for Fiscal and Financial Questions. (3-17-22)

a. The provider must manage toll-free telephone line, fax, and e-mail related to participant fiscal and financial questions. (3-17-22)

b. ~~Required Level of Expectation:~~ The provider must respond to ninety-five percent (95%) of ~~participant queries~~ calls and voicemails within two (2) business days and to written and electronic correspondence within five (5) business days. ~~(3-17-22)~~(   )

11. Track~~ing of~~ Complaints and Complaint Resolution. ~~(3-17-22)~~(   )

a. The provider must maintain a register of complaints from participants, participant employees, and others, with corrective action implemented by the provider within one (1) business day of the complaint response. ~~(3-17-22)~~(   )

b. ~~Required Level of Expectation:~~ The provider must respond to ninety-five percent (95%) of ~~complaints within one (1) business day~~ calls and voicemails within two (2) business days and to written and electronic complaints within five (5) business days. ~~(3-17-22)~~(   )

12. Web Access to Electronic Time Sheet Entry. ~~The provider must m~~Maintain web access to electronic time sheet entry for participants. ~~(3-17-22)~~(   )

13. Participant Enrollment Packets and Employment Packets. ~~The provider must p~~Prepare and distribute participant enrollment ~~packets~~ and employment packets to each participant. ~~(3-17-22)~~(   )

14. Payroll Spending Summaries. ~~The provider must p~~Provide each participant with payroll spending summaries and information about how to read the payroll spending summary each time payroll is executed. ~~(3-17-22)~~(   )

15. Quarterly Reconciliation. Each fiscal quarter after initiating service, the provider must reconcile its Medicaid Billing Report to a zero-dollar ($0) balance with the Medicaid Bureau of Financial Operations. The provider has ninety (90) days to comply with reconciling each participant's spending plan balance to a zero dollar ($0) balance with Medicaid's reimbursements. The provider must: ~~(3-17-22)~~(   )

a. ~~Required Level of Expectation: The provider must h~~Have one hundred percent (100%) compliance with the required quarterly reconciliation of the Medicaid Billing Report. ~~(3-17-22)~~(   )

b. ~~Strategy for Correcting Noncompliance: The provider must n~~Notify the Department immediately if an issue is identified that may result in the provider not reconciling the Medicaid Billing Report. The Department will notify the provider when a performance issue is identified. The Department may require the provider to submit a written corrective action plan for Department approval within two (2) business days after notification. If the provider fails to reconcile within ninety (90) days after the end of each quarter, the provider will be penalized fifty dollars ($50) each week until the provider has reconciled with Medicaid to a zero dollar ($0) balance. ~~(3-17-22)~~(   )

16. Cash Management Plan. Each provider's cash management plan must equal one point five (1.5) times the monthly payroll cycle amount~~. The cash management plan~~ and can be forms of liquid cash and lines of credit. For example, ~~in the case that the~~ if a provider's current payroll minimum has averaged one hundred thousand dollars ($100,000) per payroll cycle, the provider would be required to have one hundred fifty thousand dollars ($150,000) in a cash management plan. The Department must be ~~listed~~ on the notification list if any lines of credit are decreased in the amount accessible or terminated. The expectation is to provide a seamless payroll cycle to the participant, without loss of pay to their employees. ~~(3-17-22)~~(   )

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.03.18 – MEDICAID COST-SHARING

DOCKET NO. 16-0318-2301 (ZBR CHAPTER REWRITE, FEE RULE)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo and Cost/Benefit Analysis (CBA)

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2024 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. The pending rule will become final and effective upon the adjournment, *sine die*, of the Second Regular Session of the Sixty-seventh Idaho Legislature after approval.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 56-202(b), 56-253, and 56-257, Idaho Code, and Title XIX and Title XXI of the Social Security Act.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

Due to Executive Order 2020-01, Zero-Based Regulation, agencies are required to rewrite IDAPA chapters every 5 years on an approved schedule. This rulemaking is complying to this mandate and is scheduled for presentation to the 2024 Legislature. Under this Executive Order, the Department is rewriting this chapter of rules to prevent the accumulation of costly, ineffective, and outdated regulations and reduce regulatory burden to achieve a more efficient operation of government while serving those receiving benefits subject to Medicaid Cost-Sharing. This chapter rewrite is intended to perform a comprehensive review of this chapter in collaboration with the public to update, clarify, streamline, and simplify the rule language.

There are no changes to the pending rule and it is being adopted as originally proposed. The complete text of the proposed rule was published in the October 4, 2023, Idaho Administrative Bulletin, Vol. 23-10, pages 493 through 503.

FEE SUMMARY: Pursuant to Section 67-5224(2)(d), Idaho Code, this pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature. The following is a description of the fee or charge imposed or increased in this rulemaking:

There are no changes to the fees under this chapter of rule. This chapter establishes a premium fee schedule for Youth Empowerment Services (YES) program participants. The authorizing statutes for these fees are: Sections 56-253 and 56-257, Idaho Code.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state General Fund greater than ten thousand dollars ($10,000) during the fiscal year:

This rulemaking is not anticipated to have any fiscal impact on state funds, including the General Fund, or any other known funds.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Cindy Brock at 208-364-1983 or Jennifer Pinkerton at 208-287-1171.

DATED this 30th of November, 2023.

Trinette Middlebrook and Frank Powell
DHW – Administrative Rules Unit
450 W. State Street – 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
phone: (208) 334-5500
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THE FOLLOWING NOTICE PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 56-202(b), 56-253, and 56-257, Idaho Code and 42 CFR Part 447 Payments for services.

PUBLIC HEARING SCHEDULE: A public hearing concerning this rulemaking will be held as follows:

VIRTUAL TELECONFERENCE Via WebEx
Thursday, October 12, 2023 **9:00 a.m. - 10:00 a.m. (MT)**
Join from the meeting link **https://idhw.webex.com/idhw/j.php?MTID=maa22e58e051eda7333887306634fa3e9** **Join by meeting number** **Meeting number (access code): 2762 153 2942** **Meeting password: MSfpqxPp727 (67377977 from phones and video systems)** **Join by phone** **+1-415-527-5035 United States Toll** **+1-303-498-7536 United States Toll (Denver)**

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below. Meeting(s) will conclude after 30 minutes if no participants sign in or wish to comment in the meeting.

DESCRIPTIVE SUMMARY: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

Due to Executive Order 2020-01, Zero-Based Regulation, agencies are required to rewrite IDAPA chapters every 5 years on an approved schedule. This rulemaking is complying to this mandate and is scheduled for presentation to the 2024 Legislature. Under this Executive Order, the Department is rewriting this chapter of rules to prevent the accumulation of costly, ineffective, and outdated regulations and reduce regulatory burden to achieve a more efficient operation of government while serving those receiving benefits subject to under Medicaid Cost-Sharing. This chapter rewrite is intended to perform a comprehensive review of this chapter in collaboration with the public to update, clarify, streamline, and simplify the rule language.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased:

This chapter contains designation, records, and establishes a premium fee schedule for Youth Empowerment Services (YES) and SCHIP program participants. This chapter has no anticipated fee changes.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the State General Fund greater than ten thousand dollars ($10,000) during the fiscal year as a result of this rulemaking:

This rulemaking is not anticipated to have any fiscal impact on the State General Fund, or any other known funds.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the May 3, 2023, Idaho Administrative Bulletin Vol. 23-5, pages 150 through 151.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into this rule:

There are no incorporations by reference in this chapter of rule.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Cindy Brock at 208-364-1983 or Jennifer Pinkerton at 208-287-1171.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 25, 2023.

DATED this 6th day of July, 2023.

THE FOLLOWING IS THE TEXT OF ZBR DOCKET NO. 16-0318-2301

16.03.18 – MEDICAID COST-SHARING

000. LEGAL AUTHORITY.
Under Section 56-202(b), Idaho Code, the Department establishes and enforces rules necessary to administer public assistance programs. Under Sections 56-253, 56-255 and 56-257, Idaho Code, and 42 CFR Part 447 Payments for Service the Department establishes enforceable cost-sharing requirements within the limits of federal Medicaid law and regulations.The Department is the designated agency to administer programs under Title XIX and Title XXI of the Social Security Act. ( )

002. -- 009. (RESERVED)

010. DEFINITIONS.
In addition to definitions under Section 56-252, Idaho Code, the following definitions apply: ( )

01. Copayment (Copay). The amount a participant pays a provider for specified services. ( )

02. Department. The Idaho Department of Health and Welfare, or its designee. ( )

03. Federal Poverty Guidelines (FPG). Guidelines issued annually by the U. S. Department of Health and Human Services (HHS) at http://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines. ( )

04. Physician Office Visit. Services provided to a participant by a physician, nurse practitioner, or physician's assistant. ( )

05. Premium. A regular and periodic charge or payment for health coverage. ( )

011. -- 024. (RESERVED)

025. PARTICIPANTS NOT ALREADY FEDERALLY EXEMPT FROM COST-SHARING.
Participants in the Medicaid Workers with Disabilities (MWD) program are exempt from the cost-sharing provisions of Sections 200, 205, 207, and 400 of these rules. ( )

026. -- 049. (RESERVED)

050. GENERAL COST-SHARING.

01. Proof of Cost-Sharing Payment. If a participant believes their cost-sharing exceeded five percent (5%) of gross monthly household income, they must provide proof to the Department for an assessment of suspension or reimbursement. ( )

02. Excess Cost-Sharing. A household that establishes proof of payment for cost-sharing that exceeds five percent (5%) of gross monthly household income will be reimbursed by the Department for the amount paid that exceeds the five percent (5%), except as provided in this rule. ( )

03. Cost-Sharing Suspended. A household that exceeds the five percent (5%) maximum amount for cost-sharing for the calendar month is not required to pay cost-sharing for any household member for the remainder of the calendar month. ( )

051. - 199. (RESERVED)

200. PREMIUMS FOR PARTICIPATION UNDER THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP).

01. Household Income Above 133% of FPG. Participants with household income above one hundred thirty-three percent (133%) and equal to or less than one hundred fifty percent (150%) of the current FPG pay a monthly premium of ten dollars ($10) to the Department. ( )

02. Household Income Above 150% of FPG. Participants with household income above one hundred fifty percent (150%) and equal to or less than one hundred eighty-five percent (185%) of the current FPG pay a monthly premium of fifteen dollars ($15) to the Department. ( )

03. Premium Recalculation. Premiums are recalculated at each annual eligibility redetermination. If the Department receives verification of a reduction in household income prior to annual eligibility redetermination, the premium is recalculated. The Department waives any premium for participants who become eligible for Title XIX Medicaid. ( )

04. Premium Reduction. The monthly premium for SCHIP participants may be reduced by ten dollars ($10) per month under IDAPA 16.03.09, "Medicaid Basic Plan Benefits." ( )

201. -- 204. (RESERVED)

205. PREMIUMS FOR PARTICIPATION UNDER HOME CARE FOR CERTAIN DISABLED CHILDREN (HCCDC).

01. Household Income Above 150% and Equal to or Less Than 185% of FPG. Participants with household income above one hundred fifty percent (150%) and equal to or less than one hundred eighty-five percent (185%) of the current FPG pay a monthly premium of fifteen dollars ($15). The maximum monthly premium is limited to thirty dollars ($30). ( )

02. Household Income Above 185% of FPG. Participants with income above one hundred eighty-five percent (185%) of the current FPG pay a monthly premium. The monthly premium is a fixed percentage of household income as provided in the table below.

TABLE 205.02 SLIDING FEE SCHEDULE FOR MONTHLY PREMIUMS FOR HCCDC PARTICIPATION		
Household Income Above 185% of Current FPG		Premium Based on % of Household Income
ABOVE	LESS THAN OR EQUAL TO	
185%	250%	1.0%
250%	300%	1.5%
300%	400%	2.0%
400%	500%	2.5%
500%	600%	3.0%
600%	700%	3.5%
700%	800%	4.0%
800%	900%	4.5%
900%	No Upper Limit	5.0%

( )

03. Failure to Provide Information. Failure to provide the Department with information to determine eligibility may subject the participant to a monthly premium equal to the average monthly cost of coverage for participants receiving Medicaid Enhanced Plan Benefits through HCCDC. ( )

04. Failure to Pay Premium. Failure to pay the premium will not cause the participant to lose coverage or eligibility for services. ( )

05. Waiver of Premium. The premium is waived if the Department determines payment of the premium would cause undue hardship. Undue hardship exists when an unexpected expense would cause the household to forgo basic food or shelter to make a premium payment. Detailed documentation of the household's living expenses demonstrating such hardship must be provided to the Department. ( )

06. Premium Recalculation. Premiums are recalculated at each annual eligibility determination. If the Department receives verification of a reduction in household income prior to annual redetermination, the premium is recalculated. ( )

206. (RESERVED)

207. PREMIUMS FOR PARTICIPATION UNDER THE YOUTH EMPOWERMENT SERVICES (YES) PROGRAM.

01. Premium Fee Schedule. Participants are subject to assessment of a premium. The Department establishes a premium fee schedule that is published on the Department's website at https://healthandwelfare.idaho.gov/services-programs/medicaid-health. ( )

02. Waiver of Premium. The monthly premium under this rule is waived if the Department determines the household is unable to participate in the cost of care. ( )

03. Premium Recalculation. The premium amount is recalculated at each annual eligibility redetermination. ( )

208. -- 209. (RESERVED)

210. DEPARTMENT RESPONSIBILITIES.

01. Assessed Premiums. A participant is not assessed premiums during the initial eligibility determination. Obligation for premium payments does not begin for at least sixty (60) days after receipt of application, except for workers with disabilities under these rules. ( )

02. Premiums Not Assessed Due to Late Review. A participant cannot be assessed premiums for extra months of eligibility received due solely to the Department's untimely review of continuing eligibility, except for workers with disabilities under these rules. ( )

03. No Retroactive Premiums Assessed. A participant cannot be assessed premiums for months of retroactive eligibility. ( )

04. Notification of Premiums. The Department routinely notifies participants of their premium payment obligations including any delinquencies, if applicable. ( )

211. -- 214. (RESERVED)

215. PREMIUMS FOR PARTICIPATION IN MEDICAID WORKERS WITH DISABILITIES.

01. Workers with Disabilities. Countable income is determined under IDAPA 16.03.05, "Eligibility for Aid to the Aged, Blind, and Disabled (AABD)." The monthly premium is a fixed percentage of countable income as provided on the Department's website at https://healthandwelfare.idaho.gov/services-programs/medicaid-health. ( )

02. Recomputed Premium Amount. Premium amounts are recomputed when changes to a participant's countable income result in a different percentage premium calculation as determined in this rule, and at the annual re-determination. ( )

216. -- 249. (RESERVED)

250. DELINQUENT PREMIUM PAYMENTS.
If the participant is sixty (60) days or more past due on premium payments, the participant is contacted to determine the reason for the delinquency. If the participant's income is less than the amount used for the most recent eligibility determination, the participant is offered a new eligibility determination. The change is effective the month after the participant becomes eligible for such benefits. ( )

01. Delinquent Payments. A participant is not approved for or renewed for coverage that requires premium payments, if their premium payments are sixty (60) days or more delinquent. ( )

02. Reestablishing Eligibility. A participant can reestablish eligibility by paying the premium debt in full, unless forgiven in this rule. ( )

03. Premium Debt. Any premium debt assessed, but not paid, will be forgiven if one (1) of the following applies: ( )

a. The participant reports and the Department determines that the participant's household income is below one hundred and thirty-three percent (133%) FPG. This may occur at any time during the eligibility period; or ( )

b. A participant in the Medicaid Basic Plan has a medical condition that requires the participant to receive the benefits provided in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." ( )

251. -- 299. (RESERVED)

300. PARTICIPANTS EXEMPT FROM COPAYMENT NOT ALREADY FEDERALLY EXEMPTED.
This includes participants who have other health care coverage that is the primary payor for the services provided. ( )

301. -- 309. (RESERVED)

310. COPAYMENT FEE AMOUNTS.
The Copayment fee amount required to be paid by the participant , when applicable, is three dollars and sixty-five cents ($3.65). ( )

311. -- 319. (RESERVED)

320. SERVICES SUBJECT TO COPAYMENTS.
Participants are responsible for making copayments unless otherwise exempt or exempted under this rule for the following. ( )

01. Accessing Hospital Emergency Department for Non-Emergency Medical Conditions. ( )

02. Accessing Emergency Transportation Services for Non-Emergency Medical Conditions. ( )

03. Chiropractic Services. ( )

04. Occupational Therapy, Speech or Physical. ( )

05. Optometric Services. ( )

06. Outpatient Hospital Services. ( )

07. Podiatry Services. ( )

08. Physician Office Visit. Each physician office visit, unless the visit is for: ( )

a. A preventive service, including wellness exams, immunizations, or family planning. ( )

b. Urgent care provided at a clinic billing as an urgent care facility. ( )

321. -- 324. (RESERVED)

325. EXCEPTION TO CHARGING A COPAYMENT.
A provider may charge a copayment if the Medicaid reimbursement for the services rendered is equal to or greater than ten (10) times the amount of the copayment under these rules. ( )

326. -- 329. (RESERVED)

330. COLLECTION OF COPAYMENTS.

01. Responsibility for Collection. The provider is responsible for collection of the copayment from the participant. ( )

02. Denial of Services. The provider may require payment of applicable copayment before rendering services. ( )

03. Waiver of Copayment. The provider may waive payment of any copayment. The provider must have a written policy describing the criteria for waiving or enforcing collection of copayments. ( )

04. Reduction in Reimbursement.When a copayment is applicable, the provider's reimbursement is

reduced by the amount of the copayment regardless of whether a copayment was charged or collected by the provider. ( )

331. -- 399. (RESERVED)

400. PARTICIPATION IN THE COST OF HOME AND COMMUNITY-BASED WAIVER SERVICES (HCBS).
Participants required to participate in the cost of HCBS services as described in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," must have their share of cost determined under this rule. ( )

01. Excluded Income. Income excluded under IDAPA 16.03.05, "Eligibility for Aid to the Aged, Blind, and Disabled (AABD)," is excluded in determining participation. ( )

02. Base Participation Amount. The base participation amount is income available to the participant after subtracting all allowable deductions, except for the incurred medical expense in IDAPA 16.03.05, "Eligibility for Aid to the Aged, Blind, and Disabled (AABD)." ( )

03. Personal Needs Allowance (PNA). The participant's PNA depends on the participant's legal obligation to pay rent or mortgage and is deducted from countable income after income exclusions and any incurred medical expenses allowances. ( )

a. PNA for participants not responsible for rent or mortgage equals one hundred percent (100%) of the federal SSI benefit. ( )

b. PNA for participants responsible for rent or mortgage equals one hundred eighty percent (180%) of the federal SSI benefit. ( )

04. Participants with Developmental Disabilities. These allowances are specified in IDAPA 16.03.05, "Eligibility for Aid to the Aged, Blind, and Disabled (AABD)." PNA for adult participants receiving services under the Developmentally Disabled Waiver is three (3) times the federal SSI benefit amount to an individual in their own home. ( )

05. Incurred Medical Expenses. Amounts for certain limited medical or remedial services not covered by the participant's Idaho Medicaid Plan and not paid by a third party may be deducted from the base participation amount. The Department must determine whether incurred expenses for such limited services meet the criteria for deduction. The participant must verify such expenses for any to be considered for deduction. Costs for over-the-counter medications are included in the PNA and are not considered a medical expense. Department-approved deductions for necessary medical or remedial expenses are subtracted upon application, and updated when a participant reports changes to the Department. ( )

06. Remainder After Calculation. Any remainder after the calculation is the maximum participation amount to be deducted from the participant's provider payments to offset the cost of services. The participation amount is collected from the participant by the provider. The Department notifies the provider and the participant of the amount to be collected. ( )

07. Recalculation of Participation. The participant's participation amount is recalculated annually at eligibility redetermination or upon verified changes. ( )

08. Adjustment of Participation Overpayment or Underpayment Amounts. The participant's participation amount is reduced or increased the month following the month of overpayment or underpayment. ( )

401. -- 999. (RESERVED)

[Agency redlined courtesy copy]

16.03.18 – MEDICAID COST-SHARING

000. LEGAL AUTHORITY.
Under Section 56-202(b), Idaho Code,~~ the Legislature has delegated to~~ the Department~~ of Health and Welfare the responsibility to~~ establishes and enforces~~ such~~ rules~~ as may be~~ necessary~~ or proper~~ to administer public assistance programs~~ within the state of Idaho~~. Under Sections 56-253, 56-255 and 56-257, Idaho Code, and 42 CFR Part 447 Payments for Service the Department~~ of Health and Welfare is to~~ establishes enforceable cost-sharing requirements within the limits of federal Medicaid law and regulations.~~ Furthermore, t~~The~~ Idaho~~ Department~~ of Health and Welfare~~ is the designated agency to administer programs under Title XIX and Title XXI of the Social Security Act. ~~(3-15-22)~~(____)

~~**001. TITLE AND SCOPE.**~~

~~**01. Title**. These rules are titled IDAPA 16.03.18, "Medicaid Cost-Sharing." (3-15-22)~~

~~**02. Scope**. These rules describe the general requirements regarding the administration of the cost-sharing provisions for participation in a medical assistance program providing direct benefits in Idaho. (3-15-22)~~

~~**002. WRITTEN INTERPRETATIONS.**~~
~~This agency may have written statements which pertain to the interpretation of the rules of this chapter. These documents are available for public inspection. (____)~~

00~~3~~2. -- 009. (RESERVED)

010. DEFINITIONS.
In addition to definitions under Section 56-252, Idaho Code, the following definitions apply: (____)

01. Copayment (Copay). The amount a participant~~ is required to~~ pays~~ to the~~ a provider for specified services. ~~(3-15-22)~~(____)

~~**02. Cost-Sharing**. A payment the participant or the financially responsible adult is required to make toward the cost of the participant's health care. Cost-sharing includes both copays and premiums. (3-15-22)~~

~~**03. Creditable Health Insurance**. Creditable health insurance is coverage that provides benefits for inpatient and outpatient hospital services and physicians' medical and surgical services. Creditable coverage excludes liability, limited scope dental, vision, specified disease or other supplemental-type benefits. (3-15-22)~~

0~~4~~2. Department. The Idaho Department of Health and Welfare, or~~ a person authorized to act on behalf of the Department~~ its designee. ~~(3-15-22)~~(____)

~~**05. Family Income**. The gross income of all financially responsible adults who reside with the participant, as calculated under IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children." (3-15-22)~~

~~**06. Family Size**. Family size is the number of people living in the same home as the child. This includes relatives and other optional household members. (3-15-22)~~

0~~7~~3. Federal Poverty Guidelines (FPG). ~~The federal poverty g~~Guidelines issued annually by the U. S. Department of Health and Human Services (HHS)~~. The federal poverty guidelines are available on the U.S. Health and Human Services website~~ at~~ http://aspe.hhs.gov/poverty~~ http://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines. ~~(3-15-22)~~(____)

~~**08.** **Financially Responsible Adult**. An individual who is the biological or adoptive parent of a child and is financially responsible for the participant. (3-15-22)~~

~~**09.** **Medical Assistance**. Payments for part or all of the cost of services funded by Titles XIX or XXI of the federal Social Security Act, as amended. (3-15-22)~~

~~**10.** **Participant**. A person eligible for and enrolled in the Idaho Medical Assistance Program. (3-15-22)~~

~~11~~04. **Physician Office Visit**. Services ~~performed~~ provided to a participant by a physician, nurse practitioner, or physician's assistant ~~at the practitioner's place of business, including Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs). Indian Health Clinic/638 Clinics providing services to individuals eligible for Indian Health Services are not included~~. ~~(3-15-22)~~( )

~~12~~05. **Premium**. A regular and periodic charge or payment for health coverage. ( )

~~**13.** **Social Security Act**. 42 U.S.C. 101 et seq., authorizing, in part, federal grants to the states for medical assistance to eligible low-income individuals. (3-15-22)~~

~~**14.** **State**. The state of Idaho. (3-15-22)~~

~~**15.** **Title XIX**. Title XIX of the Social Security Act, known as Medicaid, is a medical benefits program jointly financed by the federal and state governments and administered by the states. This program pays for medical assistance for certain individuals and families with low income and limited resources. (3-15-22)~~

~~**16.** **Title XXI**. Title XXI of the Social Security Act, known as the State Children's Health Insurance Program (SCHIP). This is a program that primarily pays for medical assistance for low-income children. (3-15-22)~~

011. -- 024. (RESERVED)

025. PARTICIPANTS NOT ALREADY FEDERALLY EXEMPT FROM COST-SHARING.
~~Native American and Alaskan Native participants are exempt from the cost-sharing provisions of Sections 200, 205, 215, 320, and 400 of these rules. The participant must declare his race to the Department to receive this exemption.~~ Participants in the Medicaid Workers with Disabilities (MWD) program are exempt from the cost-sharing provisions of Sections 200, 205, 207, and 400 of these rules. ~~(3-15-22)~~( )

026. -- 049. (RESERVED)

050. GENERAL COST-SHARING.

~~**01.** **Cost-Sharing Maximum Amount**. A family will be required to pay out of pocket costs not to exceed five percent (5%) of the family's anticipated gross monthly income unless an exception is made as provided in Subsection 050.02 of this rule. (3-15-22)~~

~~**02.** **Exception to Cost-Sharing Maximum**. A family will be required to pay cost-sharing amounts as provided in Sections 215 and 400 of these rules. These cost-sharing amounts may exceed the family's five percent (5%) of anticipated gross monthly income. (3-15-22)~~

0~~3~~1. **Proof of Cost-Sharing Payment**. If a participant believes ~~that~~ their cost-sharing exceeded ~~the~~ five percent (5%) ~~cost-sharing~~ of ~~the family's anticipated~~ gross monthly household income, they must provide proof to the Department ~~of the copay amounts that were paid~~ for an assessment of suspension or reimbursement. ~~(3-15-22)~~( )

0~~4~~2. **Excess Cost-Sharing**. A ~~family~~ household that establishes proof of payment for cost-sharing that exceeds ~~the~~ five percent (5%) of ~~the family's anticipated~~ gross monthly household income will be reimbursed by the Department for the amount paid that exceeds the five percent (5%), except as provided in ~~Subsection 050.02 of~~ this rule. ~~(3-15-22)~~( )

0~~5~~3. **Cost-Sharing Suspended**. A~~ family~~ household that exceeds the five percent (5%) maximum amount for cost-sharing~~ will~~ for the calendar month is not~~ be~~ required to pay~~ a~~ cost-sharing~~ portion~~ for any~~ family participant~~ household member for the remainder of the calendar month~~ in which proof of payment is established~~. ~~(3-15-22)~~( )

051. - 199. (RESERVED)

200. PREMIUMS FOR PARTICIPATION UNDER THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP).

01. **~~Family~~ Household Income Above 133% of FPG**. ~~Each SCHIP p~~Participants with~~ family~~ household income above one hundred thirty-three percent (133%) and equal to or less than one hundred fifty percent (150%) of the current FPG~~ must~~ pay a monthly premium of ten dollars ($10) to the Department. ~~(3-15-22)~~( )

02. **~~Family~~ Household Income Above 150% of FPG**. ~~Each SCHIP p~~Participants with ~~family~~ household income above one hundred fifty percent (150%) and equal to or less than one hundred eighty-five percent (185%) of the current FPG~~ must~~ pay a monthly premium of fifteen dollars ($15) to the Department. ~~(3-15-22)~~( )

03. **Premium Recalculation**. Premiums are recalculated at each annual eligibility redetermination. If the Department receives verification of a reduction in household income prior to annual eligibility redetermination, the premium is recalculated. The Department waives any premium for participants who become eligible for Title XIX Medicaid. ( )

04. **Premium Reduction**. The monthly premium for SCHIP participants may be reduced by ten dollars ($10) per month under IDAPA 16.03.09, "Medicaid Basic Plan Benefits." ( )

201. -- 204. (RESERVED)

205. PREMIUMS FOR PARTICIPATION UNDER HOME CARE FOR CERTAIN DISABLED CHILDREN (HCCDC).

01. **~~Family~~Household Income Above 150% and Equal to or Less Than 185% of FPG**. ~~Each HCCDC p~~Participants with~~ a family~~ household income above one hundred fifty percent (150%) and equal to or less than one hundred eighty-five percent (185%) of the current FPG~~ must~~ pay a monthly premium of fifteen dollars ($15) ~~to the Department~~. The maximum monthly premium~~ a family must pay~~ is limited to thirty dollars ($30). ~~(3-15-22)~~( )

02. **~~Family~~Household Income Above 185% of FPG**.~~ Each HCCDC family~~ Participants with income above one hundred eighty-five percent (185%) of the current FPG~~ must~~ pay a monthly premium~~ to the Department~~. The monthly premium is a fixed percentage of~~ the family's~~ household income as provided in the table below.

TABLE 205.02 SLIDING FEE SCHEDULE FOR MONTHLY PREMIUMS FOR HCCDC PARTICIPATION		
~~Family~~Household Income Above 185% of Current FPG		Premium Based on % of ~~Family~~Household Income
ABOVE	LESS THAN OR EQUAL TO	
185%	250%	1.0%
250%	300%	1.5%
300%	400%	2.0%
400%	500%	2.5%

TABLE 205.02 SLIDING FEE SCHEDULE FOR MONTHLY PREMIUMS FOR HCCDC PARTICIPATION		
~~Family~~Household Income Above 185% of Current FPG		Premium Based on % of ~~Family~~Household Income
500%	600%	3.0%
600%	700%	3.5%
700%	800%	4.0%
800%	900%	4.5%
900%	No Upper Limit	5.0%

~~(3-15-22)~~(____)

~~**03.** **Reduction of Premium for Creditable Health Insurance**. A family who purchases creditable health insurance for the participant may receive a twenty-five percent (25%) reduction of the required monthly premium.~~ ~~(3-15-22)~~

0~~4~~3. **Failure to Provide Information**. Failure to provide the Department with information~~ needed~~ to determine~~ family income and household size~~ eligibility may subject the participant to a monthly premium equal to the average monthly cost of coverage for participants receiving Medicaid Enhanced Plan Benefits through HCCDC. ~~(3-15-22)~~(____)

0~~5~~4. **Failure to Pay Premium**. Failure to pay the premium~~ for an HCCDC participant~~ will not cause the participant to lose coverage or eligibility for services.~~ A participant eligible through HCCDC is exempt from the provisions of Section 250 of these rules.~~ ~~(3-15-22)~~(____)

0~~6~~5. **Waiver of Premium**. The premium~~ may be~~ is waived if the Department determines~~ that~~ payment of the premium would cause undue hardship~~ on the family~~. Undue hardship exists when an unexpected expense would cause the~~ family~~ household to forgo basic food or shelter~~ in order~~ to make a premium payment. Detailed documentation of the~~ family's~~ household's living~~ and insurance~~ expenses demonstrating such hardship must be provided to the Department. ~~(3-15-22)~~(____)

0~~7~~6. **Premium Recalculation**. ~~The p~~Premiums~~ amount is~~ are recalculated at each annual eligibility ~~renewal~~ determination. If~~ a financially responsible adult reports a reduction in family income prior to renewal~~ the Department receives verification of a reduction in household income prior to annual redetermination, the premium ~~will be reduced to the appropriate level upon verification of the reduction to the family's income~~ is recalculated. ~~When the family income is at a level that does not require premium payments, the premium will no longer be assessed.~~ ~~(3-15-22)~~(____)

206. (RESERVED)

207. PREMIUMS FOR PARTICIPATION UNDER THE YOUTH EMPOWERMENT SERVICES (YES) PROGRAM.

01. **Premium Fee Schedule**. ~~Each YES program p~~Participants~~, as that individual is defined in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Section 636, is~~ are subject to assessment of a premium~~ based on family income~~. The Department~~ will~~ establishes a premium fee schedule~~ at rates not to exceed maximums set forth in federal law and regulations governing state Medicaid programs. The fee schedule will be~~ that is published on the Department's website~~ and provided to families participating in the YES program who are subject to premiums~~ at https://healthandwelfare.idaho.gov/services-programs/medicaid-health. ~~(3-15-22)~~(____)

~~**02.** **Enforcement of Premiums**. Payment of premiums will be enforced within the limitations of federal laws and regulations governing state Medicaid programs.~~ ~~(3-15-22)~~

0~~3~~2. Waiver of Premium. The monthly premium~~ described in Subsection 207.01 of~~ under this rule~~ may be~~ is waived if the Department determines~~ that~~ the~~ family~~ household is unable to participate in the cost of care. ~~(3-15-22)~~( )

0~~4~~3. Premium Recalculation. The premium amount is recalculated at each annual eligibility redetermination.~~ If a financially responsible adult reports a reduction in family income prior to eligibility redetermination, the premium will be reduced to the appropriate level upon verification of the reduction in the family's income. When the family income is reduced to a level that does not require premium payments, the premium will no longer be assessed.~~ ~~(3-15-22)~~( )

208. -- 209. (RESERVED)

210. DEPARTMENT RESPONSIBILITIES.

01. Assessed Premiums. A participant~~ will~~ is not~~ be~~ assessed premiums during the~~ time~~ initial eligibility~~ is~~ determin~~ed~~ation. Obligation for premium payments does not begin for at least sixty (60) days after receipt of application, except for workers with disabilities under~~ Section 215 of~~ these rules. ~~(3-15-22)~~( )

02. Premiums Not Assessed Due to Late Review. A participant cannot be assessed premiums for extra months of eligibility received due solely to the Department's~~ late~~ untimely review of continuing eligibility, except for workers with disabilities under~~ Section 215 of~~ these rules. ~~(3-15-22)~~( )

03. No Retroactive Premiums Assessed. A participant cannot be assessed premiums for months of retroactive eligibility. ( )

04. Notification of Premiums. The Department~~ is required to~~ routinely~~ notify~~ notifies~~ a~~ participants of their premium payment obligations including any delinquencies, if applicable. ~~(3-15-22)~~( )

211. -- 214. (RESERVED)

215. PREMIUMS FOR PARTICIPATION IN MEDICAID~~ ENHANCED PLAN~~ WORKERS WITH DISABILITIES.

01. Workers with Disabilities.~~ A participant in the Medicaid for Workers with Disabilities coverage group must share in the cost of Medicaid coverage, if required.~~ Countable income is determined under IDAPA 16.03.05, "Eligibility for Aid to the Aged, Blind, and Disabled (AABD)." ~~A participant's premium for his share of Medicaid costs under this coverage group is determined in Subsections 215.01.a. through 215.01.c. of this rule.~~ The monthly premium is a fixed percentage of countable income as provided on the Department's website at https://healthandwelfare.idaho.gov/services-programs/medicaid-health. ~~(3-15-22)~~( )

~~**a.** A participant who has countable income at or below one hundred thirty-three percent (133%) of the current federal poverty guideline is not required to pay a premium for Medicaid. (3-15-22)~~

~~**b.** A participant who has countable income above one hundred thirty-three percent (133%) to two hundred fifty percent (250%) of the current federal poverty guideline is required to pay a monthly premium of ten dollars ($10) to the Department. (3-15-22)~~

~~**c.** A participant who has countable income in excess of two hundred fifty percent (250%) of the current federal poverty guideline is required to pay a monthly premium to the Department. The amount due is the greater of ten dollars ($10); or seven and one-half percent (7.5%) of the participant's income above two hundred fifty percent (250%) of the current federal poverty guideline. (3-15-22)~~

02. Recomputed Premium Amount. Premium amounts are recomputed when changes to a participant's countable income result in a different percentage premium calculation as determined in~~ Subsections 215.02 through 215.04 of~~ this rule, and at the annual re-determination. ~~(3-15-22)~~( )

216. -- 249. (RESERVED)

250. DELINQUENT PREMIUM PAYMENTS.

If the participant is sixty (60) days or more past due on ~~its~~ premium payments, the participant is contacted to determine the reason for the delinquency. If the participant's ~~countable~~ income is less than the amount used for the most recent eligibility determination, the participant is offered a new eligibility determination. ~~If a participant's family income is at a level that does not require premium payments, the premium will no longer be assessed.~~ The change is effective the month after the participant becomes eligible for such benefits. ~~The following Subsections 250.01 through 250.03 of this rule apply to delinquent premium payments.~~ ~~(3-15-22)~~( )

01. Delinquent Payments. A participant ~~must~~ is not ~~be~~ approved for or renewed for coverage that requires premium payments, if their premium payments are sixty (60) days or more delinquent ~~as of the last working day of their twelve (12) month eligibility period~~. ~~(3-15-22)~~( )

02. Reestablishing Eligibility. A participant can reestablish eligibility by paying the premium debt in full, unless ~~one (1) of the conditions listed in Subsection 250.03 applies~~ forgiven in this rule. ~~(3-15-22)~~( )

03. Premium Debt. Any premium debt assessed, but not paid, will be forgiven if one (1) of the following applies: ( )

a. The participant reports and the Department determines that the participant's ~~family~~ household income is below one hundred and thirty-three percent (133%) FPG. This may occur at any time during the eligibility period; or ~~(3-15-22)~~( )

b. A participant in the Medicaid Basic Plan has a medical condition that requires the participant to receive the benefits provided in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." ~~(3-15-22)~~( )

251. -- 299. (RESERVED)

300. PARTICIPANTS EXEMPT FROM COPAYMENT NOT ALREADY FEDERALLY EXEMPTED.

This includes participants who have other health care coverage that is the primary payor for the services provided. ( )

~~**01. Exempt Participants**. Certain participants are exempt from copayments for services described in Section 320.03 through 320.10 of these rules. Exempt participants include:~~ ~~(3-15-22)~~

~~**a.** A child under the age of nineteen (19) with family income less than or equal to one hundred and thirty-three percent (133%) of the current federal poverty guidelines (FPG);~~ ~~(3-15-22)~~

~~**b.** An individual age of nineteen (19) or older with family income less than or equal to one hundred percent (100%) of the current federal poverty guidelines (FPG);~~ ~~(3-15-22)~~

~~**c.** A pregnant or post-partum woman when the services provided are related to the pregnancy;~~ ~~(3-15-22)~~

~~**d.** An inpatient in a hospital, nursing facility, intermediate care facility for persons with intellectual disabilities (ICF/IID), or other medical institution, who is required to pay all but a nominal amount of their income to the institution for their care;~~ ~~(3-15-22)~~

~~**e.** An adult participant who receives services provided under a waiver of Section 1915c of the Social Security Act (SSA);~~ ~~(3-15-22)~~

~~**f.** A participant who has other health care coverage that is the primary payor for the services provided;~~ ~~(3-15-22)~~

~~**g.** A participant receiving hospice care;~~ ~~(3-15-22)~~

~~**h.** A child in foster care receiving aid or assistance under the Social Security Act (SSA), Title IV, Part B; (3-15-22)~~

~~**i.** A participant receiving adoption or foster care assistance under the Social Security Act (SSA), Title IV, Part E, regardless of age; and (3-15-22)~~

~~**j.** A woman eligible under the breast and cervical cancer eligibility group. (3-15-22)~~

~~**02.** **Notification of Copayment**. The Department will provide notification to each participant who is not exempt from the copayment requirements in Subsections 320.03 through 320.10 of these rules. (3-15-22)~~

301. -- 309. (RESERVED)

310. COPAYMENT FEE AMOUNTS.

~~**01.** **Nominal Amount**. The amount of the copayment must be a nominal amount as provided in 42 CFR 447.54. This nominal amount is set by the U.S. Department of Health and Human Services. (3-15-22)~~

~~**02.** **Fee Amount**. Beginning on November 1, 2011, t~~The~~ nominal~~ Copayment fee amount required to be paid by the participant ~~as a copayment~~, when applicable, is three dollars and sixty-five cents ($3.65).~~ This copayment amount will be adjusted annually as determined by the Secretary of Human Services.~~ ~~(3-15-22)~~( )

~~**03.** **Annual Increase**. The nominal fee amount will be increased annually by an adjusted percentage rate determined by the Secretary of Health and Human Services as set in the Social Security Act Section 1916. (3-15-22)~~

311. -- 319. (RESERVED)

320. ~~MEDICAID OUTPATIENT~~ SERVICES SUBJECT TO COPAYMENTS.

~~Medicaid p~~Participants are responsible for making copayments~~ for the outpatient services described in Subsections 320.01 through 320.10 of this rule,~~ unless otherwise exempt or exempted under this rule for the following.~~ The amount of the copayment is provided in Section 310 of these rules.~~ ~~(3-15-22)~~( )

01. Accessing Hospital Emergency Department for Non-Emergency Medical Conditions. ~~A participant who seeks care at a hospital emergency department for services that do not meet the definition of an emergency medical condition as defined in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," may be required to pay a copayment to the provider. A participant who must access a hospital emergency department in order to receive routine services for their medical condition is exempt from this provision.~~ ~~(3-15-22)~~( )

02. Accessing Emergency Transportation Services for Non-Emergency Medical Conditions. ~~A participant who accesses emergency transportation services for a condition that is determined by the Department to be a non-emergency medical condition may be required to pay a copayment to the provider of the service.~~ ~~(3-15-22)~~( )

03. Chiropractic Services.~~ Those services for spinal manipulation performed by a chiropractor.~~ ~~(3-15-22)~~( )

04. Occupational Therapy, Speech or Physical. ~~(3-15-22)~~( )

05 Optometric Services. ~~Those services performed by an optometrist that fall into the "General Ophthalmological Services" category of Current Procedural Terminology (CPT).~~ ~~(3-15-22)~~( )

06. Outpatient Hospital Services. ~~Any of the services included in Subsections 320.03 through 320.05 and Subsections 320.07 through 320.10 of this rule performed in an outpatient hospital setting. Services performed in a Hospital Emergency Department are excluded, except as provided for in Subsection 320.01 of this rule.~~ ~~(3-15-22)~~( )

~~07.~~ **~~Physical Therapy~~**~~.~~ ~~(3-15-22)~~

0~~8~~7. **Podiatry Services.** ~~Services provided by a podiatrist during an office visit.~~ ~~(3-15-22)~~(____)

0~~9~~8. **Physician Office Visit**. Each physician office visit, unless the visit is for: ~~(3-15-22)~~(____)

a. ~~The visit is for a~~A preventive service, including wellness exams, immunizations, or family planning~~;~~. ~~(3-15-22)~~(____)

b. ~~The visit is for u~~Urgent care provided at a clinic billing as an urgent care facility. ~~(3-15-22)~~(____)

~~10.~~ **~~Speech Therapy~~**~~.~~ ~~(____)~~

321. -- 324. (RESERVED)

325. EXCEPTION TO CHARGING A COPAYMENT.
~~In order for a copay to be charged by the provider, the Medicaid payment amount for the services rendered during a visit must be~~A provider may charge a copayment if the Medicaid reimbursement for the services rendered is equal to or greater than ten (10) times the amount of the copayment under ~~described in Section 310 of~~ these rules. ~~The Medicaid payment amount is determined by the Department and published in the Medicaid Fee Schedule.~~ ~~(3-15-22)~~(____)

326. -- 329. (RESERVED)

330. COLLECTION OF COPAYMENTS.

01. Responsibility for Collection. The provider ~~of services~~ is responsible for collection of the copayment from the participant. ~~(3-15-22)~~(____)

02. Denial of Services. The provider may require payment of ~~an~~ applicable copayment ~~prior to~~ before rendering services. ~~(3-15-22)~~(____)

03. Waiver of Copayment. The provider may ~~choose to~~ waive payment of any copayment. The provider must have a written policy describing the criteria for waiving or enforcing collection of copayments ~~and when the copay may be waived~~. ~~(3-15-22)~~(____)

04. Reduction in Reimbursement.When a copayment is applicable, the provider's reimbursement ~~will be~~ is reduced by the amount of the copayment regardless of whether ~~or not~~ a copayment was charged or collected by the provider. ~~(3-15-22)~~(____)

331. -- 399. (RESERVED)

400. PARTICIPATION IN THE COST OF HOME AND COMMUNITY-BASED WAIVER SERVICES (HCBS).
~~Medicaid p~~Participants required to participate in the cost of ~~Home and Community-Based Waiver (~~HCBS~~)~~ services as described in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," must have their share of cost determined ~~as described in Subsections 400.01 through 400.10 of~~ under this rule. ~~(3-15-22)~~(____)

01. Excluded Income. Income excluded under ~~the provisions of~~ IDAPA 16.03.05, "Eligibility for Aid to the Aged, Blind, and Disabled (AABD)," ~~Sections 723 and 725,~~ is excluded in determining participation. ~~(3-15-22)~~(____)

02. Base Participation Amount. The ~~B~~base participation amount is income available ~~for participation~~ to the participant after subtracting all allowable deductions, except for the incurred medical expense ~~deduction in Subsection 400.07 of this rule. Base participation is calculated by the participant's Self Reliance Specialist. The incurred medical expense deduction is calculated by the Division of Welfare.~~ in IDAPA 16.03.05, "Eligibility for Aid to the Aged, Blind, and Disabled (AABD)." ~~(3-15-22)~~(____)

~~**03.** **Community Spouse**. Except for the elderly or physically disabled participant's personal needs allowance, base participation for a participant with a community spouse is calculated under IDAPA 16.03.05, "Eligibility for Aid to the Aged, Blind, and Disabled (AABD)," Section 725. A community spouse is the spouse of an HCBS participant who is not an HCBS participant and is not institutionalized. The HCBS personal needs allowance for a participant living in adult residential care equals the federal Supplemental Security Income (SSI) benefit rate for an individual living independently. (3-15-22)~~

~~**04.** **Home and Community Based Services (HCBS) Spouse**. Except for the elderly or physically disabled participant's personal needs allowance (PNA), base participation for a participant with an HCBS spouse is calculated and specified under IDAPA 16.03.05, "Eligibility for Aid to the Aged, Blind, and Disabled (AABD)," Section 723. An HCBS spouse is the spouse of a participant who also receives HCBS. (3-15-22)~~

0~~5~~3. **Personal Needs Allowance (PNA)**. The participant's ~~personal needs allowance~~ PNA depends on ~~whether~~ the participant's ~~has a~~ legal obligation to pay rent or mortgage. ~~The participant's personal needs allowance~~ and is deducted from ~~any~~ countable income after income exclusions and ~~before other allowable deductions~~ any incurred medical expenses allowances. ~~To determine the amount of the personal needs allowance, use Table 400.05 of this rule:~~

~~TABLE 400.05 - PERSONAL NEEDS ALLOWANCE~~	
~~Amount of Personal Needs Allowance (PNA) for Participation~~	
~~Not Responsible for Rent or Mortgage~~	~~Responsible for Rent or Mortgage~~
~~One hundred percent (100%) of the federal SSI benefit for a person with no spouse~~	~~One hundred and eighty percent (180%) of the Federal SSI benefit for a person with no spouse~~

~~(3-15-22)~~(____)

a. PNA for participants not responsible for rent or mortgage equals one hundred percent (100%) of the federal SSI benefit. (____)

b. PNA for participants responsible for rent or mortgage equals one hundred eighty percent (180%) of the federal SSI benefit. (____)

0~~6~~4. **~~Developmentally Disabled~~ Participants with Developmental Disabilities**. These allowances are specified in IDAPA 16.03.05, "Eligibility for Aid to the Aged, Blind, and Disabled (AABD)." ~~The HCBS personal needs allowance~~ PNA for adult participants receiving ~~waiver~~ services under the Developmentally Disabled Waiver is three (3) times the federal SSI benefit amount to an individual in ~~his~~ their own home. ~~(3-15-22)~~(____)

0~~7~~5. **Incurred Medical Expenses**. Amounts for certain limited medical or remedial services not covered by the participant's Idaho Medicaid Plan and not paid by a third party may be deducted from the base participation amount. The Department must determine whether ~~a participant's~~ incurred expenses for such limited services meet the criteria for deduction. The participant must ~~report such expenses and provide verification in order for an expense~~ verify such expenses for any to be considered for deduction. Costs for over-the-counter medications are included in the ~~personal needs allowance~~ PNA and ~~will not be~~ are not considered a medical expense. Department-approved ~~D~~deductions for necessary medical or remedial expenses ~~approved by the Department will be deducted at application, and changed, as necessary, based on changes reported~~ are subtracted upon application, and updated when a participant reports changes to the Department ~~by the participant~~. ~~(3-15-22)~~(____)

0~~8~~6. **Remainder After Calculation**. Any remainder after the calculation ~~in Subsection 400.05 of this rule~~ is the maximum participation amount to be deducted from the participant's provider payments to offset the cost of services. The participation amount ~~will be~~ is collected from the participant by the provider. The Department notifies the provider and the participant ~~will be notified by the Department~~ of the amount to be collected.

~~(3-15-22)~~(____)

0~~9~~7. Recalculation of Participation. The participant's participation amount ~~must be~~ is recalculated annually at eligibility redetermination or ~~whenever a change in income or deductions becomes known to the Department~~ upon verified changes. ~~(3-15-22)~~(____)

~~10~~08. Adjustment of Participation Overpayment or Underpayment Amounts. The participant's participation amount is reduced or increased the month following the month ~~the participant overpaid or underpaid the provider~~ of overpayment or underpayment. ~~(3-15-22)~~(____)

401. -- 999. (RESERVED)

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.03.22 – RESIDENTIAL ASSISTED LIVING FACILITIES

DOCKET NO. 16-0322-2301

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2024 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. The pending rule will become final and effective upon the adjournment, *sine die*, of the Second Regular Session of the Sixty-seventh Idaho Legislature after approval.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 39-3305 and 39-3358, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

Many Residential Assisted Living Facilities (RALFs) have communicated they are unable to admit residents based on their staffing levels which potentially leaves residents without placement options. This rulemaking is being made by the Department of Health and Welfare in collaboration with stakeholders such as the Idaho Health Care Association. These changes are to assist and streamline the process for potential applicants for RALFs while balancing the safety of residents. The changes included allow for widening of the labor pool for RALFs, and also give the Department different options instead of only the revocation of a license.

There are no changes to the pending rule and it is being adopted as originally proposed. The complete text of the proposed rule was published in the July 5, 2023, Idaho Administrative Bulletin, Vol. 23-7, pages 80 through 85.

FEE SUMMARY: Pursuant to Section 67-5224(2)(d), Idaho Code, this pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature. The following is a description of the fee or charge imposed or increased in this rulemaking: Does not apply to this rulemaking.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state General Fund greater than ten thousand dollars ($10,000) during the fiscal year:

This rulemaking is not anticipated to have any fiscal impact on state funds, including the General Fund, or any other known funds.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Tom Moss at 208-830-6730.

DATED this 30th of November, 2023.

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THE FOLLOWING NOTICE PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 39-3305 and 39-3358, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than July 19, 2023.

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

Many facilities have communicated they are unable to admit residents based on their staffing levels which potentially leave residents without placement options. This rulemaking is being made by the Department of Health and Welfare (DHW) in collaboration with stakeholders such as the Idaho Health Care Association (IHCA). These changes are to assist and streamline the process for potential applicants for Residential Assisted Living Facilities (RALFs) while balancing the safety of residents. Changes include allows for widening of the labor pool for RALFs, and also gives the Department different options instead of only the revocation of a license.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased:

There are no fee changes associated with this proposed rulemaking.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year resulting from this rulemaking:

This rulemaking is not anticipated to have any fiscal impact on the State Funds, General Funds, or any other known funds.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the March 1, 2023, Idaho Administrative Bulletin, Volume 23-3, pages 20 through 21.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into this rule:

There are no incorporation by reference changes included in this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Tom Moss, 208-830-6730.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before July 26, 2023.

DATED this 26th day of May, 2023.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0322-2301

110. FACILITY LICENSE APPLICATION.

01. License Application. License application forms are available online at the Licensing Agency's website at http://assistedliving.dhw.idaho.gov. The applicant must provide the following information: (3-15-22)

a. A written statement that the applicant has thoroughly read and reviewed the statute, Title 39, Chapter 33, Idaho Code, and IDAPA 16.03.22, "Residential Assisted Living Facilities," and is prepared to comply with both; (3-15-22)

b. A written statement and documentation that demonstrate no license revocation or other enforcement action ~~has been taken, or~~ is in the process of being taken, against a license held, or previously held, by the applicant in Idaho or any other state or jurisdiction; (3-15-22)(____)

c. When the applicant is a firm, association, organization, partnership, business trust, corporation, government entity, or company, the administrator and other members of the organization who directly influence the facility's operation must provide the information contained in this rule; (3-15-22)

d. Each shareholder or investor holding ~~ten~~ twenty percent (~~1~~20%) or more interest in the business must be listed on the application; ~~(3-15-22)~~(____)

e. A copy of the Certificate of Assumed Business Name from the Idaho Secretary of State; (3-15-22)

f. A statement from the local fire authority that the facility is located in a lawfully constituted fire district or affirmation that a lawfully constituted fire authority will respond to a fire at the facility; (3-15-22)

g. A statement from a licensed electrician or the local or state electrical inspector that all wiring in the facility complies with current electrical codes; (3-15-22)

h. When the facility does not use an approved municipal water or sewage treatment system, a statement from a local environmental health specialist with the public health district indicating that the water supply and sewage disposal system meet the Department's requirements and standards; (3-15-22)

i. A complete set of printed operational policies and procedures; (3-15-22)

j. A detailed floor plan of the facility, including measurements of all rooms, or a copy of architectural drawings. See Sections 250 through 260, and Sections 400 through 430 of these rules. (3-15-22)

k. A copy of the Purchase Agreement, Lease Agreement, or Deed; and (3-15-22)

l. For facilities with nine (9) beds or more, signatures must be obtained from the following: (3-15-22)

i. The local zoning official documenting that the facility meets local zoning codes for occupancy; (3-15-22)

ii. The local building official documenting that the facility meets local building codes for occupancy; and (3-15-22)

iii. The local fire official documenting that the facility meets local fire codes for occupancy. (3-15-22)

02. Written Request for Building Evaluation. The applicant must request in writing to the Licensing Agency for a building evaluation of existing buildings. The request must include the physical address of the building that is to be evaluated and the name, address, and telephone number of the person who is to receive the building evaluation report. (3-15-22)

03. Building Evaluation Fee. This application and request must be accompanied by a five hundred dollar ($500) initial building evaluation fee. (3-15-22)

04. Identification of the Licensed Administrator. The applicant must provide a copy of the administrator's license and criminal history background check, and the current address for the primary residence of the administrator. (3-15-22)

05. Failure to Complete Application Process. Failure of the applicant to complete the Licensing Agency's application process within six (6) months of the original date of application, may result in a denial of the application. If the application is denied, the applicant is required to initiate a new licensing application process. (3-15-22)

(BREAK IN CONTINUITY OF SECTIONS)

215. REQUIREMENTS FOR A FACILITY ADMINISTRATOR.

Under Section 39-3321, Idaho Code, each facility must have one (1) licensed administrator assigned as the person responsible for the day-to-day operation of the facility. Multiple facilities under one (1) administrator may be allowed by the Department based on an approved plan of operation for up to three (3) buildings with a total of no more than fifty (50) beds, or up to two (2) buildings with a total of no more than eighty (80) beds. The criteria and procedure for requesting to have multiple facilities under one (1) administrator is posted on the Residential Assisted Living Facilities Program website. (3-15-22)

01. Administrator Responsibility. The administrator is responsible for ensuring that policies and procedures are developed and implemented to fulfill the requirements in Title 39, Chapter 33, Idaho Code, and IDAPA 16.03.22, “Residential Assisted Living Facilities.” (3-15-22)

02. Availability of Administrator. The facility's administrator must be on-site sufficiently to ensure safe and adequate care of the residents. The facility's administrator or their designee must be available to be on-site at the facility within two (2) hours. The facility must continuously employ an administrator. (3-15-22)

03. Lapse of Administrator. If the facility operates for more than thirty (30) days without a licensed administrator, it will result in a core issue deficiency. (3-15-22)

04. Representation of Residents. The owner or administrator, their relatives, and employees cannot act as, or seek to become the legal guardian of, or have power of attorney for any resident. Specific limited powers of attorney to address emergency procedures where competent consent cannot otherwise be obtained, are permitted. (3-15-22)

05. Responsibility for Acceptable Admissions. The administrator must ensure that no resident is knowingly admitted or retained who requires care as defined in Section 39-3307, Idaho Code, and Section 152 of these rules. (3-15-22)

06. Sexual Offender. The administrator must ensure that a nonresident on the sexual offender registry is not allowed to live or work in the facility. (3-15-22)

07. Notification to Adult Protection and Law Enforcement. The administrator must ensure that adult protection and law enforcement are notified in accordance with Sections 39-5303 and 39-5310, Idaho Code. (3-15-22)

08. Procedures for Investigations. The administrator must ensure the facility procedures for

investigation of complaints, incidents, accidents, and allegations of abuse, neglect, or exploitation are implemented to ensure resident safety. Procedures must include: (3-15-22)

a. Administrator Notification. The administrator, or person designated by the administrator, must be notified of all incidents, accidents, allegations of abuse, neglect, or exploitation immediately, and notified of complaints within one (1) business day. (3-15-22)

b. Investigation within Thirty Days. The administrator or designee must complete an investigation and written report of the findings within thirty (30) calendar days for each accident, incident, complaint, or allegation of abuse, neglect, or exploitation. (3-15-22)

c. Resident Protection. Any resident involved must be protected during the course of the investigation. (3-15-22)

d. Written Response to Complaint within Thirty Days. The person making the complaint must receive a written response from the facility of the action taken to resolve the matter, or the reason why no action was taken within thirty (30) days of the complaint. (3-15-22)

e. Corrective Action. When abuse, neglect, exploitation, incidents, and accidents occur, corrective action must be immediately taken and monitored to ensure the problem does not recur. (3-15-22)

f. Notification to Licensing Agency within One Business Day. When a reportable incident occurs, the administrator or designee must notify the Licensing Agency within one (1) business day of the incident. (3-15-22)

g. Identify and Monitor Patterns. The administrator or designee must identify and monitor patterns of accidents, incidents, or complaints and must develop interventions to prevent recurrences. (3-15-22)

09. Administrator's Designee. A person authorized in writing to act in the absence of the administrator. An administrator's designee may act in the absence of the administrator for no longer than thirty (30) consecutive days when the administrator is on vacation, has days off, is ill, or is away for training or meetings. (3-15-22)

10. Ability to Reach Administrator or Designee. The administrator or their designee must be reachable and available at all times. (3-15-22)

11. Minimum Age of Personnel. The administrator will ensure that no personnel providing hands-on care or supervision services will be under ~~eighteen~~ seventeen (1~~8~~7) years of age unless they have completed a certified nursing assistant (CNA) certification course. ~~(3-15-22)~~(____)

12. Notification to Licensing Agency. The facility must notify the Licensing Agency, in writing, within three (3) business days of a change of administrator. (3-15-22)

(BREAK IN CONTINUITY OF SECTIONS)

930. ENFORCEMENT ACTION OF TEMPORARY MANAGEMENT.

01. Need for Temporary Management. The Department may impose the action of temporary management in situations where there is a need to oversee operation of the facility and to ensure the health and safety of the facility's residents: (3-15-22)

a. During an orderly transfer of residents of the facility to other facilities; or (3-15-22)

b. Pending improvements to bring the facility into compliance with program requirements. (3-15-22)

02. Notice of Temporary Management. The Department will give written notice to the facility of the imposition of temporary management. (3-15-22)

03. Who May Serve as a Temporary Manager. The Department may appoint any person or organization that meets the following qualifications: (3-15-22)

a. The temporary manager must not have any financial interest in the facility to be managed; (3-15-22)

b. The temporary manager must not be related, within the first degree of kinship, to the facility's owner, manager, administrator, or other management principal; (3-15-22)

c. The temporary manager must possess sufficient training, expertise, and experience in the operation of a facility as would be necessary to achieve the objectives of temporary management. If the temporary manager is to serve in a facility, the manager must possess an Residential Assisted Living Administrator's license; and (3-15-22)

d. The temporary manager must not be an existing competitor of the facility who would gain an unfair competitive advantage by being appointed as temporary manager of the facility. (3-15-22)

04. Powers and Duties of the Temporary Manager. The temporary manager has the authority to direct and oversee the management, and to hire and discharge any consultant or personnel, including the administrator of the facility. The temporary manager has the authority to direct the expenditure of the revenues of the facility in a reasonable and prudent manner, to oversee the continuation of the business and the care of the residents, to oversee and direct those acts necessary to accomplish the goals of the program requirements, and to direct and oversee regular accounting. When the facility fails or refuses to carry out the directions of the temporary manager, the Department ~~will~~ may revoke the facility's license. ~~(3-15-22)~~(   )

a. The temporary manager must observe the confidentiality of the operating policies, procedures, employment practices, financial information, and all similar business information of the facility, except that the temporary manager must make reports to the Department; (3-15-22)

b. The temporary manager may be liable for gross, willful or wanton negligence, intentional acts of omissions, unexplained shortfalls in the facility's fund, and breaches of fiduciary duty; (3-15-22)

c. The temporary manager does not have authority to cause or direct the facility, its owner, or administrator to incur debt, unless to bring the facility into compliance with these rules, or to enter into any contract with a duration beyond the term of the temporary management of the facility; (3-15-22)

d. The temporary manager does not have authority to incur, without the permission of the owner, administrator, or the Department, capital expenditures in excess of two thousand dollars ($2,000), unless the capital expenditures are directly related to correcting the identified deficiencies; (3-15-22)

e. The temporary manager does not have authority to cause or direct the facility to encumber its assets or receivables; (3-15-22)

f. The temporary manager does not have authority to cause or direct a facility, which holds liability or casualty insurance coverage, to cancel or reduce its liability or casualty insurance coverage; and (3-15-22)

g. The temporary manager does not have authority to cause or direct the sale of the facility, its assets or the premises on which it is located. (3-15-22)

05. Responsibility for Payment of the Temporary Manager. All compensation and per diem costs of the temporary manager must be paid by the licensee. (3-15-22)

06. Termination of Temporary Management. A temporary manager may be replaced under the following conditions: (3-15-22)

a. The Department may require replacement of any temporary manager whose performance is deemed unsatisfactory by the Department. No formal procedure is required for such removal or replacement, but written notice of any action will be given to the facility. (3-15-22)

b. A facility subject to temporary management may petition the Department for replacement of a temporary manager whose performance it considers unsatisfactory. The petition must include why the replacement of a temporary manager is necessary or appropriate. (3-15-22)

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.04.18 – CHILDREN'S AGENCIES AND RESIDENTIAL LICENSING

DOCKET NO. 16-0418-2301

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2024 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. The pending rule will become final and effective upon the adjournment, *sine die*, of the Second Regular Session of the Sixty-seventh Idaho Legislature after approval.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 39-1207, 39-1208, 39-1209, 39-1210, 39-1213, 56-1003, 56-1004A, and 56-1005(8), Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

The Federal Bureau of Investigation (FBI) Criminal Justice Information Law Unit denied the background clearance information in the current set of rules within 16.04.18, "Children's Agencies and Residential Licensing," based on their interpretation of Pub. L. 92-544. The revised language follows the current FBI guidance to identify and clarify specific actual classes of individuals subject to a Department background check.

There are no changes to the pending rule and it is being adopted as originally proposed. The complete text of the proposed rule was published in the May 3, 2023, Idaho Administrative Bulletin, Vol. 23-5, pages 152 through 160.

FEE SUMMARY: Pursuant to Section 67-5224(2)(d), Idaho Code, this pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature. The following is a description of the fee or charge imposed or increased in this rulemaking: Does not apply to this rulemaking.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state General Fund greater than ten thousand dollars ($10,000) during the fiscal year:

There is no anticipated impact to the state General Fund, any dedicated fund, or federal fund.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Ms. Frede' Teske at 208-334-0649.

DATED this 30th of November, 2023.

Trinette Middlebrook and Frank Powell
DHW – Administrative Rules Unit
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THE FOLLOWING NOTICE PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is April 6, 2023 (Sine Die).

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule, and proposed regular rulemaking procedures have been initiated. The action is authorized pursuant to Sections 39-1207, 39-1208, 39-1209, 39-1210, 39-1213, 56-1003, 56-1004A, and 56-1005(8).

PUBLIC HEARING SCHEDULE: Public hearings concerning this rulemaking will be held as follows:

VIRTUAL TELECONFERENCES Via WebEx
Wednesday, May 10, 2023 **10:00 a.m. - 11:00 a.m. (MT)**
Join from the meeting link **https://idhw.webex.com/idhw/j.php?MTID=m0142248d5b3168792dade6300059ff38** **Join by meeting number** **Meeting number (access code): 2764 520 0612** **Meeting password: 6pKxZeZct28 (67599392 from phones and video systems)** **Join by phone** **+1-415-527-5035 United States Toll** **+1-303-498-7536 United States Toll (Denver)**
Wednesday, May 17, 2023 **10:00 a.m. - 11:00 a.m. (MT)**
Join from the meeting link **https://idhw.webex.com/idhw/j.php?MTID=m74191cf2d5548775efcaf7928ced5954** **Join by meeting number** **Meeting number (access code): 2764 726 9065** **Meeting password: XNgj9yP3b8E (96459973 from phones and video systems)** **Join by phone** **+1-415-527-5035 United States Toll** **+1-303-498-7536 United States Toll (Denver)**

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is the required finding and concise statement of its supporting reasons for adopting a temporary rule and a nontechnical explanation of the substance and purpose of the proposed rulemaking:

The Federal Bureau of Investigation (FBI) Criminal Justice Information Law Unit denied the background clearance information in the current set of rules within 16.04.18, "Children's Agencies and Residential Licensing," based on their interpretation of Pub. L. 92-544. The revised language follows the current FBI guidance to identify and clarify specific actual classes of individuals subject to a Department background checks.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section(s) 67-5226(1) (b), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate for the following reasons:

This temporary rulemaking is to align with the Federal Bureau of Investigation (FBI) request to allow the Department the ability to submit background checks through the FBI database(s).

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased:

There is no fee or charge imposed with this rulemaking.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year:

There is no anticipated impact to the state General Fund, any dedicated fund, or federal fund.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted to comply with the Federal Bureau of Investigation (FBI) Criminal Justice Information Law Unit's request to clarify the classes of individuals subject to background checks within this chapter of rule.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into this rule:

There is no change to an incorporation by reference associated with this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Ms. Frede' Teske at 208-334-0649.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before May 24, 2023.

DATED this 7th day of April, 2023.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0418-2301

000. LEGAL AUTHORITY.
Sections 39-1207, 39-1208, 39-1209, 39-1210, 39-1213, 56-1003, 56-1004A, and 56-1005(8), Idaho Code, authorizes the Department and the ~~*Idaho*~~ Board of Health and Welfare to adopt and enforce rules for licensing ~~*children's agencies, children's residential care facilities, and children's therapeutic outdoor programs*~~ these organizations. ~~*(4-6-23)*~~( )

~~***001. SCOPE AND POLICY.***~~

~~***01. Scope***~~~~*. These rules establish requirements for licensing, maintaining, and operating the following facilities or programs in Idaho:*~~ ~~*(4-6-23)*~~

~~*a.* *Children's agencies;* *(4-6-23)*~~

~~*b.* *Children's residential care facilities; and* *(4-6-23)*~~

~~*c.* *Children's therapeutic outdoor programs.* *(4-6-23)*~~

~~***02.*** ***Policy**. The Department will assure that Idaho children receive adequate substitute parental care in case of absent parents, or the temporary or permanent inability of parents to provide care and protection, or if parents are seeking alternative twenty-four (24) hour care for their children.* *(4-6-23)*~~

00~~2~~1. – 008. (RESERVED)

009. ~~*CRIMINAL HISTORY AND*~~ BACKGROUND CHECK REQUIREMENTS.

01. Compliance~~*with Background Check*~~. Background checks are required for individuals ~~*who are*~~ licensed under these rules and must comply with IDAPA 16.05.06, "Criminal History and Background Checks," except for those individuals under Subsection 009.03 of this rule. ~~*(4-6-23)*~~( )

02. Individuals Subject to Background Check Requirements. The following individuals must receive a ~~*background*~~ clearance ~~*according to*~~ under IDAPA 16.05.06, "Criminal History and Background Checks:" ~~*(4-6-23)*~~( )

a. ~~*Contract employees or volunteers that have unsupervised time with children;*~~ Adoptive parents and any other adult residing in the home at any time during the adoption process. ~~*(4-6-23)*~~( )

~~*b.* *Any adult living on the premises;* *(4-6-23)*~~

~~*c.* *Adoptive Parents;* *(4-6-23)*~~

~~*d.* *Agency Licensed Foster Parents.* *(4-6-23)*~~

~~*e*~~**b.** Children's ~~*Agency Facility Staff*~~ Agencies; ~~*(4-6-23)*~~( )

i. Chief Administrator; ( )

ii. Case Manager Supervisor; ( )

iii. Case Manager; ( )

iv. Support Staff; and ( )

v. Contractors and volunteers that have unsupervised time with children. ( )

~~*f*~~**c.** Children's Residential Care ~~*Facility Staff; and*~~ Facilities: ~~*(4-6-23)*~~( )

i. Owners; ( )

ii. Chief Administrator; ( )

iii. Medical Professional; ( )

iv. Licensed Treatment Professional; ( )

v. Case Manager Supervisor; ( )

vi. Case Manager; ( )

vii. Support Staff; ( )

viii. Direct Care Staff Supervisor; ( )

ix. Direct Care Staff; ( )

x. Teacher; and ( )

xi. Contractors and volunteers that have unsupervised time with children. ( )

~~g~~**d**. Children's Therapeutic Outdoor Programs ~~*Staff.*~~: ~~*(4-6-23)*~~( )

i. Owners; ( )

ii. Chief Administrator; ( )

iii. Field Director; ( )

iv. Licensed Treatment Professional; ( )

v. Senior Field Staff; ( )

vi. Field Staff; ( )

vii. Intern; ( )

viii. Support Staff; and ( )

ix. Contractors and volunteers that have unsupervised time with children. ( )

03. Exception~~s~~ to ~~*Background Checks*~~ Clearance Requirement. ~~*Background checks are optional for:*~~ Children's residential care facilities have discretion whether to require a clearance for any individual covered in Subsection 009.02 of this rule who has duties or performs tasks that do not involve contact with a child or their personal belongings. ~~*(4-6-23)*~~( )

~~*a. Youth in foster care who reach eighteen (18) years old and continue to reside in the same licensed foster home. (4-6-23)*~~

~~*b. Youth in a children's residential care facility who reach eighteen (18) years old who continue to live in the same licensed residential facility. (4-6-23)*~~

~~*c. Any employee, contractor, or volunteer of an organization who does not have access to a child living in a residential care facility, and who has duties or performs tasks that do not involve contact with a child or their personal belongings. (4-6-23)*~~

010. DEFINITIONS A THROUGH M.

01. Chief Administrator. The duly authorized representative or designee of an organization responsible for day-to-day operations, management, and compliance with these rules and Title 39, Chapter 12, Idaho Code. (4-6-23)

02. Child. Under Title 39, Chapter 12, Idaho Code, a "child" is an individual less than eighteen (18) years old, synonymous ~~*with juvenile or*~~ minor. ~~*(4-6-23)*~~( )

03. Child Care. The care, control, supervision, or maintenance of a child for twenty-four (24) hours a day provided as an alternative to parental care. (4-6-23)

04. Children's Agency. A business for the placement of children in foster homes or for adoption and who does not provide child care as part of that business. A children's agency includes those providing home studies, post-placement supervision, post-finalization services, and other domestic and international adoptive services under Title 39, Chapter 1202(4), Idaho Code. A children's agency does not include an Idaho certified adoption specialist. (4-6-23)

05. Children's Camp. A program of child care at a location away from the child's home that is primarily recreational and includes the overnight accommodation of the child and is not intended to provide treatment, therapy, or rehabilitation for the child. (4-6-23)

06. Children's Residential Care Facility. A children's institution as defined in Section 39-1202(6), Idaho Code, but excluding foster homes, children's therapeutic outdoor programs, accredited residential schools, and children's camps if the camps provide child care for less than nine (9) consecutive weeks in any one (1) year period. (4-6-23)

07. Children's Therapeutic Outdoor Program. A program that provides child care designed to provide behavioral, substance abuse, or mental health services to children in an outdoor setting. Also known as "outdoor program." (4-6-23)

~~***08. Continued Care**. The ongoing placement of an individual who reaches the age of eighteen (18) years but is less than twenty-one (21) years old. (4-6-23)*~~

0~~9~~8. Department. The Idaho Department of Health and Welfare, the Department Director, or designee. (4-6-23)

~~10~~09. Direct Care Staff. An employee who has direct personal interaction with children in the supervision of child care. (4-6-23)

1~~1~~0. Disrupted Placement. When a child is discharged by the organization based on the child's behaviors, or when a child is removed from an adoptive placement before the adoption is finalized. (4-6-23)

1~~2~~1. Governmental Unit. The State of Idaho, any county, municipality, or other political subdivision, or any department, division, board, or other agency thereof. (4-6-23)

1~~3~~2. Intercountry Adoption. The placement of a child from one (1) country to another for the purpose of adoption. (4-6-23)

1~~4~~3. Mechanical Restraint. Devices used to restrict a person's free movement. (4-6-23)

1~~5~~4. Medical Professional. Person who received a degree in nursing or medicine and is licensed as a nurse, licensed nurse practitioner, physician's assistant, or medical doctor. (4-6-23)

011. DEFINITIONS N THROUGH Z.

01. Nonaccredited Residential School. A residential school for any number of children that is not certified or accredited pursuant to Section 39-1207, Idaho Code, or has lost accreditation and is subject to the jurisdiction of the Department as a children's residential care facility pursuant to Section 39-1210, Idaho Code, unless and until accreditation is certified by the Idaho Department of Education. (4-6-23)

~~***02. Noncompliance**. Violation of, or inability to meet, the requirements of these rules or the terms of licensure. (4-6-23)*~~

0~~3~~2. Operator. An individual who operates or maintains within Idaho a children's residential care facility, children's agency, or outdoor program. (4-6-23)

0~~4~~3. Organization. A children's agency, a children's residential care facility, or an outdoor program. (4-6-23)

0~~*5*~~4. **Person**. Any individual, association, partnership, corporation, or any group thereof. (4-6-23)

0~~*6*~~5. **Physical Restraint Intervention**. Any intervention utilized to control the range and motion of an individual, including an escort, to assist a child in moving from one location to another. (4-6-23)

0~~*7*~~6. **Placement**. The activities and arrangements related to finding a suitable home or facility for a child. (4-6-23)

0~~*8*~~7. **Plan of Correction**. The detailed procedures developed between the Department and an organization required to bring the organization into compliance. (4-6-23)

0~~*9*~~8. **Residential School**. A residential facility for children that provides services substantially comparable to those provided in nonresidential public schools where the primary purpose is the education and academic pursuits of the students. All additional provisions of Section 39-1202(23), Idaho Code, also apply in defining "Residential School". (4-6-23)

~~*10*~~09. **Seclusion**. A room within a facility designed to temporarily isolate an individual to gain emotional or physical control by means of structure and minimal stimulation. (4-6-23)

1~~*1*~~0. **Staff-Child Ratio**. The maximum number of children allowed under the care and supervision of one (1) staff. (4-6-23)

1~~*2*~~1. **Substance Abuse Treatment Facility**. A licensed children's residential care facility participating in the public Substance use Disorder (SUD) system specializing in providing programs of treatment for children whose primary problem is alcohol or drug abuse, under IDAPA 16.07.17, "Substance Use Disorders Services." Private pay children's residential care facilities must utilize licensed professionals under IDAPA 16.07.17 to provide specialized treatment for children whose primary problem is alcohol or drug abuse. (4-6-23)

1~~*3*~~2. **Supervision**. Monitoring a child based on their individual needs to provide for their safety and protection. (4-6-23)

13. **Support Staff**. Any employee of an organization that provides food service, transportation service, maintenance service, housekeeping service, or administrative support. ( )

14. **Time-Out**. Separation of a child from an activity as a means of behavior management. (4-6-23)

15. **Training**. Instruction related to child care that increases knowledge, skill, and abilities. (4-6-23)

012. – 099. (RESERVED)

LICENSING AND CERTIFICATION
Sections 100 – 199

100. LICENSING.

~~*These rules set requirements and monitor compliance.*~~ ~~*(4-6-23)*~~

~~***01.*** ***Operator Responsibilities**. The operator must conform to the terms of the license.*~~ ~~*(4-6-23)*~~

0~~*2*~~1. **Knowledge of Standards**. The operator is responsible for knowing and always complying with the rules regulating the license. The operator is responsible for ensuring that staff are familiar with the rules governing their organization. (4-6-23)

0~~*3*~~2. **Voluntary Closure**. The operator must notify the Department of any voluntary closure prior to the closure date. (4-6-23)

0~~*4*~~3. **Voluntary Withdrawal of License**. The Department will withdraw the license of an organization

that has not provided services in the last licensed year. (4-6-23)

0~~5~~4. **Operating Without a License**. If children are found in an unlicensed organization, the Department will refer to law enforcement or Child Protective Services if it has been determined that an immediate threat to the children's health and safety exists; (4-6-23)

~~***06.*** ***Operating an Unlicensed Organization***. *Operating an unlicensed organization is a misdemeanor under Sections 39-1220 and 39-1221, Idaho Code.* *(4-6-23)*~~

0~~7~~5. **Exceptions and Exemptions**. Under Sections 39-1206 and 39-1211, Idaho Code, these rules do not apply to: (4-6-23)

a. The occasional or irregular care of a neighbor's, relative's or friend's child or children by a person not ordinarily engaged in child care; or (4-6-23)

b. Children's camps that only provide child care for any one (1) child for less than nine (9) consecutive weeks in any one (1) year period. A children's camp that provides child care for any one (1) child for more than nine (9) consecutive weeks in any one (1) year period constitutes a children's residential care facility and is subject to these rules. A children's camp that also constitutes a residential school must be governed as a residential school. (4-6-23)

(BREAK IN CONTINUITY OF SECTIONS)

102. DISPOSITION OF APPLICATIONS.
After receipt of a completed application that addresses each requirement for the organization, the Department will review the materials for compliance with these rules and will act on the application within thirty (30) days after receipt of the completed application. (4-6-23)

01. **Application Approval**. A license will be issued to any organization in compliance with these rules. The license is issued under the terms specified in the licensing survey and will be sent to the applicant. (4-6-23)

02. **License**. A license will be issued to any organization in compliance with these rules and will specify the terms of licensure, such as: (4-6-23)

a. Capacity, age range, and gender; (4-6-23)

b. Specific services under the approved program description; and (4-6-23)

c. Effective up to twelve (12) months from the date of issuance unless suspended or revoked earlier. (4-6-23)

03. **Variance**. A license will be issued to an organization that has been approved for a variance through the Department-approved process, under Section 67-5230, Idaho Code. Variances must be approved annually. (4-6-23)

04. **Provisional License** ~~***for Idaho-Licensed Organizations***~~. A provisional license may be issued to an organization when a licensing standard is not met but can be expected to be corrected within six (6) months of issuing the provisional license, provided this does not endanger the health, safety, and well-being of any child in care or who may come into care during the period of the provisional license. A provisional license will be issued according to Section 39-1216, Idaho Code. ~~*(4-6-23)*~~(____)

05. **Denial of Application**. If an application is denied, notification will be sent to the applicant stating the basis for such denial. (4-6-23)

06. ~~***Failure to C***~~**Incomplete Application Process**. Failure of the applicant to progress in the

application process will result in a denial of the application. ~~(4-6-23)~~(____)

(BREAK IN CONTINUITY OF SECTIONS)

106. COMPLAINT INVESTIGATION.
The Department will investigate complaints ~~which may include further contact with the complainant, scheduled or unannounced visits to the organization, review of records, and collateral contacts including interviews and review of records with any persons who may have knowledge of the complaint~~ and has the discretion to decide which methods and tasks of investigation to employ. Onsite investigations can be unannounced and without prior notice. ~~(4-6-23)~~(____)

(BREAK IN CONTINUITY OF SECTIONS)

108. NONRENEWAL, DENIAL, REVOCATION, OR SUSPENSION OF LICENSE.
If, upon investigation, it is found that an applicant or operator has failed or refused to comply with the provisions of the Child Care Licensing Reform Act, ~~Sections 39-1201 through 39-1224~~ Title 39, Chapter 12, Idaho Code, or with these rules, or with any provision of the license, the Department may deny, suspend, revoke, or not renew a license. The Department may also deny, suspend, revoke, or deny renewal of a license for any organization when the following is determined: ~~(4-6-23)~~(____)

01. Criminal Conviction or Relevant Record. Anyone providing direct care or working onsite under these rules is denied background clearance or refuses to comply with requirements in IDAPA 16.05.06, "Criminal History and Background Checks." (4-6-23)

02. Other Misconduct. The applicant, operator, or the chief administrator: (4-6-23)

a. Fails to furnish any data, statistics, records, or information requested by the Department without good cause or provides false information. (4-6-23)

b. Has been found guilty of, or is under investigation for, fraud, deceit, misrepresentation, or dishonesty with the operation of the organization. (4-6-23)

c. Has been found guilty of, or is under investigation for, the commission of any felony. (4-6-23)

d. Has knowingly permitted, aided, or abetted the commission of any illegal act. (4-6-23)

03. Transfer of Children. May occur under the following circumstances: (4-6-23)

a. Any condition that endangers the health or safety of any resident or child. (4-6-23)

b. An organization is not in substantial compliance with, or has repeat violations of, these rules. (4-6-23)

c. An organization has made little or no progress in correcting deficiencies within thirty (30) days from the date the Department accepted a plan of correction. (4-6-23)

d. An organization has knowingly misrepresented or omitted information on the application or other documents pertinent to obtaining a license. (4-6-23)

e. Refusal to allow Department full access to the organization's grounds, facilities, and records. (4-6-23)

f. An organization has violated the terms or conditions of a provisional license. (4-6-23)

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.06.01 – CHILD AND FAMILY SERVICES

DOCKET NO. 16-0601-2301

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2024 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. The pending rule will become final and effective upon the adjournment, *sine die*, of the Second Regular Session of the Sixty-seventh Idaho Legislature after approval.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 16-1629, 16-1623, 16-2102, 16-2406, 16-2423, and 16-2433, 39-1209 through 1211, 39-5603, 39-7501, 56-202(b), 56-204A, 56-803, 56-1003, 56-1004, 56-1004A, and 56-1007, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

Under the Adoption Section there is clear language that outlines that only social workers are responsible for assisting children in processing grief and loss as a result of their separation from their parents. Language specific to "social workers" needs to be modified to include family services workers, which includes licensed and non-licensed social workers and individuals with a human services degree. This change aligns with current staffing and practices and allows all Department staff who fall under the definition of "family services worker" (who maintains case planning and case management responsibilities) the authority to complete monthly contacts with children in foster care as required by the Social Security Act under Sections 422(b)(17) and 424(f).

There are no changes to the pending rule and it is being adopted as originally proposed. The complete text of the proposed rule was published in the July 5, 2023, Idaho Administrative Bulletin, Vol. 23-7, pages 86 through 93.

FEE SUMMARY: Pursuant to Section 67-5224(2)(d), Idaho Code, this pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature. The following is a description of the fee or charge imposed or increased in this rulemaking: Does not apply to this rulemaking.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state General Fund greater than ten thousand dollars ($10,000) during the fiscal year:

This rulemaking is not anticipated to have any fiscal impact on state funds, including the General Fund, or any other known funds.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Andie Blackwood at 208-334-5960.

DATED this 30th of November, 2023.

Trinette Middlebrook and Frank Powell
DHW – Administrative Rules Unit
450 W. State Street – 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
phone: (208) 334-5500
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e-mail:dhwrules@dhw.idaho.gov

THE FOLLOWING NOTICE PUBLISHED WITH THE TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is August 1, 2023.

AUTHORITY: In compliance with Sections 67-5221(1) and 67-5226, Idaho Code, notice is hereby given that this agency has adopted a temporary rule, and proposed regular rulemaking procedures have been initiated. The action is authorized pursuant to Sections 16-1629, 16-1623, 16-2102, 16-2406, 16-2423, and 16-2433, 39-1209 through 1211, 39-5603, 39-7501, 56-202(b), 56-204A, 56-803, 56-1003, 56-1004, 56-1004A, and 56-1007, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearings concerning this rulemaking will be held as follows:

VIRTUAL TELECONFERENCES Via WebEx
Tuesday, July 18, 2023 **6:00 p.m. - 7:00 p.m. (MT)**
Join from the meeting link **https://idhw.webex.com/idhw/j.php?MTID=mc7d53907650200da9d06e6be05c3454e** **Join by meeting number** **Meeting number (access code): 2760 984 7541** **Meeting password: pyNdh2pBp33 (79634272 from phones and video systems)** **Join by phone** **+1-415-527-5035 United States Toll** **+1-303-498-7536 United States Toll (Denver)**
Monday, July 24, 2023 **12:00 p.m. - 1:00 p.m. (MT)**
Join from the meeting link **https://idhw.webex.com/idhw/j.php?MTID=m812a3317a64004e88b620790a38ceb4a** **Join by meeting number** **Meeting number (access code): 2761 427 2715** **Meeting password: reSu3V35pYK (73783835 from phones and video systems)** **Join by phone** **+1-415-527-5035 United States Toll** **+1-303-498-7536 United States Toll (Denver)**

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below. Each meeting will conclude after 30 minutes if no participants sign into the meeting.

DESCRIPTIVE SUMMARY: The following is the required finding and concise statement of its supporting reasons for adopting a temporary rule and a nontechnical explanation of the substance and purpose of the proposed rulemaking:

Under the Adoption Section there is clear language that outlines that only social workers are responsible for assisting children in processing grief and loss as a result of their separation from their parents. Language specific to "social workers" needs to be modified to include family services workers, which includes licensed and non-licensed social workers and individuals with a human services degree. This change aligns with current staffing and practices and allows all Department staff who fall under the definition of "family services worker" (who maintains case planning and case management responsibilities) the authority to complete monthly contacts with children in foster care as required by the Social Security Act §422(b)(17) and §424(f).

TEMPORARY RULE JUSTIFICATION: Pursuant to Section(s) 67-5226(1) Section (c), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate for the following reasons:

This change is necessary for the protection of the public health, safety, or welfare of citizens utilizing the services in family services and clarifies rule to align with current practice.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased:

There are no associated fee changes due to the Temporary and Proposed rule changes in this rulemaking.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year:

This rulemaking is not anticipated to have any fiscal impact on the State Funds, General Funds, or any other known funds.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because these changes are simple, align with current practices, and clarifies processes in rule.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into this rule:

There are no incorporation by reference changes included in this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Sabrina Brown, 208-850-5662.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before July 26, 2023.

DATED this 26th day of May, 2023.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0601-2301

011. DEFINITIONS AND ABBREVIATIONS F THROUGH K.
For the purposes of these rules, the following terms are used: (3-15-22)

01. Family. Parent(s), legal guardian(s), related individuals including birth or adoptive immediate family members, extended family members and significant other individuals, who are included in the family plan. (3-15-22)

02. Family Assessment. An ongoing process based on information gained through a series of meetings

with a family to gain mutual perception of strengths and resources that can support them in creating long-term solutions related to identified service needs and safety threats to family integrity, unity, or the ability to care for their members. (3-15-22)

03. Family Case Record. Electronic and hard copy compilation of all documentation relating to a family, including legal documents, identifying information, and evaluations. (3-15-22)

04. Family (Case) Plan. Also referred to as a family service plan. A written document that serves as the guide for provision of services. The plan, developed with the family, clearly identifies who does what, when, how, and why. The family plan incorporates any special plans made for individual family members. If the family includes an Indian child, or child's tribe, tribal elders or leaders should be consulted early in the plan development. (3-15-22)

05. Family Services Worker. ~~Any of the direct service~~ Case carrying personnel~~, including social workers,~~ working in regional Child and Family Services Programs. ~~(3-15-22)~~(   )

06. Federally-Funded Guardianship Assistance for Relatives. Benefits described in Subsection 702.04 and Section 703 of these rules provided to a relative guardian for the support of a child who is fourteen (14) years of age or older, who, without guardianship assistance, would remain in the legal custody of the Department of Health and Welfare. (3-15-22)

07. Field Office. A Department of Health and Welfare service delivery site. (3-15-22)

08. Goal. A statement of the long-term outcome or plan for the child and family. (3-15-22)

09. Independent Living. Services provided to eligible foster or former foster youth, ages fourteen (14) to twenty-three (23), designed to support a successful transition to adulthood. (3-15-22)

10. Indian. Any person who is a member of an Indian tribe or who is an Alaska Native and a member of a Regional Corporation as defined in 43 U.S.C. 1606. (3-15-22)

11. Indian Child. Any unmarried person who is under the age of eighteen (18) who is: (3-15-22)

a. A member of an Indian tribe; or (3-15-22)

b. Eligible for membership in an Indian tribe, and who is the biological child of a member of an Indian tribe. (3-15-22)

12. Indian Child Welfare Act (ICWA). The Indian Child Welfare Act, 25 U.S.C. 1901, et seq. (3-15-22)

13. Indian Child's Tribe. (3-15-22)

a. The Indian tribe in which an Indian child is a member or eligible for membership, or (3-15-22)

b. In the case of an Indian child who is a member of or eligible for membership in more than one (1) tribe, the Indian tribe with which the Indian child has the more significant contacts. (3-15-22)

14. Indian Tribe. Any Indian Tribe, band, nation, or other organized group or community of Indians recognized as eligible for the services provided to Indians by the Secretary because of their status as Indians, including any Alaska Native village as defined in 43 U.S.C. 1602(c). (3-15-22)

15. Intercountry Adoption Act of 2000 (P.L. 106-279). Federal law designed to protect the rights of, and prevent abuses against children, birth families, and adoptive parents involved in adoptions (or prospective adoptions) subject to the Convention on Protection of Children and Cooperation in Respect of Intercountry Adoption, and to insure that such adoptions are in the children's best interests; and to improve the ability of the federal government to assist U.S. citizens seeking to adopt children from abroad and residents of other countries party to the Convention seeking to adopt children from the United States. (3-15-22)

16. Interethnic Adoption Provisions of 1996 (IEP). IEP prohibits delaying or denying the placement of a child for adoption or foster care on race, color or national origin of the adoptive or foster parent(s), or the child involved. (3-15-22)

17. Interstate Compact on the Placement of Children (ICPC). Interstate Compact on the Placement of Children (ICPC) in Title 16, Chapter 21, Idaho Code, ensures that the jurisdictional, administrative, and human rights obligations of interstate placement or transfers of children are protected. (3-15-22)

18. Kin. Non-relatives who have a significant, family-like relationship with a child. Kin may include godparents, close family friends, clergy, teachers, and members of a child's Indian tribe. Also known as fictive kin. (3-15-22)

012. DEFINITIONS AND ABBREVIATIONS L THROUGH R.
For the purposes of these rules, the following terms are used: (3-15-22)

01. Legal Guardianship. A judicially-created relationship, in accordance with Title 15, Chapter 5, Part 2, Idaho Code, including one made by a tribal court, between a child and a relative or non-relative. (3-15-22)

02. Licensed. Facilities or programs are licensed in accordance with the provisions of IDAPA 16.06.02, "Child Care Licensing." (3-15-22)

03. Licensing. See IDAPA 16.06.02, "Child Care Licensing," Section 100. (3-15-22)

04. Medicaid. See "Title XIX." (3-15-22)

05. Multiethnic Placement Act of 1994 (MEPA). MEPA prohibits states or public and private foster care and adoption agencies that receive federal funds from delaying or denying the placement of any child solely on the basis of race, color, or national origin. (3-15-22)

06. Parent. A person who, by birth or through adoption, is considered legally responsible for a child. The term "legal guardian" is not included in the definition of parent. (3-15-22)

07. Permanency Planning. A primary function of family services initiated in all cases to identify programs, services, and activities designed to establish permanent home and family relationships for children within a reasonable amount of time. (3-15-22)

08. Personal Care Services (PCS). Services to eligible Medicaid recipients that involve personal and medically-oriented tasks dealing with the physical or functional impairments of the individual. (3-15-22)

09. P.L. 96-272. Public Law 96-272, the federal "Adoption Assistance and Child Welfare Act of 1980." (3-15-22)

10. P.L. 105-89. Public Law 105-89, the federal "Adoptions and Safe Families Act of 1997," amends P.L. 96-272 and prohibits states from delaying or denying cross-jurisdictional adoptive placements with an approved family. (3-15-22)

11. Planning. An orderly rational process that results in identification of goals and formulation of timely strategies to fulfill such goals, within resource constraints. (3-15-22)

12. Qualified Expert Witness--ICWA. An individual who is an expert regarding tribal customs pertaining to family organization and child rearing practice, and is qualified to render an opinion as to whether continued custody of the child by the parent(s), or Indian custodian(s), is likely to result in serious emotional or physical damage to the child. (3-15-22)

13. Relative. Person related to a child by blood, marriage, or adoption. (3-15-22)

14. **Relative Guardian**. A relative who is appointed a child's legal guardian in accordance with Title 15, Chapter 5, Part 2, Idaho Code, including a guardianship established by a tribal court. (3-15-22)

15. **Reservation**. A reservation is an area of land "reserved" by or for an Indian band, village, or tribe(s) to live on and use. Reservations were created by treaty, by congressional legislation, or by executive order. Since 1934, the Secretary of the Interior has had the responsibility of establishing new reservations or adding land to existing reservations. (3-15-22)

16. **Respite Care**. Time-limited care provided to children. Respite care is utilized in circumstances that require short term, temporary care of a child by a licensed or agency-approved caregiver different from their usual caregiver. The duration of an episode of respite care ranges from one (1) partial day up to fourteen (14) consecutive days. (3-15-22)

~~**17.** **Responsible Party**. A Department social worker, clinician, or service provider who maintains responsibility and authority for case planning and case management. (3-15-22)~~

(BREAK IN CONTINUITY OF SECTIONS)

405. ALTERNATE CARE CASE MANAGEMENT.
Case management must continue while the child is in alternate care and must ensure the following: (3-15-22)

01. **Preparation for Placement**. Preparing a child for placement in alternate care is the joint responsibility of the child's family, the child (when appropriate), the family services worker, and the alternate care provider. (3-15-22)

02. **Information for Alternate Care Provider**. The Department and the family have informed the alternate care provider of their roles and responsibilities in meeting the needs of the child including: (3-15-22)

a. Any medical, health and dental needs of the child including the names and address of the child's health and educational providers, a record of the child's immunizations, the child's current medications, the child's known medical problems, and any other pertinent health information concerning the child; (3-15-22)

b. The name of the child's doctor; (3-15-22)

c. The child's current functioning and behaviors; (3-15-22)

d. A copy of the child's portion of the service plan including any visitation arrangements; (3-15-22)

e. The case history of the child, including the reason the child came into foster care, the child's legal status, and the permanency goal for the child; (3-15-22)

f. A history of the child's previous placements and reasons for placement changes, excluding information that identifies or reveals the location of any previous alternate care providers without their consent; (3-15-22)

g. The child's cultural and racial identity; (3-15-22)

h. Any educational, developmental, or special needs of the child; (3-15-22)

i. The child's interest and talents; (3-15-22)

j. The child's attachment to current caretakers; (3-15-22)

k. The individualized and unique needs of the child; (3-15-22)

l. Procedures to follow in case of emergency; and (3-15-22)

m. Any additional information, that may be required by the terms of the contract with the alternate care provider. (3-15-22)

03. Consent for Medical Care. Parent(s) or legal guardian(s) have signed a Departmental form of consent for medical care and keep the family services worker advised of where they can be reached in case of an emergency. Any refusal to give medical consent must be documented in the family case record. (3-15-22)

04. Financial Arrangements. The family services worker must assure that the alternate care provider understands the financial and payment arrangements and that necessary Department forms are completed and submitted. (3-15-22)

05. Contact with Child. The family, the family services worker, and the alternate care provider have established a schedule for frequent and regular visits with the child by the family and by the family services worker or designee. (3-15-22)

a. Face-to-face contact with a child by the ~~responsible party~~ assigned family services worker must occur at least monthly or more frequently depending on the needs of the child or the provider, or both, and the stability of the placement. Face-to-face contact may be made in settings other than where the child resides as long as contact between the ~~responsible party~~ assigned family services worker and the child occurs where the child resides a minimum of once every sixty (60) days. ~~(3-15-22)~~( )

b. The Department will have strategies in place to detect abuse, neglect, or abandonment of children in alternate care. (3-15-22)

~~**c.** Face-to-face contact between the responsible party and a child placed in an in-state group or residential care facility, located a significant distance from the responsible party's office is required a minimum of once every ninety (90) days. Communication by phone between the responsible party and the child must occur at least monthly. (3-15-22)~~

~~d~~c. Frequent and regular contact between the child and parents and other family members will be encouraged and facilitated unless it is specifically determined not to be in the best interest of the child. Such contact will be face-to-face if possible, with this contact augmented by telephone calls, written correspondence, pictures, and the use of video and other technology as may be relevant and available. (3-15-22)

~~**e.** Children who are in out-of-state placements through the Interstate Compact on the Placement of Children (ICPC) must be contacted face-to-face no less frequently than every six (6) months, by either the responsible party in Idaho, by a representative of the state in which the child is placed, or by a private agency contracted by either. Idaho will request the state in which the child is placed to have face-to-face contact with the child on a monthly basis. If the policy of the state in which the child is placed allows only for face-to-face contact every six (6) months, the responsible party in Idaho will contact the child and the child's caregiver each month by phone to confirm the child's safety and well-being. (3-15-22)~~

06. Discharge Planning. Planning for discharge from alternate care are developed with all concerned parties. Discharge planning will be initiated at the time of placement and completed prior to the child's return home or to the community. (3-15-22)

07. Transition Planning. Planning for discharge from alternate care into a permanent placement are developed with all concerned parties. Discharge planning will be initiated at the time of placement and completed prior to the child's return home or to the community. (3-15-22)

08. Financial and Support Services. As part of the discharge planning, Departmental resources are coordinated to expedite access to Department financial and medical assistance and community support services. (3-15-22)

(BREAK IN CONTINUITY OF SECTIONS)

701. SERVICES TO BE PROVIDED IN ADOPTIONS.
In addition to the core services provided under these rules, the Department must assure provision of the following: (3-15-22)

01. Response to Inquiries. Written or personal inquiries from prospective adoptive families must be answered within two (2) weeks. (3-15-22)

02. Pre-Placement Child/Family Assessment. An assessment of the child's family of origin history, needs as an individual and as part of a family, and completion of a life story book for each child preparing for adoptive placement. (3-15-22)

03. Compliance with Multi-Ethnic Placement Act and Interethnic Adoption Provisions. Selection of the most appropriate adoptive family consistent with the Multi-Ethnic Placement Act and Interethnic Adoption Provisions, if the child is not an Indian. (3-15-22)

04. (Pre-Placement) Home Study. An adoptive home study to ensure selection of an appropriate adoptive home. (3-15-22)

05. Preparation for Placement. Preparation of the child by an assigned ~~social worker~~ family services worker who will assist the child in addressing anticipated grief and loss due to separation from their parents and assisting the child with the transition into an adoptive home. ~~(3-15-22)~~( )

06. Technical Assistance. Assistance in completing the legal adoption, including compliance with the Indian Child Welfare Act. (3-15-22)

07. Adoption Assistance. A determination of eligibility for adoption assistance must be made for each child placed for adoption through the Department prior to the finalization of their adoption. Eligibility for adoption assistance is determined solely on the child's need. No means test may be applied to the adoptive family's income or resources. Once eligibility is established, the Division will negotiate a written agreement with the adoptive family. The agreement must be fully executed by all parties prior to the finalization of the adoption in order to be valid. (3-15-22)

08. Period of Support Supervision. Once a child is placed with an adoptive family, a period of support and supervision by the Department lasting at least six (6) months must be completed prior to the finalization of the adoption. If the child has been a foster child placed with the family for a period of at least six (6) months, the family may submit a written request to the Department's Child and Family Services Program Manager to reduce the supervisory period to a minimum of three (3) months. (3-15-22)

09. Post Adoption Services. Services after an adoption is final are provided within available resources. Children with negotiated adoption assistance agreements, whether from Idaho or from another state, are eligible for any services available to Idaho children. International adoptees residing in Idaho are also eligible for any services available to Idaho children under the Inter-Country Adoption of 2000 (P.L.106-279). Children with either IV-E or state adoption assistance agreements are eligible for Medicaid in Idaho. A referral from an Interstate Compact on Adoption and Medical Assistance member state will serve as a formal application for services in Idaho. Applications for Medicaid are made through the Department in accordance with IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children." (3-15-22)

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.06.02 – FOSTER CARE LICENSING

DOCKET NO. 16-0602-2301 (ZBR CHAPTER REWRITE)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo and Incorporation By Reference Synopsis (IBRS)

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2024 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. The pending rule will become final and effective upon the adjournment, *sine die*, of the Second Regular Session of the Sixty-seventh Idaho Legislature after approval.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 39-1211, 39-1213, 56-1003, 56-1004A, and 56-1005(8), Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

The 2023 Legislature requested that IDAPA chapter 16.06.02, "Child Care and Foster Care Licensing," be separated by content for Daycare Licensing and Foster Care Licensing. IDAPA chapter 16.06.02 will now contain content for "Foster Care Licensing" and IDAPA 16.06.03 will contain content for "Daycare Licensing." The update to this chapter will reflect the removal of the daycare licensing rules.

