

IDAHO ADMINISTRATIVE BULLETIN

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October 4, 2000 -- Volume 00-10

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Preface

The Idaho Administrative Bulletin is published once each month by the Department of Administration, Office of the Administrative Rules Coordinator, pursuant to Section 67-5203, Idaho Code. The Bulletin is a compilation of all administrative rulemaking documents in Idaho. The Bulletin publishes the official text notice and full text of such actions.

State agencies are required to provide public notice of rulemaking activity and invite public input. The public receives notice of a rulemaking activity through the Idaho Administrative Bulletin and the Legal Notice published monthly in local newspapers. The Legal Notice provides reasonable opportunity for public input, either oral or written, which may be presented to the agency within the time and manner specified in the Legal Notice. After the comment period closes, the agency considers fully all information submitted in regard to the rule. Comment periods are not provided in temporary or final rulemaking activities.

CITATION TO THE IDAHO ADMINISTRATIVE BULLETIN

The Bulletin is cited by year and issue number. For example, Bulletin 99-1 refers to the first Bulletin issued in calendar year 1999, Bulletin 00-1 refers to the first Bulletin issued in calendar year 2000, etc. Volume numbers, which proceed from 1 to 12 in a given year, correspond to the months of publication, i.e.; Volume No. 1 refers to January; Volume No. 2 refers to February; and so forth. Example: The Bulletin published in January of 1999 is cited as Volume 99-1, the December 1998 Bulletin is cited as Volume 98-12. The March 2000 Bulletin is cited as Volume 00-3.

RELATIONSHIP TO THE IDAHO ADMINISTRATIVE CODE

The Idaho Administrative Code is published once a year and is a compilation or supplemental compilation of all final and enforceable administrative rules in effect in Idaho. In an effort to provide the reader with current, enforceable rules, temporary rules are also published in the Administrative Code. Temporary rules and final rules that have been adopted and approved by the legislature during the legislative session, and published in the monthly Idaho Administrative Bulletin, supplement the Administrative Code. Negotiated, proposed, and pending rules are not printed in the Administrative Code and are published only in the Bulletin.

*To determine if a particular rule remains in effect, or to determine if a change has occurred, the reader should refer to the **Cumulative Index of Administrative Rulemaking**, printed in each Bulletin.*

TYPES OF RULES PUBLISHED IN THE ADMINISTRATIVE BULLETIN

The state of Idaho administrative rulemaking process comprises five distinct activities; Proposed, Negotiated, Temporary, Pending, and Final rulemaking. In the majority of cases, the process begins with proposed rulemaking and ends with final rulemaking. The following is a brief explanation of each type of administrative rule.

NEGOTIATED RULE

Negotiated rulemaking is a process in which all interested parties and the agency seek a consensus on the content of the rule. Agencies are encouraged to proceed through this informal rulemaking whenever it is feasible to do so. Publication of the text in the Administrative Bulletin by the agency is optional. This process should lead the

rulemaking to the temporary and/or proposed rule stage.

PROPOSED RULE

A proposed rulemaking is an action by an agency in which the agency is proposing to amend or repeal an existing rule or to adopt a new rule. Prior to the adoption, amendment, or repeal of a rule, the agency must publish a notice of proposed rulemaking in the Bulletin. The notice of proposed rulemaking must include:

- a) the specific statutory authority for the rulemaking including a citation to a specific federal statute or regulation if that is the basis of authority or requirement for the rulemaking;*
- b) a statement in nontechnical language of the substance of the proposed rule, including a specific description of any fee or charge imposed or increased;*
- c) the text of the proposed rule prepared in legislative format;*
- d) the location, date, and time of any public hearings the agency intends to hold on the proposed rule;*
- e) the manner in which persons may make written comments on the proposed rule, including the name and address of a person in the agency to whom comments on the proposal may be sent;*
- f) the manner in which persons may request an opportunity for an oral presentation; and*
- g) the deadline for public (written) comments on the proposed rule.*

As stated, the text of the proposed rule must be published in the Bulletin. After meeting the statutory rulemaking criteria for a proposed rule, the agency may proceed to the pending rule stage. A proposed rule does not have an assigned effective date unless published in conjunction with a temporary rule docket. An agency may vacate a proposed rulemaking if it decides not to proceed further with the promulgation process.

TEMPORARY RULE

Temporary rules may be adopted only when the governor finds that it is necessary for:

- a) the 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.*

If a rulemaking meets any one or all of the above requirements, a rule may become effective before it has been submitted to the legislature for review and the agency may proceed and adopt a temporary rule.

A temporary rule expires at the conclusion of the next succeeding regular session of the legislature unless the rule is approved, amended, or modified by concurrent resolution or when the rule has been replaced by a final rule.

In cases where the text of the temporary rule is the same as that of the proposed rule, the rulemaking can be done concurrently as a temporary/proposed rule. State law requires that the text of a proposed or temporary rule be published in the Administrative Bulletin. Combining the rulemaking allows for a single publication of the text.

An agency may rescind a temporary rule that has been adopted and is in effect if the rule is being replaced by a new temporary rule or has been published concurrently with a proposed rulemaking that is being vacated.

PENDING RULE

A pending rule is a rule that has been adopted by an agency under the regular rulemaking process and remains subject to legislative review before it becomes a final, enforceable rule.

When a pending rule is published in the Bulletin, the agency is required to include certain information in the Notice of Pending Rule. This includes:

- a) the reasons for adopting the rule;*
- b) a statement of any change between the text of the proposed rule and the pending rule with an explanation of the reasons for any changes;*
- c) the date the pending rule will become final and effective; and*
- d) an identification of any portion of the rule imposing or increasing a fee or charge.*

Agencies are required to republish the text of the rule when substantive changes have been made to the proposed rule. An agency may adopt a pending rule that varies in content from that which was originally proposed if the subject matter of the rule remains the same, the pending rule is a logical outgrowth of the proposed rule, and the original notice was written so as to assure that members of the public were reasonably notified of the subject. It is not always necessary to republish all the text of the pending rule. With the permission of the Rules Coordinator, only the Section(s) that have changed from the proposed text are republished. If no changes have been made to the previously published text, it is not required to republish the text again and only the Notice of Pending Rule is published.

FINAL RULE

A final rule is a rule that has been adopted by an agency under the regular rulemaking process and is in effect.

No pending rule adopted by an agency will become final and effective until it has been submitted to the legislature for review. Where the legislature finds that the agency has violated the legislative intent of the statute under which the rule was made, a concurrent resolution will be adopted rejecting, amending, or modifying the rule or any part thereof. A Notice of Final Rule must be published in the Idaho Administrative Bulletin for any rule that is rejected, amended, or modified by the legislature showing the changes made. A rule that has been reviewed by the legislature and has not been rejected, amended, or modified will become final with no further legislative action. No rule shall become final and effective before the conclusion of the regular or special legislative session at which the rule was submitted for review. However, a rule which is final and effective may be applied retroactively, as provided in the rule.

AVAILABILITY OF THE ADMINISTRATIVE CODE AND BULLETIN

The Idaho Administrative Code and all monthly Bulletins are available for viewing and use by the public in all 44 county law libraries, state university and college and community college libraries, the state law library, the state library, the Public Libraries in Boise, Pocatello, Idaho Falls and Twin Falls, the Lewiston City Library, East Bonner County Library, Eastern Idaho Technical College Library, Ricks College Library, and Northwest Nazarene College Library.

SUBSCRIPTIONS AND DISTRIBUTION

For subscription information and costs of publications, please contact the Department of Administration, Office of the Administrative Rules Coordinator, 650 W. State Street, Room 100, Boise, Idaho 83720-0306, telephone (208) 332-1820.

The Administrative Bulletin is an official monthly publication of the State of Idaho. Yearly subscriptions or individual copies are available for purchase.

The Administrative Code, is an annual compilation or supplemental compilation of all final and enforceable temporary administrative rules and includes tables of contents, reference guides, and a subject index.

Individual Rule Chapters and *Individual Rulemaking Dockets*, are specific portions of the Bulletin and Administrative Code produced on demand.

Internet Access - The Administrative Code and Administrative Bulletin, as well as individual chapters and dockets, are available on the Internet at the following address:

<http://www.state.id.us/> - from Idaho Home Page select "Legal" then "Administrative Rules" link.

EDITOR'S NOTE: All rules are subject to frequent change. Users should reference all current issues of the Administrative Bulletin for negotiated, temporary, proposed, pending, and final changes to all rules, or call the Office of the Administrative Rules at (208) 332-1820.

HOW TO USE THE IDAHO ADMINISTRATIVE BULLETIN

Rulemaking documents produced by state agencies and published in the *Idaho Administrative Bulletin* are organized by a numbering system. Each state agency has a two-digit identification code number known as the "IDAPA" number. (The "IDAPA" Codes are listed in the alphabetical/numerical index at the end of this Preface.) Within each agency there are divisions or departments to which a two-digit "TITLE" number is assigned. There are "CHAPTER" numbers assigned within the Title and the rule text is divided among major sections with a number of subsections. An example IDAPA number is as follows:

IDAPA 38.05.01.060.02.c.ii.

"IDAPA" refers to Administrative Rules in general that are subject to the Administrative Procedures Act and are required by this act to be published in the Idaho Administrative Code and the Idaho Administrative Bulletin.

"IDAPA 38." refers to the Idaho Department of Administration.

"05." refers to Title 05 which is the Department of Administration's Division of Purchasing.

"01." refers to Chapter 01 of Title 05, "Rules of the Division of Purchasing".

"060." refers to Major Section 060, "Content of the Invitation to Bid".

"02." refers to Subsection 060.02.

"c." refers to Subsection 060.02.c.

"ii." refers to Subsection 060.02.c.ii.

DOCKET NUMBERING SYSTEM

Internally, the Bulletin is organized sequentially using a rule docketing system. All rulemaking actions (documents) are assigned a "DOCKET NUMBER". The "Docket Number" is a series of numbers separated by a hyphen "-", (38-0501-9901). The docket numbers are published sequentially by IDAPA designation (e.g. the two-digit agency code). The following example is a breakdown of a typical rule docket:

"DOCKET NO. 38-0501-9901"

"38-" denotes the agency's IDAPA number; in this case the Department of Administration.

"0501-" refers to the TITLE AND CHAPTER numbers of the agency rule being promulgated; in this case the Division of Purchasing (TITLE 05), "Rules of the Division of Purchasing" (Chapter 01).

"9901" denotes the year and sequential order of the docket submitted and published during the year; in this case the first rulemaking action of the chapter published in calendar year 1999.

Within each Docket, only the affected sections of chapters are printed. (See **Sections Affected Index** in each Bulletin for a listing of these.) The individual sections affected are printed in the Bulletin sequentially (e.g. Section "200" appears before Section "345" and so on). Whenever the sequence of the numbering is broken the following statement will appear:

"(BREAK IN CONTINUITY OF SECTIONS)"

INTERNAL AND EXTERNAL CITATIONS TO ADMINISTRATIVE RULES IN THE CODE AND BULLETIN

When making a citation to another Section or Subsection that is part of the same rule, a typical internal citation may appear as follows:

"...as found in Section 201 of this rule." OR "...in accordance with Subsection 201.06.c. of this rule."

It may also be cited to include the IDAPA, Title, and Chapter number also, as follows:

"...in accordance with IDAPA 38.05.01.201."

"38" denotes the IDAPA number of the agency.

"05" denotes the TITLE number of the agency rule.

"01" denotes the Chapter number of the agency rule.

"201" references the main Section number of the rule that is being cited.

Citations made within a rule to a different rule chapter (external citation) should also include the name of the Department and the name of the rule chapter being referenced, as well as the IDAPA, Title, and Chapter numbers. The following is a typical example of an external citation to another rule chapter:

"...as outlined in the Rules of the Department of Administration, IDAPA 38.04.04, 'Rules Governing Capitol Mall Parking.'"

BULLETIN PUBLICATION SCHEDULE FOR CALENDAR YEAR 2000

Volume No.	Monthly Issue of Bulletin	Closing Date for Agency Filing	Publication Date
00-1	January, 2000	*November 17, 1999	January 5, 2000
00-2	February, 2000	December 22, 1999	February 2, 2000
00-3	March, 2000	January 19, 2000	March 1, 2000
00-4	April, 2000	February 23, 2000	April 5, 2000
00-5	May, 2000	March 22, 2000	May 3, 2000
00-6	June, 2000	April 19, 2000	June 7, 2000
00-7	July, 2000	May 24, 2000	July 5, 2000
00-8	August, 2000	June 21, 2000	August 2, 2000
00-9	September, 2000	July 19, 2000	September 6, 2000
00-10	October, 2000	**August 22, 2000	October 4, 2000
00-11	November, 2000	September 20, 2000	November 1, 2000
00-12	December, 2000	October 25, 2000	December 6, 2000

BULLETIN PUBLICATION SCHEDULE FOR CALENDAR YEAR 2001

Volume No.	Monthly Issue of Bulletin	Closing Date for Agency Filing	Publication Date
01-1	January, 2001	*November 15, 2000	January 3, 2001
01-2	February, 2001	December 20, 2000	February 7, 2001
01-3	March, 2001	January 24, 2001	March 7, 2001
01-4	April, 2001	February 21, 2001	April 4, 2001
01-5	May, 2001	March 21, 2001	May 2, 2001
01-6	June, 2001	April 18, 2001	June 6, 2001
01-7	July, 2001	May 23, 2001	July 4, 2001
01-8	August, 2001	June 20, 2001	August 1, 2001
01-9	September, 2001	July 18, 2001	September 5, 2001
01-10	October, 2001	**August 22, 2001	October 3, 2001
01-11	November, 2001	September 19, 2001	November 7, 2001
01-12	December, 2001	October 24, 2001	December 5, 2001

**Last day to submit proposed rulemaking before moratorium begins and last day to submit pending rules to be reviewed by the legislature.*

***Last day to submit proposed rules in order to complete rulemaking for review by legislature.*

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**IDAHO DEPARTMENT OF ADMINISTRATION
OFFICE OF THE ADMINISTRATIVE RULES COORDINATOR**

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE

DOCKET NO. 16-0100-0002

NOTICE OF LEGISLATIVE ACTION

**REGARDING SENATE BILL 1426 AND THE AMENDMENT OF TITLE 56,
IDAHO CODE, BY THE ADDITION OF CHAPTER 10 AFFECTING
THE DEPARTMENT OF HEALTH AND WELFARE**

EFFECTIVE DATE: The effective date of this action is July 1, 2000.