There are no changes to the pending rule and it is being adopted as originally proposed. The complete text of the proposed rule was published in the August 2, 2023, Idaho Administrative Bulletin, Vol. 23-8, pages 67 through 106.

FEE SUMMARY: Pursuant to Section 67-5224(2)(d), Idaho Code, this pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature. The following is a description of the fee or charge imposed or increased in this rulemaking: Does not apply to this rulemaking.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state General Fund greater than ten thousand dollars ($10,000) during the fiscal year:

This rulemaking is not anticipated to have any fiscal impact on state funds, including the General Fund, or any other known funds.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Andie Blackwood: 208-334-5960 (FACS), or Julie Sevcik, 208-863-4229.

DATED this 30th of November, 2023.

Trinette Middlebrook and Frank Powell
DHW – Administrative Rules Unit
450 W. State Street – 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
phone: (208) 334-5500
fax: (208) 334-6558
e-mail:dhwrules@dhw.idaho.gov

THE FOLLOWING NOTICE PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 39-1211, 39-1213, 56-1003, 56-1004A, and 56-1005(8), Idaho Code.

PUBLIC HEARING SCHEDULE: Two public hearings concerning this rulemaking will be held as follows:

VIRTUAL TELECONFERENCES Via WebEx
Wednesday, August 17, 2023 **10:00 a.m. - 12:00 p.m. (MT)**
Join from the meeting link **https://idhw.webex.com/idhw/j.php?MTID=mf977f9364a62f4a2684571b6ae176e0d** **Join by meeting number** **Meeting number (access code): 2764 489 3359** **Meeting password: jEhhamvs252 (53442687 from phones and video systems)** **Join by phone** **+1-415-527-5035 United States Toll** **+1-303-498-7536 United States Toll (Denver)**
Wednesday, August 17, 2023 **4:00 p.m. - 6:00 p.m. (MT)**
Join from the meeting link **https://idhw.webex.com/idhw/j.php?MTID=m9dd9bc1b157bcdc221553cc72c6ed5c4** **Join by meeting number** **Meeting number (access code): 2764 491 3545** **Meeting password: XVjt3DKMS37 (98583356 from phones and video systems)** **Join by phone** **+1-415-527-5035 United States Toll** **+1-303-498-7536 United States Toll (Denver)**

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below. Meeting(s) will conclude after 30 minutes if no participants sign in or wish to comment in the meeting.

DESCRIPTIVE SUMMARY: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

The 2023 Legislature requested that IDAPA chapter 16.06.02, “Child Care and Foster Care Licensing,” be separated by content for Child Care Licensing and Foster Care Licensing. IDAPA chapter 16.06.02 will now contain content for “Foster Care Licensing” and IDAPA 16.06.03 will contain content for “Child Care Licensing.” The update to this chapter will reflect the removal of the child care licensing rules.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased:

This chapter does not have any fees.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the State General Fund greater than ten thousand dollars ($10,000) during the fiscal year as a result of this rulemaking:

This rulemaking is not anticipated to have any fiscal impact on the State General Fund, or any other known funds.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because the 2023 Legislature requested that this existing chapter of 16.06.02, “Child Care and Foster Care Licensing,” be split into two (2) different chapters. The administrative rulemaking deadlines did not allow for negotiated rulemaking meetings to take place and due to the legislative request the Department is going forward with the separation and will offer public hearings for all the stakeholders.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into this rule:

The only remaining Incorporations By Reference will be for Crib Safety (Full Size Cribs and Non-Full Size Cribs) in Section 004 of these rules.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Kaela Whitehead: 208-789-4789 and Andie Blackwood: 208-334-5960 (FACS); Aubrie Hunt: 208-334-5686 (SR).

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before August 23, 2023.

DATED this 6th day of July, 2023.

THE FOLLOWING IS THE TEXT OF ZBR DOCKET NO. 16-0602-2301

16.06.02 – FOSTER CARE LICENSING

000. LEGAL AUTHORITY.
Sections 39-1211, 39-1213, 56-1003, 56-1004A, and 56-1005(8)Idaho Code, authorize the Department and the Board to adopt and enforce rules for licensing foster homes. ( )

001. (RESERVED)

002. INCORPORATION BY REFERENCE.
The following are incorporated by reference in these rules. ( )

01. Crib Safety - Full-Size Baby Cribs. Consumer Product Safety Commission, Compliance information for full size cribs can be found at https://www.cpsc.gov/Business--Manufacturing/Business-Education/FAQ?p=3019&tid%5b3028%5d=3028. ( )

02. Crib Safety - Non-Full-Size Baby Cribs. Consumer Product Safety Commission, Compliance

information for non-full size cribs can be found at https://www.cpsc.gov/Business--Manufacturing/Business-Education/FAQ?p=3019&tid%5b3029%5d=3029. ( )

003. -- 008. (RESERVED)

009. BACKGROUND CHECK REQUIREMENTS.

01. Department Background Check Compliance. Background checks are required for individuals licensed under these rules and must comply with IDAPA 16.05.06, "Criminal History and Background Checks," except for those individuals described in Subsection 009.04 of this rule. ( )

02. When License is Granted. The applicant(s) and any other adult(s) living in a foster home must have a completed background check under IDAPA 16.05.06, "Criminal History and Background Checks," including clearance, prior to licensure. ( )

03. Those Subject to Background Check Requirements. The following individuals must receive Department clearance prior to licensure: ( )

a. Adoptive Parents. ( )

b. Licensed Foster Parents. Requirements are under Section 202 of these rules; and ( )

c. Adults residing in a licensed foster home. ( )

04. Exceptions to Background Checks. Background checks are optional for certain youth in foster care who reach the age of eighteen (18) but are less than twenty-one (21) years of age and continue to reside in the same licensed foster home. ( )

010. DEFINITIONS A THROUGH M.

01. Board. The Idaho Board of Health and Welfare. ( )

02. Caregiver. A foster parent with whom a child in foster care has been placed or a designated official for a child care institution in which a child in foster care has been placed. ( )

03. Chief Administrator. The duly authorized representative or designee of an organization responsible for day-to-day operations, management, and compliance with these rules and Title 39, Chapter 12, Idaho Code. ( )

04. Child. ( )

a. Under Title 39, Chapter 12, Idaho Code, and these rules, "child" means an individual less than eighteen (18) years old. ( )

b. Includes individuals age eighteen (18) to twenty-one (21) who are ordered into or voluntarily entered Extended Foster Care through the Department. ( )

05. Children's Agency. A business for the placement of children in foster homes or for adoption and who does not provide child care as part of that business. A children's agency includes those providing home studies, post-placement supervision, post-finalization services, and other domestic and international adoptive services under Title 39, Chapter 1202(4), Idaho Code. A children's agency does not include an Idaho certified adoption specialist. ( )

06. Department. The Idaho Department of Health and Welfare or its authorized representatives. ( )

07. Foster Care. The twenty-four (24) hour substitute parental care for children placed away from

their parents or guardians by persons who may or may not be related to the child and for whom the state agency has placement and care responsibility. ( )

08. Foster Home. The private home of an individual or family licensed or approved as meeting the standards for foster care and providing twenty-four (24) hour substitute parental care to six (6) or fewer children. ( )

09. Foster Parent. A person(s) residing in a private home under their direct control to whom a foster care license has been issued. ( )

10. Medical Professionals. Persons who have received a degree in nursing or medicine and are licensed as a registered nurse, nurse practitioner, physician's assistant, or medical doctor. ( )

11. Household Member. Any person, other than a foster child, who resides in, or on the property of, a foster home. ( )

011. DEFINITIONS N THROUGH Z.

01. Noncompliance. Violation of, or inability to meet, the requirements of these rules or terms of licensure. ( )

02. Plan of Correction. The detailed procedures and activities developed between the Department and caregiver required to bring a foster family into conformity with these rules. ( )

03. Relative. Under Section 39-1202, Idaho Code, "relative" means a child's grandparent, great grandparent, aunt, great aunt, uncle, great uncle, brother-in-law, sister-in-law, first cousin, sibling, and half-sibling. ( )

04. Restraint. Physical interventions to control the range and motion of a child. ( )

05. Second Degree of Relationship. Refers to persons related by blood or marriage and includes their spouses. The number of degrees between two (2) relatives is calculated by summing the number of ties between each relative and the common ancestor. ( )

06. Supervision. Is defined as being within sight and normal hearing range of the child or children being cared for. ( )

07. Training. The preparation, instruction, and education related to child care that increases the knowledge, skill, and abilities of a foster parent or children's agency or volunteers. ( )

08. Variance. A temporary non-application of a foster care licensing rule that is resolved within six (6) months of approval. ( )

09. Waiver. The permanent non-application of a foster care licensing rule for relatives, if in the Department's judgment, the health and safety of the child is not compromised. ( )

012. -- 099. (RESERVED)

100. LICENSING.

01. Knowledge of Standards. The foster parent is responsible for knowing the rules applying to and covered by the foster care license, and for always conforming to them. ( )

02. Return of License. The foster parent must immediately return their license to the Department under any of the following circumstances: ( )

a. Address changes; ( )

b. Upon suspension or revocation of the license by the Department; or ( )

c. Upon voluntary discontinuation of service. ( )

101. (RESERVED)

102. DISPOSITION OF APPLICATIONS.
The Department will initiate action on each completed application within thirty (30) days after receipt that addresses each requirement for the specific type of home. Upon receipt of a completed application and study, the Department will review the materials for compliance with these rules. ( )

01. Approval of Application. The Department will issue a license to any foster home complying with these rules. The license is issued under the terms specified in the licensing study and will be mailed to the applicant. ( )

02. Regular License. The Department will issue a regular license to any foster home complying with these rules and will specify the terms of licensure, such as: ( )

a. The number of children who may receive care at any one (1) time; and ( )

b. Age range and gender if there are conditions in the foster home making such limitations necessary; ( )

c. The regular license for a foster home is in effect for one (1) year from the date of issuance unless suspended or revoked earlier; ( )

d. If the license for a foster home is for a specific child, the name of that child will be shown on the foster home license. ( )

03. Waiver. A regular license may be issued to the foster home of a relative who has received a waiver of licensing rules provided: ( )

a. The waiver is considered on an individual case basis; ( )

b. The waiver is approved for non-safety foster care rules; ( )

c. All other licensing requirements have been met; ( )

d. The approval of any waiver of rules requires the Department to document a description of the reasons for issuing a waiver, the rules being waived, and assurance that the waiver will not compromise the child's safety; and ( )

e. The approved waiver must be reviewed for continued need and approved annually. ( )

04. Variance. A regular license will be issued to a foster home approved for a variance of a licensing rule provided: ( )

a. The variance is considered on an individual case basis; ( )

b. The variance is approved for a non-safety licensing rule; ( )

c. The variance must have no adverse effect on the health, safety, and well-being of any child in care at the foster home; ( )

d. The variance is documented by the Department and includes a description of the reasons for issuing a variance and assurances that the variance will not compromise any child's health, safety, and well-being; and

( )

e. The variance must be reviewed for continued need and approval annually. ( )

05. Provisional License. May be issued to a foster home, when a licensing standard cannot be met but can be expected to be corrected within six (6) months, provided this does not affect the health, safety, and well-being of any child in care at the home. ( )

a. Will be in effect for not more than six (6) months. ( )

b. Only one (1) provisional license will be issued to a foster home in any twelve-month period under Section 39-1216, Idaho Code. ( )

06. Limited License. May be issued for the care of a specific child in a home which may not meet the requirements for a license, provided: ( )

a. The child is already in the home and has formed strong emotional ties with the foster parents; and ( )

b. It can be shown that the child's continued placement in the home would be more conducive to their welfare than removal to another home. ( )

07. Denial of Application. If an application is denied, a signed letter will be sent directly to the applicant by registered or certified mail, advising the applicant of the denial and stating the basis for such denial. An applicant whose application has been denied may not reapply until one (1) year after the date on the denial of application. ( )

08. Failure to Complete Application Process. ( )

a. Failure to complete the application process within six (6) months from the original date of application will result in application denial. ( )

b. An applicant whose application has been denied for being incomplete may not reapply until one (1) year after the date of application denial. ( )

103. RESTRICTIONS ON APPLICABILITY AND NONTRANSFER.

01. Department-Issued License. Applies only to the foster home or the person and premises designated. Each license is issued in the individual’s name, and to the address specified on the application. A license issued in the name of a foster parent applies to the period and services specified in the license. Any change in address renders the license null and void, and the foster parent must immediately return the license to the Department. ( )

02. Nontransferable. A license is nontransferable or assignable from one (1) individual to another or from one (1) location to another. ( )

03. Change in Location. When there is a change in location, the foster home must reapply for a license. ( )

104. MANDATORY VISITATIONS.
Under Section 39-1217, Idaho Code, the Department will visit and be given access to the premises of each foster home as deemed necessary by the Department to assure compliance with these rules but at intervals not to exceed twelve (12) months. ( )

105. REVISIT AND RELICENSE.
Revisit and relicense studies will document how the foster home continues to meet licensing standards. Consideration must be given to each standard, including a review of the previous study and original application to determine what

changes have occurred. A renewal application must be made by the foster home on the Department-furnished form and filled out prior to the expiration date of the license in effect. When a renewal application has been completed correctly, the existing license will, unless officially revoked, remain effective until the Department has acted on the application for renewal. ( )

106. COMPLAINTS.

01. Investigation. The Department will investigate complaints regarding foster homes. The investigation may include further contact with the complainant, scheduled or unannounced visits to the foster home, collateral contacts including interviews with the victim, parents or guardian, consultants, children in care, other persons who may have knowledge of the complaint, and inspections by fire or health officials. ( )

02. Informed of Action. If an initial preliminary investigation indicates that a more complete investigation must be made, the foster parents will be informed of the investigation, and any action to be taken, including referral for civil or criminal action. ( )

107. SUSPENSION FOR CIRCUMSTANCES BEYOND CONTROL OF FOSTER PARENT.
When circumstances occur over which the foster parent has no control including illness, epidemics, fire, flood, or contamination, which temporarily place the operation of the foster home out of compliance with these rules, the license must be suspended until the nonconformity is remedied. ( )

108. SUSPENSION OR REVOCATION FOR INFRACTIONS.
A license may be suspended for infractions of these rules and may lead to revocation if the foster parent fails to satisfy the Department that the infractions have been corrected in compliance with the rules. ( )

109. NON-RENEWAL, DENIAL, REVOCATION, OR SUSPENSION OF LICENSE.
If it is found that an applicant or foster parent has failed or refused to comply with any of the provisions of the Child Care Licensing Reform Act, Sections 39-1201 through 39-1224, Idaho Code, with these rules, or with any provision of the license, the Department may deny, suspend, revoke, or not renew a license. The Department may also deny, suspend, revoke, or deny renewal of a license for any foster home when any of the following occurs. ( )

01. Criminal Conviction or Relevant Record. Any adult residing in a foster home is denied clearance or refuses to comply with IDAPA 16.05.06, "Criminal History and Background Checks." ( )

02. Other Misconduct. The applicant or foster parent: ( )

a. Fails to furnish any data, statistics, records, or information requested by the Department without good cause or provides false information; ( )

b. Has been found guilty of, or is under investigation for, any felony; ( )

c. Has failed to exercise fiscal accountability toward a client or the Department regarding payment for services; or ( )

d. Has knowingly permitted, aided, or abetted the commission of any illegal act on the premises of the foster home. ( )

110. (RESERVED)

111. ENFORCEMENT REMEDY OF SUMMARY SUSPENSION AND TRANSFER OF CHILDREN.
The Department may summarily suspend a foster home license. Children in a foster home require the program to transfer children when the Department has determined a child's health and safety are in immediate jeopardy. ( )

112. ENFORCEMENT REMEDY REVOCATION OF LICENSE AND TRANSFER OF CHILDREN.
The Department may revoke the license of a foster home when the Department determines the home is not in compliance with these rules. Revocation and transfer of children may occur under the following circumstances: ( )

01. Endangers Health or Safety. Any condition that endangers the health or safety of any child. ( )

02. Not in Substantial Compliance. A foster home is not in substantial compliance with these rules. ( )

03. No Progress to Meet Plan of Correction. A foster home has made little or no progress in correcting deficiencies within thirty (30) days from the date the Department accepted a plan of correction. ( )

04. Repeat Violations. Repeat violations of these rules or of Title 39, Chapters 11 and 12, Idaho Code. ( )

05. Misrepresented or Omitted Information. A foster home has knowingly misrepresented or omitted information on the application or other documents pertinent to obtaining a license. ( )

06. Refusal to Allow Access. Refusal to allow Department representatives full access to the foster home and its grounds, facilities, and records. ( )

07. Violation of Terms of Provisional License. A foster home, that has violated any of the terms of a provisional license. ( )

113. EFFECT OF PREVIOUS REVOCATION OR DENIAL OF A LICENSE.
An organization cannot apply and the Department will not accept an application from any person, corporation, or partnership, including any owner with a ten percent (10%) or more interest, who has had a license denied or revoked, until five (5) years has elapsed from the date of denial, revocation, or conclusion of a final appeal, whichever occurred last. ( )

114. -- 199. (RESERVED)

200. LICENSING PROVISIONS RELATED TO THE INDIAN CHILD WELFARE ACT.
These rules do not supersede the licensing authority of Indian tribes under the Indian Child Welfare Act, P.L. 95-608, 25 USC, Sections 1901 – 1963. ( )

201. FOSTER PARENT QUALIFICATIONS AND SUITABILITY.
Foster parents must be physically and emotionally suited to care for children and to deal with the problems presented by children placed away from their own parents, family, and homes. An applicant for licensure as a foster parent must meet the following: ( )

01. Age. Be twenty-one (21) years old or older. ( )

02. Be of Good Character. ( )

03. Communication. Be able to communicate with the child, the licensing agency, and health care and other service providers. ( )

04. Personal Attributes and Experiences. Have the maturity, interpersonal qualities, temperament, and life experiences that prepare the foster parent to provide foster care. ( )

05. Availability for Child Placement. Express a willingness to provide care for the kind of children the children's agency has available for placement. ( )

06. Knowledge and Skill. Demonstrate an understanding of the care that must be provided to the children served by the children's agency or express a willingness to learn how to provide that care. ( )

07. Child Care and Supervision. Have adequate time to provide care and supervision for children. ( )

08. Income and Resources. Have a defined and sufficient source of income and be capable of managing that income to meet the needs of the foster family without relying on the payment made for the care of a foster child. ( )

09. Health. Have the physical, intellectual, and emotional health to assure appropriate care of children. ( )

10. Harmonious Home Life. Establish and maintain a harmonious home life to give children the emotional stability they need. No marital or personal problems may exist within the family that would result in undue emotional strain in the home or be harmful to the interest of children placed in the home. ( )

11. Literacy. At least one (1) adult caretaker in the home must have functional literacy. ( )

12. Acceptance of Foster Children. Demonstrate a willingness and ability to accept a child into the home as a member of the family. ( )

13. Family Supports. Demonstrate a willingness and ability to work with a foster child's legal family, future family, relatives, or Indian tribe. ( )

14. Compliance. Demonstrate a willingness and ability to comply with these rules. ( )

15. Illegal Substance. Foster parents will not use any illegal substances, abuse alcohol by consuming it in excessive amounts, or abuse legal prescription or nonprescription drugs, or both, by consuming them in excessive amounts or using them contrary to medication instructions. ( )

16. Nicotine Use. Foster parents and their guests will not smoke or vape in the foster family home, in any vehicle used to transport the child, or in the presence of the child in foster care. ( )

202. BACKGROUND CHECKS.

All applicants for a foster care license and other adult members of the household must comply with IDAPA 16.05.06, "Criminal History and Background Checks," and the following: ( )

01. Required Procedures. Each applicant for a foster home license, and any other adult household member, must complete a background check. ( )

02. Change in Household Membership. By the next working day after another adult begins residing in a foster home, a foster parent must notify the children's agency of the change in household membership and assure that the new adult household member will complete a background check within fifteen (15) days of residence in the foster home. ( )

03. Foster Parent's Child Turns Eighteen. A foster parent's child who turns eighteen (18) and lives continuously in the home is not required to have a background check except as specified in this rule. ( )

a. After turning eighteen (18) years old, if the foster parent's adult child no longer lives in the foster parent's home and subsequently resumes living in the foster home, they will be considered an adult household member and must complete a background check within fifteen (15) days from the date they became an adult household member. ( )

b. If the adult child leaves the foster home for the purpose of higher education or military service, and periodically returns to the home for less than ninety (90) days, they are not considered to be an adult household member and are not required to complete a background check. While in the home, they cannot have any unsupervised direct care responsibilities for any foster children in the home. Should they remain in the foster home for more than ninety (90) days, they will immediately be considered an adult household member and must complete a background check within fifteen (15) days from the date they became an adult household member. ( )

c. If the adult child continues to live in their parent's foster home or on the same property, they must

complete a background check within fifteen (15) days of turning twenty-one (21), This requirement is not necessary if the adult child has completed a background check between the ages of eighteen (18) and twenty-one (21). ( )

04. Background Check at Any Time. The Department retains the authority to require a background check at any time on individuals who are residing in a foster home or on the foster parent's property. ( )

05. Emergency Placement of Children. An emergency occurs when a child enters or experiences an unplanned placement change in foster care. The Department may request that a criminal justice agency perform a Federal Interstate Identification Index name-based criminal history record check of each adult residing in the home. This refers to those limited instances when placing a child in the home of relatives or fictive kin, as a result of a sudden unavailability of the child's parent or caretaker. ( )

a. All adult household members will submit fingerprints to the Department's Background Check Unit within ten (10) calendar days and follow requirements outlined in IDAPA 16.05.06, "Criminal History and Background Checks." The Department forwards the fingerprints to the State Central Record Repository for submission to the FBI within fifteen (15) calendar days from the date the name search was conducted. The Department's background check unit will positively identify the individual that is being considered to receive the child in an emergency situation as their fingerprints are submitted. ( )

b. When placement of a child in a home is denied as a result of the Department review of the name-based criminal history record check of any adult household member, all adults must still comply with Subsection 202.05.a. of this rule and IDAPA 16.05.06, "Criminal History and Background Checks." ( )

c. The child will be removed from the home immediately if any adult household member fails to provide written permission to perform a federal criminal history record check, submit fingerprints, or any adult household member is denied a Department background check clearance. ( )

203. INITIAL AND ONGOING EVALUATION.

An applicant must participate in the process and tasks to complete an initial evaluation for foster care licensure. ( )

01. Applicant Participation. The applicant must do all the following: ( )

a. Cooperate with and allow the children's agency to determine compliance with these rules to conduct an initial foster home study; ( )

b. Inform the children's agency if the applicant is currently licensed or has been previously licensed as a foster parent or the applicant has been involved in the care and supervision of children or adults; ( )

c. Provide a medical statement for each applicant, signed by a medical professional, within the twelve (12) month period prior to initial licensure for family foster care, indicating the applicant is in such physical and mental health to not adversely affect either the health or quality of care for children placed in the home; ( )

d. Provide the name of, and a signed release to obtain the following information about, each household member: ( )

i. Admission to or release from a facility, hospital, or institution for the treatment of an emotional, intellectual, or substance abuse issue; ( )

ii. Outpatient counseling, treatment, or therapy for an emotional, intellectual, or substance abuse issue; and ( )

e. Provide three (3) satisfactory references, one (1) of which may be from a person related to the applicant(s). An applicant will provide additional references upon the request of the children's agency. ( )

02. Physical and Mental Health of Household Members. All household members must be in such physical and mental health that the health, safety, or well-being of a foster child will not be adversely affected. A

health status report of any household member may be required from a medical professional if this appears advisable to the children's agency. To assure the safety and well-being of children, each household member must comply with these rules. ( )

03. Disclosure of Information. An applicant must provide the children's agency with the following or any additional information the children's agency deems necessary to complete the initial family home study: ( )

a. Names, including maiden or other names used, and ages of the applicant(s); ( )

b. Social Security Number; ( )

c. Education; ( )

d. Verification of marriages and divorces; ( )

e. Religious and cultural practices of the applicant including their willingness and ability to accommodate or provide care to a foster child of a different race, religion, or culture; ( )

f. Statement of income and financial resources and the family's management of these resources; ( )

g. Marital relationship, if applicable, including decision making, communication, and familial roles; ( )

h. Individual and family functioning and interrelationships with each household member; ( )

i. Any current family problems, including medical or mental illness, illegal drug use, prescription drug abuse, and excessive alcohol use; ( )

j. Previous criminal convictions and valid incidents of child abuse and neglect; ( )

k. Family history, including how the applicant was disciplined, childhood experiences, and problem solving; ( )

l. Child care and parenting skills; ( )

m. Methods of discipline; ( )

n. Names, ages, and addresses of all biological and adopted children currently residing in or outside the home; ( )

o. Adjustment and special needs of the applicant's children; ( )

p. Interests and hobbies; ( )

q. Reasons for applying to be a foster parent; ( )

r. Understanding of the purpose and goals of foster care; ( )

s. Prior and current experiences with foster care; ( )

t. Emotional stability and maturity in dealing with the needs, challenges, and related issues associated with the child’s placement into applicant(s) home; ( )

u. Attitudes toward foster care by immediate and extended family members and other persons who reside in the home; ( )

v. Applicant's attitudes about a foster child's family and the applicant's willingness to work with the child's family and tribe; ( )

w. Specifications of the children preferred by the family that include the number of children, age, gender, race, ethnic background, social, emotional, and educational characteristics of children preferred; ( )

x. Adequacy of the applicant's house, property, and neighborhood for the purpose of providing foster care as determined by onsite observations; ( )

y. Applicant(s) willingness to abide by the children's agency policies and procedures for discipline; ( )

z. Three (3) personal references, at least two (2) that are from persons not related to the applicants, reflecting the applicants to be of good character and possess good habits; ( )

aa. Training needs of the applicant(s); and ( )

bb. Capacity and willingness to transport a foster child in a motor vehicle. ( )

204. SUBSEQUENT EVALUATIONS.
A foster parent must comply with the following: ( )

01. Reasonable Access. A foster parent will allow the children's agency reasonable access to the foster home, including interviewing each foster parent, each foster child, and any household member to determine compliance with these rules, for child supervision purposes, and to conduct a relicense study. ( )

02. Update Information. Provide all changes to the information in the initial evaluation and subsequent evaluations. ( )

03. Family Functioning. Provide information on changes in family functioning and inter-relationships. ( )

04. Other Circumstances. Provide the children's agency with any information regarding circumstances within the family that may adversely impact the foster child. ( )

05. Plan of Correction. Cooperate with the children's agency in developing and carrying out a written plan required to correct any rule noncompliance identified by any evaluation conducted by the children's agency. ( )

205. FOSTER PARENT DUTIES.
A foster parent must do the following: ( )

01. Case Plan Implementation. Cooperate with, and assist the children's agency with implementation of the case plan for children and their families. ( )

02. Reporting Progress and Problems. Promptly and fully disclose to the children's agency information concerning a child's progress and problems. ( )

03. Termination of Placement. Provide notification to the children's agency of the need for a child to be moved from the foster home not less than fourteen (14) calendar days before the move, except when a delay would jeopardize the child's care or safety, or the safety of members of the foster family. ( )

04. Written Policies and Procedures. Maintain a copy of, be familiar with, and follow these rules and any other rules, policies, or procedures which an agency may require for foster parents and foster care. ( )

206. FOSTER PARENT TRAINING.
Each foster parent must comply with the following: ( )

01. Orientation. Each foster home applicant will receive an orientation related to the foster care program and services. ( )

02. Pre-Service. Complete not less than twenty-four (24) hours of identified training prior to the issuance of an initial foster care license. ( )

03. First Year. Prior to first annual licensing renewal, complete not less than fifteen (15) hours of identified training. ( )

04. Annual Training. Complete not less than ten (10) hours of training annually following the first year of licensing. ( )

05. Individualized Training. Complete training identified by the Department as meeting the individual needs of the foster parent(s). ( )

06. Additional Training. Complete any additional training required by the children's agency foster parent training plan. ( )

207. -- 229. (RESERVED)

230. HOME ENVIRONMENT SAFETY REQUIREMENTS.
The property, structure, premises, and furnishings of a foster home must be constructed and maintained in good repair, clean condition, with proper trash and recycling disposal, and free from rodents or insect infestation, safety hazards, and dangerous machinery and equipment. Areas and equipment that present a hazard to children must not be accessible by children. ( )

01. Living Space. The living space or structure of a foster home will be a house, mobile home (as defined under Title 39, Chapter 41, Idaho Code), housing unit, or apartment occupied by an individual or family. ( )

02. Swimming Pools, Hot Tubs, Ponds, and Other Bodies of Water. Any foster home with these water hazards on or adjacent to their property must provide the following safeguards: ( )

a. Around any of the water hazards listed in this rule, a foster child must have appropriate adult supervision consistent with the child’s age, physical ability, and developmental level; ( )

b. The area surrounding a body of water must be fenced and locked in a manner that prevents access by children under the age of twelve (12), children of any age who are not competent swimmers, or children who are developmentally younger than their chronological age of twelve (12); or ( )

c. Above ground pools must have a four-foot barrier that may be the pool structure or attached fencing, or both with a maximum vertical clearance between the top of the pool and the bottom of the barrier not exceeding four (4) inches; and ( )

i. The ladder must be removed and stored inaccessible to children under the age of twelve (12) when not in use; and ( )

ii. If the ladder cannot be removed, the steps or ladder must be surrounded by a barrier as required in Subsection 230.02.b. of this rule. ( )

d. If the area surrounding any of the water hazards listed in this rule is not fenced and locked, there must be a secured protective covering that will not allow access by a child. ( )

i. Pool or hot tub covers must be completely removed when in use; ( )

ii. When the pool or hot tub cover is in place, the cover must be free from standing water; ( )

iii. Covers must always be locked when the pool or hot tub is not in use. ( )

03. Access by Children Five Years Old and Under. Any foster home that cares for children five (5) years old and under and chooses to prevent access to a body of water by fencing must provide a fence that meets the following: ( )

a. The fence must be at least four (4) feet high with no vertical opening more than four (4) inches wide, be designed so that a young child cannot climb or squeeze under or through the fence, and surround all sides of the pool or pond; ( )

b. The gate must be self-closing and have a self-latching mechanism in proper working order out of the reach of young children; ( )

c. If the house forms one (1) side of the barrier for the pool, doors that provide unrestricted access to the pool must have alarms that produce an audible sound when the doors are opened; and ( )

d. Furniture or other large objects must not be left near the fence that would enable a child to climb on the furniture and gain access to the pool; or ( )

e. Above ground pools meet the requirements in Subsection 230.02.b. in this rule. ( )

04. Irrigation Canals or Similar Bodies of Water. A foster home caring for a child five (5) years old and under or a child who is physically or developmentally vulnerable, whose property adjoins an irrigation canal or similar body of water, must have fencing that prevents access to the canal or similar body of water by the child. ( )

05. Other Water Safety Precautions. ( )

a. Wading pools must be empty when not being used; ( )

b. Children must be under direct supervision of an adult while using a wading pool; ( )

c. Toys that attract young children to the pool area must be kept picked up and away from the pool area when not in use; ( )

d. A child who does not know how to swim must use an approved lifesaving personal flotation device; ( )

e. All swimming pools will be equipped with a life-saving device, such as a ring buoy; and ( )

f. Swimming pools that cannot be emptied after each use will have a working pump and filtration system. ( )

231. INSTALLATION, MAINTENANCE, AND INSPECTION OF FLAME AND HEAT-PRODUCING EQUIPMENT.

A foster parent must assure: ( )

01. Installation and Maintenance of Flame and Heat-Producing Equipment. That a furnace, fireplace, wood-burning stove, water heater, and other flame or heat-producing equipment is installed and maintained as recommended by the manufacturer, and fireplaces are protected by screens or other means. ( )

02. Portable Heating Devices. That portable heating devices will not be used during sleeping hours. ( )

03. Fire Inspections. An inspection by a certified fire inspector may be required at the discretion of the children's agency. ( )

04. **Water Heater**. The water temperature will not exceed 120 degrees Fahrenheit (49 degrees Celsius). ( )

232. FIRE SAFETY, EMERGENCY PLANNING, AND EVACUATION PLAN.
Each foster home must meet the following: ( )

01. **Smoke Detectors**. There will be at least one (1) single-station smoke detector (approved by a nationally recognized testing laboratory) that is installed and maintained as recommended by the manufacturer, and as follows: ( )

a. One (1) smoke detector on each floor of the home, including the basement; ( )

b. One (1) smoke detector in each bedroom used by a foster child; and ( )

c. One (1) smoke detector in areas of the home that contain flame or heat-producing equipment other than domestic stoves and clothes dryers. ( )

02. **Carbon Monoxide Detectors**. There will be at least one (1) carbon monoxide detector (approved by a nationally recognized testing laboratory) that is installed and maintained as recommended by the manufacturer. Living space that does not have equipment that produces carbon monoxide or does not have an attached garage is exempt from this requirement. Multi-level homes will have one (1) carbon monoxide detector on each level of the home and at least one (1) near all sleeping areas. ( )

03. **Additional Fire Safety Requirements**. To be within the structure of the home: ( )

a. Have at least one (1) operable fire extinguisher that is readily accessible; ( )

b. Be free of obvious fire hazards such as defective heating equipment or improperly stored flammable materials; ( )

c. Have a written emergency evacuation plan posted in a prominent place in the home and reviewed with children placed for foster care; ( )

d. Maintain a comprehensive list of emergency telephone numbers including poison control and posted in a prominent place in the home; and ( )

e. Maintain first aid supplies. ( )

233. EXITS.
There must be at least two (2) exits from each floor level used by a family member that are remote from each other, one (1) of which provides a direct, safe means of unobstructed travel to the outside at street or ground level. A window may be used as a second exit if it complies with these rules. ( )

234. DANGEROUS AND HAZARDOUS MATERIALS.
Dangerous and hazardous materials, objects, or equipment, including poisonous, explosive, or flammable substances that could present a risk to a child placed in a foster home must be stored securely and out of reach of a child, as appropriate for the age and functioning level of the child. ( )

235. FIREARMS AND AMMUNITION.
Firearms at a foster home must be stored: ( )

01. **Trigger Locks**. Unloaded and equipped with a trigger lock; ( )

02. **Unassembled and Inoperable**. Unloaded, fully inoperable, and incapable of being assembled and fired; ( )

03. Locked Cabinet or Container. Unloaded and locked in a cabinet or storage container that is inaccessible to children; or ( )

04. Gun Safe. Locked in a gun safe that is inaccessible to children; ( )

05. Ammunition. Stored and locked separately from all guns in the home. ( )

236. PETS AND DOMESTIC ANIMALS.
Any pet or domestic animal that is suspected or known to be dangerous must be kept in an area inaccessible to children. Dogs must be vaccinated for rabies. ( )

237. ADEQUATE HEAT, LIGHT, AND VENTILATION.
A foster home must have adequate heat, light, and ventilation and windows and doors will be screened if used for ventilation. ( )

238. BATHROOMS, KITCHENS, WATER SUPPLY, AND SEWAGE DISPOSAL.
A foster home must meet the following: ( )

01. Toilet Facilities. A foster home will have a minimum of one (1) flush toilet, one (1) washbasin that has warm and cold running water, and one (1) bathtub or shower that has warm and cold running water, all of which are in good working order. ( )

02. Water Supply. The water supply will meet one (1) of the following requirements: ( )

a. That it is from a source approved for a private home by the health authority under IDAPA 58.01.08, “Idaho Rules for Public Drinking Water Systems,” at the time of application and for annual renewal of such licenses; or ( )

b. Water used for consumption at a foster home is from an acceptable source, bottled water from an acceptable source, or boiled for a period specified by the local health authority under IDAPA 58.01.08, “Idaho Rules for Public Drinking Water Systems.” ( )

03. Sewage Disposal. Sewage will be disposed of through a public system, or in the absence of a public system, in a manner approved by the local health authority, under IDAPA 58.01.03 “Individual/Subsurface Sewage Disposal Rules.” ( )

04. Kitchen. A foster home will include a properly operating kitchen with a sink, refrigerator, stove, and oven. ( )

239. TRANSPORTATION.
A foster parent must comply with the following: ( )

01. Legal Requirements for Transporting Children. A foster parent, or any person acting on behalf of a foster parent, that transports a child, will possess a valid driver's license, be insured under Idaho Law, and abide by all traffic laws including the requirement that all children are in proper safety restraints while being transported as required under Sections 49-672 and 49-673, Idaho Code. ( )

02. Reliable Transportation. A foster parent will arrange for safe, reliable transportation of any foster child in their care to assure the child has access to school, community services, and the children's agency. ( )

a. Privately owned vehicles used to transport children in foster care will be properly maintained and be owned by the foster family or friends. ( )

b. Public transportation includes all reliable public transportation. ( )

03. Prohibitions of Foster Child Transportation. A foster parent will not transport a foster child while impaired by any substance including alcohol, prescription medication, or any illegal substances. ( )

240. CELL PHONE OR TELEPHONE.
Unless previously approved by the licensing agency, there must be an operating cell phone or telephone in a foster home. ( )

241. WHEELCHAIR ACCESS.
A foster home that provides care to a child who regularly requires the use of a wheelchair must be wheelchair accessible. ( )

242. CHILD PLACEMENT REQUIREMENTS.
A foster family must accept the placement of children into the home within the terms of the foster home license and the children's agency placement agreement. The following provisions will be considered for determining placement: ( )

01. Determining Factors. The number and the age group of children placed in a foster home will be determined by the following: ( )

a. The accommodations and the space in the home; ( )

b. The interest of the foster family; and ( )

c. The experience or skill of the foster family. ( )

02. Maximum Number of Children. Except as specified, the maximum number of children in care at any time, including the foster family's own children, or daycare children, will be limited to not more than six (6) children. ( )

03. Children Under Two Years Old. Except as specified in Subsection 242.04 of this rule, the maximum number of children under two (2) years old, including those of the foster family, will be limited to two (2) children or less. ( )

04. Special Circumstances Regarding Maximum Numbers of Children. The maximum number of children in care at any time may be based on the children's agency assessment and at a minimum one (1) of the following: ( )

a. To allow siblings to remain together; ( )

b. To allow a child who has an established, meaningful relationship with the family to remain with the family; ( )

c. To allow a family with special training or skills to provide care for a child who has a severe disability; or ( )

d. To allow a parenting youth in foster care to remain with the child of the parenting youth. ( )

05. Continued Care. A foster child who reaches the age of eighteen (18) may continue in foster care placement until the age of twenty-one (21) if the safety, health, and well-being of other foster children residing in the home is not jeopardized. ( )

243. INTERAGENCY PLACEMENT OF CHILDREN.
A foster family must only accept for placement children referred from the children's agency that licenses the foster home. A foster family may accept for placement a foster child from another children's agency only if that children's agency and the foster family have received prior approval for the placement of a child from the children's agency that licensed the home. ( )

244. SUBSTITUTE CARE PLACEMENT AND CHILDREN'S AGENCY NOTIFICATION.
A foster parent must: ( )

01. **Substitute Care**. Place a child in substitute care only with the prior knowledge and consent of the children's agency; and ( )

02. **Notification to Agency**. Notify the children's agency before the beginning of any planned absence that requires substitute care of a child for a period of twenty-four (24) hours or more. ( )

245. BEDROOMS.
A foster parent must comply with the following: ( )

01. **Sleeping Arrangements**. A bedroom occupied by a foster child will: ( )

a. Provide an adequate opportunity for both rest and privacy for each child; ( )

b. Be readily accessible to adult supervision as appropriate for the age and functioning level of each child; ( )

c. Have sufficient floor space to provide two (2) feet of space between beds; ( )

d. Have sufficient space for the storage of clothing and personal belongings; ( )

e. Have a finished ceiling, permanently affixed floor-to-ceiling walls, and finished flooring; ( )

f. Have a latchable door that leads to an exit from the foster home; ( )

g. Have at least one (1) outside window that complies with the following: ( )

i. Be readily accessible to children and the foster parent; ( )

ii. Be readily opened from the inside of the room; and ( )

iii. Be of sufficient size and design to allow for the evacuation of children and caregivers. ( )

h. Be free of the following: ( )

i. Household heating equipment excluding baseboard heating systems; ( )

ii. Water heater; and ( )

iii. Clothes washer and dryer. ( )

02. **Non-Ambulatory Child**. A child who is non-ambulatory and cannot readily be carried by one (1) household member will sleep in a bedroom located at ground level. ( )

03. **Sharing Bedroom with a Non-Parent Adult**. A child will not share a bedroom with a non-parent adult unless the child and adult are of the same gender and there is not more than four (4) years difference in age between the adult and the youngest child in the bedroom. ( )

04. **Sharing a Bedroom with a Foster Parent**. A child three (3) years old or older will not routinely share the bedroom with a foster parent unless the child has special health or emotional needs that require the attention of the foster parent(s) during sleeping hours. ( )

05. **Maximum Number of Children in a Bedroom**. No more than four (4) children will occupy a bedroom. The placement of more than one (1) child in a bedroom will be based on the age, behavior, functioning, individual needs of each child, and sufficient available space. ( )

06. **Children of the Opposite Gender**. Children of the opposite gender, any of whom are more than

five (5) years old, will not share the same bedroom. ( )

07. Number of Children in a Bed. Each child will have an individual bed, except that two (2) brothers or two (2) sisters of comparable age may share a bed if they have previously shared a bed or when there are no health, behavioral, or other factors indicating this is undesirable. ( )

08. Restrictions on Sleeping Arrangements. The following must not be used for sleeping purposes: ( )

a. A room or area of the foster home that is primarily used for purposes other than sleeping; ( )

b. A room or space, including an attic, that is accessible only by a ladder, folding stairway, or through a trapdoor; or ( )

c. A detached building, except in the case of an older child preparing for emancipation when it can be documented that the child's needs can best be met by that arrangement. ( )

09. Appropriate Bedding. A child will have a bed that is appropriate for the age and development of the child. Beds will be equipped with a clean and comfortable mattress that complies with the Consumer Product Safety Commission standard (https://www.cpsc.gov/), pillow, linens, and blankets appropriate for the weather. ( )

10. Infants. Adults and children, or both, will not co-sleep or bed-share with infants. Cribs will comply with Section 002 of these rules. ( )

246. BEHAVIOR MANAGEMENT AND DISCIPLINE.

Methods of behavior management and discipline for children must be positive and consistent. These methods must be based on each child's needs, stage of development, and behavior. Discipline is to promote self-control, self-esteem, and independence. ( )

01. Prohibitions. The following types of punishment of a foster child are prohibited: ( )

a. Physical force or any kind of punishment inflicted on the body, including spanking; ( )

b. Cruel and unusual physical exercise or forcing a child to take an uncomfortable position; ( )

c. Use of excessive physical labor with no benefit other than for punishment; ( )

d. Mechanical, medical, or chemical restraint; ( )

e. Locking a child in a room or area of the home; ( )

f. Denying necessary food, clothing, bedding, rest, toilet use, bathing facilities, or entrance to the foster home; ( )

g. Mental or emotional cruelty; ( )

h. Verbal abuse, ridicule, humiliation, profanity, threats, or other forms of degradation directed at a child or a child's family; ( )

i. Threats of removal from the foster home; ( )

j. Denial of visits or communication with a child's family unless authorized by a children's agency in its service plan for the child and family; and ( )

k. Denial of necessary educational, medical, counseling, or social services. ( )

02. Restraint. A foster parent who has received specific training in the use of child restraint may use reasonable restraint methods, approved by the children's agency, to prevent a child from harming themselves, other persons or property, or to allow a child to gain control of themselves. ( )

03. Authority. The authority for the discipline of a foster child must not be delegated by a foster parent to other members of the household. ( )

04. Agency Consultation. A foster parent must consult with the children's agency prior to using any behavior management or discipline technique that exceeds the scope of these rules. ( )

247. MEDICAL AND DENTAL CARE.

01. Health Care Services. A foster parent must follow and carry out the health or dental care plan for a child as directed by a medical professional. ( )

02. Child Injury and Illness. Follow the children's agency approved policies for medical care of a child who is injured or ill. ( )

03. Dispensing of Medications. Provide prescription medication as directed by a medical professional. A foster parent must not discontinue or in any way change the medication provided to a child unless directed to do so by a medical professional. ( )

04. Storage of Medication. A foster parent must store vitamins, prescriptions, and over-the-counter medications in an area that is inaccessible to a child. ( )

248. PERSONAL CARE AND HYGIENE.
A foster parent must instruct the child in personal care, hygiene, and grooming and provide the child with necessary personal care, hygiene, and grooming products appropriate to the age, gender, and needs of the child. The foster parents will seek approval from the children's agency before altering a child's physical appearance including haircuts, body piercing, and tattooing. ( )

249. FOOD AND NUTRITION.
A foster parent must provide a foster child with meals that are nutritious, well-balanced, of sufficient quantity, and serve the foster child the same meals as other members of the household unless a special diet has been prescribed by a medical professional, or unless otherwise dictated by differing needs based on a child's age, medical condition, or cultural or religious beliefs. A foster child is required to eat with other members of the family unless the child's medical condition dictates a different arrangement. Perishable foods must be refrigerated. Milk provided to foster children must be pasteurized, from a licensed dairy, or come from an animal that is documented to be free from tuberculosis, brucellosis, or other conditions that could be injurious to a child's health. ( )

250. NECESSARY CLOTHING.
A foster parent must provide a child with sufficient, clean, properly fitting clothing appropriate for the child's age, gender, individual needs, and season with clothing reflecting cultural and community standards. ( )

251. PERSONAL POSSESSIONS, ALLOWANCES, AND MONEY.
A foster parent must follow the children's agency policy regarding a child's personal possessions and when a child moves from a foster home, the foster parent will provide the child or the children's agency with all the child's possessions. ( )

252. CHILD TASKS.
A parent must permit a child to perform only those routine tasks that are within the child's ability, are reasonable, and are similar to the routine tasks expected of other members of the household of similar age and ability. ( )

253. EDUCATION.
A foster parent must cooperate with the children's agency and applicable educational organizations to implement the education and training plan for each child. ( )

254. RELIGIOUS AND CULTURAL PRACTICES.
A foster parent must provide a child in care with opportunity for spiritual development and cultural practices according to the wishes of the child and the child's parent or tribe. ( )

255. RECREATION.
A foster parent must provide or arrange access to a variety of indoor and outdoor recreational activities and encourage a child to participate in recreational activities that are appropriate for the child's age, interests, and ability. ( )

256. MAIL.
A foster parent must permit a child to send and receive mail according to the mail policy of the children's agency. ( )

257. REASONABLE AND PRUDENT PARENT STANDARD.
A caregiver must follow the reasonable and prudent parent standard. ( )

01. Reasonable and Prudent Parent Standard Defined. The reasonable and prudent parent standard means the standard characterized by careful and sensible parental decisions that maintain the health, safety, and best interests of a child while at the same time encouraging the emotional and developmental growth of the child that a caregiver must use when determining whether to allow a child in foster care under the responsibility of the state to participate in extracurricular, enrichment, cultural, or social activities. See "Caregiver" in the definitions. "Age or developmentally appropriate" means the following: ( )

a. Activities or items that are generally accepted as suitable for children of the same chronological age or level of maturity or that are determined to be developmentally appropriate for a child, based on the development of cognitive, emotional, physical, and behavioral capacities that are typical for an age or age group; and ( )

b. In the case of a specific child, activities or items that are suitable for the child based on the developmental stages attained by the child with respect to the cognitive, emotional, physical, and behavioral capacities of the child. ( )

02. Training. Each caregiver will complete training to include knowledge and skills relating to the reasonable and prudent parent standard for the participation of the child in age or developmentally appropriate activities, including knowledge and skills relating to the developmental stages of the cognitive, emotional, physical, and behavioral capacities of a child, and applying the standard to decisions such as whether to allow the child to engage in social, extracurricular, enrichment, cultural, and social activities, including sports, field trips, and overnight activities lasting one (1) or more days, and involving the signing of permission slips and arranging transportation for the child to and from extracurricular enrichment and social activities. ( )

258. -- 269. (RESERVED)

270. RECORD MANAGEMENT AND REPORTING REQUIREMENTS.
A foster parent must maintain a record for each child in the home that will include all written material provided to the foster home by the children's agency and additional information gathered by the foster parent that includes the following: ( )

01. Personal Data. The child's name, gender, date of birth, religion, race, and tribe, if applicable; ( )

02. Any Known History of Abuse and Neglect of the Child. ( )

03. Any Known Emotional and Psychological Needs of the Child. ( )

04. Any Information Known about the Child's Health. ( )

05. Any Known Behavioral Problems of the Child. ( )

271. REPORTING FOSTER HOME CHANGES.

A foster parent must report to the children's agency any significant change in the foster home by the next working day from the time a foster parent becomes aware of a change, including the following: ( )

01. Serious Illness Including Physical or Mental Health, Injury, or Death of a Foster Parent or Household Member. ( )

02. Arrests, Citations, Withheld Judgments, or Criminal Convictions of a Foster Parent or Household Member. ( )

03. Initiation of Court-Ordered Parole or Probation of a Foster Parent or Household Member. ( )

04. Admission or Release From Facilities. Admission to, or release from, a correctional facility, a hospital, or an institution for the treatment of an emotional, mental health, or substance abuse issue of a foster parent or household member. ( )

05. Change of Employment Status of a Foster Parent. ( )

06. Counseling, Treatment, or Therapy. Counseling or other methods of therapeutic treatment on an outpatient basis for an emotional, mental, or substance abuse issue of a foster parent or household member. ( )

07. Change of Residence. A foster parent will inform the children's agency of any planned change in residence and apply for licensure at the new address not less than two (2) weeks prior to a change in residence. ( )

08. Household Members. Inform the children's agency of changes in household members including minor children. ( )

09. Additional Licensing Application. A foster parent will notify the children's agency within five (5) calendar days after filing an application for a certified family home, daycare, or group daycare license. ( )

272. CONFIDENTIALITY.

A foster parent must maintain the confidentiality of any information and records regarding a foster child and the child's parents and relatives. A foster parent will release information about the foster child only to persons authorized by the children's agency responsible for the foster child. Foster parents will follow the Department's policies for the use of social media and posting of pictures of children in foster care. ( )

273. CRITICAL INCIDENT NOTIFICATION.

The foster parent must immediately notify the responsible children's agency of any of the following incidents: ( )

01. Death. Death or near death of a child in care. ( )

02. Suicide. Suicidal ideation, threats, or attempts to commit suicide by the foster child. ( )

03. Missing. When a foster child is missing from a foster home. ( )

04. Illness. Any illness or injury that requires hospitalization of a foster child. ( )

05. Law Enforcement Authorities. A foster child's detainment, arrest, or other involvement with law enforcement authorities. ( )

06. Removal of Child. Attempted removal or removal of a foster child from the foster home by any person who is not authorized by the children's agency. ( )

274. -- 999. (RESERVED)

[Agency redlined courtesy copy]

16.06.02 – ~~CHILD CARE AND~~ FOSTER CARE LICENSING

000. LEGAL AUTHORITY.
~~Under~~ Sections ~~39-1107, 39-1111, 39-1207,~~ 39-1211, 39-1213, 56-1003, 56-1004A, and 56-1005(8)~~, and 56-1007,~~ Idaho Code, ~~the Idaho Legislature~~ authorize~~s~~ the Department and the Board to adopt and enforce rules for licensing ~~daycare centers, group daycare facilities, family daycare homes, and~~ foster homes. ~~(3-28-23)~~( )

~~**001. SCOPE AND POLICY.**~~

~~**01. Scope**. These rules establish requirements for licensing, maintaining, and operating the following facilities:~~ ~~(3-28-23)~~

~~**a.** Daycare centers;~~ ~~(3-28-23)~~

~~**b.** Group daycare facilities;~~ ~~(3-28-23)~~

~~**c.** Family daycare homes (voluntarily); and~~ ~~(3-28-23)~~

~~**d.** Foster homes.~~ ~~(3-28-23)~~

~~**02. Policy**. It is the Department's policy to assure that children receive adequate substitute parental care in the absence or temporary or permanent inability of parents to provide care and protection for their children, or the parents are seeking alternative twenty-four (24) hour long-term care for their children. This policy is because children are vulnerable and not capable of protecting themselves. When parents have relinquished their children's care to others, there arises the possibility of risks to those children's lives, health, and safety. This requires the Department oversight of licensing and registration found in these rules.~~ ~~(3-28-23)~~

002. INCORPORATION BY REFERENCE.
The following ~~documents~~ are incorporated by reference in ~~this chapter of~~ these rules. ~~(3-28-23)~~( )

~~**01. Occupational Safety Health Act (OSHA)**. A copy of OSHA may be obtained at the Idaho Industrial Commission, 317 Main Street., P.O. Box 83720, Boise, Idaho, 83720-0041.~~ ~~(3-28-23)~~

0~~2~~1. Crib Safety - Full-Size Baby Cribs. Consumer Product Safety Commission, Compliance information for full size ~~C~~cribs ~~Safety Tips~~ can be found ~~on the Internet at https://www.cpsc.gov/Regulations-Laws--Standards/Rulemaking/Final-and-Proposed-Rules/Full-Size-Cribs~~ at https://www.cpsc.gov/Business--Manufacturing/Business-Education/FAQ?p=3019&tid%5b3028%5d=3028. ~~(3-28-23)~~( )

02. Crib Safety - Non-Full-Size Baby Cribs. Consumer Product Safety Commission, Compliance information for non-full size cribs can be found at https://www.cpsc.gov/Business--Manufacturing/Business-Education/FAQ?p=3019&tid%5b3029%5d=3029. ( )

003. -- 008. (RESERVED)

009. ~~CRIMINAL HISTORY AND~~ BACKGROUND CHECK REQUIREMENTS.

01. ~~Compliance with~~ Department Background Check Compliance. Background checks are required for individuals ~~who are~~ licensed under these rules~~. Individuals who are required to have background checks~~ and must comply with IDAPA 16.05.06, "Criminal History and Background Checks," except for those individuals described in Subsection 009.04 of this rule. ~~(3-28-23)~~( )

02. When License is Granted. The applicant(s) and any other adult(s) living in a foster home must

have a completed background check under IDAPA 16.05.06, "Criminal History and Background Checks," including clearance, prior to licensure. ~~(3-28-23)~~(   )

03. **~~Individuals~~ Those Subject to Background Check Requirements**. The following individuals must receive~~ background check~~ Department clearance prior to licensure: ~~(3-28-23)~~(   )

a. Adoptive Parents.~~ The background check requirements are found in IDAPA 16.04.18, "Children's Agencies and Residential Licensing," Section 009.~~ ~~(3-28-23)~~(   )

~~**b.** Daycare Center, Group Daycare Facility, and Family Day Care Home. The background check requirements are found in Section 309 of these rules and in Sections 39-1105, 39-1113, and 39-1114, Idaho Code. (3-28-23)~~

~~c~~b. Licensed Foster~~ Care Home~~ Parents. ~~The background check r~~Requirements are~~ found in~~ under Section ~~403~~202 of these rules~~ and in Section 39-1211(4), Idaho Code.~~; and ~~(3-28-23)~~(   )

c. Adults residing in a licensed foster home. (   )

04. **Exceptions to Background Checks~~ for Certain Youths~~**. Background checks are optional for certain youth~~ placed in licensed foster homes and licensed residential care facilities such as youth~~ in foster care who reach the age of eighteen (18) but are less than twenty-one (21) years~~ old~~ of age and continue to reside in the same licensed foster home. ~~(3-28-23)~~(   )

~~**05.** **Background Check at Any Time**. The Department can require a background check at any time on any individual who: (3-28-23)~~

~~**a.** Is a resident or an adult living in a licensed foster home; or (3-28-23)~~

~~**b.** Is an owner, operator, daycare center staff, group daycare facility, family daycare home, and all other individuals who are thirteen (13) years old or older who have unsupervised direct contact with children or who are regularly on the premises. (3-28-23)~~

010. DEFINITIONS A THROUGH M.

~~**01.** **Attendance**. Under Title 39, Chapter 11, Idaho Code, and Sections 300 through 399 of these rules, the number of children present at a daycare facility at any given time. (3-28-23)~~

0~~2~~1. **Board**. The Idaho~~ State~~ Board of Health and Welfare. ~~(3-28-23)~~(   )

0~~3~~2. **Caregiver**. A foster parent with whom a child in foster care has been placed or a designated official for a child care institution in which a child in foster care has been placed. (   )

0~~4~~3. **Chief Administrator**. The duly authorized representative or designee of an organization responsible for day-to-day operations, management, and compliance with these rules and Title 39, Chapter 12, Idaho Code. (   )

0~~5~~4. **Child**. (   )

a. Under Title 39, Chapter 12, Idaho Code, and~~ Sections 400 through 999 of~~ these rules, "child" means an individual less than eighteen (18) years old~~, synonymous with juvenile or minor~~. ~~(3-28-23)~~(   )

b. Includes individuals age eighteen (18) to twenty-one (21) who are ordered into or voluntarily entered Extended Foster Care through~~ Child and Family Services~~ the Department. ~~(3-28-23)~~(   )

~~**c.** Under Title 39, Chapter 11, Idaho Code, and Sections 300 through 399 of these rules, "child" means an individual less than thirteen (13) years old. (3-28-23)~~

~~**06.** **Child Care**. The care, control, supervision, or maintenance of children for twenty-four (24) hours a day which is provided as an alternative to parental care.~~ ~~(3-28-23)~~

~~**07.** **Child-Staff Ratio**. The maximum number of children allowed under the care and supervision of one (1) staff person.~~ ~~(3-28-23)~~

0~~8~~5. **Children's Agency**. ~~The Department and a person who operates a business for the placement of children in foster homes, or for adoption in a permanent home and who does not provide child care as part of that business. A children's agency does not include a licensed attorney or physician assisting or providing natural and adoptive parents with legal services or medical services necessary to initiate and complete adoptive placements~~ A business for the placement of children in foster homes or for adoption and who does not provide child care as part of that business. A children's agency includes those providing home studies, post-placement supervision, post-finalization services, and other domestic and international adoptive services under Title 39, Chapter 1202(4), Idaho Code. A children's agency does not include an Idaho certified adoption specialist. ~~(3-28-23)~~( )

~~**09.** **Continued Care**.~~

~~**a.** The ongoing placement of an individual in a foster home or transitional living placement who reaches the age of eighteen (18) years but is less than twenty-one (21) years old.~~ ~~(3-28-23)~~

~~**b.** Includes Extended Foster Care for children placed through Child and Family Services.~~ ~~(3-28-23)~~

~~**10.** **Daycare**. The care and supervision provided for compensation during part of a twenty-four (24) hour day, for a child or children not related by blood, marriage, adoption, or legal guardianship to the person(s) providing the care, in a place other than the child's or children's own home.~~ ~~(3-28-23)~~

~~**11.** **Daycare Center**. A place or facility providing daycare for compensation for thirteen (13) or more children.~~ ~~(3-28-23)~~

~~12~~06. **Department**. The Idaho Department of Health and Welfare ~~and~~ or its authorized representatives. ~~(3-28-23)~~( )

~~**13.** **Direct Care Staff**. An employee who has direct personal interaction with children in the provision of child care and is included as staff in meeting the child-staff ratio requirements.~~ ~~(3-28-23)~~

~~**14.** **Family Daycare Home**. A home, place, or facility providing daycare for six (6) or fewer children.~~ ~~(3-28-23)~~

~~15~~07. **Foster Care**. The twenty-four (24) hour substitute parental care for children placed away from their parents or guardians by persons who may or may not be related to the child and for whom the state agency has placement and care responsibility. ( )

~~16~~08. **Foster Home**. The private home of an individual or family licensed or approved as meeting the standards for foster care and providing twenty-four (24) hour substitute parental care to six (6) or fewer children. ( )

~~17~~09. **Foster Parent**. A person(s) residing in a private home under their direct control to whom a foster care license has been issued. ( )

~~**18.** **Group Daycare Facility**. A home, place, or facility providing daycare for seven (7) to twelve (12) children.~~ ~~(3-28-23)~~

1~~9~~0. **Medical Professionals**. Persons who have received a degree in nursing or medicine and are licensed as a registered nurse, nurse practitioner, physician's assistant, or medical doctor. ( )

~~20~~11. **Household Member**. Any person, other than a foster child, who resides in, or on the property of, a foster home. ( )

011. DEFINITIONS N THROUGH Z.

01. Noncompliance. Violation of, or inability to meet, the requirements of these rules or terms of licensure. ( )

~~**02. Operator**. An individual who operates or maintains a daycare center, group daycare facility, or family daycare home voluntarily licensed by the Department. (3-28-23)~~

~~**03. Person**. Any individual, group of individuals, associations, partnerships, or corporations. (3-28-23)~~

~~**04. Placement**. The activities and arrangements related to finding a suitable licensed home or facility in which a child will reside for purposes of care, treatment, adoption, or other services. (3-28-23)~~

0~~5~~2. Plan of Correction. The detailed procedures and activities developed between the Department and caregiver required to bring a ~~daycare center, group daycare facility, family daycare home voluntarily licensed by the Department, or~~ foster family into conformity with these rules. ~~(3-28-23)~~( )

~~**06. Regularly on the Premises**. For Sections 009 and 309 of these rules, "regularly on the premises" means twelve (12) hours or more in any one (1) month, or daily during any hours of operation. (3-28-23)~~

0~~7~~3. Relative. Under Section 39-1202, Idaho Code, "relative" means a child's grandparent, great grandparent, aunt, great aunt, uncle, great uncle, brother-in-law, sister-in-law, first cousin, sibling, and half-sibling. ( )

0~~8~~4. Restraint. Physical interventions to control the range and motion of a child. ( )

0~~9~~5. Second Degree of Relationship. Refers to persons related by blood or marriage and includes their spouses. The number of degrees between two (2) relatives is calculated by summing the number of ties between each relative and the common ancestor. ( )

~~**10. Social Worker**. An individual licensed under Title 54, Chapter 32, Idaho Code, and IDAPA 24.14.01, "Rules of the State Board of Social Work Examiners." (3-28-23)~~

~~**11. Staff**. Under Title 39, Chapter 11, Idaho Code, and Sections 300 through 399 of these rules, "staff" means a person who is sixteen (16) years old or older and employed by a daycare owner or operator to provide care and supervision at a daycare facility. (3-28-23)~~

~~12~~06. Supervision. ~~Under Title 39, Chapter 11, Idaho Code, and Sections 300 through 399 of these rules, "supervision" i~~Is defined as being within sight and normal hearing range of the child or children being cared for. ~~(3-28-23)~~( )

~~**13. Time-Out**. Separation of a child from group activity as a means of behavior management. (3-28-23)~~

~~14~~07. Training. The preparation, instruction, and education related to child care that increases the knowledge, skill, and abilities of a foster parent or children's agency or volunteers. ( )

~~15~~08. Variance. A temporary non-application of a foster care licensing rule that is resolved within six (6) months of approval. ( )

~~16~~09. Waiver. The permanent non-application of a foster care licensing rule for relatives, if in the Department's judgment, the health and safety of the child is not compromised. ( )

012. -- 099. (RESERVED)

~~**LICENSING**~~
~~**(Sections 100-299)**~~

100. LICENSING.
~~The purpose of licensing is to set requirements and to monitor compliance. Persons applying for licensure need to be physically and emotionally suited to protect the health, safety, and well-being of the children in their care. Physical surroundings must present no hazards to the children in care.~~ ~~(3-28-23)~~

~~**01. Responsibilities of the Foster Parent or Operator**. A foster parent or operator must conform to the terms of the license.~~ ~~(3-28-23)~~

0~~2~~1. ~~Responsible for~~ Knowledge of Standards. The foster parent ~~or operator~~ is responsible for knowing the rules applying to and covered by the ~~type of~~ foster ~~home, daycare center, group daycare facility, or family daycare home voluntarily licensed by the Department, covered by the~~ care license, and for always conforming to them. ~~(3-28-23)~~( )

~~**03. Responsible for Agency Staff Knowledge**. The operator of a child care facility or agency is responsible for ensuring that all staff members are familiar with these rules.~~ ~~(3-28-23)~~

0~~4~~2. Return of License. The foster parent ~~or operator~~ must immediately return their license to the Department under any of the following circumstances: ~~(3-28-23)~~( )

a. ~~Changes of management or a~~Address changes; ~~(3-28-23)~~( )

b. Upon suspension or revocation of the license by the Department; or ( )

c. Upon voluntary discontinuation of service. ( )

~~**05. Exceptions and Exemptions to Daycare Licensing**. Under Section 39-1103, Idaho Code, the licensing requirements in these rules do not apply to:~~ ~~(3-28-23)~~

~~**a.** Daycare facilities regulated, licensed, or certified by a city or county with local options under Section 39-1108, Idaho Code;~~ ~~(3-28-23)~~

~~**b.** The occasional or irregular care of a neighbor's, relative's or friend's child or children by a person not ordinarily in the business of providing daycare;~~ ~~(3-28-23)~~

~~**c.** The operation of a private school or religious school for educational purposes for children over four (4) years old, or a religious kindergarten;~~ ~~(3-28-23)~~

~~**d.** The provision of occasional care exclusively for children of parents who are simultaneously in the same building;~~ ~~(3-28-23)~~

~~**e.** The operation of day camps, programs, and religious schools for less than twelve (12) weeks during a calendar year or not more often than once a week; or~~ ~~(3-28-23)~~

~~**f.** The provision of care for children of a family within the second degree of relationship under Section 011 of these rules.~~ ~~(3-28-23)~~

~~**06. Exceptions and Exemptions to Daycare and Foster Home Licensing**. Under Sections 39-1213(b) and 39-1211, Idaho Code, the licensing requirements in these rules do not apply to:~~ ~~(3-28-23)~~

~~**a.** Foster homes approved by a licensed children's agency provided the standards for approval by such agency are no less restrictive than the rules established by the Board and that such agency is maintained, operated, and conforms with these rules; or~~ ~~(3-28-23)~~

~~**b.** The occasional or irregular care of a neighbor's, relative's, friend's child, or children by a person not~~

~~ordinarily engaged in child care.~~ ~~(3-28-23)~~

101. ~~APPLICATIONS FOR LICENSE.~~(RESERVED)

~~An application for a license must be submitted to the Department. Licensing studies will follow the format of these rules and will contain a specific recommendation for terms of the license. All foster homes, daycare centers, group daycare facilities, and family daycare homes voluntarily licensed by the Department must comply with applicable city and county ordinances.~~ ~~(3-28-23)~~

102. DISPOSITION OF APPLICATIONS.

The Department will initiate action on each completed application within thirty (30) days after receipt that addresses each requirement for the specific type of home ~~or facility~~. Upon receipt of a completed application and study, the Department will review the materials for compliance with these rules. ~~(3-28-23)~~( )

01. Approval of Application. ~~A license will be issued~~ The Department will issue a license to any ~~daycare center, group daycare facility, family daycare home voluntarily licensed by the Department, or~~ foster home ~~found in compliance~~ complying with these rules. The license is issued under the terms specified in the licensing study and will be mailed to the applicant. ~~(3-28-23)~~( )

02. Regular License. ~~A regular license will be issued~~ The Department will issue a regular license to any ~~daycare center, group daycare facility, family daycare home voluntarily licensed by the Department, or~~ foster home ~~found in compliance~~ complying with these rules and will specify the terms of licensure, such as: ~~(3-28-23)~~( )

~~**a.**~~ ~~Full time or daycare;~~ ~~(3-28-23)~~

~~b~~a. The number of children who may receive care at any one (1) time; and ( )

~~c~~b. Age range and gender if there are conditions in the foster home making such limitations necessary; ( )

~~d~~c. The regular license for a foster home is in effect for one (1) year from the date of issuance unless suspended or revoked earlier; ( )

~~**e.**~~ ~~A regular license for a daycare center, group daycare facility, or family daycare home voluntarily licensed by the Department is in effect for two (2) years from the date of issuance unless suspended or revoked earlier; and~~ ~~(3-28-23)~~

~~f~~d. If the license for a foster home is for a specific child ~~only~~, the name of that child will be shown on the foster home license. ~~(3-28-23)~~( )

03. Waiver. A regular license may be issued to the foster home of a relative who has received a waiver of licensing rules provided: ( )

a. The waiver is considered on an individual case basis; ( )

b. The waiver is approved ~~only~~ for non-safety foster care rules; ~~(3-28-23)~~( )

c. All other licensing requirements have been met; ( )

d. The approval of ~~a waiver of~~ any ~~foster home~~ waiver of rules requires the Department to document a description of the reasons for issuing a waiver, the rules being waived, and assurance that the waiver will not compromise the child's safety; and ~~(3-28-23)~~( )

e. The approved waiver must be reviewed for continued need and approved annually. ( )

04. Variance. A regular license will be issued to a foster home approved for a variance of a licensing rule provided: ( )

a. The variance is considered on an individual case basis; ( )

b. The variance is approved for a non-safety licensing rule~~s~~; ~~(3-28-23)~~( )

c. The~~ approval of a~~ variance must have no adverse effect on the health, safety, and well-being of any child in care at the foster home; ~~(3-28-23)~~( )

d. The~~ approval of a~~ variance is documented by the Department and includes a description of the reasons for issuing a variance and assurances that the variance will not compromise any child's health, safety, and well-being; and ~~(3-28-23)~~( )

e. The~~ approved~~ variance must be reviewed for continued need and approval annually. ~~(3-28-23)~~( )

05. Provisional License. ~~A provisional license m~~May be issued to a foster home, when a licensing standard cannot be met but can be expected to be corrected within six (6) months, provided this does not affect the health, safety, and well-being of any child in care at the home. ~~(3-28-23)~~( )

a. ~~A provisional license w~~Will be in effect for not more than six (6) months. ~~(3-28-23)~~( )

b. Only one (1) provisional license will be issued to a foster home in any twelve-month period~~ of time~~ under Section 39-1216, Idaho Code. ~~(3-28-23)~~( )

06. Limited License. ~~A limited license for a foster home m~~May be issued for the care of a specific child in a home which may not meet the requirements for a license, provided: ~~(3-28-23)~~( )

a. The child is already in the home and has formed strong emotional ties with the foster parents; and ( )

b. It can be shown that the child's continued placement in the home would be more conducive to their welfare than~~ would~~ removal to another home. ~~(3-28-23)~~( )

07. Denial of Application. If an application is denied, a signed letter will be sent directly to the applicant by registered or certified mail, advising the applicant of the denial and stating the basis for such denial. An applicant whose application has been denied may not reapply until~~ after~~ one (1) year~~ has elapsed from~~ after the date on the denial of application. ~~(3-28-23)~~( )

08. Failure to Complete Application Process. ( )

a. Failure~~ of the applicant~~ to complete the application process within six (6) months ~~of~~ from the original date of application will result in~~ a denial of the~~ application denial. ~~(3-28-23)~~( )

b. An applicant whose application has been denied for being incomplete may not reapply until~~ after~~ one (1) year~~ has elapsed from~~ after the date~~ on the denial~~ of application denial. ~~(3-28-23)~~( )

103. RESTRICTIONS ON APPLICABILITY AND NONTRANSFER.

01. Department-Issued License. ~~A license a~~Applies only to the foster home~~, daycare center, group daycare facility, family daycare home voluntarily licensed by the Department,~~ or the person and premises designated. Each license is issued in the~~ business name or~~ individual's name, and~~ only~~ to the~~ specified~~ address~~ identified~~ specified on the application~~ of the foster home, daycare center, group daycare facility or family daycare home voluntarily licensed by the Department~~. A license issued in the name of a foster parent~~, daycare center, group daycare facility, or family daycare home voluntarily licensed by the Department~~ applies~~ only~~ to the period and services specified in the license. Any change in~~ management or~~ address renders the license null and void, and the foster parent~~ or operator~~ must immediately return the license to the Department~~ under Section 100 of these rules~~. ~~(3-28-23)~~( )

02. Nontransferable. A license is nontransferable or assignable from one (1) individual to another~~, from one (1) business entity or governmental unit to another,~~ or from one (1) location to another. ~~(3-28-23)~~(_____)

03. Change in ~~Ownership, Operator, or~~ Location. When there is a change in ~~ownership, operator, or~~ location, the foster home~~, daycare center, group daycare facility or family daycare home voluntarily licensed by the Department~~ must reapply for a license ~~under Section 101 of these rules. The new owner or operator must obtain a license before starting operations~~. ~~(3-28-23)~~(_____)

104. MANDATORY VISITATIONS.

Under Section 39-1217, Idaho Code, the Department ~~must~~ will visit and be given access to the premises of each ~~licensed~~ foster home~~, as often~~ as deemed necessary by the Department to assure compliance with these rules but at intervals not to exceed twelve (12) months. ~~(3-28-23)~~(_____)

105. REVISIT AND RELICENSE.

Revisit and relicense studies will document how the ~~daycare center, group daycare facility, family daycare home voluntarily licensed by the Department, or~~ foster home continues to meet licensing standards. Consideration must be given to each standard, including a review of the previous study and original application to determine what changes have occurred. A~~n application for~~ renewal ~~of a license~~ application must be made by the ~~operator~~ foster home on the Department-furnished form ~~furnished by the Department~~ and filled out prior to the expiration date of the license ~~currently~~ in ~~force~~ effect. When a renewal application has been completed correctly, the existing license will, unless officially revoked, remain ~~in force~~ effective until the Department has acted on the application for renewal. ~~(3-28-23)~~(_____)

106. COMPLAINTS ~~AGAINST DAYCARE CENTERS, GROUP DAYCARE FACILITIES, FAMILY DAYCARE HOMES, AND FOSTER HOMES~~.

01. Investigation. The Department will investigate complaints regarding ~~daycare centers, group daycare facilities, family daycare homes voluntarily licensed by the Department, or~~ foster homes. The investigation may include further contact with the complainant, scheduled or unannounced visits to the foster home~~, daycare center, group daycare facility, or family daycare home voluntarily licensed by the Department~~, collateral contacts including interviews with the victim, parents or guardian, ~~operator, staff,~~ consultants, children in care, other persons who may have knowledge of the complaint, and inspections by fire or health officials. ~~(3-28-23)~~(_____)

02. Informed of Action. If an initial preliminary investigation indicates that a more complete investigation must be made, the foster parents~~, operator, daycare center, group daycare facility, or family daycare home voluntarily licensed by the Department~~ will be informed of the investigation, and any action to be taken, including referral for civil or criminal action. ~~(3-28-23)~~(_____)

107. SUSPENSION FOR CIRCUMSTANCES BEYOND CONTROL OF FOSTER PARENT ~~OR OPERATOR~~.

When circumstances occur over which the foster parent ~~or operator~~ has no control including illness, epidemics, fire, flood, or contamination, which temporarily place the operation of the foster home~~, child care facility, daycare center, group daycare facility, or family daycare home voluntarily licensed by the Department~~ out of compliance with these rules, the license must be suspended until the nonconformity is remedied. ~~(3-28-23)~~(_____)

108. SUSPENSION OR REVOCATION FOR INFRACTIONS.

A license may be suspended for infractions of these rules~~. Such suspension~~ and may lead to revocation if the foster parent ~~or operator~~ fails to satisfy the Department that the infractions have been corrected in compliance with the rules. ~~(3-28-23)~~(_____)

109. NON-RENEWAL, DENIAL, REVOCATION, OR SUSPENSION OF LICENSE.

If it is found that an applicant~~,~~ or foster parent~~, or operator~~ has failed or refused to comply with any of the provisions of the ~~Basic Daycare License Law, Sections 39-1101 through 39-1120, Idaho Code, or the~~ Child Care Licensing Reform Act, Sections 39-1201 through 39-1224, Idaho Code, with these rules, or with any provision of the license, the Department may deny, suspend, revoke, or not renew a license. The Department may also deny, suspend, revoke, or deny renewal of a license for any ~~daycare center, group daycare facility, family daycare home voluntarily licensed by the Department, child care facility or~~ foster home when any of the following occurs. ~~(3-28-23)~~(_____)

01. Criminal Conviction or Relevant Record. Any~~one providing direct care or working onsite under these rules~~ adult residing in a foster home is denied clearance or refuses to comply with IDAPA 16.05.06, "Criminal History and Background Checks." ~~(3-28-23)~~(   )

02. Other Misconduct. The applicant~~,~~ or foster parent~~, operator, or the person proposed as chief executive officer~~: ~~(3-28-23)~~(   )

a. Fails to furnish any data, statistics, records, or information requested by the Department without good cause or provides false information; (   )

~~**b.** Has been found guilty of or is under investigation for fraud, deceit, misrepresentation or dishonesty associated with the operation of a daycare center, group daycare facility, family daycare home voluntarily licensed by the Department, children's residential care facility or children's agency; (3-28-23)~~

~~c~~b. Has been found guilty of, or is under investigation for, ~~the commission of~~ any felony; ~~(3-28-23)~~(   )

~~d~~c. Has failed to exercise fiscal accountability toward a client or the Department regarding payment for services; or (   )

~~e~~d. Has knowingly permitted, aided, or abetted the commission of any illegal act on the premises of the ~~daycare center, group daycare facility, family daycare home voluntarily licensed by the Department, or~~ foster home. ~~(3-28-23)~~(   )

110. (RESERVED)

111. ENFORCEMENT REMEDY OF SUMMARY SUSPENSION AND TRANSFER OF CHILDREN.
The Department may summarily suspend a foster home license~~, daycare center, group daycare facility, or family daycare home voluntarily licensed by the Department~~. Children in a foster home require the program to transfer children when the Department has determined a child's health and safety are in immediate jeopardy.~~ Children in a daycare center, group daycare facility, or family daycare home voluntarily licensed by the Department, will not be transported from the home or facility, instead the parent or legal guardian will be contacted.~~ ~~(3-28-23)~~(   )

112. ENFORCEMENT REMEDY REVOCATION OF LICENSE AND TRANSFER OF CHILDREN.
The Department may revoke the license of a foster home~~, daycare center, group daycare facility, or family daycare home voluntarily licensed by the Department,~~ when the Department determines the home~~, facility, or operator~~ is not in compliance with these rules.~~ Children in a daycare center, group daycare facility, or family daycare home voluntarily licensed by the Department, will not be transported from the facility, instead the parent or legal guardian will be contacted.~~ Revocation and transfer of children may occur under the following circumstances: ~~(3-28-23)~~(   )

01. Endangers Health or Safety. Any condition that endangers the health or safety of any child. (   )

02. Not in Substantial Compliance. A foster home~~, daycare center, group daycare facility, or family daycare home voluntarily licensed by the Department~~ is not in substantial compliance with these rules. ~~(3-28-23)~~(   )

03. No Progress to Meet Plan of Correction. A foster home~~, daycare center, group daycare facility, or family daycare home voluntarily licensed by the Department~~ has made little or no progress in correcting deficiencies within thirty (30) days from the date the Department accepted a plan of correction. ~~(3-28-23)~~(   )

04. Repeat Violations. Repeat violations~~ of any requirement~~ of these rules or~~ provisions~~ of Title 39, Chapters 11 and 12, Idaho Code. ~~(3-28-23)~~(   )

05. Misrepresented or Omitted Information. A foster home~~, daycare center, group daycare facility, or family daycare home voluntarily licensed by the Department~~ has knowingly misrepresented or omitted information

on the application or other documents pertinent to obtaining a license. ~~(3-28-23)~~(____)

06. Refusal to Allow Access. Refusal to allow Department representatives full access to the foster home~~, daycare center, group daycare facility, or family daycare home voluntarily licensed by the Department~~ and its grounds, facilities, and records. ~~(3-28-23)~~(____)

07. Violation of Terms of Provisional License. A foster home, that has violated any of the terms~~ or conditions~~ of a provisional license. ~~(3-28-23)~~(____)

113. EFFECT OF PREVIOUS REVOCATION OR DENIAL OF A LICENSE.

An organization cannot apply and the Department will not accept an application from any person, corporation, or partnership, including any owner with a ten percent (10%) or more interest, who has had a license denied or revoked, until five (5) years has elapsed from the date of denial, revocation, or conclusion of a final appeal, whichever occurred last. (   )

114. -- ~~2~~199. (RESERVED)

~~**STANDARDS FOR DAYCARE**~~
~~**(Sections 300-399)**~~

~~**300. STANDARDS FOR DAYCARE.**~~

~~**01. Daycare Standards**. In addition to meeting the rules under Sections 000 through 299 of these rules, each owner, operator, or applicant seeking licensure from the Department as a daycare center, group daycare facility, or family daycare home voluntarily licensed by the Department, must also meet the requirements under Title 39, Chapter 11, Idaho Code, and Sections 300 through 399 of these rules. (3-28-23)~~

~~**02. Minimum Age of Applicant**. An individual, applying to the Department to be licensed for a daycare center, group daycare facility, or family daycare home, must be at least eighteen (18) years old. (3-28-23)~~

~~**301. TYPES OF DAYCARE LICENSES.**~~

~~Subject to the requirements under Title 39, Chapter 11, Idaho Code, and these rules, the Department will determine the type of daycare license required by an owner or operator providing daycare by counting each child in attendance, regardless of relationship to the person(s) providing the care. The following types of daycare licenses may be issued by the Department. (3-28-23)~~

~~**01. Daycare Center License**. Is issued for a place or facility providing daycare, where thirteen (13) or more children, regardless of relationship to the person(s) providing the care, are in attendance. (3-28-23)~~

~~**02. Group Daycare Facility**. Is issued for a place or facility providing daycare, where seven (7) to twelve (12) children, regardless of relationship to the person(s) providing the care, are in attendance. (3-28-23)~~

~~**03. Family Daycare Home**. Is not required to be licensed. However, a family daycare home may voluntarily elect to be licensed by the Department. (3-28-23)~~

~~**302. -- 308. (RESERVED)**~~

~~**309. CRIMINAL HISTORY AND BACKGROUND CHECK FOR DAYCARE STANDARDS.**~~

~~**01. Background Check for Daycare Centers and Group Daycare Facilities**. Each owner, operator, or applicant seeking licensure for a daycare center, group daycare facility, or a family daycare home must submit evidence that is satisfactory to the Department that the following individuals have successfully completed and received a clearance for a Department background check under Sections 39-1105 and 39-1113, Idaho Code: (3-28-23)~~

~~**a.** Owners, operators, and staff; (3-28-23)~~

~~**b.** All other individuals thirteen (13) years old or older who have unsupervised direct contact with children; or (3-28-23)~~

~~**c.** All other individuals thirteen (13) years old or older who are regularly on the premises. (3-28-23)~~

~~**02. Juvenile Justice Records**. The criminal history and background check for any individual under eighteen (18) years of age, must include a check of the juvenile justice records, as authorized by the minor and their parent or guardian. Records must be checked for each jurisdiction in which the individual has resided since becoming thirteen (13) years of age through eighteen (18) years of age. Each owner, operator, or applicant is responsible for requesting a check of the juvenile justice record, paying for the costs of a check of the juvenile justice records, and submitting them to the Department for review. A check of the juvenile justice records must include the following: (3-28-23)~~

~~**a.** Juvenile justice records of adjudication of the magistrate division of the district court; (3-28-23)~~

~~**b.** County probation services; and (3-28-23)~~

~~**c.** Department records. (3-28-23)~~

~~**03. Background Check for Family Daycare Homes**. Under Section 39-1114, Idaho Code, any person providing daycare for four (4) or more children in a family daycare home is required to comply with Sections 39-1105 and 39-1113, Idaho Code. (3-28-23)~~

~~**04. Background Check for Private Schools and Private Kindergartens**. Under Section 39-1105, Idaho Code, any person who owns, operates, or is employed by a private school for educational purposes for children four (4) through six (6) years old or a private kindergarten is required to comply with Sections 39-1105 and 39-1113, Idaho Code. (3-28-23)~~

~~**05. Cost of Background Check and Juvenile Justice Records**. Each individual who requests and obtains a Department background check is responsible for the cost of the background check and check of juvenile justice records. (3-28-23)~~

~~**06. On-going Duty to Report Convictions**. Following completion of a background check and clearance, additional criminal convictions and juvenile justice adjudications for disqualifying crimes under Section 39-1113, Idaho Code, must be self-disclosed by the individual to the owner or operator of a daycare center, group daycare facility, or family daycare home. The owner or operator must report these additional convictions and adjudications to the Department within five (5) days of learning of the conviction or adjudication. (3-28-23)~~

~~**310. -- 319. (RESERVED)**~~

~~**320. DAYCARE LICENSING FEES.**~~
~~A nonrefundable licensing fee must be paid to the Department prior to the issuance or renewal of a daycare license. (3-28-23)~~

~~**01. Daycare Licensing Fee Amounts**. The total fee for initial licensure or renewal of a daycare center, group daycare facility, or family daycare home voluntarily licensed must not exceed the following amounts: (3-28-23)~~

~~**a.** Daycare center with more than twenty-five (25) children in attendance at any given time - three hundred twenty-five dollars ($325). (3-28-23)~~

~~**b.** Daycare center with thirteen (13) to twenty-five (25) children in attendance at any given time - two hundred fifty dollars ($250). (3-28-23)~~

~~**c.** Group daycare facility - one hundred dollars ($100). (3-28-23)~~

~~**d.** Family daycare home voluntary license - one hundred dollars ($100). (3-28-23)~~

~~**02.** **Daycare Fire Inspection Fee**. Daycare fire inspection fees are payable to the local fire department or fire district official.~~ ~~(3-28-23)~~

~~**321. APPLICATION FOR DAYCARE LICENSE OR RENEWAL.**~~
~~Any individual applying for licensure as a daycare center, group daycare facility, or family daycare home voluntarily licensed by the Department must be at least eighteen (18) years old. The applicant must apply on forms provided by the Department and provide information required by the Department under this rule.~~ ~~(3-28-23)~~

~~**01.** **Completed, Signed, and Dated Application by Applicant**.~~ ~~(3-28-23)~~

~~**02.** **Licensing Fee**. The applicant must pay the appropriate licensing fee prior to the issuance of a daycare license.~~ ~~(3-28-23)~~

~~**03.** **Inspection Reports**. The following reports must be submitted to the Department with the application that prove the facility or proposed facility meets:~~ ~~(3-28-23)~~

~~**a.** Building code under IDAPA 24.39.30, "Rules of Building Safety (Building Code Rules)," where required;~~ ~~(3-28-23)~~

~~**b.** Electrical code under IDAPA 24.39.10, "Rules of the Idaho Electrical Board," where required;~~ ~~(3-28-23)~~

~~**c.** Fire code under Section 41-253, Idaho Code, where required; and~~ ~~(3-28-23)~~

~~**d.** Local planning and zoning requirements.~~ ~~(3-28-23)~~

~~**04.** **Proof of Insurance**. The applicant must provide proof of current fire and liability insurance coverage for the daycare facility.~~ ~~(3-28-23)~~

~~**05.** **Background Clearance**. Evidence that the applicant and all individuals required to have a criminal history and background check have received a clearance from the Department required in Section 309 of these rules.~~ ~~(3-28-23)~~