AUTHORITY: In compliance with Sections 67-5203 and 67-5220, Idaho Code, notice is hereby given by the Office of the Administrative Rules Coordinator that the Fifty-fifth Legislature in the Second Regular Session - 2000, passed Senate Bill 1426 and that said bill was signed into law by Governor Dirk Kempthorne, Session Law 132, herein adding a new Chapter 10 to Title 56, Idaho Code, affecting the Department of Health and Welfare.

DESCRIPTIVE SUMMARY: The following is a statement in nontechnical language of the substance of the notice and the legislative action:

Senate Bill 1426 created a Department and a Board of Environmental Quality separate from the Department of Health and Welfare. It also amended Title 56, Idaho Code, by the addition of a new Chapter 10, Title 56, Idaho Code, to define terms, to create the Department of Health and Welfare, to provide powers and duties of the director, to provide for the creation of the Board of Health and Welfare, to provide additional powers and duties of the director, to provide for construction of terms, to provide for collection of fees and to provide for criminal violations. It also provided for the transition and effect of rules.

This notice, in accordance with Section 67-5203, Idaho Code, complies with the Legislative intent of Senate Bill 1426 by updating and correcting citations to Idaho Code in the Administrative Rules of the Department of Health and Welfare. These citations identify the statutory authority granted the Department through Idaho Code.

Notwithstanding the provisions of Title 67, Chapter 52, Idaho Code, and further complying with the legislative intent of Senate Bill 1426, the following table lists the statutory citations under Title 39 that correspond to the Title 56, Chapter 10 citations within the rules now under the authority of the Department of Health and Welfare and include, but are not limited to, the following:

OLD CODE SECTION	NEW CODE SECTION FOR DHW
39-103, Definitions	56-1001, Definitions
39-104, DHW-Creation-Environmental Protection Division.	56-1002, DHW Creation-Administration-Regions
39-105, Powers and Duties of the Director	56-1003, Powers and Duties of the Director
39-106, Director-Additional Duties	56-1004, Director-Additional Duties
39-107, Board-Composition-Officers-Compensation -Powers-Subpoena-Depositions-Review-Rules	56-1005, Board-Composition-Officers-Compensation-Powers -Subpoena-Depositions-Review-Rules
39-114, Repealed.	56-1006, Title Superseded
39-117, Criminal Violation-Penalty	56-1008, Criminal Violation-Penalty
39-119, Collection of Fees for Services	56-1007, Collection of Fees for Services

The following table lists those chapters of rules affected by the statutory changes. The first column lists the IDAPA, Title and Chapter number and the name of each affected chapter. The second column lists the Sections and Subsections where the citation changes are being made in the rule chapter. The third column lists the old Idaho Code citation that appears in the corresponding Section or Subsection and the fourth column list the new Idaho Code citations that will replace the old Idaho Code citation

DEPARTMENT OF HEALTH AND WELFARE AFFECTED CHAPTERS - IDAPA 16	RULE SECTION(S)	OLD IDAHO CODE CITATION	NEW IDAHO CODE CITATION
16.02.06 - Rules Governing Quality Assurance for Idaho Clinical Laboratories	001.01	39-103(12)	56-1001(4)
	001.02	39-105(3)(b)	56-1003
	041	39-117	56-1008
16.02.10 - Idaho Reportable Diseases	004.04	39-107	56-1005
	995	39-117	56-1008
16.02.13 - Rules Governing Certification of Idaho Water Quality Laboratories	000	39-105(3)(b)	56-1003
		39-103(12)	56-1001
	017	39-117	56-1008
16.02.14 - Rules Governing Construction and Operation of Public Swimming Pools	000	39-105(3)(d)	56-1003
	060	39-117	56-1008
16.02.19 - Rules Governing Food Safety and Sanitation Standards for Food Establishments (UNICODE)	976.01	39-117	56-1008
16.02.25 - Rules Governing Fees Charged by the State Laboratory	000	39-105(3)(b)	56-1003
		39-119	56-1007
16.02.26 - Rules Governing Children's Special Health Program	000	39-105	56-1003
16.03.03 - Rules Governing Child Support Services	000		56-1004
16.04.03 - Rules Governing Fees for Community Mental Health Center Services	000	39-119	56-1007
16.04.06 - Rules Governing Fees for Adult and Child Development Center Services	000	39-119	56-1007
16.05.01 - Rules Governing Protection and Disclosure of Department Records	000	39-106	56-1003 56-1004
16.05.02 - Rules Governing Audits of Providers	000	39-105(1)	56-1003
	003.05	39-104	56-1002
16.05.03 - Rules Governing Contested Cases and Declaratory Rulings	000	39-103(1) & (3)	56-1001
		39-104	56-1002
		39-105	56-1003
		39-106	56-1004
		39-107	56-1005
	005.03	39-107	56-1005
	005.06	39-104	56-1002
	005.07	39-104	56-1002
		39-105	56-1003
		39-106	56-1004
	100.12	39-107(5)	56-1005
	101.09.m	39-107	56-1005
	102	39-107	56-1005

DEPARTMENT OF HEALTH AND WELFARE AFFECTED CHAPTERS - IDAPA 16	RULE SECTION(S)	OLD IDAHO CODE CITATION	NEW IDAHO CODE CITATION
16.05.05 - Rules Governing Fees for Health and Environmental Operating Permits, Licenses, and Inspections Services	000	39-119	56-1007
16.06.01 - Rules Governing Family and Children's Services	000	39-105(l) 39-106(l)(a) 39-119	56-1003 56-1004 56-1007
16.06.02 - Rules Governing Child Care Licensing	000	39-107(8)	56-1005
16.06.13 - Rules Governing Emergency Assistance for Families and Children	000.01.a. 000.01.b	39-105(l) 39-106(l)(a)	56-1003 56-1004

Pursuant to Section 67-5204, Idaho Code, all of the above listed changes will be incorporated into the current Idaho Administrative Code.

ASSISTANCE ON QUESTIONS: For assistance on questions concerning this notice, contact Sherri Kovach at the Department of Health and Welfare at (208) 334-5564 or Dennis Stevenson at the Office of Administrative Rules at (208) 332-1820.

DATED this 18th day of August, 1999.

Rick Thompson
Administrative Rules Coordinator
Department of Administration
P.O. Box 83720
Boise, ID 83720-0011
PHONE: (208) 334-3577
FAX: (208) 334-2395

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE
16.02.03 - RULES GOVERNING EMERGENCY MEDICAL SERVICES

DOCKET NO. 16-0203-0001

NOTICE OF PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has proposed rulemaking. The action is authorized pursuant to Section(s) 39-145(2), 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 October 18, 2000

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 non-technical explanation of the substance and purpose of the proposed rulemaking:

Rulemaking will update the Section number of the equipment standards "Incorporated by Reference" in the rules; adding a pediatric emergency medicine representative to the State EMS Advisory Committee as requested by Representative D. Reynolds; and changing the address as cited in the rule of the Bureau as a result of a relocation.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because the change was at the request of Representative D. Reynolds and the other changes were mainly a clerical update of the chapter.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rules, contact Dia Gainor at (208) 334-4000.

Anyone can submit written comments regarding this rulemaking. All written comments and data concerning the rule must be directed to the undersigned and delivered on or before October 25, 2000.

DATED this 7th day of August, 2000.

Sherri Kovach
Administrative Procedures Coordinator
DHW - Legal Services Division
450 West State Street - 10th Floor
P.O. Box 83720
Boise, Idaho 83720-0036
(208) 334-5564 phone; (208) 332-7347 fax

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0203-0001

000. LEGAL AUTHORITY.

The Idaho Board of Health and Welfare is authorized under Section 39-145, Idaho Code, to adopt rules concerning the administration of the Idaho Emergency Medical Services Act. ~~The Board of Health and Welfare has adopted the July 1, 1996, Minimum Equipment Standards for Licensed EMS Services, Version 2.0, as its standard on required EMS equipment, and hereby incorporates the Standards by reference. Copies of the Standards may be obtained from the EMS Bureau, 3092 Elder Street, P.O. Box 83720, Boise, Idaho 83720-0036.~~ (7-1-97)()

(BREAK IN CONTINUITY OF SECTIONS)

002. WRITTEN INTERPRETATIONS.

In accordance with Section 67-5201(16)(b)(iv), Idaho Code, this bureau has an EMS Standards Manual, which contains policy and interpretation of the rules of this Chapter, or to the documentation of compliance with the rules of this Chapter. Copies of the Manual may be obtained from the EMS Bureau, ~~3092 Elder Street~~ 590 W. Washington, Boise, Idaho 83702, P.O. Box 83720, Boise, Idaho 83720-0036. (7-1-97)()

(BREAK IN CONTINUITY OF SECTIONS)

004. INCORPORATION BY REFERENCE.

The Board of Health and Welfare has adopted the Minimum Equipment Standards for Licensed EMS Services, 2000 edition, Version 3.0, as its standard on required EMS equipment and hereby incorporates the Standards by reference. Copies of the Equipment Standards may be obtained from the EMS Bureau, 590 W. Washington Street, Boise, Idaho 83702, P.O. Box 83720, Boise, Idaho 83720-0036. ()

005. -- 009. (RESERVED).

00410. DEFINITIONS AND ABBREVIATIONS.

For the purposes of these rules, the following terms and abbreviations will be used, as defined below: (7-1-80)

01. Advanced Emergency Medical Technician-Ambulance (AEMT-A). An individual certified by the EMS Bureau of the Idaho Department of Health and Welfare on the basis of successful completion of an intermediate training program, examination, subsequent required continuing training, and recertification. (7-1-97)

02. Advanced Life Support (ALS). The provision of medical care, medication administration and treatment with medical devices which correspond to the knowledge and skill objectives in the EMT-Paramedic curriculum currently approved by the State Health Officer in accordance with Subsection 201.04 of these rules and within the scope of practice defined in IDAPA 22.01.06, "Rules for EMS Personnel," Subsection 011.05, by persons certified as EMT-Paramedics in accordance with these rules. (4-5-00)

03. Advertise. Communication of information to the public, institutions, or to any person concerned, by any oral, written, or graphic means including handbills, newspapers, television, radio, telephone directories and billboards. (4-5-00)

04. Agency. An applicant for designation or a licensed EMS service seeking designation. (4-5-00)

05. Ambulance. Any privately or publicly owned ground vehicle, nautical vessel, fixed wing aircraft or rotary wing aircraft used for, or intended to be used for, the transportation of sick or injured persons who may need medical attention during transport. (7-1-97)

06. Ambulance-Based Clinicians. Licensed Professional Nurses, Advanced Practice Professional Nurses, and Physician Assistants with current licenses from the Board of Nursing or the Board of Medicine, who are personnel provided by licensed EMS services. (4-5-00)

07. Board. The Idaho State Board of Health and Welfare. (12-31-91)

08. Certification. A credential issued to an individual by the EMS Bureau for a specified period of time indicating that minimum standards corresponding to one (1) or several levels of EMS proficiency have been met. (7-1-97)

- 09. Certified Personnel.** Individuals who have completed training and successfully passed examinations for training and skills proficiency in one (1) or several levels of emergency medical services. (7-1-97)
- 10. Critical Care Transfer (CCT).** The transportation of a patient with continuous care, monitoring, medication or procedures requiring knowledge or skills not contained within the EMT-Paramedic curriculum approved by the State Health Officer. Interventions provided by EMT-Paramedics are governed by the scope of practice defined in IDAPA 22.01.06, "Rules for EMS Personnel," Subsection 011.05. (4-5-00)
- 11. Director.** The Director of the Department of Health and Welfare or designated individual. (12-31-91)
- 12. Division.** The Idaho Division of Health, Department of Health and Welfare. (11-19-76)
- 13. 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. (4-5-00)
- 14. Emergency Medical Services (EMS).** The services utilized in responding to a perceived individual need for immediate care in order to prevent loss of life or aggravation of physiological or psychological illness or injury. (11-19-76)
- 15. EMS Bureau.** The Emergency Medical Services (EMS) Bureau of the Idaho Department of Health and Welfare. (11-19-76)
- 16. EMS Standards Manual.** A manual published by the EMS Bureau detailing policy information including EMS education, training, certification, licensure, and data collection. (7-1-97)
- 17. Emergency Medical Technician-Ambulance (EMT-A).** A designation issued to an EMT-B by the EMS Bureau of the Idaho Department of Health and Welfare on the basis of successful completion of supervised in-field experience. (7-1-97)
- 18. Emergency Medical Technician-Basic (EMT-B).** An individual certified by the EMS Bureau of the Idaho Department of Health and Welfare on the basis of successful completion of a basic EMT training program, examination, subsequent required continuing training, and recertification. (7-1-97)
- 19. Emergency Medical Technician-Paramedic (EMT-P).** An individual certified by the EMS Bureau of the Idaho Department of Health and Welfare on the basis of successful completion of a paramedic training program, examination, subsequent required continuing training, and recertification. (7-1-97)
- 20. First Responder.** An individual certified by the EMS Bureau of the Idaho Department of Health and Welfare on the basis of successful completion of a first responder training program, examination, subsequent required continuing training, and recertification. (7-1-97)
- 21. Licensed EMS Services.** Ambulance services and non-transport services licensed by the EMS Bureau to function in Idaho. (7-1-97)
- 22. National Registry Of Emergency Medical Technicians (NREMT).** An independent, non-governmental, not for profit organization which prepares validated examinations for the state's use in evaluating candidates for certification. (7-1-97)
- 23. Non-Transport.** A vehicle design or organizational configuration which brings EMS personnel or equipment to a location, but does not move any sick or injured person from that location. (7-1-97)
- 24. Out-Of-Hospital.** Any setting outside of a hospital, including inter-facility transfers, in which the provision of EMS may take place. (4-5-00)