~~**06.** **Statement to Comply**. The applicant must provide a written statement that these rules have been thoroughly read and reviewed and the applicant is prepared to comply with all provisions.~~ ~~(3-28-23)~~

~~**07.** **Statement Disclosing Revocation or Disciplinary Actions**. A written statement that discloses any revocation or other disciplinary action taken or in the process of being taken against the applicant as a daycare provider in any jurisdiction, or a statement from the applicant stating they have never been involved in any such action.~~ ~~(3-28-23)~~

~~**08.** **Other Information as Requested**. The applicant must provide other information that may be requested by the Department for the proper administration and enforcement of these rules.~~ ~~(3-28-23)~~

~~**09.** **Additional Requirements for License Renewal**. A daycare license must be renewed every two (2) years. The daycare operator must submit to the Department the renewal application, fee, and all required documentation in this rule at least forty-five (45) days prior to the expiration of the current daycare license.~~ ~~(3-28-23)~~

~~**10.** **Termination of Application Process**. Failure of the applicant to cooperate with the Department in the application process may result in the termination of the application process. Failure to cooperate means that the information requested is not provided within ninety (90) days, or not provided in the form requested by the Department, or both.~~ ~~(3-28-23)~~

~~**322. -- 324. (RESERVED)**~~

~~**325. ISSUANCE OF LICENSE.**~~

~~**01. Department Action**. The Department will order a health and safety inspection of the daycare facility once the application for licensure is complete and the licensing fee has been paid. (3-28-23)~~

~~**02. Issuance of a Regular License**. If the Department determines the applicant is in compliance with these rules, the Department will, within sixty (60) days from the date the completed application is submitted, issue one (1) of the following licenses stating the type of facility, the number of children who may be in attendance, and the length of time the license is effective: (3-28-23)~~

~~**a.** Daycare Center License; (3-28-23)~~

~~**b.** Group Daycare Facility License; or (3-28-23)~~

~~**c.** Family Daycare Home License. (3-28-23)~~

~~**03. Denial of Licensure**. If the Department determines the applicant is not in compliance with these rules and further determines not to issue a daycare license the Department will, within thirty (30) days from the date the completed application is submitted, issue a letter of denial of licensure stating the basis for the denial. (3-28-23)~~

~~**04. Incomplete Application**. The Department is not required to take any action on an application until the application is complete. (3-28-23)~~

~~**05. Notification of License Renewal**. The Department will notify the licensed daycare operator at least ninety (90) days prior to expiration of the license. (3-28-23)~~

~~**06. List of Licensed Daycare Facilities**. The Department will maintain a list of all licensed daycare facilities for public use. (3-28-23)~~

~~**326. -- 329. (RESERVED)**~~

~~**330. STAFF AND OTHER RECORD REQUIREMENTS.**~~
~~Each owner or operator of a daycare center, group daycare facility, or family daycare home voluntarily licensed by the Department must maintain a current list covering the previous twelve-month period of all staff and other individuals thirteen (13) years of age or older who have unsupervised direct contact with children, or are regularly on the premises. The list must specify, at a minimum, the following: (3-28-23)~~

~~**01. Legal Name**. (3-28-23)~~

~~**02. Proof of Age**. (3-28-23)~~

~~**03. Phone Number**. (3-28-23)~~

~~**04. Training Records**. (3-28-23)~~

~~**05. Verification of Background Check Clearance**. (3-28-23)~~

~~**06. Results of Juvenile Justice Records**. (3-28-23)~~

~~**07. Verification of Pediatric Rescue Breathing, Infant-Child CPR, and First Aid Certification from a Certified Instructor**. (3-28-23)~~

~~**08. Times, Dates, and Records of Hours on the Premises Each day**. (3-28-23)~~

~~**331. CHILD RECORD REQUIREMENTS.**~~
~~Each owner or operator of a daycare center, group daycare facility, or family daycare home voluntarily licensed by the Department, must maintain records for each child in attendance covering the previous twelve-month period. The~~

~~record must contain the following:~~ ~~(3-28-23)~~

~~**01. Child's Full Name**.~~ ~~(3-28-23)~~

~~**02. Date of Birth**.~~ ~~(3-28-23)~~

~~**03. Parent or Guardian's Name, Address, and Contact Information**.~~ ~~(3-28-23)~~

~~**04. Emergency Contact Information**.~~ ~~(3-28-23)~~

~~**05. Child's Health Information**.~~ ~~(3-28-23)~~

~~**a.** Immunization record or waiver of exemption form or statement;~~ ~~(3-28-23)~~

~~**b.** Any medical conditions that could affect the care of the child; and~~ ~~(3-28-23)~~

~~**c.** Medications the child is taking or may be allergic to.~~ ~~(3-28-23)~~

~~**06. Times, Dates, and Record of Attendance Each Day**.~~ ~~(3-28-23)~~

~~**332. -- 334. (RESERVED)**~~

~~**335. CHILD-STAFF RATIO.**~~

~~Under Section 39-1109, Idaho Code, the Department determines the maximum allowable child-staff ratio based on a point system.~~ ~~(3-28-23)~~

~~**01. Daycare Child-Staff Ratio Point System**.~~
~~The maximum allowable points for each staff member is twelve (12), using the following point system which is based on the age of each child in attendance:~~ ~~(3-28-23)~~

~~**a.** Under the age of twenty-four (24) months, each child equals two (2) points.~~ ~~(3-28-23)~~

~~**b.** From the age of twenty-four (24) months to under the age of thirty-six (36) months, each child equals one and one-half (1 1/2) points.~~ ~~(3-28-23)~~

~~**c.** From the age of thirty-six (36) months to under the age of five (5) years, each child equals one (1) point.~~ ~~(3-28-23)~~

~~**d.** From the age of five (5) years to under the age of thirteen (13) years, each child equals one-half (1/2) point.~~ ~~(3-28-23)~~

~~**02. Compliance with Child-Staff Ratios**. Child-staff ratios must always be maintained during all hours of operation when children are in attendance and when transporting children.~~ ~~(3-28-23)~~

~~**a.** Each child in attendance is counted by the Department for the purposes of calculating maximum allowable points, counting the number of children in attendance, and for determining compliance with child-staff ratios;~~ ~~(3-28-23)~~

~~**b.** Each adult staff member who is providing direct care for a child or children is counted by the Department as one (1) staff member for the purposes of counting the number of staff on-duty and determining compliance with child-staff ratios; and~~ ~~(3-28-23)~~

~~**c.** Each staff member sixteen (16) and seventeen (17) years old under the supervision of an adult staff member, when providing direct care for a child or children, may be counted by the Department as one (1) staff member for the purposes of counting the number of staff on-duty and determining compliance with child-staff ratios.~~ ~~(3-28-23)~~

~~**03.** **Supervision of Children**. The owner or operator and all staff are responsible for the direct care, protection, supervision, and guidance of children through active involvement or direct observation. In addition to meeting the child-staff ratio requirements, the owner or operator of a daycare center, group daycare facility, or family daycare home licensed by the Department must ensure that at least one (1) adult staff member is: (3-28-23)~~

~~**a.** Always awake and on duty on the premises during regular business hours or when children are in attendance, and (3-28-23)~~

~~**b.** Currently certified in pediatric rescue breathing, infant-child CPR, and first aid. (3-28-23)~~

~~**04.** **Napping Children**. Napping children who are not within sight of a staff member must always be within easy hearing distance. (3-28-23)~~

~~**05.** **Overnight Daycare**. For daycare operators providing overnight care of children, the following must apply: (3-28-23)~~

~~**a.** A sleeping child must sleep on the same level as the staff member who must be able to hear the child; and (3-28-23)~~

~~**b.** A staff member must be awake and on duty to release and receive a child. (3-28-23)~~

~~**336. BEHAVIOR MANAGEMENT AND DISCIPLINE.**~~
~~Methods of behavior management and discipline for children must be positive and consistent. These methods must be based on each child's needs, stage of development, and behavior. Discipline is to promote self-control, self-esteem, and independence. All of the following types of punishment of a child are prohibited: (3-28-23)~~

~~**01.** **Physical Force**. Any kind of punishment inflicted on the body, including spanking; (3-28-23)~~

~~**02.** **Cruel and Unusual Physical Exercise**. Includes forcing a child to take an uncomfortable position; (3-28-23)~~

~~**03.** **Use of Excessive Physical Labor**. With no benefit other than for punishment; (3-28-23)~~

~~**04.** **Restraint(s)**. (3-28-23)~~

~~**05.** **Locking a Child in a Room**. Or any area of the home or facility; (3-28-23)~~

~~**06.** **Denying Necessities**. Includes necessary food, clothing, bedding, rest, toilet use, personal care and sanitation, or entrance to the home or facility; (3-28-23)~~

~~**07.** **Mental or Emotional Cruelty**. (3-28-23)~~

~~**08.** **Verbal Abuse**. Includes ridicule, humiliation, profanity, threats, or other forms of degradation directed at a child or a child's family. (3-28-23)~~

~~**337. -- 339. (RESERVED)**~~

~~**340. DAYCARE CENTER TRAINING REQUIREMENTS.**~~
~~Each owner or operator of a daycare center licensed by the Department must receive and ensure that each staff member receives and completes four (4) hours of ongoing training every twelve (12) months after the staff member's date of hire. (3-28-23)~~

~~**01.** **Child Development Training**. Training must be related to continuing education in child development. (3-28-23)~~

~~**02.** **Training Hours**. It is the responsibility of the owner or operator of the daycare center to ensure that each staff member has completed four (4) hours of training each year. The training must be documented in the staff~~

~~member's record.~~ ~~(3-28-23)~~

~~03.~~ **~~Pediatric Rescue Breathing, Infant-Child CPR, and First Aid Training~~**~~. Pediatric rescue breathing, infant-child CPR, and first aid training will not count towards the required four (4) hours of annual training.~~ ~~(3-28-23)~~

~~04.~~ **~~Staff Training Records~~**~~. Each owner or operator of the daycare center is responsible for maintaining documentation of staff's training and may be asked to produce documentation at the time of license renewal.~~ ~~(3-28-23)~~

~~341. -- 344. (RESERVED)~~

~~345. MANDATORY REPORTING OF ABUSE, ABANDONMENT, OR NEGLECT.~~

~~Under Section 16-1605, Idaho Code, daycare personnel, including the owners, operators, staff, and any other person who has reason to believe that a child has been abused, abandoned, or neglected, or is being subjected to conditions or circumstances which would reasonably result in abuse, abandonment, or neglect, must report or cause to be reported within twenty-four (24) hours, such conditions or circumstances to the Department or the proper law enforcement agency.~~ ~~(3-28-23)~~

~~346. VISITATION AND ACCESS.~~

~~01.~~ **~~Visitation Rights~~**~~. Parents and guardians have the absolute right to enter the daycare premises when their child is in the care of the daycare operator. Failure or refusal to allow parental or guardian entry to the daycare premises or access to their child may result in the suspension or revocation of a daycare license.~~ ~~(3-28-23)~~

~~02.~~ **~~Denied or Limited Visitation Rights by Court Order~~**~~. If a parent or guardian has been granted limited visitation rights or denied visitation rights by a court of competent jurisdiction, and the daycare operator has written documentation from the court, Subsection 346.01 of this rule does not confer a right to visitation upon the parent or guardian.~~ ~~(3-28-23)~~

~~03.~~ **~~Department Access~~**~~. The owner or operator of a daycare center, group daycare facility, or family daycare home voluntarily licensed by the Department, must allow the Department access to the premises for reinspection at any time during the licensing period.~~ ~~(3-28-23)~~

~~347. -- 349. (RESERVED)~~

~~350. FIRE SAFETY STANDARDS.~~

~~Each daycare center, group daycare facility, or family daycare home voluntarily licensed by the Department, must comply with the fire safety standards in this rule.~~ ~~(3-28-23)~~

~~01.~~ **~~Inspections~~**~~. Inspections must be completed by the local fire official or designee. For a daycare located outside of the area of authority under Section 39-1109, Idaho Code, the Department can designate an approved inspector for daycare licensing purposes only.~~ ~~(3-28-23)~~

~~02.~~ **~~Unobstructed Exits~~**~~. Required exits must be located in such a way that an unobstructed path outside the building is provided to a public way or area of refuge.~~ ~~(3-28-23)~~

~~a.~~ ~~Exit doors must open from the inside without the use of a key or any special knowledge or effort.~~ ~~(3-28-23)~~

~~b.~~ ~~There must be at least two (2) exits located a distance apart of not less than one-half (1/2) the diagonal dimension of the building or portion used for daycare, but not to exceed seventy-five (75) feet. An exception may be made for the following:~~ ~~(3-28-23)~~

~~i.~~ ~~The distance between exits may be extended to ninety (90) feet if the building is totally protected throughout with smoke detectors; or~~ ~~(3-28-23)~~

~~ii. The distance between exits may be increased to one hundred ten (110) feet if the building is equipped with an automatic fire sprinkler system.~~ ~~(3-28-23)~~

~~**c.** The required dimensions of exits must not be less than thirty-two (32) inches of clear exit width and not be less than six (6) feet, eight (8) inches in height. An exception for sliding patio doors will be accepted as a required second exit in a family daycare home and group daycare facilities only.~~ ~~(3-28-23)~~

~~**d.** Sleeping room exits must be provided with at least one (1) emergency egress window having at least a single net clear opening of five point seven (5.7) square feet, minimum height twenty-four (24) inches, minimum width twenty (20) inches, and maximum finished sill height not over forty-four (44) inches.~~ ~~(3-28-23)~~

~~i. Approved egress windows from sleeping areas must be operable from the inside without the use of separate tools.~~ ~~(3-28-23)~~

~~ii. In lieu of egress windows, an approved exit door is acceptable.~~ ~~(3-28-23)~~

~~iii. An approved piece of furniture or platform, if anchored in place, may be approved to sit in front of a window if the sill height is over forty-four (44) inches.~~ ~~(3-28-23)~~

~~**e.** Where children are located on a story below the level of exit discharge (basement), there must be at least two (2) exits, one (1) of which must open directly to the outside. More than one (1) exit from the basement opening directly to the outside may be required, depending on the structure of the building, to ensure the safety of the occupants.~~ ~~(3-28-23)~~

~~**f.** Where children are located on a story above the level of exit discharge, there must be two (2) exits, one (1) of which must open directly to the outside and comply with building codes.~~ ~~(3-28-23)~~

~~**351. FACILITY CAPACITY AND DETERMINING OCCUPANT LOAD.**~~
~~Occupant load is determined by the local fire official or designee.~~ ~~(3-28-23)~~

~~**01. Area for Daycare Use Only**. The local fire official or designee will only use those areas used for daycare purposes when determining the occupant load.~~ ~~(3-28-23)~~

~~**02. Facilities with an Occupancy Load of Fifty or More**. Facilities with an occupancy load of fifty (50) or more occupants must meet the requirements in Section 350 of these rules in addition to this rule.~~ ~~(3-28-23)~~

~~**a.** Exit doors must swing in the direction of egress.~~ ~~(3-28-23)~~

~~**b.** Exit doors from rooms, if provided with a latch, must have panic hardware installed.~~ ~~(3-28-23)~~

~~**03. Exit Signs**. Exit signs must be installed at required exit doorways and wherever else necessary to clearly indicate the direction of egress.~~ ~~(3-28-23)~~

~~**352. FIRE EXTINGUISHERS AND SAFETY REQUIREMENTS.**~~
~~Each daycare center, group daycare facility, or family daycare home voluntarily licensed by the Department, must comply with the fire extinguisher and safety requirements in this rule as applicable for size and type of facility.~~ ~~(3-28-23)~~

~~**01. Portable Fire Extinguisher**. There must be an approved portable fire extinguisher (minimum 2A-10BC) mounted securely in a visible location not to exceed five (5) feet from the floor to the top of the extinguisher and not more than seventy five (75) feet travel distance to an extinguisher and maintained properly.~~ ~~(3-28-23)~~

~~**02. Kitchen Area**. An approved fire extinguisher must be present, or a hood-type fire suppression system must be installed in the kitchen area.~~ ~~(3-28-23)~~

~~**03. Fire Extinguishers**. Approved fire extinguishers must be maintained properly.~~ ~~(3-28-23)~~

~~**04. Facilities Over Three Thousand Square Feet**. Each daycare facility over three thousand (3,000) square feet is required to have additional fire extinguishers as approved by the local fire official or designee. (3-28-23)~~

~~**05. Fire Alarm System**. Each daycare facility with over fifty (50) children, must have an approved fire alarm system installed. (3-28-23)~~

~~**06. Smoke Detectors**. Smoke detectors must be installed and maintained in the following locations: (3-28-23)~~

~~**a.** On the ceiling, wall outside, or each separate sleeping area in the immediate vicinity of bedrooms; (3-28-23)~~

~~**b.** In each room used for sleeping purposes; and (3-28-23)~~

~~**c.** In each story within a facility including basements. (3-28-23)~~

~~**d.** If there is a basement, there must be a smoke detector installed in the basement having a stairway which opens from the basement into the facility. Such detector must be connected to a sounding device or other detector to provide an alarm which is audible in the sleeping area. (3-28-23)~~

~~**07. Automatic Sprinkler Systems**. An automatic sprinkler system must be provided in all daycare facilities greater than twenty thousand (20,000) square feet in area or when the number of children under the age of eighteen (18) months exceeds one hundred (100). (3-28-23)~~

~~**353. FIRE SAFETY AND EVACUATION PLANS.**~~
~~Each daycare center, group daycare facility, or family daycare home voluntarily licensed by the Department, must have an approved fire safety and evacuation plan prepared that includes the following: (3-28-23)~~

~~**01. Evacuation**. Procedures and policies for accounting for staff and children after an evacuation is completed. (3-28-23)~~

~~**02. Evacuation Plan and Assembly Point for Children and Staff**. (3-28-23)~~

~~**03. Locations of Facility Exits**. (3-28-23)~~

~~**04. Evacuation Routes**. (3-28-23)~~

~~**05. Location of Fire Alarms**. (3-28-23)~~

~~**06. Location of Fire Extinguishers**. (3-28-23)~~

~~**07. Annual Review**. Fire safety and evacuation plans must be reviewed or updated annually and available in the facility for reference and review. (3-28-23)~~

~~**08. Frequency of Fire and Emergency Evacuation Drills**. Fire and evacuation drills must be conducted on a routine schedule and all staff and children must participate. (3-28-23)~~

~~**354. -- 359. (RESERVED)**~~

~~**360. HEALTH STANDARDS.**~~
~~Each daycare center, group daycare facility, or family daycare home voluntarily licensed by the Department, must comply with the following. Health inspections will be completed by a qualified inspector designated by the Department. (3-28-23)~~

~~**01. Food Source**. Food must be from an approved source under IDAPA 16.02.19, "Idaho Food Code." Food must not be served past expiration or "use by" date. (3-28-23)~~

~~**02. Food Preparation**. Food for use in daycare facilities must be prepared and served in a sanitary manner with sanitized utensils and on surfaces that have been cleaned, rinsed, and sanitized prior to use to prevent cross-contamination. (3-28-23)~~

~~**a.** Frozen food must be thawed in the refrigerator, under cold running water, or as part of the cooking process. Food must be cooked to proper temperatures under IDAPA 16.02.19, "Idaho Food Code." (3-28-23)~~

~~**b.** Individuals preparing food must use proper hand-washing techniques, minimize bare hand contact with food, and wear clean clothes. (3-28-23)~~

~~**03. Food Temperatures**. Potentially hazardous foods must be kept refrigerated at forty-one degrees Fahrenheit (41°F) or below, held hot at one hundred thirty-five degrees Fahrenheit (135°F) or more, and reheated or cooled at safe temperatures under IDAPA 16.02.19, "Idaho Food Code." Refrigerators must be equipped with an accurate thermometer. (3-28-23)~~

~~**04. Food Storage**. All food that is served in daycare facilities must be stored in such a manner that protects it from potential contamination. There must be no evidence of pests present in the daycare facility. (3-28-23)~~

~~**05. Food Contact Surfaces**. Food contact surfaces must be kept clean and sanitized, including counters, serving tables, high chair trays, and cutting boards. (3-28-23)~~

~~**06. Dishwashing Sanitizing**. Dishes, glasses, utensils, silverware, and all other objects used for food preparation and eating must be sanitized using appropriate sanitizing procedures. (3-28-23)~~

~~**07. Utensil Storage**. Clean utensils must be stored on clean shelves or drawers and not subject to recontamination, and sharp knives and other sharp objects be kept out of reach of children. (3-28-23)~~

~~**08. Garbage**. Garbage must be kept covered or inaccessible to children. (3-28-23)~~

~~**09. Hand Washing**. Children and facility staff must be provided with individual or disposable towels for hand drying, and the hand washing area be equipped with soap and warm and cold running water. (3-28-23)~~

~~**10. Diaper Changing**. Diaper changing must be conducted in such a manner as to prevent the spread of communicable diseases, be separate from food preparation and serving areas, and have easy access to a hand-washing sink. (3-28-23)~~

~~**11. Sleeping Areas**. Children sleeping at the facility must have separate cots, mats, or beds and blankets. (3-28-23)~~

~~**12. Restrooms, Water Supply, and Sewage**. All daycare facilities must have restrooms. (3-28-23)~~

~~**a.** Each facility must have at least one (1) flushable toilet and at least one (1) hand washing sink with warm and cold water per restroom. (3-28-23)~~

~~**b.** Plumbing and bathroom fixtures must be in good condition. (3-28-23)~~

~~**c.** All daycare facilities and homes must comply with IDAPA 24.39.30, "Rules of Building Safety (Building Code Rules). (3-28-23)~~

~~**13. Water Supply**. The facility's water supply must meet one (1) of the following requirements: (3-28-23)~~

~~**a.** Be from a public water system that is maintained under IDAPA 58.01.08, "Idaho Rules for Public Drinking Water Systems," at the time of initial or renewal application; or (3-28-23)~~

~~b. Be from a private source, such as well or spring, be tested annually for bacteria and nitrate, and be approved by the Department.~~ ~~(3-28-23)~~

~~c. Water used for consumption at a daycare facility is from an acceptable source. Temporary use of bottled water or boiled water may be allowed for a period specified by the Department.~~ ~~(3-28-23)~~

~~**14. Sewage Disposal**. Facility sewage must be disposed of through a public system, or in the absence of a public system, in a manner approved by the local health authority under IDAPA 58.01.03 "Individual/Subsurface Sewage Disposal Rules."~~ ~~(3-28-23)~~

~~**15. Use of Alcohol and Illegal Drugs**. Alcohol and illegal drugs must not be used by operators, children, staff, volunteers, visitors at daycare facilities, in the presence of children during hours of operation, or in vehicles while transporting children.~~ ~~(3-28-23)~~

~~a. Any individual under the influence of alcohol or drugs is not be permitted at or in the daycare facility.~~ ~~(3-28-23)~~

~~b. Illegal drugs are prohibited by law and therefore are not allowed on the premises of a licensed daycare facility at any time.~~ ~~(3-28-23)~~

~~**16. Smoke-Free Environment**. Children must be afforded a smoke-free environment during all daycare hours, whether indoors or outdoors. While children are in care, the operator and all staff must ensure that no smoking or other tobacco use occurs within the facility, in outdoor areas, or in vehicles when children are present.~~ ~~(3-28-23)~~

~~**17. Medication**. No person can administer any medication to a child without it first being authorized by a parent or caretaker. All medications, refrigerated or unrefrigerated, must be in a locked box or otherwise inaccessible to children.~~ ~~(3-28-23)~~

~~**18. Adequate Heat, Light, and Ventilation**. A daycare facility must have adequate heat, light, and ventilation. Windows and doors must be screened if used for ventilation.~~ ~~(3-28-23)~~

~~**19. Immunizations**. Daycare operators must comply with requirements under IDAPA 16.02.11, "Immunization Requirements for Licensed Day care Facility Attendees."~~ ~~(3-28-23)~~

~~**361. MISCELLANEOUS SAFETY REQUIREMENTS.**~~

~~Each daycare center, group daycare facility, or family daycare home voluntarily licensed by the Department must comply with the following.~~ ~~(3-28-23)~~

~~**01. Telephone**. An operable telephone or cell phone must always be available in the facility with the following conditions:~~ ~~(3-28-23)~~

~~a. The telephone number used must be made available to parents and guardians.~~ ~~(3-28-23)~~

~~b. Emergency phone numbers to include 911, an adult emergency substitute operator, and the address and phone number of the facility must be posted by the telephone or in a location that is easily and always visible.~~ ~~(3-28-23)~~

~~**02. Heat-Producing Equipment**. A furnace, fireplace, wood-burning stove, water heater, and other flame or heat-producing equipment must be installed and maintained as recommended by the manufacturer and protected on all surfaces by screens or other means.~~ ~~(3-28-23)~~

~~**03. Portable Heating Devices**. Portable heating devices must be limited and approved for use and location by the Fire Inspector prior to use within a facility.~~ ~~(3-28-23)~~

~~**04. Storage of Weapons, Firearms, and Ammunition**. Firearms or other weapons stored at a daycare facility must be kept in a locked cabinet, gun safe, or other container that is inaccessible to children, while children~~

are in attendance. Keys to these containers must also be inaccessible to children. (3-28-23)

a. Ammunition must be stored in a locked container separate from firearms. (3-28-23)

b. Matches, lighters, and any other means of starting fires must be kept away from and out of the reach of children. (3-28-23)

c. Other weapons that could cause harm must be stored out of reach of children. (3-28-23)

05. Animals and Pets. Any pet or animal present at the facility, indoors or outdoors, must be in good health, show no evidence of carrying disease, and be a friendly companion of the children. The operator must maintain the animal's vaccinations and vaccination records which will be made available to the Department upon request. (3-28-23)

06. Storage of Hazardous Materials. Cleaning materials, flammable liquids, detergents, aerosol cans, pesticides, and other poisonous and toxic materials must be kept in their original containers and in a place inaccessible to children. They must be used in such a way that will not contaminate play surfaces, food, food preparation areas, or constitute a hazard to the children. (3-28-23)

362. -- 364. (RESERVED)

365. BUILDINGS, GROUNDS, FURNISHINGS, AND EQUIPMENT.

Each daycare center, group daycare facility, or family daycare home voluntarily licensed by the Department must comply with the following: (3-28-23)

01. Appliances and Electrical Cords. All appliances, lamp cords, exposed light sockets, and electrical outlets will be protected to prevent electrocution. (3-28-23)

02. Balconies and Stairways. Balconies and stairways accessible to children will have substantial railings as required by IDAPA 24.39.30, "Rules of Building Safety (Building Code Rules). (3-28-23)

03. Stairway Protection. Where an operator cares for children less than three (3) years old, stairways will be protected to prevent child access to stairs. (3-28-23)

04. Hazardous Area Restrictions. Based on the age and functioning level of children in care and the type of hazard and the area surrounding the hazard will be restricted to prevent easy access to the hazard. (3-28-23)

05. Fueled Equipment. Fueled equipment including motorcycles, mopeds, lawn-care equipment, and portable cooking equipment will not be stored or repaired in areas where children are present. (3-28-23)

06. Water Hazards. Above and below ground pools, hot tubs, ponds, and other bodies of water that are on the daycare facility premises must provide the following safeguards: (3-28-23)

a. The area surrounding the body of water must be fenced and locked in a manner that prevents access by children and meets the following: (3-28-23)

i. The fence will be at least four (4) feet high with no vertical opening more than four (4) inches wide and designed so that a young child cannot climb or squeeze under or through the fence. The fence will surround all sides of the pool and have a self-closing gate that has a self-latching mechanism in proper working order that is out of the reach of young children. (3-28-23)

ii. If the house forms one (1) side of the barrier for the pool, all doors that provide unrestricted access to the pool will have alarms that produce an audible sound when the door is opened. (3-28-23)

b. Furniture or other large objects will not be left near the fence in a manner that would enable a child to climb on the furniture or other large object and gain access to the pool. If the area surrounding a pool, hot tub, pond, or other body of water is not fenced and locked, there will be a secured protective covering that prevents access

~~by a child.~~ ~~(3-28-23)~~

~~**c.**~~ ~~Wading pools and buckets will be empty when not in use.~~ ~~(3-28-23)~~

~~**d.**~~ ~~Children will be under direct supervision of an adult staff member who is certified in pediatric rescue breathing, infant-child CPR, and first aid while using a bathtub, pool, hot tub, pond, or other body of water.~~ ~~(3-28-23)~~

~~**e.**~~ ~~A minimum of a four (4) foot high fence that prevents access from the daycare facility premises, if the daycare premises are adjacent to a body of water.~~ ~~(3-28-23)~~

~~**07.**~~ ~~**Indoor Play Areas and Toys**. The indoor play areas will be clean, have age-appropriate toys, and be free from accumulation of dirt, rubbish, or other health hazards.~~ ~~(3-28-23)~~

~~**08.**~~ ~~**Outdoor Play Areas and Toys**. Any outdoor play area must be maintained free from hazards such as wells, machinery, and animal waste.~~ ~~(3-28-23)~~

~~**a.**~~ ~~If any part of the play area is adjacent to a busy roadway, drainage or irrigation ditch, stream, large holes, or other hazardous areas, the play area will be enclosed with a fence in good repair that is at least four (4) feet high without any holes or spaces greater than four (4) inches in diameter.~~ ~~(3-28-23)~~

~~**b.**~~ ~~Outdoor equipment, such as climbing apparatus, slides, and swings will be anchored firmly and placed in a safe location and according to the manufacturer's instructions.~~ ~~(3-28-23)~~

~~**c.**~~ ~~Outdoor play areas will be designed so that all parts always visible and are easily supervised by a staff member.~~ ~~(3-28-23)~~

~~**d.**~~ ~~Toys, play equipment, and any other equipment used by the children will be of substantial construction and free from rough edges and sharp corners. Unguarded ladders on slides will be kept in good repair and well-maintained.~~ ~~(3-28-23)~~

~~**e.**~~ ~~Toys and objects with a diameter of less than one (1) inch (two point five (2.5) centimeters), objects with removable parts that have a diameter of less than one (1) inch (two point five (2.5) centimeters), plastic bags, styrofoam objects, and balloons will not be accessible to children ages three (3) and under or children who are known to place such objects in their mouths.~~ ~~(3-28-23)~~

~~**366. -- 389.**~~ ~~**(RESERVED)**~~

~~**390.**~~ ~~**CONTINUED COMPLIANCE, REPORTING CHANGES, AND CRITICAL INCIDENTS.**~~
~~Each daycare owner or operator must always remain in compliance with fire, safety, and health requirements under these rules.~~ ~~(3-28-23)~~

~~**01.**~~ ~~**Posting of License and Other Information**.~~ ~~(3-28-23)~~

~~**a.**~~ ~~A daycare license issued by the Department to operators must be posted in plain view where it can be seen by parents and the public upon entering the facility.~~ ~~(3-28-23)~~

~~**b.**~~ ~~A daycare must post the Department's contact information and the statewide number to file daycare complaints.~~ ~~(3-28-23)~~

~~**02.**~~ ~~**Reporting Changes**. The Department must be notified of any changes that would affect the terms of licensure or could affect the health, well-being, or safety of children.~~ ~~(3-28-23)~~

~~**03.**~~ ~~**Critical Incidents**. A daycare operator must report any of the following to the Department within twenty-four (24) hours:~~ ~~(3-28-23)~~

~~**a.**~~ ~~Serious injury or death of a child at the facility;~~ ~~(3-28-23)~~

~~**b.** Any arrests, citations, withheld judgments, or criminal convictions of disqualifying crimes under Section 39-1113, Idaho Code, of an operator or any individual regularly on the premises of the facility and provide documentation that the individual is not working with children or is not on the premises. (3-28-23)~~

~~**391. -- 394. (RESERVED)**~~

~~**395. FAILURE TO COMPLY.**~~

~~**01. Misdemeanors to Operate Without a License**. It is a misdemeanor to operate a daycare center or group daycare facility without first obtaining a daycare license from the Department or to operate a daycare center or group daycare facility without posting the license in a place easily seen by a parent or the general public. (3-28-23)~~

~~**a.** The Department may grant a grace period of no more than sixty (60) days to allow the daycare facility to comply with these rules and with Title 39, Chapter 11, Idaho Code. (3-28-23)~~

~~**b.** The operator or owner must agree to begin the application process under Section 321 of these rules within one (1) business day of identification by the Department that a daycare owner or operator is noncompliant with Title 39, Chapter 11, Idaho Code, or this chapter of rules. (3-28-23)~~

~~**02. Misdemeanor to Operate Without Obtaining a Background Check**. It is a misdemeanor to operate a family daycare home caring for four (4) or more children without obtaining the required background check under Section 39-1105, Idaho Code. If there is an initial citation for violation of Section 39-1115, and a person makes the applications required within twenty (20) days, the complaint will be dismissed. Operating a family daycare home for four (4) or more children after failure to pass the required background check is a misdemeanor. (3-28-23)~~

~~**03. Misdemeanor to Provide Daycare if Guilty of Certain Offenses**. It is a misdemeanor to provide daycare services if found guilty of any offenses under Section 39-1113, Idaho Code. (3-28-23)~~

~~**396. -- 399. (RESERVED)**~~

~~**STANDARDS FOR FOSTER HOMES**~~
~~**(Sections 400-499)**~~

~~**400. STANDARDS FOR FOSTER HOMES.**~~
~~The standards for licensing foster homes are to insure that children of the state who must live away from their parents receive adequate substitute parental care to address their need for safety, health, and well-being, that the persons providing this care are capable and suitable to meet the protection needs of children living in foster homes, and the physical environment in which these children reside is a safe setting. (3-28-23)~~

~~401~~200. LICENSING PROVISIONS RELATED TO THE INDIAN CHILD WELFARE ACT.
These rules do not supersede the licensing authority of Indian tribes under the Indian Child Welfare Act, P.L. 95-608, 25 USC, Sections 1901 – 1963. ( )

~~402~~201. FOSTER PARENT QUALIFICATIONS AND SUITABILITY.
Foster parents must be physically and emotionally suited to care for children and to deal with the problems presented by children placed away from their own parents, family, and homes. An applicant for licensure as a foster parent must meet the following: ( )

01. ~~Minimum~~ Age. Be twenty-one (21) years old or older. ~~(3-28-23)~~( )

02. Be of Good Character. ~~Be of good character.~~ ~~(3-28-23)~~( )

03. Communication. Be able to communicate with the child, the licensing agency, and health care and other service providers. ( )

04. Personal Attributes and Experiences. Have the maturity, interpersonal qualities, temperament,

and life experiences that prepare the foster parent to provide foster care. ( )

05. Availability for Child Placement. Express a willingness to provide care for the kind of children the children's agency has available for placement. ( )

06. Knowledge and Skill. Demonstrate an understanding of the care that must be provided to the children served by the children's agency or express a willingness to learn how to provide that care. ( )

07. Child Care and Supervision. Have adequate time to provide care and supervision for children. ( )

08. Income and Resources. Have a defined and sufficient source of income and be capable of managing that income to meet the needs of the foster family without relying on the payment made for the care of a foster child. ( )

09. Health. Have the physical, intellectual, and emotional health to assure appropriate care of children. ( )

10. Harmonious Home Life. Establish and maintain a harmonious home life to give children the emotional stability they need. No marital or personal problems may exist within the family that would result in undue emotional strain in the home or be harmful to the interest of children placed in the home. ( )

11. Literacy. At least one (1) adult caretaker in the home must have functional literacy. ( )

12. Acceptance of Foster Children. Demonstrate a willingness and ability to accept a child into the home as a member of the family. ( )

13. Family Supports. Demonstrate a willingness and ability to work with a foster child's legal family, future family, relatives, or Indian tribe. ( )

14. Compliance ~~with Licensing Rules~~. Demonstrate a willingness and ability to comply with ~~the licensing rules for foster homes~~ these rules. ~~(3-28-23)~~( )

15. Illegal Substance. Foster parents will not use any illegal substances, abuse alcohol by consuming it in excessive amounts, or abuse legal prescription or nonprescription drugs, or both, by consuming them in excessive amounts or using them contrary to medication instructions. ( )

16. Nicotine Use. Foster parents and their guests will not smoke or vape in the foster family home, in any vehicle used to transport the child, or in the presence of the child in foster care. ( )

~~403~~202. ~~CRIMINAL HISTORY AND~~ BACKGROUND CHECKS ~~FOR FOSTER CARE LICENSE~~.
All applicants for a foster care license and other adult members of the household must comply with IDAPA 16.05.06, "Criminal History and Background Checks," and the following: ( )

01. Required Procedures. Each applicant for a foster home license, and any other adult household member, must ~~participate in~~ complete a background check. ~~(3-28-23)~~( )

02. Change in Household Membership. By the next working day after another adult begins residing in a ~~licensed~~ foster home, a foster parent must notify the children's agency of the change in household membership and assure that the new adult household member will complete a background check within fifteen (15) days of residence in the foster home. ( )

03. Foster Parent's Child Turns Eighteen. A foster parent's child who turns eighteen (18) and lives continuously in the home is not required to have a background check except as specified in ~~Subsection 404.03.c. of~~ this rule. ~~(3-28-23)~~( )

a. After turning eighteen (18) years old, if the foster parent's adult child no longer lives in the foster

parent's home and subsequently resumes living in the ~~licensed~~ foster home, they will be considered an adult household member and must complete a background check within fifteen (15) days from the date they became an adult household member. ~~(3-28-23)~~( )

b. If the adult child leaves the foster home for the purpose of higher education or military service, and periodically returns to the home for less than ninety (90) days, they are not considered to be an adult household member and are not required to complete a background check. While in the home, they cannot have any unsupervised direct care responsibilities for any foster children in the home. Should they remain in the foster home for more than ninety (90) days, they will immediately be considered an adult household member and must complete a background check within fifteen (15) days from the date they became an adult household member. ( )

c. If the adult child continues to live in their parent's ~~licensed~~ foster home or on the same property, they must complete a background check within fifteen (15) days of turning twenty-one (21), This requirement is not necessary if the adult child has completed a background check between the ages of eighteen (18) and twenty-one (21). ~~(3-28-23)~~( )

04. Background Check at Any Time. The Department retains the authority to require a background check at any time on individuals who are residing in a ~~licensed~~ foster home or on the foster parent's property. ~~(3-28-23)~~( )

05. Emergency Placement of Children. An emergency occurs when a child enters or experiences an unplanned placement change in foster care. The Department may request that a criminal justice agency perform a Federal Interstate Identification Index name-based criminal history record check of each adult residing in the home. This refers to those limited instances when placing a child in the home of relatives or fictive kin, as a result of a sudden unavailability of the child's parent or caretaker. ( )

a. All adult household members will submit fingerprints to the Department's Background Check Unit within ten (10) calendar days and follow requirements outlined in IDAPA 16.05.06, "Criminal History and Background Checks." The Department forwards the fingerprints to the State Central Record Repository for submission to the FBI within fifteen (15) calendar days from the date the name search was conducted. The Department's background check unit will positively identify the individual that is being considered to receive the child in an emergency situation as their fingerprints are submitted. ( )

b. When placement of a child in a home is denied as a result of the Department review of the name-based criminal history record check of any adult household member, all adults must still comply with Subsection 202.05.a. of this rule and IDAPA 16.05.06, "Criminal History and Background Checks." ( )

c. The child will be removed from the home immediately if any adult household member fails to provide written permission to perform a federal criminal history record check, submit fingerprints, or any adult household member is denied a Department background check clearance. ( )

~~404~~203. INITIAL AND ONGOING EVALUATION.

An applicant must participate in the process and tasks to complete an initial evaluation for foster care licensure. ( )

01. Applicant Participation. The applicant must do all the following: ( )

a. Cooperate with and allow the children's agency to determine compliance with these rules to conduct an initial foster home study; ( )

b. Inform the children's agency if the applicant is currently licensed or has been previously licensed as a foster parent or the applicant has been involved in the care and supervision of children or adults; ( )

c. Provide a medical statement for each applicant, signed by a medical professional, within the twelve (12) month period prior to initial licensure for family foster care, indicating the applicant is in such physical and mental health ~~so as~~ to not adversely affect either the health or quality of care for children placed in the home; ~~(3-28-23)~~( )

d. Provide the name of, and a signed release to obtain the following information about, each household member: ( )

i. Admission to or release from a facility, hospital, or institution for the treatment of an emotional, intellectual, or substance abuse issue; ( )

ii. Outpatient counseling, treatment, or therapy for an emotional, intellectual, or substance abuse issue; and ( )

e. Provide three (3) satisfactory references, one (1) of which may be from a person related to the applicant(s). An applicant will provide additional references upon the request of the children's agency. ( )

02. Physical and Mental Health of Household Members. All household members must be in such physical and mental health that the health, safety, or well-being of a foster child will not be adversely affected. A health status report of any household member may be required from a medical professional if this appears advisable to the children's agency. To assure the safety and well-being of children, each household member must comply with these rules. ~~(3-28-23)~~( )

03. Disclosure of Information. An applicant must provide the children's agency with the following or any additional information the children's agency deems necessary to complete the initial family home study: ( )

a. ~~The n~~Names, including maiden or other names used, and ages of the applicant(s); ~~(3-28-23)~~( )

b. Social Security Number; ( )

c. Education; ( )

d. Verification of marriages and divorces; ( )

e. Religious and cultural practices of the applicant including their willingness and ability to accommodate or provide care to a foster child of a different race, religion, or culture; ( )

f. ~~A s~~Statement of income and financial resources and the family's management of these resources; ~~(3-28-23)~~( )

g. Marital relationship, if applicable, including decision making, communication, and familial roles ~~within the family~~; ~~(3-28-23)~~( )

h. Individual and family functioning and interrelationships with each household member; ( )

i. Any current family problems, including medical or mental illness, illegal drug use, prescription drug abuse, and excessive alcohol use; ( )

j. Previous criminal convictions and valid incidents of child abuse and neglect; ( )

k. Family history, including how the applicant was disciplined, childhood experiences, and problem solving; ( )

l. Child care and parenting skills; ( )

m. Methods of discipline; ( )

n. ~~The n~~Names, ages, and addresses of all biological and adopted children currently residing in or outside the home; ~~(3-28-23)~~( )

o. Adjustment and special needs of the applicant's children; ( )

p. Interests and hobbies; ( )

q. Reasons for applying to be a foster parent; ( )

r. Understanding of the purpose and goals of foster care; ( )

s. Prior and current experiences with foster care; ( )

t. Emotional stability and maturity in dealing with the needs, challenges, and related issues associated with the child's placement into applicant(s) home; ( )

u. ~~The a~~Attitudes toward foster care by immediate and extended family members~~ of the family~~ and other persons who reside in the home; ~~(3-28-23)~~( )

v. ~~The a~~Applicant's attitudes about a foster child's family and the applicant's willingness to work with the child's family and tribe; ~~(3-28-23)~~( )

w. Specifications of the children preferred by the family that include the number of children, age, gender, race, ethnic background, social, emotional, and educational characteristics of children preferred; ( )

x. Adequacy of the applicant's house, property, and neighborhood for the purpose of providing foster care as determined by onsite observations; ( )

y. ~~The a~~Applicant(s) willingness to abide by the children's agency policies and procedures for discipline; ~~(3-28-23)~~( )

z. Three (3) personal references, at least two (2) that are from persons not related to the applicants, reflecting the applicants to be of good character and possess good habits; ( )

aa. Training needs of the applicant(s); and ( )

bb. ~~The c~~Capacity and willingness to transport a foster child in a motor vehicle. ~~(3-28-23)~~( )

~~405~~204. SUBSEQUENT EVALUATIONS.
A foster parent must comply with the following~~ for the subsequent evaluation required for a foster care license~~: ~~(3-28-23)~~( )

01. Reasonable Access. A foster parent will allow the children's agency reasonable access to the foster home, including interviewing each foster parent, each foster child, and any household member to determine ~~continued~~ compliance with~~ licensing standards~~ these rules, for child supervision purposes, and to conduct a ~~recertification~~ relicense study. ~~(3-28-23)~~( )

02. Update Information. Provide all changes to the information~~ contained~~ in the initial evaluation and subsequent evaluations. ~~(3-28-23)~~( )

03. Family Functioning. Provide information on~~ any~~ changes in family functioning and inter-relationships. ~~(3-28-23)~~( )

04. Other Circumstances. Provide the children's agency with any information regarding circumstances within the family that may adversely impact the foster child. ( )

05. ~~Written~~ Plan of Correction. Cooperate with the children's agency in developing and carrying out a written plan required to correct any rule noncompliance identified by any evaluation conducted by the children's agency. ~~(3-28-23)~~( )

~~406~~205. FOSTER PARENT DUTIES.
A foster parent must do the following: ( )

01. Case Plan Implementation. Cooperate with, and assist the children's agency~~ in the~~ with implementation of the case plan for children and their families. ~~(3-28-23)~~( )

02. Reporting Progress and Problems. Promptly and fully disclose to the children's agency information concerning a child's progress and problems. ( )

03. Termination of Placement~~ by the Foster Family~~. Provide notification to the children's agency of the need for a child to be moved from the foster home not less than fourteen (14) calendar days before the move, except when a delay would jeopardize the child's care or safety, or the safety of members of the foster family. ~~(3-28-23)~~( )

04. Written Policies and Procedures~~ for Foster Families~~. Maintain a copy of, be familiar with, and follow these rules and any other rules, policies, or procedures which an agency may require for foster parents and foster care. ~~(3-28-23)~~( )

~~407~~206. FOSTER PARENT TRAINING.
Each foster parent must comply with the following: ( )

01. Orientation. Each foster home applicant~~ for a foster home license~~ will receive an orientation related to the foster care program and services. ~~(3-28-23)~~( )

02. Pre-Service. Complete not less than twenty-four (24) hours of identified training prior to the issuance of an initial foster care license. ( )

03. First Year. Prior to first annual licensing renewal, complete not less than fifteen (15) hours of identified training. ( )

04. Annual Training. Complete not less than ten (10) hours of training annually following the first year of licensing. ( )

05. Individualized Training. Complete training identified by the Department as meeting the individual needs of the foster parent(s). ( )

06. Additional Training. Complete any additional training~~ as~~ required by the children's agency foster parent training plan. ~~(3-28-23)~~( )

~~408~~207. -- ~~4~~229. (RESERVED)

~~4~~230. HOME ENVIRONMENT SAFETY REQUIREMENTS.
The property, structure, premises, and furnishings of a foster home must be constructed and maintained in good repair,~~ in a~~ clean condition, with proper trash and recycling disposal, and free from rodents or insect infestation, safety hazards, and dangerous machinery and equipment. Areas and equipment that present a hazard to children must not be accessible by children. ~~(3-28-23)~~( )

01. Living Space. The living space or structure of a foster home will be a house, mobile home (as defined under Title 39, Chapter 41, Idaho Code), housing unit, or apartment occupied by an individual or family. ( )

02. Swimming Pools, Hot Tubs, Ponds, and Other Bodies of Water~~ for Use by Children~~. Any ~~licensed~~ foster home with these water hazards on or adjacent to their property must provide the following safeguards: ~~(3-28-23)~~( )

a. Around any of the water hazards listed in~~ Subsection 430.02 of~~ this rule, a foster child must have appropriate adult supervision consistent with the child's age, physical ability, and developmental level;

~~(3-28-23)~~( )

b. The area surrounding a body of water must be fenced and locked in a manner that prevents access by children under the age of twelve (12), children of any age who are not competent swimmers, or children who are developmentally younger than their chronological age of twelve (12); or ( )

c. Above ground pools must have a four-foot barrier that may be the pool structure or attached fencing, or both with a maximum vertical clearance between the top of the pool and the bottom of the barrier not exceeding four (4) inches; and ( )

i. The ladder must be removed and stored inaccessible to children under the age of twelve (12) when not in use; and ( )

ii. If the ladder cannot be removed, the steps or ladder must be surrounded by a barrier as required in Subsection ~~4~~230.0~~1~~2.b. of this rule. ~~(3-28-23)~~( )

d. If the area surrounding any of the water hazards listed in~~ Subsection 430.02 of~~ this rule~~,~~ is not fenced and locked, there must be a secured protective covering that will not allow access by a child. ~~(3-28-23)~~( )

i. Pool or hot tub covers must be completely removed when in use; ( )

ii. When the pool or hot tub cover is in place, the cover must be free from standing water; ( )

iii. Covers must always be locked when the pool or hot tub is not in use. ( )

03. Access by Children Five Years Old and Under. Any~~ licensed~~ foster home that cares for children five (5) years old and under and chooses to prevent access to a body of water by fencing must provide a fence that meets the following: ~~(3-28-23)~~( )

a. The fence must be at least four (4) feet high with no vertical opening more than four (4) inches wide, be designed so that a young child cannot climb or squeeze under or through the fence, and surround all sides of the pool or pond; ( )

b. The gate must be self-closing and have a self-latching mechanism in proper working order out of the reach of young children; ( )

c. If the house forms one (1) side of the barrier for the pool, doors that provide unrestricted access to the pool must have alarms that produce an audible sound when the doors are opened; and ( )

d. Furniture or other large objects must not be left near the fence that would enable a child to climb on the furniture and gain access to the pool; or ( )

e. Above ground pools meet the requirements in Subsection ~~4~~230.0~~1~~2.~~c~~b. in this rule.~~(3-28-23)~~( )

04. Irrigation Canals or Similar Bod~~y~~ies of Water. A~~ licensed~~ foster home caring for a child five (5) years old and under or a child who is physically or developmentally vulnerable, whose property adjoins an irrigation canal or similar body of water, must have fencing that prevents access to the canal or similar body of water by the child. ~~(3-28-23)~~( )

05. Other Water Safety Precautions. ( )

a. Wading pools must be empty when not being used; ( )

b. Children must be under direct supervision of an adult while using a wading pool; ( )

c. Toys that attract young children to the pool area must be kept picked up and away from the pool area when not in use; ( )

d. A child who does not know how to swim must use an approved lifesaving personal flotation device; ( )

e. All swimming pools will be equipped with a life-saving device, such as a ring buoy; and ( )

f. Swimming pools that cannot be emptied after each use will have a working pump and filtration system. ( )

~~4~~231. INSTALLATION, MAINTENANCE, AND INSPECTION OF FLAME AND HEAT-PRODUCING EQUIPMENT.
A foster parent must assure: ( )

01. Installation and Maintenance of Flame and Heat-Producing Equipment. That a furnace, fireplace, wood-burning stove, water heater, and other flame or heat-producing equipment is installed and maintained as recommended by the manufacturer, and fireplaces are protected by screens or other means. ( )

02. Portable Heating Devices. That portable heating devices will not be used during sleeping hours. ( )

03. Fire Inspections. An inspection by a certified fire inspector may be required at the discretion of the children's agency. ( )

04. Water Heater. The water temperature will not exceed 120 degrees Fahrenheit (49 degrees Celsius). ( )

~~4~~232. FIRE SAFETY, EMERGENCY PLANNING, AND EVACUATION PLAN.
Each foster home must meet the following ~~standards~~: ~~(3-28-23)~~( )

01. Smoke Detectors. There will be at least one (1) single-station smoke detector (approved by a nationally recognized testing laboratory) that is installed and maintained as recommended by the manufacturer, and as follows: ( )

a. One (1) smoke detector on each floor of the home, including the basement; ( )

b. One (1) smoke detector in each bedroom used by a foster child; and ( )

c. One (1) smoke detector in areas of the home that contain flame or heat-producing equipment other than domestic stoves and clothes dryers. ( )

02. Carbon Monoxide Detectors. There will be at least one (1) carbon monoxide detector (approved by a nationally recognized testing laboratory) that is installed and maintained as recommended by the manufacturer. Living space that does not have equipment ~~which~~ that produces carbon monoxide or does not have an attached garage is exempt from this requirement. Multi-level homes will have one (1) carbon monoxide detector on each level of the home and at least one (1) near all sleeping areas. ~~(3-28-23)~~( )

03. Additional Fire Safety Requirements. To be within the structure of the home: ( )

a. Have at least one (1) operable fire extinguisher that is readily accessible; ( )

b. Be free of obvious fire hazards such as defective heating equipment or improperly stored flammable materials; ( )

c. Have a written emergency evacuation plan posted in a prominent place in the home and reviewed with children placed for foster care; ( )

d. Maintain a comprehensive list of emergency telephone numbers including poison control and

posted in a prominent place in the home; and ( )

e. Maintain first aid supplies. ( )

4233. EXITS.
There must be at least two (2) exits from each floor level used by a family member that are remote from each other, one (1) of which provides a direct, safe means of unobstructed travel to the outside at street or ground level. A window may be used as a second exit if it complies with these rules. ( )

4234. DANGEROUS AND HAZARDOUS MATERIALS.
Dangerous and hazardous materials, objects, or equipment, including poisonous, explosive, or flammable substances that could present a risk to a child placed in a foster home must be stored securely and out of reach of a child, as appropriate for the age and functioning level of the child. ( )

4235. FIREARMS AND AMMUNITION.
Firearms at a foster home must be stored: ( )

01. Trigger Locks. Unloaded and equipped with a trigger lock; ( )

02. Unassembled and Inoperable. Unloaded, fully inoperable, and incapable of being assembled and fired; ( )

03. Locked Cabinet or Container. Unloaded and locked in a cabinet or storage container that is inaccessible to children; or ( )

04. Gun Safe. Locked in a gun safe that is inaccessible to children; ( )

05. Ammunition. Stored and locked separately from all guns in the home. ( )

4236. PETS AND DOMESTIC ANIMALS.
Any pet or domestic animal that is suspected or known to be dangerous must be kept in an area inaccessible to children. Dogs must be vaccinated for rabies. ( )

4237. ADEQUATE HEAT, LIGHT, AND VENTILATION.
A foster home must have adequate heat, light, and ventilation and windows and doors will be screened if used for ventilation. ( )

4238. BATHROOMS, KITCHENS, WATER SUPPLY, AND SEWAGE DISPOSAL.
A foster home must meet the following: ( )

01. Toilet Facilities. A foster home will have a minimum of one (1) flush toilet, one (1) washbasin that has warm and cold running water, and one (1) bathtub or shower that has warm and cold running water, all of which are in good working order. ( )

02. Water Supply. The water supply will meet one (1) of the following requirements: ( )

a. That it is from a source approved for a private home by the health authority under IDAPA 58.01.08, "Idaho Rules for Public Drinking Water Systems," at the time of application and for annual renewal of such licenses; or ( )

b. Water used for consumption at a foster home is from an acceptable source, bottled water from an acceptable source, or boiled for a period specified by the local health authority under IDAPA 58.01.08, "Idaho Rules for Public Drinking Water Systems." ( )

03. Sewage Disposal. Sewage will be disposed of through a public system, or in the absence of a public system, in a manner approved by the local health authority, under IDAPA 58.01.03 "Individual/Subsurface Sewage Disposal Rules." ( )

04. Kitchen. A foster home will include a properly operating kitchen with a sink, refrigerator, stove, and oven. ( )

~~4~~239. TRANSPORTATION.
A foster parent must comply with the following: ( )

01. Legal Requirements for Transporting Children. A foster parent, or any person acting on behalf of a foster parent, that transports a child, will possess a valid driver's license, be insured under Idaho Law, and abide by all traffic laws including the requirement that all children are in proper safety restraints while being transported as required under Sections 49-672 and 49-673, Idaho Code~~, and Section 49-673, Idaho Code~~. ~~(3-28-23)~~( )

02. Reliable Transportation. A foster parent will arrange for safe, reliable transportation of any foster child in their care to assure the child has access to school, community services, and the children's agency. ( )

a. Privately owned vehicles used to transport children in foster care will be properly maintained and be owned by the foster family or friends. ( )

b. Public transportation includes all reliable public transportation. ( )

03. Prohibitions of Foster Child Transportation. A foster parent will not transport a foster child while impaired by any substance including alcohol, prescription medication, or any illegal substances. ( )

~~4~~240. CELL PHONE OR TELEPHONE.
Unless previously approved by the licensing agency, there must be an operating cell phone or telephone in a foster home. ( )

~~4~~241. WHEELCHAIR ACCESS.
A foster home that provides care to a child who regularly requires the use of a wheelchair must be wheelchair accessible. ( )

~~4~~242. CHILD PLACEMENT REQUIREMENTS.
A foster family must accept the placement of children into the home within the terms of the foster home license~~ or certification~~ and the children's agency placement agreement. The following provisions will be considered for determining placement: ~~(3-28-23)~~( )

01. Determining Factors. The number and the age group of children placed in a foster home will be determined by the following: ( )

a. The accommodations and the space in the home; ( )

b. The interest of the foster family; and ( )

c. The experience or skill of the foster family. ( )

02. Maximum Number of Children. Except as specified, the maximum number of children in care at any time, including the foster family's own children, or daycare children, will be limited to not more than six (6) children. ( )

03. Children Under Two Years Old. Except as specified in Subsection ~~4~~242.04 of this rule, the maximum number of children under two (2) years old, including those of the foster family, will be limited to two (2) children or less. ~~(3-28-23)~~( )

04. Special Circumstances Regarding Maximum Numbers of Children. The maximum number of children in care at any time may be based on the children's agency assessment and at a minimum one (1) of the following: ( )

a. To allow siblings to remain together; ( )

b. To allow a child who has an established, meaningful relationship with the family to remain with the family; ( )

c. To allow a family with special training or skills to provide care for a child who has a severe disability; or ( )

d. To allow a parenting youth in foster care to remain with the child of the parenting youth. ( )

05. Continued Care. A foster child who reaches the age of eighteen (18) may continue in foster care placement until the age of twenty-one (21) if the safety, health, and well-being of other foster children residing in the home is not jeopardized. ( )

~~4~~243. INTERAGENCY PLACEMENT OF CHILDREN.
A foster family must only accept for placement children referred from the children's agency that licenses~~ or certifies~~ the foster home. A foster family may accept for placement a foster child from another children's agency only if that children's agency and the foster family have received prior approval for the placement of a child from the children's agency that licensed~~ or certified~~ the home. ~~(3-28-23)~~( )

~~4~~244. SUBSTITUTE CARE PLACEMENT AND CHILDREN'S AGENCY NOTIFICATION.
A foster parent must: ( )

01. Substitute Care. Place a child in substitute care only with the prior knowledge and consent of the children's agency; and ( )

02. Notification to Agency. Notify the children's agency before the beginning of any planned absence that requires substitute care of a child for a period of twenty-four (24) hours or more. ( )

~~4~~245. BEDROOMS.
A foster parent must comply with the following: ( )

01. Sleeping Arrangements. A bedroom occupied by a foster child will: ( )

a. Provide an adequate opportunity for both rest and privacy for each child; ( )

b. Be readily accessible to adult supervision as appropriate for the age and functioning level of each child; ( )

c. Have sufficient floor space to provide two (2) feet of space between beds; ( )

d. Have sufficient space for the storage of clothing and personal belongings; ( )

e. Have a finished ceiling, permanently affixed floor-to-ceiling walls, and finished flooring; ( )

f. Have a latchable door that leads to an exit from the foster home; ( )

g. Have at least one (1) outside window that complies with the following: ( )

i. ~~Is~~Be readily accessible to children and the foster parent; ~~(3-28-23)~~( )

ii. ~~Is~~Be readily opened from the inside of the room; and ~~(3-28-23)~~( )

iii. ~~Is~~Be of sufficient size and design to allow for the evacuation of children and caregivers. ~~(3-28-23)~~( )

h. ~~Is~~Be free of the following: ~~(3-28-23)~~( )

i. Household heating equipment excluding baseboard heating systems; ( )

ii. Water heater; and ( )

iii. Clothes washer and dryer. ( )

02. Non-Ambulatory Child. A child who is non-ambulatory and cannot readily be carried by one (1) household member will sleep in a bedroom located at ground level. ( )

03. Sharing Bedroom with a Non-Parent Adult. A child will not share a bedroom with a non-parent adult unless the child and adult are of the same gender and there is not more than four (4) years difference in age between the adult and the youngest child in the bedroom. ( )

04. Sharing a Bedroom with a Foster Parent. A child three (3) years old or older will not routinely share the bedroom with a foster parent unless the child has special health or emotional needs that require the attention of the foster parent(s) during sleeping hours. ( )

05. Maximum Number of Children in a Bedroom. No more than four (4) children will occupy a bedroom. The placement of more than one (1) child in a bedroom will be based on the age, behavior, functioning, individual needs of each child, and sufficient available space. ( )

06. Children of the Opposite Gender. Children of the opposite gender, any of whom are more than five (5) years old, will not share the same bedroom. ( )

07. Number of Children in a Bed. Each child will have an individual bed, except that two (2) brothers or two (2) sisters of comparable age may share a bed if they have previously shared a bed or when there are no health, behavioral, or other factors indicating this is undesirable. ( )

08. Restrictions on Sleeping Arrangements. The following must not be used for sleeping purposes: ( )

a. A room or area of the foster home that is primarily used for purposes other than sleeping; ( )

b. A room or space, including an attic, that is accessible only by a ladder, folding stairway, or through a trapdoor; or ( )

c. A detached building, except in the case of an older child preparing for emancipation when it can be documented that the child's needs can best be met by that arrangement. ( )

09. Appropriate Bedding. A child will have a bed that is appropriate for the age and development of the child. Beds will be equipped with a clean and comfortable mattress that complies with the Consumer Product Safety Commission standard (https://www.cpsc.gov/), pillow, linens, and blankets appropriate for the weather. ( )

10. Infants. Adults and children, or both, will not co-sleep or bed-share with infants. Cribs will comply with S~~ubs~~ection 002~~.02~~ of these rules. ~~(3-28-23)~~( )

~~4~~246. BEHAVIOR MANAGEMENT AND DISCIPLINE.

Methods of behavior management and discipline for children must be positive and consistent. These methods must be based on each child's needs, stage of development, and behavior. Discipline is to promote self-control, self-esteem, and independence. ( )

01. Prohibitions. The following types of punishment of a foster child are prohibited: ( )

a. Physical force or any kind of punishment inflicted on the body, including spanking; ( )

b. Cruel and unusual physical exercise or forcing a child to take an uncomfortable position; ( )

c. Use of excessive physical labor with no benefit other than for punishment; ( )

d. Mechanical, medical, or chemical restraint; ( )

e. Locking a child in a room or area of the home; ( )

f. Denying necessary food, clothing, bedding, rest, toilet use, bathing facilities, or entrance to the foster home; ( )

g. Mental or emotional cruelty; ( )

h. Verbal abuse, ridicule, humiliation, profanity, threats, or other forms of degradation directed at a child or a child's family; ( )

i. Threats of removal from the foster home; ( )

j. Denial of visits or communication with a child's family unless authorized by a children's agency in its service plan for the child and family; and ( )

k. Denial of necessary educational, medical, counseling, or social services. ( )

02. Restraint. A foster parent who has received specific training in the use of child restraint may use reasonable restraint methods, approved by the children's agency, to prevent a child from harming themselves, other persons or property, or to allow a child to gain control of themselves. ( )

03. Authority. The authority for the discipline of a foster child must not be delegated by a foster parent to other members of the household. ( )

04. Agency Consultation. A foster parent must consult with the children's agency prior to using any behavior management or discipline technique that exceeds the scope of these rules. ( )

~~4~~247. MEDICAL AND DENTAL CARE.

01. Health Care Services. A foster parent must follow and carry out the health or dental care plan for a child as directed by a medical professional. ( )

02. Child Injury and Illness. Follow the children's agency approved policies for medical care of a child who is injured or ill. ( )

03. Dispensing of Medications. Provide prescription medication as directed by a medical professional. A foster parent must not discontinue or in any way change the medication provided to a child unless directed to do so by a medical professional. ( )

04. Storage of Medication. A foster parent must store vitamins, prescriptions, and over-the-counter medications in an area that is inaccessible to a child. ( )

~~4~~248. PERSONAL CARE AND HYGIENE.
A foster parent must instruct the child in personal care, hygiene, and grooming and provide the child with necessary personal care, hygiene, and grooming products appropriate to the age, gender, and needs of the child. The foster parents will seek approval from the children’s agency before altering a child’s physical appearance including haircuts, body piercing, and tattooing. ( )

~~4~~249. FOOD AND NUTRITION.
A foster parent must provide a foster child with meals that are nutritious, well-balanced, of sufficient quantity, and serve the foster child the same meals as other members of the household unless a special diet has been prescribed by

a medical professional, or unless otherwise dictated by differing needs based on a child's age, medical condition, or cultural or religious beliefs. A foster child is required to eat with other members of the family unless the child's medical condition dictates a different arrangement. Perishable foods must be refrigerated. Milk provided to foster children must be pasteurized, from a licensed dairy, or come from an animal that is documented to be free from tuberculosis, brucellosis, or other conditions that could be injurious to a child's health. ( )

4250. NECESSARY CLOTHING.
A foster parent must provide a child with sufficient, clean, properly fitting clothing appropriate for the child's age, gender, individual needs, and season with clothing reflecting cultural and community standards. ( )

4251. PERSONAL POSSESSIONS, ALLOWANCES, AND MONEY.
A foster parent must follow the children's agency policy regarding a child's personal possessions and when a child moves from a foster home, the foster parent will provide the child or the children's agency with all of the child's possessions. (3-28-23)( )

4252. CHILD TASKS.
A parent must permit a child to perform only those routine tasks that are within the child's ability, are reasonable, and are similar to the routine tasks expected of other members of the household of similar age and ability. ( )

4253. EDUCATION.
A foster parent must cooperate with the children's agency and applicable educational organizations to implement the education and training plan for each child. ( )

4254. RELIGIOUS AND CULTURAL PRACTICES.
A foster parent must provide a child in care with opportunity for spiritual development and cultural practices according to the wishes of the child and the child's parent or tribe. ( )

4255. RECREATION.
A foster parent must provide or arrange access to a variety of indoor and outdoor recreational activities and encourage a child to participate in recreational activities that are appropriate for the child's age, interests, and ability. ( )

4256. MAIL.
A foster parent must permit a child to send and receive mail according to the mail policy of the children's agency. ( )

4257. REASONABLE AND PRUDENT PARENT STANDARD.
A caregiver must follow the reasonable and prudent parent standard. ( )

01. Reasonable and Prudent Parent Standard Defined. The reasonable and prudent parent standard means the standard characterized by careful and sensible parental decisions that maintain the health, safety, and best interests of a child while at the same time encouraging the emotional and developmental growth of the child that a caregiver must use when determining whether to allow a child in foster care under the responsibility of the state to participate in extracurricular, enrichment, cultural, or social activities. See "Caregiver" in the definitions. "Age or developmentally appropriate" means the following: ( )

a. Activities or items that are generally accepted as suitable for children of the same chronological age or level of maturity or that are determined to be developmentally appropriate for a child, based on the development of cognitive, emotional, physical, and behavioral capacities that are typical for an age or age group; and ( )

b. In the case of a specific child, activities or items that are suitable for the child based on the developmental stages attained by the child with respect to the cognitive, emotional, physical, and behavioral capacities of the child. ( )

02. Training. Each caregiver will complete training to include knowledge and skills relating to the reasonable and prudent parent standard for the participation of the child in age or developmentally appropriate activities, including knowledge and skills relating to the developmental stages of the cognitive, emotional, physical, and behavioral capacities of a child, and applying the standard to decisions such as whether to allow the child to

engage in social, extracurricular, enrichment, cultural, and social activities, including sports, field trips, and overnight activities lasting one (1) or more days, and involving the signing of permission slips and arranging transportation for the child to and from extracurricular enrichment and social activities. ( )

4258. -- 4269. (RESERVED)

4270. RECORD MANAGEMENT AND REPORTING REQUIREMENTS.
A foster parent must maintain a record for each child in the home that will include all written material provided to the foster home by the children's agency and additional information gathered by the foster parent that includes the following: ( )

01. Personal Data. The child's name, gender, date of birth, religion, race, and tribe, if applicable; ( )

02. Any Known History of Abuse and Neglect of the Child. ( )

03. Any Known Emotional and Psychological Needs of the Child. ( )

04. Any Information Known about the Child's Health. ( )

05. Any Known Behavioral Problems of the Child. ( )

4271. REPORTING FOSTER HOME CHANGES.
A foster parent must report to the children's agency any significant change in the foster home by the next working day from the time a foster parent becomes aware of a change, including the following: ( )

01. Serious Illness Including Physical or Mental Health, Injury, or Death of a Foster Parent or Household Member. Serious illness including physical or mental health, injury, or death of a foster parent or a household member. (3-28-23)( )

02. Arrests, Citations, Withheld Judgments, or Criminal Convictions of a Foster Parent or Household Member. Any arrests, citations, withheld judgments, or criminal convictions of a foster parent or household member. (3-28-23)( )

03. Initiation of Court-Ordered Parole and or Probation of a Foster Parent or Household Member. Initiation of court-ordered parole or probation of a foster parent or household member. (3-28-23)( )

04. Admission or Release From Facilities. Admission to, or release from, a correctional facility, a hospital, or an institution for the treatment of an emotional, mental health, or substance abuse issue of a foster parent or household member. ( )

05. Change of Employment Status of a Foster Parent. A change of employment status of a foster parent. (3-28-23)( )

06. Counseling, Treatment, or Therapy. Counseling or other methods of therapeutic treatment on an outpatient basis for an emotional, mental, or substance abuse issue of a foster parent or household member. ( )

07. Change of Residence. A foster parent will inform the children's agency of any planned change in residence and apply for licensure at the new address not less than two (2) weeks prior to a change in residence. ( )

08. Household Members. Inform the children's agency of changes in household members including minor children. ( )

09. Additional Licensing Application. A foster parent will notify the children's agency within five (5) calendar days after filing an application for a certified family home, daycare, or group daycare license. ( )

4272. CONFIDENTIALITY.
A foster parent must maintain the confidentiality of any information and records regarding a foster child and the child's parents and relatives. A foster parent will release information about the foster child only to persons authorized by the children's agency responsible for the foster child. Foster parents will follow the Department's policies for the use of social media and posting of pictures of children in foster care. ( )

4273. CRITICAL INCIDENT NOTIFICATION.
The foster parent must immediately notify the responsible children's agency of any of the following incidents: ( )

01. Death. Death or near death of a child in care. ( )

02. Suicide. Suicidal ideation, threats, or attempts to commit suicide by the foster child. ( )

03. Missing. When a foster child is missing from a foster home. ( )

04. Illness. Any illness or injury that requires hospitalization of a foster child. ( )

05. Law Enforcement Authorities. A foster child's detainment, arrest, or other involvement with law enforcement authorities. ( )

06. Removal of Child. Attempted removal or removal of a foster child from the foster home by any person who is not authorized by the children's agency. ( )

4274. -- 999. (RESERVED)

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.06.03 – DAYCARE LICENSING

DOCKET NO. 16-0603-2301 (NEW CHAPTER, FEE RULE)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo, Incorporation By Reference Synopsis (IBRS), & Cost/Benefit Analysis (CBA)

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2024 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. The pending rule will become final and effective upon the adjournment, *sine die*, of the Second Regular Session of the Sixty-seventh Idaho Legislature after approval.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 39-1107, 39-1111, 56-1003, 56-1004A, 56-1005(8), and 56-1007, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

The House Health and Welfare Committee of the 2023 Legislature requested that IDAPA chapter 16.06.02, "Child Care and Foster Care Licensing," be separated by content for Daycare Licensing and Foster Care Licensing. IDAPA chapter 16.06.03 will now contain content for "Daycare Licensing" and IDAPA 16.06.02 will contain content for "Foster Care Licensing." The update to this chapter will reflect only content regarding daycare licensing rules.

There are no changes to the pending rule and it is being adopted as originally proposed. The complete text of the proposed rule was published in the August 2, 2023, Idaho Administrative Bulletin, Vol. 23-8, pages 107 through 127.

FEE SUMMARY: Pursuant to Section 67-5224(2)(d), Idaho Code, this pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature. The following is a description of the fee or charge imposed or increased in this rulemaking:

Fees are required to be paid by daycare providers for licensing. In this new chapter of rules, there are no changes to fees currently paid by childcare providers for licensing. The authorizing statutes for these fees are Sections 39-1107 and 56-1007, Idaho Code.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state General Fund greater than ten thousand dollars ($10,000) during the fiscal year:

This rulemaking is not anticipated to have any fiscal impact on state funds, including the General Fund, or any other known funds.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Aubrie Hunt at 208-334-5686.

DATED this 30th of November, 2023.

Trinette Middlebrook and Frank Powell
DHW – Administrative Rules Unit
450 W. State Street – 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
phone: (208) 334-5500
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THE FOLLOWING NOTICE PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 39-1107, 39-1111, 56-1003, 56-1004A, 56-1005(8), and 56-1007, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearings concerning this rulemaking will be held as follows:

VIRTUAL TELECONFERENCES Via WebEx
Wednesday, August 17, 2023 **10:00 a.m. - 12:00 p.m. (MT)**
Join from the meeting link **https://idhw.webex.com/idhw/j.php?MTID=mf977f9364a62f4a2684571b6ae176e0d** **Join by meeting number** **Meeting number (access code): 2764 489 3359** **Meeting password: jEhhamvs252 (53442687 from phones and video systems)** **Join by phone** **+1-415-527-5035 United States Toll** **+1-303-498-7536 United States Toll (Denver)**
Wednesday, August 17, 2023 **4:00 p.m. - 6:00 p.m. (MT**
Join from the meeting link **https://idhw.webex.com/idhw/j.php?MTID=m9dd9bc1b157bcdc221553cc72c6ed5c4** **Join by meeting number** **Meeting number (access code): 2764 491 3545** **Meeting password: XVjt3DKMS37 (98583356 from phones and video systems)** **Join by phone** **+1-415-527-5035 United States Toll** **+1-303-498-7536 United States Toll (Denver)**

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below. Meeting(s) will conclude after 30 minutes if no participants sign in or wish to comment in the meeting.

DESCRIPTIVE SUMMARY: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

The House Health and Welfare Committee of the 2023 Legislature requested that IDAPA chapter 16.06.02, “Child Care and Foster Care Licensing,” be separated by content for Daycare Licensing and Foster Care Licensing. IDAPA chapter 16.06.03 will now contain content for “Daycare Licensing” and IDAPA 16.06.02 will contain content for “Foster Care Licensing.” The update to this chapter will reflect only content regarding daycare licensing rules.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased:

This chapter contains fees associated with Daycare Licensing, which specifies licensing fees for daycare centers, daycare facilities, group daycare facilities, and family daycare home voluntary licenses.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the State General Fund greater than ten thousand dollars ($10,000) during the fiscal year as a result of this rulemaking:

This rulemaking is not anticipated to have any fiscal impact on the State General Fund, or any other known funds. As required in state statute, any additional costs will be funded completely by the federal Child Care Development Block Grant using preexisting processes and automated systems. Such funds are sufficient to meet all proposed costs for the foreseeable future.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because the 2023 Legislature requested that the existing chapter of 16.06.02, "Child Care and Foster Care Licensing," be split into two (2) different chapters. The administrative rulemaking deadlines did not allow for negotiated rulemaking meetings to take place and due to the legislative request the Department is going forward with the separation and will offer public hearings for all the stakeholders.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into this rule:

The Incorporations By Reference (IBRs) include Occupational Safety Health Act (OSHA) and Crib Safety (for Full Size Baby Cribs and Non-Full Size baby Cribs) by the Consumer Product Safety Commission in Section 001 of these rules. The IBRs are not changing from the current version of IDAPA 16.06.02, "Child Care and Foster Care Licensing," to this new chapter of proposed language in IDAPA 16.06.03, "Daycare Licensing."

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Aubrie Hunt: 208-334-5686.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before August 23, 2023.

DATED this 6th day of July, 2023.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0603-2301

16.06.03 – DAYCARE LICENSING

000. LEGAL AUTHORITY.
Sections 39-1107, 39-1111, 56-1003, 56-1004A, 56-1005(8), and 56-1007, Idaho Code, authorize the Department and the Board to adopt and enforce rules for licensing daycare centers, group daycare facilities, and family daycare homes. ( )

001. INCORPORATION BY REFERENCE.

01. Occupational Safety Health Act (OSHA). A copy of OSHA may be obtained at the Idaho Industrial Commission, 317 Main Street., P.O. Box 83720, Boise, Idaho, 83720-0041 or at https://www.osha.gov/

sites/default/files/publications/OSHA2001.pdf. ( )

02. Crib Safety – Full Size Baby Cribs. Crib Safety. Consumer Product Safety Commission, Compliance information for full size cribs can be found at https://www.cpsc.gov/Business--Manufacturing/Business-Education/FAQ?p=3019&tid%5b3028%5d=3028. ( )

03. Crib Safety -- Non-Full-Size Baby Cribs. Crib Safety. Consumer Product Safety Commission, Compliance information for non-full size cribs can be found at https://www.cpsc.gov/Business--Manufacturing/Business-Education/FAQ?p=3019&tid%5b3029%5d=3029. ( )

002. – 008. (RESERVED)

009. BACKGROUND CHECK REQUIREMENTS.

01. Compliance. Department enhanced background checks are required for individuals licensed under these rules and must comply with IDAPA 16.05.06, "Criminal History and Background Checks." ( )

02. Background Check Requirements. Each owner, operator, or applicant seeking licensure for a daycare facility must submit evidence that the following individuals successfully completed and received a clearance for a Department enhanced background check, at least every five (5) years, under Sections 39-1105 and 39-1113, Idaho Code: ( )

a. Owners, operators, and staff; ( )

b. All other individuals thirteen (13) years old or older who have unsupervised direct contact with children; or ( )

c. All other individuals thirteen (13) years old or older who are in the household or regularly on the premises. ( )

03. Family Daycare Homes. Under Section 39-1114, Idaho Code, any person providing daycare for four (4) or more children in a family daycare home is required to comply with Sections 39- 1105 and 39-1113, Idaho Code. ( )

04. Background Check Frequency. The Department can require a background check at any time on any individual who is an owner, operator, staff, household member of a daycare facility, and all other individuals who are thirteen (13) years old or older who have unsupervised direct contact with children or who are regularly on the premises. ( )

05. Juvenile Justice Records. The enhanced background check for individuals under eighteen (18) years, must include a check of the juvenile justice records, as authorized by the minor and their parent or guardian. Records must be checked for each jurisdiction in which the individual has resided since becoming thirteen (13) through eighteen (18) years old. Each owner, operator, or applicant is responsible for requesting a check of the juvenile justice record, the associated costs of these records, and submitting them to the Department for review. A check of the juvenile justice records must include the following: ( )

a. Juvenile justice records of adjudication of the magistrate division of the district court; ( )

b. County probation services; and ( )

c. Department records. ( )

06. Cost of Background Check and Juvenile Justice Records. Each individual who requests and obtains a Department background check is responsible for the cost of the background check and check of juvenile justice records. ( )

07. Private Schools and Private Kindergartens. Under Section 39-1105, Idaho Code, any person

who owns, operates, or is employed by a private school for educational purposes for children four (4) through six (6) years old or a private kindergarten must comply with Sections 39-1105 and 39-1113, Idaho Code. ( )

08. Reporting Convictions. Following completion of a background check and clearance, additional criminal convictions, and juvenile justice adjudications for disqualifying crimes under Section 39-1113, Idaho Code, must be self-disclosed by the individual to the owner or operator of a daycare facility. The owner or operator must report these additional convictions and adjudications to the Department within five (5) days of learning of the conviction or adjudication. ( )

010. DEFINITIONS A THROUGH M.

01. Attendance. Under Title 39, Chapter 11, Idaho Code, and these rules, the number of children present at a daycare facility at any given time. ( )

02. Board. The Idaho Board of Health and Welfare. ( )

03. Child. Under Title 39, Chapter 11, Idaho Code, and these rules, "child" means an individual less than thirteen (13) years old. ( )

04. Child-Staff Ratio. The maximum number of children allowed under the care and supervision of one (1) staff person. ( )

05. Daycare. The care and supervision provided for compensation during part of a twenty-four (24) hour day, for a child(ren) not related by blood, marriage, adoption, or legal guardianship to the person(s) providing the care, in a place other than the child(ren)'s own home. ( )

06. Daycare Center. A place or facility providing daycare for compensation for thirteen (13) or more children. ( )

07. Department. The Idaho Department of Health and Welfare or its designee. ( )

08. Family Daycare Home. A home, place, or facility providing daycare for six (6) or fewer children. ( )

09. Group Daycare Facility. A home, place, or facility providing daycare for seven (7) to twelve (12) children. ( )

10. Household Member. Any individual who resides in, or on the property of, a daycare center, group daycare facility, or family daycare home. ( )

011. DEFINITIONS N THROUGH Z.

01. Noncompliance. Violation of, or inability to meet, the requirements of these rules or terms of licensure. ( )

02. Plan of Correction. The detailed procedures and activities developed between the Department and the owner, operator, or both, required to bring a daycare facility into conformity with these rules. ( )

03. Regularly on the Premises. Means twelve (12) hours or more in any one (1) month, or daily during any hours of operation. ( )

04. Relative. A child's grandparent, great grandparent, aunt, great aunt, uncle, great uncle, brother-in-law, sister-in-law, first cousin, sibling, and half-sibling. ( )

05. Restraint. Physical interventions to control the range and motion of a child. ( )

06. Second Degree of Relationship. Refers to persons related by blood or marriage, and includes their

spouses. The number of degrees between two (2) relatives is calculated by summing the number of ties between each relative and the common ancestor. ( )

07. **Staff**. A person who is sixteen (16) years old or older and employed by a daycare owner or operator to provide care and supervision at a daycare facility under Title 39, Chapter 11, Idaho Code, and these rules and includes the following: ( )

a. Operator. An individual who operates or maintains a licensed daycare facility. ( )

b. Owner. A person, individual, group of individuals, associations, partnerships, corporation, or any other entity that has legal control and authority over a daycare business. ( )

c. Provider. A person who is sixteen (16) years old or older, who provides care and supervision at a daycare facility and is included in meeting the child-staff ratio requirements. ( )

08. **Supervision**. Within sight and normal hearing range of the child(ren) being cared for under Title 39, Chapter 11, Idaho Code, and these rules. ( )

09. **Training**. Preparation, instruction, and continuing education related to daycare services that increase the knowledge, skill, and abilities of a provider, owner, operator, staff, or volunteer. ( )

012. – 099. **(RESERVED)**

100. **DAYCARE LICENSING.**

The purpose of licensing is to set requirements and to monitor compliance. Providers need to be physically and emotionally suited to protect the health, safety, and well-being of the children in their care. Physical surroundings must present no hazards to the children in care. ( )

01. **Operator Responsibilities**. An operator must conform to the terms of the license. ( )

02. **Knowledge of Standards**. The operator is responsible for knowing the rules applying to the daycare facility covered by the license, and for always complying with these rules. ( )

03. **Staff Knowledge**. The operator of a daycare facility is responsible for ensuring that all staff are familiar with these rules. ( )

04. **Daycare Standards**. Each owner, operator, or applicant seeking licensure from the Department as a daycare facility, must meet the requirements under Title 39, Chapter 11, Idaho Code, and these rules. ( )

05. **List of Licensed Daycare Facilities**. The Department will maintain a list of all licensed daycare facilities for public use. ( )

06. **Exceptions and Exemptions to Daycare Licensing**. Under Section 39-1103, Idaho Code, the licensing requirements in these rules do not apply to: ( )

a. Daycare facilities regulated, licensed, or certified by a city or county with local options under Section 39-1108, Idaho Code; ( )

b. The occasional or irregular care of a neighbor's, relative's or friend's child or children by a person not ordinarily in the business of providing daycare; ( )

c. The operation of a private school or religious school for educational purposes for children over four (4) years old, or a religious kindergarten; ( )

d. The provision of occasional care exclusively for children of parents who are simultaneously in the same building; ( )

e. The operation of day camps, programs, and religious schools for less than twelve (12) weeks during a calendar year or not more often than once a week and after school programs for children over four (4) years of age or in kindergarten; and ( )

f. The provision of care for children of a family within the second degree of relationship under Section 011 of these rules. ( )

101. TYPES OF DAYCARE LICENSES.

Under Title 39, Chapter 11, Idaho Code, and these rules, the Department will determine the type of daycare license needed by an owner or operator providing daycare by counting each child in attendance, regardless of relationship to the person(s) providing the care. The following types of daycare licenses may be issued by the Department. ( )

01. Daycare Center License. Issued for a place or facility providing daycare, where thirteen (13) or more children, regardless of relationship to the person(s) providing the care, are in attendance. ( )

02. Group Daycare Facility. Issued for a place or facility providing daycare, where seven (7) to twelve (12) children, regardless of relationship to the person(s) providing the care, are in attendance. ( )

03. Family Daycare Home. Not required to be licensed. A family daycare home, place, or facility may voluntarily elect to be licensed by the Department. ( )

102. – 120. (RESERVED)

121. APPLICATION FOR DAYCARE LICENSE OR RENEWAL.

Any individual applying for licensure as a daycare facility must be at least eighteen (18) years old, apply, and provide information required by the Department under this rule, to include: ( )

01. Completed Licensing Application. ( )

02. Licensing Fee. The applicant must pay the appropriate licensing fee prior to the issuance of a daycare license. ( )

03. Inspection Reports. The following reports must be submitted to the Department with the application that prove the facility or proposed facility meets: ( )

a. Building code under IDAPA 24.39.30, "Rules of Building Safety (Building Code Rules)," where required; ( )

b. Electrical code under IDAPA 24.39.10, "Rules of the Idaho Electrical Board," where required; ( )

c. Fire code under Section 41-253, Idaho Code, where required; and ( )

d. Local planning and zoning requirements. All daycare facilities must comply with applicable city and county ordinances. ( )

04. Proof of Insurance. The applicant must provide proof of current fire and liability insurance coverage for the daycare facility. ( )

05. Background Clearance. Evidence that the applicant and all individuals required to have a background check have received a clearance from the Department. ( )

06. Statement to Comply. As part of the application, the applicant must thoroughly read and review these rules and agree that they are prepared to comply with all provisions. Providers must also certify that they will not harm, shake, or abuse children, and that children in their care will not experience maltreatment under 45 CFR 98.41. ( )

07. Statement Disclosing Revocation or Disciplinary Actions. A written statement that discloses any revocation or other disciplinary action taken or in the process of being taken against the applicant as a daycare provider in any jurisdiction, or a statement from the applicant stating they have never been involved in any such action. ( )

08. Other Information as Requested. The applicant must provide other information that may be requested by the Department for the proper administration and enforcement of these rules. ( )

09. Health and Safety Inspection. The Department will order a health and safety inspection of the daycare facility once the application for licensure is complete and the licensing fee has been paid. ( )

10. Additional Requirements for License Renewal. A daycare license must be renewed every two (2) years. The daycare operator must submit to the Department the renewal application, fee, and all required documentation in this rule at least forty-five (45) days prior to the expiration of the current daycare license. ( )

11. Relicense. When a renewal application has been completed correctly, the existing license will, unless officially revoked, remain in force until the Department has acted on the application for renewal. ( )

122. DAYCARE LICENSING FEES.

A nonrefundable licensing fee must be paid to the Department prior to the issuance or renewal of a daycare license. The total fee for initial licensure or renewal of a daycare facility must not exceed the following amounts: ( )

01. Daycare Center with More than Twenty-Five Children in Attendance at Any Given Time. Three hundred twenty-five dollars ($325). ( )

02. Daycare Center with Thirteen to Twenty-Five Children in Attendance at Any Given Time. Two hundred fifty dollars ($250). ( )

03. Group Daycare Facility. One hundred dollars ($100). ( )

04. Family Daycare Home Voluntary License. One hundred dollars ($100). ( )

123. DISPOSITION OF APPLICATIONS.

The Department will initiate action on each completed application within thirty (30) days after receipt that addresses each requirement for the specific type of daycare license. Upon receipt of a completed application, the Department will review the materials for compliance with these rules. ( )

01. Termination of Application Process. Failure of the applicant to cooperate with the Department in the application process may result in the termination of the application process. Failure to cooperate means that the information requested is not provided within ninety (90) days, or not provided in the form requested by the Department, or both. ( )

02. Denial of Application. If an application is denied, a signed letter will be sent directly to the applicant by registered or certified mail, advising the applicant of the denial and stating the basis for such denial. An applicant whose application has been denied may not reapply until after one (1) year has elapsed from the date on the denial of application. ( )

03. Failure to Complete Application Process. Failure of the applicant to complete the application process within six (6) months of the original date of application will result in a denial of the application. ( )

04. Denial of Licensure. If the Department determines the applicant is not in compliance with these rules and further determines not to issue a daycare license, the Department will, within thirty (30) days from the date the completed application is submitted, issue a letter of denial of licensure stating the basis for the denial. ( )

05. Incomplete Application. The Department is not required to take any action on an application until the application is complete. ( )

06. **Notification of License Renewal**. The Department will notify the licensed daycare operator at least ninety (90) days prior to expiration of the license. ( )

124. ISSUANCE OF LICENSE.

01. **Regular License**. If the Department determines the applicant is complying with these rules, the Department will, within sixty (60) days from the date the completed application is submitted, issue one (1) of the following licenses: ( )

a. Daycare Center; ( )

b. Group Daycare Facility; or ( )

c. Family Daycare Home. ( )

02. **Licensing Document**. The license will state the type of facility, the occupancy load, number of children who may be in attendance if such limitations are necessary, and the length of time the license is effective. The license is issued under the terms specified and will be mailed to the applicant. ( )

a. A regular license for a daycare facility licensed by the Department is in effect for two (2) years from the date of issuance unless suspended or revoked earlier. ( )

b. A daycare license issued by the Department to operators must be posted in plain view where it can be seen by parents and the public upon entering the facility. ( )

125. – 149. (RESERVED)

150. RESTRICTIONS ON APPLICABILITY AND NONTRANSFER.

01. **Issued License**. A license applies only to the daycare facility licensed by the Department, or the person and premises designated. Each license is issued in the business name or individual name, and only to the specified address identified on the application of the facility. A license issued in the name of a daycare facility licensed by the Department applies only to the period and services specified in the license. ( )

02. **Return of License**. The operator must immediately return their license to the Department under any of the following circumstances: ( )

a. Changes of management or address; ( )

b. Upon suspension or revocation of the license; or ( )

c. Upon voluntary discontinuation of service. ( )

03. **Nontransferable**. A license is nontransferable or assignable from one (1) individual to another, from one (1) business entity or governmental unit to another, or from one (1) location to another. ( )

04. **Change in Ownership or Location**. When there is a change in ownership or location, the daycare facility must reapply for a license. A license must be obtained before starting operations. ( )

151. – 199. (RESERVED)

200. STAFF AND OTHER RECORD REQUIREMENTS.

Each owner or operator of a daycare facility must maintain a current list covering the previous twelve-month period of all staff and other individuals thirteen (13) years old or older who have unsupervised direct contact with children, or are regularly on the premises. The record must contain the following: ( )

01. **Legal Name**. ( )

02. Proof of Age. ( )

03. Phone Number. ( )

04. Training Records. ( )

05. Verification of Background Check Clearance. ( )

06. Results of Juvenile Justice Records. ( )

07. Verification of Pediatric Rescue Breathing, Infant-Child CPR, and Pediatric First Aid Certification from a Certified Instructor. ( )

08. Times, Dates, and Records of Hours on the Premises Each Day. ( )

201. CHILD RECORD REQUIREMENTS.
Each owner or operator of a daycare facility must maintain records for each child in attendance covering the previous twelve-month period. The record must contain the following: ( )

01. Child's Full Name. ( )

02. Date of Birth. ( )

03. Parent or Guardian's Name, Address, and Contact Information. ( )

04. Emergency Contact Information. ( )

05. Child's Health Information. ( )

a. Immunization record or waiver of exemption form or statement; ( )

b. Any medical conditions or allergies that could affect the care of the child; and ( )

c. Medications the child is taking or may be allergic to. ( )

06. Times, Dates, and Record of Attendance Each Day. Sign-in/out records, electronic or manual, including the signature of a parent or guardian. ( )

202. – 299. (RESERVED)

300. CHILD-STAFF RATIO.
Under Section 39-1109, Idaho Code, the Department determines the maximum allowable child-staff ratio based on a point system. ( )

01. Daycare Child-Staff Ratio Point System. The maximum allowable points for each staff is twelve (12), using the following point system which is based on the age of each child in attendance: ( )

a. Under twenty-four (24) months old, each child equals two (2) points. ( )

b. From twenty-four (24) months old to under thirty-six (36) months, each child equals one and one-half (1 1/2) points. ( )

c. From thirty-six (36) months old to under five (5) years, each child equals one (1) point. ( )

d. From five (5) years old to under thirteen (13) years, each child equals one-half (1/2) point. ( )

02. Child-Staff Ratios. Ratios must be maintained during all hours of operation when children are in attendance and when transporting children. ( )

a. Each child in attendance is counted by the Department for the purposes of calculating maximum allowable points, counting the number of children in attendance, and for determining compliance with child-staff ratios; ( )

b. Each adult staff who is providing direct care for a child(ren) is counted by the Department as one (1) staff for the purposes of counting the number of staff on-duty and determining compliance with child-staff ratios; and ( )

c. Each staff sixteen (16) and seventeen (17) years old must be under the supervision of an adult staff, when providing direct care for a child(ren), and may be counted by the Department as one (1) staff for the purposes of counting the number of staff on-duty and determining compliance with child-staff ratios. ( )

03. Supervision of Children. The owner or operator and all staff are responsible for the direct care, protection, supervision, and guidance of children through active involvement or direct observation. In addition to meeting the child-staff ratio requirements, the owner or operator of a daycare facility must ensure that: ( )

a. At least one (1) adult staff is always awake and on duty on the premises during regular business hours or when children are in attendance; and ( )

b. All providers, owners, and staff who provide direct care to children must have current certification in pediatric rescue breathing (CPR) and pediatric first aid from a certified instructor. Providers who do not have these certifications will not count in child-staff ratios. ( )

04. Sleeping Children. Must be within sight and normal hearing range of a provider. ( )

05. Overnight Daycare. For daycare operators providing overnight care of children, the following must apply: ( )

a. A sleeping child sleeps on the same level as the staff member who must be able to hear the child; and ( )

b. A staff member is awake and on duty to release and receive a child. ( )

c. Children sleeping at the facility have separate cots, mats, or beds and blankets. ( )

d. A child will not share a bed with a non-parent adult. ( )