25. Physician. A person licensed by the State Board of Medicine to practice medicine or surgery or osteopathic medicine or surgery in Idaho. (11-17-96)

26. Pre-Hospital. Any setting (including standbys) outside of a hospital, with the exception of the inter-facility transfer, in which the provision of EMS may take place. (4-5-00)

27. State Health Officer. The Administrator of the Division of Health. (11-19-76)

28. Transfer. The transportation of a patient from one (1) medical care facility to another by ambulance. (4-5-00)

00511. -- 099. (RESERVED).

100. STATEWIDE EMS ADVISORY COMMITTEE.

The Director will appoint a Statewide EMS Advisory Committee to provide counsel to the Department in administering the EMS Act. The Committee members will have a normal tenure of three (3) years after which time they may be excused or reappointed. However, in order to afford continuity, initial appointments will be made to one-third (1/3) of the membership for two (2) years, one-third (1/3) for three (3) years, and one-third (1/3) of the membership for four (4) years. The Committee chairman will be selected by the State Health Officer. (7-1-97)

- 01. Committee Membership.** The Statewide EMS Advisory Committee will be constituted as follows: (7-1-80)
- a. One (1) representative recommended by the State Board of Medicine; and (4-8-94)
 - b. One (1) representative recommended by the Idaho Chapter of ACEP; and (4-8-94)
 - c. One (1) representative recommended by the Committee on Trauma of the Idaho Chapter of the American College of Surgeons; and (4-8-94)
 - d. One (1) representative recommended by the State Board of Nursing; and (4-8-94)
 - e. One (1) representative recommended by the Idaho Medical Association; and (4-8-94)
 - f. One (1) representative recommended by the Idaho Hospital Association; and (4-8-94)
 - and g. One (1) representative of local government recommended by the Idaho Association of Counties; (4-8-94)
 - h. One (1) representative of a career third service EMS/Ambulance organization; and (4-8-94)
 - i. One (1) representative of a volunteer third service EMS/Ambulance organization; and (4-8-94)
 - j. One (1) representative of a third service non-transport EMS organization; and (4-8-94)
 - k. One (1) representative of a fire department based EMS/Ambulance recommended by the Idaho Fire Chiefs Association; and (4-8-94)
 - l. One (1) representative of a fire department based non-transport EMS organization; and (4-8-94)
 - m. One (1) representative of an air medical EMS organization; and (7-1-97)
 - n. One (1) Emergency Medical Technician-Basic who represents the interests of Idaho providers certified at that level; and (4-8-94)
 - o. One (1) Advanced Emergency Medical Technician Ambulance who represents the interests of

Idaho providers certified at that level; and (7-1-97)

p. One (1) Emergency Medical Technician-Paramedic who represents the interests of Idaho providers certified at that level; and (4-8-94)

q. One (1) representative who is an administrative county EMS director; and (4-8-94)

r. One (1) EMS instructor who represents the interests of Idaho EMS educators and evaluators; and (4-8-94)

s. One (1) consumer; and (4-5-00)

t. One (1) representative of a private EMS transport organization; and (4-5-00)

u. One (1) pediatrician who represents the interests of children in the EMS system recommended by the Idaho Chapter of the American Academy of Pediatrics; and ~~(4-5-00)~~()

v. One (1) board certified or equivalent pediatric emergency medicine physician. ()

02. Responsibilities Of Committee. The EMS Advisory Committee will meet at least annually or as needed for the purposes of: (7-1-80)

a. Reviewing policies and procedures for provision of emergency medical services and recommending same to the Division; (11-19-76)

b. Reviewing EMS training curricula, training standards, and examination processes and recommending same to the Division; (4-8-94)

c. Reviewing EMS candidate selection policy and candidate performance requirements and recommending to the Division certification of standards for EMS personnel; (7-1-97)

d. Reviewing and making recommendations for disciplinary action regarding EMS personnel who have not complied with EMS policies; (11-19-76)

e. Reviewing and making recommendations on the licensing of ambulance services in Idaho. (11-19-76)

f. Reviewing and making recommendations on the licensing of non-transport services in Idaho. (7-1-97)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE
16.03.01 - RULES GOVERNING ELIGIBILITY FOR MEDICAID FOR FAMILIES AND CHILDREN
DOCKET NO. 16-0301-0002
NOTICE OF TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The temporary rule is effective November 1, 2000.

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 Section(s) 56-1004(1), Idaho Code.

PUBLIC HEARING SCHEDULE: Pursuant to Section 67-5222(2), Idaho Code, 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 October 18, 2000.

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 non-technical explanation of the substance and purpose of the proposed rulemaking:

The methodology for income eligibility will no longer employ retroactive averaging. The change will reinstate a methodology used through October 31, 1999 in which income is converted to a monthly amount and prospective budgeting is used for determining eligibility for future months.

TEMPORARY RULE JUSTIFICATION: The temporary rule has been adopted in accordance with Section 67-5226, Idaho Code and is necessary in order to comply with deadlines in amendments to governing law or federal programs.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was conducted with HCFA and the CHIP Oversight Committee.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary or proposed rule, contact Patti Campbell at (208) 334-5818.

Anyone can submit written comments regarding this proposed rule. All written comments and data concerning the rule must be directed to the undersigned and must be postmarked on or before October 25, 2000.

DATED this 9th day of August, 2000.

Sherri Kovach
Administrative Procedures Coordinator
DHW - Division of Legal Services
450 West State Street, 10th Floor
P.O. Box 83720, Boise, Idaho 83720-0036
(208) 334-5564 phone, (208) 332-7347 fax

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0301-0002

331. -- 348~~5~~. (RESERVED).

346. DETERMINING INCOME ELIGIBILITY FOR THE MONTH OF APPLICATION.

Calculate the household's countable income for the application month, and compare the income against the income limits for the appropriate Medicaid program. Use actual income for each of the three (3) retroactive months to determine eligibility for that month. Determine eligibility for each retroactive month separately. (11-1-00)T

347. ANTICIPATING INCOME.

Anticipate income to determine continuing eligibility. Compare the household's countable anticipated income against the income limits for the appropriate Medicaid program. (11-1-00)T

349~~8~~. DETERMINING INCOME AVAILABILITY AVAILABLE TO THE HOUSEHOLD.