301. BEHAVIOR MANAGEMENT AND DISCIPLINE.

Methods of behavior management and discipline for children must be positive and consistent. These methods must be based on each child's needs, stage of development, and behavior. Discipline is to promote self-control, self-esteem, and independence. All of the following are prohibited: ( )

01. Physical Force. Any punishment inflicted on the body, including spanking; ( )

02. Cruel and Unusual Physical Exercise. Includes forcing a child to take an uncomfortable position; ( )

03. Use of Excessive Physical Labor. With no benefit other than for punishment; ( )

04. Restraint(s). ( )

05. Locking a Child in a Room. Or any area of the home or facility; ( )

06. Denying Necessities. Includes necessary food, clothing, bedding, rest, toilet use, personal care and

sanitation, or entrance to the home or facility; ( )

07. Mental or Emotional Cruelty. ( )

08. Verbal Abuse. Includes ridicule, humiliation, profanity, threats, or other forms of degradation directed at a child or their family. ( )

302. – 329. (RESERVED)

330. TRAINING REQUIREMENTS.

Each owner or operator of a daycare facility must receive and ensure that each staff receives and completes four (4) hours of ongoing child development training every twelve (12) months after the staff 's date of hire. ( )

01. Child Development Training. Must be related to continuing education in child development areas related to daycare such as continuing education in: ( )

a. Child development; ( )

b. Behavior management and support; ( )

c. Teaching and curriculum; ( )

d. Health and safety; and ( )

e. Business practices. ( )

02. Training Hours. It is the responsibility of the owner or operator of the daycare center to ensure that each staff has completed four (4) hours of training each year. The training must be documented in the staff's record. ( )

03. Pediatric Rescue Breathing, Infant-Child CPR, and Pediatric First Aid Training. These trainings do not count towards the required four (4) hours of annual training. ( )

04. Staff Training Records. Each owner or operator of the daycare facility is responsible for maintaining documentation of each staff's training and may be asked to produce documentation at license renewal. ( )

331. – 349. (RESERVED)

350. PARENTAL VISITATION AND ACCESS.

01. Visitation Rights. Parents and guardians have the absolute right to enter the daycare premises when their child is in the care of the daycare operator. Failure or refusal to allow parental or guardian entry to the daycare premises or access to their child may result in the suspension or revocation of a daycare license. ( )

02. Denied or Limited Visitation Rights by Court Order. If a parent or guardian has been granted limited visitation rights or denied visitation rights by a court of competent jurisdiction, and the daycare operator has written documentation from the court, this rule does not confer a right to visitation upon the parent or guardian. ( )

351. – 359. (RESERVED)

360. FIRE SAFETY STANDARDS.

Each daycare facility must comply with the following. ( )

01. Inspections. Must be completed by the local fire official or designee. For a daycare located outside of the area of authority under Section 39-1109, Idaho Code, the Department can designate an approved inspector for

daycare licensing purposes only. ( )

02. Daycare Fire Inspection Fees. Are payable to the local fire department or fire district official. ( )

03. Unobstructed Exits. Required exits must be located in such a way that an unobstructed path outside the building is provided to a public way or area of refuge. ( )

a. Exit doors must open from the inside without the use of a key or any special knowledge or effort. ( )

b. There must be at least two (2) exits located a distance apart of not less than one-half (1/2) the diagonal dimension of the building or portion used for daycare, but not to exceed seventy-five (75) feet. An exception may be made for the following: ( )

i. The distance between exits may be extended to ninety (90) feet if the building is totally protected throughout with smoke detectors; or ( )

ii. The distance between exits may be increased to one hundred ten (110) feet if the building is equipped with an automatic fire sprinkler system. ( )

c. The required dimensions of exits must not be less than thirty-two (32) inches of clear exit width and not be less than six (6) feet, eight (8) inches in height. An exception for sliding patio doors will be accepted as a required second exit in a family daycare home and group daycare facility only. ( )

d. Sleeping room exits must be provided with at least one (1) emergency egress window having at least a single net clear opening of five point seven (5.7) square feet, minimum height twenty-four (24) inches, minimum width twenty (20) inches, and maximum finished sill height not over forty-four (44) inches. ( )

i. Approved egress windows from sleeping areas must be operable from the inside without the use of separate tools. ( )

ii. In lieu of egress windows, an approved exit door is acceptable. ( )

iii. An approved piece of furniture or platform, if anchored in place, may be approved to sit in front of a window if the sill height is over forty-four (44) inches. ( )

e. Where children are located on a story below the level of exit discharge (basement), there must be at least two (2) exits, one (1) of which must open directly to the outside. More than one (1) exit from the basement opening directly to the outside may be required, depending on the structure of the building, to ensure the safety of the occupants. ( )

f. Where children are located on a story above the level of exit discharge, there must be two (2) exits, one (1) of which must open directly to the outside and comply with building codes. ( )

361. FACILITY CAPACITY AND DETERMINING OCCUPANT LOAD.
Occupant load is determined by the local fire official or designee. ( )

01. Area for Daycare Use Only. The local fire official or designee will only use those areas used for daycare purposes when determining the occupant load. ( )

02. Facilities with an Occupancy Load of Fifty or More. Must meet the requirements in Section 360 of these rules and this rule. ( )

a. Exit doors must swing in the direction of egress. ( )

b. Exit doors from rooms, if provided with a latch, must have panic hardware installed. ( )

03. Exit Signs. Must be installed at required exit doorways and wherever else necessary to clearly indicate the direction of egress. ( )

362. FIRE EXTINGUISHERS AND SAFETY REQUIREMENTS.
Each daycare facility must comply with the following fire extinguisher and safety requirements as applicable for size and type of facility. ( )

01. Portable Fire Extinguisher. There must be an approved portable fire extinguisher (minimum 2A-10BC) mounted securely in a visible location not to exceed five (5) feet from the floor to the top of the extinguisher and not more than seventy five (75) feet travel distance to an extinguisher and maintained properly. ( )

02. Kitchen Area. An approved fire extinguisher must be present, or a hood-type fire suppression system be installed in the kitchen area. ( )

03. Fire Extinguishers. Approved fire extinguishers must be maintained properly. ( )

04. Facilities Over Three Thousand Square Feet. Each daycare facility over three thousand (3,000) square feet is required to have additional fire extinguishers as approved by the local fire official or designee. ( )

05. Fire Alarm System. Each daycare facility with over fifty (50) children, must have an approved fire alarm system installed. ( )

06. Smoke Detectors. Must be installed and maintained in the following locations: ( )

a. On the ceiling, wall outside, or each separate sleeping area in the immediate vicinity of bedrooms; ( )

b. In each room used for sleeping purposes; and ( )

c. In each story within a facility including basements. ( )

d. If there is a basement, there must be a smoke detector installed in the basement having a stairway which opens from the basement into the facility. Such detector must be connected to a sounding device or other detector to provide an alarm that is audible in the sleeping area. ( )

07. Automatic Sprinkler Systems. Must be provided in all daycare facilities greater than twenty thousand (20,000) square feet in area or when the number of children under the age of eighteen (18) months exceeds one hundred (100). ( )

363. FIRE SAFETY AND EVACUATION PLANS.
Each daycare facility must have an approved fire safety and evacuation plan prepared that includes the following: ( )

01. Evacuation. Procedures and policies for accounting for staff and children after an evacuation is completed. ( )

02. Evacuation Plan and Assembly Point for Children and Staff. ( )

03. Locations of Facility Exits. ( )

04. Evacuation Routes. ( )

05. Location of Fire Alarms. ( )

06. Location of Fire Extinguishers. ( )

07. Annual Review. Fire safety and evacuation plans must be reviewed or updated annually and available in the facility for reference and review. ( )

08. Fire and Emergency Evacuation Drills. Must be conducted on a routine schedule at least two (2) times each year and all staff and children must participate. ( )

364. – 379. (RESERVED)

380. HEALTH STANDARDS.
Each daycare facility licensed by the Department, must comply with the following. Health inspections must be conducted annually by a qualified inspector designated by the Department and will be unannounced. ( )

01. Food. Must be from an approved source under IDAPA 16.02.19, "Idaho Food Code." Food must not be served past expiration or "use by" date. ( )

02. Food Preparation. Food for use in daycare facilities must be prepared and served in a sanitary manner with sanitized utensils and on surfaces that have been cleaned, rinsed, and sanitized prior to use to prevent cross-contamination. ( )

a. Frozen food must be thawed in the refrigerator, under cold running water, or as part of the cooking process and cooked to proper temperatures under IDAPA 16.02.19, "Idaho Food Code." ( )

b. Individuals preparing food must use proper hand-washing techniques, minimize bare hand contact with food, and wear clean clothes. ( )

03. Food Temperatures. Potentially hazardous foods must be kept refrigerated at forty-one degrees Fahrenheit (41°F) or below, held hot at one hundred thirty-five degrees Fahrenheit (135°F) or more, and reheated or cooled at safe temperatures under IDAPA 16.02.19, "Idaho Food Code." Refrigerators must be equipped with an accurate thermometer. ( )

04. Food Storage. All food that is served in daycare facilities must be stored in such a manner that protects it from potential contamination. There must be no evidence of pests present in the daycare facility. ( )

05. Food Contact Surfaces. Must be kept clean and sanitized, including counters, serving tables, high chair trays, and cutting boards. ( )

06. Dishwashing Sanitizing. Dishes, glasses, utensils, silverware, and all other objects used for food preparation and eating must be sanitized using appropriate sanitizing procedures. ( )

07. Utensil Storage. Clean utensils must be stored on clean shelves or drawers and not subject to recontamination, and sharp knives and other sharp objects be kept out of reach of children. ( )

08. Garbage. Must be kept covered or inaccessible to children. ( )

09. Hand Washing. Children and facility staff must be provided with individual or disposable towels for hand drying, and the hand washing area be equipped with soap and warm and cold running water. ( )

10. Diaper Changing. Must be conducted in such a manner as to prevent the spread of communicable diseases, be separate from food preparation and serving areas, and have easy access to a hand washing sink. ( )

11. Sleeping Areas. Children sleeping at the facility must have separate cots, mats, or beds and blankets. ( )

12. Safe Sleep. Providers must place newborn infants up to twelve (12) months old in a safe sleep environment. Safe sleep practices include alone, on their backs, and in a Consumer Product Safety Commission (CPSC) certified sleep space. ( )

13. Restrooms, Water Supply, and Sewage. All daycare facilities must have restrooms. ( )

a. Each facility must have at least one (1) flushable toilet and one (1) hand washing sink with warm and cold water per restroom. ( )

b. Plumbing and bathroom fixtures must be in good condition. ( )

c. All daycare facilities and homes must comply with IDAPA 24.39.30, "Rules of Building Safety (Building Code Rules)." ( )

14. Water Supply. The facility's water supply must meet one (1) of the following requirements: ( )

a. Be from a public water system that is maintained under IDAPA 58.01.08, "Idaho Rules for Public Drinking Water Systems," at the time of initial or renewal application; or ( )

b. Be from a private source, such as well or spring, be tested annually for bacteria and nitrate, and be approved by the Department. ( )

c. Water used for consumption at a daycare facility is from an acceptable source. Temporary use of bottled water or boiled water may be allowed for a period specified by the Department. ( )

15. Sewage Disposal. Facility sewage must be disposed of through a public system, or in the absence of a public system, in a manner approved by the local health authority under IDAPA 58.01.03 "Individual/Subsurface Sewage Disposal Rules." ( )

16. Alcohol and Illegal Drugs. Must not be used by providers, owners, operators, staff, volunteers, children, or visitors at daycare facilities, in the presence of children during hours of operation, or in vehicles while transporting children. ( )

a. Any individual under the influence of alcohol or drugs is not permitted at or in the daycare facility. ( )

b. Illegal drugs are prohibited by law and therefore are not allowed on the premises of any licensed daycare facility at any time. ( )

17. Smoke-Free Environment. Children must be afforded a smoke-free environment during all daycare hours, whether indoors or outdoors. While children are in care, the operator and all staff must ensure that no smoking or other tobacco use occurs within the facility, in outdoor areas, or in vehicles when children are present. ( )

18. Transportation. Provider that transports a child(ren) will possess a valid driver's license, be insured under Idaho Law, and abide by all traffic laws including the requirement that all children are in proper safety restraints while being transported under Section 49-672, Idaho Code, and Section 49-673, Idaho Code. Vehicles used to transport children will be properly maintained and in good working condition. ( )

19. Disaster and Emergency Planning. Providers must have documented plans for emergencies resulting from a natural disaster, or human-caused event that include: ( )

a. Procedures for evacuation, relocation, shelter-in-place, lock-down, communication and reunification with families, continuity of operations, and accommodation of infants and toddlers and children with disabilities or chronic medical conditions. ( )

b. Procedures for staff and volunteer emergency preparedness training and practice drills. ( )

c. Guidelines for the continuation of daycare services in the period following the emergency or disaster. ( )

d. Procedures for the prevention of and response to emergencies due to food and allergic reactions. ( )

20. Medication. No person can administer any medication to a child without it first being authorized by a parent or caretaker. All medications, refrigerated or unrefrigerated, must be in a locked box or otherwise in inaccessible to children. ( )

21. Adequate Heat, Light, and Ventilation. A daycare facility must have adequate heat, light and ventilation. Windows and doors must be screened if used for ventilation. ( )

22. Immunizations. Daycare operators must comply with requirements under IDAPA 16.02.11, "Immunization Requirements for Licensed Daycare Facility Attendees." ( )

381. MISCELLANEOUS SAFETY REQUIREMENTS.

Each daycare facility licensed by the Department must comply with the following: ( )

01. Telephone. An operable telephone or cell phone must always be available in the facility with the following conditions: ( )

a. The telephone number used must be made available to parents and guardians. ( )

b. Emergency phone numbers to include 911, an adult emergency substitute operator, and the address and phone number of the facility must be posted by the telephone or in a location that is easily and always visible. ( )

02. Heat-Producing Equipment. A furnace, fireplace, wood-burning stove, water heater, and other flame or heat-producing equipment must be installed and maintained as recommended by the manufacturer and protected on all surfaces by screens or other means. ( )

03. Portable Heating Devices. Must be limited and approved for use and location by the Fire Inspector prior to use within a facility and will not be used during sleeping hours. ( )

04. Storage of Weapons, Firearms, and Ammunition. Firearms or other weapons stored at a daycare facility must be kept in a locked cabinet, gun safe, or other container that is inaccessible to children, while children are in attendance. Keys to these containers must also be inaccessible to children. ( )

a. Ammunition must be stored in a locked container separate from firearms. ( )

b. Matches, lighters, and any other means of starting fires must be kept away from and out of the reach of children. ( )

c. Other weapons that could cause harm must be stored out of reach of children. ( )

05. Animals and Pets. Any pet or animal present at the facility, indoors or outdoors, must be in good health, show no evidence of carrying disease, and be a friendly companion of the children. The operator must maintain the animal's vaccinations and vaccination records which will be made available to the Department upon request. ( )

06. Hazardous Materials. Cleaning materials, flammable liquids, detergents, aerosol cans, pesticides, and other poisonous and toxic materials must be kept in their original containers and in a place inaccessible to children. They must be used in such a way that will not contaminate play surfaces, food, food preparation areas, or constitute a hazard to the children. Biocontaminants must be disposed of appropriately. ( )

382. – 399. (RESERVED)

400. BUILDINGS, GROUNDS, FURNISHINGS, AND EQUIPMENT.

Each daycare facility licensed by the Department must comply with the following: ( )

01. Appliances and Electrical Cords. All appliances, lamp cords, exposed light sockets, and electrical outlets will be protected to prevent electrocution. ( )

02. Balconies and Stairways. Balconies and stairways accessible to children will have substantial railings as required by IDAPA 24.39.30, "Rules of Building Safety (Building Code Rules). ( )

03. Stairway Protection. Where an operator cares for children less than three (3) years old, stairways will be protected to prevent child access to stairs. ( )

04. Hazardous Area Restrictions. Based on the age and functioning level of children in care and the type of hazard and the area surrounding the hazard, the area will be restricted to prevent easy access to the hazard. ( )

05. Fueled Equipment. Fueled equipment including motorcycles, mopeds, lawncare equipment, and portable cooking equipment. This equipment will not be stored or repaired in areas where children are present. ( )

06. Water Hazards. Above and below ground pools, hot tubs, ponds, and other bodies of water that are on the daycare facility premises must provide the following safeguards: ( )

a. The area surrounding the body of water must be fenced and locked in a manner that prevents access by children and meets the following ( )

i. The fence will be at least four (4) feet high with no vertical opening more than four (4) inches wide and designed so that a young child cannot climb or squeeze under or through the fence. The fence will surround all sides of the pool and have a self-closing gate that has a self-latching mechanism in proper working order that is out of the reach of young children. ( )

ii. If the house forms one (1) side of the barrier for the pool, all doors that provide unrestricted access to the pool will have alarms that produce an audible sound when the door is opened. ( )

b. Furniture or other large objects will not be left near the fence in a manner that would enable a child to climb on the furniture or other large object and gain access to the pool. If the area surrounding a pool, hot tub, pond, or other body of water is not fenced and locked, there will be a secured protective covering that prevents access by a child. ( )

c. Wading pools and buckets will be empty when not in use. ( )

d. Children will be under direct supervision of adult staff who are certified in pediatric CPR and pediatric first aid while using a bathtub, pool, hot tub, pond, or other body of water. ( )

e. A minimum of a four (4) foot high fence that prevents access from the daycare facility premises if the daycare premises are adjacent to a body of water. ( )

07. Indoor Play Areas and Toys. The indoor play areas will be clean, have age-appropriate toys, and be free from accumulation of dirt, rubbish, or other health hazards. ( )

08. Outdoor Play Areas and Toys. Any outdoor play area must be maintained free from hazards such as wells, machinery, and animal waste. ( )

a. If any part of the play area is adjacent to a busy roadway, drainage or irrigation ditch, stream, large holes, or other hazardous areas, the play area will be enclosed with a fence in good repair that is at least four (4) feet high without any holes or spaces greater than four (4) inches in diameter. ( )

b. Outdoor equipment, such as climbing apparatus, slides, and swings will be anchored firmly and

placed in a safe location and according to the manufacturer's instructions. ( )

c. Outdoor play areas will be designed so that all parts are always visible and easily supervised by staff. ( )

d. Toys, play equipment, and any other equipment used by the children will be of substantial construction and free from rough edges and sharp corners. Unguarded ladders on slides will be kept in good repair and well-maintained. ( )

e. Toys and objects with a diameter of less than one (1) inch (two point five (2.5) centimeters), objects with removable parts that have a diameter of less than one (1) inch (two point five (2.5) centimeters), plastic bags, styrofoam objects, and balloons will not be accessible to children ages three (3) and under, or children who are known to place such objects in their mouths. ( )

401. – 419. (RESERVED)

420. CONTINUED COMPLIANCE, REPORTING CHANGES, AND CRITICAL INCIDENTS.

Each daycare owner or operator must always comply with the fire, safety, and health requirements under these rules and the following: ( )

01. Department Access. The owner, operator, or staff of a daycare facility must allow the Department access to the premises and records for reinspection at any time during the licensing period. ( )

02. Posting Information. A daycare must post the Department's contact information and the statewide number to file daycare complaints. ( )

03. Reporting Changes. The owner, operator, or staff of a daycare facility notifies the Department of any changes that affect the terms of licensure or could affect the health, well-being, or safety of children. ( )

04. Critical Incidents. A daycare operator must report any of the following to the Department within twenty-four (24) hours: ( )

a. Any injury that requires hospitalization of a child. ( )

b. Death or near death of a child in care. ( )

c. When a child is missing from a daycare facility. ( )

d. Any arrests, citations, withheld judgments, or criminal convictions of disqualifying crimes under Section 39-1113, Idaho Code, of an operator or any individual regularly on the premises of the facility and provide documentation that the individual is not working with children or is not on the premises. ( )

421. MANDATORY REPORTING OF ABUSE, ABANDONMENT, OR NEGLECT.

Under Section 16-1605, Idaho Code, daycare owners, operators, staff, and any other person who has reason to believe that a child has been abused, abandoned, or neglected, or is being subjected to conditions or circumstances which would reasonably result in abuse, abandonment, or neglect, must report or cause to be reported within twenty-four (24) hours, such conditions or circumstances to the Department or the proper law enforcement agency. ( )

422. – 439. (RESERVED)

440. FAILURE TO COMPLY.

01. Misdemeanors to Operate Without a License. It is a misdemeanor to operate a daycare center or group daycare facility without first obtaining a daycare license from the Department or to operate a daycare center or group daycare facility without posting the license in a place easily seen by a parent or the general public. ( )

a. The Department may grant a grace period of no more than sixty (60) days to allow the daycare

facility to comply with these rules and with Title 39, Chapter 11, Idaho Code. ( )

b. The operator or owner must agree to begin the application process under Section 121 of these rules within one (1) business day of identification by the Department that a daycare owner or operator is noncompliant with Title 39, Chapter 11, Idaho Code, or these rules. ( )

02. Misdemeanor to Operate Without Obtaining a Background Check. It is a misdemeanor to operate a family daycare home caring for four (4) or more children without obtaining the required background check under Section 39-1105, Idaho Code. If there is an initial citation for violation of Section 39-1115, and a person makes the applications required within twenty (20) days, the complaint will be dismissed. Operating a family daycare home for four (4) or more children after failure to pass the required background check is a misdemeanor. ( )

03. Misdemeanor to Provide Daycare if Guilty of Certain Offenses. It is a misdemeanor to provide daycare services if found guilty of any offenses under Section 39-1113, Idaho Code. ( )

441. COMPLAINTS AGAINST DAYCARE FACILITIES.

01. Investigation. The Department will investigate complaints regarding daycare facilities. The investigation may include further contact with the complainant, scheduled or unannounced visits to the daycare facility, collateral contacts including interviews with the victim, parents or guardian, operator, staff, consultants, children in care, other persons who may have knowledge of the complaint, and inspections by fire or health officials. ( )

02. Informed of Action. If an initial preliminary investigation indicates that a more complete investigation must be made, the operator of the licensed daycare facility licensed by the Department will be informed of the investigation, and any action to be taken, including referral for civil or criminal action. ( )

442. SUSPENSION FOR CIRCUMSTANCES BEYOND CONTROL OF OPERATOR.

When circumstances occur over which the operator has no control including illness, epidemics, fire, flood, or contamination, which temporarily place the operation of the daycare facility out of compliance with these rules, the license must be suspended until the nonconformity is remedied. ( )

443. SUSPENSION OR REVOCATION FOR INFRACTIONS.

A license may be suspended for infractions of these rules. Such suspension may lead to revocation if the operator fails to satisfy the Department that the infractions have been corrected in compliance with these rules. ( )

444. NON-RENEWAL, DENIAL, REVOCATION, OR SUSPENSION OF LICENSE.

If it is found that an owner or operator has failed or refused to comply with any of the provisions of the Basic Daycare License Law, Sections 39-1101 through 39-1120, Idaho Code, with these rules, or with any provision of the license, the Department may deny, suspend, revoke, or not renew a license. The Department may also deny, suspend, revoke, or deny renewal of a license for any daycare facility when any of the following occurs. ( )

01. Criminal Conviction or Relevant Record. Anyone providing direct care or working onsite under these rules is denied clearance or refuses to comply with IDAPA 16.05.06, "Criminal History and Background Checks." ( )

02. Other Misconduct. The owner, operator, or both: ( )

a. Fail to furnish any data, statistics, records, or information requested by the Department without good cause or provide false information. ( )

b. Have been found guilty of or is under investigation for fraud, deceit, misrepresentation, or dishonesty associated with the operation of a daycare facility licensed by the Department. ( )

c. Have been found guilty of or is under investigation for the commission of any felony. ( )

d. Have failed to exercise fiscal accountability toward a client or the Department regarding payment

for services; or ( )

e. Have knowingly permitted, aided, or abetted the commission of any illegal act on the premises of the daycare facility. ( )

445. – 449. (RESERVED)

450. ENFORCEMENT REMEDY OF SUMMARY SUSPENSION AND TRANSFER OF CHILDREN.
The Department may summarily suspend a daycare facility. Children in a daycare facility will not be transported from the facility, instead the parent or legal guardian will be contacted. ( )

451. ENFORCEMENT REMEDY REVOCATION OF LICENSE AND TRANSFER OF CHILDREN.
The Department may revoke the license of a daycare facility when the Department determines the facility or operator is not complying with these rules. Children in a daycare facility will not be transported from the facility, instead the parent or legal guardian will be contacted. Revocation may occur under the following circumstances: ( )

01. Endangers Health or Safety. Any condition that endangers the health or safety of any child. ( )

02. Not in Substantial Compliance. A daycare facility is not in substantial compliance with these rules. ( )

03. No Progress to Meet Plan of Correction. A daycare facility has made little or no progress in correcting deficiencies within thirty (30) days from the date the Department accepted a plan of correction. ( )

04. Repeat Violations. Repeat violations of any requirement of these rules or provisions of Title 39, Chapters 11, Idaho Code. ( )

05. Misrepresented or Omitted Information. A daycare facility has knowingly misrepresented or omitted information on the application or other documents pertinent to obtaining a license. ( )

06. Refusal to Allow Access. Refusal to allow Department or its representatives full access to the daycare facility and its grounds, facilities, and records. ( )

07. Immediate Access to Documentation. Fails to provide, upon written request by the Department or its agents, immediate access to documentation required to be maintained. ( )

08. Abusive Conduct. Has been found to have engaged in abusive conduct that fails to meet professionally recognized standards for daycare, or results in physical harm, pain, or mental anguish to children. ( )

452. EFFECT OF PREVIOUS REVOCATION OR DENIAL OF A LICENSE.
An organization cannot apply and the Department will not accept an application from any person, corporation, or partnership, including any managing employee, officer, owner, or spouse, partner, or relative of an owner of an entity who has had a license denied or revoked, until five (5) years has elapsed from the date of denial, revocation, or conclusion of a final appeal, whichever occurred last. ( )

453. – 999. (RESERVED)

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.07.19 – PEER SUPPORT SPECIALIST AND FAMILY SUPPORT PARTNER CERTIFICATION

DOCKET NO. 16-0719-2301 (ZBR CHAPTER REWRITE)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo and Incorporation By Reference Synopsis (IBRS)

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2024 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. The pending rule will become final and effective upon the adjournment, *sine die*, of the second Regular Session of the Sixty-seventh Idaho Legislature after approval.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 39-3140, 56-1003, and 56-1004, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

Under Executive Order 2020-01: Zero-Based Regulation, the Department is striving to prevent the accumulation of costly, ineffective, and outdated regulations and reduce regulatory burden to achieve a more efficient operation of government. The rule changes are intended to perform a comprehensive review of this chapter by collaborating with the public to streamline or simplify this rule language. The title of this IDAPA chapter is changing from “Certification of Peer Support Specialist and Family Support Partners” to “Peer Support Specialist and Family Support Partner Certification.”

There are no changes to the pending rule and it is being adopted as originally proposed. The complete text of the proposed rule was published in the August 2, 2023, Idaho Administrative Bulletin, Vol. 23-8, pages 128 through 141.

FEE SUMMARY: Pursuant to Section 67-5224(2)(d), Idaho Code, this pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature. The following is a description of the fee or charge imposed or increased in this rulemaking: Not Applicable.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state General Fund greater than ten thousand dollars ($10,000) during the fiscal year:

This rulemaking is not anticipated to have any fiscal impact on the state funds, the General Fund, or any other known funds.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Treena Clark at 208-334-6611, or Cade Hulbert at 208-334-0463.

DATED this 9th day of November, 2023.

Trinette Middlebrook and Frank Powell
DHW – Administrative Rules Unit
450 W. State Street – 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
phone: (208) 334-5500
fax: (208) 334-6558
email: dhwrules@dhw.idaho.gov

THE FOLLOWING NOTICE PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 39-3140, 56-1003, and 56-1004, Idaho Code.

PUBLIC HEARING SCHEDULE: A public hearing concerning this rulemaking will be held as follows:

VIRTUAL TELECONFERENCE Via WebEx
Wednesday, August 15, 2023 **11:00 a.m. - 12:00 p.m. (MT)**
Join from the meeting link **https://idhw.webex.com/idhw/j.php?MTID=ma8341dbc2a87a354a0c47691193cbf76** **Join by meeting number** **Meeting number (access code): 2762 529 7876** **Meeting password: 7PpJUGXMS32 (77758496 from phones and video systems)** **Join by phone** **+1-415-527-5035 United States Toll** **+1-303-498-7536 United States Toll (Denver)**

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below. Meeting(s) will conclude after 30 minutes if no participants sign in or wish to comment in the meeting.

DESCRIPTIVE SUMMARY: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

Under Executive Order 2020-01: Zero-Based Regulation, the Department is striving to prevent the accumulation of costly, ineffective, and outdated regulations and reduce regulatory burden to achieve a more efficient operation of government. The rule changes are intended to perform a comprehensive review of this chapter by collaborating with the public to streamline or simplify this rule language.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased:

This chapter contains no fees or charges.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the State General Fund greater than ten thousand dollars ($10,000) during the fiscal year as a result of this rulemaking:

This rulemaking is not anticipated to have any fiscal impact on the State General Fund, or any other known funds.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the February 1, 2023, Idaho Administrative Bulletin, Vol. 23-2, pages 12 - 13.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into this rule:

This chapter of rule contains two (2) new incorporations by reference:
1. Idaho Certified Peer Support Specialist Code of Ethics and Professional Conduct, rev 08/2015; and
2. Idaho Certified Family Support Partner Code of Ethics, rev 09/2020.

These codes of ethics have been revised and posted online. The text related to these has been removed from the chapter and the revised versions incorporated by reference, both to save space in the chapter and ensure that the codes of ethics continue to have the force and effect of law.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Treena Clark at 208-334-6611, or Cade Hulbert at 208-334-0463.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before August 23, 2023.

DATED this 6th day of July, 2023.

THE FOLLOWING IS THE TEXT OF ZBR DOCKET NO. 16-0719-2301

16.07.19 – PEER SUPPORT SPECIALIST AND FAMILY SUPPORT PARTNER CERTIFICATION

000. LEGAL AUTHORITY.
Title 39, Chapter 31, Idaho Code, delegates the Department as the state behavioral health authority for the establishment, maintenance, and oversight of behavioral health services. Section 39-3140, Idaho Code, authorizes the Department to promulgate and enforce rules under the Regional Behavioral Health Services Act. Sections 56-1003, 56-1004, Idaho Code, authorize the Director to adopt and enforce rules to administer mental health programs. ( )

001. (RESERVED)

002. INCORPORATION BY REFERENCE.
The following documents are incorporated by reference: ( )

01. Idaho Certified Peer Support Specialist Code of Ethics and Professional Conduct, rev 08/2015. Copies may be obtained from the Department at: https://publicdocuments.dhw.idaho.gov/WebLink/DocView.aspx?id=4037&dbid=0&repo=PUBLIC-DOCUMENTS ( )

02. Idaho Certified Family Support Partner Code of Ethics, rev 09/2020. Copies may be obtained from the Department at https://publicdocuments.dhw.idaho.gov/WebLink/DocView.aspx?id=4036&dbid=0&repo=PUBLIC-DOCUMENTS ( )

003. -- 009. (RESERVED)

010. DEFINITIONS.
In addition to definitions under Section 39-3122, Idaho Code, the following definitions apply. ( )

01. **Certificate**. Issued by the Department to an individual who is a behavioral health peer support specialist or a family support partner who the Department deems to be in compliance with these rules. ( )

02. **Department**. The Idaho Department of Health and Welfare, or its designee. ( )

03. **Director**. The Director of the Department, or designee. ( )

04. **Family Support Partner**. An individual who has lived experience raising a child who has a behavioral health disorder diagnosis, mental illness, or mental illness with a co-occurring substance use disorder, has specialized training related to such care, and who has successfully navigated the various systems of care. ( )

05. **Family Support Partner Services**. Family-to-family services are non-clinical support services provided by family support partners who have participated in mental health services, and who have received training in how to share their experiences with others facing similar challenges. ( )

06. **Lived Experience**. Life experiences of an individual who has received behavioral health services or has raised a child who is living with a behavioral health diagnosis, mental illness, or mental illness with a co-occurring substance use disorder, and has at least one (1) year of lived experience navigating the behavioral health systems. ( )

07. **Peer Support Services**. Non-clinical services provided by peer support specialists who are on their own recovery journey, and who have received training in supporting others who are actively involved in their own recovery process. ( )

08. **Peer Support Specialist**. An individual in recovery from mental illness or mental illness with a co-occurring substance use disorder who uses lived experience and specialized training to assist other individuals in recovery. ( )

011. -- 099. (RESERVED)

100. APPLICATION FOR CERTIFICATION.
An applicant must furnish the following information prior to any certification being issued. ( )

01. **Completed Application**. Each applicant completes and signs an application for certification on Department-approved forms. ( )

02. **Verification of Education, Training, and Experience**. Each applicant must provide verification to the Department of the following: ( )

a. A copy of their high school diploma, GED certificate, or a Bachelor's degree in a human services field; ( )

b. Documentation of completion of training required for the certification being sought according to the requirements in Sections 200 and 300 of these rules; and ( )

c. A summary of work or volunteer experience, including documentation of supervised hours. ( )

03. **Code of Ethics Acknowledgment**. Each applicant submits a signed and dated Code of Ethics Acknowledgment. ( )

101. -- 109. (RESERVED)

110. TYPES OF CERTIFICATION.

01. **Peer Support Specialist**. ( )

02. Family Support Partner. ( )

111. DURATION OF CERTIFICATION.

01. Six-Month Certification. Applies to an applicant that has completed the requirements in Sections 200 and 300 of these rules for initial certification, but may be lacking work or volunteer experience and supervised hours. ( )

02. Full Certification. Applies to an applicant that has completed the requirements in Sections 200 and 300 of these rules for certification, including work or volunteer experience and supervised hours. Full certification is valid for one (1) year. ( )

112. RENEWAL OF CERTIFICATION.
Each certified peer support specialist or certified family support partner must: ( )

01. Submit Renewal Application. When seeking certification renewal submit a completed renewal application prior to expiration of current certificate. ( )

02. Continuing Education. Provide documentation of a minimum of ten (10) hours of continuing education as follows: ( )

a. Continuing education obtained in competency areas listed in training requirements germane to the type of certification being renewed; and ( )

b. At least one (1) hour of continuing education for each renewal period must be in ethics. ( )

03. Code of Ethics Acknowledgment. Submit an updated signed, and dated Code of Ethics Acknowledgment. ( )

113. EXTENSION OF CERTIFICATION.
Certified peer support specialists or certified family support partners may request an extension prior to the expiration of their certificate if they need more time to gain required work or volunteer experience, supervised hours, or continuing education hours. Certified peer support specialists or certified family support partners on: ( )

01. Six-Month Certifications. Are eligible for one (1) four-month extension while they work towards the requirements for full certification. ( )

02. Full Certification. Are eligible for one (1) four-month extension while they work towards the continuing education hours required for certification renewal. ( )

114. -- 119. (RESERVED)

120. RECIPROCITY.
An applicant who holds a valid and current certificate or license in good standing issued by the regulatory entity of another state, which in the opinion of the Department imposed substantially equivalent requirements, may apply for reciprocity for certification as a peer support specialist or a family support partner. Each applicant seeking reciprocity must: ( )

01. Complete and Sign an Application on Department-Approved Forms. ( )

02. Provide the Following Verification of Education and Experience. ( )

a. Education experience summary; ( )

b. Continuing education/training hours received since certification; ( )

c. Statement of personal experience; ( )

d. Work or volunteer experience summary form with documentation of supervised hours; and ( )

e. Documentation of current certification or licensure issued by the other state's regulatory entity. ( )

03. Submit a Signed and Dated Idaho Code of Ethics Acknowledgment. ( )

121. -- 149. (RESERVED)

150. INACTIVE STATUS.
A certified peer specialist or certified family support partner, in good standing, may request a temporary inactive status due to an inability to meet certification requirements related to a decline in physical, mental health, or extenuating circumstances. ( )

01. Request for Inactive Status. An individual who is certified must submit a request in writing to the Department asking for inactive status. ( )

02. Inactive Certification Status. The Department may grant inactive status to a certified individual for up to one (1) year. ( )

03. Reactivation of Certification. When the individual desires to reactivate status, they must submit a new application along with an updated and signed Code of Ethics Acknowledgment and documentation of fulfillment of continuing education requirements for the previous twelve (12) months to the Department. ( )

151. -- 199. (RESERVED)

200. PEER SUPPORT SPECIALIST -- CERTIFICATION QUALIFICATIONS AND REQUIREMENTS.
Each applicant must be at least eighteen (18) years old and meet the following minimum qualifications and requirements to be certified as a Peer Support Specialist. ( )

01. Educational Requirements. Each applicant has a high school diploma or GED certificate. ( )

02. Training Requirements. Each applicant has completed forty (40) hours of training that includes the following Peer Support Specialist competency areas: ( )

a. Motivation and empowerment; ( )

b. The stages of recovery and the role peers play within it; ( )

c. The state behavioral health system and the role peers play within it; ( )

d. Advocacy for recovery programs and for the peers they serve; ( )

e. The practice of recovery values: authenticity, self-determination, diversity, and inclusion; ( )

f. How to tell your recovery story and use your story to help others; ( )

g. Ethics; ( )

h. The awareness of risk factors in participants' behaviors and the ability to access appropriate services; ( )

i. The use of interpersonal and professional communication skills; ( )

j. Stages of change; ( )

k. Work place dynamics and processes; ( )

l. The Certified Peer Support Specialist's roles and duties on the job; ( )

m. Relationship building; ( )

n. Family dynamics; ( )

o. The effects of trauma and use of a trauma-informed approach; ( )

p. Wellness and natural supports; ( )

q. Boundaries and self-care; ( )

r. Cultural sensitivity; ( )

s. Recovery plans; and ( )

t. Local, state, and national resources. ( )

03. Work or Volunteer Experience Requirements. Each applicant has obtained supervised experience providing peer support services. A six-month (6) certification may be granted under Section 111 of these rules to an applicant who lacks the required experience. ( )

a. An applicant who holds a bachelor's degree in a human services field documents one hundred (100) hours of peer support specialist experience. ( )

b. An applicant who does not hold a bachelor's degree in a human support services field documents two hundred (200) hours of peer support specialist experience. ( )

c. An applicant documents at a minimum twenty (20) hours of supervised peer support services work or volunteer experience. ( )

04. Person Self-Identified with Lived Experience. Each applicant identifies as an individual with lived experience in recovery from mental illness or mental illness with a co-occurring substance use disorder. ( )

201. -- 249. (RESERVED)

250. PEER SUPPORT SPECIALISTS -- CODE OF ETHICS AND PROFESSIONAL CONDUCT.

All certified peer support specialists must understand and comply with the Idaho Certified Peer Support Specialist Code of Ethics and Professional Conduct incorporated by reference under Section 002 of these rules. ( )

251. -- 299. (RESERVED)

300. FAMILY SUPPORT PARTNER -- CERTIFICATION QUALIFICATIONS AND REQUIREMENTS.

Each applicant must be at least eighteen (18) years of age and meet the following minimum qualifications and requirements to be certified as a family support partner. ( )

01. Educational Requirements. Each applicant has a high school diploma or GED certificate. ( )

02. Training Requirements. Each applicant has completed a minimum of forty (40) hours of training that includes the following Family Support Partner competency areas: ( )

a. Overview of mental illness and substance use disorders and their effects on the brain; ( )

b. Advocacy skills used in multiple systems (children's behavioral health system, education and special education system, child welfare system, and juvenile court system); ( )

c. Ethics; ( )

d. The awareness of risk factors in participants' behaviors and the ability to access appropriate services; ( )

e. The use of interpersonal and professional communication skills; ( )

f. Stages of change; ( )

g. Motivation and empowerment; ( )

h. Parenting special needs children and family dynamics; ( )

i. The recovery process; ( )

j. The effects of trauma and use of a trauma-informed approach; ( )

k. Wellness and natural supports; ( )

l. Family-centered planning; ( )

m. Boundaries and self-care; ( )

n. Cultural sensitivity; ( )

o. The children's mental health system; ( )

p. How to tell your story and use your story to help others; ( )

q. The child and family team and how to be a team player; ( )

r. Work place dynamics and process; ( )

s. The Certified Family Support Partner’s role and duties on the job; ( )

t. Relationship building; ( )

u. Recovery plans; and ( )

v. Local, state, and national resources. ( )

03. **Work or Volunteer Experience Requirements**. Each applicant has obtained supervised experience providing family support services. A six (6) month certification may be granted under Section 111 of these rules to an applicant who lacks required experience. ( )

a. An applicant that holds a bachelor's degree in a human services field documents one hundred (100) hours of family support partner experience. ( )

b. An applicant that does not hold a bachelor's degree in a human support services field documents two hundred (200) hours of family support partner experience. ( )

c. An applicant documents at a minimum twenty (20) hours of supervised family support services work or volunteer experience. ( )

04. Person Self-Identified with Lived Experience. Each applicant identifies as an individual with lived experience as a parent or adult caregiver who is raising, or has raised, a child who lives with a mental illness or mental illness with a co-occurring substance use disorder. ( )

301. -- 349. (RESERVED)

350. FAMILY SUPPORT PARTNERS -- CODE OF ETHICS AND PROFESSIONAL CONDUCT.
All certified family support partners must understand and comply with the Idaho Certified Family Support Partner Code of Ethics incorporated by reference under Section 002 of these rules. ( )

351. -- 399. (RESERVED)

400. SUPERVISOR FOR PEER SUPPORT SPECIALIST OR FAMILY SUPPORT PARTNER -- QUALIFICATIONS AND REQUIREMENTS.
An individual must meet the following requirements to provide supervision to a peer support specialist or family support partner. ( )

01. Bachelor's Degree or Higher. To supervise a peer support specialist or family support partner, an individual holds a bachelor's degree or higher in a human services field. ( )

02. Supervisory Position. An individual is in a supervisory position and works in that capacity within the agency. ( )

401. -- 499. (RESERVED)

500. COMPLAINTS.
A complaint is an informal process to address the concerns of an individual. Any individual may file a written complaint or concern with the Department regarding a certified peer support specialist or certified family support partner. ( )

01. Complaint Content. A complaint must include: ( )

a. The full name, mailing address, phone number, and email contact for the person reporting the complaint; ( )

b. A description of the nature of the complaint, including the desired outcome. ( )

02. Department Response. The Department will respond to the complaint within thirty (30) days of receipt of the complaint. This process may include gathering additional information from involved parties, including the complainant. ( )

501. -- 509. (RESERVED)

510. GRIEVANCES.
A grievance is a type of complaint about the certification decision that has been made following application to the Department. When an applicant is denied certification, questions the results of the application review process, or is subject to an action that they deem unjustified, the applicant may submit a written grievance to the Department. ( )

01. Grievance Content. The grievance must include: ( )

a. The full name, mailing address, phone number, and email contact for the person reporting the grievance; and ( )

b. A detailed explanation of the decision that is being contested, from the perspective of the complainant, including any steps already taken to resolve the issue. ( )

02. Department Response. The Department will respond within sixty (60) days of receipt of the grievance. This process may include gathering additional information from involved parties. ( )

511. -- 519. (RESERVED)

520. DENIAL, REVOCATION, OR SUSPENSION OF CERTIFICATION.
The Department may deny, suspend, or revoke an individual's application, certification, or certification renewal as a peer support specialist or family support partner for noncompliance with these rules. ( )

521. -- 524. (RESERVED)

525. IMMEDIATE DENIAL, REVOCATION, OR SUSPENSION.
The Department may deny, revoke, or suspend a certification or certification renewal, without prior notice, when conditions exist that endanger the health and safety of any participant. ( )

526. -- 529. (RESERVED)

530. REASONS FOR DENIAL, REVOCATION, OR SUSPENSION.
An individual may have a certification denied, revoked, or suspended for any of the following reasons. ( )

01. Failure to Comply with These Rules and the Code of Ethics. ( )

02. Failure to Provide Information Requested by the Department. ( )

03. Misrepresentation of Information. Misrepresentation by the applicant in an application, or in documents required by the Department for certification. ( )

04. Conflict of Interest. Conflict of interest in which a certified individual exploits their position as a Certified Peer Support Specialist or a Certified Family Support Partner for personal benefit. ( )

05. Negligent Performance or Fraud. A criminal, civil, or administrative determination that a certified individual has committed fraud or gross negligence in their capacity as a Certified Peer Support Specialist or Certified Family Support Partner. ( )

06. Failure to Correct. Failure to correct within thirty (30) days of written notice, any unacceptable conduct, practice, or condition as determined by the Department. ( )

531. -- 534. (RESERVED)

535. APPEAL OF DEPARTMENT DECISION.
An applicant or certificate holder may appeal a Department decision to deny, suspend, or revoke a certification under IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings." ( )

536. -- 539. (RESERVED)

540. REAPPLICATION FOR CERTIFICATION.
Following a denial, suspension, or revocation of certification or certification renewal, the same applicant may not reapply for certification for a period of six (6) months after the effective date of the action. Applicants reapplying after a suspension or revocation adhere to the same continuing education and ethics requirements under Section 112 of these rules. ( )

541. -- 999. (RESERVED)

[Agency redlined courtesy copy]

16.07.19 – CERTIFICATION OF PEER SUPPORT SPECIALISTS AND FAMILY SUPPORT PARTNERS

000. LEGAL AUTHORITY.
~~Under~~ Title 39, Chapter 31, Idaho Code, delegates the ~~Idaho Legislature has delegated to the~~ Department ~~of Health and Welfare~~ as the state behavioral health authority for the establishment, maintenance, and oversight of ~~the state of Idaho's~~ behavioral health services. Section 39-3140, Idaho Code, authorizes the Department to promulgate and enforce rules ~~to carry out the purposes and intent of~~under the Regional Behavioral Health Services Act. ~~Under~~ Sections 56-1003, 56-1004, Idaho Code, authorize the Director ~~of the Department is authorized~~ to adopt and enforce rules to ~~supervise and~~ administer mental health programs. ~~(3-17-22)~~( )

001. ~~TITLE AND SCOPE.~~(RESERVED)

~~**01. Title**. These rules are titled IDAPA 16.07.19, "Certification of Peer Support Specialists and Family Support Partners." (3-17-22)~~

~~**02. Scope**. These rules establish the minimum qualifications and requirements for certification of peer support specialists and family support partners in Idaho including enforcement actions. (3-17-22)~~

002. INCORPORATION BY REFERENCE.
The following documents are incorporated by reference: ( )

01. Idaho Certified Peer Support Specialist Code of Ethics and Professional Conduct, rev 08/2015. Copies may be obtained from the Department at: https://publicdocuments.dhw.idaho.gov/WebLink/DocView.aspx?id=4037&dbid=0&repo=PUBLIC-DOCUMENTS ( )

02. Idaho Certified Family Support Partner Code of Ethics, rev 09/2020. Copies may be obtained from the Department at https://publicdocuments.dhw.idaho.gov/WebLink/DocView.aspx?id=4036&dbid=0&repo=PUBLIC-DOCUMENTS ( )

00~~2~~3. -- 009. (RESERVED)

010. DEFINITIONS.
~~For the purposes of these rules~~ In addition to definitions under Section 39-3122, Idaho Code, the following ~~terms~~ definitions apply. ~~(3-17-22)~~( )

~~**01. Behavioral Health Program**. A behavioral health program refers to an organization offering mental health or substance use disorders treatment services that includes the organization's facilities, management, staffing patterns, treatment, and related activities. (3-17-22)~~

0~~2~~1. Certificate. ~~A certificate i~~Issued by the Department to an individual who is a behavioral health peer support specialist or a family support partner who the Department deems to be in compliance with these rules. ~~(3-17-22)~~( )

0~~3~~2. Department. The Idaho Department of Health and Welfare, or its designee. ( )

0~~4~~3. Director. The Director of the Department ~~of Health and Welfare~~, or designee. ~~(3-17-22)~~( )

0~~5~~4. Family Support Partner. An individual who has lived experience raising a child who has a behavioral health disorder diagnosis, mental illness, or mental illness with a co-occurring substance use disorder, has specialized training related to such care, and who has successfully navigated the various systems of care. ( )

0~~6~~5. Family Support Partner Services. Family-to-family services are non-clinical support services provided by family support partners who have participated in mental health services, and who have received training in how to share their experiences with others facing similar challenges. ( )

0~~7~~6. Lived Experience. Life experiences of an individual who has received behavioral health services or has raised a child who is living with a behavioral health diagnosis, mental illness, or mental illness with a co-occurring substance use disorder, and has at least one (1) year of lived experience navigating the behavioral health systems. ( )

0~~8~~7. Peer Support Services. Non-clinical services ~~are~~ provided by peer support specialists who are on their own recovery journey, and who have received training in supporting others who are actively involved in their own recovery process. ~~(3-17-22)~~( )

0~~9~~8. Peer Support Specialist. An individual in recovery from mental illness or mental illness with a co-occurring substance use disorder who uses lived experience and specialized training to assist other individuals in recovery. ( )

011. -- 099. (RESERVED)

100. APPLICATION FOR CERTIFICATION.

An applicant ~~for any certification by the Department~~ must furnish the following information prior to any certification being issued. ~~(3-17-22)~~( )

01. Completed Application. Each applicant ~~must~~ completes and signs an application for certification on Department-approved forms ~~approved by the Department~~. ~~(3-17-22)~~( )

02. Verification of Education, Training, and Experience. Each applicant must provide verification to the Department of the following: ( )

a. A copy of their high school diploma, GED certificate, or a Bachelor's degree in a human services field; ( )

b. Documentation of ~~successful~~ completion of training required for the certification being sought according to the requirements in Sections 200 and 300 of these rules; and ~~(3-17-22)~~( )

c. A summary of work or volunteer experience, including documentation of supervised hours. ( )

03. Code of Ethics Acknowledgment. Each applicant ~~must~~ submits a signed and dated Code of Ethics Acknowledgment. ~~(3-17-22)~~( )

101. -- 109. (RESERVED)

110. TYPES OF CERTIFICATION.

01. Peer Support Specialist. ( )

02. Family Support Partner. ( )

111. DURATION OF CERTIFICATION.

01. Six-Month Certification. ~~A six (6) month certification a~~Applies to an applicant that has completed the requirements in Sections 200 and 300 of these rules for initial certification, but may be lacking work or volunteer experience and supervised hours. ~~(3-17-22)~~( )

02. Full Certification. ~~A full certification a~~Applies to an applicant that has completed ~~all~~the requirements in Sections 200 and 300 of these rules for certification, including work or volunteer experience and

supervised hours. Full certification is valid for one (1) year. (3-17-22)( )

112. RENEWAL OF CERTIFICATION.
Each certified peer support specialist or certified family support partner must: ( )

01. Submit Renewal Application. Each certified peer support specialist or certified family support partner who isWhen seeking certification renewal must submit a completed renewal application prior to expiration of current certificate. (3-17-22)( )

02. Continuing Education. Each certified peer support specialist or certified family support partner must pProvide documentation of a minimum of ten (10) hours of continuing education as follows: (3-17-22)( )

a. Continuing education obtained in competency areas listed in training requirements germane to the type of certification being renewed; and ( )

b. At least one (1) hour of continuing education for each renewal period must be in ethics. ( )

03. Code of Ethics Acknowledgment. Each certified peer support specialist or certified family support partner must sSubmit an updated signed, and dated Code of Ethics Acknowledgment. (3-17-22)( )

113. EXTENSION OF CERTIFICATION.
Certified peer support specialists or certified family support partners may request an extension prior to the expiration of their certificate if they need more time to gain required work or volunteer experience, supervised hours, or continuing education hours. Certified peer support specialists or certified family support partners on: ( )

01. Six-Month Certifications. Are eligible for one (1) four-month extension while they work towards the requirements for full certification. ( )

02. Full Certification. Are eligible for one (1) four-month extension while they work towards the continuing education hours required for certification renewal. ( )

1134. -- 119. (RESERVED)

120. RECIPROCITY.
An applicant forwho holds a valid and current certificate or license in good standing issued by the regulatory entity of another state, which in the opinion of the Department imposed substantially equivalent requirements, may apply for reciprocity for certification as a peer support specialist or a family support partner., certificate must be a holder of a current and active license or certificate at the level for which certification is sought, and be in good standing in the profession, and with the other state who is the authorizing regulatory entity for licensure or certification. Each applicant seeking reciprocity must: (3-17-22)( )

01. Completed and Sign an Application on Department-Approved Forms. Each applicant must complete and sign an application for reciprocity on forms approved by the Department. (3-17-22)( )

02. Provide Verification of Education, Training, and Experience the Following Verification of Education and Experience. Each applicant seeking reciprocity must provide the Department with the following: (3-17-22)( )

a. Education experience summary; ( )

b. Continuing education/training hours received since certification; ( )

c. Statement of personal experience; and (3-17-22)( )

d. Work or volunteer experience summary form with documentation of supervised hours.; and (3-17-22)( )

e. Documentation of current certification or licensure issued by the other state's regulatory entity. ( )

03. Submit a Signed and Dated Idaho Code of Ethics Acknowledgment.~~ Each applicant seeking reciprocity must submit a signed and dated Code of Ethics Acknowledgment.~~ ~~(3-17-22)~~( )

~~**04. Documentation From Other State**. Documentation of licensure or certification must be received from the other state's issuing regulatory agency. The other state's licensing or certification requirements must be substantially equivalent to, or higher than, those required in this chapter of rules.~~ ~~(3-17-22)~~

121. -- 149. (RESERVED)

150. INACTIVE STATUS.

A certified peer specialist or certified family support partner, in good standing, may request a~~n~~ temporary inactive status due to an inability to meet ~~re~~certification requirements related to a decline in physical, mental health, or extenuating circumstances. ~~(3-17-22)~~( )

01. Request for Inactive Status. An individual who is certified must submit a request in writing to the Department asking for inactive status. ( )

02. Inactive Certification Status. The Department may grant inactive status to a certified individual for up to one (1) year. ( )

03. Reactivation of Certification. When the individual desires to reactivate status, they must submit a new application along with an updated and signed Code of Ethics Acknowledgment and documentation of fulfillment of continuing education requirements for the previous twelve (12) months ~~must be submitted~~ to the Department. ~~(3-17-22)~~( )

151. -- 199. (RESERVED)

200. PEER SUPPORT SPECIALIST -- CERTIFICATION QUALIFICATIONS AND REQUIREMENTS.

Each applicant must be at least eighteen (18) years ~~of age~~old and meet the following minimum qualifications and requirements ~~listed below~~ to be certified as a Peer Support Specialist~~ in Idaho~~. ~~(3-17-22)~~( )

01. Educational Requirements. Each applicant ~~for a peer support specialist certification must have~~has a high school diploma or GED certificate. ~~(3-17-22)~~( )

02. Training Requirements. Each applicant ~~must~~has complete**d** forty (40) hours of training that includes the following Peer Support Specialist competency areas: ~~(3-17-22)~~( )

a. Motivation and empowerment; ( )

b. The stages of recovery and the role peers play within it; ( )

c. The state behavioral health system and the role peers play within it; ( )

d. Advocacy for recovery programs and for the peers they serve; ( )

e. The practice of recovery values: authenticity, self-determination, diversity, and inclusion; ( )

f. How to tell your recovery story and use your story to help others; ( )

g. Ethics; ( )

h. The awareness of risk factors in participants' behaviors and the ability to access appropriate services; ( )

i. The use of interpersonal and professional communication skills; ( )

j. Stages of change; ( )

k. Work place dynamics and processes; ( )

l. The Certified Peer Support Specialist's roles and duties on the job; ( )

m. Relationship building; ( )

n. Family dynamics; ( )

o. The effects of trauma and use of a trauma-informed approach; ~~(3-17-22)~~( )

p. Wellness and natural supports; ( )

q. Boundaries and self-care; ( )

r. Cultural sensitivity; ( )

s. Recovery plans; and ( )

t. Local, state, and national resources. ( )

03. Work or Volunteer Experience Requirements. Each applicant ~~must~~has obtained supervised experience providing peer support services. A six-month (6) certification may be granted ~~according to~~under Section 111 of these rules to an applicant who lacks the required experience. ~~(3-17-22)~~( )

a. An applicant who holds a bachelor's degree in a human services field ~~must~~ documents one hundred (100) hours of peer support specialist experience. ~~(3-17-22)~~( )

b. An applicant who does not hold a bachelor's degree in a human support services field ~~must~~ documents two hundred (200) hours of peer support specialist experience. ~~(3-17-22)~~( )

c. An applicant ~~must~~ documents at a minimum twenty (20) hours of supervised peer support services work or volunteer experience. ~~(3-17-22)~~( )

~~**04. Supervision Requirements**. A six-month (6) certification may be granted according to Section 111 of these rules to an applicant who lacks the required work or volunteer supervision hours required in Subsection 200.03 of this rule. (3-17-22)~~

0~~5~~4. Person Self-Identified with Lived Experience. Each applicant ~~must~~ identif~~y~~ies as an individual with lived experience in recovery from mental illness or mental illness with a co-occurring substance use disorder. ~~(3-17-22)~~( )

201. -- 249. (RESERVED)

250. PEER SUPPORT SPECIALISTS -- CODE OF ETHICS AND PROFESSIONAL CONDUCT.
All certified peer support specialists must understand and comply with the Idaho Certified Peer Support Specialist Code of Ethics and Professional Conduct incorporated by reference under Section 002 of these rules. ( )

~~**01. Peer Support**. Peer Support is a helping relationship between mental health clients and Certified Peer Support Specialists. The primary responsibility of Certified Peer Support Specialists is to help those they serve achieve self-directed recovery. They believe that every individual has strengths and the ability to learn and grow. (3-17-22)~~

~~**02.** **Certified Peer Support Specialists**. Certified peer support specialists are committed to providing and advocating for effective recovery-based services for the people they serve in order for these individuals to meet their own needs, desires, and goals. (3-17-22)~~

~~**03.** **Certified Peer Support Specialist Professional Conduct**. A certified peer support specialist must: (3-17-22)~~

~~**a.** Seek to role-model recovery; (3-17-22)~~

~~**b.** Respect the rights and dignity of those they serve; (3-17-22)~~

~~**c.** Respect the privacy and confidentiality of those they serve; (3-17-22)~~

~~**d.** Openly share their personal recovery stories with colleagues and those they serve; (3-17-22)~~

~~**e.** Maintain high standards of personal conduct and conduct themselves in a manner that fosters their own recovery; (3-17-22)~~

~~**f.** Never intimidate, threaten, or harass those they serve; never use undue influence, physical force, or verbal abuse with those they serve; and never make unwarranted promises of benefits to those they serve; (3-17-22)~~

~~**g.** Not practice, condone, facilitate, or collaborate with any form of discrimination on the basis of ethnicity, race, gender, sexual orientation, age, religion, national origin, marital status, political belief, or mental or physical disability; (3-17-22)~~

~~**h.** Never engage in sexual/intimate activities with colleagues or those they serve; (3-17-22)~~

~~**i.** Not accept gifts of significant value from those they serve; (3-17-22)~~

~~**j.** Not enter into dual relationships or commitments that conflict with the interests of those they serve; (3-17-22)~~

~~**k.** Not abuse substances under any circumstances while they are employed as a Certified Peer Support Specialist; (3-17-22)~~

~~**l.** Work to equalize the power differentials that may occur in the peer support/client relationship; (3-17-22)~~

~~**m.** Ensure that all information and documentation provided is true and accurate to the best of their knowledge; (3-17-22)~~

~~**n.** Keep current with emerging knowledge relevant to recovery, and openly share this knowledge with their colleagues and those they serve; (3-17-22)~~

~~**o.** Remain aware of their skills and limitations, and do not provide services or represent themselves as expert in areas for which they do not have sufficient knowledge or expertise; and (3-17-22)~~

~~**p.** Not hold a clinical role nor offer primary treatment for mental health issues, prescribe medicine, act as a legal representative or provide legal advice, participate in the determination of competence, or provide counseling, therapy, social work, drug testing, or diagnosis of symptoms and disorders. (3-17-22)~~

~~**04.** **Ethics Training**. A certified peer support specialist must complete ethics training at least once per year, and maintain personal documentation of completed ethics training. (3-17-22)~~

~~**05.** **Comply with Code of Ethics**. A certified peer support specialist must understand and comply with these rules and Idaho's Certified Peer Support Specialists Code of Ethics and Professional Conduct. (3-17-22)~~

251. -- 299. (RESERVED)

300. FAMILY SUPPORT PARTNER -- CERTIFICATION QUALIFICATIONS AND REQUIREMENTS.
Each applicant must be at least eighteen (18) years of age and meet the following minimum qualifications and requirements ~~listed below~~ to be certified as a family support partner~~ in Idaho~~. ~~(3-17-22)~~( )

01. Educational Requirements. Each applicant ~~for a family support partner certification must have, at a minimum,~~has a high school diploma or GED certificate. ~~(3-17-22)~~( )

02. Training Requirements. Each applicant ~~must~~has complete~~d~~ a minimum of forty (40) hours of training that includes~~, at a minimum,~~ the following Family Support Partner competency areas: ~~(3-17-22)~~( )

a. Overview of mental illness and substance use disorders and their effects on the brain; ( )

b. Advocacy skills used in multiple systems (children's behavioral health system, education and special education system, child welfare system, and juvenile court system); ( )

c. Ethics; ( )

d. The awareness of risk factors in participants' behaviors and the ability to access appropriate services; ( )

e. The use of interpersonal and professional communication skills; ( )

f. Stages of change; ( )

g. Motivation and empowerment; ( )

h. Parenting special needs children and family dynamics; ( )

i. The recovery process; ( )

j. The effects of trauma and use of a trauma-informed approach; ( )

k. Wellness and natural supports; ( )

l. Family-centered planning; ( )

m. Boundaries and self-care; ( )

n. Cultural sensitivity; ( )

o. The children's mental health system; ( )

p. How to tell your story and use your story to help others; ( )

q. The child and family team and how to be a team player; ( )

r. Work place dynamics and process; ( )

s. The Certified Family Support Partner’s role and duties on the job; ( )

t. Relationship building; ( )

u. Recovery plans; and ( )

v. Local, state, and national resources. ( )

03. Work or Volunteer Experience Requirements. Each applicant ~~must~~has obtained supervised experience providing family support services. A six (6) month certification may be granted ~~according to~~under Section 111 of these rules to an applicant who lacks required experience. ~~(3-17-22)~~( )

a. An applicant that holds a bachelor's degree in a human services field ~~must~~ documents one hundred (100) hours of family support partner experience. ~~(3-17-22)~~( )

b. An applicant that does not hold a bachelor's degree in a human support services field ~~must~~ documents two hundred (200) hours of family support partner experience. ~~(3-17-22)~~( )

c. An applicant ~~must~~ documents at a minimum twenty (20) hours of supervised family support services work or volunteer experience. ~~(3-17-22)~~( )

~~**04. Supervision Requirements**. A six (6) month certification may be granted according to Section 111 of these rules to an applicant who lacks the required work or volunteer supervision hours required in Subsection 300.03 of this rule. (3-17-22)~~

0~~5~~4. Person Self-Identified with Lived Experience. Each applicant ~~must~~ identif~~y~~ies as an individual with lived experience as a parent or adult caregiver who is raising, ~~a child~~ or has raised, a child who lives with a mental illness or mental illness with a co-occurring substance use disorder. ~~(3-17-22)~~( )

301. -- 349. (RESERVED)

350. FAMILY SUPPORT PARTNERS -- CODE OF ETHICS AND PROFESSIONAL CONDUCT.
All certified family support partners must understand and comply with the Idaho Certified Family Support Partner Code of Ethics incorporated by reference under Section 002 of these rules. ( )

~~**01. Family Support Principles**. These family support principles are intended to serve as a guide for certified family support partners and those who are working toward full certification in their everyday professional conduct that includes various roles, relationships, and levels of responsibilities within their jobs. (3-17-22)~~

~~**02. Certified Family Support Partner Integrity**. In order to maintain high standards of competency and integrity, a certified family support partner must: (3-17-22)~~

~~**a.** Apply the principles of resiliency, wellness and recovery, or both, family-driven approach, youth-guided or youth-driven approach, consumer-driven approach, and peer-to-peer mutual-learning principles in every day interactions with family members; (3-17-22)~~

~~**b.** Promote the family member's ethical decision-making and personal responsibility consistent with that family member's culture, values, and beliefs; (3-17-22)~~

~~**c.** Promote the family members' voices and the articulation of their values in planning and evaluating children's behavioral health related issues; (3-17-22)~~

~~**d.** Teach, mentor, coach, and support family members to articulate goals that reflect each family member's current needs and strengths; (3-17-22)~~

~~**e.** Demonstrate respect for the cultural-based values of the family members engaged in peer support; (3-17-22)~~

~~**f.** Communicate information in ways that are both developmentally and culturally appropriate; (3-17-22)~~

~~**g.** Empower family members to be fully informed in preparing to make decisions and understand the implications of these decisions; (3-17-22)~~

~~**h.** Maintain high standards of professional competence and integrity; (3-17-22)~~

~~**i.** Abstain from discriminating against or refusing services to anyone on the basis of race, ethnicity, gender, gender identity, religion/spirituality, culture, national origin, age, sexual orientation, marital status, language preference, socioeconomic status, or disability; (3-17-22)~~

~~**j.** Only assist family members whose concerns are within one's competency as determined by one's education, training, experience, and on-going supervision or consultation; (3-17-22)~~

~~**k.** Abstain from establishing or maintaining a relationship for the sole purpose of financial remuneration to self or the agency with which one is associated; and (3-17-22)~~

~~**l.** Terminate a relationship when it becomes reasonably clear that the peer relationship is no longer the desire of the family member. (3-17-22)~~

~~**03. Certified Family Support Partner Safety**. In order to maintain the safety of all family members involved with family support services, a certified family support partner must: (3-17-22)~~

~~**a.** Comply with all laws and regulations applicable to the jurisdiction in which the peer support services are provided, including confidentiality; (3-17-22)~~

~~**b.** Maintain confidentiality in personal and professional communication and ensure that family members have authorized the use or release of any and all information about themselves or family members for whom they have legal authority, including verbal statements, writings, or re-release of documents; (3-17-22)~~

~~**c.** Respect the privacy of partner agencies and not distribute internal or draft documents or share private, internal conversations; (3-17-22)~~

~~**d.** When complying with laws and regulations involving mandatory reporting of harm, abuse, or neglect, make every effort to involve the family members in the planning for services and ensure that no further harm is done to family members as the result of the reporting; (3-17-22)~~

~~**e.** Discuss and explain to family members the rights, roles, expectations, benefits, and limitations of the peer support process; (3-17-22)~~

~~**f.** Avoid ambiguity in the relationship with family members and ensure clarity of the certified family support partner's role at all times; (3-17-22)~~

~~**g.** Maintain a positive relationship with family members, refraining from premature or unannounced ceasing of the relationship until a reasonable alternative arrangement is made for continuation of similar peer support services; (3-17-22)~~

~~**h.** Abstain from engaging in intimate, emotional, or physical relationships with family members engaged in a peer support relationship; (3-17-22)~~

~~**i.** Neither offer nor accept gifts, other than token gifts, related to the professional service of peer support, including personal barter services, payment for referrals, or other remunerations; and (3-17-22)~~

~~**j.** Abstain from engaging in personal financial transactions with family members engaged in a peer support relationship. (3-17-22)~~

~~**04. Certified Family Support Partner Professional Responsibility**. Through educational activities, supervision and personal commitment, a certified family support partner must: (3-17-22)~~

~~**a.** Stay informed and up-to-date with regard to the research, policy, and developments in the field of parent/peer support and children's emotional, developmental, behavioral (including substance use), or mental health~~

~~which relates to one's own practice area and children's general health and wellbeing;~~ ~~(3-17-22)~~

~~**b.** Engage in helping relationships that include skills-building, not exceeding one's scope of practice, experience, training, education, or competence;~~ ~~(3-17-22)~~

~~**c.** Perform or hold oneself out as competent to perform only peer services not beyond one's education, training, experience, or competence;~~ ~~(3-17-22)~~

~~**d.** Seek appropriate professional supervision/consultation or assistance for one's personal problems or conflicts that may impair or affect work/volunteer performance or judgment;~~ ~~(3-17-22)~~

~~**e.** File a complaint with the certification body for Family Support Partners when one has reason to believe that another family support partner is, or has been, engaged in conduct that violates the law or these rules. Making a complaint to the certification body for Family Support Partners is an additional requirement, not a substitute for, or alternative to, any duty of filing reports required by statute or regulation;~~ ~~(3-17-22)~~

~~**f.** Refrain from distorting, misusing, or misrepresenting one's experience, knowledge, skills, or research findings;~~ ~~(3-17-22)~~

~~**g.** Refrain from financially or professionally exploiting a colleague or representing a colleague's work, associated with the provision of peer support or the profession of peer support, as one's own;~~ ~~(3-17-22)~~

~~**h.** In the role of a supervisor/consultant, be responsible for maintaining the quality of one's own supervisory/consultation skills and obtaining supervision/consultation for work as a supervisor/consultant;~~ ~~(3-17-22)~~

~~**i.** In the role of a researcher, be aware of and comply with federal and state laws and regulations, agency regulations, and professional standards governing the conduct of research, including ensuring the participants' complete informed consent for participating or declining to participate in a study; and~~ ~~(3-17-22)~~

~~**j.** In the role as a volunteer, member, or employee of an organization, give credit to persons for published or unpublished original ideas, take reasonable precautions to ensure that one's employer or affiliate organization promotes and advertises materials accurately and factually.~~ ~~(3-17-22)~~

~~**05. Ethics Training**. A certified family support partner must complete ethics training at least once per year, and maintain personal documentation of completed ethics training.~~ ~~(3-17-22)~~

~~**06. Comply with Code of Ethics**. A certified family support partner must understand and comply with these rules and Idaho's Certified Family Support Partners Code of Ethics.~~ ~~(3-17-22)~~

351. -- 399. (RESERVED)

400. SUPERVISOR FOR PEER SUPPORT SPECIALIST OR FAMILY SUPPORT PARTNER -- QUALIFICATIONS AND REQUIREMENTS.

An individual must meet the following requirements to provide supervision to a peer support specialist or family support partner. ( )

01. Bachelor's Degree or Higher. ~~In order t~~To supervise a peer support specialist or family support partner, an individual ~~must~~ holds a bachelor's degree or higher in a human services field. ~~(3-17-22)~~( )

02. Supervisory Position. An individual ~~must be~~is in a supervisory position and works in that capacity within the agency. ~~(3-17-22)~~( )

401. -- 499. (RESERVED)

500. COMPLAINTS.

A complaint is an informal process to address the concerns of an individual. Any individual may file a written complaint or concern with the Department regarding a certified peer support specialist~~,~~ or certified family support

partner~~, or a behavioral health program~~. ~~(3-17-22)~~( )

01. Complaint Content. A complaint must include: ( )

a. The full name, mailing address, phone number, and email contact for the person reporting the complaint; ( )

b. A description of the nature of the complaint, including the desired outcome. ( )

02. Department Response~~ to Complaint~~. The Department will respond to the complaint within thirty (30) days of receipt of the complaint. This process may include gathering additional information from involved parties, including the complainant. ~~(3-17-22)~~( )

501. -- 509. (RESERVED)

510. GRIEVANCES.

A grievance is a type of complaint about the certification decision that has been made following application to the Department. When an applicant is denied certification, questions the results of the application review process, or is subject to an action that they deem unjustified, the applicant may submit a written grievance to the Department. ( )

01. Grievance Content. The grievance must include: ( )

a. The full name, mailing address, phone number, and email contact for the person reporting the grievance; and ( )

b. A detailed explanation of the decision that is being contested, from the perspective of the complainant, including any steps already taken to resolve the issue. ( )

02. Department Response~~ to Grievance~~. The Department will respond within sixty (60) days of receipt of the grievance. This process may include gathering additional information from involved parties. ~~(3-17-22)~~( )

511. -- 519. (RESERVED)

520. DENIAL, REVOCATION, OR SUSPENSION OF CERTIFICATION.

The Department may deny, suspend, or revoke an individual's application, certification, or ~~re~~certification renewal as a peer support specialist or family support partner for noncompliance with these rules. ~~(3-17-22)~~( )

521. -- 524. (RESERVED)

525. IMMEDIATE DENIAL, REVOCATION, OR SUSPENSION.

The Department may deny, revoke, or suspend a certification or ~~re~~certification renewal, without prior notice, when conditions exist that endanger the health and safety of any participant. ~~(3-17-22)~~( )

526. -- 529. (RESERVED)

530. REASONS FOR DENIAL, REVOCATION, OR SUSPENSION.

An individual may have a certification denied, revoked, or suspended for any ~~one (1)~~ of the following reasons~~ listed below~~. ~~(3-17-22)~~( )

01. Failure to Comply with These Rules and the Code of Ethics. ~~Failure to comply with these rules and the code of ethics described in Sections 250 and 350 of these rules.~~ ~~(3-17-22)~~( )

02. Failure to Provide Information Requested by the Depart,ent. ~~Failure to provide information requested by the Department.~~ ~~(3-17-22)~~( )

~~**03.** **Failure to Perform**. Inadequate knowledge or performance that is demonstrated by repeated substandard peer or quality assurance reviews. (3-17-22)~~

04~~4~~3. **Misrepresentation of Information~~ Provided~~**. Misrepresentation by the applicant in an application, or in documents required by the Department for certification. ~~(3-17-22)~~( )

0~~5~~4. **Conflict of Interest**. Conflict of interest in which a certified individual exploits their position as a Certified Peer Support Specialist or a Certified Family Support Partner for personal benefit. ( )

0~~6~~5. **Negligent Performance or Fraud**. A criminal, civil, or administrative determination that a certified individual has committed fraud or gross negligence in their capacity as a Certified Peer Support Specialist or Certified Family Support Partner. ( )

0~~7~~6. **Failure to Correct**. Failure to correct within thirty (30) days of written notice, any unacceptable conduct, practice, or condition as determined by the Department. ( )

531. -- 534. (RESERVED)

535. APPEAL OF DEPARTMENT DECISION.

An applicant or certificate holder may appeal a Department decision to deny, suspend, or revoke a certification ~~according to~~under IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings." ~~(3-17-22)~~( )

536. -- 539. (RESERVED)

540. REAPPLICATION FOR CERTIFICATION.

Following a denial, suspension, or revocation of certification or ~~re~~certification renewal, the same applicant may not reapply for certification for a period of six (6) months after the effective date of the action. Applicants reapplying after a suspension or revocation adhere to the same continuing education and ethics requirements under Section 112 of these rules. ~~(3-17-22)~~( )

541. -- 999. (RESERVED)

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.07.25 – PREVENTION OF MINORS' ACCESS TO TOBACCO OR ELECTRONIC SMOKING DEVICE PRODUCTS

DOCKET NO. 16-0725-2301 (ZBR CHAPTER REWRITE)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2024 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. The pending rule will become final and effective upon the adjournment, *sine die*, of the second Regular Session of the Sixty-seventh Idaho Legislature after approval.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 39-5704, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

Under Executive Order 2020-01: Zero-Based Regulation, the Department is striving to prevent the accumulation of costly, ineffective, and outdated regulations and reduce regulatory burden to achieve a more efficient operation of government. The rule changes are intended to perform a comprehensive review of this chapter by collaborating with the public to streamline or simplify this rule language. The title of this IDAPA chapter is changing from "Prevention of Minors' Access to Tobacco Products" to "Prevention of Minors' Access to Tobacco or Electronic Smoking Device Products."

There are no changes to the pending rule and it is being adopted as originally proposed. The complete text of the proposed rule was published in the August 2, 2023, Idaho Administrative Bulletin, Vol. 23-8, pages 142 through 152.

FEE SUMMARY: Pursuant to Section 67-5224(2)(d), Idaho Code, this pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature. The following is a description of the fee or charge imposed or increased in this rulemaking: Not Applicable.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state General Fund greater than ten thousand dollars ($10,000) during the fiscal year:

This rulemaking is not anticipated to have any fiscal impact on the state funds, the General Fund, or any other known funds.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Treena Clark at 208-334-6611.

DATED this 9th day of November, 2023.

Trinette Middlebrook and Frank Powell
DHW – Administrative Rules Unit
450 W. State Street – 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
phone: (208) 334-5500
fax: (208) 334-6558
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THE FOLLOWING NOTICE PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 39-5704, Idaho Code.

PUBLIC HEARING SCHEDULE: A public hearing concerning this rulemaking will be held as follows:

VIRTUAL Public Hearing via WebEx
Thursday, August 17, 2023 **1:00 p.m. to 2:00 p.m. (MT)**
Join from the meeting link: **https://idhw.webex.com/idhw/j.php?MTID=mdaa511429fd71130a544f088517221da** **Join by meeting number:** **Meeting number (access code): 2763 435 3346** **Meeting password: 7pfHxVaNx66 (77349826 from phones and video systems)** **Join by phone** **+1-415-527-5035 United States Toll** **+1-303-498-7536 United States Toll (Denver)**

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below. Meeting(s) will conclude after 30 minutes if no participants sign in or wish to comment in the meeting.

DESCRIPTIVE SUMMARY: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

Under Executive Order 2020-01: Zero-Based Regulation, the Department is striving to prevent the accumulation of costly, ineffective, and outdated regulations and reduce regulatory burden to achieve a more efficient operation of government. The rule changes are intended to perform a comprehensive review of this chapter by collaborating with the public to streamline or simplify this rule language.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: There are no fees in this chapter of rules.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the State General Fund greater than ten thousand dollars ($10,000) during the fiscal year as a result of this rulemaking:

This rulemaking is not anticipated to have any fiscal impact on the State General Fund, or any other known funds.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(1), Idaho Code, negotiated rulemaking was conducted. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the March 1, 2023, Idaho Administrative Bulletin, Vol. 23-3, pages 24-25.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into this rule: There are no incorporations by reference in this chapter of rules.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Treena Clark at 208-334-6611.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before August 23, 2023.

DATED this 6th day of July, 2023.

THE FOLLOWING IS THE TEXT OF ZBR DOCKET NO. 16-0725-2301

16.07.25 – PREVENTION OF MINORS' ACCESS TO TOBACCO OR ELECTRONIC SMOKING DEVICE PRODUCTS

000. LEGAL AUTHORITY.
Section 39-5704, Idaho Code, authorizes the Department to promulgate rules regarding permitting of tobacco product or electronic smoking device retailers, inspections, and compliance checks, training program, and employment practices. ( )

001. -- 009. (RESERVED)

010. DEFINITIONS.
In addition to the definitions under Section 39-5702, Idaho Code, the following definitions apply: ( )

01. Business. Any company, partnership, firm, sole proprietorship, association, corporation, organization, or other legal entity, or a representative of the foregoing entities that sells or distributes tobacco or electronic smoking device products. Wholesalers' or manufacturers' representatives in the course of their employment are not included in these rules. ( )

02. Delivery Sale. The distribution of tobacco or electronic smoking device products to a consumer in a state where either: ( )

a. The individual submits the order for a purchase of tobacco or electronic smoking device products by a telephone call or other voice transmission method, data transfer via computer networks, including the internet and other online services or by use of a facsimile machine transmission or use of the mails; or ( )

b. When tobacco or electronic smoking device products are delivered by use of the mails or a delivery service. ( )

03. Delivery Service. Any person who is engaged in the commercial delivery of letters, packages, or other containers. This includes permittees who take an order for tobacco or electronic smoking device products and then deliver the tobacco or electronic smoking device products without using a third-party delivery service. ( )

04. Department. The Idaho Department of Health and Welfare, or its representative. ( )

05. Direct Sale. Any face to face, or in person sale, of a tobacco or electronic smoking device product by a permittee, or their employee, to an individual. ( )

06. Location. The street address and building in which the tobacco or electronic smoking device products are sold, or the uniform resource locator (URL) for retailers who sell tobacco or electronic smoking device products exclusively via the internet. ( )

07. Minor. A person under twenty-one (21) years old. ( )

08. Permit Endorsement. An endorsement identifies a sale or delivery method used by a permittee to sell tobacco or electronic smoking device products. There are three (3) types of endorsements that may be included on a permit. The three (3) endorsement types are: ( )

a. Delivery Sales; ( )

b. Delivery Service; and ( )

c. Direct Sales. ( )

09. Photographic Identification. In all cases, the identification bears a photograph and a date of birth. Verification is not required by these rules if the buyer is known to the seller to be age twenty-one (21) or older. Types of identification include: ( )

a. State, district, territorial, possession, provincial, national, or other equivalent government driver's license; or ( )

b. State identification card or military identification card; or ( )

c. A valid passport. ( )

10. Purchaser. An individual who seeks to buy or who buys a tobacco product or electronic smoking device. ( )

11. Random Unannounced Inspection. An inspection of business by a law enforcement agency or by the Department, with or without the assistance of a minor, to monitor compliance with these rules. ( )

a. Random. At any time, without a schedule or frequency. ( )

b. Unannounced. Without previous notification. ( )

12. Retail Sales Minor-Exempt Permit. A permit that is issued to retail locations whose revenues from the sale of alcoholic beverages for on-site consumption are at least fifty-five percent (55%) of total revenues, or whose products and services are primarily obscene, pornographic, profane, or sexually oriented. A permittee issued this type of permit is exempt from minor-assisted inspections where minors are not allowed on the premises and such prohibition is clearly posted at all entrances. ( )

13. Tobacco or Electronic Smoking Device Product. Any substance that contains is made of, or is derived from tobacco or nicotine including devices and device components used to consume these products, as outlined under Section 39-5702(13), Idaho Code. ( )

14. Vendor Assisted Sales. Any sale or distribution in which the customer has no access to the product except through the assistance of the seller. The seller physically dispenses the tobacco or electronic smoking device product to the purchaser. ( )

15. Violation. An action contrary to Title 39, Chapter 57, Idaho Code, or IDAPA 16.07.25, "Prevention of Minors' Access to Tobacco or Electronic Smoking Device Products." ( )

011. -- 019. (RESERVED)

020. APPLICATION FOR PERMIT.

All businesses that sell or distribute tobacco or electronic smoking device products to the public must obtain a permit issued annually by the Department. ( )

01. Where to Obtain an Application for Permit. A hard-copy application can be obtained, at no cost to the applicant, from the Department at PO Box 83720, Boise, Idaho 83720-0036. A permit may also be obtained, at no cost to the applicant, via the internet at http://www.tobaccopermits.com/Idaho. ( )

02. Permits. A separate permit must be obtained for each business location. The permit is non-transferable to another person, business, or location. The applicant selects endorsements for each method of sale or delivery it uses. If a place of business sells or distributes tobacco or electronic smoking device by more than one (1) method, it selects an endorsement for each type. ( )

a. Issuance of a Permit. A permit is issued when a new tobacco or electronic smoking device retail outlet has been established, when a currently permitted business is sold to new owners, or when a currently permitted business is moved to a different physical location. Permits are issued to tobacco or electronic smoking device retailers established in a permanent location. Permits may not be issued for a retailer doing business in a temporary location. ( )

b. Closure of a Permit. A permit is closed when the permittee closes the business, no longer sells tobacco or electronic smoking device products, moves to a different physical location, or sells the business. ( )

c. Revocation of a Permit. A permit is revoked by the Department when: ( )

i. It is determined a new permit was fraudulently obtained to avoid penalties accrued on an existing permit; or ( )

ii. The holder of a permit, suspended under Section 39-5708(5), has failed to provide evidence of a training to the Department that complies with Subsection 021.04 of these rules. ( )

d. Temporary Permits. Are not allowed.This includes permits for temporary markets, community events, fairs, tasting events, and mobile businesses. ( )

e. Expiration of a Permit. All permits expire annually at midnight on December 31 of each calendar year. ( )

03. Renewal of Permit. All permits must be renewed annually and are valid only for that calendar year. ( )

a. The Department will mail notices of renewal for permits no later than ninety (90) days prior to the expiration date on the permit. ( )

b. Applications for renewal must be submitted annually for each business location through written application or online services, where available. ( )

c. A business with multiple locations may submit a single written application to renew the permit at each site, so long as the application is accompanied by a list of business permit numbers, locations, and addresses. ( )

d. A permit will not be renewed for any location until any past due fines for violations are paid in full. Fines are considered past due when not paid within ten (10) days of the citation date, or within ten (10) days after notification that the fine is upheld upon appeal, whichever is later. Violation fines under appeal are not considered past due. ( )

04. Application for Exemption. Businesses seeking exemption from vendor assisted sales must submit information to the Department to establish compliance with the following criteria: ( )

a. Tobacco or electronic smoking device products comprise at least seventy-five percent (75%) of total merchandise as determined by sales reported to the Idaho State Tax Commission; ( )

b. Minors are not allowed in exempt businesses and there is a sign on all entrances prohibiting minors; and ( )

c. There is a separate entrance to the outside air or to a common area not under shared ownership by the exempt business. ( )

021. PERMITTEE RESPONSIBILITIES.

The permittee must comply with the following: ( )

01. Possession of Permit. Each business location has a permit. ( )

02. Visibility. The permit is available upon request at each site. ( )

03. Display of Sign. Each business displays, at each business site, a sign that states: "State Law Prohibits the Sale of Tobacco or Electronic Smoking Device Products to Persons Under the Age of twenty-one (21) Years. Proof of Age Required. Anyone Who Sells or Distributes Tobacco or Electronic Smoking Device to a Minor is Subject to Strict Fines and Penalties. Minors are Subject to Fines and Penalties." ( )

04. Training Program. Each permittee is responsible to train employees responsible for the sale or distribution of tobacco or electronic smoking device products under Title 39, Chapter 57, Idaho Code, and these rules. Training must cover the provisions of the law regarding minors' access to tobacco or electronic smoking device products, and, at a minimum, include the following elements: ( )

a. Understanding that state law prohibits the sale of any tobacco or electronic smoking device products to anyone under twenty-one (21) years old, that photo identification verification of age is required for any persons not personally known to be at least twenty-one (21) years old to the seller, and that anyone who sells to someone under twenty-one (21) years old will be fined one hundred dollars ($100) per offense. ( )

b. Understanding of the definitions of "tobacco or electronic smoking device" products as defined under Section 39-5702(13), Idaho Code. ( )

c. Understanding that random inspections will be conducted to ensure compliance with Section 39-5701 et. seq., Idaho Code. ( )

d. All sales must be vendor-assisted unless the store is exempt from the vendor-assisted requirement. ( )

e. Products must be sold in their original sealed packaging from the manufacturer. ( )

f. Employee is given a copy of, and has reviewed, Section 39-5701 et. seq., Idaho Code, and these rules. ( )

g. Permittee retains a form signed by that employee on file stating that the employee understands the tobacco product or electronic smoking device laws dealing with minors and the consequences of an unlawful purchase of tobacco products or electronic smoking devices. ( )

05. Permit Requirements. All permittees are required to be familiar with and comply with the requirements of Title 39, Chapter 57, Idaho Code, as that act pertains to the permittee's sales of tobacco or electronic smoking device products. ( )

022. DELIVERY SALE ADDITIONAL REQUIREMENTS.

In addition to the requirements of Title 39, Chapter 57, Idaho Code, all permittees holding a Delivery Sale Endorsement, who mail or ship tobacco or electronic smoking device products must imprint in clearly legible text the words: "TOBACCO OR ELECTRONIC SMOKING DEVICE PRODUCT, MUST BE 21 YEARS OF AGE TO ACCEPT" on the shipping package. ( )

023. -- 050. (RESERVED)

051. CIVIL PENALTIES FOR VIOLATION OF PERMIT.
Civil penalties for violation of a permit are addressed under Section 39-5708, Idaho Code. ( )

01. Violations by the Seller. ( )

a. The seller will receive a one hundred dollar ($100) fine for each violation of these rules. ( )

b. Each violation will be recorded with the Department and may be accessed by potential employers upon the written consent of the seller as a portion of the training permit documentation. ( )

02. Violations by the Permittee. ( )

a. The permittee may provide evidence of training to the Department as a mitigating factor of a violation. Such evidence must be submitted to the Department within ten (10) business days from the date of the violation. ( )

b. When a permit is suspended, the Department will set the beginning date of the suspension. The permittee's training and employment practices will be considered as a mitigating factor in determining the length of the permit suspension. ( )

03. All Fine Payments. Must be received by the Department within ten (10) days of the date of the citation. Fine payments are to be paid online or mailed tothe Department address in the citation letter. ( )

052. CRIMINAL PENALTIES.

01. Selling or Distributing Without a Permit. Criminal penalties apply to any business or individual(s) who sells or distributes tobacco or electronic smoking device products to the public without a permit. ( )

02. Department Notified of Violation. If the Department is notified of a violation of Section 39-5709 et seq., Idaho Code, the Department will contact the appropriate law enforcement authority. ( )

053. -- 100. (RESERVED)

101. INSPECTIONS.

01. Random and Unannounced Inspections. The total number of random and unannounced inspections under this rule will be determined by: ( )

a. The number of permittees on the last day of each calendar year multiplied by the percentage of violations for the preceding year multiplied by a factor of ten (10). ( )

b. In no instance will the total number of inspections be less than the number of permittees, or exceed twice the number of permittees. ( )

c. The Department and the Idaho State Police will conduct at least one (1) unannounced inspection per year at every known business location identified as a retailer of tobacco or electronic smoking device products to the public. All additional inspections required to meet the total number specified under Section 101 of this rule will be conducted in a random manner. ( )

02. Law Enforcement Agency Inspections. ( )

a. In addition to the inspections under Subsection 101.01 of this rule, any law enforcement agency may conduct inspections consistent with agency policy and procedure with or without a minor at any business location, at any time, where tobacco or electronic smoking device products are sold or distributed to the public. ( )

b. Law enforcement agencies conducting inspections under Subsection 101.02.a. of this rule will report the results from their inspections to the Department. All citations will become part of the permittee's permanent record. ( )

03. Complaint Investigation. ( )

a. The Department will refer all written complaints concerning the sale of tobacco or electronic smoking device products to minors to the appropriate agency, as determined by the Department, for investigation. ( )

b. Inspections conducted as part of the investigation of a written complaint are not included in the overall number of inspections identified under Subsections 101.01 and 101.02 of this rule. Citations issued during the investigation of a written complaint will be added to the permittee's permanent record. ( )

04. Issuance of Citation or Report. For inspections conducted under Subsection 101.01 of this rule, a representative of the business will be provided with a report, within two (2) business days, after the inspection. The date the Department provides notification of the citation will be used for determination of timely payment of fines and all other administrative actions including requests for waivers and request for appeals. ( )

102. -- 999. (RESERVED)

[Agency redlined courtesy copy]

16.07.25 – PREVENTION OF MINORS' ACCESS TO TOBACCO OR ELECTRONIC SMOKING DEVICE PRODUCTS

000. LEGAL AUTHORITY.
~~Under~~ Section 39-5704, Idaho Code, authorizes the Department ~~of Health and Welfare is authorized~~ to promulgate rules ~~in compliance with Title 39, Chapter 57 for the prevention of minors' access to tobacco products~~ regarding permitting of tobacco product or electronic smoking device retailers, inspections, and compliance checks, training program, and employment practices. ~~(3-17-22)~~( )

~~**001. TITLE AND SCOPE.**~~

~~**01. Title**. These rules are titled IDAPA 16.07.25, "Prevention of Minors' Access to Tobacco Products." (3-17-22)~~

~~**02. Scope**. This rule implements provisions of Section 39-5701 et seq., Idaho Code. The Code defines the following: (3-17-22)~~

~~**a.** Possession, distribution, or use of tobacco products by a minor; (3-17-22)~~

~~**b.** Permit process for tobacco product retailers; (3-17-22)~~

~~**c.** Sale or distribution of tobacco products to a minor; (3-17-22)~~

~~**d.** Vendor-assisted sales; (3-17-22)~~

~~**e.** Opened packages and samples; (3-17-22)~~

~~**f.** Civil and criminal penalties for sales violations; and (3-17-22)~~

~~**g.** Conduct of enforcement actions. (3-17-22)~~

00~~2~~1. -- 009. (RESERVED)

010. DEFINITIONS.

~~The terms used in this rule are defined as~~In addition to the definitions under Section 39-5702, Idaho Code, the follow~~s~~ing definitions apply: ~~(3-17-22)~~(   )

01. Business. Any company, partnership, firm, sole proprietorship, association, corporation, organization, or other legal entity, or a representative of the foregoing entities that sells or distributes tobacco or electronic smoking device products. Wholesalers' or manufacturers' representatives in the course of their employment are not included in ~~the scope of~~ these rules. ~~(3-17-22)~~(   )

02. Delivery Sale. The distribution of tobacco or electronic smoking device products to a consumer in a state where either: ~~(3-17-22)~~(   )

a. The individual submits the order for a purchase of tobacco or electronic smoking device products by a telephone call or other voice transmission method~~;~~, data transfer via computer networks, including the internet and other online services~~;~~v or by use of a facsimile machine transmission or use of the mails; or ~~(3-17-22)~~(   )

b. When tobacco or electronic smoking device products are delivered by use of the mails or a delivery service. ~~(3-17-22)~~(   )

03. Delivery Service. Any person who is engaged in the commercial delivery of letters, packages, or other containers. This includes permittees who take an order for tobacco or electronic smoking device products and then deliver the tobacco or electronic smoking device products without using a third-party delivery service. ~~(3-17-22)~~(   )

04. Department. The Idaho Department of Health and Welfare, ~~(DHW)~~ or its ~~duly authorized representative~~representative. ~~(3-17-22)~~(   )

05. Direct Sale. Any face to face, or in person sale, of a tobacco or electronic smoking device product by a permittee, or their employee, to an individual. ~~(3-17-22)~~(   )

~~**06. Distribute**. To give, deliver, sell, offer to give, offer to deliver, offer to sell, or cause any person to do the same or hire any person to do the same. (3-17-22)~~

~~**07. Effective Training**. Training must include, at a minimum, the provisions of the law regarding minors' access to tobacco products as indicated on the suggested Employee Training form that is included with the permit provided by the Department and found in Appendix A of these rules. Such training will be presumed effective for purposes of civil penalty actions in the first, second, and third violations within a two (2) year period. (3-17-22)~~

~~**08. Evidence of Effective Training**. Documentation provided by a permittee in response to a violation of this chapter clearly identifying that the permittee had a training program meeting the definition for effective training in place at the time of the violation and had on file a form signed by the employee prior to the violation stating understanding of the tobacco laws dealing with minors and the unlawful purchase of tobacco. (3-17-22)~~

0~~9~~6. Location. The street address and building in which the tobacco or electronic smoking device

products are sold, or the uniform resource locator (URL) for retailers who sell tobacco or electronic smoking device products exclusively via the internet. ~~(3-17-22)~~( )

~~1~~07. **Minor**. A person under ~~eighteen~~twenty-one (~~18~~21) years ~~of age~~old. ~~(3-17-22)~~( )

~~11.~~ ~~**Permit**. A permit issued by the Department for the sale or distribution of tobacco products.~~ ~~(3-17-22)~~

~~12~~08. **Permit Endorsement**. An endorsement identifies a sale or delivery method used by a permittee to sell tobacco or electronic smoking device products. There are three (3) types of endorsements that may be included on a permit. The three (3) endorsement types are: ~~(3-17-22)~~( )

a. Delivery Sales; ( )

b. Delivery Service; and ( )

c. Direct Sales. ( )

~~13.~~ ~~**Permittee**. The holder of a valid permit for the sale or distribution of tobacco products.~~ ~~(3-17-22)~~

~~14~~09. **Photographic Identification**. In all cases, the identification ~~must~~ bears a photograph and a date of birth. Verification is not required by these rules if the buyer is known to the seller to be age ~~eighteen~~twenty-one (~~18~~21) or older. Types of identification include: ~~(3-17-22)~~( )

a. State, district, territorial, possession, provincial, national, or other equivalent government driver's license; or ( )

b. State identification card or military identification card; or ( )

c. A valid passport. ( )

1~~5~~0. **Purchaser**. An individual who seeks to buy or who buys a tobacco product or electronic smoking device. ~~(3-17-22)~~( )

1~~6~~1. **Random Unannounced Inspection**. An inspection of business by a law enforcement agency or by the Department, with or without the assistance of a minor, to monitor compliance ~~of this chapter~~with these rules. ~~(3-17-22)~~( )

a. Random. At any time, without a schedule or frequency. ( )

b. Unannounced. Without previous notification. ( )

1~~7~~2. **Retail Sales Minor-Exempt Permit**. A permit that is issued to retail locations whose revenues from the sale of alcoholic beverages for on-site consumption are at least fifty-five percent (55%) of total revenues, or whose products and services are primarily obscene, pornographic, profane, or sexually oriented. A permittee issued this type of permit is exempt from minor-assisted inspections where minors are not allowed on the premises and such prohibition is clearly posted at all entrances. ( )

~~18.~~ ~~**Seller**. The person who physically sells or distributes tobacco products.~~ ~~(3-17-22)~~

1~~9~~3. **Tobacco or Electronic Smoking Device Product**. Any substance that contains is made of, or is derived from tobacco or nicotine including devices and device components used to consume these products, as outlined under Section 39-5702(13), Idaho Code~~:~~. ~~(3-17-22)~~( )

~~a.~~ ~~Cigarettes;~~ ~~(3-17-22)~~

~~b.~~ ~~Cigars;~~ ~~(3-17-22)~~

~~**c.** Pipes; (3-17-22)~~

~~**d.** Snuff; (3-17-22)~~

~~**e.** Smoking Tobacco; (3-17-22)~~

~~**f.** Tobacco Paper; and (3-17-22)~~

~~**g.** Smokeless Tobacco. (3-17-22)~~

~~**20.** **Vending Machine**. Any mechanical, electronic, or other similar device which, upon the insertion of tokens, money, or any other form of payment, dispenses tobacco products. (3-17-22)~~

~~21~~14. **Vendor Assisted Sales**. Any sale or distribution in which the customer has no access to the product except through the assistance of the seller. The seller ~~must~~ physically dispenses the tobacco or electronic smoking device product to the purchaser. ~~(3-17-22)~~( )

~~22~~15. **Violation**. An action contrary to Title 39, Chapter 57, Idaho Code, or IDAPA 16.07.25, "Prevention of Minors' Access to Tobacco or Electronic Smoking Device Products." ~~(3-17-22)~~( )

~~**23.** **Without a Permit**. A business that has failed to obtain a permit or a business whose permit is suspended or revoked. (3-17-22)~~

011. -- 019. (RESERVED)

020. APPLICATION FOR PERMIT.

All businesses that sell or distribute tobacco or electronic smoking device products to the public must obtain a permit issued annually by the Department~~ of Health and Welfare~~. ~~(3-17-22)~~( )

01. **Where to Obtain an Application for Permit**. A hard-copy application can be obtained, at no cost to the applicant, from the Department ~~of Health and Welfare, Division of Behavioral Health,~~at PO Box 83720, Boise, Idaho 83720-0036. A permit may also be obtained, at no cost to the applicant, via the internet at http://www.tobaccopermits.com/Idaho. ~~(3-17-22)~~( )

02. **Permits**. A separate permit must be obtained for each business location. The permit is non-transferable to another person, business, or location. The applicant ~~must request~~selects endorsements for each method of sale or delivery it uses. If a place of business sells or distributes tobacco or electronic smoking device by more than one (1) method, it ~~must have~~selects an endorsement for each type. ~~(3-17-22)~~( )

a. Issuance of a Permit. A permit ~~may be~~is issued when a new tobacco or electronic smoking device retail outlet has been established, when a currently permitted business is sold to new owners, or when a currently permitted business is moved to a different physical location. Permits ~~may be~~are issued to tobacco or electronic smoking device retailers established in a permanent location. Permits may not be issued for a retailer doing business in a temporary location. ~~(3-17-22)~~( )

b. Closure of a Permit. A permit ~~may be~~is closed when the permittee closes the business, no longer sells tobacco or electronic smoking device products, moves to a different physical location, or sells the business~~ to a new owner~~. ~~(3-17-22)~~( )

c. Revocation of a Permit. A permit ~~may be~~is revoked by the Department ~~of Health and Welfare~~ when: ~~(3-17-22)~~( )

i. It is determined a new permit was fraudulently obtained to avoid penalties accrued on an existing permit; or ( )

ii. The holder of a permit, suspended~~ as established in~~ under Section 39-5708(5), has failed to provide

~~an effective~~ evidence of a training ~~plan~~ to the Department that complies with Subsection 021.04 of these rules. ~~(3-17-22)~~(   )

d. Temporary Permits. ~~Temporary permits a~~Are not allowed ~~under 39-5704, Idaho Code~~.This includes permits for temporary markets, community events, fairs, tasting events, and mobile businesses. ~~(3-17-22)~~(   )

e. Expiration of a Permit. All permits expire annually at midnight on December 31 of each calendar year. (   )

03. Renewal of Permit. All permits must be renewed annually and are valid only for ~~twelve (12) calendar months~~that calendar year. ~~(3-17-22)~~(   )

a. The Department will mail notices of renewal for permits no later than ninety (90) days prior to the expiration date on the permit. (   )

b. A~~n~~ applications for renewal must be submitted annually for each business location through written application or online services, where available. ~~(3-17-22)~~(   )

c. A business with multiple locations may submit a single written application to renew the permit at each site, so long as the application is accompanied by a list of business permit numbers, locations, and addresses. (   )

d. A permit will not be renewed for any location until any past due fines for violations are paid in full. Fines are considered past due when not paid within ten (10) days of the citation date, or within ten (10) days after notification that the fine is upheld upon appeal, whichever is later. Violation fines under appeal are not considered past due. (   )

04. Application for Exemption. Businesses seeking exemption from vendor assisted sales must submit information to the Department to establish compliance with the following criteria: (   )

a. Tobacco or electronic smoking device products comprise at least seventy-five percent (75%) of total merchandise as determined by sales reported to the Idaho State Tax Commission; ~~(3-17-22)~~(   )

b. Minors are not allowed in exempt businesses and there is a sign on all entrances prohibiting minors; and (   )

c. There ~~must be~~is a separate entrance to the outside air or to a common area not under shared ownership by the exempt business. ~~(3-17-22)~~(   )

021. PERMITTEE RESPONSIBILITIES.
The permittee ~~is responsible for~~must comply with the following: ~~(3-17-22)~~(   )

01. Possession of Permit. Each business location ~~must have~~has a permit. ~~(3-17-22)~~(   )

02. Visibility. The permit ~~must be~~is available upon request at each site. ~~(3-17-22)~~(   )

03. Display of Sign. Each business ~~may~~ displays, at each business site, a sign that states: "State Law Prohibits the Sale of Tobacco or Electronic Smoking Device Products to Persons Under the Age of ~~Eighteen~~twenty-one (~~18~~21) Years. Proof of Age Required. Anyone Who Sells or Distributes Tobacco or Electronic Smoking Device to a Minor is Subject to Strict Fines and Penalties. Minors are Subject to Fines and Penalties." ~~(3-17-22)~~(   )

04. ~~Effective~~ Training Program. Each permittee is responsible to train employees ~~as to the requirements of~~ responsible for the sale or distribution of tobacco or electronic smoking device products under Title 39, Chapter 57, Idaho Code, and these rules. Training must cover the provisions of the law regarding minors' access to tobacco or electronic smoking device products, and, at a minimum, include the following elements: ~~(3-17-22)~~(   )

a. ~~Unless the permittee has its own training program as described in Subsection 021.04.b. of this rule, the employer must, at a minimum, read to the seller or prospective seller who may be responsible for sale or distribution of tobacco products, or assure the seller or prospective seller has read the information contained on the Employee Training form found in Appendix A of these rules and have them initial each statement, and sign and date the form indicating an understanding of the provisions of the law governing minors' access to tobacco products.~~Understanding that state law prohibits the sale of any tobacco or electronic smoking device products to anyone under twenty-one (21) years old, that photo identification verification of age is required for any persons not personally known to be at least twenty-one (21) years old to the seller, and that anyone who sells to someone under twenty-one (21) years old will be fined one hundred dollars ($100) per offense. ~~(3-17-22)~~( )

b. ~~Permittee may have their own training program, but it must contain all of the elements listed in the Employee Training form found in Appendix A of these rules. The seller or prospective seller who may be responsible for sale or distribution of tobacco products must affirm in writing their acknowledgment of such training.~~Understanding of the definitions of "tobacco or electronic smoking device" products as defined under Section 39-5702(13), Idaho Code. ~~(3-17-22)~~( )

c. Understanding that random inspections will be conducted to ensure compliance with Section 39-5701 et. seq., Idaho Code. ( )

d. All sales must be vendor-assisted unless the store is exempt from the vendor-assisted requirement. ( )

e. Products must be sold in their original sealed packaging from the manufacturer. ( )

f. Employee is given a copy of, and has reviewed, Section 39-5701 et. seq., Idaho Code, and these rules. ( )

g. Permittee retains a form signed by that employee on file stating that the employee understands the tobacco product or electronic smoking device laws dealing with minors and the consequences of an unlawful purchase of tobacco products or electronic smoking devices. ( )

05. Permit Requirements. All permittees are required to be familiar with and comply with the requirements of Title 39, Chapter 57, Idaho Code, as that act pertains to the permittee's sales of tobacco or electronic smoking device products. ~~(3-17-22)~~( )

022. DELIVERY SALE ADDITIONAL REQUIREMENTS.

In addition to the requirements of Title 39, Chapter 57, Idaho Code, all permittees holding a Delivery Sale Endorsement, who mail or ship tobacco or electronic smoking device products must ~~:~~ ~~(3-17-22)~~

~~**01.**~~ ~~**Shipping Package Requirements**. I~~imprint in clearly legible~~, black ink letters, that are no less than one (1) inch tall,~~text the words: "TOBACCO OR ELECTRONIC SMOKING DEVICE PRODUCT, MUST BE ~~18~~21 YEARS OF AGE TO ACCEPT" on the ~~exterior top and bottom of the~~ shipping package. ~~(3-17-22)~~( )

~~**02.**~~ ~~**Delivery Requirements**. Require that tobacco products only be delivered in a face-to-face delivery to the address on the original shipping label. The individual receiving the delivery must be verified to be at least eighteen (18) years of age and have the same address as on the original shipping label.~~ ~~(3-17-22)~~

023. -- 050. (RESERVED)

051. CIVIL PENALTIES FOR VIOLATION OF PERMIT.

Civil penalties for violation of a permit are addressed under Section 39-5708, Idaho Code. ( )

01. Violations by the Seller. ( )

a. The seller will receive a one hundred dollar ($100) fine for each violation of these rules. ~~(3-17-22)~~( )

b. Each violation will be recorded with the Department and may be accessed by potential employers upon the written consent of the seller as a portion of the training permit documentation. ( )

02. Violations by the Permittee. ( )

a. ~~First violation. The permittee will be notified in writing of the violation and penalties to be levied for further violations. No fine will be imposed.~~The permittee may provide evidence of training to the Department as a mitigating factor of a violation. Such evidence must be submitted to the Department within ten (10) business days from the date of the violation. ~~(3-17-22)~~( )

b. ~~Second violation in a two (2) year period.~~When a permit is suspended, the Department will set the beginning date of the suspension. The permittee's training and employment practices will be considered as a mitigating factor in determining the length of the permit suspension. ~~(3-17-22)~~( )

~~i. The permittee will be fined two hundred dollars ($200). (3-17-22)~~

~~ii. If the permittee provides evidence of effective training, provided to the seller prior to the second violation, within ten (10) business days from the date of violation, the Department will waive the fine. (3-17-22)~~

~~iii. The permittee will be notified in writing of the penalties to be levied for further violations. (3-17-22)~~

~~**c.** Third violation in a two (2) year period. (3-17-22)~~

~~i. The permittee will be fined two hundred dollars ($200). (3-17-22)~~

~~ii. The permit will be suspended for up to seven (7) days beginning upon a date set by the Department following the third violation. Evidence of effective employee training will be a mitigating factor in determining the length of the permit suspension. (3-17-22)~~

~~iii. The permittee must remove all tobacco products from public sight for the duration of the revocation of the permit. (3-17-22)~~

~~iv. If the violation is by an employee, at the same location, who was involved in any previous citation for violation, the permittee will be fined four hundred dollars ($400). (3-17-22)~~

~~**d.** Fourth or subsequent violation in a two (2) year period. (3-17-22)~~

~~i. The permittee will be fined four hundred dollars ($400). (3-17-22)~~

~~ii. The permit will be revoked until such time as the permittee demonstrates an effective training program to the Department, but in no case will the revocation be less than thirty (30) days. (3-17-22)~~

~~iii. The permittee must remove all tobacco products from public sight for the duration of the revocation of the permit. (3-17-22)~~

03. All Fine Payments~~**of Fines**~~. ~~All fine payments m~~Must be received by the Department within ten (10) days of the date of the citation. Fine payments ~~should~~are to be paid online or mailed to~~, Tobacco Project Office, 450 West State Street, 3rd Floor, Boise, ID 83720-0036~~the Department address in the citation letter. ~~(3-17-22)~~( )

052. CRIMINAL PENALTIES.

01. Selling or Distributing Without a Permit. Criminal penalties apply to any business or individual(s) who sells or distributes tobacco or electronic smoking device products to the public without a permit. ~~(3-17-22)~~( )

02. Department Notified of Violation. If the Department is notified of a violation of Section 39-5709 et seq., Idaho Code, the Department will contact the appropriate law enforcement authority. ( )

053. -- 100. (RESERVED)

101. INSPECTIONS.

01. Random and Unannounced Inspections. The total number of random and unannounced inspections under ~~Section 101 of~~ this rule will be determined by: ~~(3-17-22)~~( )

a. The number of permittees on the last day of each calendar year multiplied by the percentage of violations for the preceding year multiplied by a factor of ten (10).~~ A calculation checklist is provided under Appendix B;~~ ~~(3-17-22)~~( )

b. In no instance will the total number of inspections be less than the number of permittees, or exceed twice the number of permittees. ( )

c. The Department and the Idaho State Police ~~must~~will conduct at least one (1) unannounced inspection per year at every known business location identified as a retailer of tobacco or electronic smoking device products to the public. All additional inspections required to meet the total number specified under Section 101 of this rule ~~must~~will be conducted in a random manner. ~~(3-17-22)~~( )

~~**02. Who Will Inspect**. Inspections will be conducted for all minor-exempt permit locations by an adult enforcement officer. For all other permit locations, inspections will be conducted by an adult enforcement officer accompanied by a minor. (3-17-22)~~

0~~3~~2. Law Enforcement Agency Inspections. ( )

a. In addition to the inspections ~~set forth in~~under Subsection 101.01 of this rule, any law enforcement agency may conduct inspections consistent with agency policy and procedure with or without a minor at any business location, at any time, where tobacco or electronic smoking device products are sold or distributed to the public. ~~(3-17-22)~~( )

b. Law enforcement agencies conducting inspections under Subsection 101.0~~3~~2.a. of this rule will report the results from their inspections to the Department. All citations will become part of the permittee's permanent record. ~~(3-17-22)~~( )

0~~4~~3. Complaint Investigation. ( )

a. The Department ~~must~~will refer all written complaints concerning the sale of tobacco or electronic smoking device products to minors to the appropriate agency, as determined by the Department, for investigation. ~~(3-17-22)~~( )

b. Inspections conducted as part of the investigation of a written complaint are not included in the overall number of inspections identified under Subsections 101.01 and 101.0~~3~~2 of this rule. Citations issued during the investigation of a written complaint ~~must~~will be added to the permittee's permanent record. ~~(3-17-22)~~( )

0~~5~~4. Issuance of Citation or Report. For inspections conducted under Subsection 101.01 of this rule, a representative of the business will be provided with a report, within two (2) business days, after the inspection. The date the Department provides notification of the citation ~~must~~will be used for determination of timely payment of fines and all other administrative actions including requests for waivers and request for appeals. ~~(3-17-22)~~( )

102. -- 999. (RESERVED)

APPENDIX A
EMPLOYEE TRAINING FORM

The following may be used for training of employees to assure that they are aware of the current law regarding youth access to tobacco products in the state of Idaho. This would constitute "minimum" training required by the employer as indicated in Section 39-5701 et seq., Idaho Code.

Have the employee initial each section and sign at the bottom.

_____ I understand the state law prohibits the sale of ANY tobacco products to persons under 18 years of age and that verification of age is required for any sale of tobacco products.

_____ I understand that I am to ask for photo identification from any persons whom I do not personally know to be at least 18 years of age and verify their age before a sale of tobacco products.

_____ I understand that sales to anyone under the age of 18 can result in a personal fine to me of $100 for the first offense.

_____ I understand that "tobacco products" includes any substance that contains tobacco including, but not limited to, cigarettes, cigars, pipes, snuff, smoking tobacco, tobacco papers, or smokeless tobacco. (Section 39-5702 (13), Idaho Code)

_____ I understand that this store may be inspected at any time for compliance with the state law regarding "youth access to tobacco products."

_____ I understand that all sales must be "vendor assisted" unless the store in which I work has 75% of the total merchandise available for sale as tobacco products. This store is _____ is not _____ exempted from the vendor assisted requirement. (check one)

_____ I understand that cigarettes **must** be sold only in their original sealed package from the manufacturer. (Section 39-5707, Idaho Code)

_____ I have been given a copy of Section 39-5701 et seq., Idaho Code, and IDAPA 16.07.25, "Prevention of Minor's Access to Tobacco Products."

I have read and agree to these statements and have had all my questions answered regarding my responsibilities as a seller of tobacco products in the state of Idaho.

By signing this agreement, I consent to having a current or potential employer contact the Department of Health and Welfare to determine if I have received citations for violation Title 39, Chapter 57, Idaho Code.

______________________________	______________________________
Printed Name of Employee	Employee's Signature
______________________________	______________________________
Witnessed	Date

(3-17-22)

~~APPENDIX B~~
~~RANDOM AND UNANNOUNCED INSPECTION CHECKLIST~~

~~Inspection Year~~ _________

~~1.~~ ~~Overall Violation Rate for Prior Year (20__) (Percentage)______x__.____~~

~~2.~~ ~~Number of Permittees as of December 31, 20____:________________~~

~~3.~~ ~~Multiply the Overall Violation Rate for Prior Year by the Number of Permittees:~~ ____________

~~4.~~ ~~Multiply the results of Step 3 by 10:~~ _______________

~~5.~~ ~~The Result of Step 4 is the Total of Random and Unannounced Inspections:~~________________

~~(3-17-22)~~

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

16.07.39 – DESIGNATED EXAMINERS AND DISPOSITIONERS

DOCKET NO. 16-0739-2301

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo and Incorporation By Reference Synopsis (IBRS)

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2024 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. The pending rule will become final and effective upon the adjournment, *sine die*, of the Second Regular Session of the Sixty-seventh Idaho Legislature after approval.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Sections 16-2403, 66-317, 56-1003, and 56-1004, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

These changes are being initiated to align and comply with new statute changes from Senate Bill 1327 (2022). The consequences of this rulemaking not being approved will prevent designations as a Senior Designated Examiners and will result in the continued use of outdated regulations that increases the regulatory burden on behavioral health professionals in Idaho. The application and letter of designation for designated examiners and dispositioners will be updated as a result of this rulemaking being approved.

There are no changes to the pending rule and it is being adopted as originally proposed. The complete text of the proposed rule was published in the October 4, 2023, Idaho Administrative Bulletin, Vol. 23-10, pages 504 through 511.

FEE SUMMARY: Pursuant to Section 67-5224(2)(d), Idaho Code, this pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature. The following is a description of the fee or charge imposed or increased in this rulemaking: Does not apply to this rulemaking.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state General Fund greater than ten thousand dollars ($10,000) during the fiscal year:

This rulemaking is not anticipated to have any fiscal impact on state funds, including the General Fund, or any other known funds.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Treena Clark at 208-334-6611.

DATED this 30th of November, 2023.

Trinette Middlebrook and Frank Powell
DHW – Administrative Rules Unit
450 W. State Street – 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
phone: (208) 334-5500
fax: (208) 334-6558
e-mail: dhwrules@dhw.idaho.gov

THE FOLLOWING NOTICE PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 16-2403, 66-317, 56-1003, and 56-1004, Idaho Code.

PUBLIC HEARING SCHEDULE: Two Public hearings concerning this rulemaking will be held as follows:

VIRTUAL TELECONFERENCE Via WebEx
Monday, October 16, 2023 **10:00 a.m. - 11:00 a.m. (MT)**
Join from the meeting link: **https://idhw.webex.com/idhw/j.php?MTID=mdd58f7a4277a841d9ed6e81a1c9752c6** ***Join by meeting number:*** **Meeting number (access code): 2762 045 6415** **Meeting password: rPKHVAfB379 (77548232 from phones and video systems)** ***Join by phone:*** **+1-415-527-5035 United States Toll** **+1-303-498-7536 United States Toll (Denver)**

VIRTUAL TELECONFERENCE Via WebEx
Wednesday, October 18, 2023 **1:00 p.m. - 2:00 p.m. (MT)**
Join from the meeting link: **https://idhw.webex.com/idhw/j.php?MTID=m901e9a6f246ffa3be14ef1855c197049** ***Join by meeting number:*** **Meeting number (access code): 2760 391 9633** **Meeting password: VnEn734Xsuy (86367349 from phones and video systems)** ***Join by phone:*** **+1-415-527-5035 United States Toll** **+1-303-498-7536 United States Toll (Denver)**

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

These changes are being initiated to align and comply with new statute changes from Senate Bill 1327 (2022). The consequences of this rulemaking not being approved will prevent designations as a Senior Designated Examiners and will result in the continued use of outdated regulations that increases the regulatory burden on behavioral health professionals in Idaho. The application and letter of designation for designated examiners and dispositioners will be updated as a result of this rulemaking being approved.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased:

This chapter contains no fees or charges.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year as a result of this rulemaking:

There is no anticipated fiscal impact to the state general fund, and the Division of Behavioral Health will use dedicated funds already allocated.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because these changes are being done to comply with Senate Bill 1327 (2022).

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into this rule:

This rulemaking incorporates by reference the revised Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR), replacing the currently incorporated document, DSM-5. This document is incorporated by reference to save space in the chapter and ensure that it continues to have the force and effect of law.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Treena Clark at 208-334-6611.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 25, 2023.

DATED this 1st day of September, 2023.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0739-2301

~~**001. SCOPE.**~~
~~These rules set forth the qualifications, appointment requirements, appointment process, duration of appointment, revocation of appointment, and requirements for reappointment for designated examiners and designated dispositioners in Idaho.~~ ~~(3-17-22)~~

00~~2~~1. INCORPORATION BY REFERENCE.
American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5TR) Washington, DC, American Psychiatric Association, 20~~13~~22, is hereby incorporated by reference under this chapter of rules. Copies of the manual are available from the American Psychiatric Association, ~~1000 Wilson Boulevard~~ 800 Maine Avenue, Suite ~~1825~~ 900, ~~Arlington, VA~~ Washington DC ~~22209-3901~~ 20024. ~~A copy of the manual is also available for public review at the Department of Health and Welfare, 450 West State Street, Boise, Idaho, 83702.~~ ~~(3-17-22)~~(   )

00~~3~~2. -- 008. (RESERVED)

009. CRIMINAL HISTORY AND BACKGROUND CHECK REQUIREMENTS.
Each individual who is seeking appointment as a designated examiner, senior designated examiner, or designated dispositioner~~, or both,~~ must comply with the provisions in IDAPA 16.05.06, "Criminal History and Background Checks." An individual who is seeking appointment is available to practice as a designated examiner, senior designated examiner or designated dispositioner on a provisional basis at the discretion of the Department once the individual has completed the following: ~~(3-17-22)~~( )

01. ~~Submission Of Criminal History~~Background Check Application. An individual has submitted their ~~criminal history and~~ background check application; ~~(3-17-22)~~( )

02. Application Review. The completed application has been reviewed by the ~~Regional Behavioral Health Program~~ Hub Manager or the State Hospital Administrative Director of the region where the applicant intends to practice, and no disqualifying crimes or relevant records are disclosed on the application. ~~(3-17-22)~~( )

010. DEFINITIONS.
~~For the purposes of these rules, the following terms apply:~~ ~~(3-17-22)~~

01. Advanced Practice Registered Nurse. ~~An individual licensed as an Advanced Practice Registered Nurse~~ Licensed under Title 54, Chapter 14, Idaho Code. ~~(3-17-22)~~( )

02. Clinical Professional Counselor (LCPC). ~~An individual licensed as a Clinical Professional Counselor~~ Licensed under Title 54, Chapter 34, Idaho Code. ~~(3-17-22)~~( )

03. Clinical Social Worker (LCSW). ~~An individual licensed as a Clinical Social Worker~~ Licensed under Title 54, Chapter 32, Idaho Code. ~~(3-17-22)~~( )

04. Department. The Idaho Department of Health and Welfare or designee. ~~(3-17-22)~~( )

05. Designated Dispositioner. A ~~designated dispositioner is a~~ designated examiner ~~employed~~ under contract with the Department and designated by the Director. ~~(3-17-22)~~( )

06. Designated Examination. An evaluation by an appointed mental health professional to determine if an individual is mentally ill, and if the individual is either likely to injure themselves or others, or is gravely disabled due to mental illness. ~~(3-17-22)~~( )

07. Designated Examiner. A ~~designated examiner is a~~ psychiatrist, psychologist, psychiatric nurse, social worker, or such other mental health professional ~~as may be~~ designated under these rules. ~~(3-17-22)~~( )

08. Director. The Director of the ~~Idaho~~ Department ~~of Health and Welfare~~ or their designee. ~~(3-17-22)~~( )

09. Division. The Department's Division of Behavioral Health. (3-17-22)

10. Hub Manager. An individual responsible for and provides direction for the Division's adult and children's clinical mental health services in one (1) of the three (3) division hubs. Hubs are delineated by Department regions: Northern Idaho (Regions 1 and 2) Southwest Idaho (Regions 3 and 4) Eastern Idaho (Regions 5, 6, and 7). ( )

1~~0~~1. Marriage and Family Therapist (LMFT). ~~An individual licensed as a Marriage and Family Therapist~~ Licensed under Title 54, Chapter 34, Idaho Code. ~~(3-17-22)~~( )

1~~1~~2. Master~~s of~~ Social Worker (LMSW). ~~An individual licensed as a Masters of Social Work~~ Licensed under Title 54, Chapter 32, Idaho Code. ~~(3-17-22)~~( )

1~~2~~3. Physician. ~~An individual licensed as a Physician to practice medicine~~Licensed under Title 54, Chapter 18, Idaho Code. ~~(3-17-22)~~( )

1~~3~~4. Physician Assistant.~~ An individual licensed as a Physician Assistant~~ Licensed under Title 54, Chapter 18, Idaho Code. ~~(3-17-22)~~(____)

1~~4~~5. Professional Counselor (LPC).~~ An individual licensed as a Professional Counselor~~ Licensed under Title 54, Chapter 34, Idaho Code. ~~(3-17-22)~~(____)

1~~5~~6. Psychologist. An individual licensed to practice psychology in Idaho as defined under Title 54, Chapter 23, Idaho Code. ~~(3-17-22)~~(____)

011. -- 199. (RESERVED)

200. ~~MINIMUM~~ QUALIFICATIONS AND REQUIREMENTS FOR APPOINTMENT AS A DESIGNATED EXAMINER.

To be appointed and practice as a designated examiner~~ in Idaho~~, an applicant must meet the following~~ minimum qualifications and requirements~~: ~~(3-17-22)~~(____)

01. Required License. Each applicant maintains their professional licensure for the duration of their appointment and be one (1) of the following: (3-17-22)

a. Physician; (3-17-22)

b. Psychologist; (3-17-22)

c. Advanced Practice Registered Nurse; (3-17-22)

d. Clinical Professional Counselor; (3-17-22)

e. Professional Counselor; (3-17-22)

f. Clinical Social Worker; (3-17-22)

g. Masters Social Worker; (3-17-22)

h. Marriage and Family Therapist. (3-17-22)

i. Physician Assistant. (3-17-22)

j. Psychiatrist. (____)

k. Psychiatric Nurse. (____)

02. Required Experience and Abilities.~~ Each applicant meets the minimum requirements and qualifications listed below:~~ ~~(3-17-22)~~(____)

a. At least two (2) years of post-master's degree experience in a clinical mental health setting which includes: (3-17-22)

i. Assessment of the likelihood of danger to self or others, grave disability, capacity to give informed consent, and capacity to understand legal proceedings; (3-17-22)

ii. Use of DSM-5TR diagnostic criteria; ~~(3-17-22)~~(____)

iii. Treatment of mental health disorders including knowledge of treatment modalities and experience applying treatment modalities in a clinical setting; and (3-17-22)

iv. An understanding of the differences between behavior due to mental illness, which poses a substantial likelihood of serious harm to self or others, or which may result in grave disability from behavior which

does not represent such a threat or risk. ~~(3-17-22)~~(____)

b. Knowledge of and experience applying Idaho mental health law based on the required training outlined under Subsection 200.03 of this rule including: (3-17-22)

i. Experience that demonstrates understanding of the judicial process, including the conduct of commitment hearings. (3-17-22)

ii. Experience preparing reports for the court and testifying before a court of law. Experience includes demonstrating an ability to provide the court with a thorough and complete oral and written evaluation that addresses the standards and questions set forth in the law; and (3-17-22)

iii. Knowledge of a client's legal rights. (3-17-22)

03. Required Training. Completion of: (3-17-22)

a. A minimum of six (6) hours of training, provided by a Department-approved trainer, on the role of designated examiners and the processes used in fulfilling the responsibilities of designated examiners. (3-17-22)

b. A minimum of four (4) additional hours observing a designated examiner conducting a designated examination. (3-17-22)

201. MINIMUM QUALIFICATIONS AND REQUIREMENTS FOR APPOINTMENT AS A SENIOR DESIGNATED EXAMINER.
To be appointed and practice as a senior designated examiner, an applicant must meet the requirements of Section 66-317(17), Idaho Code, and Subsections 200.02 and 200.03 of these rules. (____)

20~~1~~2. -- 299. (RESERVED)

300. MINIMUM QUALIFICATIONS AND REQUIREMENTS FOR APPOINTMENT AS A DESIGNATED DISPOSITIONER.
To be appointed as a designated dispositioner ~~in Idaho~~, an applicant must meet the following ~~minimum qualifications and requirements~~. ~~(3-17-22)~~(____)

01. Appointment as a Designated Examiner. Applicants for designated dispositioner are also appointed as a designated examiner by the Director. (3-17-22)

02. Required Experience and Abilities. Each applicant has received training on the available treatment alternatives, types of treatment available for appropriate placement, and level of care requirements all within Idaho. (3-17-22)

301. -- 399. (RESERVED)

400. APPOINTMENT OR REAPPOINTMENT AS A DESIGNATED EXAMINER, SENIOR DESIGNATED EXAMINER OR DESIGNATED DISPOSITIONER.
Each applicant seeking an appointment or reappointment as a designated examiner or designated dispositioner, must submit the following information to the ~~Regional Behavioral Health Program Manager~~ Hub of the region where they intend to practice or the State Hospital Administrative Director of the hospital at which they intend to practice. ~~(3-17-22)~~(____)

01. Complete an Application. Each applicant completes and signs an application using forms approved by the Department. (3-17-22)

02. Provide Verification of Credentials. Each applicant provides the Department with the following: (3-17-22)

a. A current resume that documents: (3-17-22)

i. The applicant's degree, the date the degree was awarded, and the school from which the degree was received; and (3-17-22)

ii. How the applicant meets the requirements under ~~Subsection~~ Section 20~~0~~1~~.02~~ of these rules. ~~(3-17-22)~~(____)

b. ~~A copy of the applicant's license~~Documentation of current licensure. If the applicant is an LMSW, they must also provide ~~a copy~~ documentation of the supervision plan approved by the Board of Social Work Examiners; ~~(3-17-22)~~(____)

c. Evidence of completion of the required ten (10) hours of training within sixty (60) days prior to the date of application under Subsection 200.03 of these rules showing the date(s), place(s), number of hours of training, and the qualifications of the person(s) providing the training. Applicants seeking reappointment, prior to their current appointment expiring, are not required to provide evidence of training; ~~(3-17-22)~~(____)

d. Documentation of a ~~criminal history and~~ background check clearance completed within ninety (90) days of the date of the application. Department employees who have had continuous employment with the Department may use a previous background check clearance received through their Department employment ~~with the Department~~. ~~(3-17-22)~~(____)

03. Regional or Hospital Recommendation. (3-17-22)

a. To be eligible for consideration and appointment or reappointment as a designated examiner, senior designated examiner, or designated dispositioner, each applicant must receive a favorable recommendation from a ~~Regional Behavioral Health Program~~ Hub Manager or State Hospital Administrative Director. ~~(3-17-22)~~(____)

b. Within thirty (30) days of the receipt of a completed and signed application, the ~~Regional Behavioral Health Program~~ Hub Manager or the State Hospital Administrative Director of the region where they intend to practice will review the applicant's qualifications and, if satisfied, sign the application and forward it to the Division along with all the information provided by the applicant as required under Subsection 400.02 of this rule. ~~(3-17-22)~~(____)

c. Each ~~Regional Program~~ Hub Manager and State Hospital Administrative Director agrees to honor recommendations for appointments made by another ~~Regional Behavioral Health Program~~ Hub Manager or State Hospital Administrative Director. ~~(3-17-22)~~(____)

04. Final Decision on Appointment. (3-17-22)

a. Upon receiving a favorable recommendation under Subsection 400.03 of ~~these~~ this rule~~s~~, the Division will review each application for completeness and compliance with these rules. ~~(3-17-22)~~(____)

b. Upon completion of this review, the Division will make recommendations to the Director regarding appointments as designated examiner, senior designated examiner, or designated dispositioner. ~~(3-17-22)~~(____)

c. The Director has the authority to appoint applicants for designated examiner, senior designated examiner, or designated dispositioner who meet the requirements under these rules. ~~(3-17-22)~~(____)

d. The Division will notify each applicant in writing of the Department's decision within sixty (60) days of the date the application was received by the Division. (3-17-22)

05. Appointment. An appointed designated examiner, senior designated examiner, or designated dispositioner may practice in any region of the state or at any state hospital at the discretion of the ~~Regional Program~~ Hub Manager or State Hospital Administrative Director. ~~(3-17-22)~~(____)

06. Reappointment. (3-17-22)

a. The request for reappointment must be received by the Division at least sixty (60) days prior to the expiration date of the previous appointment of the designated examiner, senior designated examiner, or designated dispositioner. ~~(3-17-22)~~(____)

b. If a designated examiner, senior designated examiner, or designated dispositioner allows their appointment to expire, the applicant must follow appointment requirements under ~~Section 400 of~~ this rule. Department employees who have had continuous Department employment ~~with the Department may~~ have the reapplication process waived. ~~(3-17-22)~~(____)

401. -- 499. (RESERVED)

500. DURATION OF APPOINTMENT AS DESIGNATED EXAMINER, SENIOR DESIGNATED EXAMINER OR DESIGNATED DISPOSITIONER.

01. Appointment. ~~Appointment e~~Expires one (1) year from the date of appointment, unless the designated examiner, senior designated examiner, or designated dispositioner applies for, and is granted, a reappointment. ~~(3-17-22)~~(____)

02. Reappointment. ~~Reappointment e~~Expires two (2) years from the date of such appointment. ~~(3-17-22)~~(____)

03. Expiration of Appointment Upon Leaving Department Employment. When an individual serving as a designated dispositioner leaves ~~the employ of the~~ Department employment, their designation of dispositioner is suspended, until such time that the appointment expires, or the individual is under contract with the Department as a designated dispositioner. ~~(3-17-22)~~(____)

501. -- 699. (RESERVED)

700. REVOCATION OF APPOINTMENT AS DESIGNATED EXAMINER, SENIOR DESIGNATED EXAMINER OR DESIGNATED DISPOSITIONER.
The Department may deny, suspend, or revoke the appointment or reappointment of designated examiners, senior designated examiner, and designated dispositioners~~, or both,~~ under the following procedures: ~~(3-17-22)~~(____)

01. Emergency Denial, Suspension, Revocation of Appointment or Reappointment. The Department will deny, suspend, or revoke appointment or reappointment, without prior notice, when conditions exist that endanger the health or safety of any client. (3-17-22)

02. Written Request for Denial, Suspension, or Revocation of Appointment or Reappointment. In the absence of an emergency, a written request from the ~~Regional Behavioral Health Program~~ Hub Manager or State Hospital Administrative Director will be made to the Division stating the reason(s) for the requested denial, suspension, or revocation of an appointment or reappointment. ~~(3-17-22)~~(____)

03. Grounds for Revocation of Appointment or Reappointment. The Department may deny, suspend, or revoke an appointment or reappointment for any of the following reasons: (3-17-22)

a. Failure to comply with these rules. (3-17-22)

b. Failure to furnish data, information, or records as requested by the Department. (3-17-22)

c. Revocation or suspension of the applicant's professional license. (3-17-22)

d. Refusal to participate in a quality assurance process as requested by the Department. (3-17-22)

e. Inadequate knowledge or performance as demonstrated by repeated substandard peer or quality assurance reviews. (3-17-22)

f. Misrepresentation by the applicant in their application, or in documents required by the

Department, or by an appointee in which there is a criminal, civil, or administrative determination that they have misrepresented the facts or the law to the court or administrative agency. (3-17-22)

g. Conflict of interest in which an appointee exploits their position as a designated examiner, senior designated examiner, or designated dispositioner for personal benefit. ~~(3-17-22)~~( )

h. A criminal, civil, or administrative determination that an appointee has committed fraud or gross negligence in their capacity as a designated examiner, senior designated examiner. or designated dispositioner. ~~(3-17-22)~~( )

i. Substantiated disposition of a child protection referral or adult protection referral. (3-17-22)

j. Failure to correct within thirty (30) days of written notice, any unacceptable conduct, practice, or condition as determined by the Department to be detrimental to public health or safety. (3-17-22)

04. Appeal of Department Decision. Applicants may appeal a Department decision to deny, suspend, or revoke an appointment under IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings." (3-17-22)

05. Reapplication for Appointment. Following denial, suspension, or revocation of appointment or reappointment, the same appointee may not reapply for appointment for a period of one (1) year after the effective date of the action. (3-17-22)

IDAPA 24 – DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSES

24.06.01 – RULES FOR THE LICENSURE OF OCCUPATIONAL THERAPISTS AND OCCUPATIONAL THERAPY ASSISTANTS

DOCKET NO. 24-0601-2301 (ZBR CHAPTER REWRITE)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo and Cost/Benefit Analysis (CBA)

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2024 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. The pending rule will become final and effective upon the adjournment, *sine die*, of the Second Regular Session of the Sixty-seventh Idaho Legislature after approval.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section(s) 67-2604, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

Under Executive Order 2020-01, Zero-Based Regulation, the Occupational Therapy Licensure Board is striving to prevent the accumulation of costly, ineffective, and outdated regulations and reduce regulatory burden to achieve a more efficient operation of government.

There are no changes to the pending rule, and it is being adopted as originally proposed. The complete text of the proposed rule was published in the August 2, 2023, Idaho Administrative Bulletin, Vol. 23-8, pages 212-223.

FEE SUMMARY: The following is a description of the fee or charge imposed or increased in this rulemaking as authorized in Section 54-3712, Idaho Code. Pursuant to Section 67-5224(2)(d), Idaho Code, this pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature.

The fees for applications, licenses, registrations and reinstatement as designated in Rule 400 of these rules are authorized in Section 54-3712, Idaho Code. None of these fees are being changed as a result of this rulemaking or since they were previously reviewed by the Idaho Legislature.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year:

This rulemaking is not anticipated to have any negative fiscal impact on the State General Fund.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Katie Stuart, Bureau Chief, at 208-577-2489.

DATED this 1st day of November, 2023.

Katie Stuart
Bureau Chief
11341 W. Chinden Blvd., Bldg. #4
Boise, ID 83714
Phone: (208) 577-2489
Email: katie.stuart@dopl.idaho.gov

THE FOLLOWING NOTICE PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section 67-2604, Idaho Code, and Sections 54-3712, 54-3715, 54-3717, and 54-3720, Idaho Code.

PUBLIC HEARING SCHEDULE: A public hearing concerning this rulemaking will be held as follows:

Wednesday, August 23, 2023 – 1:30 p.m. MT

Division of Occupational and Professional Licenses
Chinden Campus Building 4
11341 W. Chinden Blvd., Bldg. #4
Boise, ID 83714

Telephone and web conferencing information will be posted on:
https://dopl.idaho.gov/calendar/ and https://townhall.idaho.gov/

The hearing site will be accessible to persons with disabilities, if needed. Requests for accommodation must be made not later than five (5) days prior to the meeting to the agency address below.

DESCRIPTIVE SUMMARY: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

Under Executive Order 2020-01, Zero-Based Regulation, the Occupational Therapy Licensure Board is striving to prevent the accumulation of costly, ineffective, and outdated regulations and reduce regulatory burden to achieve a more efficient operation of government. In conjunction with stakeholders, the proposed rule changes reflect a comprehensive review of this chapter by collaborating with the public to streamline or simplify the rule language in this chapter and to use plain language for better understanding. This proposed rulemaking updates the rules to comply with governing statute and Executive Order 2020-01.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased:

The fees for licenses, permits, and reinstatement as designated in Rule 400 of these proposed rules are authorized in Section 54-3712, Idaho Code. None of these fees are being changed as a result of this rulemaking or since being previously reviewed by the Idaho legislature.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the State General Fund greater than ten thousand dollars ($10,000) during the fiscal year as a result of this rulemaking:

This rulemaking is not anticipated to have any negative fiscal impact on the State General Fund.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was conducted under Docket No. 24-ZBRR-2301. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the April 5, 2023 Idaho Administrative Bulletin, Vol. 23-4, pp. 42-46.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into this rule: N/A.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Michael Hyde, Bureau Chief, at (208) 332-7133.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before August 23, 2023.

DATED this 6th day of July, 2023.

THE FOLLOWING IS THE TEXT OF ZBR DOCKET NO. 24-0601-2301

24.06.01 – RULES FOR THE LICENSURE OF OCCUPATIONAL THERAPISTS AND OCCUPATIONAL THERAPY ASSISTANTS

000. LEGAL AUTHORITY.
These rules are promulgated pursuant to Sections 54-3712, 54-3715, 54-3717, and 54-3720 Idaho Code. ( )

001. SCOPE.
These rules govern the practice of occupational therapy in Idaho. ( )

002. -- 099. (RESERVED)

100. LICENSURE.

01. Approved Education. An educational program in occupational therapy accredited by the American Occupational Therapy Association's Accreditation Council for Occupational Therapy Education (ACOTE), or by a predecessor or successor organization recognized by the United States Secretary of Education, the Council for Higher Education Accreditation, or both. ( )

02. Supervised Fieldwork. During the period of supervised fieldwork, students must be under daily in-person contact with an occupational therapist or occupational therapy assistant who is appropriately supervised by an occupational therapist. The occupational therapist is responsible for the overall use and actions of the student. ( )

03. Continuing Education. Occupational Therapists and Occupational Therapy Assistants must complete and maintain proof of completion of ten (10) hours of germane continuing education each year during the licensee's renewal cycle. Proof of completion must be provided to the board upon request and must include licensee's name, date of activity or when course was completed, provider name, course title, description of course/activity, and number of contact hours. ( )

101. -- 199. (RESERVED)

200. PRACTICE STANDARDS.

01. Scope of Practice. Occupational Therapists and Occupational Therapy Assistants must possess the education, training, and experience within their scope of practice to perform occupational therapy tasks. ( )

02. Supervision Requirements. Supervision is the direction and review of service delivery, treatment

plans, and treatment outcomes. Unless otherwise specified in this rule, in-person or synchronous interaction at least once a month is the minimum level of supervision that must be provided. Methods of supervision may include but are not limited to line-of-sight supervision with the supervisor's physical presence when services are being provided and/or in-person contact by the supervisor where services are being provided to ensure the safe and effective delivery of occupational therapy. ( )

a. Limited Permit Holders. Limited permit holders must be supervised by an occupational therapist. This requires daily in-person contact with the supervisor at the site where service is provided. ( )

b. Occupational Therapy Assistants. Occupational therapy assistants must be supervised by an occupational therapist at least once per month by no less than telecommunications. ( )

c. Occupational Therapy Aides. The occupational therapist or occupational therapy assistant must train the aide to perform client-related and non-client-related tasks at least once per month. Client-related tasks are routine tasks during which the aide may interact with the client but does not act as a primary service provider of occupational therapy services. Occupational therapists and occupational therapy assistants must document all training and supervision of an aide. ( )

i. The following factors must be present when an occupational therapist or occupational therapy assistant assigns a selected client-related task to the aide: The supervisor must be physically present when services are being provided to clients by the aide; the outcome of the assigned task must be predictable; the situation of the client and the environment must be stable and will not require the aide to make judgments, interpretations, or adaptations; and the routine and process of the task must have been clearly established. ( )

201. -- 299. (RESERVED)

300. DISCIPLINE.

01. Civil Penalty. The Board may impose a fine up to the amount of any economic advantage obtained through the violation. ( )

301. -- 399. (RESERVED)

400. FEES.

All fees are non-refundable.

FEE TYPE	AMOUNT (Not to Exceed)	RENEWAL FEE (Not to Exceed)
Initial Licensure for Occupational Therapists	$80	$40
Initial Licensure for Occupational Therapy Assistants	$60	$30
Limited Permit or Temporary License	$25	
Reinstatement Fee	As provided in Section 67-2614, Idaho Code.	

( )

401. -- 999. (RESERVED)

[Agency redlined courtesy copy]

24.06.01 – RULES FOR THE LICENSURE OF OCCUPATIONAL THERAPISTS AND OCCUPATIONAL THERAPY ASSISTANTS

000. LEGAL AUTHORITY.
These rules are promulgated pursuant to Sections 54-3712, 54-3715, 54-3717~~(2)~~, and 54-3720, Idaho Code.( )

001. SCOPE.
These rules govern the practice of occupational therapy in Idaho.( )

002. -- ~~009~~099.(RESERVED)

~~**010. DEFINITIONS.**~~

~~**01. Client-Related Tasks**. Client-related tasks are routine tasks during which the aide may interact with the client but does not act as a primary service provider of occupational therapy services.( )~~

~~**02. Direct Line-of-Sight Supervision**. Direct line-of-sight supervision requires the supervisor's physical presence when services are being provided to clients by the individual under supervision.( )~~

~~**03. Direct Supervision**. Direct supervision requires daily, in-person contact by the supervisor at the site where services are provided to clients by the individual under supervision.( )~~

~~**04. Evaluation**. Evaluation is the process of obtaining and interpreting data necessary for treatment, which includes, but is not limited to, planning for and documenting the review, specific observation, interviewing, and administering data collection procedures, which include, but are not limited to, the use of standardized tests, performance checklists, and activities and tasks designed to evaluate specific performance abilities.( )~~

~~**05. General Supervision**. General Supervision requires in-person or synchronous interaction at least once per month by an occupational therapist and contact by other means as needed. Other means of contact include, but are not limited to, electronic communications such as email.( )~~

~~**06. Routine Supervision**. Routine Supervision requires in-person or synchronous interaction at least once every two (2) weeks by an occupational therapist and contact by other means as needed. Other means of contact include, but are not limited to, electronic communications such as email.( )~~

200~~.0211~~.PRACTICE STANDARDS~~SUPERVISION~~.

~~An occupational therapist shall supervise and be responsible for the patient care given by occupational therapy assistants, limited permit holders, aides, and students. An occupational therapist's or occupational therapy assistant's failure to provide appropriate supervision in accordance with these rules is grounds for discipline.( )~~

01. Scope of Practice. Occupational Therapists and Occupational Therapy Assistants must possess the education, training, and experience within their scope of practice to perform occupational therapy tasks."

02~~1~~.b. Occupational Therapy Assistants. Occupational therapy assistants must be supervised by an occupational therapist, at least once per month by no less than telecommunications. ~~. General Supervision must be provided at a minimum.( )~~

02.a. Limited Permit Holders. Limited permit holders must be supervised by an occupational therapist or occupational therapy assistant. This requires daily in-person contact with the supervisor at the site where service is provided.~~. Direct supervision must be provided at a minimum. The occupational therapist is responsible for the overall use and actions of the limited permit holder.~~( )

02~~3~~.c. Occupational Therapy Aides. The occupational therapist or occupational therapy assistant must train the aide to perform client-related and non-client-related tasks at least once per month. Client-related tasks are routine tasks during which the aide may interact with the client but does not act as a primary service provider of occupational therapy services. Occupational therapists and occupational therapy assistants must document all training and supervision of an aide. ~~Occupational therapy aides do not provide skilled occupational therapy services. An aide must be trained by an occupational therapist or an occupational therapy assistant to perform specifically delegated tasks. The occupational therapist is responsible for the overall use and actions of the aide. The occupational therapist must oversee the development, documentation, and implementation of a plan to supervise and routinely assess the ability of the occupational therapy aide to carry out non-client related and client-related tasks. The occupational therapy assistant may contribute to the development and documentation of this plan.~~ ( )

i~~a~~. The following factors must be present when an occupational therapist or occupational therapy assistant assigns a selected client-related task to the aide: The supervisor's physical presence when services are being provided to clients by the aide: the outcome of the assigned task is predictable, the situation of the client and the environment is stable and will not require that judgment, interpretations, or adaptations be made by the aide, the client has demonstrated some previous performance ability in executing the task, and the task routine and process have been clearly established.( )

~~i. The outcome of the assigned task is predictable;( )~~

~~ii. The situation of the client and the environment is stable and will not require that judgment, interpretations, or adaptations be made by the aide;( )~~

~~iii. The client has demonstrated some previous performance ability in executing the task; and ( )~~

~~iv. The task routine and process have been clearly established. ( )~~

~~b. Before assigning client-related and non-client related tasks to an aide, the occupational therapist or occupational therapy assistant must ensure that the aide is able to competently perform the task.( )~~

~~c. The occupational therapist or occupational therapy assistant must train the aide to perform client-related and non-client related tasks at least once per month.( )~~

~~d. An aide must perform client-related tasks under the direct line-of-sight supervision of an occupational therapist or occupational therapy assistant.( )~~

~~e. Occupational therapists and occupational therapy assistants must document all training and supervision of an aide.( )~~

~~04. **Students**. Students must be under~~ ~~daily in-person contact with~~ ~~the direct on-site supervision of an occupational therapist or occupational therapy assistant who is appropriately supervised by an occupational therapist. The occupational therapist is responsible for the overall use and actions of the student.( )~~

02~~5~~. Supervision Requirements. Supervision is the direction and review of service delivery, treatment plans, and treatment outcomes. Unless otherwise specified in this rule, in-person, or synchronous interaction at least once a month ~~General Supervision~~ is the minimum level of supervision that must be provided. Methods of supervision may include~~,~~ but are not limited to, line-of-sight supervision with the supervisor's physical presence when services are being provided and/ or in-person contact by the supervisor where services are being provided to ensure the safe and effective delivery of occupational therapy.-

~~Direct Line-of-Sight Supervision, Direct Supervision, Routine Supervision, or General Supervision, as needed to ensure the safe and effective delivery of occupational therapy.( )~~

~~a. An occupational therapist and an occupational therapy assistant must ensure the delivery of services by the individual being supervised is appropriate for client care and safety and must evaluate:( )~~

i. The complexity of client needs;( )

ii. The number and diversity of clients;( )

iii. The skills of the occupational therapist assistant, aide, or limited permit holder;( )

iv. The type of practice setting;( )

v. The requirements of the practice setting; and( )

vi. Other regulatory requirements applicable to the practice setting or delivery of services.( )

b. Supervision must be documented in a manner appropriate to the supervised position and the setting. The documentation must be kept as required by Section 013 of these rules.( )

c. Supervision must include consultation at appropriate intervals regarding evaluation, intervention, progress, reevaluation and discharge planning for each patient. Consultation must be documented and signed by the supervisor and supervisee.( )

012. RECORD KEEPING.
Occupational therapists and occupational therapy assistants must maintain adequate records that are consistent with the standard business practices of the setting in which the licensee is providing occupational therapy or supervision and that show necessary client care, supervision provided by the licensee, and compliance with regulatory requirements applicable to the setting.( )

013. -- 019.(Reserved)

02100. GENERAL QUALIFICATIONS FOR LICENSURE.

01. APPLICANT. **THE BOARD MAY REFUSE LICENSURE IF IT FINDS THE APPLICANT HAS ENGAGED IN CONDUCT PROHIBITED BY SECTION 54-3718, IDAHO CODE; PROVIDED, THE BOARD SHALL TAKE INTO CONSIDERATION THE REHABILITATION OF THE APPLICANT AND OTHER MITIGATING CIRCUMSTANCES.( )**

012. Approved Education. Each applicant shall provide evidence of successful completion of the academic requirements of aAn educational program in occupational therapy that is accredited by the American Occupational Therapy Association's Accreditation Council for Occupational Therapy Education (ACOTE), or by a predecessor or successor organization recognized by the United States Secretary of Education, the Council for Higher Education Accreditation, or both.( )

02. Supervised Fieldwork. During the period of supervised fieldwork, students must be under daily in-person contact with an occupational therapist or occupational therapy assistant who is appropriately supervised by an occupational therapist. The occupational therapist is responsible for the overall use and actions of the student.( )

03. Continuing Education. Occupational Therapists and Occupational Therapy Assistants must complete and maintain proof of completion of ten (10) hours of germane continuing education each year during the licensee's renewal cycle. Proof of completion must be provided to the board upon request and must include licensee's name, date of activity or when course was completed, provider name, course title, description of course/activity, and number of contact hours.
03. Examination. Each applicant shall either pass an examination required by the Board or shall be entitled to apply for licensure by endorsement or limited permit.( )

a. The written examination shall be the examination conducted by the National Board for Certification in Occupational Therapy, Inc. (NBCOT) and the passing score shall be the passing score established by the NBCOT. ( )

04. **Examination** An applicant for licensure by examination who fails to pass the examination on two (2) attempts must submit a new application.( )

021. Application For Licensure.

01. Licensure by Endorsement. An applicant may be eligible for licensure without examination if they he or she meets all of the other qualifications prescribed in Section 54-3709, Idaho Code, and also holds a current valid license or registration from some other state, territory or district of the United States, or certified by the National Board for Certification in Occupational Therapy providing they meet Idaho standards and are equivalent to the requirements for licensure pursuant to these rules.( )

02. Limited Permit. The Board may issue a Limited Permit to an application who has graduated from an occupational therapy ist or graduate occupational therapy assistant school approved by the Board and has completed supervised fieldwork. who meets the requirements set forth by Sections 54-3706(1) and 54-3706(2), Idaho Code, who has not yet passed the examination as required in Paragraph 020.04.a. of these rules. ( )

a. A Limited Permit shall only allow a person to practice occupational therapy in association with and under the supervision of a licensed occupational therapist. A Limited Permit shall be valid six (6) months from the date of issue. A Limited Permit may be extended by the Board for good cause.( )

04. Temporary License. The Board may issue a temporary license to a person applying for licensure as an occupational therapist or an occupational therapy assistant if the person is currently licensed and in good standing to practice in another jurisdiction and meets that jurisdiction's requirements for licensure by endorsement. ( )

a. A temporary license shall automatically expire once the Board has processed the person's application for licensure and issued or denied the applied-for license, or in six (6) months after the date on which the Board issued the temporary license, whichever is sooner.( )

05. Personal Interview. The Board may, at its discretion, require the applicant to appear for a personal interview.( )

022. Written Statement Of Suitability For Licensure.
An applicant who, or whose license, has a criminal conviction, finding of guilt, withheld judgment, or suspended sentence for any crime under any municipal, state, or federal law other than minor traffic offenses, or has been subject to discipline by any state professional regulatory agency or professional organization must submit with the application a written statement and any supplemental information establishing the applicant's current suitability for licensure. ( )

01. Consideration of Factors and Evidence. The Board shall consider the factors set forth in Section 67-9411, Idaho Code.( )

02. Interview. The Board may, at its discretion, grant an interview of the applicant.( )

03. Applicant Bears the Burden. The applicant shall bear the burden of establishing the applicant's current suitability for licensure.( )

023. -- 024.(Reserved)

025. Continuing Education.

01. Requirement. Each licensee must successfully complete, in the twelve (12) months preceding license renewal, a minimum of ten (10) contact hours of continuing education, as approved by the Board.( )

a. One (1) contact hour is equivalent to one (1) clock hour for the purpose of obtaining continuing education. ( )

b. The Board will waive the continuing education requirement for the first license renewal after initial licensure. ( )

02. **Attestation**. The licensee attests, as part of the annual license renewal process, that the licensee is in compliance with the continuing education requirement.( )

03. **Courses and Activities**. At least five (5) of the contact hours directly relate to the delivery of occupational therapy services. The remaining contact hours are germane to the practice of occupational therapy and relate to other areas of a licensee's practice. A licensee may take online or home study courses or self-competency assessments, as long as a course completion certificate is provided.( )

a. The delivery of occupational therapy services may include: models, theories or frameworks that relate to client care in preventing or minimizing impairment, enabling function within the person/environment or community context.( )

b. Other areas may include, but are not limited to, occupation based theory assessment/interview techniques, intervention strategies, and community/environment as related to the licensee's practice.( )

c. Continuing education acceptable to the Board includes, but is not limited to, programs or activities sponsored by the American Occupational Therapy Association (AOTA), the Idaho Occupational Therapy Association (IOTA), or National Board for Certification in Occupational Therapy (NBCOT); post-professional coursework completed through any approved or accredited educational institution; or otherwise meet all of the following criteria: ( )

i. The program or activity contributes directly to professional knowledge, skill, and ability;( )

ii. The program or activity relates directly to the practice of occupational therapy; and( )

iii. The program or activity must be objectively measurable in terms of the hours involved.( )

04. **Carry Over and Duplication**. A maximum of ten (10) continuing education hours may be carried forward from the immediately preceding year, and may not be carried forward more than one renewal year. If the licensee completes two (2) or more courses having substantially the same content during any one (1) renewal period, the licensee only will receive continuing education credit for one (1) of the courses.( )

05. **Documentation**. A licensee need not submit documentation of continuing education when the licensee renews a license. However, a licensee will maintain documentation verifying that the licensee has completed the continuing education requirement for a period of four (4) years from the date of completion. A licensee must submit the verification documentation to the Board if the licensee is audited by the Board. A percentage of occupational therapists and certified occupational therapy assistants will be audited every year. Documentation for all activities must include licensee's name, date of activity or when course was completed, provider name, course title, description of course/activity, and number of contact hours.( )

a. Continuing education course work. The required documentation for this activity is a certificate or documentation of attendance.( )

b. In-service training. The required documentation for this activity is a certificate or documentation of attendance. ( )

c. Professional conference or workshop. The required documentation for this activity is a certificate or documentation of attendance.( )

d. Course work offered by an accredited college or university, provided that the course work is taken after the licensee has obtained a degree in occupational therapy, and the course work provides skills and knowledge beyond entry-level skills or knowledge. The required documentation for this activity is a transcript.( )

e. Publications. The required documentation for this activity is a copy of the publication.( )

f. Presentations. The required documentation for this activity is a copy of the presentation or program listing. Any particular presentation may be reported only once per reporting period.( )

g. Interactive online courses and evidence-based competency assessments. The required documentation for this activity is a certificate or documentation of completion.( )

h. Development of instructional materials incorporating alternative media such as video, audio and/or software programs to advance professional skills of others. The required documentation for this activity is a program description. The media/software materials must be available if requested during audit process.( )

i. Professional manuscript review. The required documentation for this activity is a letter from the publishing organization verifying review of manuscript. A maximum of five (5) hours is allowed per renewal period for this category. ( )

j. Guest lecturer for occupational therapy related academic course work (academia not primary role). The required documentation for this activity is a letter or other documentation from instructor.( )

k. Serving on a professional board, committee, disciplinary panel, or association. The required documentation for this activity is a letter or other documentation from the organization. A maximum of five (5) hours is allowed per renewal period for this category.( )

l. Level II fieldwork direct supervision of an occupational therapy student or occupational therapy assistant student by site designated supervisor(s). The required documentation for this activity is the name of student(s), letter of verification from school, and dates of fieldwork.( )

06. **Exemptions**. A licensee may request an exemption from the continuing education requirement for a particular renewal period for reasonable cause. The licensee must provide any information requested by the Board to assist in substantiating the licensee's need for a claimed exemption:( )

026. -- 029.(Reserved)

030. Inactive Status.

01. **Request for Inactive Status**. Occupational Therapists and Occupational Therapy Assistants requesting an inactive status during the renewal of their active license must submit a written request and pay the established fee. ( )

02. **Inactive License Status**.( )

a. Licensees may not practice in Idaho while on inactive status.( )

b. All continuing education requirements will be waived for any year or portion thereof that a licensee maintains an inactive license and is not actively practicing or supervising in Idaho, subject to Subsection 030.03 of these rules.( )

03. **Reinstatement to Full Licensure from Inactive Status**.( )

a. Return to Active Status of License - Inactive for Five (5) or Fewer Years. An inactive license holder whose license has been inactive for five (5) or fewer years may convert from inactive to active license status by: ( )

i. Providing documentation to the Board showing successful completion within the previous twelve (12) months of the continuing education requirements for renewal of an active license; and( )

ii. Paying a fee equivalent to the difference between the current inactive fee and the active renewal fee. ( )

~~**b.** Return to Active Status of License - Inactive for Greater than Five (5) Years. An inactive license holder whose license has been inactive for greater than five (5) years may convert from inactive to active license status by: ( )~~

~~i. Providing documentation to the Board showing successful completion within the previous twelve (12) months of the continuing education requirements for renewal of an active license; and( )~~

~~ii. Providing proof that the licensee has actively engaged in the practice of occupational therapy in another state or territory of the United States for at least three (3) of the immediately preceding five (5) years, or provide proof that the licensee is competent to practice in Idaho.( )~~

~~iii. The Board may consider the following factors when determining proof of competency:( )~~

~~(1) Number of years of practice prior to transfer from active status;( )~~

~~(2) Employment in a field similar to occupational therapy; and( )~~

~~(3) Any other factors the Board deems appropriate.( )~~

~~031. (Reserved)~~

~~0~~300~~2~~. DISCIPLINE ~~DENIAL OR REFUSAL TO RENEW, SUSPENSION OR REVOCATION OF LICENSE~~.

~~**01.** **Grounds for Discipline**. In addition to the grounds set forth in Section 54-3718, Idaho Code, applicants may be denied or refused licensure and licensees are subject to discipline upon the following grounds, including but not limited to:( )~~

~~**a.** Obtaining a license by means of fraud, misrepresentation, or concealment of material facts;( )~~

~~**b.** Being guilty of unprofessional conduct or violating the Code of Ethics in Appendix A, incorporated herein by reference governing said licensees, including the provision of health care which fails to meet the standard of health care provided by other qualified licensees in the same community or similar communities, taking into account the licensee's training, experience and the degree of expertise to which he holds himself out to the public;( )~~

~~**c.** The unauthorized practice of medicine;( )~~

~~**d.** Failure to properly supervise persons as required in these rules.( )~~

01~~2~~. Civil Penalty~~ies~~. ~~In addition to any other disciplinary sanctions the Board may impose against a licensee, t~~The Board may impose a fine ~~of~~ up to ~~one thousand dollars ($1,000) per violation, or in such greater~~the amount ~~as the Board may deem necessary to deprive the licensee~~ of any economic advantage ~~gained by~~obtained through the violation~~licensee through the conduct that resulted in discipline and that reimburses the Board for costs of the investigation and disciplinary proceedings~~. ( )

~~**033. -- 040.(RESERVED)**~~

~~0~~400~~1~~. FEES.
All fees are non-refundable.

FEE TYPE	AMOUNT ~~(Not to Exceed)~~	RENEWAL FEE ~~(Not to Exceed)~~

Initial Licensure for Occupational Therapists	$80	$40
Initial Licensure for Occupational Therapy Assistants	$60	$30
Limited Permit or Temporary License	$25	
Reinstatement Fee	As provided in Section 67-2614, Idaho Code.	
~~Inactive License Renewal~~	~~$20~~	
~~Inactive to Active License~~	~~The difference between the current inactive and active license renewal fees~~	

( )

042. --999.(RESERVED)

IDAPA 24 – DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSES

24.11.01 – RULES OF THE STATE BOARD OF PODIATRY

DOCKET NO. 24-1101-2301 (ZBR CHAPTER REWRITE)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo, Incorporation By Reference Synopsis (IBRS), & Cost/Benefit Analysis (CBA)

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2024 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. The pending rule will become final and effective upon the adjournment, *sine die*, of the Second Regular Session of the Sixty-seventh Idaho Legislature after approval.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section(s) 67-2604, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

Under Executive Order 2020-01, Zero-Based Regulation, the State Board of Podiatry is striving to prevent the accumulation of costly, ineffective, and outdated regulations and reduce regulatory burden to achieve a more efficient operation of government.

Section 67-5229, Idaho Code, requires agencies to identify materials incorporated by reference with specificity, including the date when the material was published. To correct this omission from the proposed rule, the text of the pending rule has been amended in accordance with Section 67-5227, Idaho Code. Only those sections that have changes that differ from the proposed text are printed in this bulletin. The complete text of the proposed rule was published in the August 2, 2023, Idaho Administrative Bulletin, Vol. 23-8, pages 224-231.

FEE SUMMARY: The following is a description of the fee or charge imposed or increased in this rulemaking as authorized in Sections 54-606, 54-607, and 54-613, Idaho Code. Pursuant to Section 67-5224(2)(d), Idaho Code, this pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature.

The fees for applications, licenses, registrations and reinstatement as designated in Rule 400 of these rules are authorized in Sections 54-606, 54-607, and 54-613, Idaho Code. None of these fees are being changed as a result of this rulemaking or since they were previously reviewed by the Idaho Legislature.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year:

This rulemaking is not anticipated to have any negative fiscal impact on the State General Fund.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Katie Stuart, Bureau Chief, at 208-577-2489.

DATED this 1st day of November, 2023.

Katie Stuart
Bureau Chief
11341 W. Chinden Blvd., Bldg. #4
Boise, ID 83714
Phone: (208) 577-2489
Email: katie.stuart@dopl.idaho.gov

THE FOLLOWING NOTICE PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section 67-2604, Idaho Code, and Sections 54-605 and 54-606, Idaho Code.

PUBLIC HEARING SCHEDULE: A public hearing concerning this rulemaking will be held as follows:

Wednesday, August 23, 2023 – 1:30 p.m. (MT)

Division of Occupational and Professional Licenses
Chinden Campus Building 4
11341 W. Chinden Blvd., Bldg. #4
Boise, ID 83714

Telephone and web conferencing information will be posted on:
https://dopl.idaho.gov/calendar/ and https://townhall.idaho.gov/

The hearing site will be accessible to persons with disabilities, if needed. Requests for accommodation must be made not later than five (5) days prior to the meeting to the agency address below.

DESCRIPTIVE SUMMARY: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

Under Executive Order 2020-01, Zero-Based Regulation, the State Board of Podiatry is striving to prevent the accumulation of costly, ineffective, and outdated regulations and reduce regulatory burden to achieve a more efficient operation of government. In conjunction with stakeholders, the proposed rule changes reflect a comprehensive review of this chapter by collaborating with the public to streamline or simplify the rule language in this chapter and to use plain language for better understanding. This proposed rulemaking updates the rules to comply with governing statute and Executive Order 2020-01.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased:

The fees for applications and licenses as designated in Rule 400 of these proposed rules are authorized in Sections 54-606, 54-607, and 54-613, Idaho Code. None of these fees are being changed as a result of this rulemaking or since being previously reviewed by the Idaho legislature.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the State General Fund greater than ten thousand dollars ($10,000) during the fiscal year as a result of this rulemaking:

This rulemaking is not anticipated to have any negative fiscal impact on the State General Fund.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was conducted under Docket No. 24-ZBRR-2301. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the April 5, 2023 Idaho Administrative Bulletin, Vol. 23-4, pp. 42-46.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into this rule: Per Section 54-605(7), the board adopted the "Code of Ethics" published by the American Podiatric Medical Association, Inc. as the standards of ethics for the practice of podiatry in Idaho.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Michael Hyde, Bureau Chief, at (208) 332-7133.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before August 23, 2023.

DATED this July 6, 2023.

THE FOLLOWING IS THE TEXT OF ZBR DOCKET NO. 24-1101-2301

24.11.01 – RULES OF THE STATE BOARD OF PODIATRY

000. LEGAL AUTHORITY.
These rules are promulgated pursuant to Sections 54-605 and 54-606, Idaho Code. ( )

001. SCOPE.
These rules govern the practice of podiatry in Idaho. ( )

002. INCORPORATION BY REFERENCE.
The document titled "Code of Ethics," published and adopted by the American Podiatric Medical Association, Inc., effective March of 2022, is adopted and incorporated by reference and is available on the association's website at https://www.apma.org/AboutUs/content.cfm?ItemNumber=1368. ( )

003. -- 099. (RESERVED)

100. LICENSURE.

01. Approved Education. Applicants must graduate from a four (4) year school of podiatry located within the United States or Canada approved by the Council on Podiatric Medical Education and the American Podiatric Medical Association, or its foreign equivalent. ( )

02. Accredited Podiatric Residency. Applicants must complete a podiatric residency approved by the Council on Podiatric Medical Education of no less than twenty-four (24) months, a minimum of twelve (12) months of which must be surgical. Proof of completion must be received directly from the residency program. ( )

03. Approved Examination: Applicants for licensure by examination must successfully pass all parts of the American Podiatric Medical Licensing Examination administered by the National Board of Podiatric Medical Examiners. ( )

04. Continuing Education. Licensees must submit proof of completion of thirty (30) hours of continuing education every two (2) years, reported with their renewal application. All continuing education courses must be germane to the practice of podiatry. ( )

101. -- 199. (RESERVED)

200. PRACTICE STANDARDS.

01. Ethical Practice. A licensee must comply with the applicable standard of care when practicing podiatry, taking into account the licensee's education, training, and experience. ( )

201. -- 399. (RESERVED)

400. FEES.
All fees are non-refundable.

FEE TYPE	AMOUNT
Application	$200
Original License	$400
Annual Renewal	$500

( )

401. -- 999. (RESERVED)

[Agency redlined courtesy copy]

Italicized text **indicates changes between the text of the proposed rule as adopted in the pending rule.**

24.11.01 – RULES OF THE STATE BOARD OF PODIATRY

000. LEGAL AUTHORITY.
These rules are promulgated pursuant to Sections 54-605 and 54-606, Idaho Code.( )

001. SCOPE.
These rules govern the practice of podiatry in Idaho.( )

002. INCORPORATION BY REFERENCE.
~~The document titled American Podiatric Medical Association's Code of Ethics as published by the American Podiatric Medical Association, dated March 2013 and referenced in Section 500, is herein incorporated by reference and is available for review at the Board's office and on the Board's web site at https://apps.dopl.idaho.gov/DOPLPortal/BoardAdditional.aspx?Bureau=POD&BureauLinkID=38.~~
The current and updated document titled "Code of Ethics," published by the America Podiatric Medical Association, Inc. is ~~herein~~ adopted and incorporated by reference and is available on the association's website. ~~Code of Ethics_FINAL_1669749709677_2.pdf (apma.org)~~ (https://www.apma.org/files/Code%20of%20Ethics_FINAL_1669749709677_2.pdf) ( )

PENDING TEXT 002

The ~~*current and updated*~~ document titled "Code of Ethics," published *and adopted* by the America Podiatric Medical Association, Inc. *, effective March of 2022,* is adopted and incorporated by reference and is available on the association's website. (https://www.apma.org/files/Code%20of%20Ethics_FINAL_1669749709677_2.pdf).*( )*

003. -- ~~009~~099.(RESERVED)

~~**010. DEFINITIONS AND STANDARDS.**~~

~~**01. Reputable School**. A "reputable school" of podiatry is defined as an approved podiatry school located within the United States or Canada and designated as such by the Council on Podiatric Medical Education and the American Podiatric Medical Association.( )~~

~~**011. -- 149.(RESERVED)**~~

~~**150. PRE-PROFESSIONAL EDUCATION.**~~
~~All applicants must provide official documentation of credits granted for at least two (2) full years of general college study in a college or university of recognized standing.( )~~

~~**151. PROFESSIONAL EDUCATION.**~~
~~All applicants must possess evidence of graduation from four (4) full years of study in a reputable school of podiatry, as defined in Subsection 010.02 of these rules.( )~~

100. LICENSURE ~~**152.PODIATRIC RESIDENCY.**~~

01. Approved Education. Applicants must graduate from a four (4) year school of podiatry located within the United States or Canada approved by the Council on Podiatric Medical Education and the American Podiatric Medical Association, or its foreign equivalent. ( )

~~**01. Residency Required for Licensure**~~**02. Accredited Podiatric Residency.** Applicants must complete a ~~candidate may not apply for licensure until completion of an accredited~~ podiatric residency ~~as~~ approved by the Council on Podiatric Medical Education of no less than twenty-four (24) months, a minimum of twelve (12) months of which must be surgical. Proof of completion must be received directly from the residency program.( )

03. Approved Examination. Applicants for licensure by examination must successfully pass all parts of the American Podiatric Medical Licensing Examination administered by the National Board of Podiatric Medical Examiners. ( )

04. Continuing Education. Licensees must submit proof of completion of thirty (30) hours of continuing education every two (2) years, reported with their renewal application. All continuing education courses must be germane to the practice of podiatry. ( )

~~**02. Submission of Verification of Residency Curriculum**. Notwithstanding the provisions of Subsection 152.01, a candidate must provide directly from the residency program such official documentation of completion of the entire curriculum as the board may require. Any deviation of this requirement must be approved by the Board. ( )~~

~~153~~101. -- 199.(RESERVED)

~~**200. CREDENTIALS TO BE FILED BY ALL APPLICANTS.**~~

~~**01. Certified Copy of National Board Results**. A copy of the applicable National Board results that has been certified as true and correct by the examining entity.( )~~

~~**02. Educational Certificate Requirement**. Each applicant must provide official documentation of a collegiate education of not less than two (2) years in an accredited college or university giving instruction in letters and sciences. ( )~~

~~**03. Diploma**. Certified photostatic copy of diploma granted by any college of podiatry and official certified transcripts indicating graduation from the program.( )~~

~~**04. Residency Certification Requirement**. All applications must include certification of completion of a residency as defined in Rule 152.( )~~

~~201. -- 299.(Reserved)~~

~~3~~400. FEES.
All fees are non-refundable.~~; if a license is not issued, the license fee will be refunded.~~.

~~FEE~~ TYPE	AMOUNT ~~(Not to Exceed)~~
Application	$200
Original License	$400
~~Written Examination~~	~~Set by National Examining Entity~~
Annual Renewal	$500
~~Inactive License Annual Renewal~~	~~$250~~

( )

~~301~~401. -- ~~399~~999.(RESERVED)

~~**400. LICENSURE BY EXAMINATION.**~~

~~**01. Examination of Applicants.** All applicants must successfully pass all parts of the American Podiatric Medical Licensing Examination developed and administered by the National Board of Podiatric Medical Examiners. ( )~~

~~**02. Passing Grade**. A passing grade in all subjects examined is the grade established by the examination provider.( )~~

~~**401. LICENSURE BY ENDORSEMENT.**~~
~~Under Section 54-613, Idaho Code, applicants for licensure by endorsement may be granted a license upon the approval of the Board. Each applicant for licensure by endorsement must have a license in good standing in another jurisdiction. provide documentation for each of the following before licensure will be considered:( )~~

~~**01. Certification of License**. Certification of having maintained a current license or other authority to practice issued by a regulatory board of Podiatry in any state or territory.( )~~

~~**02. Credentials**. Credentials as required in Subsections 200.01 through 200.04.( )~~

~~**03. Examination**. Successful passage of a written licensure examination covering all those subjects noted in Section 54-606, Idaho Code. Official certification of examination must be received by the board directly from, the applicant's state or territory of licensure or the national board of podiatric medical examiners.:( )~~

~~**a.** The applicant's state or territory of licensure; or( )~~

~~**b.** The national board of podiatric medical examiners.( )~~

~~**04. Residency**. Proof of completion of the residency requirement, as set forth in Subsection 200.04 of this rule. However, if the applicant graduated from a college of podiatry prior to 1993, this requirement will be waived. ( )~~

~~**05. Practical Experience**. Having practiced podiatry under licensure for three (3) of the last five (5) years immediately prior to the date of application.( )~~

~~**06.** **Continuing Education**. Having completed at least fifteen (15) hours of continuing education germane to the practice of podiatry during the twelve (12) months prior to the date of application.( )~~

~~**07.** **Disciplinary Action**. Has not been the subject of any disciplinary action including pending or unresolved licensure actions within the last five (5) years immediately prior to application and has never had a license to practice podiatry revoked or suspended either voluntarily or involuntarily in any jurisdiction.( )~~

~~**402. TEMPORARY LICENSES.**~~
~~No temporary licenses will be granted for the practice of podiatry in Idaho.( )~~

~~**403. -- 409.(RESERVED)**~~

~~**410. ORIGINAL APPLICATION.**~~
~~The original application will be considered null and void after a period of two (2) years from date of original application if no license has been issued.( )~~

~~**411. -- 424.(RESERVED)**~~

~~**425. INACTIVE STATUS.**~~

~~**01.** **Request for Inactive Status**. Each person requesting an inactive status during the renewal of their active license must submit a written request and pay the inactive license fee.( )~~

~~**02.** **Inactive License Status**.( )~~

~~**a.** All continuing education requirements will be waived during the time that a licensee maintains an inactive license in Idaho.( )~~

~~**b.** When the licensee desires active status, the licensee must show acceptable fulfillment of continuing education requirements for the previous twelve (12) months and submit a fee equivalent to the difference between the inactive and active renewal fee.( )~~

~~**426. -- 449.(RESERVED)**~~

200. PRACTICE STANDARDS ~~**450.SCOPE OF PRACTICE.**~~

01. **Ethical Practice.** A licensee must comply with the applicable standard of care when practicing podiatry, taking into account the licensee's education, training, and experience. ( )

~~**01.** **Competence**. Upon being granted a license to practice podiatry, a practitioner is authorized to provide only those services and treatments for which that practitioner has the education, training, and experience to provide. has been trained and prepared to provide. Information contained within the application file and supplemental certified information of additional training and experience included in the credential file maintained by the practitioner is prima facie evidence of the practitioner's education and experience. It is the responsibility of the individual practitioner to ensure that the information in his credential file is accurate, complete and supplemented to support all procedures, applications and treatments employed by the practitioner. Practice beyond a practitioner's documented education and experience may violate the adopted code of ethics and be grounds for discipline by the board. ( )~~

~~**02.** **Advanced Surgical Procedures**. Advanced surgical procedures must be performed in a licensed hospital or certified ambulatory surgical center accredited by a nationally recognized accreditation entity the joint commission on accreditation of healthcare organizations or the accreditation association for ambulatory health care wwhere a peer review system is in place. Advanced surgical procedures are defined as:( )~~

~~**a.** Ankle fractures - Open Reduction and Internal Fixation.( )~~

~~**b.** Ankle and rearfoot arthrodesis.( )~~

~~c. Nerve surgery of the leg.( )~~

~~d. Major tendon repair or transfer surgery - proximal to ankle.( )~~

~~e. Autogenous bone grafting.( )~~

~~f. External fixation of the rearfoot, ankle and leg.( )~~

~~451~~201. -- ~~499~~399.(RESERVED)

~~**500. STANDARDS OF THE ETHICAL PRACTICE OF PODIATRY.**~~
~~The standards for the ethical practice of podiatry is the American Podiatric Medical Association's Code of Ethics as referenced in Section 002 of these rules and are hereby adopted and apply to all practitioners of podiatry.( )~~

~~**501. -- 549.(RESERVED)**~~

~~**550. DISCIPLINE.**~~

~~**01. Civil Fine**. The Board may impose a civil fine not to exceed one thousand dollars ($1,000) upon a licensed podiatrist for each violation of Sections 54-608 and 54-609, Idaho Code.( )~~

~~**02. Costs and Fees**. The Board may order a licensed podiatrist to pay the costs and fees incurred by the Board in the investigation or prosecution of the licensee for violation of Sections 54-608 and 54-609, Idaho Code.( )~~

~~**551. -- 699.(RESERVED)**~~

~~**700. CONTINUING EDUCATION.**~~

~~**01. Education Requirement for License Renewal**. Each podiatrist licensed by the state of Idaho must complete in each twelve-month period preceding the renewal of a license to practice podiatry in Idaho, a minimum of fifteen (15) full hours of podiatry continuing education. Continuing education includes lectures, conferences, seminars, moderator-guided panel discussions, clinical and practical workshops, internet-based learning and home study. Education must be germane to the practice of podiatry; and( )~~

~~a. Approved by the Council on Podiatric Medical Education; or( )~~

~~b. Otherwise approved by the Board.( )~~

~~**02. Submission of License Renewal Application Form**. Each licensed Idaho podiatrist will be furnished a license renewal application form by the Division of Occupational and Professional Licenses on which each podiatrist will be required to certify by signed affidavit that compliance with the continuing education requirements has been met and must submit the renewal application together with the required fees to the Division. ( )~~

~~**03. Verification of Completion**. A licensee must maintain verification of completion by securing authorized signatures or other documentation from the course instructors or sponsoring institution substantiating any and all hours completed by the licensee. This verification must be maintained by the licensee and provided to the Board upon the request of the Board or its agent. The Board will conduct random audits to monitor compliance. Failure to provide proof of meeting the continuing education upon request of the Board will be grounds for disciplinary action.( )~~

~~**04. Carryover of Continuing Education Hours**. Continuing education not claimed for credit in the current renewal year may be credited for the next renewal year. A maximum of fifteen (15) hours may be carried forward from the immediately preceding year.( )~~

~~**05.** **Special Exemption**. The Board has authority to make exceptions for reasons of individual hardship, including health, when certified by a medical doctor, or for other good cause. The licensee must provide any information requested by the Board to assist in substantiating hardship cases. This exemption is granted at the sole discretion of the Board.( )~~

~~**701. -- 999.(RESERVED)**~~

IDAPA 24 – DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSES

24.13.01 – RULES GOVERNING THE PHYSICAL THERAPY LICENSURE BOARD

DOCKET NO. 24-1301-2301 (ZBR CHAPTER REWRITE)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo, Incorporation By Reference Synopsis (IBRS), & Cost/Benefit Analysis (CBA)

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2024 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. The pending rule will become final and effective upon the adjournment, *sine die*, of the Second Regular Session of the Sixty-seventh Idaho Legislature after approval.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section(s) 67-2604, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

Under Executive Order 2020-01, Zero-Based Regulation, the Physical Therapy Licensure Board is striving to prevent the accumulation of costly, ineffective, and outdated regulations and reduce regulatory burden to achieve a more efficient operation of government.

Section 67-5229, Idaho Code, requires agencies to identify materials incorporated by reference with specificity, including the date when the material was published. To correct this omission from the proposed rule, the text of the pending rule has been amended in accordance with Section 67-5227, Idaho Code. Only those sections that have changes that differ from the proposed text are printed in this bulletin. The complete text of the proposed rule was published in the August 2, 2023, Idaho Administrative Bulletin, Vol. 23-8, pages 232-248.

FEE SUMMARY: The following is a description of the fee or charge imposed or increased in this rulemaking as authorized in Section 54-2207, Idaho Code. Pursuant to Section 67-5224(2)(d), Idaho Code, this pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature.

The fees for applications, licenses, registrations and reinstatement as designated in Rule 400 of these rules are authorized in Section 54-2207, Idaho Code. None of these fees are being changed as a result of this rulemaking or since they were previously reviewed by the Idaho Legislature.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year:

This rulemaking is not anticipated to have any negative fiscal impact on the State General Fund.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Katie Stuart, Bureau Chief, at 208-577-2489.

DATED this 1st day of November, 2023.

Katie Stuart
Bureau Chief
11341 W. Chinden Blvd., Bldg. #4
Boise, ID 83714
Phone: (208) 577-2489
Email: katie.stuart@dopl.idaho.gov

THE FOLLOWING NOTICE PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section 67-2604, Idaho Code, and Sections 54-2206, 54-2207, 54-2209, and 54-2221, Idaho Code.

PUBLIC HEARING SCHEDULE: A public hearing concerning this rulemaking will be held as follows:

Wednesday, August 23, 2023 – 1:30 p.m. (MT)

Division of Occupational and Professional Licenses
Chinden Campus Building 4
11341 W. Chinden Blvd., Bldg. #4
Boise, ID 83714

Telephone and web conferencing information will be posted on:
https://dopl.idaho.gov/calendar/ and https://townhall.idaho.gov/

The hearing site will be accessible to persons with disabilities, if needed. Requests for accommodation must be made not later than five (5) days prior to the meeting to the agency address below.

DESCRIPTIVE SUMMARY: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

Under Executive Order 2020-01, Zero-Based Regulation, the Physical Therapy Licensure Board is striving to prevent the accumulation of costly, ineffective, and outdated regulations and reduce regulatory burden to achieve a more efficient operation of government. In conjunction with stakeholders, the proposed rule changes reflect a comprehensive review of this chapter by collaborating with the public to streamline or simplify the rule language in this chapter and to use plain language for better understanding. This proposed rulemaking updates the rules to comply with governing statute and Executive Order 2020-01.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased:

The fees for applications, examinations, and licenses as designated in Rule 400 of these proposed rules are authorized in Section 54-2207, Idaho Code. None of these fees are being changed as a result of this rulemaking or since being previously reviewed by the Idaho legislature.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the State General Fund greater than ten thousand dollars ($10,000) during the fiscal year as a result of this rulemaking: This rulemaking is not anticipated to have any negative fiscal impact on the State General Fund.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was conducted under Docket No. 24-ZBRR-2301. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the April 5, 2023 Idaho Administrative Bulletin, Vol. 23-4, pp. 42-46.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into this rule:

Per Section 54-2216(3), the board adopted the American Physical Therapy Association's "Code of Ethics for the Physical Therapist" and "Standards of Ethical Conduct for the Physical Therapist Assistant" as the standards of ethics for physical therapy professionals in Idaho.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Michael Hyde, Bureau Chief, at (208) 332-7133.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before August 23, 2023.

DATED this July 6, 2023.

THE FOLLOWING IS THE TEXT OF ZBR DOCKET NO. 24-1301-2301

24.13.01 – RULES GOVERNING THE PHYSICAL THERAPY LICENSURE BOARD

000. LEGAL AUTHORITY.
These rules are promulgated pursuant to Sections 54-2206, 54-2207, 54-2209, and 54-2221 Idaho Code. ( )

001. SCOPE.
These rules govern the practice of physical therapy in Idaho. ( )

002. INCORPORATION BY REFERENCE.
The documents titled "Code of Ethics for the Physical Therapist" and "Standards of Ethical Conduct for the Physical Therapist Assistant" published by the American Physical Therapy Association, effective August 12, 2020, are adopted and incorporated by reference and available on the APTA website. (Code of Ethics for the Physical Therapist | APTA) and (Standards of Ethical Conduct for the Physical Therapist Assistant | APTA). ( )

003. -- 099. (RESERVED)

100. LICENSURE.

01. Examinations: An applicant must successfully pass the National Physical Therapy Examination (NPTE), with a minimum score set by the Federation of State Boards of Physical Therapy. Foreign-educated applicants whose native language is not English must also successfully pass either: (a) the Test of English as a Foreign Language (TOEFL) with a minimum passing score of two hundred twenty (220) for the computer test and five hundred sixty (560) for the paper test; or (b) the Test of English as a Foreign Language – Internet-Based Test (TOEFL IBT) with a minimum passing score of twenty-four (24) in writing, twenty-six (26) in speaking, twenty-one (21) in reading, and eighteen (18) in listening. ( )

02. Continuing Education. ( )

a. Renewal of License. Every person holding a license issued by the Board must complete thirty-two (32) contact hours of continuing education every two years. ( )

b. Reinstatement of License. Any license canceled for failure to renew may be reinstated in accordance with Section 67-2614, Idaho Code, with the exception that the applicant must submit proof of having met the following continuing education requirements: ( )

i. For licenses expired for three (3) years or less, sixteen (16) hours of continuing education; or ( )

ii. For licenses expired for more than three (3) years, thirty-two (32) hours of continuing education. ( )

c. Contact Hours. The contact hours of continuing education must be obtained in areas of study germane to the practice of physical therapy, and for which the licensee is issued a certificate of completion or transcript. ( )

d. Documentation of Attendance. The applicant must maintain documentation verifying attendance by securing authorized signatures or other documentation from the course instructors, providers, or sponsoring institution substantiating any hours attended by the licensee. This documentation must be provided to the Board upon request by the Board or its agent. ( )

101. -- 199. (RESERVED)

200. PRACTICE STANDARDS.

01. Scope of Practice. Physical Therapists and Physical Therapist Assistants must possess the education, training, and experience within their scope of practice to perform physical therapy tasks. ( )

02. Supervision. Supervision is oversight of a person by a licensed physical therapist when the licensed physical therapist is immediately available in person, by telephone, or by electronic communication to assist the person. A physical therapist shall supervise and be responsible for patient care given by physical therapist assistants, supportive personnel, physical therapy students, and physical therapist assistant students. ( )

a. Procedures and Interventions Performed Exclusively by Physical Therapists. The following procedures and interventions shall be performed exclusively by a physical therapist: ( )

i. Interpretation of a referral for physical therapy if a referral has been received. ( )

ii. Performance of the initial patient evaluation and problem identification including a diagnosis for physical therapy and a prognosis for physical therapy. ( )

iii. Development or modification of a treatment plan of care which is based on the initial evaluation, and which includes long-term and short-term physical therapy treatment goals. ( )

iv. Assessment of the competence of physical therapist assistants, physical therapy students, physical therapist assistant students, and supportive personnel to perform assigned procedures, interventions, and routine tasks. ( )

v. Selection and delegation of appropriate portions of treatment procedures, interventions, and routine physical therapy tasks to the physical therapist assistants, physical therapy students, physical therapist assistant students, and supportive personnel. ( )

vi. Performance of a re-evaluation when any change in a patient's condition occurs that is not consistent with the physical therapy treatment plan of care, patient's anticipated progress, and physical therapy treatment goals. ( )

vii. Performance and documentation of a discharge evaluation and summary of the physical therapy treatment plan. ( )

03. Supervision of Physical Therapist Assistants. A physical therapist assistant must be supervised by a physical therapist by no less than telecommunication. ( )

a. A physical therapist assistant must not change a procedure or intervention unless such change of procedure or intervention has been included within the treatment plan of care as set forth by a physical therapist. ( )

b. A physical therapist assistant may not continue to provide treatment as specified under a treatment plan of care if a patient's condition changes such that further treatment necessitates a change in the established treatment plan of care, unless the physical therapist assistant has consulted with the supervising physical therapist prior to the patient's next appointment for physical therapy, and a re-evaluation is completed by the supervising physical therapist. ( )

c. The supervising physical therapist must provide direct personal contact with the patient and assess the plan of care on or before every ten (10) visits or once a week if treatment is performed more than once per day but no less often than once every sixty (60) days. The supervising physical therapist's assessment must be documented in the patient record. ( )

d. A physical therapist assistant may refuse to perform any procedure, intervention, or task delegated by a physical therapist when such procedure, intervention, or task is beyond the physical therapist assistant's skill level or scope of practice standards. ( )

e. A physical therapist is not required to co-sign any treatment related documents prepared by a physical therapist assistant, unless required to do so in accordance with law, or by a third party. ( )

04. Supervision of Supportive Personnel. Any routine physical therapy tasks performed by supportive personnel requires a physical therapist's or physical therapist assistant's direct and continuous physical presence and availability to render direction, in person on the premises where physical therapy is being provided. The physical therapist or physical therapist assistant must have direct contact with the patient during each session and assess patient response to delegated treatment. ( )

05. Supervision of Physical Therapist and Physical Therapist Assistant Students. Supervision of physical therapist students and physical therapist assistant students requires availability of the physical therapist or physical therapist assistant to render direction in person and on the premises where physical therapy is being provided. ( )

a. A physical therapy student is required to sign all treatment notes with the designation "SPT" after their name, and all such signatures require the co-signature of the supervising physical therapist. ( )

b. A physical therapist assistant student is required to sign all treatment notes with the designation "SPTA" after their name, and all such signatures require the co-signature of the supervising physical therapist or supervising physical therapist assistant. ( )

201. -- 299. (RESERVED)

300. DISCIPLINE.

01. Civil Fine. The Board may impose a civil fine not to exceed one thousand dollars ($1,000.00) for each violation upon anyone licensed under Title 54, Chapter 22, Idaho Code who is found by the Board to be in violation of Section 54-2219, Idaho Code. ( )

301. -- 399. (RESERVED)

400. FEES.
All fees are non-refundable. The examination or reexamination fee are in addition to the application fee and must accompany the application.