All income from financially responsible ~~persons~~ household members is counted for Medicaid eligibility. Income is available when the participant has a legal interest in a liquidated sum. Income must be under the control of the participant during the period for which need is being determined. Income is available when action can be taken by the individual to obtain or use it. The participant must take all necessary steps to obtain program benefits for which he may be eligible. This includes RSDI, unemployment insurance, and worker's compensation. ~~(11-1-99)T~~(11-1-00)T

349. CALCULATING A FULL MONTH'S INCOME USING ACTUAL AND PROJECTED INCOME.

Calculate the monthly income, using actual income already received during the month and income expected to be received in the month. The household and the Department must agree this is a reasonable estimate of that month's income. (11-1-00)T

01. Full Month's Income Expected From An Ongoing Source. If no changes are expected, use the actual income received in the past thirty (30) days to project a full month's income. If changes are expected, project the income for the month with the new information. (11-1-00)T

02. Full Month's Income Not Expected From An Ongoing Source. If a full month's income is not expected from an ongoing source, count the income expected for the month. If the actual amount is known, use the actual income. If the actual income is unknown, project the expected income for that month. (11-1-00)T

03. Full Month's Income Not Expected From A New Source. If income is from a new source, and a full month's income is not expected, count the actual income expected for the month. Do not convert the new source of income to a monthly amount. If the actual income is unknown, project the expected income for that month. (11-1-00)T

04. Income From Terminated Source. If income is from a terminated source, and no additional income is expected in a future month, count the actual income received during the month. Do not convert income to a monthly amount, if a full month's income from the terminated source is not expected. (11-1-00)T

05. Seasonal Income. If income changes seasonally, consider the household's income from the last season and any pay changes to project the month's income. (11-1-00)T

06. Fluctuating Income. When income fluctuates each pay period, and the rate of pay remains the same, average the income from the past thirty (30) days to determine the average pay period amount. Convert the average pay period amount to a full month's income. (11-1-00)T

07. Income Paid As Salary. Count income paid as salary at the expected monthly salary rate. Do not count salary at an hourly rate. (11-1-00)T

350. COMPUTING INCOME CONVERTING INCOME TO A MONTHLY AMOUNT.

At application and redetermination income eligibility is computed as listed in Subsections 350.01 through 350.02. If a full month's income is expected, but income is received more often than monthly, convert the income to a monthly amount using the appropriate formula in Subsections 350.01 through 350.03. ~~(11-1-99)T~~(11-1-00)T

01. Current And Anticipated Income Exceeds Limit. When countable income for the application or

~~redetermination month exceeds the income limit, the income is from a new or continuing source, and is expected to continue at the same rate, the family is not income eligible.~~ **Weekly Income.** Multiply weekly income by four point three (4.3). ~~(11-1-99)F(11-1-00)T~~

02. ~~Current Or Anticipated Income Is Below Limit.~~ ~~When countable income in the application or redetermination month is below the income limit, or the income exceeds the limit but is not expected to continue at the same rate, the family may be income eligible using any one (1) of the options listed in Subsections 350.02.a. through 350.02.e.~~ **Bi-Weekly Income.** Multiply bi-weekly income by two point one five (2.15). ~~(11-1-99)F(11-1-00)T~~

~~a. **Four Month Average.** When an average of the countable income for the application or redetermination month and the three (3) prior calendar months is below the income limit, the family is income eligible.~~ ~~(11-1-99)T~~

~~b. **Twelve Month Average.** When an average of the countable income for the application or redetermination month and the three (3) prior calendar months exceeds the income limit, an average of the most recent twelve (12) month income may be used. The twelve (12) month average must reasonably reflect expected income. If the twelve (12) month average is below the income limit, the family is income eligible.~~ ~~(11-1-99)T~~

~~e. **Anticipate Income.** When countable income exceeds the income limit using the four (4) month average, and a twelve (12) month average does not reasonably reflect expected income, project anticipated income based on the family's current circumstances. If the projected income is below the income limit, the family is income eligible.~~ ~~(11-1-99)T~~

03. Semi-Monthly Income. Multiply semi-monthly income by two (2). (11-1-00)T

(BREAK IN CONTINUITY OF SECTIONS)

357. EARNED INCOME DISREGARDS.

Earned income disregards are subtracted from ~~averaged monthly~~ earnings after they are converted to a monthly amount, if the participant is not eligible without the disregards. The earned income disregards are the standard disregard, thirty dollars (\$30) plus one-third (1/3) disregard, and the dependent care disregard. Disregards are subtracted in that order. ~~(11-1-99)F(11-1-00)T~~

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE
16.03.04 - RULES GOVERNING THE FOOD STAMP PROGRAM IN IDAHO

DOCKET NO. 16-0304-0002

NOTICE OF TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The temporary rule is effective October 1, 2000.

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 Section(s) 56-202(b) and 56-1004, Idaho Code.

PUBLIC HEARING SCHEDULE: Pursuant to Section 67-5222(2), Idaho Code, 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 October 18, 2000.

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 non-technical explanation of the substance and purpose of the proposed rulemaking:

Rulemaking changes the gross and net income limits, the maximum monthly allotments and the Standard Utility Allowance (SUA).

TEMPORARY RULE JUSTIFICATION: The temporary rule has been adopted in accordance with Section 67-5226, Idaho Code and is necessary in order to comply with deadlines in amendments to governing law or federal programs and to confer a benefit.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because the rulemaking is to comply with deadlines in amendments to governing law.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary or proposed rule, contact Patti Campbell at (208) 334-5818.

Anyone can submit written comments regarding this proposed rule. All written comments and data concerning the rule must be directed to the undersigned and must be postmarked on or before October 25, 2000.

DATED this 3rd day of August, 2000.

Sherri Kovach
Administrative Procedures Coordinator
DHW - Division of Legal Services
450 West State Street, 10th Floor
P.O. Box 83720
Boise, Idaho 83720-0036
(208) 334-5564 phone, (208) 332-7347 fax

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0304-0002

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. Categorically eligible households are exempt from gross and net income limits. All members of categorically eligible households must be approved for TAFI, AABD, or SSI. Households with elderly or disabled household members are exempt from the gross income limit. Gross income limits are listed in Table 532.

TABLE 532 - GROSS INCOME LIMIT	
Household Size	Gross Income Limit
1	\$ 893 <u>905</u>
2	\$1, 492 <u>19</u>
3	\$1, 504 <u>33</u>
4	\$1,8 70 <u>48</u>
5	\$2,1 75 <u>62</u>
6	\$2,4 27 <u>76</u>
7	\$2,7 26 <u>90</u>
8	\$3, 032 <u>104</u>
Each Added Person	Add \$ 306 <u>15</u>

~~(4-5-00)~~(10-1-00)T

(BREAK IN CONTINUITY OF SECTIONS)

543. STANDARD UTILITY ALLOWANCE (SUA).

The shelter deduction is computed using the SUA or actual utility costs. The SUA is described below: (6-1-94)

01. Standard Utility Allowance (SUA). The Standard Utility Allowance (SUA) can be used instead of actual costs of heating, cooling, cooking fuel, electricity, the basic service fee for one (1) telephone, water, sewer and garbage collection. The SUA is one hundred ~~seventy-six~~ eighty-nine dollars (\$~~176~~89). The household must be told if actual utility costs exceed the SUA, the actual costs can be used if the household proves these costs.