FEE TYPE	AMOUNT	RENEWAL
Physical Therapist License	$25	$25
Physical Therapist Assistant License	$20	$20

FEE TYPE	AMOUNT	RENEWAL
Examination	Established by examination entity plus an administrative fee not to exceed $20	
Application	$25	

( )

401. -- 999. (RESERVED)

[Agency redlined courtesy copy]

Italicized text **indicates changes between the text of the proposed rule as adopted in the pending rule.**

24.13.01 – RULES GOVERNING THE PHYSICAL THERAPY LICENSURE BOARD

000. LEGAL AUTHORITY.
These rules are promulgated pursuant to Section 54-2206, 54-2207, 54-2209, and 54-2221, Idaho Code.( )

001. SCOPE.
These rules govern the practice of physical therapy in Idaho.( )

002. INCORPORATION BY REFERENCE.
The current and updated documents titled "Code of Ethics for the Physical Therapist" and "Standards of Ethical Conduct for the Physical Therapist Assistant" published by the American Physical Therapy Association are adopted and incorporated by reference and available on the APTA website. (Code of Ethics for the Physical Therapist | APTA) and (Standards of Ethical Conduct for the Physical Therapist Assistant | APTA) ( )

PENDING TEXT 002
The ~~*current and updated*~~ documents titled "Code of Ethics for the Physical Therapist" and "Standards of Ethical Conduct for the Physical Therapist Assistant" published by the American Physical Therapy Association*, effective August 12, 2020,* are adopted and incorporated by reference and available on the APTA website. (Code of Ethics for the Physical Therapist | APTA) and (Standards of Ethical Conduct for the Physical Therapist Assistant | APTA).
( )

~~002~~003. -- ~~009~~099. (RESERVED)

~~**010. DEFINITIONS.**~~

~~**01. Supportive Personnel**. An individual, or individuals, who are neither a physical therapist or a physical therapist assistant, but who are employed by and/or trained under the direction of a licensed physical therapist to perform designated non-treatment patient related tasks and routine physical therapy tasks.( )~~

~~**02. Non-Treatment Patient Related Tasks**. Actions and procedures related to patient care that do not involve direct patient treatment or direct personal supervision, but do require a level of supervision not less than general supervision, including, but not limited to: treatment area preparation and clean-up, equipment set-up, heat and cold pack preparation, preparation of a patient for treatment by a physical therapist or physical therapist assistant, transportation of patients to and from treatment, and assistance to a physical therapist or physical therapist assistant when such assistance is requested by a physical therapist or physical therapist assistant when safety and effective treatment would so require.( )~~

~~**03.** **Routine Physical Therapy Tasks**. Actions and procedures within the scope of practice of physical therapy, which do not require the special skills or training of a physical therapist or physical therapist assistant, rendered directly to a patient by supportive personnel at the request of and under the direct personal supervision of a physical therapist or physical therapist assistant.( )~~

~~**04.** **Testing**.( )~~

~~**a.** Standard methods and techniques used in the practice of physical therapy to gather data about individuals including:( )~~

~~i. Electrodiagnostic and electrophysiological measurements;( )~~

~~ii. Assessment or evaluation of muscle strength, force, endurance and tone;( )~~

~~iii. Reflexes;( )~~

~~iv. Automatic reactions;( )~~

~~v. Posture and body mechanics;( )~~

~~vi. Movement skill and accuracy;( )~~

~~vii. Joint range of motion and stability;( )~~

~~viii. Sensation;( )~~

~~ix. Perception;( )~~

~~x. Peripheral nerve function integrity;( )~~

~~xi. Locomotor skills;( )~~

~~xii. Fit, function and comfort of prosthetic, orthotic, and other assistive devices;( )~~

~~xiii. Limb volume, symmetry, length and circumference;( )~~

~~xiv. Clinical evaluation of cardiac and respiratory status to include adequacy of pulses, noninvasive assessment of peripheral circulation, thoracic excursion, vital capacity, and breathing patterns;( )~~

~~xv. Vital signs such as pulse, respiratory rate, and blood pressure;( )~~

~~xvi. Activities of daily living; and the physical environment of the home and work place; and( )~~

~~xvii. Pain patterns, localization and modifying factors; and( )~~

~~xviii. Photosensitivity.( )~~

~~**b.** Specifically excluded are the ordering of electromyographic study, electrocardiography, thermography, invasive vascular study, selective injection tests, or complex cardiac or respiratory function studies without consultation and direction of a physician.( )~~

~~**05.** **Functional Mobility Training**. Includes gait training, locomotion training, and posture training. ( )~~

~~**06.** **Manual Therapy**. Skilled hand movements to mobilize or manipulate soft tissues and joints for the purpose of: ( )~~

~~a. Modulating pain, increasing range of motion, reducing or eliminating soft tissue swelling, inflammation or restriction;( )~~

~~b. Inducing relaxation;( )~~

~~c. Improving contractile and non-contractile tissue extensibility; and( )~~

~~d. Improving pulmonary function.( )~~

~~07. **Physical Agents or Modalities**. Thermal, acoustic, radiant, mechanical, or electrical energy used to produce physiologic changes in tissues.( )~~

~~08. **General Supervision**. A physical therapist's availability at least by means of telecommunications, which does not require a physical therapist to be on the premises where physical therapy is being provided, for the direction of a physical therapist assistant.( )~~

~~09. **Direct Supervision**. A physical therapist's or physical therapist assistant's physical presence and availability to render direction in person and on the premises where physical therapy is being provided.( )~~

~~10. **Direct Personal Supervision**. A physical therapist's or physical therapist assistant's direct and continuous physical presence and availability to render direction, in person and on the premises where physical therapy is being provided. The physical therapist or physical therapist assistant must have direct contact with the patient during each session and assess patient response to delegated treatment.( )~~

~~11. **Supervising Physical Therapist**. A licensed physical therapist who developed and recorded the initial plan of care and/or who has maintained regular treatment sessions with a patient. Such physical therapist's designation of another licensed physical therapist if the physical therapist who developed and recorded the initial plan of care or maintained regular treatment sessions is not available to provide direction at least by means of telecommunications.( )~~

~~12. **Nationally Accredited School**. A school or course of physical therapy or physical therapist assistant with a curriculum approved by the Commission on Accreditation in Physical Therapy Education (CAPTE) or an accrediting agency recognized by the U.S. Department of Education, the Council on Postsecondary Accreditation, or a successor entity, or both.( )~~

~~13. **Examination**. The examination is the National Physical Therapy Examination (NPTE) administered by Federation of State Boards of Physical Therapy. The examination may also include a jurisprudence examination adopted by the Board.( )~~

~~**01. Supervision:** supervision and oversight of a person by a licensed physical therapist when the licensed physical therapist is immediately available in person, by telephone, or by electronic communication to assist the person.~~

~~**011. -- 015.(RESERVED)**~~

200~~016~~. PRACTICE STANDARDS ~~SUPERVISION~~.

01. Scope of Practice. Physical Therapists and Physical Therapist Assistants must possess the education, training, and experience within their scope of practice to perform physical therapy tasks. ( )

02. Supervision. Supervision is oversight of a person by a licensed physical therapist when the licensed physical therapist is immediately available in person, by telephone, or by electronic communication to assist the person. A physical therapist shall supervise and be responsible for patient care given by physical therapist assistants, supportive personnel, physical therapy students, and physical therapist assistant students.( )

~~01~~**a. Procedures and Interventions Performed Exclusively by Physical Therapist**. The following procedures and interventions shall be performed exclusively by a physical therapist:( )

~~a~~**i.** Interpretation of a referral for physical therapy if a referral has been received.( )

~~b~~**ii.** Performance of the initial patient evaluation and problem identification including a diagnosis for physical therapy and a prognosis for physical therapy.( )

~~c~~**iii.** Development or modification of a treatment plan of care which is based on the initial evaluation and which includes long-term and short-term physical therapy treatment goals.( )

~~d~~**iv.** Assessment of the competence of physical therapist assistants, physical therapy students, physical therapist assistant students, and supportive personnel to perform assigned procedures, interventions and routine tasks. ( )

~~e~~**v.** Selection and delegation of appropriate portions of treatment procedures, interventions and routine physical therapy tasks to the physical therapist assistants, physical therapy students, physical therapist assistant students, and supportive personnel.( )

~~f~~**vi.** Performance of a re-evaluation when any change in a patient's condition occurs that is not consistent with the physical therapy treatment plan of care, patient's anticipated progress, and physical therapy treatment goals. ( )

~~g~~**vii.** Performance and documentation of a discharge evaluation and summary of the physical therapy treatment plan. ( )

~~**h.** Performance of dry needling.( )~~

03~~2~~. Supervision of Physical Therapist Assistants. A physical therapist assistant must be supervised by a physical therapist by no less than telecommunication ~~standard than general supervision~~.( )

a. A physical therapist assistant must not change a procedure or intervention unless such change of procedure or intervention has been included within the treatment plan of care as set forth by a physical therapist. ( )

b. A physical therapist assistant may not continue to provide treatment as specified under a treatment plan of care if a patient's condition changes such that further treatment necessitates a change in the established treatment plan of care unless the physical therapist assistant has consulted with the supervising physical therapist prior to the patient's next appointment for physical therapy, and a re-evaluation is completed by the supervising physical therapist.( )

c. The supervising physical therapist must provide direct personal contact with the patient and assess the plan of care on or before every ten (10) visits or once a week if treatment is performed more than once per day but no less often than once every sixty (60) days. The supervising therapist's assessment must be documented in the patient record. ( )

d. A physical therapist assistant may refuse to perform any procedure, intervention, or task delegated by a physical therapist when such procedure, intervention, or task is beyond the physical therapist assistant's skill level or scope of practice standards.( )

e. A physical therapist is not required to co-sign any treatment related documents prepared by a physical therapist assistant, unless required to do so in accordance with law, or by a third-party.( )

04~~3~~. Supervision of Supportive Personnel. Any routine physical therapy tasks performed by supportive personnel requires a physical therapist's or physical therapist assistant's direct and continuous physical presence and availability to render direction, in person on the premises where physical therapy is being provided. The physical therapist or physical therapist assistant must have direct contact with the patient during each session and assess patient response to delegated treatment. ~~direct personal supervision.~~( )

05~~4~~. Supervision of Physical Therapist~~y~~ and Physical Therapist Assistant Students. Supervision of

physical therapist~~y~~ students and physical therapist assistant students requires availability of the physical therapist or physical therapist assistant to render direction in person and on the premises where physical therapy is being provided. ~~direct supervision.~~( )

~~**a.** A physical therapy student is only supervised by the direct supervision of a physical therapist.( )~~

~~b~~a. A physical therapy student is required to sign all treatment notes with the designation "SPT" after their name, and all such signatures require the co-signature of the supervising physical therapist.( )

~~c~~b. A physical therapist assistant student is required to sign all treatment notes with the designation "SPTA" after their name, and all such signatures require the co-signature of the supervising physical therapist or supervising physical therapist assistant.( )

~~**05. Supervision Ratios**.( )~~

~~**a.** At any one time, the physical therapist may supervise up to a total of three supervised personnel, who are physical therapist assistants or supportive personnel. If the physical therapist is supervising the maximum of three supervised personnel at any one time, no more than two of the supervised personnel may be supportive personnel or physical therapist assistants.( )~~

~~**b.** In addition to the supervised personnel authorized in a. of this subsection, the physical therapist may supervise two persons engaging in direct patient care who are pursuing a course of study leading to a degree as a physical therapist or a physical therapist assistant.( )~~

~~017~~201. -- 299~~174~~. (RESERVED)

100~~75~~. ~~REQUIREMENTS FOR~~ LICENSURE.

~~An individual shall be entitled to a license upon the submission of proof and approval that the individual has successfully passed the NPTE with a scaled score of at least six hundred (600) and the jurisprudence examination with a score of at least seventy-five percent (75%). Foreign educated individuals whose native language is not English must submit proof of successfully passing one (1) of the following English proficiency exams:( )~~

~~**01. Test of English as a Foreign Language (TOEFL)**. Minimum passing scores of two hundred twenty (220) for computer test and five hundred sixty (560) for paper test;( )~~

~~**02. Test of English as a Foreign Language – Internet-Based Test (TOEFL IBT)**. Minimum passing scores of twenty-four (24) in writing; twenty-six (26) in speaking, twenty-one (21) in reading, and eighteen (18) in listening; or( )~~

01. Examinations. An applicant must successfully pass the National Physical Therapy Examination (NPTE), with a minimum score set by the Federation of State Boards of Physical Therapy. Foreign-educated applicants whose native language is not English must also successfully pass either: (a) the Test of English as a Foreign Language (TOEFL) with a minimum passing score of two hundred twenty (220) for the computer test and five hundred sixty (560) for the paper test; or (b) the Test of English as a Foreign Language – Internet-Based Test (TOEFL IBT) with a minimum passing score of twenty-four (24) in writing, twenty-six (26) in speaking, twenty-one (21) in reading, and eighteen (18) in listening.

~~**03. Alternative Exams**. as otherwise approved by the Board.( )~~

~~**176. INACTIVE STATUS.**~~

~~**01. Request for Inactive Status**. Licensees requesting an inactive status during the renewal of their active license must submit a written request and pay the established fee.( )~~

~~**02. Continuing Education**. All continuing education requirements will be waived for any year or portion thereof that a licensee maintains an inactive license and is not actively practicing in Idaho.( )~~

~~**03.** **Reinstatement to Full Licensure from Inactive Status**.~~

~~**a.** Return to Active Status of License - Inactive for Five (5) or Fewer Years. An inactive license holder whose license has been inactive for five (5) or fewer years may convert from inactive to active license status by:( )~~

~~i. Providing documentation to the Board showing successful completion within the previous twelve (12) months of the following continuing education requirements:( )~~

~~(1). Licenses inactive for three (3) years or less, one (1) year of continuing education; or( )~~

~~(2). Licenses inactive for more than three (3) years, two (2) years of continuing education; and( )~~

~~ii. Paying the appropriate fee.( )~~

~~**b.** Return to Active Status of License - Inactive for Greater than Five (5) Years. An inactive license holder whose license has been inactive for greater than five (5) years may convert from inactive to active license status by: ( )~~

~~i. Providing documentation to the Board showing successful completion within the previous twelve (12) months of two (2) years of continuing education requirements; and( )~~

~~ii. Providing proof that the licensee has actively engaged in the practice of physical therapy in another state or territory of the United States for at least three (3) of the immediately preceding five (5) years or provide proof that the licensee is competent to practice in Idaho.( )~~

~~iii. The Board may consider the following factors when determining proof of competency:( )~~

~~(1). Number of years of practice prior to transfer from active status;( )~~

~~(2). Employment in a field similar to physical therapy; and( )~~

~~(3). Any other factors the Board deems appropriate.( )~~

~~**177. -- 179.(RESERVED)**~~

~~**180. DRY NEEDLING CERTIFICATION.**~~
~~The Board may grant certification for dry needling to a physical therapist who completes an application, pays the applicable fees, and meets the following requirements:( )~~

~~**01.** **Training and Education**. At least one (1) year of practice as a licensed physical therapist and successful completion of a Board approved course that is a minimum of twenty-seven (27) hours of in-person instruction of which no less than sixteen (16) hours must be hands-on application of dry needling techniques by the physical therapist.( )~~

~~**02.** **Course Approval**. The Board will review course curriculum, including a course syllabus, prior to approval. The course must:( )~~

~~**a.** Be taught by a qualified instructor as shown by education and experience;( )~~

~~**b.** Include instruction and training on indications/contraindications for dry needling, safe needling technique, and blood borne pathogens;( )~~

~~**c.** Require successful completion of an assessment of proficiency in dry needling, which includes a practical demonstration of the physical therapist's dry needling skills.( )~~

~~**03.** **Course Completion**. Completion of this education and training may have occurred prior to the effective date of these rules.( )~~

~~**181. DRY NEEDLING RECERTIFICATION.**~~

~~**01.** **Issuance**. Dry needling certification shall be issued every three (3) years by timely submission of a physical therapy license renewal application, payment of the physical therapy license renewal fee, the dry needling certification fee, and payment of fines, costs, fees or other amounts that are due and owing to the Board or in compliance with a payment arrangement with the Board, and verifying to the Board that the licensee is in compliance with the requirements for dry needling certification as provided in the Board's laws and rules.( )~~

~~**02.** **Expiration Date**. Physical Therapists dry needling certification expires on the expiration date of their physical therapy license and must be issued every three (3) years. Proof of completion of a minimum of twenty-seven (27) hours of in-person instruction of which no less than sixteen (16) hours must be hands-on application of dry needling techniques by the physical therapist, must be provided for renewal of their license. The Board must waive the dry needling certification fee in conjunction with the first timely renewal of the physical therapy license after initial dry needling certification.( )~~

~~**03.** **Failure to Comply with Issuance Requirements**.~~

~~**a.** If a licensee with dry needling certification fails to verify meeting dry needling issuance requirements when renewing their physical therapy license, the dry needling certification is canceled and the physical therapy license will be renewed without dry needling certification.( )~~

~~**b.** If a licensee with dry needling certification fails to timely renew their physical therapy license, their dry needling certification is canceled.( )~~

~~**182. -- 199.(RESERVED)**~~

~~2~~400. FEES.
All fees are non-refundable.

FEE TYPE	AMOUNT ~~(Not to Exceed)~~	RENEWAL ~~(Not to Exceed)~~
Physical Therapist License	$25	$25
Physical Therapist Assistant License	$20	$20
Examination	Established by examination entity plus an administrative fee not to exceed $20	
~~Reinstatement~~	~~As provided in Section 67-2614, Idaho Code~~	
Application	$25	
~~Dry Needling Certification~~	~~$25~~	~~$25~~
~~Physical Therapist Inactive~~	~~$15~~	~~$15~~
~~Physical Therapist Assistant Inactive~~	~~$10~~	~~$10~~
~~Inactive to Active License~~	~~The difference between the inactive fee and active license renewal fee~~	

( )

~~201~~401. -- ~~249~~999. (RESERVED)

~~25~~ 100.02 Continuing Education. ~~REQUIREMENT.~~

~~01~~a. Renewal of License. Every person holding a license issued by the Board must ~~annually~~ complete ~~sixteen (16)~~ thirty-two (32) contact hours of continuing education every two years.~~prior to license renewal~~.( )

~~02~~b. Reinstatement of License. Any license canceled for failure to renew may be reinstated in accordance with Section 67-2614, Idaho Code, with the exception that the applicant must submit proof of having met the following continuing education requirements:( )

i. For licenses expired for three (3) years or less, one (1) year of continuing education; or ( )

ii. For licenses expired for more than three (3) years, thirty-two (32) hours of continuing education.( )

~~03~~c. Contact Hours. The contact hours of continuing education must be obtained in areas of study germane to the practice for which the license is issued a certificate of completion or transcript. ~~as approved by the board.~~ ( )

~~04~~d. Documentation of Attendance. The applicant must provide documentation verifying attendance by securing authorized signatures or other documentation from the course instructors, providers, or sponsoring institution substantiating any hours attended by the licensee. This documentation must be maintained by the licensee and provided to the board upon request by the board or its agent.( )

~~**05. Excess Hours**. Continuing education hours accumulated during the twelve (12) months immediately preceding the license expiration date may be applied toward meeting the continuing education requirement for the next license renewal. Hours in excess of the required hours may be carried forward. Excess hours may be used only during the next renewal period and may not be carried forward more than one (1) time.( )~~

~~**06. Compliance Audit**. The board may conduct random continuing education audits of those persons required to obtain continuing education in order to renew a license and require that proof acceptable to the board of meeting the continuing education requirement be submitted to the Division. Failure to provide proof of meeting the continuing education upon request of the board are grounds for disciplinary action.( )~~

~~**07. Special Exemption**. The board has authority to make exceptions for reasons of individual hardship, including health or other good cause. The licensee must provide any information requested by the board to assist in substantiating hardship cases. This exemption is granted at the sole discretion of the board.( )~~

~~**08. Continuing Education Credit Hours**. Hours of continuing education credit may be obtained by attending and participating in a continuing education activity approved by the Board.( )~~

~~a. General Criteria. A continuing education activity which meets all of the following criteria is appropriate for continuing education credit:( )~~

~~i. Constitutes an organized program of learning which contributes directly to the professional competency of the licensee;( )~~

~~ii. Pertains to subject matters integrally related and germane to the practice of the profession;( )~~

~~iii. Conducted by individuals who have specialized education, training and experience to be considered qualified to present the subject matter of the program. The Board may request documentation of the qualifications of presenters;( )~~

~~iv. Application for Board approval is accompanied by a paper, manual or outline which describes the specific offering and includes the program schedule, goals and objectives; and( )~~

~~v. Provides proof of attendance to licensees in attendance including: Date, location, course title,~~

presenter(s); Number of program contact hours (One (1) contact hour equals one (1) hour of continuing education credit.); and the official signature or verification of the program sponsor.( )

b. Specific Criteria. Continuing education hours of credit may be obtained by:( )

i. Presenting professional programs which meet the criteria listed in these rules. Two (2) hours of credit will be awarded for each hour of presentation by the licensee. A course schedule or brochure must be maintained for audit;( )

ii. Providing official transcripts indicating successful completion of academic courses which apply to the field of physical therapy in order to receive the following continuing education credits:( )

(1) One (1) academic semester hour = fifteen (15) continuing education hours of credit;( )

(2) One (1) academic trimester hour = twelve (12) continuing education hours of credit;( )

(3) One (1) academic quarter hour = ten (10) continuing education hours of credit.( )

iii. Attending workshops, conferences, symposiums or electronically transmitted, live interactive conferences which relate directly to the professional competency of the licensee;( )

iv. Authoring research or other activities that are published in a recognized professional publication. The licensee will receive five (5) hours of credit per page;( )

v. Viewing videotaped presentations if the following criteria are met:( )

(1) There is a sponsoring group or agency;( )

(2) There is a facilitator or program official present;( )

(3) The program official may not be the only attendee; and( )

(4) The program meets all the criteria specified in these rules;( )

vi. Participating in home study courses that have a certificate of completion;( )

vii. Participating in courses that have business-related topics: marketing, time management, government regulations, and other like topics;( )

viii. Participating in courses that have personal skills topics: career burnout, communication skills, human relations, and other like topics;( )

ix. Participating in courses that have general health topics: clinical research, CPR, child abuse reporting, and other like topics; ( )

x. Supervision of a physical therapist student or physical therapist assistant student in an accredited college program. The licensee will receive four (4) hours of credit per year; and( )

xi. Completion and awarding of Board Certification or recertification by American Board of Physical Therapy Specialists (ABPTS). The licensee will receive sixteen (16) hours for the year the certification or recertification was received.( )

09. Course Approval. Courses of study relevant to physical therapy and sponsored or provided by the American Physical Therapy Association (APTA) or any of its sections or local chapters; CAPTE; the National Athletic Trainers Association; an accredited, or candidate for accreditation, college or university; or otherwise approved by the Board.( )

~~**10.** **Submitting False Reports or Failure to Comply**. The Board may condition, limit, suspend, or refuse to renew the license of any individual whom the Board determines submitted a false report of continuing education or failed to comply with the continuing education requirements.( )~~

<u>10</u>~~25~~1. -- ~~274~~<u>199</u>.(RESERVED)

~~275~~<u>300</u>. DISCIPLIN<u>E</u>~~ARY PENALTY~~.

~~**01.** **Disciplinary Procedures**. The disciplinary procedures of the Division are the disciplinary procedures of the Board.( )~~

0<u>1</u>~~2~~. **Civil Fine**. The Board may impose a civil fine not to exceed one thousand dollars ($1,000) for each violation upon anyone licensed under Title 54, Chapter 22, Idaho Code who is found by the Board to be in violation of Section 54-2219, Idaho Code.( )

~~**276. -- 299.(RESERVED)**~~

~~**300. CODE OF ETHICS.**~~
~~Physical therapists and physical therapist assistants are responsible for maintaining and promoting ethical practice in accordance with the ethical principles set forth in Appendix A and Appendix B to these rules.( )~~

301. -- ~~9~~<u>3</u>99.(RESERVED)

~~**Appendix A - Physical Therapist Code Of Ethics**~~

~~**Preamble**~~

~~This Code of Ethics of the American Physical Therapy Association sets forth principles for the ethical practice of physical therapy. All physical therapists are responsible for maintaining and promoting ethical practice. To this end, the physical therapist shall act in the best interest of the patient/client. This Code of Ethics shall be binding on all physical therapists.~~

~~**Principle 1**~~
~~A physical therapist shall respect the rights and dignity of all individuals and shall provide compassionate care.~~

~~**Principle 2**~~

~~A physical therapist shall act in a trustworthy manner toward patients/clients and in all other aspects of physical therapy practice.~~

~~**Principle 3**~~

~~A physical therapist shall comply with laws and regulations governing physical therapy and shall strive to effect changes that benefit patients/clients.~~

~~**Principle 4**~~

~~A physical therapist shall exercise sound professional judgment.~~

~~**Principle 5**~~

~~A physical therapist shall achieve and maintain professional competence.~~

~~**Principle 6**~~

~~A physical therapist shall maintain and promote high standards for physical therapy practice, education, and~~

~~research.~~

~~Principle 7~~

~~A physical therapist shall seek only such remuneration as is deserved and reasonable for physical therapy services.~~

~~Principle 8~~

~~A physical therapist shall provide and make available accurate and relevant information to patients/clients about their care and to the public about physical therapy services.~~

~~Principle 9~~

~~A physical therapist shall protect the public and the profession from unethical, incompetent, and illegal acts.~~

~~Principle 10~~

~~A physical therapist shall endeavor to address the health needs of society.~~

~~Principle 11~~

~~A physical therapist shall respect the rights, knowledge, and skills of colleagues and other health care professionals.~~

~~APPENDIX B – PHYSICAL THERAPIST ASSISTANT CODE OF ETHICS~~

~~Preamble~~
~~This document of the American Physical Therapy Association sets forth standards for the ethical conduct of the physical therapist assistant. All physical therapist assistants are responsible for maintaining high standards of conduct while assisting physical therapists. The physical therapist assistant shall act in the best interest of the patient/client. These standards of conduct shall be binding on all physical therapist assistants.~~

~~Standard 1~~

~~A physical therapist assistant shall respect the rights and dignity of all individuals and shall provide compassionate care.~~

~~Standard 2~~

~~A physical therapist assistant shall act in a trustworthy manner toward patients/clients.~~

~~Standard 3~~

~~A physical therapist assistant shall provide selected physical therapy interventions only under the supervision and direction of a physical therapist.~~

~~Standard 4~~

~~A physical therapy assistant shall comply with laws and regulations governing physical therapy.~~

~~Standard 5~~

~~A physical therapist assistant shall achieve and maintain competence in the provision of selected physical therapy interventions.~~

~~**Standard 6**~~

~~A physical therapist assistant shall make judgments that are commensurate with his or her educational and legal qualifications as a physical therapist assistant.~~

~~**Standard 7**~~

~~A physical therapist assistant shall protect the public and the profession from unethical, incompetent, and illegal~~

IDAPA 24 – DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSES

24.14.01 – RULES OF THE STATE BOARD OF SOCIAL WORK EXAMINERS

DOCKET NO. 24-1401-2301 (ZBR CHAPTER REWRITE, FEE RULE)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo and Cost/Benefit Analysis (CBA)

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2024 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. The pending rule will become final and effective upon the adjournment, *sine die*, of the Second Regular Session of the Sixty-seventh Idaho Legislature after approval.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 67-2604, Idaho Code, and Sections 54-3204, 54-3209, 54-3211, 54-3212, 67-2614, 67-9406, and 67-9409, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

The pending rule is being adopted under Executive Order 2020-01, Zero Based Regulation. Text amended since these rules were published as proposed are as follows:

- 100.03 - "apprenticeship program" was changed to "supervised clinical experience" for clarity;
- 100.05 - "for four (4) years" was added to limit the scope of agency inquiries;
- 100.06 - reintroduced language that had previously been removed from the rules, causing confusion;
- 200.04.f. - added the word "former clients" for public protection;
- 200.04.g. - added new subsection to specify allowable sexual behavior with former clients;
- 200.04.h. - removed language made duplicative by adding section 6 above; and
- 200.05.a. - changed gendered language to neutral language.

The text of the pending rule has been amended in accordance with Section 67-5227, Idaho Code. Only those sections that have changes that differ from the proposed text are printed in this bulletin. The complete text of the proposed rule was published in the September 6, 2023, Idaho Administrative Bulletin, Vol. 23-9, pages 323-340.

FEE SUMMARY: Pursuant to Section 67-5224(2)(d), Idaho Code, this pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature. The following is a description of the fee or charge imposed or increased in this rulemaking:

As authorized in Sections 54-3209 and 67-2614, Idaho Code, none of the fees for applications, licenses, registrations and reinstatement as designated in Rule 400 are being changed as a result of this rulemaking or since being previously reviewed by the Idaho Legislature.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year:

This rulemaking is not anticipated to have any negative fiscal impact on the State General Fund.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Katie Stuart at 208-577-2489.

DATED this 6th day of December, 2023.

Katie Stuart
Bureau Chief
11341 W. Chinden Blvd., Bldg. #4
Boise, ID 83714
Phone: (208) 577-2489
Email: katie.stuart@dopl.idaho.gov
Website: https://dopl.idaho.gov/

THE FOLLOWING NOTICE PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. This rulemaking action is authorized pursuant to Section 67-2604, Idaho Code, and Sections 54-3204, 54-3209, 54-3211, 54-3212, 67-2614, 67-9406, and 67-9409, Idaho Code.

PUBLIC HEARING SCHEDULE: The public hearing concerning this rulemaking will be held as follows:

Thursday, September 14, 2023, 9:00 a.m. MT

Division of Occupational and Professional Licenses
Chinden Campus Building 4
11341 W. Chinden Blvd., Bldg. #4
Boise, ID 83714

Telephone and web conferencing information will be posted on:
https://dopl.idaho.gov/calendar/ and https://townhall.idaho.gov/

The hearing site will be accessible to persons with disabilities, if needed. Requests for accommodation must be made not later than five (5) days prior to the meeting to the agency address below.

DESCRIPTIVE SUMMARY AND STATEMENT OF PURPOSE: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

Under Executive Order 2020-01, Zero-Based Regulation, the Board of Social Work Examiners is striving to prevent the accumulation of costly, ineffective, and outdated regulations and reduce regulatory burden to achieve a more efficient operation of government. In conjunction with stakeholders, the proposed rule changes reflect a comprehensive review of this chapter by collaborating with the public to streamline or simplify the rule language in this chapter and to use plain language for better understanding. This proposed rulemaking updates the rules to comply with governing statute and Executive Order 2020-01.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased:

The fees for applications, licenses, and reinstatement as designated in Rule 400 of these proposed rules are authorized in Section 54-3209, Idaho Code. None of these fees are being changed as a result of this rulemaking or since being previously reviewed by the Idaho legislature.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year as a result of this rulemaking:

This rulemaking is not anticipated to have any negative fiscal impact on the State General Fund.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was conducted under Docket No. 24-ZBRR-2301. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the April 5, 2023 Idaho Administrative Bulletin, Vol. 23-4, pp. 42-46.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into this rule: N/A.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS, OBTAINING DRAFT COPIES: For assistance on technical questions concerning this proposed rule, contact Katie Stuart, Administration Bureau Chief, at (208) 577-2489. Materials pertaining to the proposed rulemaking, including any available preliminary rule drafts, can be found on the following DOPL website: https://dopl.idaho.gov/rulemaking/.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before September 27, 2023.

DATED this 8th day of August, 2023.

THE FOLLOWING IS THE TEXT OF ZBR DOCKET NO. 24-1401-2301

24.14.01 – RULES OF THE STATE BOARD OF SOCIAL WORK EXAMINERS

000. LEGAL AUTHORITY.
These rules are promulgated pursuant to Section 54-3204, Idaho Code. ( )

001. SCOPE.
These rules govern the practice of social work in Idaho. ( )

002. DEFINITIONS.

01. Psychotherapy. Treatment methods using a specialized, formal interaction between a Clinical Social Worker and an individual, couple, family, or group in which a therapeutic relationship is established, maintained, or sustained to understand unconscious processes, intrapersonal, interpersonal, and psychosocial dynamics, and the diagnosis and treatment of mental, emotional, and behavioral disorders, conditions, and addictions. ( )

02. Relative. For the purposes of these rules, a relative is a person's spouse, parent, child, or sibling, regardless of whether the relation is by blood, through marriage, or by law. ( )

03. Supervisor. A clinical social worker who has been licensed for at least two (2) years, has not been disciplined for acts relating to client care within the past five (5) years, and has completed fifteen (15) hours of clinical supervisor training. ( )

04. Supportive Counseling. A method used to assist individuals, couples, families, and groups in learning how to solve problems and make decisions about personal, health, social, educational, vocational, financial, and other interpersonal concerns. This help in the maintenance of adaptive patterns is done in the interview through reassurance, advice giving, information providing, and pointing out client strengths and resources. Supportive

counseling does not seek to reach unconscious material. ( )

003. -- 099. (RESERVED)

100. LICENSURE.

01. Approved College, University, or Program. An educational institution accredited by the US Department of Education, a regionally accredited institution of higher education, or as otherwise approved by the Board, and a social work program accredited by the Council on Social Work Education (CSWE) or as otherwise approved by the Board. ( )

02. Approved Examination. The applicable Association of Social Work Boards (ASWB) licensing examination for the license type, passed within the previous seven (7) years. ( )

03. Approved Postgraduate Supervised Clinical Experience for Clinical Social Worker License. Three thousand (3,000) hours of supervised clinical social work experience must be completed over the course of no fewer than two (2) years and no more than five (5) years, including 1.) one thousand seven hundred fifty (1,750) hours of direct client contact involving treatment in clinical social work as defined and one thousand two hundred fifty (1,250) hours of assessment, diagnosis, and other clinical social work, including indirect hours that may occur outside the presence of a client; and 2.) at least one hundred (100) hours of in-person or remote live electronic connection face-to-face contact with the supervisor, and with no more than fifty (50) hours of the face-to-face contact hours involving group supervision. At least fifty percent (50%) of the supervision must be provided by a licensed clinical social worker, with the remaining supervision provided by a licensed clinical psychologist, psychiatrist, clinical professional counselor, or marriage and family therapist. The supervisor must be licensed in the state in which the supervised experience was obtained. Supervision for clinical work must continue until clinical licensure is issued. The supervised clinical experience must comply with all criteria identified on the Clinical Social Work Supervision Report Forms. Supervision must be interactive and consultative teaching directed toward the enhancement and improvement of the individual's social work values, knowledge, methods, and techniques. Hours spent on case management will not count toward clinical social work hours. ( )

a. Any licensee who has reached the maximum of five (5) years of experience and who is awaiting passing test results may not continue to practice under supervision and may only practice at the level of licensure that they currently hold. ( )

b. If the supervised experience was completed more than five (5) years prior to application for licensure the Board will evaluate the applicant's competency, including evaluating completion of continuing education, supervised practice, examination, and/or practice in another jurisdiction. ( )

04. Endorsement. In addition to the requirement in Section 54-3208, Idaho Code, the applicant must have successfully passed the approved examination for the license type or an equivalent, unless such an examination was not required at the time of the applicant's original licensure. ( )

05. Continuing Education. To renew or return to active status, licensees must complete during the preceding twenty-four (24) months, and retain proof of completion for four (4) years, of thirty (30) hours of continuing education, two (2) hours of which must be in professional ethics and the remainder germane to the practice of social work. CE hours may be obtained for preparing and providing germane continuing education or training to other professionals and for individual research projects. Courses that are part of the curriculum of an accredited university, college or other educational institution are allotted CE credit at the rate of fifteen (15) CE hours for each semester hour or ten (10) CE hours for each quarter hour of school credit awarded. ( )

06. Inactive Status. A licensee requesting inactive status must submit the required form and pay the inactive license fee. To return to active status a licensee must meet the continuing education requirements and submit a fee equivalent to the difference between the inactive and active renewal fee. After five (5) years of going inactive, a licensee must demonstrate competency to resume practice, as required by the Board. The requirements may include, but are not limited to, education, supervised practice, examination, and/or practice in another jurisdiction. ( )

101. -- 199. (RESERVED)

200. PRACTICE STANDARDS.

01. Baccalaureate Social Work. The application of social work theory, knowledge, methods, and ethics to restore or enhance social or psychosocial functioning of individuals, couples, families, groups, organizations, and communities. Baccalaureate social work is a generalist practice that includes assessment, planning, intervention, evaluation, case management, information and referral, supportive counseling, supervision, and consultation with clients. Baccalaureate social work also includes advocacy, education, community organization, and the development, implementation and administration of policies, programs, and activities. Bachelor level social workers are prohibited from performing psychotherapy. ( )

02. Master's Social Work. The application of social work theory, knowledge, methods and ethics, and the professional use of self to restore or enhance social, psychosocial or biopsychosocial functioning of individuals, couples, families, groups, organizations, and communities. Master's social work requires the application of specialized knowledge and advanced practice skills in the areas of assessment, treatment planning, implementation and evaluation, case management, information and referral, supportive counseling, supervision and consultation with clients, advocacy, teaching, research, community organization, and the development, implementation, and administration of policies, programs, and activities. Master level social workers who do not hold clinical licensure may provide psychotherapy only under the supervision of a licensed clinical social worker, psychologist, or psychiatrist. ( )

03. Clinical Social Work. The practice of clinical social work is a specialty within the practice of master's social work and requires the application of specialized clinical knowledge and advanced clinical skills in the areas of assessment, diagnosis, and treatment of mental, emotional, and behavioral disorders, conditions and addictions. Clinical social work is based on knowledge and theory of psychosocial development, behavior, psychopathology, motivation, interpersonal relationships, environmental stress, social systems, and cultural diversity, with particular attention to person-in-environment. It shares with all social work practice the goal of enhancement and maintenance of psychosocial functioning, including psychotherapy, of individuals, couples, families, and small groups. ( )

04. Code of Professional Conduct. ( )

a. A social worker must operate within their education, training, and experience and meet the applicable standard of care provided by other qualified social workers in the same or similar community and under the same or similar circumstances. A standard of care violation may exist where a social worker engages in professional conduct that a reasonable social worker would not under the same or similar circumstances and in the same or similar community, or where the social worker knew or should have known the professional conduct would cause unreasonable harm to the client. ( )

b. When a social worker leaves an agency or practice, clients must be provided prompt notice and the opportunity to remain with the agency or practice, or to continue care with the social worker. ( )

c. A social worker will not divide a fee or accept or give anything of value for receiving or making a referral. ( )

d. A social worker will provide clients with accurate and complete information regarding the extent and nature of the services available to them. ( )

e. While a social worker may terminate, transfer, or refer a client when the services are no longer needed or in the client's best interests, prompt notification should be provided to the client. The social worker must attempt to make appropriate referrals as indicated by the client's need or request for services. ( )

f. A social worker may not exploit, sexually or otherwise, their professional relationships with clients, supervisees, former clients, supervisors, students, employees, or research participants. ( )

g. A social worker may not engage in romantic or sexual acts with a client during and for ten (10) years following termination of a social worker's services. A social worker must not provide social work services to a

person with whom they have had a romantic or sexual relationship. ( )

h. A social worker may not engage in romantic or sexual acts with a relative of a client, or a person known to the social worker to have a close personal relationship with the client when it has the potential to be harmful to the client, during and for three (3) years following termination of a social worker's services. ( )

i. In providing services, a social worker may not discriminate on the basis of age, gender, gender identity, sexual orientation, race, color, religion, national origin, mental status, physical disability, social or economic status, political belief, or any other preference or personal characteristic, condition or status. ( )

j. A social worker must obtain the client's or legal guardian's informed written consent when a client is to be involved in a research project. A social worker must explain the research, including any implications. ( )

k. A social worker must obtain informed consent of clients before taping, recording, or permitting third party observation. ( )

l. A social worker must safeguard information given by clients in providing client services. ( )

m. A social worker, regardless of personal or professional relationship, must report a licensee's violation of the Board's law or rules. ( )

n. A social worker may not disseminate or cause the dissemination of any fraudulent or deceptive advertisement. ( )

o. A social worker may not engage in dual or multiple relationships with clients or with relatives of a client, or with individuals with whom clients have close personal relationships known to the social worker, in which a reasonable and prudent social worker would conclude after appropriate assessment that there is a risk of harm or exploitation to the client or of impairing a social worker's objectivity or professional judgment. A dual or multiple relationship is a relationship that occurs when a social worker interacts with a client in more than one capacity, whether it be before, during, or after the professional, social, or business relationship. Dual or multiple relationships can occur simultaneously or consecutively. After an appropriate assessment determines that the relationship does not create a risk of harm or exploitation to the client and will not impair a social worker's objectivity or professional judgment, the social worker must document in case records, prior to the interaction, when feasible, the rationale for such a relationship, and the potential benefits. ( )

p. A social worker may not purchase goods or services from a client or otherwise engage in a business relationship with a client except when 1) the client is providing necessary goods or services to the general public; 2) a reasonable and prudent social worker would determine that it is not practical or reasonable to obtain the goods or services from another provider; and 3) a reasonable and prudent social worker would conclude after appropriate and documented assessment that engaging in the business relationship will not be detrimental to the client or the professional relationship. ( )

05. Competency. ( )

a. A social worker must only represent themself and practice in a competent manner within the boundaries of their education, training, licensure level, supervision, and other relevant professional experience. ( )

b. A social worker must only practice within new areas or use new intervention techniques or approaches after engaging in appropriate study, training, consultation, or supervision. ( )

c. A social worker must exercise careful judgment when generally recognized standards do not exist with respect to an emerging area of practice and take responsible steps to ensure the competence of his practice. ( )

201. -- 399. (RESERVED)

400. FEES.
All fees are non-refundable.

FEE TYPE	AMOUNT (Not to Exceed)	RENEWAL (Not to Exceed)	INACTIVE (Not to Exceed)
Application	$70		
Endorsement License	$90		
Licensed Clinical Social Worker	$70	$90	$45
Licensed Masters Social Worker	$70	$80	$40
Licensed Social Worker	$70	$80	$40
Reinstatement	In accordance with Section 67-2614, Idaho Code		

( )

401. -- 999. (RESERVED)

[Agency redlined courtesy copy]

***Italicized text* indicates changes between the text of the proposed rule as adopted in the pending rule.**

24.14.01 – RULES OF THE STATE BOARD OF SOCIAL WORK EXAMINERS

000. LEGAL AUTHORITY.
These rules are promulgated pursuant to Section 54-3204, Idaho Code.( )

001. SCOPE.
These rules govern the practice of social work in Idaho.( )

~~**002. -- 009.(RESERVED)**~~

0~~1~~02. DEFINITIONS.

~~**01. Professionalism**. Behavior exhibited on the part of an applicant which is in conformity with the Social Work Code of Professional Conduct as defined in Section 450 of these rules and within the limits of state law. ( )~~

0~~2~~1. Psychotherapy. Treatment methods using a specialized, formal interaction between a Clinical Social Worker and an individual, couple, family, or group in which a therapeutic relationship is established, maintained, or sustained to understand unconscious processes, intrapersonal, interpersonal, and psychosocial dynamics, and the diagnosis and treatment of mental, emotional, and behavioral disorders, conditions, and addictions. ( )

0~~3~~2. Relative. For the purposes of these rules, a relative is a person's spouse, parent, child, or sibling, regardless of whether the relation is by blood, through marriage, or by law.( )

03. Supervisor. A clinical social worker who has been licensed for at least two years, has not been disciplined for acts relating to client care within the past five (5) years, and has completed fifteen hours of clinical supervisor training. ( )

04. Supportive Counseling. ~~Supportive counseling by a social worker means a~~A method used ~~by social workers~~ to assist individuals, couples, families, and groups in learning how to solve problems and make decisions about personal, health, social, educational, vocational, financial, and other interpersonal concerns. This help in the maintenance of adaptive patterns is done in the interview through reassurance, advice giving, information providing, and pointing out client strengths and resources. Supportive counseling does not seek to reach unconscious material. ( )

~~**011. -- 099.(RESERVED)**~~

100. ~~APPROVED COLLEGES AND UNIVERSITIES.~~LICENSURE

01. Approved College, University, or Program. An~~y~~ educational institution accredited by the US Department of Education, a regionally accredited institution of higher education, or as otherwise approved by the Board, and ~~college, university, or school of social work that is accredited or is a candidate for accreditation by the Northwest Commission on Colleges and Universities or any similar accrediting body, and that offers~~ a social work program ~~that is~~ accredited by the Council on Social Work Education (CSWE) or ~~that is~~ as otherwise approved by the Board. ~~The social work program must be a recognizable, coherent organizational entity within the institution.~~( )

~~**101. -- 199.(RESERVED)**~~

~~**200. LICENSING QUALIFICATIONS AND DEFINITION OF TERMS.**~~
~~All applicants for licensing under the Social Work Licensing Act must meet the minimum qualifications as set forth by this act. ( )~~

~~**01. Educational Requirements**. Educational requirements must be verified by submission of official transcripts sent directly to the Board from the educational institution or from the repository of primary source credentialing information administered by the Association of Social Work Boards (ASWB). Applicants are responsible for arranging transmission of this information.( )~~

20~~1~~0. PRACTICE ~~OF SOCIAL WORK~~STANDARDS.

01. Baccalaureate Social Work. The application of social work theory, knowledge, methods, and ethics to restore or enhance social or psychosocial functioning of individuals, couples, families, groups, organizations, and communities. Baccalaureate social work is a generalist practice that includes assessment, planning, intervention, evaluation, case management, information and referral, supportive counseling, supervision, and consultation with clients. Baccalaureate social work also includes advocacy, education, community organization, and the development, implementation and administration of policies, programs, and activities. Bachelor level social workers are prohibited from performing psychotherapy. ~~Baccalaureate social work can include independent practice, but not private practice.~~( )

02. Master's Social Work. The application of social work theory, knowledge, methods and ethics, and the professional use of self to restore or enhance social, psychosocial or biopsychosocial functioning of individuals, couples, families, groups, organizations, and communities. Master's social work requires the application of specialized knowledge and advanced practice skills in the areas of assessment, treatment planning, implementation and evaluation, case management, information and referral, supportive counseling, supervision and consultation with clients, advocacy, teaching, research, community organization, and the development, implementation, and administration of policies, programs, and activities. Master level social workers who do not hold clinical licensure may provide psychotherapy only under the supervision of a licensed clinical social worker, psychologist, or psychiatrist ~~and in accordance with an approved supervision plan. Master's social work can include independent practice, but not private practice~~.( )

03. Clinical Social Work. The practice of clinical social work is a specialty within the practice of

master's social work and requires the application of specialized clinical knowledge and advanced clinical skills in the areas of assessment, diagnosis, and treatment of mental, emotional, and behavioral disorders, conditions and addictions. Clinical social work is based on knowledge and theory of psychosocial development, behavior, psychopathology, motivation, interpersonal relationships, environmental stress, social systems, and cultural diversity, with particular attention to person-in-environment. It shares with all social work practice the goal of enhancement and maintenance of psychosocial functioning, including psychotherapy, of individuals, couples, families, and small groups. ~~Clinical social work includes, but is not limited to, individual, couples, family and group psychotherapy, and includes independent and private practice.~~( )

~~**04. Employment of a Social Worker**. A social worker employed directly by a physician, psychologist or other social worker, or by a public or private agency, institution, hospital, nursing home, rehabilitation center, or any similar facility, is not to be considered within the definition of an independent practitioner. Furthermore, a social worker who contracts with an agency or institution that assumes full responsibility for and supervises the services provided to clients is not considered to be a private practitioner.( )~~

~~202. -- 209.(Reserved)~~

~~**210. SUPERVISION.**~~

~~**01. Generally Applicable Supervision Requirements**. All supervised experience, as set forth in this section, must meet the following requirements:( )~~

~~**a.** Supervision must be consultative-teaching supervision which is directed toward enhancement and improvement of the individual's social work values, knowledge, methods, and techniques.( )~~

~~**b.** A minimum of one hundred (100) hours of the required supervision must be face-to-face contact with the supervisor and must occur on a regular and on-going basis. Supervision may include a face-to-face setting provided by a secure live electronic connection. The secure live electronic connection must comply with any applicable state and federal laws, rules and regulations, including the health insurance portability and accountability act (HIPAA). ( )~~

~~i. A supervisee may count in full all time in a supervisory session where the ratio of supervisor to supervisees does not exceed one (1) supervisor to two (2) social workers. All one hundred (100) hours may be earned in such a one (1) to two (2) setting.( )~~

~~ii. Group supervision may count for no more than fifty (50) hours of face-to-face contact. Group supervision may count only where the ratio of supervisor to supervisees does not exceed one (1) supervisor to six (6) supervisees, and the allowable countable time must be prorated by the following formula: total session minutes divided by total supervisees, multiplied by two (2) equals the maximum allowable countable time per supervisee for the session. i.e. a supervisee attending a one (1) hour group supervisory session consisting of six (6) supervisees must be allowed twenty (20) minutes of group supervision credit (60 minutes/6 supervisees x 2 = 20 minutes).( )~~

~~**02. Pursuing Licensure As Independent Practitioners**. Requirements for supervision of baccalaureate or master's social workers pursuing licensure as independent practitioners.( )~~

~~**a.** Develop a plan for supervision that must be reviewed and approved by a designated Board member prior to commencement of supervision.( )~~

~~**b.** Complete a minimum of three thousand (3,000) hours of supervised social work experience. The hours must be accumulated in not less than two (2) years but in not more than five (5) years unless an extension is approved by the Board for good cause shown.( )~~

~~**c.** Supervision must be provided by a qualified and experienced licensed social worker with a current license in good standing and approved to pursue independent practice.( )~~

~~i. For a baccalaureate social worker the supervisor must hold a license at the baccalaureate, masters, or clinical level. ( )~~

ii. For a masters social worker the supervisor must hold a license at the masters, or clinical level. ( )

iii. Prior to a change in supervisors, the supervisee must notify the Board and the change must be approved by a designated member of the Board prior to the commencement of supervision by the new supervisor. ( )

iv. The supervisee may not have more than two (2) supervisors at any given time.( )

03. Pursuing Licensure AsApproved Postgraduate Supervised Clinical Experience for Clinical Social Worker License. Requirements for supervision of master's social workers pursuing licensure as clinical social worker. ( )

a. Develop a plan for supervision that must be reviewed and approved by a designated Board member prior to commencement of supervision.( )

b. Complete a minimum of tThree thousand (3,000) hours of supervised clinical social work experience must be completed over the course of no fewer than two (2) years and no more than five (5) years, including 1.) focused on clinical social work. The hours must be accumulated in not less than two (2) years but in not more than five (5) years unless an extension is approved by the Board for good cause shown. The hours must also meet the following:( )

i. Oone thousand seven hundred fifty (1,750) hours of direct client contact involving treatment in clinical social work as defined; and ( )

ii. Oone thousand two hundred fifty (1,250) hours involving of assessment, diagnosis, and other clinical social work, including indirect hours that may occur outside the presence of a client; as defined.( ) and 2.) at least one hundred (100) hours of in-person or remote live electronic connection face-to-face contact with the supervisor, and with no more than fifty (50) hours of the face-to-face contact hours involving group supervision.

c. At least Ffifty percent (50%) of the supervision supervised experience must be provided by a licensed clinical social worker, with registered as a supervisor pursuant to Section 211 of these rules. Tthe remaining fifty percent (50%) of supervision may be provided by one or more of the following:( )

i. A licensed clinical social worker who is registered as a supervisor pursuant to Section 211;( )

ii. A a licensed clinical psychologist, ;( )

iii. A psychiatrist, person licensed to practice medicine and surgery who practices in the area of psychiatry; ( )

iv. A licensed clinical professional counselor, registered as a supervisor by the Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists; or( )

v. A licensedor marriage and family therapist. The supervisor must be licensed in the state in which the supervised experience was obtained. Supervision for clinical work must continue until clinical licensure is issued. The apprenticeship program must comply with all criteria identified on the Clinical Social Work Supervision Report Forms. Supervision must be interactive and consultative teaching directed toward the enhancement and improvement of the individual's social work values, knowledge, methods, and techniques. Hours spent on case management will not count toward clinical social work hours. registered as a supervisor by the Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists.( )

PENDING TEXT 100.03

03. Approved Postgraduate Supervised Clinical Experience for Clinical Social Worker License. Three thousand (3,000) hours of supervised clinical social work experience must be completed over the course of no fewer than two (2) years and no more than five (5) years, including 1.) one thousand seven hundred fifty (1,750)

hours of direct client contact involving treatment in clinical social work as defined and one thousand two hundred fifty (1,250) hours of assessment, diagnosis, and other clinical social work, including indirect hours that may occur outside the presence of a client; and 2.) at least one hundred (100) hours of in-person or remote live electronic connection face-to-face contact with the supervisor, and with no more than fifty (50) hours of the face-to-face contact hours involving group supervision. At least fifty percent (50%) of the supervision must be provided by a licensed clinical social worker, with the remaining supervision provided by a licensed clinical psychologist, psychiatrist, clinical professional counselor, or marriage and family therapist. The supervisor must be licensed in the state in which the supervised experience was obtained. Supervision for clinical work must continue until clinical licensure is issued. The ~~*apprenticeship program*~~ *supervised clinical experience* must comply with all criteria identified on the Clinical Social Work Supervision Report Forms. Supervision must be interactive and consultative teaching directed toward the enhancement and improvement of the individual's social work values, knowledge, methods, and techniques. Hours spent on case management will not count toward clinical social work hours.*( )*

a. Any licensee who has reached the maximum of five (5) years of experience and who is awaiting passing test results may not continue to practice under supervision and may only practice at the level of licensure that they currently hold. ( )

b. If the supervised experience was completed more than five (5) years prior to application for licensure the Board will evaluate the applicant's competency, including evaluating completion of continuing education, supervised practice, examination, and/or practice in another jurisdiction. ( )

~~**d.** Prior to a change in supervisors, the supervisee must notify the Board and the change must be approved by a designated member of the Board prior to the commencement of supervision by the new supervisor. ( )~~

~~**e.** The supervisee may not have more than two (2) supervisors at any given time.( )~~

~~**04. Out-of-State Supervised Experience**. The Board may consider supervised experience obtained outside the state of Idaho submitted for Idaho licensure purposes as proscribed under Section 210.03 and consistent with that jurisdictions laws. Such experience, whether already obtained or planned to be obtained, must be included in the plan for supervision and reviewed and approved by a designated Board member.( )~~

~~**a.** Previous supervised experience must have been obtained within the five (5) year period preceding the submission of the plan for supervision and must have been obtained in compliance with the law and rules of the state in which the experience was obtained.( )~~

~~**211. SOCIAL WORK SUPERVISOR REGISTRATION.**~~
~~Idaho licensed social workers must be registered with the Board in order to provide postgraduate supervision for those individuals in Idaho pursuing licensure as a clinical social worker.( )~~

~~**01. Requirements for Registration**.( )~~

~~**a.** Document at least two-years' experience as a licensed clinical social worker.( )~~

~~**b.** Have not been the subject of any disciplinary action for five (5) years prior to application for registration. ( )~~

~~**c.** Document fifteen (15) contact hours of education in clinical supervisor training within the past five (5) years, as approved by the Board, or if previously registered as a supervisor with the Board, document six (6) hours of education in advanced supervisor training as approved by the Board.( )~~

~~**02. Registration**.( )~~

~~**a.** Upon receipt of a completed application verifying compliance with the requirements for~~

~~registration as a supervisor, the applicant must be registered as a supervisor.( )~~

~~**b.** A supervisor's registration must remain valid only so long as the individual's clinical social worker license remains current and in good standing.( )~~

~~**03.** **Renewal**. A supervisor's registration is valid for a term of five (5) years. To renew a supervisor registration, the registered supervisor must submit a renewal application and:( )~~

~~**a.** Hold an active Idaho clinical social worker license which has not been subject to discipline, the Board may, in its discretion, approve a supervisor who has been previously disciplined based on the nature of the discipline and the time elapsed; and( )~~

~~**b.** Document six (6) hours of continuing education in advanced supervisor training as approved by the Board and completed within the previous five (5) years.( )~~

~~**212. -- 224.(RESERVED)**~~

~~**225. INACTIVE STATUS.**~~

0~~1~~6. ~~**Request for**~~ **Inactive Status**. ~~Each person~~ A licensee requesting ~~an~~ inactive status must submit the required form and pay the inactive license fee. ( )

~~**02.** **Inactive License Status**.( )~~

~~**a.** All continuing education requirements will be waived for any year or portion thereof that a licensee maintains an inactive license and is not actively practicing or supervising in Idaho( )~~

~~**b.** To return to active status, a licensee must complete one (1) year of continuing education requirements and submit a fee equivalent to the difference between the inactive and active renewal fee.( )~~

~~**03.** **Return to Active Status After Five (5) Years or More of Inactive Status**. Licensee must provide an account to the Board for that period of time during which the license was inactive and fulfilling requirements that~~After five (5) years of going inactive, a licensee must demonstrate competency to resume practice, as required by the Board. Th~~os~~e requirements may include, but are not limited to, education, supervised practice, ~~and~~ examination, ~~as determined by the Board. The Board may consider~~and/or practice in another jurisdiction. ~~in determining competency.~~( )

PENDING TEXT 100.06

06. **Inactive Status**. A licensee requesting inactive status must submit the required form and pay the inactive license fee. *To return to active status a licensee must meet the continuing education requirements and submit a fee equivalent to the difference between the inactive and active renewal fee.* After five (5) years of going inactive, a licensee must demonstrate competency to resume practice, as required by the Board. The requirements may include, but are not limited to, education, supervised practice, examination, and/or practice in another jurisdiction.*( )*

~~**226. -- 299.(RESERVED)**~~

~~3~~400. FEES.
All fees are non-refundable.

FEE TYPE	AMOUNT (Not to Exceed)	RENEWAL (Not to Exceed)	INACTIVE (Not to Exceed)

Application	$70		
~~Examination~~	~~Set by testing service~~		
Endorsement ~~and l~~License	$90		
Licensed Clinical Social Worker	$70	$90	$45
Licensed Masters Social Worker	$70	$80	$40
Licensed Social Worker	$70	$80	$40
Reinstatement	In accordance with Section 67-2614, Idaho Code		

( )

~~**301. -- 349.(RESERVED)**~~

~~**350. EXAMINATIONS AND ENDORSEMENT.**~~
~~Applications for examination and endorsement may be reviewed and approved by a designated Board member upon determination that the applicant meets the qualifications. Approval to sit for examination does not obligate the Board to issue a license if it is later determined that the applicant does not meet the requirements for licensure.( )~~

0~~1~~2. Approved Examination. The applicable ~~Board approves the uniform, nationally standardized examination of the~~ Association of Social Work Boards (ASWB) ~~as the Idaho~~ licens~~ure~~ing examination for the license type, passed within the previous seven (7) years.( )

~~**a.** Bachelor level candidates are required to successfully pass the bachelor's examination.( )~~

~~**b.** Masters level candidates are required to successfully pass the master's examination.( )~~

~~**c.** Clinical level candidates are required to successfully pass the clinical examination.( )~~

~~**02. Graduation Date to Qualify for Exam**. Candidates for examination who can satisfy the Board that they will be graduating at the end of the spring, summer, or fall terms of any given year may qualify for examination immediately preceding the date of graduation.( )~~

0~~3~~4. Endorsement. In addition to the requirement in Section 54-3208, Idaho Code, the applicant must have successfully passed the approved examination for the license type or an equivalent, unless such an examination was not required at the time of the applicant's original licensure. ~~The Board may grant a license to any person who submits an application and who:~~( )

~~**a.** Holds a current, active social work license, at the level for which a license is being sought, issued by the authorized regulatory entity in another state or country, the certification of which must be received directly by the Board from the issuing agency; and( )~~

~~**b.** Has not been disciplined within the last five (5) years, had a license revoked, suspended, restricted, or otherwise sanctioned by any regulatory entity and has never voluntarily surrendered a license; and( )~~

~~**c.** Has not been convicted, found guilty, or received a withheld judgment or suspended sentence for any crime that is inconsistent with the profession of social work. ( )~~

~~**d.** Has successfully passed an examination, as referenced in Subsection 350.02, or an examination provided by the Professional Examination Service (PES) at the clinical social worker and social worker level or the~~

~~Education Testing Service (ETS) examination; and( )~~

~~e.~~ ~~Has certified under oath to abide by the laws and rules governing the practice of social work in Idaho and the code of professional conduct.( )~~

~~f.~~ ~~The Board may waive the examination requirement in Subsection 350.05.d. for an applicant who was not required to pass such an examination at the time the applicant initially obtained a social work license, provided that the applicant meets all other requirements in this subsection and has actively practiced social work for five (5) of the last seven (7) years preceding application.( )~~

~~**351. CONTINUING EDUCATION.**~~

0~~1~~5. Continuing Education~~– Requirements~~. To renew or return to active status, licensees must complete during the preceding twenty-four (24) months, and retain proof of completion, of thirty (30) hours of continuing education, two (2) hours of which must be in professional ethics and the remainder germane to the practice of social work. CE hours may be obtained for preparing and providing germane continuing education or training to other professionals and for individual research projects. ( )

~~a.~~ ~~Continuing education is required for renewal at all levels of social work licensure in Idaho. The Board may waive this requirement upon a showing of good cause.( )~~

~~b.~~ ~~Each licensee must complete a minimum of twenty (20) continuing education (CE) hours, including at least one (1) hour in professional ethics.( )~~

~~c.~~ ~~Compliance with the continuing education (CE) requirements for licensees must be reported annually. A continuing education course taken in any renewal year, but not claimed for CE credit in that year, may be utilized for credit in the following renewal year.( )~~

~~d.~~ ~~Licensees will maintain documentation verifying CE attendance and curriculum for a period of four (4) years. This documentation will be subject to audit by the board.( )~~

~~e.~~ ~~Licensees are not required to comply with this requirement during the first year in which they become licensed under the social work act.( )~~

~~f.~~ ~~One (1) continuing education hour equals one (1) clock hour.( )~~

~~g.~~ Courses that are part of the curriculum of an accredited university, college or other educational institution are allotted CE credit at the rate of fifteen (15) CE hours for each semester hour or ten (10) CE hours for each quarter hour of school credit awarded.( )

PENDING TEXT 100.05

05. Continuing Education. To renew or return to active status, licensees must complete during the preceding twenty-four (24) months, and retain proof of completion *for four years*, of thirty (30) hours of continuing education, two (2) hours of which must be in professional ethics and the remainder germane to the practice of social work. CE hours may be obtained for preparing and providing germane continuing education or training to other professionals and for individual research projects. Courses that are part of the curriculum of an accredited university, college or other educational institution are allotted CE credit at the rate of fifteen (15) CE hours for each semester hour or ten (10) CE hours for each quarter hour of school credit awarded.*( )*

~~h.~~ ~~Applications for reinstatement of a canceled license must include documented proof of meeting the continuing education requirements for the previous twelve (12) months. The requirement for professional ethics training continues during any period of cancellation.( )~~

~~**02.** **Categories of Continuing Education**.( )~~

~~**a.** Category I. Category I includes formally organized learning events, ideally involving face-to-face interaction with a teacher for the purpose of accomplishing specific learning objectives. Courses, workshops, conferences, practice oriented seminars, staff development and training activities coordinated and/or taught by approved and recognized educators also are included in this category. Because of our geographic location and sparse population, closed circuit T.V., video and audio tapes, internet based courses, and correspondence courses may be substituted for face-to-face contact if the course is interactive or requires an examination.( )~~

~~**b.** Category II. No more than ten (10) CE hours may be obtained from this category. Category II consists of a variety of self-directed professional study activities and growth experiences. Examples include making an initial presentation on professional issues or programs, teaching a course for the first time, presenting a lecture or conducting a workshop for the first time, editing or writing professional books or articles, and conducting professional research.( )~~

~~**c.** The subject matter of all approved continuing education must be germane to the practice of social work as defined in Section 54-3202, Idaho Code, and may include the specialties of Marriage and Family Therapy, Psychiatry, Psychiatric Nursing, or Psychology.( )~~

~~**03. Continuing Education Sources**.( )~~

~~**a.** Continuing education course providers must include:( )~~

~~i. Professional Associations. Continuing education hours may be obtained by participating in activities sponsored by or approved by professional associations including but not limited to the Idaho Chapter of the National Association of Social Workers, Idaho Society for Clinical Social Workers. The professional association must certify the number of clock hours of educational content in each sponsored or approved activity.( )~~

~~ii. Educational Institutions. Continuing education hours may be obtained by completing coursework not below your level of licensing or by participating in continuing education programs sponsored by or approved by educational institutions accredited by a regional body recognized by the Council on Post Secondary Accreditation. The educational institution must certify the number of clock hours of educational content in each sponsored or approved program.( )~~

~~iii. Government Agencies, Schools and Hospitals. Continuing education hours may be obtained by participating in in-service training, courses or workshops sponsored by federal, state, or local government agencies, public school systems and licensed hospitals. The provider must certify the number of clock hours of educational content in each approved activity.( )~~

~~iv. Private social service agencies and other entities. Continuing education hours may be obtained by participating in continuing education programs sponsored by agencies or entities who regularly provide social work services. The provider must certify the number of clock hours of educational content in each approved activity. ( )~~

~~**b.** All continuing education hours must be relevant to the profession of social work at the individual's particular level of social work licensure. The presenter's level of education must be at the licensee's level or above. Continuing education for clinical licensees must be clinical in nature except that five (5) hours each year may be non-clinical but must be germane to the practice of social work. Final approval of acceptable programs rests with the Board. ( )~~

~~**04. Documentation**.( )~~

~~**a.** Each licensee must maintain documentation verifying CE attendance and curriculum for a period of four (4) years from the date of completion. This documentation will be subject to audit by the Board.( )~~

~~**b.** Licensees must attest, on their annual license renewal application, that they have satisfied the continuing education requirements. False attestation of satisfaction of the continuing education requirements on a renewal application will subject the licensee to disciplinary action, including revocation.( )~~

~~**e.** Continuing education documents must be in the form of a certificate of attendance, a statement signed by the provider verifying participation in the activity, an official transcript, or other documentation such as a certificate or letter from the sponsoring entity that includes the title of the activity, the subject material covered, the dates and number of hours credited, and the presenter's full name and professional credentials, or other documentation as the Board may require.( )~~

~~**352. -- 399.(RESERVED)**~~

~~**400. UNPROFESSIONAL CONDUCT.**~~
~~"Unprofessional conduct" is further defined as any violation of the Social Work Code of Professional Conduct. ( )~~

~~**401. -- 449.(RESERVED)**~~

~~**450. STATEMENT OF PUBLIC POLICY AND CODE OF PROFESSIONAL CONDUCT.**~~
~~The profession of social work is dedicated to serving people; the professional relationship between social workers and clients thus is governed by the highest moral and ethical values. The client is in a vulnerable role that extends beyond the time frame of actual services. In both social and professional interactions, this vulnerability is taken into consideration whether the person is currently or has been a client. Following is the Code of Professional Conduct: ( )~~

0~~1~~4. Code of Professional Conduct.~~The Social Worker's Ethical Responsibility to Clients~~. ( )

a. ~~For the purpose of this Code of Professional Conduct, a client is anyone for whom the social worker provides social work services directly or indirectly through consultations, staffings, or supervision with other professionals.~~A social worker must operate within their education, training, and experience and meet the applicable standard of care provided by other qualified social workers in the same or similar community and under the same or similar circumstances. A standard of care violation may exist where a social worker engages in professional conduct that a reasonable social worker would not under the same or similar circumstances and in the same or similar community, or where the social worker knew or should have known the professional conduct would cause unreasonable harm to the client.( )

~~**b.** The social worker will not commit fraud nor misrepresent services performed.( )~~

~~c~~b. ~~The~~ When a social worker ~~will not solicit the clients of~~ leaves an agency or practice, clients must be ~~for which they provide~~provided prompt notice and the opportunity to remain with the agency or ~~services for his private~~ practice, or to continue care with the social worker.( )

~~d~~c. ~~The~~ A social worker will not divide a fee or accept or give anything of value for receiving or making a referral.( )

~~e~~d. ~~The~~ A social worker will provide clients with accurate and complete information regarding the extent and nature of the services available to them.( )

~~f~~e. ~~The~~ While a social worker ~~will~~ may terminate, transfer, or refer a client when the services ~~service to clients, and professional relationships with them, when such service and relationships~~ are no longer ~~required~~ needed or in the client's best~~which a conflict of~~ interests, ~~arises~~ prompt notification should be provided to the client. The social worker must attempt to make appropriate referrals as indicated by the client's need or request for services. ( )

~~**g.** A social worker may not violate a position of trust by knowingly committing any act detrimental to a client. ( )~~

~~h~~f. A social worker may not exploit, sexually or otherwise, their professional relationships with clients ~~(or former clients)~~, supervisees, supervisors, students, employees, or research participants.~~, sexually or otherwise. Social workers will not condone or engage in sexual harassment. Sexual harassment is defined as deliberate or~~

~~repeated comments, gestures, or physical contacts of a sexual nature that are unwelcomed by the recipient.~~( )

~~i~~g. A social worker may not engage in romantic or sexual acts with a client, ~~or with a person who has been a client within the past three (3) years, with~~ a relative of a client, or ~~with~~ a person known to the social worker ~~with whom the client maintains~~ to have a close personal relationship with the client when it has the potential to be harmful to the client, during and for three (3) years following termination of a social worker's services. A social worker must not provide social work services to a person with whom ~~he/she has~~they have had a romantic or sexual relationship. ( )

~~02.~~ ~~The Social Worker's Conduct and Comportment as a Social Worker~~.( )

~~a~~h. In providing services, a social worker may not discriminate on the basis of age, gender, gender identity, sexual orientation, race, color, religion, national origin, mental status, physical disability, social or economic status, political belief, or any other preference or personal characteristic, condition or status.( )

~~b.~~ ~~Social workers may not undertake any activity in which their personal problems are likely to lead to inadequate performance or harm to a client, colleague, student, or research participant. If engaged in such activity when they become aware of their personal problems, they must seek competent professional assistance to determine whether they should suspend, terminate, or limit the scope of their professional activities.( )~~

~~c.~~ ~~A social worker may not practice while impaired by medication, alcohol, drugs, or other chemicals. A social worker may not practice under a mental or physical condition that impairs the ability to practice safely.( )~~

~~d.~~ ~~A social worker may not repeatedly fail to keep scheduled appointments.( )~~

~~e.~~ ~~The social worker who anticipates the termination or interruption of service to clients must notify clients promptly and seek the transfer, referral, or continuation of services in relation to the clients' needs and preferences. ( )~~

~~f.~~ ~~The social worker must attempt to make appropriate referrals as indicated by the client's need for services. ( )~~

~~g~~i. A social worker must obtain the client's or legal guardian's informed written consent when a client is to be involved in a~~ny~~ research project. A social worker must explain the research, including any implications.( )

~~h~~j. ~~The~~ A social worker must obtain informed consent of clients before taping, recording, or permitting third party observation ~~of their activities~~.( )

~~i~~k. A social worker must safeguard information given by clients in providing client services. ~~Except when required by law or judicial order, a social worker must obtain the client's informed written consent before releasing confidential information from the setting or facility except for compelling reasons defined as but not limited to:~~ ( )

~~i. Consultation with another professional on behalf of the client thought to be dangerous to self or others; ( )~~

~~ii. Duty to warn pursuant to Chapter 19, Title 6, Idaho Code;( )~~

~~iii. Child abuse and sexual molestation pursuant to Chapter 16, Title 16, Idaho Code; and( )~~

~~iv. Any other situation in accordance with statutory requirements.( )~~

~~j~~l. A social worker, regardless of personal or professional relationship, must report a~~ny~~ licensee's violation of the Board's law or rules~~, including Code of Professional Conduct, by a person certified under Chapter 32, Title 54, Idaho Code~~.( )

0~~3~~5. Competen__cy.__**~~t Practice for Social Workers~~**. ~~All social workers must practice in a competent manner consistent with their level of education, training and experience.( )~~

a. A social worker must only represent himself and practice in a competent manner within the boundaries of his education, training, licensure level, supervision, and other relevant professional experience.( )

PENDING TEXT 200.04.f. through 200.05.a.

f. A social worker may not exploit, sexually or otherwise, their professional relationships with clients, supervisees, *former clients,* supervisors, students, employees, or research participants.*( )*

g. *A social worker may not engage in romantic or sexual acts with a client during and for ten (10) years following termination of a social worker's services. A social worker must not provide social work services to a person with whom they have had a romantic or sexual relationship.( )*

***~~g~~h*.** A social worker may not engage in romantic or sexual acts with *~~a client~~*, a relative of a client, or a person known to the social worker to have a close personal relationship with the client when it has the potential to be harmful to the client, during and for three (3) years following termination of a social worker's services. *~~A social worker must not provide social work services to a person with whom they have had a romantic or sexual relationship.~~* *( )*

***~~h~~i*.** In providing services, a social worker may not discriminate on the basis of age, gender, gender identity, sexual orientation, race, color, religion, national origin, mental status, physical disability, social or economic status, political belief, or any other preference or personal characteristic, condition or status.( )

***~~i~~j*.** A social worker must obtain the client's or legal guardian's informed written consent when a client is to be involved in a research project. A social worker must explain the research, including any implications. ( )

***~~j~~k*.** A social worker must obtain informed consent of clients before taping, recording, or permitting third party observation.( )

***~~k~~l*.** A social worker must safeguard information given by clients in providing client services. ( )

***~~l~~m*.** A social worker, regardless of personal or professional relationship, must report a licensee's violation of the Board's law or rules.( )

***~~m~~n*.** A social worker may not disseminate or cause the dissemination of any fraudulent or deceptive advertisement. ( )

***~~n~~o*.** A social worker may not engage in dual or multiple relationships with clients or with relatives of a client, or with individuals with whom clients have close personal relationships known to the social worker, in which a reasonable and prudent social worker would conclude after appropriate assessment that there is a risk of harm or exploitation to the client or of impairing a social worker's objectivity or professional judgment. A dual or multiple relationship is a relationship that occurs when a social worker interacts with a client in more than one capacity, whether it be before, during, or after the professional, social, or business relationship. Dual or multiple relationships can occur simultaneously or consecutively. After an appropriate assessment determines that the relationship does not create a risk of harm or exploitation to the client and will not impair a social worker's objectivity or professional

judgment, the social worker must document in case records, prior to the interaction, when feasible, the rationale for such a relationship, and the potential benefits.( )

~~o~~p. A social worker may not purchase goods or services from a client or otherwise engage in a business relationship with a client except when 1) the client is providing necessary goods or services to the general public; 2) a reasonable and prudent social worker would determine that it is not practical or reasonable to obtain the goods or services from another provider; and 3) a reasonable and prudent social worker would conclude after appropriate and documented assessment that engaging in the business relationship will not be detrimental to the client or the professional relationship.( )

05. Competency. ( )

a. A social worker must only represent ~~hi~~themself and practice in a competent manner within the boundaries of ~~his~~ their education, training, licensure level, supervision, and other relevant professional experience. ( )

b. A social worker must only practice within new areas or use new intervention techniques or approaches after engaging in appropriate study, training, consultation, or supervision.( )

c. A social worker must exercise careful judgment~~,~~ when generally recognized standards do not exist with respect to an emerging area of practice~~,~~ and take responsible steps to ensure the competence of his practice. ( )

~~04~~m. ~~**The Advertising Rules for Social Workers**~~. ~~No~~A social worker may not disseminate or cause the dissemination of any fraudulent or deceptive advertisement. ~~or advertising that is any way fraudulent, false, deceptive or misleading. Any advertisement or advertising is deemed by the board to be fraudulent, false, deceptive, or misleading if it:~~( )

~~**a.** Contains a misrepresentation of fact; or( )~~

~~**b.** Is misleading or deceptive because in its content or in the context in which it is presented it makes only a partial disclosure of relevant facts. More specifically, it is misleading and deceptive for a social worker to advertise free services or services for a specific charge when in fact the social worker is transmitting a higher charge for the advertised services to a third party payor for payment or charges the patient or a third party. It is misleading and deceptive for a social worker or a group of social workers to advertise a social work referral service or bureau unless the advertisement specifically names each of the individual social workers who are participating in the referral service or bureau.( )~~

~~**c.** Creates false or unjustified expectations of beneficial treatment or successful outcomes; or( )~~

~~**d.** Fails to identify conspicuously the social worker or social workers referred to in the advertising as a social worker or social workers; or( )~~

~~**e.** Contains any representation or claims, as to which the social worker, referred to in the advertising, fails to perform; or( )~~

~~**f.** Contains any representation which identifies the social worker practice being advertised by a name which does not include the terms "social worker," "social work," or some easily recognizable derivation thereof; or ( )~~

~~**g.** Contains any representation that the practitioner has received any license or recognition by the state of Idaho or its authorized agents, which is superior to the license and recognition granted to any social worker who successfully meets the licensing requirements of Chapter 32, Title 54, Idaho Code; or( )~~

~~h. Appears in any classified directory, listing, or compendium under a heading, which when considered together with the advertisement, has the capacity or tendency to be deceptive or misleading with respect to the profession or professional status of the social worker; or( )~~

~~i. Contains any other representation, statement, or claim which is misleading or deceptive.( )~~

~~05~~**n**. ~~**Dual Relationships**.~~ A social worker may not engage in dual or multiple relationships with clients~~,~~ or with relatives of a client, or with individuals with whom clients ~~maintain~~ have close personal relationships known to the social worker, in which a reasonable and prudent social worker would conclude after appropriate assessment that there is a risk of harm or exploitation to the client or of impairing a social worker's objectivity or professional judgment. A dual or multiple relationship is a relationship that occurs when a social worker interacts with a client in more than one capacity, whether it be before, during, or after the professional, social, or business relationship. Dual or multiple relationships can occur simultaneously or consecutively. After an appropriate assessment determines that the relationship does not create a risk of harm or exploitation to the client and will not impair a social worker's objectivity or professional judgment, the social worker must document in case records, prior to the interaction, when feasible, the rationale for such a relationship, and the potential benefits ~~to the client, and anticipated consequences for the client~~.( )

~~06~~**o**. ~~**Business Relationships**.~~ A social worker may not purchase goods or services from a client or otherwise engage in a business relationship with a client except when ~~:( )~~

~~a.~~ 1.) ~~T~~the client is providing necessary goods or services to the general public; ~~( )~~

~~b.~~ 2.) ~~A~~a reasonable and prudent social worker would determine that it is not practical or reasonable to obtain the goods or services from another provider; and~~( )~~

~~c.~~ 3.) ~~A~~a reasonable and prudent social worker would ~~determine~~ conclude after appropriate and documented assessment that engaging in the business relationship will not be detrimental to the client or the professional relationship.( )

~~07. **Bartering**. Bartering is the acceptance of goods, services, or other nonmonetary remuneration from a client in return for a social worker's services. Social workers may not barter except when such arrangement is not exploitative and:( )~~

~~a. Is initiated by the client and with the client's written informed consent; and( )~~

~~b. Has an easily determined fair market value of the goods or services received.( )~~

~~**451. -- 474.(RESERVED)**~~

~~**475. DISCIPLINE.**~~

~~01. **Civil Fine**. The Board may impose a civil fine not to exceed one thousand dollars ($1,000) upon a licensed social worker for each violation of Section 54-3211, Idaho Code.( )~~

~~02. **Costs and Fees**. The Board may order a licensed social worker to pay the costs and fees incurred by the Board in the investigation or prosecution of the licensee for violation of Section 54-3211, Idaho Code.( )~~

~~**476. -- 999.(RESERVED)**~~

IDAPA 24 – DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSES

24.15.01 – RULES OF THE IDAHO LICENSING BOARD OF PROFESSIONAL COUNSELORS AND MARRIAGE AND FAMILY THERAPISTS

DOCKET NO. 24-1501-2301 (ZBR CHAPTER REWRITE)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo, Incorporation By Reference Synopsis (IBRS), & Cost/Benefit Analysis (CBA)

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2024 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. The pending rule will become final and effective, July 1, 2024, after approval.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 54-3402, 54-3404, 54-3405, 54-3406, and 54-3410, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

The pending rule is being adopted under Executive Order 2020-01, Zero Based Regulation. Text amended since these rules were published as proposed are as follows:

- The text “current and updated” was removed from incorporation by reference language to ensure no authority is delegated to a third party;
- 100.01.a. – removed the word “otherwise,” as it was unnecessary;
- 100.01.c. – clarified educational institution supervision, as “Practicum” may have multiple meanings, and different universities may approach supervision differently;
- 100.02.a. – updated to clarify supervision is of “direct client contact”;
- 100.03.a. – removed the word “otherwise,” as it was unnecessary;
- 100.06 – clarified interns were “post-post graduate”;
- 100.07 – updated Continuing Education in response to feedback, changing required classes and referring to ethical obligations;
- 200.02.b. – provided a sunset date for LPC supervision and reintroduced contact hour supervising training requirements erroneously deleted from previous; and
- 200.03 – updated “acknowledged” to “documented”.

The text of the pending rule has been amended in accordance with Section 67-5227, Idaho Code. Only those sections that have changes that differ from the proposed text are printed in this bulletin. The complete text of the proposed rule was published in the August 2, 2023 Idaho Administrative Bulletin, Vol. 23-8, pages 249-266.

FEE SUMMARY: The following is a description of the fee or charge imposed or increased in this rulemaking as authorized in Sections 54-3402 et. seq., and 67-2614, Idaho Code. Pursuant to Section 67-5224(2)(d), Idaho Code, this pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature.

The fees for applications, licenses, registrations, and reinstatement as designated in Rule 400 of these proposed rules are authorized in Sections 54-3402 et. seq., and 67-2614, Idaho Code. None of these fees are being changed as a result of this rulemaking or since being previously reviewed by the Idaho Legislature.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year: This rulemaking is not anticipated to have any negative fiscal impact on the State General Fund.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Katie Stuart at 208-577-2489.

DATED this 1st day of November, 2023.

Katie Stuart
Bureau Chief
11341 W. Chinden Blvd., Bldg. #4
Boise, ID 83714
Phone: (208) 577-2489
Email: katie.stuart@dopl.idaho.gov

THE FOLLOWING NOTICE PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section 67-2604, Idaho Code and Sections 54-3402, 54-3404, 54-3405, 54-3405A, 54-3405B, 54-3405C, 54-3406, and 54-3410A, Idaho Code.

PUBLIC HEARING SCHEDULE: A public hearing concerning this rulemaking will be held as follows:

Tuesday, August 15, 2023 – 11:00 a.m. (MT)
Division of Occupational and Professional Licenses **Chinden Campus Building 4** **11341 W. Chinden Blvd., Bldg. #4** **Boise, ID 83714** **Telephone and web conferencing information will be posted on:** **https://dopl.idaho.gov/calendar/ and https://townhall.idaho.gov/**

The hearing site will be accessible to persons with disabilities, if needed. Requests for accommodation must be made not later than five (5) days prior to the meeting to the agency address below.

DESCRIPTIVE SUMMARY: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

Under **Executive Order 2020-01**, Zero-Based Regulation, the Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists is striving to prevent the accumulation of costly, ineffective, and outdated regulations and reduce regulatory burden to achieve a more efficient operation of government. In conjunction with stakeholders, the proposed rule changes reflect a comprehensive review of this chapter by collaborating with the public to streamline or simplify the rule language in this chapter and to use plain language for better understanding. This proposed rulemaking updates the rules to comply with governing statute and Executive Order 2020-01.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased:

The fees for applications, examinations, licenses, registrations and reinstatement as designated in Rule 400 of these proposed rules are authorized in Sections 54-3411 and 67-2614, Idaho Code. None of these fees are being changed as a result of this rulemaking or since being previously reviewed by the Idaho Legislature.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the State General Fund greater than ten thousand dollars ($10,000) during the fiscal year as a result of this rulemaking:

This rulemaking is not anticipated to have any negative fiscal impact on the State General Fund.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was conducted under Docket No. 24-ZBRR-2301. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the April 5, 2023 Idaho Administrative Bulletin, Vol. 23-4, pp. 42-46.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into this rule:

Per Section 54-3404(3), the board adopted the American Counseling Association's "ACA Code of Ethics" and the American Association for Marriage and Family Therapy's "Code of Ethics" as the codes of ethics for professional counselors and marriage and family therapists in Idaho.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Michael Hyde, Bureau Chief, at (208) 332-7133.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before August 23, 2023.

DATED this July 6, 2023.

THE FOLLOWING IS THE TEXT OF ZBR DOCKET NO. 24-1501-2301

24.15.01 – RULES OF THE IDAHO LICENSING BOARD OF PROFESSIONAL COUNSELORS AND MARRIAGE AND FAMILY THERAPISTS

000. LEGAL AUTHORITY.
These rules are promulgated pursuant to Sections 54-3402, 54-3404, 54-3405, 54-3405A, 54-3405B, 54-3405C, 54-3406, and 54-3410A, Idaho Code. ( )

001. SCOPE.
These rules govern the practices of professional counseling and of marriage and family therapy in Idaho. ( )

002. INCORPORATION BY REFERENCE.

01. ACA Code of Ethics. The document titled "ACA Code of Ethics," published by the American Counseling Association (ACA) is herein adopted and incorporated by reference and is available on the ACA website: https://www.counseling.org/resources/aca-code-of-ethics.pdf. ( )

02. AAMFT Code of Ethics. The document titled "AAMFT Code of Ethics," published by the American Association for Marriage and Family Therapy (AAMFT) is herein adopted and incorporated by reference and is available on the AAMFT website: https://www.aamft.org/Legal_Ethics/Code_of_Ethics.aspx. ( )

003. DEFINITIONS.

01. Supervisor. A clinical professional counselor, marriage and family therapist, psychologist, clinical social worker, or psychiatrist, whose license is active, current, and in good standing and who, when applicable, is approved as a supervisor in the state where the supervisee is practicing. ( )

02. Individual Supervision. Individual Supervision is supervision that occurs with no more than two supervisees to one supervisor. ( )

03. Group Supervision. Group Supervision is supervision that occurs with three or more supervisees to at least one supervisor. ( )

004. -- 099. (RESERVED)

100. LICENSURE.

01. Professional Counselor. ( )

a. Approved Graduate Program. A graduate program that is primarily counseling in nature and is accredited by the Council for Accreditation of Counseling and Related Educational Programs (CACREP) or substantially similar and approved by the Board. ( )

b. Required Examination. The National Counselor Examination prepared by the National Board of Certified Counselors (NBCC). ( )

c. Acceptable Supervised Experience. Four hundred (400) of the one thousand (1,000) hours must be direct client contact and the supervised experience must include a minimum of one (1) hour of individual supervision for every twenty (20) hours of direct client contact. A supervised graduate-level educational experience (i.e. practicum or internship) may be utilized to fulfill this requirement which can be provided by a counselor education faculty member or doctoral student at an accredited college or university, or a site supervisor approved by an accredited college or university. ( )

02. Clinical Professional Counselor. ( )

a. Approved Experience. One thousand (1,000) of the two thousand (2,000) direct client contact hours must be supervised by a licensed clinical professional counselor, with the remaining supervision provided by any supervisor as defined in these rules; and one (1) hour of clinical supervision for every thirty (30) hours of direct client contact, with at least half of the supervised hours involving individual, rather than group, supervision. ( )

b. Required Examination. The National Clinical Mental Health Counselor Examination (NCMHCE) prepared by the National Board of Certified Counselors (NBCC). ( )

03. Associate Marriage And Family Therapist. ( )

a. Approved Graduate Program. A graduate program in marriage and family therapy or a related field which is accredited by the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) or the Council for Accreditation of Counseling and Related Educational Programs Marriage, Couple, and Family Counseling (CACREP-MCFC), or is substantially similar and approved by the Board. ( )

b. Required Practicum. The practicum must occur over a period of twelve (12) months or longer and require three hundred (300) hours of direct client contact, of which at least one hundred (100) hours must be with two or more individuals conjointly who share an ongoing relationship beyond that which occurs in the therapeutic experience itself. These hours may be completed as part of a practicum, registered intern supervised experience, or supervised experience in another jurisdiction. ( )

c. Required Examination. The National Marital and Family Therapy Examination as approved by the Association of Marital and Family Therapy Regulatory Boards (AMFTRB) or another recognized competency examination in marriage and family therapy that is approved by the Board. ( )

04. Marriage And Family Therapists. ( )

a. Approved Graduate Program. A graduate program in marriage and family therapy or a related field accredited by the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) or substantially similar and otherwise approved by the Board. ( )

b. Required Practicum. See Rule 100.03.b. ( )

c. Required Postgraduate Supervised Experience. Two thousand (2,000) hours of direct client contact over a period of at least two (2) years which includes: (1) one thousand (1,000) direct client contact hours with two or more individuals conjointly who share an ongoing relationship beyond that which occurs in the therapeutic experience itself; and (2) two hundred (200) hours of supervision, of which one hundred (100) hours must be individual, rather than group, supervision. One hundred (100) hours must be supervised by a licensed marriage and family therapist, with the remaining one hundred (100) hours of supervision provided by a supervisor who has at least two (2) years of experience practicing marriage and family therapy. ( )

d. Required Examination. The National Marital and Family Therapy Examination as approved by the Association of Marital and Family Therapy Regulatory Boards (AMFTRB) or another recognized competency examination in marriage and family therapy that is approved by the Board. ( )

05. Foreign Educated Applicants. Applicants with a graduate degree from a country other than the United States may be required to submit a certification from a credential evaluation service that is a member of the National Association of Credential Evaluation Services (NACES). The service must certify that the graduate degree is equivalent to an approved graduate degree from the United States. All information submitted to the Board must be submitted with an English translation. ( )

06. Registered Post-Graduate Interns. A post-graduate intern registration is required to engage in the supervised practice of counseling or marriage and family therapy while completing supervised experience hours or while awaiting examination results. To register as an intern, the individual must: (1) have an approved graduate degree as defined in these Rules; and (2) designate a supervisor approved by the Board. An individual may not practice as an intern for more than four (4) years from the original date of registration, unless good cause is demonstrated to the board. ( )

07. Continuing Education. In each twenty-four (24) month period preceding the renewal of a license, all licensees must complete six (6) hours in ethics, three (3) hours of boundaries, and three (3) hours in suicide assessment or intervention. Additionally, licensees are required to comply with the continuing education and competence sections of the Codes of Ethics pertaining to their licensure. ( )

101. -- 199. (RESERVED)

200. PRACTICE STANDARDS.

01. Licensees. Licensees must comply with Board-adopted Code of Ethics pertaining to their licensure. ( )

02. Supervision. ( )

a. Registered interns obtaining supervised or postgraduate experience hours must be supervised by a Board-approved supervisor and must explicitly identify themselves as interns in documentation and advertising. ( )

b. To become an approved supervisor, be licensed as a clinical professional counselor or licensed marriage and family therapist, document a minimum of fifteen (15) contact hours of relevant education in supervisor training, and have received no discipline in the five (5) years prior to the approval request, provided the Board may approve a supervisor with disciplinary action for failing to complete continuing education requirements. A supervisor must supervise in conformance with statute and the guidelines for supervisors set forth in the ACA or AAMFT Code of Ethics. A licensed professional counselor may be an approved supervisor until July 1, 2026. ( )

03. Informed Consent and Information Disclosure. The receipt of the disclosure must be documented in writing by the client and the licensee or intern, and such disclosure of information must include: the licensee's name, license type, license number, business address and phone number; if the licensee is a supervisee, the name of any supervisor, contact information for the supervisor, including address and phone number, and a statement that the intern is practicing under the supervision of licensee; the purposes, goals, techniques, procedures, limitations, potential risks, and benefits of services; the extents and limits of confidentiality; the client's rights to participate in treatment decisions, to seek a second opinion, to file a complaint without retaliation, and to refuse treatment; the fee structure, billing arrangements, and cancellation policy; a statement that the Board regulates the licensee's and intern's practices and providing the Board's phone number and address; and a statement that sexual intimacy is never appropriate with a client and should be reported to the Board. ( )

201. -- 399. (RESERVED)

400. FEES.

TYPE	INITIAL FEE	ANNUAL RENEWAL FEE
Application	$100	
License	$100	$120
Intern Registration	$25	
Reinstatement Fee	As provided in Section 67-2614, Idaho Code	
Examination and Reexamination	$25 administrative fee plus amount charged by exam administrator	

( )

401. -- 999. (RESERVED)

[Agency redlined courtesy copy]

Italicized text **indicates changes between the text of the proposed rule as adopted in the pending rule.**

24.15.01 – RULES OF THE IDAHO LICENSING BOARD OF PROFESSIONAL COUNSELORS AND MARRIAGE AND FAMILY THERAPISTS

000. LEGAL AUTHORITY.
These rules are promulgated pursuant to Sections 54-3402, 54-3404, 54-3405, 54-3405A, 54-3405B, 54-3405C, 54-3406, and 54-3410A, Idaho Code.( )

001. SCOPE.
These rules govern the practices of professional counseling and ~~practice~~ of marriage and family ~~therapists~~ therapy in Idaho. ( )

~~**002. -- 003.(RESERVED)**~~

~~004~~002. INCORPORATION BY REFERENCE.

01. ACA Code of Ethics. The current and updated document titled "ACA Code of Ethics," ~~as~~

published by the American Counseling Association (ACA)~~), effective 2014,~~ is herein adopted and incorporated by reference and is available ~~from the Board's office and website~~on the ACA website: https://www.counseling.org/resources/aca-code-of-ethics.pdf.(   )

PENDING TEXT 002.01

01. ACA Code of Ethics. The~~*current and updated*~~ document titled "ACA Code of Ethics," published by the American Counseling Association (ACA) is herein adopted and incorporated by reference and is available on the ACA website: https://www.counseling.org/resources/aca-code-of-ethics.pdf.*(   )*

02. AAMFT Code of Ethics. The current and updated document titled "AAMFT Code of Ethics," ~~as~~ published by the American Association for Marriage and Family Therapy (AAMFT)~~, effective January 1, 2015,~~ is herein adopted and incorporated by reference and is available ~~from the Board's office and website~~on the AAMFT website: https://www.aamft.org/Legal_Ethics/Code_of_Ethics.aspx.~~(   )~~

PENDING TEXT 002.02

02. AAMFT Code of Ethics. The~~*current and updated*~~ document titled "AAMFT Code of Ethics," published by the American Association for Marriage and Family Therapy (AAMFT) is herein adopted and incorporated by reference and is available on the AAMFT website: https://www.aamft.org/Legal_Ethics/Code_of_Ethics.aspx.*(   )*

~~**03. Guidelines**. The document titled "Approved Supervision Designation Handbook" that provides supervision guidelines for supervisors, as published by the American Association for Marriage and Family Therapy (AAMFT), dated October 2007, is herein incorporated by reference and is available from the Board's office and website. (   )~~

~~**005. -- 009.(RESERVED)**~~

~~010~~003. DEFINITIONS.

~~**01. Accredited University or College**. An accredited university or college is a college or university accredited by a regional accrediting agency as identified by the U.S. Department of Education.(   )~~

~~**02. Face-to-face Setting**. May include a secure live electronic face-to-face connection between the supervisor and supervisee.(   )~~

~~03~~01. ~~Licensed Mental Health Professional~~ Supervisor. A clinical professional counselor, marriage and family therapist, psychologist, clinical social worker, or psychiatrist, whose license ~~in Idaho~~ is active, current, and in good standing and who, when applicable, is ~~registered~~ approved as a supervisor ~~with their respective licensing board~~in the state where the supervisee is practicing.

~~**02. Internship.** Internship is a supervised clinical experience taken as part of and/or outside of a graduate program.(   )~~

~~04~~03. ~~Practicum~~~~. The term p~~Practicum ~~is a supervised clinical experience~~ ~~includes a practicum, internship, or a combination, taken as part of the~~ a ~~graduate level program.(   )~~

~~05~~04. ~~Supplemental Practicum Hours~~~~. Supplemental practicum hours are hours of direct client contact that are supervised at a ratio of one (1) hour of supervision for every ten (10) hours of direct client contact by a registered~~ approved ~~supervisor for the profession for which the applicant is seeking licensure.(   )~~

052. **Individual Supervision**. Individual Supervision is supervision that occurs with no more than two supervisees to one supervisor.

063. **Group Supervision**. Group Supervision is supervision that occurs with three or more supervisees to at least one supervisor. Group supervision is defined as up to eight (8) supervisees and one (1) supervisor unless occurring as part of an accredited educational program.

011. -- 149.(RESERVED)

150100. QUALIFICATIONS FOR PROFESSIONAL COUNSELOR LICENSURE.
Licensure as a "professional counselor" is restricted to persons who have successfully completed the required examination and each of the following:( )

01. **Professional Counselor.**
a. Approved Graduate Program. A graduate program that is primarily counseling in nature and is **Graduate Program**. Possess a master's degree or higher, which includes an educational specialist degree, that is primarily counseling in nature, from an accredited university or college offering a graduate program in counseling, provided that the program is either:( )

a. Approvedaccredited by the Council for Accreditation of Counseling and Related Educational Programs (CACREP); or substantially similar and otherwise approved by the Board.( )

PENDING TEXT 100.01.a.

a. Approved Graduate Program. A graduate program that is primarily counseling in nature and is accredited by the Council for Accreditation of Counseling and Related Educational Programs (CACREP) or substantially similar and *otherwise* approved by the Board.*( )*

b. A counseling program of at least sixty (60) semester hours or ninety (90) quarter hours in length and that at a minimum includes successful completion of one (1) graduate level course unique to the eight (8) areas and an advanced counseling practicum as follows:( )

i. Human growth and development: Includes studies that provide a broad understanding of the nature and needs of individuals at all developmental levels. Emphasis is placed on psychological, sociological, and physiological approaches. Also included are areas such as human behavior (normal and abnormal), personality theory, and learning theory.( )

ii. Social and cultural foundations: Includes studies of change, ethnic groups, subcultures, changing roles of women, sexism, urban and rural societies, population patterns, cultural mores, use of leisure time, and differing life patterns.( )

iii. The helping relationship: Includes philosophic bases of the helping relationship: Consultation theory and/or an emphasis on the development of counselor and client (or consultee) self-awareness and self-understanding. ( )

iv. Groups: Includes theory and types of groups, as well as descriptions of group practices, methods dynamics, and facilitative skills. It includes either a supervised practice and/or a group experience.( )

v. Life-style and career development: Includes areas such as vocational-choice theory, relationship between career choice and life-style, sources of occupational and educational information, approaches to career decision-making processes, and career-development exploration techniques.( )

vi. Appraisal of the individual: Includes the development of a framework for understanding the individual, including methods of data gathering and interpretation, individual and group testing, case-study

approaches and the study of individual differences. Ethnic, cultural, and sex factors are also considered.( )

vii. Research and evaluation: Includes areas such as statistics, research design, and development of research and demonstration proposals. It also includes understanding legislation relating to the development of research, program development, and demonstration proposals, as well as the development and evaluation of program objectives. ( )

viii. Professional orientation: Includes goals and objectives of professional counseling organizations, codes of ethics, legal consideration, standards of preparation, certification, and licensing and role of identity of counselors. ( )

ix. Advanced counseling practicum: Complete at least two (2) semester courses of an advanced counseling practicum taken at the graduate school level, provided that the applicant completed a total of two hundred eighty hours (280) of direct client contact that is supervised at the ratio of at least one (1) hour of one-to-one supervision for every ten (10) hours of experience in the setting. An applicant may complete one (1) supplemental practicum hour for every hour in which the practicum was deficient and that meets the requirements of Subsection 230.02 of these rules.( )

b. Required Examination. The National Counselor Examination prepared by the National Board of Certified Counselors (NBCC).

02c. Acceptable Supervised Experience Requirement. One thousand (1,000) hours of supervised experience in counseling acceptable to the Board.( )

a. Of the one thousand (1,000) hours required in Section 54-3405, Idaho Code, is defined as one thousand (1,000) clock hours of experience working in a counseling setting, fFour hundred (400) of the one thousand (1,000) hours of which must be direct client contact and . Supervised experience in practicum taken at the graduate level may be utilized. Tthe supervised experience must includes a minimum of one (1) hour of Iindividual Ssupervision of face-to-face or one-to-one (1/1) or one-to-two (1/2) supervision with the supervisor for every twenty (20) hours of job/internship experiencedirect client contact. A supervised graduate-level practicum may be utilized to fulfill this requirement which can be provided by a counselor education faculty member or doctoral student at an accredited college or university.( )

PENDING TEXT 100.01.c.

c. Acceptable Supervised Experience. Four hundred (400) of the one thousand (1,000) hours must be direct client contact and the supervised experience must include a minimum of one (1) hour of individual supervision for every twenty (20) hours of direct client contact. A supervised graduate-level *practicum* *educational experience (i.e. practicum or internship)* may be utilized to fulfill this requirement which can be provided by a counselor education faculty member or doctoral student at an accredited college or university*, or a site supervisor approved by an accredited college or university.( )*

b. Supervision must be provided in compliance with the ACA Code of Ethics that was adopted by the Board at the time the supervision and provided by a counselor education faculty member at an accredited college or university, Professional Counselor, registered with the Board as a supervisor, or a licensed mental health professional supervisor as defined in these rules. If the applicant's supervision was provided in another state, it must have been provided by a counseling professional licensed by that state, provided the requirements for licensure in that state are substantially equivalent to the requirements in Idaho.( )

c. Experience in counseling is defined as assisting individuals or groups, through the counseling relationship, to develop an understanding of personal problems, to define goals, and to plan action reflecting interests, abilities, aptitudes, and needs as related to persona-social concerns, educational progress, and occupations and careers. Counseling experience may include the use of appraisal instruments, referral activities, and research findings. ( )

d. The Board considers the recommendation of the supervisor(s) when determining the acceptability of the applicant's supervised experience.( )

~~**151. -- 224.(RESERVED)**~~

~~225~~02. Clinical Professional Counselor ~~LICENSURE~~.
~~Licensure as a "clinical professional counselor" is restricted to applicants who have successfully passed the required examination and have met the following:( )~~

~~**01.** **License**. Hold a "professional counselor" license in this state or a license or other authorization in another state that has substantially similar requirements to a licensed professional counselor in this state, provided the license or authorization is current and in good standing; and~~( )

~~02~~a. Approved Experience. ~~Pursuant to Section 54-3405A, Idaho Code, applicants must:~~~~Document two thousand (2,000) hours of direct client contact experience under supervision accumulated in no less than a two (2) year period after licensure or other authorization to practice in any state.( )~~

~~**a.**~~ ~~All applicants must p~~Provide ~~verification of meeting at least o~~One thousand (1,000) of the two thousand (2,000) hours ~~of supervised experience under the supervision~~ of supervision by a licensed ~~Clinical~~ clinical ~~Professional~~ professional ~~Counselor~~ counselor~~registered as a supervisor~~~~approved by~~ ~~with the Board~~, with the remaining supervision ~~. The remainder of the supervision may be~~ provided by ~~a licensed mental health professional~~ any supervisor as defined in these rules; and ~~. If the applicant's supervision was provided in another state, it must have been provided by a counseling professional licensed by that state, provided the requirements for license and supervision are substantially equivalent to the requirements in Idaho.( )~~

~~**b.**~~ ~~Provide verification of~~ ~~O~~one (1) hour of clinical supervision for every thirty (30) hours of direct client contact, with at least half of the supervised hours involving individual, rather than group, supervision.~~is required. Individual supervision is defined as one (1) hour of face-to-face, one-on-one (1:1) or one-to-two (1:2) supervision to every thirty (30) hours of direct client contact. Supervision must be provided in a face-to-face setting. ( )~~

PENDING TEXT 100.02.a.

a. Approved Experience. One thousand (1,000) of the two thousand (2,000) *direct client contact* hours ~~*of supervision*~~ *must be supervised* by a licensed clinical professional counselor, with the remaining supervision provided by any supervisor as defined in these rules; and one (1) hour of clinical supervision for every thirty (30) hours of direct client contact, with at least half of the supervised hours involving individual, rather than group, supervision.*( )*

~~**c.**~~ ~~N~~~~Group Supervision comprising n~~~~o more than one-half (1/2) of the required supervision~~ ~~supervision~~ ~~hours~~. ~~may be group supervision.( )~~

~~**03.** **Recommendation of the Supervisor(s)**. The Board considers the recommendation of the supervisor(s) when determining the acceptability of the applicant's supervised experience.( )~~

b. Required Examination. The National Clinical Mental Health Counselor Examination (NCMHCE) prepared by the National Board of Certified Counselors (NBCC).

~~**226. -- 229.(RESERVED)**~~

~~230~~03. ~~QUALIFICATIONS FOR~~ Associate Marriage And Family Therapist.
~~An applicant for associate marriage and family therapist licensure must pass the required examination and meet the following: ( )~~

~~01~~a. ~~**Graduate Degree**.~~ Approved Graduate Program. A graduate program ~~Possess a master's degree or higher,~~ in marriage and family therapy or a related field~~, from an accredited university or college provided that the program~~which is accredited by ~~Possess a graduate degree as outlined in Subsection 238.01 of these rules or a master's~~

~~degree or higher in marriage and family therapy or a related field from an accredited university or college, provided that the graduate program meets one of the following:( )~~

~~a.~~ ~~Accredited by the~~ the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE)~~;~~, ~~or ( )~~

~~b.~~ ~~Accredited by~~ or the Council for Accreditation of Counseling and Related Educational Programs~~-~~ Marriage, Couple, and Family Counseling (CACREP-MCFC),~~;~~ or is substantially similar and otherwise approved by the ~~b~~Board. ~~( )~~

PENDING TEXT 100.03.a.

a. Approved Graduate Program. A graduate program in marriage and family therapy or a related field which is accredited by the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) or the Council for Accreditation of Counseling and Related Educational Programs Marriage, Couple, and Family Counseling (CACREP-MCFC), or is substantially similar and ~~*otherwise*~~ approved by the Board.*( )*

~~c.~~ ~~The program includes, at a minimum, twenty-seven (27) semester credits or thirty-six (36) quarter credits of the graduate level coursework set forth in Subsection 238.01.b of these rules.( )~~

~~02~~**b.** Required Practicum. ~~Completion of a supervised practicum in~~ The practicum must occur~~In~~ ~~no less than a~~ over a period of twelve (12) months or longer and require ~~period, as part of the graduate program. The practicum~~applicants ~~must consist of~~complete ~~at least~~ three hundred (300) hours of direct client contact, of which at least one hundred ~~fifty~~ (~~150~~100) hours must be with ~~couples, families and other systems,~~two or more individuals conjointly who share an ongoing relationship beyond that which occurs in the therapeutic experience itself. ~~provided that the Board may grant a license to an applicant who completed a practicum with fewer than the required hours and completed one (1) supplemental practicum hour for every hour in which the practicum was deficient. Supplemental practicum hours must be~~ These hours may be completed as part of a practicum, ~~R~~registered ~~I~~intern supervised experience, or supervised ~~practice~~experience in another jurisdiction.~~:( )~~

c. Required Examination. The National Marital and Family Therapy Examination as approved by the Association of Marital and Family Therapy Regulatory Boards (AMFTRB) or another recognized competency examination in marriage and family therapy that is approved by the Board.

~~a.~~ ~~A Registered Intern under Section 245 of these rules; or ( )~~

~~b.~~ ~~Supervised practice in another jurisdiction that is sufficient to be considered substantially similar to the supplemental practicum hour requirements of these rules; or( )~~

~~c.~~ ~~A combination of Paragraph 02.a. and 02.b. of this subsection.( )~~

~~**231. – 237.(RESERVED)**~~

~~238~~**04. Marriage And Family Therapists.**
~~An applicant for marriage and family therapist licensure must pass the required examination and meet the following: ( )~~

~~01~~**a.** ~~**Graduate Degree**~~. Approved Graduate Program. A graduate program ~~Possess a master's degree or higher~~ in marriage and family therapy or a related field ~~from an accredited university or college provided that the program is either: ( )~~

~~a.~~ ~~A~~accredited by the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE)~~;~~ or substantially similar and otherwise approved by the Board.( )

~~b.~~ ~~A program of at least sixty (60) semester hours or ninety (90) quarter hours in length and that~~

~~includes at a minimum:( )~~

~~i. Marriage and family studies – Nine (9) semester credit hours or twelve (12) quarter credit hours: includes theoretical foundations, history, philosophy, etiology and contemporary conceptual directions of marriage and family therapy or marriage and family counseling; family systems theories and other relevant theories and their application in working with a wide variety of family structures, including families in transition, nontraditional families and blended families, and a diverse range of presenting issues; and preventive approaches, including premarital counseling, parent skill training and relationship enhancement, for working with couples, families, individuals, subsystems and other systems;( )~~

~~ii. Marriage and family therapy – Nine (9) semester credit hours or twelve (12) quarter credit hours: includes the practice of marriage and family therapy related to theory, and a comprehensive survey and substantive understanding of the major models of marriage and family therapy or marriage and family counseling; and interviewing and assessment skills for working with couples, families, individuals, subsystems and other systems, and skills in the appropriate implementation of systematic interventions across a variety of presenting clinical issues including, but not limited to, socioeconomic disadvantage, abuse and addiction;( )~~

~~iii. Biopsychosocial health and development across the lifespan – Nine (9) semester credit hours or twelve (12) quarter credit hours: includes individual development and transitions across the life span; family, marital and couple life cycle development and family relationships, family of origin and intergenerational influences, cultural influences, ethnicity, race, socioeconomic status, religious beliefs, gender, sexual orientation, social and equity issues and disability; human sexual development, function and dysfunction, impacts on individuals, couples and families, and strategies for intervention and resolution; and issues of violence, abuse and substance use in a relational context, and strategies for intervention and resolution;( )~~

~~iv. Psychological and mental health competency – Six (6) semester credit hours or eight (8) quarter credit hours: includes psychopathology, including etiology, assessment, evaluation and treatment of mental disorders, use of the current diagnostic and statistical manual of mental disorders, differential diagnosis and multiaxial diagnosis; standard mental health diagnostic assessment methods and instruments, including standardized tests; and psychotropic medications and the role of referral to and cooperation with other mental health practitioners in treatment planning, and case management skills for working with individuals, couples, families, and other systems and relational groups;( )~~

~~v. Professional ethics and identity – Three (3) semester credit hours or four (4) quarter credit hours: includes professional identity, including professional socialization, professional organizations, training standards, credentialing bodies, licensure, certification, practice settings and collaboration with other disciplines; ethical and legal issues related to the practice of marriage and family therapy, legal responsibilities of marriage and family therapy and marriage and family counseling practice and research, business aspects, reimbursement, recordkeeping, family law, confidentiality issues and the relevant codes of ethics, including the code of ethics specified by the board; and the interface between therapist responsibility and the professional, social and political context of treatment;( )~~

~~vi. Research – Three (3) semester credit hours or four (4) quarter credit hours: includes research in marriage and family therapy or marriage and family counseling and its application to working with couples and families; and research methodology, quantitative and qualitative methods, statistics, data analysis, ethics and legal considerations of conducting research, and evaluation of research.( )~~

~~02~~b. Required Practicum. See Rule 100.03.b. ~~Completed a supervised practicum, including any supplemental practicum hours, which meets the requirements of Subsection 230.02 of these rules.~~.( )

~~03~~c. Required Postgraduate Supervised ~~Marriage and Family Therapy~~ Experience~~ Requirements~~. ~~Completed at least three thousand (3,000) hours of graduate or post-graduate supervised experience in marriage and family therapy that meets the following requirements: ( )~~

~~a.~~ ~~A minimum of t~~Two thousand (2,000) hours of~~post-master's~~ direct client contact~~ hours,~~ over a period of ~~not less than~~at least two (2) years~~,~~ which ~~must~~ includes: (1) ~~a minimum of~~ one thousand (1,000) direct client

contact hours with two or more individuals conjointly who share an ongoing relationship beyond that which occurs in the therapeutic experience itself; and couples, families, and other systems; and( )

b. (2) A minimum of two hundred (200) hours of post-master's supervision, of which one hundred (100) hours must be individual, rather than group, supervision. One hundred (100) hours must be supervised by a licensed marriage and family therapist, with the remaining supervision provided by a supervisor who has at least two (2) years of experience practicing marriage and family therapy. .( )

d. Required Examination. The National Marital and Family Therapy Examination as approved by the Association of Marital and Family Therapy Regulatory Boards (AMFTRB) or another recognized competency examination in marriage and family therapy that is approved by the Board.

c. Other hours must support development as a marriage and family therapist, and may include: additional hours of supervision, additional practicum hours above the three hundred (300) hours required in Subsection 230.02 of these rules, writing clinical reports, writing case notes, case consultation, coordination of care, administering tests, and attending workshops, training sessions, and conferences.( )

de. A minimum of one hundred (100) hours post-master's supervision must be obtained from a registered marriage and family therapist supervisor. The remaining one hundred (100) hours of supervision may also be obtained from a licensed mental health professional supervisor as defined in these rules who documents.:( )

i. A a minimum of five two (52) years of experience providing marriage and family therapy.; and( )

ii. Fifteen (15) contact hours of education in supervisor training; and( )

iii. Has not been the subject of any disciplinary action for five (5) years immediately prior to providing supervision.( )

ed. No more than one hundred (100) hours of gGroup sSupervision are allowed. Group supervision is defined as up to six (6) supervisees and one (1) supervisor; and( )

f. Individual supervision is defined as up to two (2) supervisees per supervisor; and( )

g. Supervision must employ observation of client contact such as the use of audio technologies or video technologies or co-therapy, or live supervision; and( )

h. A supervisor may not act as an applicant's personal Professional Counselor/Therapist.( )

i. The Board considers the recommendation of the supervisor(s) when determining the acceptability of the applicant's supervised experience.( )

j. Supervision obtained in another jurisdiction or from a supervisor in another jurisdiction must conform with the jurisdiction's requirements provided they are substantially equivalent to Idaho's requirements. ( )

239. SUPERVISOR REQUIREMENTS.
200. PRACTICE STANDARDS

Licensees in Idaho must meet the following criteria to bebe registered with approved by the board to provide supervision for those individuals pursuing licensure in the state of Idaho as a counselor or marriage and family therapist. ( )

01. Licensees must comply with Board-adopted Code of Ethics pertaining to their licensure.

02. **RequirementsSupervision. for Registration**. The board will register an applicant who:( )

a. Registered interns obtaining supervised or postgraduate experience hours must be supervised by a Board-approved supervisor and must explicitly identify themselves as interns in documentation and advertising.

b. To become an approved supervisor, the supervisor must submit an application; Possesses two (2) years experience as a Bbe licensed as a clinical professional counselor (LCPC), or licensed marriage and family therapist; and (LMFT), or similar authorization to practice in another jurisdiction respective to the profession for which the applicant seeks registration as ato supervisorsupervise, and document at least one thousand five hundred (1,500) hours of direct client contact as a counselor or two thousand (2,000) hours of direct client contact with couples, families, and other systems as a marriage and family therapist.( )

b. Possess two (2) years of experience under the licensure required in subsection (a). This requirement will be suspended for LCPCs until July 1, 2026.

bc. Documents A minimum of fifteen (15) contact hours of relevant education in supervisor training as approved by the Board.( )

cd. Has not been subject to disciplined in the for five (5) years prior to registrationsupervisionthe approval request, provided that the Board may in its discretion approve a supervisor with disciplinary action for failing to complete continuing education requirements.( )

02. Supervision.( )

a. A registered supervisor must provide supervisionsupervise in conformance with statute and the guidelines for supervisors set forth in the American Counseling Association (ACA) Code of Ethics for counselor supervisors or the American Association for Marriage and Family Therapists (AAMFT) Code of Ethics. and the guidelines set forth in the AAMFT Code of Ethics for marriage and family therapist supervisors.( )

PENDING TEXT 200.02.b.

b. To become an approved supervisor, be licensed as a clinical professional counselor or licensed marriage and family therapist*; and not been*, *document a minimum of fifteen (15) contact hours of relevant education in supervisor training, and have received no* discipline*d* in the five (5) years prior to the approval request, provided the Board may approve a supervisor with disciplinary action for failing to complete continuing education requirements. A supervisor must supervise in conformance with statute and the guidelines for supervisors set forth in the ACA or AAMFT Code of Ethics. *A licensed professional counselor may be an approved supervisor until July 1, 2026.* *( )*

b. Unless the primary work role of an individual is as a clinical supervisor, a registered supervisor may not supervise more than six (6) supervisees concurrently.( )

c. Supervision must be provided in a face-to-face setting, which includes secure live electronic face-to-face connection between the supervisor and supervisee.( )

d. A registered supervisor must ensure that informed consent containing information about the roles of the supervisor and supervisee is obtained from clients of the supervisee.( )

03. Renewal. A supervisor's registration is valid for a term of five (5) years, provided the supervisor's license remains current, active, in good standing, and is not subject to discipline. To renew a supervisor registration, the licensee must submit to the Board a complete application for registration renewal and document six (6) hours of continuing education in advanced supervisor training as approved by the Board and completed within the previous twenty-four (24) months, unless good cause is shown.( )

240. EXAMINATION FOR LICENSURE.

Applicants must have successfully completed passed the required appropriate written examination:.( )

01. Examination. The required written examination is:( )

a01. For counselor applicants, the National Counselor Examination prepared by the National Board of Certified Counselors (NBCC).( )

b02. For clinical counselor applicants, the National Clinical Mental Health Counselor Examination (NCMHCE) prepared by the National Board of Certified Counselors (NBCC).( )

c03. For associate marriage and family therapist and marriage and family therapist applicants, the National Marital and Family Therapy Examination as approved by the Association of Marital and Family Therapy Regulatory Boards (AMFTRB) or another recognized competency examination in marriage and family therapy that is approved by the Board.( )

02. **Time and Place**. The examination will be conducted at a time and place specified by the Board or the examining entity.( )

03. **Successful Passage**. Successful passage of the examination is defined as achievement of the passing score set by the preparer of the examination. Reexamination consists of the entire examination.( )

241100.05.NON-UNITED StatesForeign Educated Applicants.

Applicants with a graduate degree from a country other than the United States may be required to submit a certification from a credential evaluation service that is a member of the National Association of Credential Evaluation Services (NACES) or approved by the Board. The service must certify that the graduate degree is equivalent to an approved graduate degree from the United States. All costs for the certification are the responsibility of the applicant. All information submitted to the Board must be submitted with an English translation.( )

242. -- 244.(RESERVED)

245100.06.Registered Interns. An intern registration is required to engage in the supervised practice of counseling or marriage and family therapy while completing supervised experience hours or while awaiting examination results. To register as an intern, the individual must: (1) have an approved graduate degree as defined in these Rules; and (2) designate a supervisor approved by the Board. An individual may not practice as an intern for more than four (4) years from the original date of registration, unless good cause is demonstrated to the board.

The Board may issue a registration to allow an intern to engage in the practice of counseling or marriage and family therapy while completing either the supervised experience or supplemental practicum hours required for licensure or while waiting for passing examination results. A registered intern may only practice only under the direct supervision of a person registered as a supervisor with the Board or otherwise approved to provide supervision under this chapter. ( )

PENDING TEXT 100.06

06. ***Registered Post-Graduate*** **Interns**. An *post-graduate* intern registration is required to engage in the supervised practice of counseling or marriage and family therapy while completing supervised experience hours or while awaiting examination results. To register as an intern, the individual must: (1) have an approved graduate degree as defined in these Rules; and (2) designate a supervisor approved by the Board. An individual may not practice as an intern for more than four (4) years from the original date of registration, unless good cause is demonstrated to the board.*( )*

01. **Requirements for Registration**. An applicant must meet the following requirements:( )

a. Possess a graduate degree in counseling, marriage and family therapy, or a closely related field from an accredited university or college.( )

b. Designate a supervisor who is registered withapproved by the board. as a supervisor as set forth in these rules or who is otherwise approved to provide marriage and family therapy supervision as set forth in Section 238 of these rules.( )

~~**02.** **Supervision**. The designated supervisor is responsible to provide supervision and ensure that a Registered Intern is competent to practice such counseling or marriage and family therapy as may be provided. ( )~~

~~**03**~~**02**. ~~**Designation of Intern Status**. Only a Registered Intern may use the title Registered Counselor Intern or Registered Marriage and Family Therapist Intern. Registered interns must explicitly state that they are interns in their documentation and advertising~~, ~~, such as business cards, informed consent forms, and other disclosures. ( )~~

~~**04**~~**03**. ~~**Expiration**. An individual may not practice as an intern for more than four (4) years from the original date of registration, unless good cause is demonstrated to the board.( )~~

~~**246. -- 249.(RESERVED)**~~

~~250~~400. FEES.

~~**01.** **Application, License, and Registration Fee**. All fees are non refundable:~~

~~LICENSE/PERMIT/ REGISTRATION~~TYPE	INITIAL FEE ~~(Not to Exceed)~~	ANNUAL RENEWAL FEE ~~(Not to Exceed)~~
Application	$100	
License	$100	$120
Intern Registration	$25	
Reinstatement Fee	As provided in Section 67-2614, Idaho Code	
~~Senior License~~		~~$60~~
~~Inactive License~~		~~$60~~
~~Inactive to Active License Fee~~	~~The difference between the current inactive and active license renewal fees~~	
Examination and Reexamination	$25 administrative fee plus amount charged by exam administrator	

( )

~~**02.** **Examination or Reexamination Fee**. The examination or reexamination fees are the fees set by the provider of the approved examination plus an administration fee of twenty-five dollars ($25) for the Marriage and Family Therapy examination.( )~~

~~**251. -- 299.(RESERVED)**~~

~~**300. ENDORSEMENT.**~~
~~The Board may grant a license by endorsement to an applicant who~~ holds a license or certificate in a jurisdiction ~~pays the required fee, submits a completed board-approved application, and satisfies the Board that they hold a valid and current license in good standing issued by the authorized regulatory entity of another state, territory, or jurisdiction of the United States, which in the opinion of the Board~~ that ~~imposes substantially equivalent licensing requirements~~ as set forth in these rules.( )

~~301. -- 349.(RESERVED)~~

~~350. CODE OF ETHICS.~~
~~The Board adopts the American Counseling Association (ACA) Code of Ethics and the American Association for Marriage and Family Therapy (AAMFT) Code of Ethics. All licensees must adhere to the appropriate Code of Ethics pertaining to their licensure.~~( )

~~351. -- 359.(RESERVED)~~

~~360. INACTIVE STATUS.~~

~~01. REQUEST FOR INACTIVE STATUS. EACH PERSON REQUESTING AN INACTIVE STATUS MUST SUBMIT A WRITTEN REQUEST AND PAY THE ESTABLISHED FEE.( )~~

~~02. INACTIVE LICENSE STATUS.( )~~

~~A. ALL CONTINUING EDUCATION REQUIREMENTS WILL BE WAIVED FOR ANY YEAR OR PORTION THEREOF THAT A LICENSEE MAINTAINS AN INACTIVE LICENSE.( )~~

~~B. WHEN THE LICENSEE DESIRES ACTIVE STATUS, THE LICENSEE MUST SHOW ACCEPTABLE FULFILLMENT OF CONTINUING EDUCATION REQUIREMENTS FOR THE PREVIOUS TWELVE (12) MONTHS AND SUBMIT A FEE EQUIVALENT TO THE DIFFERENCE BETWEEN THE INACTIVE AND ACTIVE RENEWAL FEE, PROVIDED THAT A LICENSEE WHOSE LICENSE HAS BEEN INACTIVE FIVE (5) YEARS OR MORE MUST PROVIDE AN ACCOUNT TO THE BOARD FOR THAT PERIOD OF TIME DURING WHICH THE LICENSE WAS INACTIVE AND FULFILL REQUIREMENTS THAT DEMONSTRATE COMPETENCY TO RESUME PRACTICE. THOSE REQUIREMENTS MAY INCLUDE, BUT ARE NOT LIMITED TO, EDUCATION, SUPERVISED PRACTICE, AND EXAMINATION AS DETERMINED BY THE BOARD. THE BOARD MAY CONSIDER PRACTICE IN ANOTHER JURISDICTION IN DETERMINING COMPETENCY.( )~~

~~C. LICENSEES MAY NOT PRACTICE OR SUPERVISE COUNSELING OR MARRIAGE AND FAMILY THERAPY IN IDAHO WHILE ON INACTIVE STATUS.( )~~

~~361. -- 374.(RESERVED)~~

~~375. SENIOR STATUS.~~

~~01. REQUEST FOR SENIOR STATUS. EACH PERSON HAVING ATTAINED THE AGE OF SIXTY-FIVE (65) AND REQUESTING A SENIOR STATUS DURING THE RENEWAL OF THEIR ACTIVE LICENSE MUST SUBMIT A WRITTEN REQUEST AND PAY THE ESTABLISHED FEE.( )~~

~~02. CONTINUING EDUCATION. CONTINUING EDUCATION MUST BE COMPLETED ANNUALLY PER SECTION 425 OF THIS RULE.( )~~

~~376. --~~424.(RESERVED)

~~425~~100.07.Continuing Education.

~~01.~~ All licensees must complete in each twenty-four-month period preceding the renewal of a license, ~~forty (40) contact hours of continuing education. A contact hour is one (1) hour of actual participation in a continuing education activity, exclusive of breaks.( )~~

~~01.~~ **~~Contact Hours~~**~~. The contact hours of continuing education must be obtained in areas of study germane to the practice for which the license is issued as approved by the Board. No less~~ ~~no fewer~~ ~~than~~ six (6) ~~contact~~ hours ~~for each renewal period must be~~ in ethics and ~~, which must be specific to legal issues, law, or ethics~~~~, and no fewer than~~ six (6) hours in suicide assessment or intervention. ~~Therapeutic workshops, retreats and other self-help~~

~~activities are not considered continuing education training unless specific parts of the experience are applicable to counseling or therapy practice.( )~~

PENDING TEXT 100.07

07. Continuing Education. In each twenty-four (24) month period preceding the renewal of a license, all licensees must complete six (6) hours in ethics ~~*and six (6)*~~ *, three (3) hours of boundaries, and three (3)* hours in suicide assessment or intervention. *Additionally, licensees are required to comply with the continuing education and competence sections of the Codes of Ethics pertaining to their licensure.( )*

~~**02. Documentation of Attendance**. Each licensee must maintain documentation verifying hours of attendance by securing authorized signatures or other documentation from the course instructors, providers, or sponsoring institution. This documentation is subject to audit and must be provide documentation verifying completion of continuing educationd upon request by the Board or its agent. Prior to reinstatement of an expired license pursuant to Idaho Code Section 67-2614, the licensee will attest to completion of the continuing education requirements of license renewal.( )~~

~~**03. Approved Contact Hours, Limitations, and Required Documents**.( )~~

~~**a.** College or University Courses for Credit or Audit. There is no limit to the contact hours that a licensee may obtain in this category during each reporting period. However, all courses are subject to Board approval. For college or university courses, one (1) semester credit equals fifteen (15) contact hours; one (1) quarter credit equals ten (10) contact hours. The licensee must provide the Board with a copy of the licensee's transcript substantiating any hours attended by the licensee.( )~~

~~**b.** Seminars, Workshops, Conferences. There is no limit to the contact hours that a licensee may obtain in this category during each reporting period. Verifying documentation is a copy of the certificate, or letter signed by course instructors, providers, or sponsoring institution substantiating any hours attended by the licensee. ( )~~

~~**c.** Publications. A maximum of eight (8) contact hours may be counted in this category during each reporting period. Publication activities are limited to articles in journals, a chapter in an edited book, or a published book or professional publication. Verifying documentation is a copy of the cover page or the article or book in which the licensee has been published. For a chapter in an edited book the licensee must submit a copy of the table of contents. ( )~~

~~**d.** Presentations. A maximum of eight (8) contact hours may be counted in this category during each reporting period. Class, conference, or workshop presentations may be used for contact hour credit if the topic is germane to the field. A specific presentation given repeatedly can only be counted once. A particular presentation will qualify for contact hour credit one (1) time in a five (5) year period. Only actual presentation time may be counted; preparation time does not qualify for contact hour credit. Verifying documentation is a copy of the conference program or a letter from the sponsor, host organization, or professional colleague.( )~~

~~**e.** Clinical Supervision and Case Consultation. A maximum of ten (10) contact hours of received supervision/consultation may be counted in this category during each reporting period. In order to qualify for contact hour credit, supervision/consultation must be received on a regular basis with a set agenda. No credit will be given for the licensee's supervision of others. Verifying documentation is a letter from the supervisor or consultant listing periods of supervision or consultation.( )~~

~~**f.** Dissertation. A maximum of ten (10) contact hours may be counted in this category during each reporting period. Verifying documentation is a copy of the licensee's transcript and the title of the dissertation. ( )~~

~~**g.** Leadership. A maximum of eight (8) contact hours may be counted in this category during each reporting period. Verifying documentation is a letter from a professional colleague listing the position of leadership,~~

~~periods of leadership, and the name of the organization under which the leadership took place. The following leadership positions qualify for continuing education credits:( )~~

~~i. Executive officer of a state or national counseling or therapy organization;( )~~

~~ii. Editor or editorial board service of a professional counseling or therapy journal;( )~~

~~iii. Member of a national ethics disciplinary review committee rendering licenses, certification, or professional membership;( )~~

~~iv. Active member of a counseling or therapy working committee producing a substantial written product; ( )~~

~~v. Chair of a major counseling or therapy conference or convention; or( )~~

~~vi. Other leadership positions with justifiable professional learning experiences.( )~~

~~h. Home Study and On-line Education. There is no limit to the contact hours that a licensee may obtain in this category during each reporting period. Home study or on-line courses qualify for contact hours, provided that the course is provided by a Board-approved continuing education provider or a course pre-approved by the Board. Verifying documentation is a copy of the certification that is verified by the authorized signatures from the course instructors, providers, or sponsoring institution and substantiates any hours completed by the licensee. A licensee seeking contact credit for reading a publication must submit results from a test on the information contained within the publication and administered by an independent third-party.( )~~

~~i. Board Meetings. Continuing education credit may be granted for a maximum of four (4) hours each renewal period for time spent attending two (2) Board meetings.( )~~

~~04~~~~02.~~ ~~**Waiver**. The Board may waive continuing education requirements for reasons of individual hardship, including health (certified by a medical doctor) or other good cause. The licensee must request such waiver prior to renewal and provide any information requested by the Board to assist in substantiating hardship cases. This waiver is granted at the sole discretion of the Board.( )~~

~~**426. – 524.(RESERVED)**~~

~~525~~200.03.~~DOCUMENTATION OF~~ Informed Consent and Information Disclosure.
~~In accordance with Section 54-3410A, Idaho Code, all licensees and registered interns will document the process of obtaining the informed consent of clients at the beginning of treatment and at other times as appropriate. Licensees and interns must adhere to their respective Codes of Ethics and state law in obtaining informed consent and disclosing information to clients.~~ The receipt of the disclosure must be acknowledged in writing by ~~both~~ the client ~~,~~ and the licensee or intern, and such disclosure of information ~~concerning their practice~~ must include: the licensee's name, license type, license number, business address and phone number; if the licensee is a supervisee, the name of any supervisor, contact information for the supervisor, including address and phone number, and a statement that the intern is practicing under the supervision of licensee; the purposes, goals, techniques, procedures, limitations, potential risks, and benefits of services; the extents and limits of confidentiality; the client's rights to participate in treatment decisions, to seek a second opinion, to file a complaint without retaliation, and to refuse treatment; the fee structure, billing arrangements, and cancellation policy; a statement that the Board regulates the licensee's and intern's practices and providing the Board's phone number and address; and a statement that sexual intimacy is never appropriate with a client and should be reported to the Board.( )

PENDING TEXT 200.03

03. Informed Consent and Information Disclosure. The receipt of the disclosure must be ~~*acknowledged*~~ *documented* in writing by the client and the licensee or intern, and such disclosure of information must include: the licensee's name, license type, license number, business address and phone number; if the licensee is a supervisee, the name of any supervisor, contact information for the supervisor, including address and phone number,

and a statement that the intern is practicing under the supervision of licensee; the purposes, goals, techniques, procedures, limitations, potential risks, and benefits of services; the extents and limits of confidentiality; the client's rights to participate in treatment decisions, to seek a second opinion, to file a complaint without retaliation, and to refuse treatment; the fee structure, billing arrangements, and cancellation policy; a statement that the Board regulates the licensee's and intern's practices and providing the Board's phone number and address; and a statement that sexual intimacy is never appropriate with a client and should be reported to the Board.( )

~~**01. Name, Business Address and Phone Number of Licensee or Intern**. If the licensee or intern is practicing under supervision, the statement must include the licensee or intern status as such and the designated qualified supervisor's name, business address and phone number;( )~~

~~**02. License Type and License Number, Credentials, and Certifications**.( )~~

~~**03. Education**. Education with the name(s) of the institution(s) attended and the specific degree(s) received;( )~~

~~**04. Theoretical Orientation and Approach**. Counseling or marriage and family therapy;( )~~

~~**05. Relationship**. Information about the nature of the clinical relationship; fee structure and billing arrangements; cancellation policy;( )~~

~~**06. The Extent and Limits of Confidentiality**.( )~~

~~**07. Written Statement**. A statement that sexual intimacy is never appropriate with a client and should be reported to the board.( )~~

~~**08. Client's Rights**. The client's rights to be a participant in treatment decisions, to seek a second opinion, to file a complaint without retaliation, and to refuse treatment.( )~~

~~**09. Board Information**. The name, address, and phone number of the Board with the information that the practice of licensees and interns is regulated by the Board.( )~~

~~526~~401. -- 999.(RESERVED)

IDAPA 24 – DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSES

24.16.01 – RULES OF THE STATE BOARD OF DENTURITRY

DOCKET NO. 24-1601-2301 (ZBR CHAPTER REWRITE)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo and Cost/Benefit Analysis (CBA)

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2024 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. The pending rule will become final and effective upon the adjournment, *sine die*, of the Second Regular Session of the Sixty-seventh Idaho Legislature after approval.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section(s) 67-2604, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

Under Executive Order 2020-01, Zero-Based Regulation, the State Board of Denturitry is striving to prevent the accumulation of costly, ineffective, and outdated regulations and reduce regulatory burden to achieve a more efficient operation of government.

There are no changes to the pending rule, and it is being adopted as originally proposed. The complete text of the proposed rule was published in the August 2, 2023, Idaho Administrative Bulletin, Vol. 23-8, pages 267-279.

FEE SUMMARY: The following is a description of the fee or charge imposed or increased in this rulemaking as authorized in Sections 54-3309 and 54-3312, Idaho Code. Pursuant to Section 67-5224(2)(d), Idaho Code, this pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature.

The fees for applications, licenses, registrations and reinstatement as designated in Rule 400 of these rules are authorized in Sections 54-3309 and 54-3312, Idaho Code. None of these fees are being changed as a result of this rulemaking or since they were previously reviewed by the Idaho Legislature.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year:

This rulemaking is not anticipated to have any negative fiscal impact on the State General Fund.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Katie Stuart, Bureau Chief, at 208-577-2489.

DATED this 1st day of November, 2023.

Katie Stuart
Bureau Chief
11341 W. Chinden Blvd., Bldg. #4
Boise, ID 83714
Phone: (208) 577-2489
Email: katie.stuart@dopl.idaho.gov

THE FOLLOWING NOTICE PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section 67-2604, Idaho Code, and Sections 54-3309, 54-3310, 54-3311, and 54-3314, Idaho Code.

PUBLIC HEARING SCHEDULE: A public hearing concerning this rulemaking will be held as follows:

Wednesday, August 23, 2023 – 1:30 p.m. (MT)

Division of Occupational and Professional Licenses
Chinden Campus Building 4
11341 W. Chinden Blvd., Bldg. #4
Boise, ID 83714

Telephone and web conferencing information will be posted on:
https://dopl.idaho.gov/calendar/ and https://townhall.idaho.gov/

The hearing site will be accessible to persons with disabilities, if needed. Requests for accommodation must be made not later than five (5) days prior to the meeting to the agency address below.

DESCRIPTIVE SUMMARY: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

Under Executive Order 2020-01, Zero-Based Regulation, the State Board of Denturitry is striving to prevent the accumulation of costly, ineffective, and outdated regulations and reduce regulatory burden to achieve a more efficient operation of government. In conjunction with stakeholders, the proposed rule changes reflect a comprehensive review of this chapter by collaborating with the public to streamline or simplify the rule language in this chapter and to use plain language for better understanding. This proposed rulemaking updates the rules to comply with governing statute and Executive Order 2020-01.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased:

The fees for applications, examinations, and licenses as designated in Rule 400 of these proposed rules are authorized in Section 54-3312, Idaho Code. None of these fees are being changed as a result of this rulemaking or since being previously reviewed by the Idaho Legislature.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the State General Fund greater than ten thousand dollars ($10,000) during the fiscal year as a result of this rulemaking:

This rulemaking is not anticipated to have any negative fiscal impact on the State General Fund.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was conducted under Docket No. 24-ZBRR-2301. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the April 5, 2023 Idaho Administrative Bulletin, Vol. 23-4, pp. 42-46.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into this rule: N/A.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Michael Hyde, Bureau Chief, at (208) 332-7133.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before August 23, 2023.

DATED this July 6, 2023.

THE FOLLOWING IS THE TEXT OF ZBR DOCKET NO. 24-1601-2301

24.16.01 – RULES OF THE STATE BOARD OF DENTURITRY

000. LEGAL AUTHORITY.
These rules are promulgated pursuant to Sections 54-3309, 54-3310, 54-3311, and 54-3314, Idaho Code. ( )

001. SCOPE.
These rules govern the practice of denturitry in Idaho. ( )

002. -- 009. (RESERVED)

010. DEFINITIONS.

01. Denture Technician. A person who is limited to making, constructing, altering, reproducing, or repairing of a full or partial, upper, or lower removable prosthetic denture but is not allowed to make an impression or come in direct contact with a patient. ( )

011. -- 099. (RESERVED)

100. LICENSURE.

01. Examination. The Board will accept either the Idaho Denturitry Exam, administered by the Board, or the Universal Testing Services (UTS) Denturitry Exam. ( )

a. Idaho Denturitry Examination. Applicants must pass both the written and practical examinations with a score of seventy-five percent (75%) or better. Applicants who fail one or both examinations will be required to pay a re-examination fee to the Board prior to retaking the failed examination(s). ( )

b. UTS Denturitry Examination. Applicants must pass the written and the practical sections of the examination, each with a score of seventy-five percent (75%) or better. ( )

02. Internship. To be eligible for internship, the applicant must have completed the educational requirements set forth in Section 54-3310(b), Idaho Code. During the internship, the supervising denturist must be present and directly observe any intern interaction with a patient. ( )

03. Internship Equivalency. A one (1) year internship acquired through a formal training program in an acceptable school will be accepted toward the two (2) year required internship for licensure. A person is considered to have the equivalent of two (2) years internship under a licensed denturist who has met and verifies one (1) of the following within the five (5) years immediately preceding application: ( )

a. Two (2) years internship as a denture lab technician under a licensed dentist; or ( )

b. Two (2) years in the military as a denture lab technician; or ( )

c. Three (3) years experience as a denturist under licensure in another state or Canada. ( )

04. Continuing Education. Continuing education must be germane to the practice of denturitry. ( )

101. -- 199. (RESERVED)

200. PRACTICE STANDARDS.

01. Minimum Facility Standards. A Denturist office must be properly equipped to ensure the safe, clean, and sanitary condition necessary and appropriate for proper operation and the safe preparation of dentures. ( )

02. Maintain Adequate Records. Adequate records mean legible records which contain, at minimum, evidence of information deemed appropriate for patient care and copies of statements of charges delivered or provided to the patient or client. All records must comply with HIPPA. ( )

201. -- 299. (RESERVED)

300. DISCIPLINE.

01. False Advertisements. No denturist may disseminate or cause the dissemination of any advertisement or advertising that is in any way fraudulent, false, deceptive, or misleading. ( )

02. Civil Penalty. The Board may impose a fine up to the amount of any economic advantage obtained through the violation. ( )

301. -- 399. (RESERVED)

400. FEES.
All fees are non-refundable.

FEE TYPE	AMOUNT
License Application and Examination	$300
Re-examination	$300
Intern Application and Permit	$300
Initial License	$300
Annual Renewal	$750

( )

401. -- 999. (RESERVED)

[Agency redlined courtesy copy]

24.16.01 – RULES OF THE STATE BOARD OF DENTURITRY

000. LEGAL AUTHORITY.
These rules are promulgated pursuant to Sections 54-3309, 54-3310, 54-3311, and 54-3314, Idaho Code.( )

001. SCOPE.
These rules govern the practice of denturitry in Idaho.( )

002. -- 009.(RESERVED)

010002. DEFINITIONS.

01. Denturist Services. For purposes of the unconditional ninety (90) day guarantee prescribed in Section 54-3320(e), Idaho Code, denturist services include any and all prosthetic dental appliances and materials and/or services related to the furnishing or supplying of such a denture, including preparatory work, construction, fitting, furnishing, supplying, altering, repairing or reproducing any prosthetic dental appliance or device.( )

012. Denture Technician. A person who is limited to making, constructing, altering, reproducing or repairing of a full or partial, upper or lower removable prosthetic denture, the repairing of a removable partial upper or lower prosthetic denture but is not allowed to make an impression or come in direct contact with a patient.( )

011003. -- 14099.(RESERVED)

1050. EXAMINATIONS.LICENSURE.

01. Date of Licensure Examination. The licensure examination will be held no less than two (2) times per year at such times and places as may be determined by the Board.( )

02. Content. Examinations include both a written theory examination and a practical demonstration of skills. ( )

03. Grading. An applicant must obtain a score of seventy-five percent (75%) or better on each part of the examination in order to pass the examination.( )

01. Examination. The Board will accept either the Idaho Denturitry Exam, administered by the Board, or the Universal Testing Services (UTS) Denturitry Exam.

a. Idaho Denturitry Examination. Applicants must pass both the written and practical examinations with a score of seventy-five percent (75%) or better. Applicants who fail one or both examinations will be required to pay a re-examination fee to the Board prior to retaking the failed examination(s).

b. UTS Denturitry Examination. Applicants must pass the written and the practical sections of the examination, each with a score of seventy-five percent (75%) or better.

02. Internship. To be eligible for internship, the applicant must have completed the educational requirements set forth in Section 54-3310(b), Idaho Code. During the internship, the supervising denturist must be present and directly observe any intern interaction with a patient.( )

03. Internship Equivalency. A one (1) year internship acquired through a formal training program in an acceptable school will be accepted toward the two (2) year required internship for licensure. A person is considered to have the equivalent of two (2) years internship under a licensed denturist who has met and verifies one

(1) of the following within the five (5) years immediately preceding application:( )

a. Two (2) years internship as a denture lab technician under a licensed dentist; or( )

b. Two (2) years in the military as a denture lab technician; or( )

c. Three (3) years experience as a denturist under licensure in another state or Canada.( )

04. **Continuing Education**. Continuing education must be germane to the practice of denturitry. ( )

~~**04.** **Re-Examination**.( )~~

~~**a.** Applicants who fail either part or all of the examination will be required to make application and pay the required fees prior to being eligible to retake the failed part of the examination.( )~~

~~**b.** Applicants failing either part or all of the examination on the first attempt will not be required to complete any additional instruction prior to being eligible to make application and retake the examination.( )~~

~~**c.** Applicants failing either part or all of the examination on a second attempt and all subsequent attempts are not eligible to make application and retake the examination within one (1) year of the date of the examination failure The Board may recommend additional course work or clinical work for any applicant who has failed an examination two (2) or more times.( )~~

~~151. -- 199.(Reserved)~~

~~**200. APPLICATIONS.**~~

~~**01.** **Application Form for Licensure**. Applications for licensure must be made on forms approved by the Board and furnished by the Division of Occupational and Professional Licenses and include all other documents necessary to establish the applicant meets the requirements for licensure except examination and is eligible to take the licensure examination.( )~~

~~**02.** **Authorization for Examination**.( )~~

~~**a.** After the Board evaluates the applicant's qualifications to take the examination the applicant will be notified in writing of the approval or denial, and, if denied, the reason for the denial.( )~~

~~**b.** At the time the Board approves an applicant to take the examination the Board will set the date and location(s) of the next examination if it has not already been set. Approved applicants will be notified of the date and location(s) of the next examination.( )~~

~~201~~101. -- 19~~24~~9.(RESERVED)

~~25~~400. FEES.
All fees are non-refundable.

FEE TYPE	AMOUNT ~~(Not to Exceed)~~
License Application and Examination	$300
~~License Application and~~ Re-examination	$300
Intern Application and Permit	$300
Initial License	$300

~~Inactive License~~	~~$50~~
Annual Renewal	$750

( )

~~251~~401. -- ~~2~~999.(RESERVED)

~~300. INTERNSHIP.~~

~~**01. Requirements and Conditions for Internship**.( )~~

~~**a.** To be eligible for internship the applicant must have completed:( )~~

~~i. The educational requirements set forth in Section 54-3310(b), Idaho Code; or( )~~

~~ii. Have denturitry experience of three (3) years within the five (5) years immediately preceding application. ( )~~

~~**b.** Where an internship is established based on experience, the internship is valid only while the intern is actively pursuing completion of Idaho licensure requirements.( )~~

~~**c.** Application must be made on forms provided by the Division of Occupational and Professional Licenses and must:( )~~

~~i. Document the location of practice;( )~~

~~ii. Include the name and address of the supervising denturist or dentist;( )~~

~~iii. Include a sworn or affirmed statement by the supervising denturist or dentist;( )~~

~~iv. Include a sworn or affirmed statement by the supervisor accepting supervision of the intern; ( )~~

~~v. Include a sworn statement by applicant that he is knowledgeable of law and rules and will abide by all requirements of such law and rules; and( )~~

~~vi. Include such other information necessary to establish applicant's qualifications for licensure as a denturist and establish compliance with pre-intern requirements.( )~~

~~**d.** The supervising denturist or dentist must be present and directly observe any intern interaction with a patient. ( )~~

~~**e.** Two (2) years of internship under the supervision of a licensed denturist must be completed in not less than twenty-four (24) months and may not exceed thirty (30) months except as approved by the Board.( )~~

~~**02. Internship Equivalency**. A person is considered to have the equivalent of two (2) years internship under a licensed denturist who has met and verifies one (1) of the following within the five (5) years immediately preceding application:( )~~

~~**a.** Two (2) years internship as a denture lab technician under a licensed dentist; or( )~~

~~**b.** Two (2) years in the military as a denture lab technician; or( )~~

~~**c.** Three (3) years experience as a denturist under licensure in another state or Canada.( )~~

~~**03.** **Internship Not to Exceed One Year**. Internship not to exceed one (1) year acquired through a formal training program in an acceptable school will be accepted toward the two (2) year required internship for licensure.( )~~

~~**04.** **Training Requirements**. Each year of required internship consists of two thousand (2,000) clock hours of training and performance of the following minimum procedures for licensure.( )~~

~~**a.** Procedures include all steps required in constructing a finished denture but are not limited to the following: ( )~~

~~i. Bite registrations, Articulations, Setups, Try ins, -- twelve (12) minimum. ( )~~

~~ii. Processed relines (one (1) plate = one (1) unit) -- twenty-four (24) units. ( )~~

~~ii. Patient charting, Operatory sanitation, Oral examination, Impressions, preliminary and final (pour models, custom trays), Processing (wax up, flask-boil out, packing, grind-polish), Delivery-post adjustment -- thirty-six (36) minimum.( )~~

~~iv. Tooth repairs, Broken or fractured plates or partials -- forty-eight (48) minimum.~~

~~i. Patient charting -- thirty-six (36) minimum.( )~~

~~ii. Operatory sanitation -- thirty-six (36) minimum.( )~~

~~iii. Oral examination -- thirty-six (36) minimum.( )~~

~~iv. Impressions, preliminary and final (pour models, custom trays) -- thirty-six (36) minimum.( )~~

~~v. Bite registrations -- twelve (12) minimum.( )~~

~~vi. Articulations -- twelve (12) minimum.( )~~

~~vii. Set ups -- twelve (12) minimum.( )~~

~~viii. Try ins -- twelve (12) minimum.( )~~

~~ix. Processing (wax up, flask-boil out, packing, grind-polish) -- thirty-six (36) minimum.( )~~

~~x. Delivery-post adjustment -- thirty-six (36) minimum.( )~~

~~**b.** Processed relines (one (1) plate = one (1) unit) -- twenty-four (24) units.( )~~

~~**c.** Tooth repairs -- forty-eight (48) minimum.( )~~

~~**d.** Broken or fractured plates or partials -- forty-eight (48) minimum.( )~~

~~**05.** **Reporting Requirements**. Interns must file reports, attested to by the supervisor, with the Board on forms provided by the Division of Occupational and Professional Licenses on a monthly basis and recapped at termination or completion of the training.( )~~

~~**06.** **Denture Clinic Requirements**. Denture clinic requirements for approved internship training: ( )~~

~~**a.** There may not be more than one (1) internee per licensed denturist or dentist who is practicing at the clinic on a full time basis.( )~~

~~**b.** There must be a separate work station in the laboratory area for each intern with standard~~

~~equipment, i.e. lathe, torch and storage space. The intern must provide necessary hand tools to perform the duties of the denture profession. Use of the operatory facilities and other equipment will be shared with the intern.( )~~

~~**07. Internship Supervisor Requirements**. Hold an Idaho denturist license in good standing, be approved in advance for each internship, and have actively practiced denturitry for the last three (3) of the five (5) years~~

~~**a.** A supervisor must:( )~~

~~i. Be approved in advance by the Board for each internship.( )~~

~~ii. Not have been the subject of any disciplinary action by the Board, by the Idaho Board of Dentistry or by any other jurisdiction for five (5) years immediately prior to being approved as the supervisor.( )~~

~~**b.** A supervisor that is a denturist must:( )~~

~~i. Hold an Idaho denturist license that is current and in good standing and is renewed as provided in these rules; and ( )~~

~~ii. Have actively practiced denturitry for at least three (3) of the five (5) years immediately prior to being approved as the supervisor.( )~~

~~**c.** A supervisor that is a dentist must: Hold an Idaho dentist license that is current and in good standing and is renewed as provided in Chapter 9, Title 54, Idaho Code; and have actively practiced general dentistry, or a dental specialty accepted by the Board, for at least three (3) of the five (5) years immediately prior to being approved as a supervisor.( )~~

~~i. Hold an Idaho dentist license that is current and in good standing and is renewed as provided in Chapter 9, Title 54, Idaho Code; and( )~~

~~ii. Have actively practiced general dentistry, or a dental specialty accepted by the Board, for at least three (3) of the five (5) years immediately prior to being approved as a supervisor.( )~~

~~**d.** Supervise only one (1) intern. A supervisor will not be approved to supervise more than one (1) intern at a time. ( )~~

~~**e.** Termination of supervisor approval. Approval of the supervisor immediately terminates if the supervisor is disciplined or ceases to meet supervisor requirements.( )~~

~~**301. -- 314.(RESERVED)**~~

~~**315. INACTIVE LICENSURE STATUS.**~~

~~**01. Request License be Placed on Inactive Status**. A denturitry licensee may request the Board that his license be placed upon inactive status for no more than five years. A licensee on inactive status may not provide or perform denturist services.( )~~

~~**02. Reactivating Inactive License**. A licensee on inactive status may reactivate his license to active status by paying the renewal fee for an active license and providing proof they have completed and obtained such continuing education as required by Board rule.( )~~

~~**316. -- 349.(RESERVED)**~~

~~**350. CONTINUING EDUCATION.**~~
~~The Board may accredit education programs for purposes of continuing education where the subject matter of the program is determined to be pertinent to the practice of denturitry.( )~~

~~**01.** **Subjects**. Subjects deemed pertinent to the practice of denturitry are those set forth in Section 54-3311(b), Idaho Code, and may also include ethics courses. Licensees may attend courses that are offered asynchronous and synchronously.~~ ( )

~~**02.** **Request for Approval**. Requests for approval of continuing education programs must be made to the Board, in writing, and provide an outline of the program which the Board is being asked to approve. The request must also address the matters set forth in Subsection 350.05 below. Requests may accompany the annual renewal form or may be made to the Board in advance of the program for which approval is sought as indicated in Subsection 350.03, below.~~( )

~~**03.** **Requests for Pre-Approval**. Requests for pre-approval of continuing education programs must be made to the Board, in writing, and provide an outline of the program which the Board is being asked to approve. Requests for pre-approval must also address the matters set forth in Subsection 350.05 below.~~( )

~~**a.** Requests for pre-approval must be received by the Division of Occupational and Professional Licenses no less than eleven (11) working days prior to the date of the program.~~( )

~~**b.** Requests for pre-approval which are not denied within ten (10) working days from receipt by the Division will be deemed approved.~~( )

~~**c.** Only those continuing education programs sponsored by recognized educational institutions (such as accredited colleges or universities), state or national denturist boards or associations, will be eligible for pre-approval consideration by the Board. All other programs will be considered at the time of renewal.~~( )

~~**04.** **Credit for Continuing Education Attendance**. Continuing education credit will be given only for actual time in attendance by the licensee. No credit will be given for non-instructive time. Correspondence or Home Study courses are not eligible for continuing education credits.~~( )

~~**05.** **Requests for Approval of Programs**. All requests for approval or pre-approval of educational programs must be accompanied by a statement that includes the name of the instructor or instructors, the date and time and location of the course, the specific agenda for the course, and a statement by the licensee of how the course is believed to be pertinent to the practice of denturitry as specified in Section 54-3311(b), Idaho Code.~~( )

~~**351. -- 399.(RESERVED)**~~

~~**400. INSPECTIONS.**~~

~~**01.** **Who May Examine or Inspect**. The Board or its agents may examine and inspect the place of business of any denturist at anytime during business hours or upon at least seventy-two (72) hours notice made by U.S. mail to the address of record of the denturist when the Board or its agents are unable to establish the regular business hours.~~ ( )

~~**02.** **Reason for Inspection**. Inspections are made to insure compliance with the Standards of Conduct and practice set forth in Section 450. Deficiencies are a violation of Section 450 and actionable against the denturist under Section 54-3314(e), Idaho Code.~~( )

~~**401. -- 449.(RESERVED)**~~

~~450~~200. ~~STANDARDS OF CONDUCT AND~~ PRACTICE STANDARDS.

01. Minimum Facility Standards. A Denturist office must be properly equipped to ensure the safe, clean, and sanitary condition necessary and appropriate for proper operation and the safe preparation of dentures.

02. Maintain adequate records. Adequate records mean legible records which contain, at minimum, evidence of information deemed appropriate for patient care and copies of statements of charges delivered or provided to the patient or client. All records must comply with HIPPA.

~~**01.** **Sanitation**.~~( )

~~a.~~ ~~There must be three (3) separate rooms; a reception room, and operatory room and a laboratory.~~ ~~( )~~

~~b.~~ ~~The operatory room must have hot and cold running water, basin with approved disposal system; disinfectant soap; single-use towels, a cuspidor with running water and a closed waste receptacle.( )~~

~~c.~~ ~~The laboratory room must have hot and cold running water, and basin with approved disposal system.~~ ~~( )~~

~~d.~~ ~~There must be a method of sterilization and disinfection evident and in use to insure the protection of the public.~~ ~~( )~~

~~e.~~ ~~All floors, walls, ceiling and benches must be kept in a sanitary condition at all times.( )~~

~~f.~~ ~~Every patient must have a separate and clean bib and a disposable cup.( )~~

~~g.~~ ~~The hands of every denturist must be washed in the presence of every patient with germicidal or antiseptic soap and water. Every denturist must wear disposable gloves.( )~~

~~h.~~ ~~Adequate and conveniently located toilet facilities with hot and cold running water, basin with approved disposal system, soap and single use towels will be provided within the building.( )~~

~~i.~~ ~~All denturist offices are open to inspection anytime during the business hours to inspection by the Board or its agents.( )~~

~~**02.**~~ ~~**Office Standards**.( )~~

~~a.~~ ~~Denturists must take care to use proper sterilization and sanitation techniques in all phases of their work.~~ ~~( )~~

~~b.~~ ~~A complete record of each patient must be kept.( )~~

~~c.~~ ~~All teeth and materials used must meet ADA standards.( )~~

~~**03.**~~ ~~**Advertisements**.( )~~

~~a.~~ ~~No denturist may disseminate or cause the dissemination of any advertisement or advertising that is any way fraudulent, false, deceptive or misleading.( )~~

~~**04.**~~ ~~**General Conditions**.( )~~

~~a.~~ ~~Conditions deemed by investigators to be a menace to the public health will be brought to the attention of the Board for consideration and immediate action.( )~~

~~b.~~ ~~These Standards of Conduct and Practice must be conspicuously posted in every licensed denturist's place of business.( )~~

~~**05.**~~ ~~**Patient Record**. A denturist must record, update and maintain documentation for each patient relevant to health history, clinical examinations and treatment, and financial data. Documentation must be written or computerized. Records must be maintained in compliance with any applicable state and federal laws, rules and regulations, including the health insurance portability and accountability act (HIPAA), P.L. 104-191 (1996), and the health information technology for economic and clinical health act (HITECH), P.L. 111-115 (2009). Such records must be accessible to other providers and to the patient in accordance with applicable laws, rules and regulations. Records must include, but are not limited to, the following:( )~~

~~a.~~ ~~Patient data, including name, address, date and description of examination;( )~~

~~**b.** Evidence of informed consent;( )~~

~~**c.** Date and description of treatment, services rendered, and any complications;( )~~

~~**d.** Health history as applicable; and( )~~

~~**e.** Any other information deemed appropriate to patient care.( )~~

~~**06.** **Record Retention**. Patient documentation, written or archived electronically by computer, must be retained for a minimum of seven (7) years and available upon request by the Board.( )~~

~~451~~201. -- ~~474~~299. (RESERVED)

~~**475. REGISTRATION STATEMENT.**~~
~~To enable the Board to examine or inspect the place of business of any licensed denturist as referred to in Section 54-3314(5)(b), Idaho Code, the filing of an annual statement is required of all licensed denturists.( )~~

~~**01.** **Statement**. must list the name and principal place of business of the denturist who is responsible for the practice of denturitry at that location.( )~~

~~**02.** **Other Business Locations**. Any other business locations maintained by the principal denturist and all denturists employed at the business.( )~~

~~**03.** **Date of Filing**. must be filed with the Board annually or within ten (10) days of any change in either location, identity of principal denturist or denturist employees.( )~~

~~**04.** **Failure to Timely File**. Failure to timely file or update this statement will constitute grounds for discipline pursuant to Section 54-3314(a), Idaho Code.( )~~

~~**476. GUARANTEE OF DENTURIST SERVICES.**~~
~~As prescribed in Section 54-3320(c), Idaho Code, unconditional guarantee of denturist services will require that the licensee refund, in full, any monies received in connection with the providing of denturist services, if demanded by the purchaser within ninety (90) days of delivery of the dentures, or the providing of services for which a fee is charged. ( )~~

~~**01.** **Ninety-Day Period**. The ninety (90) day period will be tolled for any period in which the denturist has taken possession or control of the dentures after original delivery.( )~~

~~**02.** **Written Contract**. By written contract signed by the purchaser, the denturist may specify the amount of the purchase price of the dentures, if any, that is nonrefundable should the consumer choose to cancel the purchase within the guarantee period.( )~~

~~**03.** **Nonrefundable Amount**. Under no circumstances will the nonrefundable amount exceed twenty-five percent (25%) of the total purchase price of the dentures.( )~~

~~**04.** **Limitation**. There is no limitation on the consumer's right to cancel.( )~~

~~**05.** **Cancellation of Agreement**. If the licensee elects to cancel the agreement or refuses to provide adjustments or other appropriate services to the consumer, the consumer will be entitled to a complete refund. ( )~~

~~**477. -- 479.(RESERVED)**~~

~~48~~300. DISCIPLINE.

~~**01.** **Civil Fine**. The Board may impose a civil fine not to exceed one thousand dollars ($1,000) upon a~~

licensed denturist for each violation of Section 54-3314(a), Idaho Code.( )

02. **Costs and Fees**. The Board may order a licensed denturist to pay the costs and fees incurred by the Board in the investigation or prosecution of the licensee for violation of Section 54-3314(a), Idaho Code.( )

03. **Failing to maintain adequate records**. Adequate records mean legible records which contain, at minimum, evidence of information deemed appropriate for patient care and copies of statements of charges delivered or provided to the patient or client. Must be in compliance with HIPPA.

014. **False Advertisements**. No denturist may disseminate or cause the dissemination of any advertisement or advertising that is in any way fraudulent, false, deceptive or misleading.( )

02. **Civil Penalty.** The Board may impose a fine up to the amount of any economic advantage obtained through the violation.( )

48301. -- 9399.(RESERVED)

IDAPA 24 – DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSES

24.27.01 – RULES OF THE IDAHO STATE BOARD OF MASSAGE THERAPY

DOCKET NO. 24-2701-2301 (ZBR CHAPTER REWRITE, FEE RULE)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo, Incorporation By Reference Synopsis (IBRS), & Cost/Benefit Analysis (CBA)

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2024 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. The pending rule will become final and effective, July 1, 2024, after approval.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 54-4007, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

The pending rule is being adopted under Executive Order 2020-01, Zero Based Regulation. Text amended since these rules were published as proposed are as follows:

- Rules were reordered to match publication guidelines; and
- The text "current and updated" was removed from incorporation by reference language to ensure no authority is delegated to a third party.

The text of the pending rule has been amended in accordance with Section 67-5227, Idaho Code. Only those sections that have changes that differ from the proposed text are printed in this bulletin. The complete text of the proposed rule was published in the August 2, 2023 Idaho Administrative Bulletin, Vol. 23-8, pages 280-295.

FEE SUMMARY: The following is a description of the fee or charge imposed or increased in this rulemaking as authorized in Sections 54-4001 et. seq., and 67-2614, Idaho Code. Pursuant to Section 67-5224(2)(d), Idaho Code, this pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature.

The fees for applications, licenses, registrations and reinstatement as designated in Rule 400 of these pending rules are authorized in Sections 54-4001 et. seq., and 67-2614, Idaho Code. None of these fees are being changed as a result of this rulemaking or since being previously reviewed by the Idaho Legislature.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year:

This rulemaking is not anticipated to have any negative fiscal impact on the State General Fund.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Katie Stuart at 208-577-2489.

DATED this 1st day of November, 2023.

Katie Stuart
Bureau Chief
11341 W. Chinden Blvd., Bldg. #4
Boise, ID 83714
Phone: (208) 577-2489
Email: katie.stuart@dopl.idaho.gov

THE FOLLOWING NOTICE PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section 67-2604, Idaho Code and Section 54-4007, Idaho Code.

PUBLIC HEARING SCHEDULE: A public hearing concerning this rulemaking will be held as follows:

Tuesday, August 15, 2023 – 10:00 a.m. (MT)
Division of Occupational and Professional Licenses **Chinden Campus Building 4** **11341 W. Chinden Blvd., Bldg. #4** **Boise, ID 83714** **Telephone and web conferencing information will be posted on:** **https://dopl.idaho.gov/calendar/ and https://townhall.idaho.gov/**

The hearing site will be accessible to persons with disabilities, if needed. Requests for accommodation must be made not later than five (5) days prior to the meeting to the agency address below.

DESCRIPTIVE SUMMARY: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

Under Executive Order 2020-01, Zero-Based Regulation, the Idaho State Board of Massage Therapy is striving to prevent the accumulation of costly, ineffective, and outdated regulations and reduce regulatory burden to achieve a more efficient operation of government. In conjunction with stakeholders, the proposed rule changes reflect a comprehensive review of this chapter by collaborating with the public to streamline or simplify the rule language in this chapter and to use plain language for better understanding. This proposed rulemaking updates the rules to comply with governing statute and Executive Order 2020-01.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased:

The fees for applications, licenses, and permits as designated in Rule 400 of these proposed rules are authorized in Section 54-4008, Idaho Code. None of these fees are being changed as a result of this rulemaking or since being previously reviewed by the Idaho Legislature.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the State General Fund greater than ten thousand dollars ($10,000) during the fiscal year as a result of this rulemaking:

This rulemaking is not anticipated to have any negative fiscal impact on the State General Fund.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was conducted under Docket No. 24-ZBRR-2301. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the April 5, 2023 Idaho Administrative Bulletin, Vol. 23-4, pp. 42-46.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into this rule: N/A.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Michael Hyde, Bureau Chief, at (208) 332-7133.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before August 23, 2023.

DATED this July 6, 2023.

THE FOLLOWING IS THE TEXT OF ZBR DOCKET NO. 24-2701-2301

24.27.01 – RULES OF THE IDAHO STATE BOARD OF MASSAGE THERAPY

000. LEGAL AUTHORITY.
These rules are promulgated pursuant to Section 54-4007, Idaho Code. ( )

001. SCOPE.
These rules regulate the profession of massage therapy. ( )

002. INCORPORATED BY REFERENCE.
The document titled "Code of Ethics," except XVIII, published by the NCBTMB is herein adopted and incorporated by reference and is available on the NCBTMB website: https://www.ncbtmb.org/code-of-ethics/. ( )

003. -- 099. (RESERVED)

100. LICENSURE.

01. Approved Examinations. A passing score on either the MBLEx, the NCETMB, NESL, or the NCETM examination or an examination deemed by the Board to be equivalent. ( )

02. Approved Educational Program. The registered program must have a minimum of three-hundred ninety (390) hours of in-class supervised hours of coursework and one-hundred ten (110) hours supervised clinical work or supervised massage therapy fieldwork experience. Clinical work may take place either on campus excluding instructional hours, or in an offsite location approved by the school. Students are not permitted to render any clinical services to clients until students have completed at least twenty percent (20%) of the required hours of instruction. All clinical services must be performed under the supervision of a person fully licensed. ( )

03. Provisional Permit. Upon application to the Board and payment of the required fees, an applicant may be issued a provisional permit to practice massage therapy if the applicant meets all the requirements for licensure under section 54-4009, Idaho Code, except for having successfully passed a Board-approved nationally recognized competency examination in massage therapy. While working pursuant to a provisional permit, the permit holder must be supervised by any person licensed in Idaho to provide massage therapy and whose license is in good standing. An applicant will be issued only one (1) provisional permit that is valid for a period not to exceed six (6) months. A provisional permit may be renewed only upon a showing of good cause. ( )

101. -- 199. (RESERVED)

200. PRACTICE STANDARDS.

01. Supervision of Clinical Work. The supervising massage therapist must consult with the student, evaluate student performance and be available to render direction in person where massage therapy is being provided. ( )

201. -- 399. (RESERVED)

400. FEES.
All fees are non-refundable.

FEE TYPE	AMOUNT (Not to Exceed)
Application	$50
Original License	$65
Annual Renewal	$65
License by Endorsement	$75
Provisional Permit	$25

( )

401-- 999. (RESERVED)

[Agency redlined courtesy copy]

Italicized text **indicates changes between the text of the proposed rule as adopted in the pending rule.**

24.27.01 – RULES OF THE IDAHO STATE BOARD OF MASSAGE THERAPY

000. LEGAL AUTHORITY.
These rules are promulgated pursuant to Section 54-4007, Idaho Code.( )

001. SCOPE.
These rules regulate the profession of massage therapy.( )

~~002~~003. -- ~~009~~099. (RESERVED)

~~**010. DEFINITIONS.**~~

~~**01. Approved Massage Program**. A massage therapy program conducted by an entity that is registered with the Idaho State Board of Education pursuant to Chapter 24, Title 33, Idaho Code, or with a comparable authority in another state, and that meets the entry-level educational requirements as set forth in Section 600 of these rules.( )~~

~~**02. Clinical Work**. Supervised hands-on clinical work by a student enrolled in a board-approved course of instruction to gain experience prior to graduation. Supervised, hands-on training in Clinical work may take place either on campusa classroom setting excluding instructional hours, or in an offsite location approved by the school. The student may not hold themself out as a massage therapist nor receive compensation for services provided. ( )~~

~~**03. Code of Ethics**. The Idaho Code of Ethics for Massage Therapy attached to these rules as Appendix A. ( )~~

~~**04.** **Standards of Practice**. The Standards of Practice of Massage Therapy attached to these rules as Appendix B. ( )~~

~~**011. -- 199.(RESERVED)**~~

~~**200. APPLICATION.**~~

~~**01.** **Filing an Application**. Applicants for licensure must submit a complete application, verified under oath, to the Board at its official address. The application must be on the forms approved by the Board and submitted together with the appropriate fee(s) and supporting documentation.( )~~

~~**02.** **Supplemental Documents**. The applicant must provide or facilitate the provision of any supplemental third party documents that may be required under the qualifications for the license being sought. ( )~~

~~**201. -- 249.(RESERVED)**~~

~~250~~400. FEES.
All fees are non-refundable. ~~except that, if a license is not issued, the license fee will be refunded~~

FEE TYPE	AMOUNT (Not to Exceed)
Application	$50
Original License	$65
Annual Renewal	$65
License by Endorsement	$75
~~Temporary License~~	~~$25~~
Provisional Permit	$25
~~Reinstatement~~	~~As provided in Section 67-2614, Idaho Code~~
~~Examination~~	~~Established by Administrator~~

( )

~~**251. -- 299.(RESERVED)**~~

~~300~~100. ~~REQUIREMENTS FOR ORIGINAL~~ LICENSURE.
~~Applicants for licensure must complete an application on a board approved form submitted together with the appropriate fee(s) and proof of compliance with Idaho Code Section 54-4009.~~

~~The Board may grant a license to an applicant for licensure who completes an application as set forth in Section 200 of these rules and meets the following general, education, and examination requirements:( )~~

~~**01.** **General**.( )~~

~~**a.** An applicant must provide evidence of being at least eighteen (18) years of age.( )~~

~~**b.** An applicant must certify that he/she has not been found guilty, convicted, received a withheld judgment, or suspended sentence for a felony or a crime involving moral turpitude, or if the applicant has been found guilty, convicted, received a withheld judgment, or suspended sentence for such a crime, the applicant must submit a~~

~~written statement of suitability for licensure as set forth in Section 306 of these rules.~~( )

~~**c.** An applicant must certify that he/she has not been convicted of a crime under any municipal, state, or federal narcotic or controlled substance law, or if the applicant has been convicted of such a crime, the applicant must submit a written statement of suitability for licensure as set forth in Section 306 of these rules.~~( )

~~**d.** An applicant must certify that their license has not been subject to any disciplinary action by a regulatory entity in another state, territory or country including, but not limited to, having an application for licensure denied. If the applicant or their license has been subject to discipline, the applicant must submit a written statement of suitability for licensure as set forth in Section 306 of these rules.~~( )

~~**301. -- 304.(RESERVED)**~~

~~305~~01. Approved Examinations.

~~Approved examinations are the following examinations or another nationally recognized competency examination in massage therapy that is approved by the Board.~~( )

~~01. Approved Examinations.~~ ( )

~~a. Massage and Bodywork Licensing Examination (MBLEx) as administered by the Federation of State Massage Therapy Boards (FSMTB);~~( )

~~b.~~ A passing score on either the MBLEx, the NCETMB, NESL, or the NCETM examination or an examination deemed by the Board to be equivalent.~~National Certification Examination for Therapeutic Massage and Bodywork (NCETMB) or National Certification Examination for Therapeutic Massage (NCETM) as administered by the National Certification Board for Therapeutic Massage and Bodywork (NCBTMB), if taken before February 1, 2015~~. ( )

~~**c.** Other nationally recognized competency examinations in massage therapy that are approved by the Board. A written request for approval must be submitted to the Board together with supporting documentation as may be requested by the Board.~~( )

~~**02. Successful Passage**. A passing score, or successful passage of the exam, will be determined by the entity administering the exam.~~( )

~~**03. Date of Exam**. The passage of the exam may have occurred prior to the effective date of these rules.~~ ( )

~~**306. WRITTEN STATEMENT OF SUITABILITY FOR LICENSURE.**~~

~~An applicant who or whose license has a conviction, finding of guilt, withheld judgment, or suspended sentence for a felony or crime involving moral turpitude, has a conviction for any crime under any municipal, state, or federal narcotic or controlled substance law, or has been subject to discipline in another state, territory or country must submit with his application a written statement and any supplemental information establishing his current suitability for licensure.~~ ( )

~~**01. Consideration of Factors and Evidence**. The Board considers the factors set forth in Section 67-9411, Idaho Code.~~( )

~~**02. Interview**. The Board may, at its discretion, grant an interview of the applicant.~~( )

~~**03. Applicant Bears the Burden**. The applicant bears the burden of establishing his current suitability for licensure.~~( )

~~**307. -- 309.(RESERVED)**~~

~~**310. REQUIREMENTS FOR LICENSURE BY ENDORSEMENT.**~~

~~The Board may grant a license to an applicant for licensure by endorsement who completes an application as set forth~~

~~in Section 200 and meets the following requirements:( )~~

~~**01. Holds a Current License**. The applicant must be the holder of a current active license or certificate in good standing in the profession, and at the level for which a license is being sought, issued by the authorized regulatory entity in another state. The state must have licensing or certification requirements substantially equivalent to or higher than those required for new applicants in Idaho. The certification of licensure or certification must be received by the Board from the issuing agency;( )~~

~~**02. Has Not Been Disciplined**. The applicant or his/her license must have not been voluntarily surrendered, revoked, or suspended by any regulatory entity. The Board may consider an applicant who, or whose license, has been restricted, denied, sanctioned, or otherwise disciplined. If the applicant or his/her license has been subject to discipline, the applicant must submit a written statement of suitability for licensure as set forth in Section 306 of these rules;( )~~

~~**03. Is of Good Moral Character**. The applicant must not have been found guilty, convicted, received a withheld judgment, or suspended sentence for any felony or any crime involving moral turpitude. If the applicant has been found guilty, convicted, received a withheld judgment, or suspended sentence for such a crime the applicant must submit a written statement of suitability for licensure as set forth in Section 306 of these rules; and ( )~~

~~**04. Has Not Been Convicted of a Drug Offense**. The applicant must not have been convicted of any crime under any municipal, state, or federal narcotic or controlled substance law. If the applicant has been convicted of such a crime, the applicant must submit a written statement of suitability for licensure as set forth in Section 306 of these rules. ( )~~

~~**311. -- 319.(RESERVED)**~~

~~**320. TEMPORARY LICENSE.**~~

~~**01. General**. Any person who has submitted to the Board a complete application for licensure by examination under Section 54-4009, Idaho Code, or by endorsement under Section 54-4010, Idaho Code, together with the required fees, may apply for a temporary license to practice massage therapy while their application is being processed by the Board.( )~~

~~**02. Duration**. An applicant will be issued only one (1) temporary license that will be valid for a period not to exceed four (4) months or until the Board acts upon the licensure application, whichever occurs first. ( )~~

~~**321. -- 329.(RESERVED)**~~

~~330~~100.03.Provisional Permit.
Upon application to the Board and payment of the required fees, an applicant may be issued a provisional permit to practice massage therapy if the applicant meets all the requirements for licensure under section 54-4009, Idaho Code, except for having successfully passed a Board-approved nationally recognized competency examination in massage therapy ~~that is approved by the Board as described in Subsection 305.01~~. While working pursuant to a provisional permit, the permit holder must be supervised by any person licensed in Idaho to provide massage therapy and whose license is in good standing.~~( )~~

~~**01. General**. A provisional permit will be issued subject to the following conditions:( )~~

~~**a.** The applicant must certify that the applicant will take the next scheduled examination for licensure approved by the Board, and that the applicant has not failed two (2) previous examinations for licensure; and( )~~

~~**b.** a licensed massage therapist certifies to the Board that the applicant will practice massage therapy only under the supervision of the licensed massage therapist while both are in the same location.( )~~

~~**02. Duration and Renewal.**~~ An applicant will be issued only one (1) provisional permit that is valid

for a period not to exceed six (6) months. ~~or until the applicant is issued a temporary license or the Board acts upon the massage therapist license application, whichever occurs first.~~ A provisional permit may ~~only~~ be renewed ~~once~~ only upon a showing of good cause.( )

~~**331. -- 399.(RESERVED)**~~

~~**400. RENEWAL OR EXPIRATION OF LICENSE.**~~
~~A license expires on the license holder's birth date. The individual must annually renew the license before the license holder's birth date. Licenses not so renewed will be immediately canceled in accordance with Section 67-2614, Idaho Code. ( )~~

~~**01. Renewal**. A license must be renewed before it expires by submitting a complete application for renewal on forms approved by the Board together with the renewal fee. As part of a complete renewal application, the licensee will attest to completion of the required continuing education pursuant to Section 500 of these rules. False attestation of satisfaction of the continuing education requirements on a renewal application subjects the licensee to disciplinary action, including revocation.( )~~

~~**02. Reinstatement**. A license that has been canceled for failure to renew may be reinstated in accordance with Section 67-2614, Idaho Code.( )~~

~~**a.** Within five (5) years of cancellation, an applicant seeking reinstatement must submit to the Board evidence that the applicant has completed the required continuing education together with a complete renewal application and appropriate fee(s).( )~~

~~i. The applicant must submit evidence of completion of continuing education hours totaling the hours required at the time of cancellation and for each year the license was canceled.( )~~

~~ii. The applicant must pay a reinstatement fee as set forth in Section 250 of these rules.( )~~

~~**b.** After five (5) years of cancellation, the applicant will be treated as a new applicant, and application must be made on the same forms and in the same manner as an application for an original license in accordance with Section 200 of these rules.( )~~

~~401. -- 499.(Reserved)~~

~~**500. CONTINUING EDUCATION.**~~
~~All licensees must comply with the following continuing education requirements:( )~~

~~**01. Requirement**. Beginning with the second renewal of their license, a licensee is required to complete a minimum of six (6) hours of continuing education, which includes one (1.0) hour in ethics, within the preceding twelve (12) months that meet the requirements in Sections 501, 502 and 503 of these rules.( )~~

~~**a.** An hour is defined as fifty (50) minutes out of each sixty (60) minute segment.( )~~

~~**b.** Continuing education credit will only be given for actual time in attendance or for the time spent participating in the educational activity.( )~~

~~**c.** The educational course setting may include a classroom, conference, seminar, on-line or a virtual classroom. ( )~~

~~**d.** If the licensee completes two (2) or more courses having substantially the same content during any one (1) renewal period, the licensee will only receive continuing education credit for one (1) of the courses.( )~~

~~**02. Documentation**. Each licensee must maintain documentation verifying continuing education course attendance and curriculum, or completion of the educational activity for a period of five (5) years from the date of completion. This documentation will be subject to audit by the Board.( )~~

a. Documented evidence of meeting the continuing education course requirement must be in the form of a certificate or letter from the sponsoring entity that includes verification of attendance by the licensee, the title of the activity, the subject material covered, the dates and number of hours credited, and the presenter's full name and professional credentials. Documented evidence of completing a continuing education activity must be in such form as to document both completion and date of the activity.( )

b. A licensee must submit the verification documentation to the Board, if requested by the Board. In the event a licensee fails to provide the Board with acceptable documentation of the hours attested to on the renewal application, the licensee may be subject to disciplinary action.( )

03. **Waiver**. The Board may waive the requirements of this rule for reasons of individual hardship, including health or other good cause. The licensee should request the waiver in advance of renewal and must provide any information requested by the Board to assist in substantiating hardship cases. This waiver is granted at the sole discretion of the Board.( )

04. **Carryover of Continuing Education Hours**. Continuing education hours not claimed in the current renewal year may be claimed in the next renewal year. A maximum of six (6) hours may be carried forward from the immediately preceding year, and may not be carried forward more than one renewal year.( )

05. **Exemption**. A licensee is exempt from the continuing education requirements under this Section for the period between the initial issuance of the original license and the first expiration date of that license.( )

501. APPROVAL OF CONTINUING EDUCATION COURSES.

Approved continuing education courses are those courses and programs that meet the requirements of these rules, and are approved, sponsored, or provided by the following entities or organizations, or otherwise approved by the Board: ( )

01. A College or University. Accredited by a nationally recognized accrediting agency as recognized by the United States Secretary of Education;( )

02. Federal, State or Local Governmental Entities; and( )

03. National and State Massage Therapy Associations.( )

04. **Provider Course Approval**. Other courses may be approved by the Board based upon documentation submitted by a continuing education provider. Requests for approval of courses made by the provider must be submitted on a form approved by the Board that includes:( )

a. The nature and subject of the course and its relevancy to the practice of massage therapy;( )

b. The name of instructor(s) and their qualifications;( )

c. The date, time and location of the course;( )

d. The specific agenda for the course;( )

e. The number of continuing education hours requested;( )

f. The procedures for verification of attendance; and( )

g. Other information as may be requested by the Board.( )

h. Upon review of all information requested, the Board may deny any request for a course that does not meet the requirements of Idaho law or rule. Board approval of a course will be granted for a period not to exceed five (5) years, or until the course materials or instructors are changed, whichever may occur first.( )

05. **Licensee Course Approval**. Other courses may be approved by the Board based upon

~~documentation submitted by the licensee. All requests for approval must be made to the Board in writing and include the nature and subject of the course and its relevancy to the practice of massage therapy, name of instructor(s) and their qualifications, date, time and location of the course, and procedures for verification of attendance.( )~~

~~502. Continuing Education Activities.~~

~~The following educational activities qualify for continuing education as set forth:( )~~

~~**01.** Teaching a Course For The First Time, Not to Exceed Six Hours. A report must be submitted, including the name of the course, course outline, qualifications for teaching, number of hours taught, number of participants taught, date and location of the training.( )~~

~~**02.** Publishing Articles or Books. The hours awarded as determined at the discretion of the Board. ( )~~

~~**03.** **Self Study**. Using books, audio tapes, video tapes, DVD's, research materials, professional publications, online sources, and/or other electronic sources/methods documented by a type-written two-page report summarizing the study content.( )~~

~~**503. CONTENT OF CONTINUING EDUCATION.**~~
~~The content of continuing education activities and course content must be germane to the practice of massage therapy as defined in Section 54-4002, Idaho Code, and courses in ethics must also be specific to legal issues, law, standards of practice, or ethics.( )~~

~~**01.** **Continuing Education**. Content germane to the practice of massage therapy includes, but is not limited to: ( )~~

~~**a.** Applications of massage and bodywork therapy for specific needs, conditions, or client populations. ( )~~

~~**b.** Client assessment protocols, skills for client record keeping, strategies for interfacing with other health care providers.( )~~

~~**c.** Use of external agents such as water, sound, heat, cold, or topical applications of plant or mineral-based substances. ( )~~

~~**d.** Body-centered or somatic psychology, psychophysiology, or interpersonal skills which may include communication skills, boundary functions, dual relationships, transference, counter-transference, and projection.( )~~

~~**e.** Standards of practice, professional ethics, or state laws.( )~~

~~**f.** Strategies for the marketing of massage and bodywork therapy practices.( )~~

~~**g.** Theory or practice of ergonomics as applied to therapists or clients.( )~~

~~**h.** Hygiene, methods of infectious disease control, organization and management of the treatment environment. ( )~~

~~**i.** Body sciences, which may include anatomy, physiology, kinesiology or pathology, as they apply to massage therapy.( )~~

~~**j.** Certified CPR or first aid training.( )~~

~~**504. -- 599.(RESERVED)**~~

~~600~~02. Approved Educational Program. ~~STANDARDS.~~

~~**APPROVED EDUCATIONAL PROGRAMS ARE THOSE PROGRAMS CONDUCTED BY AN ENTITY THAT MEET THE DEFINITION IN SECTION 010 AND THAT CONSIST**~~ The registered program must have ~~of~~ a minimum of ~~five hundred~~three-hundred ninety (~~500~~390) hours of in-class supervised hours of coursework and ~~clinical~~ one-hundred ten (110) hours supervised clinical work or supervised massage therapy fieldwork experience. Clinical work may take place either on campus excluding instructional hours, or in an offsite location approved by the school.~~**THAT MEETS THE FOLLOWING ENTRY-LEVEL EDUCATIONAL STANDARDS AS SET BY THE BOARD.:**~~ ~~( )~~

~~**01. Coursework Content and Hours**. Coursework must include the following content areas and minimum hours: ( )~~

~~**a.** Two hundred (200) hours in massage and bodywork assessment, theory, and application;( )~~

~~**b.** One hundred twenty-five (125) hours in body systems including anatomy, physiology, and kinesiology; ( )~~

~~**c.** Forty (40) hours in pathology;( )~~

~~**d.** Twenty-five (25) hours in business and ethics; and ( )~~

~~**02. Clinical Work**. A minimum of one hundred ten (110) hours must be clinical work. ( )~~

~~**a.**~~ Students are not permitted to render any clinical services to clients until students have completed at least twenty percent (20%) of the required hours of instruction. ~~( )~~

~~**b.**~~ All clinical services must be performed under the supervision of a person fully licensed.( )

~~601~~200. ~~SUPERVISION~~PRACTICE STANDARDS.

01. Supervision of Clinical Work. The supervising massage therapist must consult with the student, evaluate student performance and be ~~physically present and~~ available to render direction in person ~~and on the premises~~ where massage therapy is being provided.( )

~~**02. Supervision of Fieldwork**. The supervising massage therapist must be available to render direction either in person or by means of telecommunications but is not required to be physically present on the premises where massage therapy is being provided.( )~~

~~**602. -- 699.(RESERVED)**~~

~~**700. SCOPE OF PRACTICE.**~~
~~All licensees must practice in a competent manner consistent with their level of education, training, and experience. ( )~~

~~**701. -- 749.(RESERVED)**~~

~~**750. STANDARDS OF PRACTICE.**~~
~~All licensees must comply with the Idaho Standards of Practice for Massage Therapy as approved by the Board and attached as Appendix B.~~

~~**751. -- 799.(RESERVED)**~~

~~800~~002. ~~CODE OF ETHICS~~INCORPORATED BY REFERENCE.
~~All licensees must comply with the Code of Ethics for Massage Therapy as approved by the Board and attached to these rules as Appendix A.~~

The ~~current and updated~~ document titled "Code of Ethics", except XVIII, published by the NCBTMB is herein adopted and incorporated by reference and is available on the NCBTMB website: https://www.ncbtmb.org/code-of-ethics/.