~~(4-5-00)~~(10-1-00)T

02. SUA Qualifications. To qualify for the SUA, households must: (6-1-94)

a. Receive energy assistance payments made under the Low Income Home Energy Assistance Act of 1981; or (6-1-94)

b. The household must have a primary heating or cooling system. The household must have out-of-pocket heating or cooling costs billed on a regular or irregular basis. The heating or cooling costs must be separate from rent or mortgage payments. If not billed regularly for heating or cooling costs, the household must be otherwise Food Stamp eligible between billing periods. (6-1-94)

c. If the household claims cooling costs, the household must have either an air conditioning system or a room air conditioner to qualify for the SUA. (6-1-94)

d. If the household claims heating costs, the household must have expenses for a primary source of

heat. Households buying wood for their primary source of heat may get the SUA Cutting their own wood for the primary source of heat does not qualify a household for the SUA. Supplemental heat sources like, space heaters, electric blankets, cook stoves and a secondary heat source like a fireplace do not qualify households for the SUA.

(6-1-94)

(BREAK IN CONTINUITY OF SECTIONS)

549. NET INCOME LIMIT TEST.

Categorically eligible households do not have a net income limit. For all other households, including those with an elderly or disabled household member, compare the net income to the net income eligibility limit for that size household. This comparison must be completed for initial eligibility and when income changes. When the household income changes to a different income eligibility limit, apply the different limit. If the net income of the household exceeds the net income limit the household is not eligible for Food Stamps, unless categorically eligible. Net income limits are listed in Table 549.

TABLE 549 - NET INCOME LIMITS	
Household Size	Net Income Limit
1	\$ 687 <u>96</u>
2	\$ 922 <u>38</u>
3	\$ 1,157 <u>80</u>
4	\$ 1,392 <u>421</u>
5	\$ 1,627 <u>63</u>
6	\$ 1,862 <u>905</u>
7	\$ 2,097 <u>146</u>
8	\$ 2,332 <u>88</u>
Each Added Person Add	\$ 235 <u>42</u>

~~(4-5-00)~~(10-1-00)T

(BREAK IN CONTINUITY OF SECTIONS)

581. MAXIMUM FOOD STAMPS BY HOUSEHOLD SIZE.

The maximum Food Stamp amount by household size is listed in Table 581.

TABLE 581 - MAXIMUM FOOD STAMPS BY HOUSEHOLD SIZE	
Household Size	Maximum Food Stamps
1	\$ 127 <u>30</u>
2	\$ 234 <u>8</u>
3	\$ 335 <u>41</u>

TABLE 581 - MAXIMUM FOOD STAMPS BY HOUSEHOLD SIZE	
Household Size	Maximum Food Stamps
4	\$426 <u>34</u>
5	\$506 <u>15</u>
6	\$607 <u>18</u>
7	\$677 <u>83</u>
8	\$767 <u>81</u>
Each Added Person	Add \$96 <u>8</u>

~~(4-5-00)~~(10-1-00)T

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE
16.03.05 - RULES GOVERNING ELIGIBILITY FOR AID TO THE AGED, BLIND AND DISABLED
DOCKET NO. 16-0305-0002
NOTICE OF TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The temporary rule is effective October 1, 2000.

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 Section(s) 56-1004(1), Idaho Code.

PUBLIC HEARING SCHEDULE: Pursuant to Section 67-5222(2), Idaho Code, 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 October 18, 2000.

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 non-technical explanation of the substance and purpose of the proposed rulemaking:

Under current rules, a veteran's aid and attendance and unusual medical expense payments from the VA are not counted as income in computing the participant's share in the cost of his nursing home care or Home and Community Based Services. Under the proposed rule, this money will be counted as income for computing the participant's share in the cost of care if he lives in a State-operated veterans' home.

TEMPORARY RULE JUSTIFICATION: The temporary rule has been adopted in accordance with Section 67-5226, Idaho Code and is necessary in order to comply with deadlines in amendments to governing law or federal programs.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because the rulemaking changes are to comply with federal Medicaid laws.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary or proposed rule, contact Patti Campbell at (208) 334-5818.

Anyone can submit written comments regarding this proposed rule. All written comments and data concerning the rule must be directed to the undersigned and must be postmarked on or before October 25, 2000.

DATED this 10th day of August, 2000.

Sherri Kovach
Administrative Procedures Coordinator
DHW - Division of Legal Services
450 West State Street, 10th Floor
P.O. Box 83720
Boise, Idaho 83720-0036
(208) 334-5564 phone, (208) 332-7347 fax

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0305-0002

721. 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 the mentally retarded. Long-term care certification is determined using IDAPA 16.03.09, "Rules Governing Medical Assistance," Subsection 160.09.

(7-1-99)

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. The principal balance of an excluded real estate contract is not a resource, unless it is more restrictive to Medicaid eligibility than counting the contract as a resource.

(7-1-99)

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 likely to remain, in long-term care at least thirty (30) consecutive days.

(7-1-99)

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.

(7-1-99)

04. Income Not Counted. The income listed in Subsections 721.04.a. through 721.04.e. 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, ~~except a~~ A VA "Aid and Attendance" allowance and any increment which represents a for VA Unusual Medical Expenses allowance is not counted in determining participation in the cost of long-term care, unless the veteran lives in a state operated veterans' home.

~~(7-1-99)~~(10-1-00)T

a. Excluded AABD income. Income excluded or disregarded, in determining eligibility for AABD cash, is not counted.

(7-1-99)

b. RSDI increase. The September 1972 RSDI increase is not counted.

(7-1-99)

c. VA aid and attendance. Any VA Aid and Attendance allowance, including any increment which 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.

~~(7-1-99)~~(10-1-00)T

d. RSDI COLA increase. 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.

(7-1-99)

e. Income paid into exempt income trust. Income paid into an income trust exempt from counting for Medicaid eligibility under Sections 701.01 through 701.03 is used for patient liability is not counted. Income paid to the trust and not used for patient liability, is subject to the asset transfer penalty.

(7-1-99)

(BREAK IN CONTINUITY OF SECTIONS)

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.