PENDING TEXT 002

002. INCORPORATED BY REFERENCE.

The ~~*current and updated*~~ document titled "Code of Ethics," except XVIII, published by the NCBTMB is herein adopted and incorporated by reference and is available on the NCBTMB website: https://www.ncbtmb.org/code-of-ethics/. ( )

~~Licens~~

~~**801. -- 899.(RESERVED)**~~

~~**900. DISCIPLINE.**~~

~~If the Board determines that grounds for discipline exist for violations of Title 54, Chapter 40, Idaho Code, violations of these rules, or both, it may impose disciplinary sanctions against the licensee including, without limitation, any or all of the following:( )~~

~~**01. Refuse License**. Refuse to issue, renew, or reinstate a license;( )~~

~~**02. Revoke License**. Revoke or suspend the licensee's license(s);( )~~

~~**03. Restrict License**. Condition, restrict, or limit the licensee's practice, license, or both;( )~~

~~**04. Administrative Fine**. Impose an administrative fine not to exceed one thousand dollars ($1,000) for each violation of the Board's laws or rules; and( )~~

~~**05. Licensee Costs**. Order a licensee to pay the costs and fees incurred by the Board in the investigation, prosecution, or both, of the licensee for violation(s) of the Board's laws, rules, or both.( )~~

~~901~~401. -- 999.(RESERVED)

~~**IDAHO BOARD OF MASSAGE THERAPY CODE OF ETHICS -- APPENDIX A**~~

~~Preamble: This Code of Ethics is a summary statement of the standards of conduct that define ethical practice of massage therapy. All licensees are responsible for maintaining and promoting ethical practice.~~

~~A licensee shall:~~

~~**1.** Conduct all business and professional activities honestly and within their scope of practice and all applicable legal and regulatory requirements.~~

~~**2.** Inform clients of the limitations of the licensee's practice, the limitations of massage therapy, and the contraindications for massage therapy.~~

~~**3.** Refer the client to other professionals or services if the treatment or service is beyond the licensee's scope of practice.~~

~~**4.** Not engage in any sexual conduct, sexual activities, or sexualizing behavior involving a client, even if the client attempts to sexualize the relationship. Sexual activity includes any verbal and/or nonverbal behavior for the purpose of soliciting, receiving, or giving sexual gratification.~~

~~5. Be truthful in advertising and marketing, and not misrepresent services, charges for services, credentials, training, experience or results.~~

~~6. Safeguard the confidentiality of all client information, unless disclosure is requested by the client in writing or as allowed or required by law.~~

~~7. Obtain informed and voluntary consent from clients.~~

~~8. Allow a client the right to refuse, modify or terminate treatment regardless of prior consent given.~~

~~9. Provide draping and treatment in a way that ensures the safety, comfort, and privacy of the client.~~

~~10. Possess the right to refuse to treat any person or part of the body.~~

~~11. Refuse any gifts or benefits that are intended to influence a referral, decision, treatment or the professional relationship between the licensee and the client.~~

~~12. Report to the Idaho Board of Massage Therapy any unlicensed practice of massage therapy, and any evidence indicating unethical, incompetent or illegal acts committed by a licensee or individual.~~

~~13. Do no harm to the physical, mental, and emotional well being of clients.~~

~~IDAHO BOARD OF MASSAGE THERAPY STANDARDS OF PRACTICE -- APPENDIX B~~

~~Standard I: Professionalism~~

~~In his/her professional role the licensee shall:~~

~~1. Cooperate with any Board investigation regarding any alleged violation of the Massage Therapy law or rules.~~

~~2. Use professional verbal, nonverbal, and written communications.~~

~~3. Provide an environment that is safe for the client and which meets all legal requirements for health and safety.~~

~~4. Use standard precautions to ensure professional hygienic practices and maintain a level of personal hygiene appropriate for practitioners in the therapeutic setting.~~

~~5. Wear clothing that is clean and professional.~~

~~6. Obtain voluntary and informed consent from the client, or written informed consent from client's legal guardian, prior to initiating the treatment plan.~~

~~7. If applicable, conduct an accurate needs assessment, develop a plan of care with the client, and update the plan as needed.~~

~~8. Use appropriate draping to protect the client's physical and emotional privacy. When clients remain dressed for seated massage or sports massage, draping is not required.~~

~~9. Not practice under the influence of alcohol, drugs, or any illegal substances, with the exception of legal or prescribed dosage of medication which does not impair the licensee.~~

~~Standard II: Legal and Ethical Requirements~~

~~In his/her professional role the licensee shall:~~

~~**1.** Maintain accurate and complete client billing and records. Client Records includes notes written by a licensee and kept in a separate client file that indicates the date of the session, areas of complaint as stated by client, and observations made and actions taken by the licensee.~~

~~**2.** Report within thirty (30) days to the Idaho Board of Massage Therapy any felony or misdemeanor criminal convictions of the licensee.~~

~~Standard III: Confidentiality~~

~~In his/her professional role the licensee shall:~~

~~**1.** Protect the confidentiality of the client's identity in conversations, all advertisements, and any and all other matters unless disclosure of identifiable information is requested or permitted by the client in writing or is required or allowed by law.~~

~~**2.** Protect the interests of clients who are minors or clients who are unable to give voluntary and informed consent by securing written informed consent from an appropriate third party or guardian.~~

~~**3.** Solicit only information that is relevant or reasonable to the professional relationship.~~

~~**4.** Maintain the client files for a minimum period of seven (7) years.~~

~~**5.** Store and dispose of client files in a secure manner.~~

~~Standard IV: Business Practices~~

~~In his/her professional role the licensee shall:~~

~~**1.** Not use sensational, sexual, or provocative language and/or pictures to advertise or promote their business.~~

~~**2.** Display/discuss a schedule of fees in advance of the session that is clearly understood by the client or potential client.~~

~~**3.** Make financial arrangements in advance that are clearly understood by, and safeguard the best interests of, the client or consumer.~~

~~Standard V: Roles and Boundaries~~

~~In his/her professional role the licensee shall:~~

~~**1.** Not participate in client relationships that could impair professional judgment or result in exploitation of the client.~~

~~Standard VI: Prevention of Sexual Misconduct~~

~~In his/her professional role the licensee shall:~~

~~**1.** Not engage in any behavior that sexualizes, or appears to sexualize, the client/licensee relationship.~~

~~**2.** Not participate in a sexual relationship or sexual conduct with the client, whether consensual or otherwise, from the beginning of the client/licensee relationship and for a minimum of twelve (12) months after the termination of the client/licensee relationship.~~

~~**3.** In the event that the client initiates sexual behavior, clarify the purpose of the therapeutic session and, if such conduct does not cease, terminate or refuse the session.~~

IDAPA 24 – DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSES

24.31.01 – RULES OF THE IDAHO STATE BOARD OF DENTISTRY

DOCKET NO. 24-3101-2301 (ZBR CHAPTER REWRITE, FEE RULE)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo, Incorporation By Reference Synopsis (IBRS), & Cost/Benefit Analysis (CBA)

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2024 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. The pending rule will become final and effective upon the adjournment, *sine die*, of the Second Regular Session of the Sixty-seventh Idaho Legislature after approval.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 67-2604, Idaho Code, and Sections 54-902, 54-902A, 54-903, 54-906, 54-906A, 54-912, 54-915, 54-916, 54-918, 54-920, 54-924, 54-936, 67-2614, 67-9406, and 67-9409, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change:

Under Executive Order 2020-01, Zero-Based Regulation, the Board of Dentistry is striving to prevent the accumulation of costly, ineffective, and outdated regulations and reduce regulatory burden to achieve a more efficient operation of government.

Finding that the ADA guidelines for use of sedation, where not otherwise covered by the Board's existing rules, would impose greater restrictions on Idaho dentists, the Board eliminated those guidelines, including references throughout the chapter. Certain scrivener's errors were corrected, including eliminating a reference to "extended access" in the dental hygiene practice section and updating a reference in the dental therapy practice section from Rule 35 to Rule 200.04, as it had been redesignated in the proposed rules. In response to stakeholder feedback, the Board also amended "trained" to "educated and trained" and removed "at the supervision level set by the dentist" in the rules governing dental hygiene practice, and the Board eliminated gendered language throughout. Finally, Section 67-5229, Idaho Code, requires agencies to identify materials incorporated by reference with specificity, including the date when the material was published. To correct these errors and omissions from the proposed rule, the text of the pending rule has been amended in accordance with Section 67-5227, Idaho Code.

Only those sections that have changes that differ from the proposed text are printed in this bulletin. The complete text of the proposed rule was published in the September 6, 2023, Idaho Administrative Bulletin, Vol. 23-9, pages 341–364.

FEE SUMMARY: Pursuant to Section 67-5224(2)(d), Idaho Code, this pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature. The following is a description of the fee or charge imposed or increased in this rulemaking:

The fees for applications, licenses, registrations and reinstatement as designated in Rule 400 of these rules are authorized in Section 54-916, Idaho Code. None of these fees are being changed as a result of this rulemaking or since they were previously reviewed by the Idaho Legislature.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year:

This rulemaking is not anticipated to have any negative fiscal impact on the State General Fund.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Katie Stuart, Bureau Chief, at 208-577-2489.

DATED this 6th day of December, 2023.

Katie Stuart
Bureau Chief
11341 W. Chinden Blvd., Bldg. #4
Boise, ID 83714
Phone: (208) 577-2489
Email: katie.stuart@dopl.idaho.gov

THE FOLLOWING NOTICE PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. This rulemaking action is authorized pursuant to Section 67-2604, Idaho Code, and Sections 54-902, 54-902A, 54-903, 54-906, 54-906A, 54-912, 54-915, 54-916, 54-918, 54-920, 54-924, 54-936, 67-2614, 67-9406, and 67-9409, Idaho Code.

PUBLIC HEARING SCHEDULE: The public hearing concerning this rulemaking will be held as follows:

Thursday, September 14, 2023, 9:00 a.m. MT

Division of Occupational and Professional Licenses
Chinden Campus Building 4
11341 W. Chinden Blvd., Bldg. #4
Boise, ID 83714

Telephone and web conferencing information will be posted on:
https://dopl.idaho.gov/calendar/ and https://townhall.idaho.gov/

The hearing site will be accessible to persons with disabilities, if needed. Requests for accommodation must be made not later than five (5) days prior to the meeting to the agency address below.

DESCRIPTIVE SUMMARY AND STATEMENT OF PURPOSE: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

Under Executive Order 2020-01, Zero-Based Regulation, the Idaho Board of Dentistry is striving to prevent the accumulation of costly, ineffective, and outdated regulations and reduce regulatory burden to achieve a more efficient operation of government. In conjunction with stakeholders, the proposed rule changes reflect a comprehensive review of this chapter by collaborating with the public to streamline or simplify the rule language in this chapter and to use plain language for better understanding. This proposed rulemaking updates the rules to comply with governing statute and Executive Order 2020-01.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased:

The fees for applications, licenses, and reinstatement as designated in Rule 400 of these proposed rules are

authorized in Section 54-916, Idaho Code. None of these fees are being changed as a result of this rulemaking or since being previously reviewed by the Idaho legislature.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year as a result of this rulemaking:

This rulemaking is not anticipated to have any negative fiscal impact on the State General Fund.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was conducted under Docket No. 24-ZBRR-2301. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the April 5, 2023 Idaho Administrative Bulletin, Vol. 23-4, pp. 42-46.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into this rule:

- Office Anesthesia Evaluation Manual, published by the American Association of Oral and Maxillofacial Surgeons (AAOMS);
- Guidelines for Infection Control in Dental Health-Care Settings, published by the Centers for Disease Control and Prevention (CDC);
- Guidelines for Use of Sedation and General Anesthesia by Dentists, published by the American Dental Association (ADA);
- Principles of Ethics, Code of Professional Conduct, and Advisory Opinions, published by the American Dental Association (ADA);
- Standards for Clinical Dental Hygiene Practice, published by the American Dental Hygienists Association (ADHA).

The materials cited are incorporated by reference because they would be unduly cumbersome, expensive, or otherwise inexpedient to republish whole or in part. The materials cited are codes, standards, or rules adopted by nationally recognized organizations or associations.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS, OBTAINING DRAFT COPIES: For assistance on technical questions concerning this proposed rule, contact Katie Stuart, Bureau Chief, at (208) 577-2489. Materials pertaining to the proposed rulemaking, including any available preliminary rule drafts, can be found on the following DOPL website: https://dopl.idaho.gov/rulemaking/.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before September 27, 2023.

DATED this 4th day of August, 2023.

THE FOLLOWING IS THE TEXT OF ZBR DOCKET NO. 24-3101-2301

24.31.01 – RULES OF THE IDAHO STATE BOARD OF DENTISTRY

000. LEGAL AUTHORITY.
This Chapter is adopted under the legal authority of Chapter 9, Title 54, Idaho Code. ( )

001. SCOPE.
The rules constitute the minimum requirements for licensure and regulation of dentists, dental hygienists, and dental

therapists. ( )

002. INCORPORATION BY REFERENCE.
Pursuant to Section 67-5229, Idaho Code, this chapter incorporates by reference the following documents available on the Board's website: ( )

01. Professional Standards. ( )

a. AAOMS, Office Anesthesia Evaluation Manual, 8th Edition, 2012. ( )

b. CDC, Guidelines for Infection Control in Dental Health-Care Settings, 2003. ( )

c. ADA, Principles of Ethics, Code of Professional Conduct and Advisory Opinions, January 2009. ( )

d. ADHA Hygienists' Association, Standards for Clinical Dental Hygiene Practice, 2016. ( )

003. ABBREVIATIONS.

01. ADA. American Dental Association. ( )

02. ADHA. American Dental Hygienists Association. ( )

03. AAOMS. American Association of Oral and Maxillofacial Surgeons. ( )

04. BLS. Basic Life Support. ( )

05. CDC. Centers for Disease Control and Prevention. ( )

06. CODA. Commission on Dental Accreditation. ( )

07. INBDE. Integrated National Board Dental Examination. ( )

08. NBDHE. National Board Dental Hygiene Examination. ( )

004. -- 099. (RESERVED)

100. LICENSURE

01. Requirements For Licensure. ( )

a. Applicants for licensure must furnish proof of graduation from a program in dentistry, dental hygiene, or dental therapy accredited by CODA at the time of applicant's graduation. ( )

b. Applicants for initial licensure will provide proof of current BLS certification. Practicing licensees must maintain current BLS certification. ( )

02. Examinations For Licensure. ( )

a. Written Examination. Applicants for dentistry and dental hygiene are required to pass the INBDE or NBDHE. Dental therapists must successfully complete a board-approved written examination. ( )

b. Clinical Examination. Applicants for general dentistry, dental hygiene or dental therapy are required to pass a Board-approved clinical examination upon such subjects as specified by the Board. Applicants for dental hygiene and dental therapy must pass a board-approved clinical local anesthesia examination. Clinical examination results will be valid for licensure by examination for a period of (5) five years from the date of successful completion of the examination. ( )

03. Dental Hygienists – License Endorsements. The Board may grant license endorsements to qualified dental hygienists as follows: ( )

a. Restorative Endorsement. Notwithstanding any other provision of these rules, a qualified dental hygienist holding a restorative endorsement may perform specified restorative functions under the direct supervision of a dentist. Permissible restorative functions under this endorsement are limited to the placement of a direct restoration into a tooth prepared by a dentist and the carving, contouring and adjustment of the contacts and occlusion of the restoration. Upon application, the Board may grant a restorative endorsement to a person holding an unrestricted active status dental hygienist's license issued by the Board who provides satisfactory proof that the following requirements are met: ( )

i. The person has successfully completed a clinical restorative examination approved by the Board; and ( )

ii. The person has not been disciplined by the Board or another licensing authority. ( )

b. Renewal. A person meeting all other requirements for renewal of a license to practice dental hygiene is also entitled to renewal of a license endorsement for the effective period of the license. An endorsement immediately expires and is cancelled at such time as a person no longer holds an unrestricted active status dental hygienist's license issued by the Board. ( )

04. Licensure Of Dental Specialists. ( )

a. Requirements for Specialty Licensure. Each applicant for specialty licensure must have graduated from a CODA accredited dental school and successfully completed a CODA accredited postdoctoral advanced dental education program of at least two full-time academic years. ( )

b. Examination. Examination requirements for applicants who have met the requirements for licensure as a specialist: ( )

i. Passed a general licensure examination acceptable to the Board or, ( )

ii. If passed a general licensure examination not acceptable to the Board, passed a specialty examination or, ( )

iii. Be certified by the American Board of that particular specialty as of the date of application for specialty licensure. ( )

05. Moderate Sedation, General Anesthesia And Deep Sedation. Dentists licensed in the state of Idaho may administer moderate sedation, general anesthesia, or deep sedation once they have obtained a permit from the Board. A dentist may not administer moderate sedation to children under sixteen (16) years of age and one hundred (100) pounds unless they have qualified for and been issued a moderate parenteral sedation permit. A moderate enteral sedation permit authorizes dentists to administer sedation by either enteral or combination inhalation-enteral routes of administration. A moderate parenteral, general anesthesia, or deep sedation permit authorizes a dentist to administer sedation by any route of administration. The qualified dentist is responsible for the sedative management, adequacy of the facility and staff, diagnosis and treatment of emergencies related to the administration of moderate sedation, general anesthesia, or deep sedation and providing the equipment, drugs and protocol for patient rescue. ( )

a. Training Requirements. For Moderate Sedation Permits, completion of training in the administration of moderate sedation to a level consistent with requirements established by the Board within the five (5) year period immediately prior to the date of application. For General Anesthesia and Deep Sedation Permits, completion of an advanced education program accredited by CODA that affords comprehensive training necessary to administer and manage deep sedation or general anesthesia within the five (5) year period immediately preceding the date of application. The five (5) year requirement is not applicable to applicants who hold an equivalent permit in another state which has been in effect for the twelve (12) month period immediately prior to the application date.

Qualifying training courses must be sponsored by or affiliated with a dental school accredited by CODA, or be approved by the Board. ( )

b. Permit Renewal. Before the expiration date of a permit, the board will provide notice of renewal to the licensee. Failure to timely submit a renewal application and permit fee shall result in expiration of the permit and termination of the licensee's right to administer sedation. Failure to submit a complete renewal application and permit fee within thirty (30) days of expiration of the permit shall result in cancellation of the permit. Renewal of the permit will be required every five (5) years. Proof of a minimum of twenty-five (25) continuing education credit hours in sedation which may include training in medical/office emergencies will be required to renew a permit. ( )

c. Reinstatement. A dentist may apply for reinstatement of a canceled or surrendered permit issued by the Board within five (5) years of the date of the permit's cancellation or surrender. Applicants for reinstatement of a sedation permit must satisfy the facility and personnel requirements and verify they have obtained an average of five (5) continuing education credit hours in sedation for each year subsequent to the date upon which the permit was canceled or surrendered. A fee for reinstatement will be assessed. ( )

06. Continuing Education Requirements. A licensee renewing an active status license shall report 30 oral health/health-related continuing education hour credits to the Board of verifiable CE or volunteer practice. ( )

101. -- 199. (RESERVED)

200. PRACTICE STANDARDS.

01. Dental Hygienists – Practice. Dental hygienists are authorized under the supervision of a licensed dentist to perform dental hygiene services for which they are educated and trained unless prohibited by these rules. ( )

02. Dental Hygienists – Prohibited Practice. ( )

a. Diagnosis and Treatment. Definitive diagnosis and dental treatment planning. ( )

b. Operative Preparation. The operative preparation of teeth for the placement of restorative materials. ( )

c. Intraoral Placement or Carving. The intraoral placement or carving of restorative materials unless authorized by issuance of a restorative endorsement. ( )

d. Anesthesia. Administration of any general anesthesia or moderate sedation. ( )

e. Final Placement. Final placement of any fixed or removable appliances. ( )

f. Final Removal. Final removal of any fixed appliance. ( )

g. Cutting Procedures. Cutting procedures utilized in the preparation of the coronal or root portion of the tooth, or cutting procedures involving the supportive structures of the tooth. ( )

h. Root Canal. Placement of the final root canal filling. ( )

i. Occlusal Equilibration Procedures. Occlusal equilibration procedures for any prosthetic restoration, whether fixed or removable. ( )

j. Other Final Placement. Final placement of prefabricated or cast restorations or crowns. ( )

03. Dental Assistants – Practice. Dental assistants are authorized to perform dental services for which they are trained unless prohibited by these rules. Dental assistants must be directly supervised by a dentist when performing intraoral procedures except when providing palliative care as directed by the supervising dentist. ( )

a. Prohibited Duties. A dental assistant is prohibited from performing the following duties: ( )

i. The intraoral placement or carving of permanent restorative materials. ( )

ii. Any irreversible procedure. ( )

iii. The administration of any sedation or local injectable anesthetic. ( )

iv. Removal of calculus. ( )

v. Use of an air polisher. ( )

vi. Any intra-oral procedure using a high-speed handpiece, except for the removal of orthodontic cement or resin. ( )

vii. Any dental hygiene prohibited duty. ( )

04. Dental Therapists – Practice. Dental therapists are authorized to perform activities specified by the supervising dentist who practices in the same practice setting in conformity with a written collaborative practice agreement at the supervision levels set forth in the agreement. ( )

05. Dental Therapists – Prohibited Practice. ( )

a. Sedation. Administration of minimal, moderate or deep sedation or general anesthesia except as otherwise allowed by these rules; ( )

b. Cutting Procedures. Cutting procedures involving the supportive structures of the tooth including both the soft and hard tissues. ( )

c. Periodontal Therapy. Periodontal scaling and root planing, including the removal of subgingival calculus. ( )

d. All Extractions with Exception. All extractions except: ( )

i. Under direct supervision. ( )

ii. Non-surgical extractions. ( )

e. Under general supervision or as specified in Subsection 200.04. ( )

i. Removal of periodontally diseased teeth with class III mobility. ( )

ii. Removal of coronal remnants of deciduous teeth. ( )

f. Root Canal Therapy. ( )

g. All Fixed and Removable Prosthodontics (except stainless steel crowns). ( )

h. Orthodontics. ( )

06. Limitation of Practice. No dentist may announce or otherwise hold himself out to the public as a specialist unless he has been issued a specialty license. Any individual granted a specialty license must limit his practice to the specialty(s) in which he is licensed. ( )

07. Specialty Advertising. The specialty advertising rules are intended to allow the public to be informed about dental specialties and to require appropriate disclosures to avoid misperceptions on the part of the

public. An advertisement may not state that a licensee is a specialist unless the licensee has been granted a license in that specialty area of dental practice by the Board. A licensee who has not been granted a specialty license by the Board may advertise as being qualified in a recognized specialty area of dental practice so long as each such advertisement, regardless of form, contains a prominent, clearly worded disclaimer that the licensee is "licensed as a general dentist". A licensee may not advertise as being a specialist in or as specializing in any area of dental practice which is not a Board recognized and licensed specialty area unless the advertisement, regardless of form, contains a prominent, clearly worded disclaimer that the advertised area of dental practice is not recognized as a specialty area of dental practice by the Idaho Board of Dentistry. Any disclaimer in a written advertisement shall be in the same font style and size as that in the listing of the specialty area. ( )

08. Patient Records. A record must be maintained for each person receiving dental services, regardless of whether any fee is charged. Records must be in the form of an acronym such as "PARQ" (Procedure, Alternatives, Risks and Questions) or "SOAP" (Subjective Objective Assessment Plan) or their equivalent. Patient records must be maintained for no less than seven (7) years from the date of last entry unless: the patient requests the records be transferred to another dentist who will maintain the records, the dentist gives the records to the patient, or the dentist transfers the dentist's practice to another dentist who will maintain the records. ( )

09. Infection Control. Licensees and dental assistants must comply with current CDC infection control guidelines related to personal protective equipment, instrument sterilization, sterilizing device testing, disinfection of non-critical and clinical contact surfaces, and contaminated waste disposal. Heat sterilizing devices must be tested each calendar week in which patients are treated. Testing results must be retained by the licensee for the current calendar year and the two preceding calendar years. ( )

10. Emergency Medications Or Drugs. The following emergency medications or drugs are required in all sites where anesthetic agents of any kind are administered: anti-anaphylactic agent, antihistaminic, aspirin, bronchodilator, coronary artery vasodilator, and glucose. ( )

11. Local Anesthesia. Dental offices in which local anesthesia is administered to patients shall, at a minimum, have and maintain suction equipment capable of aspirating gastric contents from the mouth and pharynx, a portable oxygen delivery system including full face masks and a bag-valve mask combination capable of delivering positive pressure, oxygen-enriched ventilation to the patient, a blood pressure cuff of appropriate size and a stethoscope. ( )

12. Nitrous Oxide/Oxygen. Persons licensed to practice and dental assistants trained in accordance with these rules may administer nitrous oxide/oxygen to patients. Dental offices where nitrous oxide/oxygen is administered to patients must have the following: a fail-safe nitrous oxide delivery system that is maintained in working order; a scavenging system; and a positive-pressure oxygen delivery system suitable for the patient being treated. ( )

13. Minimal Sedation. Persons licensed to practice dentistry may administer minimal sedation to patients of sixteen (16) years of age or older. When the intent is minimal sedation, the appropriate dosing of a single enteral drug is no more than the maximum FDA-recommended dose for unmonitored home use. In cases where the patient weighs less than one hundred (100) pounds, or is under the age of sixteen (16) years, minimal sedation may be administered without a permit by use of nitrous oxide, or with a single enteral dose of a sedative agent administered in the dental office. ( )

14. Use Of Other Anesthesia Personnel. A dentist who does not hold a sedation permit may perform dental procedures in a dental office on a patient who receives sedation induced by an anesthesiologist, a certified registered nurse anesthetist, or another dentist with a sedation permit. The qualified sedation provider who induces sedation will monitor the patient's condition until the patient is discharged. The sedation record must be maintained in the patient's dental record and is the responsibility of the dentist who is performing the dental procedures. A dentist who intends to use the services of a qualified sedation provider must notify the Board in writing of his intent. Such notification need only be submitted once every licensing period. ( )

15. Incident Reporting. Dentists must report to the Board, in writing, within seven (7) days after the death or transport to a hospital or emergency center for medical treatment for a period exceeding twenty-four (24) hours of any patient. ( )

201. -- 299. (RESERVED)

300. DISCIPLINE.

01. Suspension, Revocation Or Restriction Of Sedation Permit. The Board may, at any time and for just cause, institute proceedings to revoke, suspend, or otherwise restrict a sedation permit. If the Board determines that emergency action is necessary to protect the public, summary suspension may be ordered pending further proceedings. Proceedings to suspend, revoke or restrict a permit shall be subject to applicable statutes and rules governing administrative procedures before the Board. ( )

02. Unprofessional Conduct. A licensee shall not engage in unprofessional conduct in the course of their practice. Unprofessional conduct by a person licensed under the provisions of Title 54, Chapter 9, Idaho Code, is defined as, but not limited to, any of the following: ( )

a. Fraud. Obtaining fees by fraud or misrepresentation, or over-treatment either directly or through an insurance carrier. ( )

b. Unlicensed Practice. Employing directly or indirectly any suspended or unlicensed individual as defined in Title 54, Chapter 9, Idaho Code. ( )

c. Unlawful Practice. Aiding or abetting licensed persons to practice unlawfully. ( )

d. Dividing Fees. A dentist shall not divide a fee for dental services with another party, who is not a partner or associate in their practice of dentistry, unless: ( )

i. The patient consents to employment of the other party after a full disclosure that a division of fees will be made; ( )

ii. The division is made in proportion to the services performed and responsibility assumed by each dentist or party. ( )

e. Prescription Drugs. Prescribing or administering prescription drugs not reasonably necessary for, or within the scope of, providing dental services for a patient. A dentist may not prescribe or administer prescription drugs to themself. A dentist shall not use controlled substances as an inducement to secure or maintain dental patronage or aid in the maintenance of any person's drug addiction by selling, giving or prescribing prescription drugs. ( )

f. Harassment. The use of threats or harassment to delay or obstruct any person in providing evidence in any possible or actual disciplinary action, or other legal action; or the discharge of an employee primarily based on the employee's attempt to comply with the provisions of Title 54, Chapter 9, Idaho Code, or the Board's Rules, or to aid in such compliance. ( )

g. Discipline in Other States. Conduct themself in such manner as results in a suspension, revocation, or other disciplinary proceedings with respect to their license in another state. ( )

h. Altering Records. Alter a patient's record with intent to deceive. ( )

i. Office Conditions. Unsanitary or unsafe office conditions, as determined by the customary practice and standards of the dental profession in the state of Idaho and CDC guidelines as incorporated by reference in these rules. ( )

j. Abandonment of Patients. Abandonment of patients by licensees before the completion of a phase of treatment, as such phase of treatment is contemplated by the customary practice and standards of the dental profession in the state of Idaho, without first advising the patient of such abandonment and of further treatment that is necessary. ( )

k. Use of Intoxicants. Practicing while under the influence of an intoxicant or controlled substance where the same impairs the licensee's ability to practice with reasonable and ordinary care. ( )

l. Mental or Physical Condition. The inability to practice with reasonable skill and safety to patients by reason of age, illness, or as a result of any mental or physical condition. ( )

m. Consent. Revealing personally identifiable facts, data or information obtained in a professional capacity without prior consent of the patient, except as authorized or required by law. ( )

n. Scope of Practice. Practicing or offering to practice beyond the scope permitted by law, or accepting and performing professional responsibilities that the licensee knows or has reason to know that he or she is not competent to perform. ( )

o. Delegating Duties. Delegating professional responsibilities to a person when the licensee delegating such responsibilities knows, or with the exercise of reasonable care and control should know, that such a person is not qualified by training or by licensure to perform them. ( )

p. Unauthorized Treatment. Performing professional services that have not been authorized by the patient or his legal representative. ( )

q. Supervision. Failing to exercise appropriate supervision over persons who are authorized to practice only under the supervision of a licensed professional. ( )

r. Legal Compliance. Failure to comply with any provisions of federal, state or local laws, statutes, rules, and regulations governing or affecting the practice of dentistry, dental hygiene, or dental therapy. ( )

s. Exploiting Patients. Exercising undue influence on a patient in such manner as to exploit a patient for the financial or personal gain of a practitioner or of a third party. ( )

t. Misrepresentation. Willful misrepresentation of the benefits or effectiveness of dental services. ( )

u. Disclosure. Failure to advise patients or their representatives in understandable terms of the treatment to be rendered, alternatives, the name and professional designation of the provider rendering treatment, and disclosure of reasonably anticipated fees relative to the treatment proposed. ( )

v. Sexual Misconduct. Making suggestive, sexual or improper advances toward any person or committing any lewd or lascivious act upon or with any person in the course of dental practice. ( )

w. Patient Management. Use of unreasonable and/or damaging force to manage patients, including but not limited to hitting, slapping or physical restraints. ( )

x. Compliance Professional Standards. Failure to comply with professional standards applicable to the practice of dentistry, dental hygiene, or dental therapy as incorporated by reference in this chapter. ( )

y. Failure to Provide Records to a Patient or Patient's Legal Guardian. Refusal or failure to provide a patient or patient's legal guardian with records within five (5) business days. A patient or patient's legal guardian may not be denied a copy of his records for any reason, regardless of whether the person has paid for the dental services rendered. A person may be charged for the actual cost of providing the records but in no circumstances may a person be charged an additional processing or handling fee or any charge in addition to the actual cost. ( )

z. Failure to Cooperate with Authorities. Failure to cooperate with authorities in the investigation of any alleged misconduct or interfering with a Board investigation by willful misrepresentation of facts, willful failure to provide information upon request of the Board, or the use of threats or harassment against any patient or witness to prevent them from providing evidence. ( )

aa. Advertising. Advertise in a way that is false, deceptive, misleading or not readily subject to

verification. ( )

301. – 399. (RESERVED)

400. FEES.

01. Application and License Fees. Fees are as follows:

License/Permit Type	Application Fee	License/Permit Fee
Dentist/Dental Specialist	$300	Active Status: $375 Inactive Status: $160
Dental Hygienist	$150	Active Status: $175 Inactive Status: $85
Dental Therapist	$200	Active Status: $250 Inactive Status: $125
Sedation Permit	$300	$300

( )

401. -- 999. (RESERVED)

[Agency redlined courtesy copy]

***Italicized text* indicates changes between the text of the proposed rule as adopted in the pending rule.**

24.31.01 – RULES OF THE IDAHO STATE BOARD OF DENTISTRY

000. LEGAL AUTHORITY.
This Chapter is adopted under the legal authority of Chapter 9, Title 54, Idaho Code.( )

001. SCOPE.
The rules constitute the minimum requirements for licensure and regulation of dentists, dental hygienists, and dental therapists. ( )

002. INCORPORATION BY REFERENCE.
Pursuant to Section 67-5229, Idaho Code, this chapter incorporates by reference the most recent and updated ~~following~~ documents available on the Board's website:( )

01. Professional Standards.( )

a. AAOMS, Office Anesthesia Evaluation Manual~~, 8th Edition, 2012~~.( )

b. CDC, Guidelines for Infection Control in Dental Health-Care Settings~~, 2003~~.( )

c. ADA, Guidelines for Use of Sedation and General Anesthesia by Dentists.

~~c~~d. ADA, Principles of Ethics, Code of Professional Conduct and Advisory Opinions, January 2009. ( )

~~d~~e. ADHA Hygienists' Association, Standards for Clinical Dental Hygiene Practice, 2016.( )

PENDING TEXT 002

002. INCORPORATION BY REFERENCE.

Pursuant to Section 67-5229, Idaho Code, this chapter incorporates by reference the ~~*most recent and updated*~~ *following* documents available on the Board's website:*( )*

01. Professional Standards. ( )

a. AAOMS, Office Anesthesia Evaluation Manual*, 8th Edition, 2012*. *( )*

b. CDC, Guidelines for Infection Control in Dental Health-Care Settings*, 2003*. *( )*

~~*c. ADA, Guidelines for Use of Sedation and General Anesthesia by Dentists. ( )*~~

~~d~~c. ADA, Principles of Ethics, Code of Professional Conduct and Advisory Opinions, January 2009. ( )

~~e~~*d*. ADHA Hygienists' Association, Standards for Clinical Dental Hygiene Practice, 2016. ( )

~~**003. -- 009.(RESERVED)**~~

~~010~~003. ~~DEFINITIONS AND~~ ABBREVIATIONS.

~~**01. ACLS**. Advanced Cardiovascular Life Support or Pediatric Advanced Life Support.( )~~

~~02~~01. ADA. American Dental Association.( )

~~03~~02. ADHA. American Dental Hygienists Association.( )

~~04~~03. AAOMS. American Association of Oral and Maxillofacial Surgeons.( )

~~05~~04. BLS. Basic Life Support.( )

~~06~~05. CDC. Centers for Disease Control and Prevention.( )

~~07~~06. CODA. Commission on Dental Accreditation.( )

07. INBDE. Integrated National Board Dental Examination

~~**08. Deep Sedation**. A drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilator function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.( )~~

~~**09. Enteral**. Administration of a drug in which the agent is absorbed through the gastrointestinal tract or mucosa. ( )~~

~~**10. EPA**. United States Environmental Protection Agency.( )~~

~~**11. General Anesthesia**. A drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilator function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required~~

~~because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.( )~~

~~12. **Inhalation**. Administration of a gaseous or volatile agent introduced into the lungs and whose primary effect is due to absorption through the gas/blood interface.( )~~

~~13. **Local Anesthesia**. The elimination of sensation, especially pain, in one (1) part of the body by the topical application or regional injection of a drug.( )~~

~~14. **Minimal Sedation**. A minimally depressed level of consciousness that retains the patient's ability to independently and continuously maintain an airway and respond normally to tactile stimulation and verbal command. Although cognitive function and coordination may be modestly impaired, ventilator and cardiovascular functions are unaffected. In accord with this particular definition, the drugs and/or techniques used should carry a margin of safety wide enough never to render unintended loss of consciousness. Further, patients whose only response is reflex withdrawal from repeated painful stimuli would not be considered to be in a state of minimal sedation. ( )~~

~~15. **Moderate Sedation**. A drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained. ( )~~

~~16. **Monitor or Monitoring**. The direct clinical observation of a patient during the administration of sedation by a person trained to observe the physical condition of the patient and capable of assisting with emergency or other procedures.( )~~

~~17. **NBDE**. National Board Dental Examination.( )~~

~~18~~08. **NBDHE**. National Board Dental Hygiene Examination.( )

~~19. **Operator**. The supervising dentist or another person who is authorized by these rules to induce and administer sedation.( )~~

~~20. **Parenteral**. Administration of a drug which bypasses the gastrointestinal tract [i.e., intramuscular, intravenous, intranasal, submucosal, subcutaneous, intraosseous].( )~~

~~21. **Sedation**. The administration of minimal, moderate, and deep sedation and general anesthesia. ( )~~

004. – 099.(Reserved)

011. APPLICATION AND LICENSE FEES.

~~Application fees are not refunded. A license shall not be issued or renewed unless fees have been paid. License fees are prorated from date of initial licensure to the next successive license renewal date. The application fees and license~~ F~~f~~ees are as follows:

License/Permit Type	Application Fee	License/Permit Fee
Dentist/Dental Specialist	$300	Active Status: $375 Inactive Status: $160
Dental Hygienist	$150	Active Status: $175 Inactive Status: $85
Dental Therapist	$200	Active Status: $250 Inactive Status: $125

Sedation Permit	$300	$300

( )

012. EXAMINATIONS FOR LICENSURE.

01. Written Examination. ~~Successful completion of the NBDE may be required of all applicants for a license to practice dentistry or a dental specialty. Successful completion of the NBDHE may be required of all applicants for a license to practice dental hygiene.~~ Applicants for dentistry and dental hygiene are required to pass the INBDE or NBDHE. Dental therapists must successfully complete a board-approved written examination. ~~Any other written examination will be specified by the Board.~~( )

02. Clinical Examination. ~~All~~ Aapplicants for ~~a license to practice~~ general dentistry, dental hygiene or dental therapy are required to pass a Board-approved clinical examination upon such subjects as specified by the Board. Applicants for dental hygiene and dental therapy ~~licensure~~ must pass a board-approved clinical local anesthesia examination. Clinical examination results will be valid for licensure by examination for a period of (5) five years from the date of successful completion of the examination.( )

013. REQUIREMENTS FOR LICENSURE.
Applicants for licensure ~~to practice dentistry~~ must furnish proof of graduation from a ~~school of dentistry~~program in dentistry, dental hygiene, or dental therapy accredited by CODA at the time of applicant's graduation. ~~Applicants for licensure to practice dental hygiene must furnish proof of graduation from a dental hygiene program accredited by CODA at the time of applicant's graduation. Applicants for licensure to practice dental therapy must furnish proof of graduation from a dental therapy program accredited by CODA at the time of applicant's graduation.( )~~

014. REQUIREMENT FOR BLS.
Applicants for initial licensure will provide proof of current BLS certification. Practicing licensees must maintain current BLS certification.( )

015. CONTINUING EDUCATION REQUIREMENTS.
A licensee renewing an active status license shall report 30 oral health/health-related continuing education hour credits to the Board of verifiable CE or volunteer practice.( )

~~**016. -- 020.(RESERVED)**~~

~~**021. PROVISIONAL LICENSURE.**~~
~~This type of license may be granted at the Board's discretion to applicants with active practice within the previous (2) years, current license in good standing in another state, and evidence of not failing an exam given by the Board.~~
~~( )~~

~~**022. VOLUNTEER DENTAL HYGIENE SERVICES.**~~
~~A person holding an unrestricted active status dental hygiene license issued by the Board may provide dental hygiene services in an extended access oral health care setting without being issued an extended access license endorsement. The dental hygiene services performed are limited to oral health screening and patient assessment, preventive and oral health education, preparation and review of health history, non-surgical periodontal treatment, oral prophylaxis, the application of caries preventive agents including fluoride, the application of pit and fissure sealants with recommendation that the patient will be examined by a dentist;( )~~

023. DENTAL HYGIENISTS – LICENSE ENDORSEMENTS.
The Board may grant license endorsements to qualified dental hygienists as follows:( )

~~**01. Extended Access Endorsement**. Upon application, the Board may grant an extended access endorsement to a person holding an unrestricted active status dental hygienist's license issued by the Board who provides satisfactory proof that all of the following requirements are met:( )~~

~~**a.** The person has been licensed as a dental hygienist during the two (2) year period immediately prior to the date of application for an extended access endorsement;( )~~

~~**b.** For a minimum of one thousand (1000) total hours within the previous two (2) years, the person has either been employed as a dental hygienist in supervised clinical practice or has been engaged as a clinical practice educator in an approved dental hygiene school;( )~~

~~**c.** The person has not been disciplined by the Board or another licensing authority upon grounds that bear a demonstrable relationship to the ability of the dental hygienist to safely and competently practice under general supervision in an extended access oral health care setting; and( )~~

~~**d.** Any person holding an unrestricted active status dental hygienist's license issued by the Board who is employed as a dental hygienist in an extended access oral health care setting in this state may be granted an extended access endorsement without being required to satisfy the experience requirements specified in this rule. ( )~~

02. ~~**Extended Access**~~ **Restorative Endorsement**. Notwithstanding any other provision of these rules, a qualified dental hygienist holding a~~n~~ ~~extended access~~ restorative endorsement may perform specified restorative functions under the direct supervision of a dentist ~~in an extended access oral health care setting~~. Permissible restorative functions under this endorsement are limited to the placement of a direct restoration into a tooth prepared by a dentist and the carving, contouring and adjustment of the contacts and occlusion of the restoration. Upon application, the Board may grant a~~n~~ ~~extended access~~ restorative endorsement to a person holding an unrestricted active status dental hygienist's license issued by the Board who provides satisfactory proof that the following requirements are met:( )

a. The person has successfully completed ~~the Western Regional Examining Board's~~a clinical restorative examination ~~or an equivalent restorative examination~~ approved by the Board; and( )

b. The person has not been disciplined by the Board or another licensing authority ~~upon grounds that bear a demonstrable relationship to the ability of the dental hygienist to safely and competently practice under in an extended access oral health care setting~~.( )

03. **Renewal**. ~~Upon payment of the appropriate license fee and completion of required CE credits specified for a license endorsement, a~~A person meeting all other requirements for renewal of a license to practice dental hygiene is also entitled to renewal of a license endorsement for the effective period of the license. An endorsement immediately expires and is cancelled at such time as a person no longer holds an unrestricted active status dental hygienist's license issued by the Board ~~or upon a person's failure to complete the required CE~~.( )

024. LICENSURE OF DENTAL SPECIALISTS.

01. **Requirements for Specialty Licensure**. Each applicant for specialty licensure must have graduated from a CODA accredited dental school ~~and hold a license to practice general dentistry in the state of Idaho or another state. The Board may grant licensure in specialty areas of dentistry for which a dentist has~~ and successfully completed a CODA accredited postdoctoral advanced dental education program of at least two full-time academic years. ( )

02. **Examination**. ~~Specialty licensure in those specialties recognized may be granted solely at the discretion of the Board. An examination covering the applicant's chosen field may be required and, if so, will be conducted by the Board or a testing agent.~~ Examination requirements for a~~A~~pplicants who have met the requirements for licensure as a specialist ~~may be required to pass an examination as follows~~:( )

a. ~~Applicants who have p~~Passed a general licensure examination acceptable to the Board ~~may be granted specialty licensure by Board approval.~~ or,( )

b. ~~Applicants who have~~ If passed a general licensure examination not acceptable to the Board, ~~may be required to~~ passed a specialty examination~~.~~ or, ( )

c. ~~Applicants who are~~ Be certified by the American Board of that particular specialty as of the date of application for specialty licensure ~~may be granted specialty licensure by Board approval~~.( )

03. Limitation of Practice. No dentist may announce or otherwise hold himself out to the public as a specialist unless he has ~~first complied with the requirements established by the Board for such specialty and has~~ been issued a specialty license ~~authorizing him to do so~~. Any individual granted a specialty license must limit his practice to the specialty(s) in which he is licensed.( )

025. SPECIALTY ADVERTISING.
The specialty advertising rules are intended to allow the public to be informed about dental specialties and to require appropriate disclosures to avoid misperceptions on the part of the public.~~( )~~

~~**01. Recognized Specialty License.**~~ An advertisement may not state that a licensee is a specialist unless the licensee has been granted a license in that specialty area of dental practice by the Board. ~~Use of words or terms in advertisements such as "Specialist," "Board Certified," "Diplomate," "Practice Limited To," and "Limited To Specialty Of" shall be prima facie evidence that the licensee is holding himself out to the public as a licensed specialist in a specialty area of dental practice.( )~~

~~**02. Disclaimer**.~~ A licensee who has not been granted a specialty license by the Board may advertise as being qualified in a recognized specialty area of dental practice so long as each such advertisement, regardless of form, contains a prominent, clearly worded disclaimer that the licensee is "licensed as a general dentist" ~~or that the specialty services "will be provided by a general dentist." Any disclaimer in a written advertisement must be in the same font style and size as that in the listing of the specialty area.( )~~

~~**03. Unrecognized Specialty**.~~ A licensee may not advertise as being a specialist in or as specializing in any area of dental practice which is not a Board recognized and licensed specialty area unless the advertisement, regardless of form, contains a prominent, clearly worded disclaimer that the advertised area of dental practice is not recognized as a specialty area of dental practice by the Idaho Board of Dentistry. Any disclaimer in a written advertisement shall be in the same font style and size as that in the listing of the specialty area.( )

026. PATIENT RECORDS.
A record must be maintained for each person receiving dental services, regardless of whether any fee is charged. Records must be in the form of an acronym such as "PARQ" (Procedure, Alternatives, Risks and Questions) or "SOAP" (Subjective Objective Assessment Plan) or their equivalent. Patient records must be maintained for no less than seven (7) years from the date of last entry unless: the patient requests the records be transferred to another dentist who will maintain the records, the dentist gives the records to the patient, or the dentist transfers the dentist's practice to another dentist who will maintain the records.( )

~~**027. -- 030.(RESERVED)**~~

031. INFECTION CONTROL.
~~In determining what constitutes unacceptable patient care with respect to infection control, the Board may consider current infection control guidelines such as those of the CDC. Additionally, L~~Llicensees and dental assistants must comply with ~~the following requirements:~~ current CDC infection control guidelines related to personal protective equipment, instrument sterilization, sterilizing device testing, disinfection of non-critical and clinical contact surfaces, and contaminated waste disposal. Heat sterilizing devices must be tested each calendar week in which patients are treated. Testing results must be retained by the licensee for the current calendar year and the two preceding calendar years.( )

~~**01. Gloves, Masks, and Eyewear**. Disposable gloves must be worn whenever placing fingers into the mouth of a patient or when handling blood or saliva contaminated instruments or equipment. Appropriate hand hygiene must be performed prior to gloving. Masks and protective eyewear or chin-length shields must be worn when spattering of blood or other body fluids is likely.( )~~

~~**02. Instrument Sterilization**. Between each patient use, instruments and other equipment that come in contact with body fluids must be sterilized.( )~~

~~**03. Sterilizing Devices Testing**. Heat sterilizing devices must be tested for proper function by means of a biological monitoring system that indicates micro-organisms kill. Devices must be tested each calendar week in which scheduled patients are treated. Testing results must be retained by the licensee for the current calendar year and the two (2) preceding calendar years.( )~~

~~**04. Non-Critical Surfaces**. Environmental surfaces that are contaminated by blood or saliva must be disinfected with an EPA registered hospital disinfectant.( )~~

~~**05. Clinical Contact Surfaces**. Impervious backed paper, aluminum foil, or plastic wrap should be used to cover surfaces that may be contaminated by blood or saliva. The cover must be replaced between patients. If barriers are not used, surfaces must be cleaned and disinfected between patients by using an EPA registered hospital disinfectant. ( )~~

~~**06. Disposal**. All contaminated wastes and sharps must be disposed of according to any governmental requirements. ( )~~

032. EMERGENCY MEDICATIONS OR DRUGS.

The following emergency medications or drugs are required in all sites where anesthetic agents of any kind are administered: anti-anaphylactic agent, antihistaminic, aspirin, bronchodilator, coronary artery vasodilator, and glucose. ( )

033. DENTAL HYGIENISTS – PRACTICE.

Dental hygienists are ~~hereby~~ authorized ~~to perform the activities specified below:~~ under the supervision of a licensed dentist, at the supervision level set by the dentist, to perform dental hygiene services for which they are trained unless prohibited by these rules.( )

~~**01. General Supervision**. A dental hygienist may perform specified duties under general supervision as follows: ( )~~

~~**a.** Oral prophylaxis (removal of stains and plaque biofilm and if present, supragingival and/or subgingival calculus);( )~~

~~**b.** Medical history assessments and intra-oral and extra-oral assessments (including charting of the oral cavity and surrounding structures, taking case histories and periodontal assessment);( )~~

~~**c.** Developing patient care plans for prophylaxis, non-surgical periodontal therapy and supportive and evaluative care in accordance with the treatment parameters set by supervising dentist;( )~~

~~**d.** Root planing;( )~~

~~**e.** Non-surgical periodontal therapy;( )~~

~~**f.** Closed subgingival curettage;( )~~

~~**g.** Administration of local anesthesia;( )~~

~~**h.** Removal of marginal overhangs (use of high speed handpieces or surgical instruments is prohibited); ( )~~

~~**i.** Application of topical antibiotics or antimicrobials (used in non-surgical periodontal therapy); ( )~~

~~**j.** Provide patient education and instruction in oral health education and preventive techniques; ( )~~

~~**k.** Placement of antibiotic treated materials pursuant to dentist authorization;( )~~

~~**l.** Administration and monitoring of nitrous oxide/oxygen; and( )~~

~~**m.** All duties which may be performed by a dental assistant.( )~~

~~**02.** **Direct Supervision**. A dental hygienist may perform specified duties under direct supervision as follows: ( )~~

~~**a.** Use of a laser restricted to gingival curettage and bleaching.( )~~

PENDING TEXT 200.01

01. Dental Hygienists – Practice. Dental hygienists are authorized under the supervision of a licensed dentist~~*, at the supervision level set by the dentist,*~~ to perform dental hygiene services for which they are *educated and* trained unless prohibited by these rules.*( )*

034. DENTAL HYGIENISTS – PROHIBITED PRACTICE.

01. Diagnosis and Treatment. Definitive diagnosis and dental treatment planning.( )

02. Operative Preparation. The operative preparation of teeth for the placement of restorative materials. ( )

03. Intraoral Placement or Carving. The intraoral placement or carving of restorative materials unless authorized by issuance of an extended access restorative endorsement.( )

PENDING TEXT 200.02.c.

c. Intraoral Placement or Carving. The intraoral placement or carving of restorative materials unless authorized by issuance of a~~*n extended access*~~ restorative endorsement.*( )*

04. Anesthesia. Administration of any general anesthesia or moderate sedation.( )

05. Final Placement. Final placement of any fixed or removable appliances.( )

06. Final Removal. Final removal of any fixed appliance.( )

07. Cutting Procedures. Cutting procedures utilized in the preparation of the coronal or root portion of the tooth, or cutting procedures involving the supportive structures of the tooth.( )

08. Root Canal. Placement of the final root canal filling.( )

09. Occlusal Equilibration Procedures. Occlusal equilibration procedures for any prosthetic restoration, whether fixed or removable.( )

10. Other Final Placement. Final placement of prefabricated or cast restorations or crowns.( )

035. DENTAL THERAPISTS – PRACTICE.
Dental therapists are authorized to perform activities specified by the supervising dentist who practices in the same practice setting in conformity with a written collaborative practice agreement at the supervision levels set forth in the agreement. ( )

036. DENTAL THERAPISTS – PROHIBITED PRACTICE.

01. Sedation. Administration of minimal, moderate or deep sedation or general anesthesia except as

otherwise allowed by these rules;( )

02. Cutting Procedures. Cutting procedures involving the supportive structures of the tooth including both the soft and hard tissues.( )

03. Periodontal Therapy. Periodontal scaling and root planing, including the removal of subgingival calculus. ( )

04. All Extractions with Exception. All extractions except:( )

a. Under direct supervision.( )

i. Non-surgical extractions.( )

b. Under general supervision or as specified in Section 035.( )

PENDING TEXT 200.05.e.

e. Under general supervision or as specified in S*ubs*ection ~~*035*~~ *200.04*. *( )*

i. Removal of periodontally diseased teeth with class III mobility.( )

ii. Removal of coronal remnants of deciduous teeth.( )

05. Root Canal Therapy.( )

06. All Fixed and Removable Prosthodontics (except stainless steel crowns).( )

07. Orthodontics.( )

037. DENTAL ASSISTANTS – PRACTICE.

Dental assistants are authorized to perform dental services for which they are trained unless prohibited by these rules. Dental assistants must be directly supervised by a dentist when performing intraoral procedures except when providing palliative care as directed by the supervising dentist.( )

01. Prohibited Duties. A dental assistant is prohibited from performing the following duties:( )

a. The intraoral placement or carving of permanent restorative materials.( )

b. Any irreversible procedure.( )

c. The administration of any sedation or local injectable anesthetic.( )

d. Removal of calculus.( )

e. Use of an air polisher.( )

f. Any intra-oral procedure using a high-speed handpiece, except for the removal of orthodontic cement or resin. ( )

g. Any dental hygiene prohibited duty.( )

~~**038. 040.(RESERVED)**~~

041. LOCAL ANESTHESIA.

Dental offices in which local anesthesia is administered to patients shall, at a minimum, have and maintain suction equipment capable of aspirating gastric contents from the mouth and pharynx, a portable oxygen delivery system including full face masks and a bag-valve mask combination capable of delivering positive pressure, oxygen-enriched ventilation to the patient, a blood pressure cuff of appropriate size and a stethoscope.( )

042. NITROUS OXIDE/OXYGEN.
Persons licensed to practice and dental assistants trained in accordance with these rules may administer nitrous oxide/oxygen to patients.~~( )~~

~~**01. Patient Safety**. A dentist must evaluate the patient to ensure the patient is an appropriate candidate for nitrous oxide/oxygen; ensure that any patient under nitrous oxide/oxygen is continually monitored; and ensure that a second person is in the practice setting who can immediately respond to any request from the person administering the nitrous oxide/oxygen.( )~~

~~**02. Required Facilities and Equipment**.~~ Dental offices where nitrous oxide/oxygen is administered to patients must have the following: a fail-safe nitrous oxide delivery system that is maintained in working order; a scavenging system; and a positive-pressure oxygen delivery system suitable for the patient being treated.~~( )~~

~~**03. Personnel**. For nitrous oxide/oxygen administration, personnel shall include an operator and an assistant currently certified in BLS.~~( )

043. MINIMAL SEDATION.
Persons licensed to practice dentistry may administer minimal sedation to patients of sixteen (16) years of age or older following the ADA guidelines as incorporated by reference pursuant to these rules. When the intent is minimal sedation, the appropriate dosing of a single enteral drug is no more than the maximum FDA-recommended dose for unmonitored home use. In cases where the patient weighs less than one hundred (100) pounds, or is under the age of sixteen (16) years, minimal sedation may be administered without a permit by use of nitrous oxide, or with a single enteral dose of a sedative agent administered in the dental office.( )

PENDING TEXT 200.13

13. Minimal Sedation. Persons licensed to practice dentistry may administer minimal sedation to patients of sixteen (16) years of age or older~~*following the ADA guidelines as incorporated by reference pursuant to these rules*~~. When the intent is minimal sedation, the appropriate dosing of a single enteral drug is no more than the maximum FDA-recommended dose for unmonitored home use. In cases where the patient weighs less than one hundred (100) pounds, or is under the age of sixteen (16) years, minimal sedation may be administered without a permit by use of nitrous oxide, or with a single enteral dose of a sedative agent administered in the dental office.
( )

~~**01. Patient Safety**. The administration of minimal sedation is permissible so long as it does not produce an alteration of the state of consciousness in a patient to the level of moderate sedation, general anesthesia, or deep sedation. A dentist must qualify for and obtain a permit from the Board to be authorized to sedate patients to the level of moderate sedation, general anesthesia, or deep sedation. Nitrous oxide/oxygen may be used in combination with a single enteral drug in minimal sedation, except as described in Section 043 of these rules. Notwithstanding any other provision in these rules, a dentist must initiate and regulate the administration of nitrous oxide/oxygen when used in combination with minimal sedation.( )~~

~~**02. Personnel**. At least one (1) additional person currently certified in BLS must be present in addition to the dentist.( )~~

044. MODERATE SEDATION, GENERAL ANESTHESIA AND DEEP SEDATION.
Dentists licensed in the state of Idaho ~~cannot~~ may administer moderate sedation, general anesthesia, or deep sedation ~~in the practice of dentistry unless~~ following the ADA guidelines incorporated by reference pursuant to these rules once they have obtained a permit from the Board. ~~A moderate sedation permit may be either enteral or parenteral.~~ A

dentist may not administer moderate sedation to children under sixteen (16) years of age and one hundred (100) pounds unless they have qualified for and been issued a moderate parenteral sedation permit. A moderate enteral sedation permit authorizes dentists to administer sedation by either enteral or combination inhalation-enteral routes of administration. A moderate parenteral, general anesthesia, or deep sedation permit authorizes a dentist to administer sedation by any route of administration.~~ To qualify for a moderate, general anesthesia, or deep sedation permit, a dentist must provide proof of the following:~~( )

PENDING TEXT 100.05

05. Moderate Sedation, General Anesthesia And Deep Sedation. Dentists licensed in the state of Idaho may administer moderate sedation, general anesthesia, or deep sedation~~*following the ADA guidelines incorporated by reference pursuant to these rules*~~ once they have obtained a permit from the Board. A dentist may not administer moderate sedation to children under sixteen (16) years of age and one hundred (100) pounds unless they have qualified for and been issued a moderate parenteral sedation permit. A moderate enteral sedation permit authorizes dentists to administer sedation by either enteral or combination inhalation-enteral routes of administration. A moderate parenteral, general anesthesia, or deep sedation permit authorizes a dentist to administer sedation by any route of administration. The qualified dentist is responsible for the sedative management, adequacy of the facility and staff, diagnosis and treatment of emergencies related to the administration of moderate sedation, general anesthesia, or deep sedation and providing the equipment, drugs and protocol for patient rescue.*( )*

01. Training Requirements. For Moderate Sedation Permits, completion of training in the administration of moderate sedation to a level consistent with requirements established by the Board within the five (5) year period immediately prior to the date of application. For General Anesthesia and Deep Sedation Permits, completion of an advanced education program accredited by CODA that affords comprehensive training necessary to administer and manage deep sedation or general anesthesia within the five (5) year period immediately preceding the date of application. The five (5) year requirement is not applicable to applicants who hold an equivalent permit in another state which has been in effect for the twelve (12) month period immediately prior to the application date. Qualifying training courses must be sponsored by or affiliated with a dental school accredited by CODA, or be approved by the Board.( )

~~**02. ACLS.** Verification of current certification in ACLS or PALS, whichever is appropriate for the patient being sedated.( )~~

03. ~~**Office Inspection.**~~ The qualified dentist is responsible for the sedative management, adequacy of the facility and staff, diagnosis and treatment of emergencies related to the administration of moderate sedation, general anesthesia, or deep sedation and providing the equipment, drugs and protocol for patient rescue. ~~Evaluators appointed by the Board will inspect the adequacy of the facility and competence of the sedation team prior to issuance of a moderate, general anesthesia, or deep sedation permit and at intervals not to exceed five (5) years. For general anesthesia and deep sedation, the Board adopts the standards incorporated by reference in these rules, as set forth by the AAOMS in their office anesthesia evaluation manual.( )~~

~~**a.** Facility, Equipment and Drug Requirements. The following facilities, equipment and drugs must be available for immediate use during the sedation and recovery phase:( )~~

~~i. An operating room large enough to adequately accommodate the patient on an operating table or in an operating chair and to allow an operating team of at least two (2) individuals to freely move about the patient; ( )~~

~~ii. An operating table or chair that permits the patient to be positioned so the operating team can maintain the patient's airway, quickly alter the patient's position in an emergency, and provide a firm platform for the administration of basic life support;( )~~

~~iii. A lighting system that permits evaluation of the patient's skin and mucosal color and a backup lighting system of sufficient intensity to permit completion of any operation underway in the event of a general power~~

~~failure; ( )~~

~~iv. Suction equipment that permits aspiration of the oral and pharyngeal cavities and a backup suction device which will function in the event of a general power failure;( )~~

~~v. An oxygen delivery system with adequate full face mask and appropriate connectors that is capable of delivering high flow oxygen to the patient under positive pressure, together with an adequate backup system;( )~~

~~vi. A recovery area that has available oxygen, adequate lighting, suction and electrical outlets. The recovery area can be the operating room( )~~

~~vii. A sphygmomanometer, pulse oximeter, oral and nasopharyngeal airways, supraglottic airway devices, and automated external defibrillator (AED); and( )~~

~~viii. Emergency drugs including, but not limited to, pharmacologic antagonists appropriate to the drugs used, bronchodilators, and antihistamines.( )~~

~~ix. Additional emergency equipment and drugs required for moderate parenteral sedation permits include precordial/pretracheal stethoscope or end-tidal carbon dioxide monitor, intravenous fluid administration equipment, vasopressors, and anticonvulsants.( )~~

~~x. Additional emergency equipment and drugs required for general anesthesia and deep sedation permits include precordial/pretracheal stethoscope and end-tidal carbon dioxide monitor, intravenous fluid administration equipment, vasopressors, and anticonvulsants.( )~~

~~**b.** Personnel( )~~

~~i. For moderate sedation, the minimum number of personnel is two (2) including: the operator and one (1) additional individual currently certified in BLS.( )~~

~~ii. For general anesthesia or deep sedation, the minimum number of personnel is three (3) including: the operator and two (2) additional individuals currently certified in BLS. When the same individual administering the general anesthesia or deep sedation is performing the dental procedure one (1) of the additional individuals must be designated for patient monitoring. ( )~~

~~iii. Auxiliary personnel must have documented training in BLS, will have specific assignments, and shall have current knowledge of the emergency cart inventory. The dentist and all office personnel must participate in documented periodic reviews of office emergency protocol, including simulated exercises, to assure proper equipment function and staff interaction.( )~~

~~**c.** Pre-sedation Requirements. Before inducing moderate sedation, general anesthesia, or deep sedation a dentist must:( )~~

~~i. Evaluate the patient's medical history and document, using the American Society of Anesthesiologists Patient Physical Status Classifications, that the patient is an appropriate candidate for moderate sedation, general anesthesia, or deep sedation;( )~~

~~ii. Give written preoperative and postoperative instructions to the patient or, when appropriate due to age or psychological status of the patient, the patient's guardian;( )~~

~~iii. Obtain written informed consent from the patient or patient's guardian for the sedation; and ( )~~

~~iv. Maintain a sedation record and enter the individual patient's sedation into a case/drug log.( )~~

~~**d.** Patient Monitoring. Patients must be monitored as follows:( )~~

~~i. For moderate sedation the patient must be continuously monitored using pulse oximetry. For general anesthesia or deep sedation, the patient must be continuously monitored using pulse oximetry and end-tidal carbon dioxide monitors.( )~~

~~ii. The patient's blood pressure, heart rate, and respiration must be recorded every five (5) minutes during the sedation and then continued every fifteen (15) minutes until the patient meets the requirements for discharge. These recordings must be documented in the patient record. The record must also include documentation of preoperative and postoperative vital signs, all medications administered with dosages, time intervals and route of administration. If this information cannot be obtained, the reasons must be documented in the patient's record. ( )~~

~~iii. During the recovery phase, the patient shall be monitored by an individual trained to monitor patients recovering from sedation;( )~~

~~iv. A dentist will not release a patient who has undergone sedation except to the care of a responsible third party; ( )~~

~~v. The dentist will assess the patient's responsiveness using preoperative values as normal guidelines and discharge the patient only when the following criteria are met: vital signs are stable, patient is alert and oriented, and the patient can ambulate with minimal assistance; and( )~~

~~vi. A discharge entry will be made by the dentist in the patient's record indicating the patient's condition upon discharge and the name of the responsible party to whom the patient was discharged.( )~~

~~**e.** Sedation of Other Patients. The permit holder must not initiate sedation on another patient until the previous patient is in a stable monitored condition and in the recovery phase following discontinuation of their sedation.~~ ( )

045. SEDATION PERMIT RENEWAL.

01. Permit Renewal. Before the expiration date of a permit, the board will provide notice of renewal to the licensee. Failure to timely submit a renewal application and permit fee shall result in expiration of the permit and termination of the licensee's right to administer sedation. Failure to submit a complete renewal application and permit fee within thirty (30) days of expiration of the permit shall result in cancellation of the permit. Renewal of the permit will be required every five (5) years. Proof of a minimum of twenty-five (25) continuing education credit hours in sedation which may include training in medical/office emergencies will be required to renew a permit. ~~In addition to the continuing education credit hours, a dentist must:( )~~

~~**a.** For a moderate enteral sedation permit, maintain current certification in BLS or ACLS.( )~~

~~**b.** For a moderate parenteral, general anesthesia, or deep sedation permit, maintain current certification in ACLS.~~( )

02. Reinstatement. A dentist may apply for reinstatement of a canceled or surrendered permit issued by the Board within five (5) years of the date of the permit's cancellation or surrender. Applicants for reinstatement of a sedation permit must satisfy the facility and personnel requirements and verify they have obtained an average of five (5) continuing education credit hours in sedation for each year subsequent to the date upon which the permit was canceled or surrendered. A fee for reinstatement will be assessed.( )

046. SUSPENSION, REVOCATION OR RESTRICTION OF SEDATION PERMIT.
The Board may, at any time and for just cause, institute proceedings to revoke, suspend, or otherwise restrict a sedation permit~~ issued pursuant to Section 044 of these rules~~. If the Board determines that emergency action is necessary to protect the public, summary suspension may be ordered pending further proceedings. Proceedings to suspend, revoke or restrict a permit shall be subject to applicable statutes and rules governing administrative procedures before the Board.( )

~~047. DETERMINATION OF DEGREE OF SEDATION BY THE BOARD.~~
~~In any matter under review or in any proceeding being conducted in which the Board must determine the degree of central nervous system depression, the Board may base its findings or conclusions on, among other matters, the type, and dosages, and routes of administration of drugs administered to the patient and what result can reasonably be expected from those drugs in those dosages and routes administered in a patient of that physical and psychological status.~~ ( )

048. USE OF OTHER ANESTHESIA PERSONNEL.
A dentist who does not hold a sedation permit may perform dental procedures in a dental office on a patient who receives sedation induced by an anesthesiologist, a certified registered nurse anesthetist, or another dentist with a sedation permit ~~as follows:~~.( )

~~01. Facility, Equipment, Drugs, and Personnel Requirements~~~~. The dentist will have the same facility, equipment, drugs, and personnel available during the procedure and during recovery as required of a dentist who has a permit for the level of sedation being provided.( )~~

~~02. Patient's Condition Monitored Until Discharge~~~~.~~ The qualified sedation provider who induces sedation will monitor the patient's condition until the patient is discharged~~ and record the patient's condition at discharge in the patient's dental record as required by the rules applicable to the level of sedation being induced~~. The sedation record must be maintained in the patient's dental record and is the responsibility of the dentist who is performing the dental procedures.~~( )~~

~~03. Use of Services of a Qualified Sedation Provider~~~~.~~ A dentist who intends to use the services of a qualified sedation provider must notify the Board in writing of his intent. Such notification need only be submitted once every licensing period. ~~( )~~

~~04. Advertising~~~~. A dentist who intends to use the services of a qualified sedation provider may advertise the service provided so long as each such advertisement contains a prominent disclaimer that the service "will be provided by a qualified sedation provider."~~( )

049. INCIDENT REPORTING.
Dentists must report to the Board, in writing, within seven (7) days after the death or transport to a hospital or emergency center for medical treatment for a period exceeding twenty-four (24) hours of any patient~~ to whom sedation was administered~~.( )

~~050. -- 055.(RESERVED)~~

056. UNPROFESSIONAL CONDUCT.
A licensee shall not engage in unprofessional conduct in the course of his practice. Unprofessional conduct by a person licensed under the provisions of Title 54, Chapter 9, Idaho Code, is defined as, but not limited to, ~~one (1)~~any of the following: ( )

PENDING TEXT 300.02

02. Unprofessional Conduct. A licensee shall not engage in unprofessional conduct in the course of ~~*his*~~ *their* practice. Unprofessional conduct by a person licensed under the provisions of Title 54, Chapter 9, Idaho Code, is defined as, but not limited to, any of the following:*( )*

01. Fraud. Obtaining fees by fraud or misrepresentation, or over-treatment either directly or through an insurance carrier.( )

02. Unlicensed Practice. Employing directly or indirectly any suspended or unlicensed individual as defined in Title 54, Chapter 9, Idaho Code.( )

03. Unlawful Practice. Aiding or abetting licensed persons to practice unlawfully.( )

04. Dividing Fees. A dentist shall not divide a fee for dental services with another party, who is not a partner or associate with him in the practice of dentistry, unless:( )

a. The patient consents to employment of the other party after a full disclosure that a division of fees will be made; ( )

b. The division is made in proportion to the services performed and responsibility assumed by each dentist or party. ( )

05. Prescription Drugs. Prescribing or administering prescription drugs not reasonably necessary for, or within the scope of, providing dental services for a patient. A dentist may not prescribe or administer prescription drugs to himself. A dentist shall not use controlled substances as an inducement to secure or maintain dental patronage or aid in the maintenance of any person's drug addiction by selling, giving or prescribing prescription drugs. ( )

PENDING TEXT 300.02.d. through e.

d. Dividing Fees. A dentist shall not divide a fee for dental services with another party, who is not a partner or associate ~~with him~~ in the<u>ir</u> practice of dentistry, unless:*( )*

i. The patient consents to employment of the other party after a full disclosure that a division of fees will be made; ( )

ii. The division is made in proportion to the services performed and responsibility assumed by each dentist or party. ( )

e. Prescription Drugs. Prescribing or administering prescription drugs not reasonably necessary for, or within the scope of, providing dental services for a patient. A dentist may not prescribe or administer prescription drugs to ~~himself~~ <u>themself</u>. A dentist shall not use controlled substances as an inducement to secure or maintain dental patronage or aid in the maintenance of any person's drug addiction by selling, giving or prescribing prescription drugs. *( )*

06. Harassment. The use of threats or harassment to delay or obstruct any person in providing evidence in any possible or actual disciplinary action, or other legal action; or the discharge of an employee primarily based on the employee's attempt to comply with the provisions of Title 54, Chapter 9, Idaho Code, or the Board's Rules, or to aid in such compliance.( )

07. Discipline in Other States. Conduct himself in such manner as results in a suspension, revocation or other disciplinary proceedings with respect to his license in another state.( )

PENDING TEXT 300.02.d. through e.

g. Discipline in Other States. Conduct ~~himself~~ <u>themself</u> in such manner as results in a suspension, revocation, or other disciplinary proceedings with respect to ~~his~~ <u>their</u> license in another state.*( )*

08. Altering Records. Alter a patient's record with intent to deceive.( )

09. Office Conditions. Unsanitary or unsafe office conditions, as determined by the customary practice and standards of the dental profession in the state of Idaho and CDC guidelines as incorporated by reference in these rules. ( )

10. Abandonment of Patients. Abandonment of patients by licensees before the completion of a phase of treatment, as such phase of treatment is contemplated by the customary practice and standards of the dental profession in the state of Idaho, without first advising the patient of such abandonment and of further treatment that is necessary. ( )

11. Use of Intoxicants. Practicing while under the influence of an intoxicant or controlled substance where the same impairs the licensee's ability to practice with reasonable and ordinary care.( )

12. Mental or Physical Condition. The inability to practice with reasonable skill and safety to patients by reason of age, illness, or as a result of any mental or physical condition.( )

13. Consent. Revealing personally identifiable facts, data or information obtained in a professional capacity without prior consent of the patient, except as authorized or required by law.( )

14. Scope of Practice. Practicing or offering to practice beyond the scope permitted by law, or accepting and performing professional responsibilities that the licensee knows or has reason to know that he or she is not competent to perform.( )

15. Delegating Duties. Delegating professional responsibilities to a person when the licensee delegating such responsibilities knows, or with the exercise of reasonable care and control should know, that such a person is not qualified by training or by licensure to perform them.( )

16. Unauthorized Treatment. Performing professional services that have not been authorized by the patient or his legal representative.( )

17. Supervision. Failing to exercise appropriate supervision over persons who are authorized to practice only under the supervision of a licensed professional.( )

18. Legal Compliance. Failure to comply with any provisions of federal, state or local laws, statutes, rules, and regulations governing or affecting the practice of dentistry, ~~or~~ dental hygiene, or dental therapy.( )

19. Exploiting Patients. Exercising undue influence on a patient in such manner as to exploit a patient for the financial or personal gain of a practitioner or of a third party.( )

20. Misrepresentation. Willful misrepresentation of the benefits or effectiveness of dental services. ( )

21. Disclosure. Failure to advise patients or their representatives in understandable terms of the treatment to be rendered, alternatives, the name and professional designation of the provider rendering treatment, and disclosure of reasonably anticipated fees relative to the treatment proposed.( )

22. Sexual Misconduct. Making suggestive, sexual or improper advances toward any ~~patient~~ person or committing any lewd or lascivious act upon or with any ~~patient~~person in the course of dental practice.( )

23. Patient Management. Use of unreasonable and/or damaging force to manage patients, including but not limited to hitting, slapping or physical restraints.( )

24. Compliance ~~with Dentist~~ Professional Standards. Failure ~~by a dentist~~ to comply with professional standards applicable to the practice of dentistry, dental hygiene, or dental therapy as incorporated by reference in this chapter.( )

~~**25. Compliance with Dental Hygienist Professional Standards**. Failure by a dental hygienist to comply with professional standards applicable to the practice of dental hygiene, as incorporated by reference in this chapter.~~ ( )

26. Failure to Provide Records to a Patient or Patient's Legal Guardian. Refusal or failure to

provide a patient or patient's legal guardian with records within five (5) business days. A patient or patient's legal guardian may not be denied a copy of his records for any reason, regardless of whether the person has paid for the dental services rendered. A person may be charged for the actual cost of providing the records but in no circumstances may a person be charged an additional processing or handling fee or any charge in addition to the actual cost. ( )

27. **Failure to Cooperate with Authorities**. Failure to cooperate with authorities in the investigation of any alleged misconduct or interfering with a Board investigation by willful misrepresentation of facts, willful failure to provide information upon request of the Board, or the use of threats or harassment against any patient or witness to prevent them from providing evidence.( )

28. **Advertising**. Advertise in a way that is false, deceptive, misleading or not readily subject to verification. ( )

~~**057. – 999.(RESERVED)**~~

IDAPA 24 – DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSES

24.33.01 – RULES OF THE BOARD OF MEDICINE FOR THE LICENSURE TO PRACTICE MEDICINE AND OSTEOPATHIC MEDICINE IN IDAHO

DOCKET NO. 24-3301-2301

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2024 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. The pending rule will become final and effective upon the adjournment, *sine die*, of the Second Regular Session of the Sixty-seventh Idaho Legislature after approval.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 67-2604, Idaho Code and Sections 6-1002, 54-1806, 54-1806A, 54-1807, 54-1812, 54-1813, 54-1814, 54-1841, 54-1867, 67-2614, 67-9406, and 67-9409, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change:

Legislation passed during the First Regular Session of the Sixty-seventh Idaho Legislature amended the Medical Practice Act by removing registration requirements for supervising physicians and by adding a temporary registration for certain experienced international medical graduates. This rulemaking is necessary to address those amendments.

There are no changes to the pending rule and it is being adopted as originally proposed. The complete text of the proposed rule was published in the October 4, 2023, Idaho Administrative Bulletin, Vol. 23-10, pages 544–546.

FEE SUMMARY: Pursuant to Section 67-5224(2)(d), Idaho Code, this pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature. The following is a description of the fee or charge imposed or increased in this rulemaking:

The pending amendments to the rules do not impose any new or increased fees.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year:

This rulemaking is not anticipated to have any negative fiscal impact on the State General Fund.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Katie Stuart, Bureau Chief, at 208-577-2489.

DATED this 6th day of December, 2023.

Katie Stuart
Bureau Chief
11341 W. Chinden Blvd., Bldg. #4
Boise, ID 83714
Phone: (208) 577-2489
Email: katie.stuart@dopl.idaho.gov

THE FOLLOWING NOTICE PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. This negotiated rulemaking action is authorized pursuant to Section 67-2604, Idaho Code, and Sections 6-1002, 54-1806, 54-1806A, 54-1807, 54-1812, 54-1813, 54-1814, 54-1841, 54-1867, 67-2614, 67-9406 and 67-9409, Idaho Code.

PUBLIC HEARING SCHEDULE: The public hearing concerning this rulemaking will be held as follows:

Monday, October 16, 2023, 9:00 a.m. MT

Division of Occupational and Professional Licenses
Chinden Campus Building 4
11341 W. Chinden Blvd., Bldg. #4
Boise, ID 83714

Telephone and web conferencing information will be posted on:
https://dopl.idaho.gov/calendar/ and https://townhall.idaho.gov/

The hearing site will be accessible to persons with disabilities, if needed. Requests for accommodation must be made not later than five (5) days prior to the meeting to the agency address below.

DESCRIPTIVE SUMMARY AND STATEMENT OF PURPOSE: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

This rulemaking is being proposed to address legislative changes made through House Bill 3 and Senate Bill 1094. The legislative changes, which went into effect on July 1, 2023, resulted in the removal of the registration requirement for supervising physicians and the addition of a temporary registration for certain experienced international medical graduates. The proposed rulemaking will address these statutory changes.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: N/A.

The proposed amendments to the rules do not impose any new or increased fees.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year as a result of this rulemaking:

This rulemaking is not anticipated to have any negative fiscal impact on the State General Fund.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was conducted under Docket No. 24-3301-2301. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the July 5, 2023, Idaho Administrative Bulletin, Vol. 23-7, pp.94-95.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into this rule: N/A.

No materials have been incorporated by reference into the proposed rules.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS, OBTAINING DRAFT COPIES: For assistance on technical questions concerning this proposed rule, contact Katie Stuart, Bureau Chief, at (208) 577-2489. Materials pertaining to the proposed rulemaking, including any available preliminary rule drafts, can be found on the following DOPL website: https://dopl.idaho.gov/rulemaking/.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 25, 2023.

DATED this 1st day of September, 2023.

THE FOLLOWING IS THE TEXT OF ZBR DOCKET NO. 24-3301-2301

151. DEFINITIONS RELATING TO SUPERVISING AND DIRECTING PHYSICIANS.

01. Athletic Trainer. A person who has met the qualifications for licensure as set forth in Title 54, Chapter 39, Idaho Code, is licensed under that chapter, and carries out the practice of athletic training under the direction of a designated Idaho licensed physician, registered with the Board. (3-28-23)

02. Directing Physician. A designated Idaho licensed physician, registered with the Board pursuant to this chapter and Title 54, Chapter 39, Idaho Code, who oversees the practice of athletic training and is responsible for the athletic training services provided by the athletic trainer. This chapter does not authorize the practice of medicine or any of its branches by a person not so licensed by the Board. (3-28-23)

03. Medical Personnel. An individual who provides cosmetic treatments using prescriptive medical/cosmetic devices and products that are exclusively non-incisive or non-ablative under the direction and supervision of a supervising physician ~~registered with the Board~~, pursuant to the applicable Idaho statutes and the applicable rules promulgated by the Board. ~~(3-28-23)~~( )

04. Supervising Physician of Interns or Residents. Any person approved by ~~and registered with~~ the Board who is licensed to practice medicine and surgery or osteopathic medicine and surgery in Idaho, who signs the application for registration of an intern or resident, and who is responsible for the direction and supervision of their activities. ~~(3-28-23)~~( )

05. Supervising Physician of Medical Personnel. An Idaho licensed physician ~~who is registered with the Board pursuant to this chapter,~~ who supervises and has full responsibility for cosmetic treatments using prescriptive medical/cosmetic devices and products provided by medical personnel. ~~(3-28-23)~~( )

(BREAK IN CONTINUITY OF SECTIONS)

243. ~~RESIDENT AND INTERN~~ TEMPORARY REGISTRATION.

01. Eligibility. Any person identified in Section 54-1813(2), Idaho Code. ( )

0~~1~~2. Registration Certificate. ~~Upon approval of the registration application, the Board may issue a registration certificate that sets forth the period during which the registrant may engage in activities that may involve the practice of medicine.~~ Each registration will be issued for a period of ~~not less than~~ one (1) year and ~~will set forth its expiration date on the face of the certificate. Each registration~~ will identify the supervising physician. Each registrant will notify the Board in writing of any change of the supervising physician or the program or course of study fourteen

(14) days prior to any such change. If the Board deems the~~ intern or resident~~ applicant qualified, and if the course of study requires, the Board may additionally certify on the registration certificate that the~~ intern or resident~~ registrant is qualified to write prescriptions for Class III through Class V scheduled medications. ~~(3-28-23)~~(____)

0~~2~~3. **~~Termination of Registration~~Discipline**. ~~The r~~Registrations~~ of an intern or resident~~ may be terminated, suspended, or made conditional by the Board on the grounds set forth in Section 54-1814, Idaho Code~~, and under the procedures set forth in Section 54-1806A, Idaho Code~~. ~~(3-28-23)~~(____)

0~~3~~4. **Annual Renewal~~ of Registration~~**. ~~Each r~~Registration~~ must~~ may be renewed annually~~ prior to its expiration date. Any registration~~ and, if not renewed by~~ its~~ the expiration date, will be canceled. ~~(3-28-23)~~(____)

0~~4~~5. **Notification of Changes**.~~ Each r~~Registrants must notify the Board in writing of any adverse action or termination, whatever the outcome, from any post graduate training program and any name changes within fourteen (14) days of such event. ~~(3-28-23)~~(____)

0~~5~~6. **Disclosure**. ~~It is the responsibility of each~~A registrant~~ to~~ must ensure~~ that every~~ patients are~~ is aware of the fact~~ informed that~~ such intern and resident~~ the registrant is currently enrolled in a post graduate training program and working under the supervision of a licensed physician. ~~(3-28-23)~~(____)

244. FEES - TABLE.

Nonrefundable fees are as follows:

Fees~~ – Table~~		
~~Resident and Intern~~Temporary Registration ~~Fee~~	-	~~Not more than~~ $25 annually
~~Registration Annual Renewal Fee~~	-	~~Not more than $25~~

~~(3-28-23)~~(____)

IDAPA 24 – DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSING

24.36.01 – RULES OF THE IDAHO STATE BOARD OF PHARMACY

DOCKET NO. 24-3601-2301

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2024 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. Should the pending rule be approved, it will become final and effective upon the adjournment, *sine die*, of the Second Regular Session of the Sixty-seventh Idaho Legislature.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section 67-2604, Idaho Code, and Sections 37-2702, 37-2715, 54-1717, 54-1753, 54-1755, 67-2614, 67-9406, and 67-9409, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change:

The Idaho Board of Pharmacy engaged in this rulemaking pursuant to Section 67-5230, Idaho Code. In September 2023, the Board granted a waiver of IDAPA 24.36.01.301.04. Pursuant to Section 67-5230, Idaho Code, the Board initiated rulemaking proceedings to allow all similarly situated persons to derive the same benefits granted to the individual who petitioned for the waiver.

There are no changes to the pending rule and it is being adopted as originally proposed. The complete text of the proposed rule was published in the December 6, 2023, Idaho Administrative Bulletin, Vol. 23-12, pages 162–164.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: N/A.

The pending amendments to the rules do not impose any new or increased fees.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year: N/A.

This rulemaking is not anticipated to have any negative fiscal impact on the State General Fund.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Katie Stuart, Bureau Chief, at 208-577-2489.

DATED this 3rd day of January, 2024.

Katie Stuart
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THE FOLLOWING NOTICE PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. This rulemaking action is authorized pursuant to Section 67-2604, Idaho Code, and Sections 37-2702, 37-2715, 54-1717, 54-1753, and 54-1755, 67-2614, 67-9406 and 67-9409, Idaho Code.

PUBLIC HEARING SCHEDULE: The public hearing concerning this rulemaking will be held as follows:

Thursday, December 14, 2023, 10:00 a.m. MT

Division of Occupational and Professional Licenses
Chinden Campus Building 4
11341 W. Chinden Blvd., Bldg. #4
Boise, ID 83714

Telephone and web conferencing information will be posted on:
https://dopl.idaho.gov/calendar/ and https://townhall.idaho.gov/

The hearing site will be accessible to persons with disabilities, if needed. Requests for accommodation must be made not later than five (5) days prior to the meeting to the agency address below.

DESCRIPTIVE SUMMARY: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

This rulemaking is being done pursuant to Section 67-5230, Idaho Code. The Idaho State Board of Pharmacy recently granted a waiver of IDAPA 24.36.01.301.04. Pursuant to Section 67-5230, Idaho Code, the Board has initiated rulemaking proceedings to allow all similarly situated persons to derive the same benefits granted to the individual who petitioned for the waiver.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: N/A

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year as a result of this rulemaking: N/A

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because this rulemaking is mandatory pursuant to Section 67-5230, Idaho Code.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into this rule: N/A

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS, OBTAINING DRAFT COPIES: For assistance on technical questions concerning this proposed rule, contact Katie Stewart, Bureau Chief, at (208) 577-2489. Materials pertaining to the proposed rulemaking, including any available preliminary rule drafts, can be found on the following DOPL website: https://dopl.idaho.gov/rulemaking/.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before December 27, 2023.

DATED this 14th Day of November, 2023.

Katie Stuart
Bureau Chief- Administration
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Email: katie.stuart@dopl.idaho.gov

THE FOLLOWING IS THE TEXT OF DOCKET NO. 24-3601-2301

011. DEFINITIONS AND ABBREVIATIONS (O – Z).
The definitions set forth in Sections 54-1705 and 37-2701, Idaho Code, are applicable to these rules. In addition, the following terms have the meanings set forth below: (3-28-23)

01. Parenteral Admixture. The preparation and labeling of sterile products intended for administration by injection. (3-28-23)

02. Pharmaceutical Care Services. A broad range of services, activities and responsibilities intended to optimize drug-related therapeutic outcomes for patients consistent with Rule 100. Pharmaceutical care services may be performed independent of, or concurrently with, the dispensing or administration of a drug or device and also encompasses services provided by way of DTM under a collaborative practice agreement. Pharmaceutical care services are not limited to, but may include one (1) or more of the following: (3-28-23)

a. Performing or obtaining necessary assessments of the patient's health status, including the performance of health screening activities or testing; (3-28-23)

b. Reviewing, analyzing, evaluating, formulating or providing a drug utilization plan; (3-28-23)

c. Monitoring and evaluating the patient's response to drug therapy, including safety and effectiveness; (3-28-23)

d. Coordinating and integrating pharmaceutical care services within the broader health care management services being provided to the patient; (3-28-23)

e. Ordering and interpreting laboratory tests; (3-28-23)

f. Performing drug product selection, substitution, prescription adaptation, or refill authorization as provided in these rules;~~ and~~ ~~(3-28-23)~~(____)

g. Prescribing drugs and devices as provided in these rules~~.~~; and ~~(3-28-23)~~(____)

h. Delegating services and duties to appropriate support personnel. (____)

03. PDMP. Prescription Drug Monitoring Program. (3-28-23)

04. Prescriber. An individual currently licensed, registered, or otherwise authorized to prescribe and administer drugs in the course of professional practice. (3-28-23)

05. Purple Book. The list of licensed biological products with reference product exclusivity and

biosimilarity or interchangeability evaluations published by the FDA under the Public Health Service Act. (3-28-23)

06. Readily Retrievable. Records are considered readily retrievable if they are able to be completely and legibly produced upon request within seventy-two (72) hours. (3-28-23)

07. Reconstitution. The process of adding a diluent to a powdered medication to prepare a solution or suspension, according to the product's labeling or the manufacturer's instructions. (3-28-23)

08. Restricted Drug Storage Area. The area of a drug outlet where prescription drugs are prepared, compounded, distributed, dispensed, or stored. (3-28-23)

09. Therapeutic Equivalent Drugs. Products assigned an "A" code by the FDA in the Approved Drug Products with Therapeutic Equivalence Evaluations (Orange Book) and animal drug products published in the FDA Approved Animal Drug Products (Green Book). (3-28-23)

10. USP-NF. United State Pharmacopeia-National Formulary. (3-28-23)

(BREAK IN CONTINUITY OF SECTIONS)

301. DRUG OUTLETS THAT DISPENSE PRESCRIPTION DRUGS: MINIMUM PRESCRIPTION FILLING REQUIREMENTS.

Unless exempted by these rules, each drug outlet that dispenses prescription drugs to patients in Idaho must meet the following minimum requirements either at the drug outlet or through offsite pharmacy services: (3-28-23)

01. Valid Prescription Drug Order. Prescription drugs may only be dispensed pursuant to a valid prescription drug order as set forth in Subchapter E of these rules. (3-28-23)

02. Prospective Drug Review. Prospective drug review must be provided. (3-28-23)

03. Labeling. Each drug must bear a complete and accurate label as set forth in these rules. (3-28-23)

04. Verification of Dispensing Accuracy. Verification of dispensing accuracy must be performed to compare the drug stock selected to the drug prescribed. If not performed by a pharmacist or prescriber, an electronic verification system must be used that confirms the drug stock selected to fill the prescription is the same as indicated on the prescription label. ~~A compounded drug may only be verified by a pharmacist or prescriber.~~ ~~(3-28-23)~~(____)

05. Patient Counseling. Counseling must be provided. (3-28-23)

IDAPA 24 – DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSES

24.40.01 – RULES FOR THE BOARD OF NATUROPATHIC HEALTH CARE

DOCKET NO. 24-4001-2301 (NEW CHAPTER, FEE RULE)

NOTICE OF RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo & Cost/Benefit Analysis (CBA)

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2024 Idaho State Legislature and must be approved by concurrent resolution of the Legislature to go into effect, in accordance with Section 67-5224(2)(c), Idaho Code. The pending rule will become final and effective upon the adjournment, *sine die*, of the Second Regular Session of the Sixty-seventh Idaho Legislature after approval.

AUTHORITY: In compliance with Section 67-5224, Idaho Code, notice is hereby given that this agency has adopted a pending rule. The action is authorized pursuant to Section(s) 67-2604, Idaho Code.

DESCRIPTIVE SUMMARY: The following is a concise explanatory statement of the reasons for adopting the pending rule and a statement of any change between the text of the proposed rule and the text of the pending rule with an explanation of the reasons for the change.

There are no changes to the pending rule, and it is being adopted as originally proposed. The complete text of the proposed rule was published in the September 6, 2023, Idaho Administrative Bulletin, Vol. 23-9, pages 475-477.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased:

The fees for applications, licenses, registrations and reinstatement as designated in Rule 400 of these rules are authorized in Sections 54-5904 and 54-5909, Idaho Code. Pursuant to Section 67-5224(2)(d), Idaho Code, this pending fee rule shall not become final and effective unless affirmatively approved by concurrent resolution of the Legislature.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year:

This rulemaking is not anticipated to have any negative fiscal impact on the State General Fund.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Katie Stuart, Bureau Chief, at 208-577-2489.

DATED this 1st day of November, 2023.

Katie Stuart
Bureau Chief
11341 W. Chinden Blvd., Bldg. #4
Boise, ID 83714
Phone: (208) 577-2489
Email: katie.stuart@dopl.idaho.gov

THE FOLLOWING NOTICE PUBLISHED WITH THE PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. This rulemaking action is authorized pursuant to Section 67-2604, Idaho Code, and Sections 54-5904, 54-5909, 67-2614, 67-9406 and 67-9409, Idaho Code.

PUBLIC HEARING SCHEDULE: The public hearing concerning this rulemaking will be held as follows:

Thursday, September 14, 2023, 10:00 a.m. MT

Division of Occupational and Professional Licenses
Chinden Campus Building 4
11341 W. Chinden Blvd., Bldg. #4
Boise, ID 83714

Telephone and web conferencing information will be posted on:
https://dopl.idaho.gov/calendar/ and https://townhall.idaho.gov/

The hearing site will be accessible to persons with disabilities, if needed. Requests for accommodation must be made not later than five (5) days prior to the meeting to the agency address below.

DESCRIPTIVE SUMMARY AND STATEMENT OF PURPOSE: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

This rulemaking is being presented to address legislative changes made through Senate Bill 1330 during the 2022 legislative session. The legislative changes, which went into effect on July 1, 2022, resulted in the creation of a new statutory chapter: Chapter 59, Title 54, Idaho Code. They also included the creation of a new licensure authority, the Naturopathic Health Care Board, new licensure and registration types, and authority for the board to promulgate rules related to the new naturopathic license and naturopathic registration. In conjunction with stakeholders, the proposed rule is an effort to give effect and meaning to the statutory changes.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased:

The fees for licenses and registrations as designated in Rule 400 of these proposed rules are authorized in Sections 54-5904 and 54-5909, Idaho Code. The fee for licensure, both initial and annual renewal, is set at $400. The fee for registration, both initial and annual renewal, is set at $250.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year as a result of this rulemaking:

This rulemaking is not anticipated to have any negative fiscal impact on the State General Fund.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220, Idaho Code, negotiated rulemaking was conducted under Docket No. 24-4001-2301. The Notice of Intent to Promulgate Rules - Negotiated Rulemaking was published in the July 5, 2023, Idaho Administrative Bulletin, Vol. 23-7, pp.98-99.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into this rule: N/A.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS, OBTAINING DRAFT COPIES: For assistance on technical questions concerning this proposed rule, contact Katie Stuart, Bureau Chief, at (208) 577-2489. Materials pertaining to the proposed rulemaking, including any available preliminary rule drafts, can be found on the following DOPL website: https://dopl.idaho.gov/rulemaking/.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before September 27, 2023.

DATED this 4th day of August, 2023.

THE FOLLOWING IS THE TEXT OF DOCKET NO. 24-4001-2301

24.40.01 – RULES FOR THE BOARD OF NATUROPATHIC HEALTH CARE

000. LEGAL AUTHORITY.
These rules are promulgated pursuant to Sections 54-5904 and 54-5909(4), Idaho Code. ( )

001. SCOPE.
These rules govern the practice of licensed naturopathic doctors and registered naturopaths in Idaho. ( )

002. -- 099. (RESERVED)

100. LICENSURE.

01. Approved Examination. The Naturopathic Doctors Licensing Examination (NDLEX) administered by the National Board of Naturopathic Examiners, or a naturopathic competency examination administered by the American Naturopathic Medical Certification Board. ( )

02. Continuing Education. To renew, licensees must complete, during the prior licensing period, and retain proof of completion of twenty (20) hours of continuing education germane to health care. To renew, registrants must complete, during the prior registration period, and retain proof of completion of twelve (12) hours of continuing education germane to health care. ( )

101. -- 399. (RESERVED)

400. FEES.

FEE TYPE	INITIAL	ANNUAL RENEWAL
Licensure	$400	$400
Registration	$250	$250

( )

401. --999. (RESERVED)