(7-1-99)

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 total income less the deductions in Subsection 723.03. (7-1-99)

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 share of the couple's community income, plus his own separate income. The deductions in Table 723.03 are subtracted from his income. (7-1-99)

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 most recent admission, must have the deductions in Subsection 723.03.a. through 723.03.n. subtracted from his 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. (7-1-99)

- a. AABD income exclusions. Subtract income excluded in determining eligibility for AABD cash. (7-1-99)
- 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, unless the veteran lives in a state operated veterans' home. ~~(7-1-99)~~(10-1-00)T
- c. 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. (7-1-99)
- d. AABD payment. Subtract 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. (7-1-99)
- e. Protected VA pension. Subtract a protected VA pension for a veteran with no spouse or dependents or for a surviving spouse with no dependents. (7-1-99)
- f. Personal needs. Subtract thirty dollars (\$30) for the participant's personal needs. For a veteran or surviving spouse with a protected VA pension, the protected pension substitutes for the thirty dollar (\$30) personal needs deduction. (7-1-99)
- 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 gross earned income. 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. (1-1-00)T
- h. Home maintenance. Subtract two hundred and twelve dollars (\$212) for home maintenance cost if the participant had an independent living situation, before his admission for long-term care. His 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. (7-1-99)
- i. Maintenance need. Subtract a maintenance need deduction for a family member, living in the long-term care participant's home. 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. (7-1-99)
- j. 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. 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. (7-1-99)

k. **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. (7-1-99)

l. **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. (7-1-99)

m. **Trust fees.** Subtract up to twenty-five dollars (\$25) monthly paid to the trustee for administering the participant's trust. (7-1-99)

n. **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. (7-1-99)

o. **Income Garnished for Child Support.** Subtract income garnished for child support to the extent the expense is not already accounted for in computing the maintenance need standard. (1-1-00)T

(BREAK IN CONTINUITY OF SECTIONS)

725. PATIENT LIABILITY FOR PARTICIPANT WITH COMMUNITY SPOUSE.

After income ownership is decided, patient liability is determined using steps in Table 725.

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, <u>unless the veteran lives in a state operated veterans' home.</u>
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. Protected VA Pension	Subtract a protected VA pension for a veteran with no spouse or dependents or for a surviving spouse with no dependents.
06. Personal Needs	Subtract thirty dollars (\$30) for the participant's personal needs. Do not allow this deduction for a veteran or surviving spouse with a protected VA pension. The protected pension substitutes for the thirty dollar (\$30) personal needs deduction.

TABLE 725 - INCOME DEDUCTIONS FOR PARTICIPANT IN FACILITY	
Step	Procedure
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.	<p>Compute the Community Spouse Allowance (CSA) using Step a. through Step c.</p> <p>Compute the Shelter Adjustment.</p> <p>Add the current Food Stamp Program Standard Utility Allowance to the community spouse's shelter costs.</p> <p>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.</p> <p>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.</p> <p>The Shelter Adjustment is the positive balance remaining.</p>
09. Community Spouse Allowance: Step b.	<p>Compute the Community Spouse Need Standard (CSNS).</p> <p>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.</p>
10. Community Spouse Allowance: Step c.	<p>Compute the Community Spouse Allowance.</p> <p>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.</p> <p>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.</p>

TABLE 725 - INCOME DEDUCTIONS FOR PARTICIPANT IN FACILITY	
Step	Procedure
11. Family Member Allowance (FMA)	<p>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.</p> <p>Any remainder is the FMA for that family member. The FMA is allowed, whether or not it is actually paid by the participant.</p> <p>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.</p>
12. Medicare and Health Insurance Premiums	<p>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.</p>
13. Mandatory Income Taxes	<p>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.</p>
14. Guardian Fees	<p>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.</p>
15. Trust Fees	<p>Subtract up to twenty-five dollars (\$25) monthly paid to the trustee for administering the participant's trust.</p>
16. Impairment Related Work Expenses	<p>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.</p>
17. Income Garnisheed for Child Support	<p>Subtract income garnisheed for child support to the extent the expense is not already accounted for in computing the Family Member Allowance.</p>

~~(1-1-00)F(10-1-00)T~~

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE
16.03.09 - RULES GOVERNING THE MEDICAL ASSISTANCE PROGRAM
DOCKET NO. 16-0309-0008
NOTICE OF TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The temporary rule is effective January 1, 2000.

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 Section(s) 56-202(f), Idaho Code.

PUBLIC HEARING SCHEDULE: Pursuant to Section 67-5222(2), Idaho Code, 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 October 18, 2000.

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 non-technical explanation of the substance and purpose of the proposed rulemaking:

This rulemaking deletes text referencing the maintenance of a mailing list for Medical Assistance manual updates and adds the reference for Internet access. The Division Administrator stopped the maintenance of the list and mailing of updates to individuals in September 1998.

TEMPORARY RULE JUSTIFICATION: A temporary rule has been adopted in accordance with Section 67-5226, Idaho Code and are necessary in order to protect the public health, safety, or welfare.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because the Department of Administration began keeping the most current version of the rules, the need to maintain a mailing list for the Medical Assistance manual updates became obsolete.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary or proposed rule, contact Becca D. Ruhl at (208) 364-1840.

Anyone can submit written comments regarding this proposed rule. All written comments and data concerning the rule must be directed to the undersigned and must be postmarked on or before October 25, 2000.

DATED this 4th day of August, 2000.

Sherri Kovach
Administrative Procedures Coordinator
DHW - Division of Legal Services
450 West State Street, 10th Floor
P.O. Box 83720
Boise, Idaho 83720-0036
(208) 334-5564 phone, (208) 332-7347 fax

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0308-0008

010. PUBLIC ACCESS TO PROGRAM INFORMATION.

01. Location Of Rules Governing Medical Assistance. A current copy of the rules governing medical assistance, as well as other MA program information affecting the public, is to be maintained by the Department in the Central Office and in each field office. (11-10-81)

02. Availability Of Materials. Copies of the rules governing medical assistance or other MA program information affecting the public will be furnished to any individual or organization who, in accordance with Idaho Department of Health and Welfare Rules, IDAPA 16.05.01, "Rules Governing the Protection and Disclosure of Department Records (Confidentiality)": (11-10-81)

~~a. Formally requests for specific information.~~ (11-10-81)

~~b. Formally requests to be placed on a mailing list to receive amendments to MA program policy from~~
can be submitted to the Department's Administrative Procedure Section, 450 W. State Street, P.O. Box 83720, Boise, ID 83720-0036. (11-10-81)(1-1-00)T

03. Cost Of Materials. A fee, to cover actual reproduction costs, will be assessed for all requests for copies of information. (11-10-81)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE
16.03.09 - RULES GOVERNING THE MEDICAL ASSISTANCE PROGRAM

DOCKET NO. 16-0309-0009

NOTICE OF TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The temporary rule is effective July 1, 2000.

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 Section(s) 56-202(f), Idaho Code.

PUBLIC HEARING SCHEDULE: Pursuant to Section 67-5222(2), Idaho Code, 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 October 18, 2000.

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 non-technical explanation of the substance and purpose of the proposed rulemaking:

HB 797 requires that the Department reduce its current one hundred (100) visit limitation on Physical Therapy visits and preauthorized any medically necessary visits over that limit. This rule change reduces the number of unauthorized visits to twenty-five (25) per calendar year and require authorization for any visits over the twenty-five (25) by the Department of Health and Welfare. In addition to these changes, technical terminology changes are made in the "Developmental Disability Section" of these rules.

TEMPORARY RULE JUSTIFICATION: Temporary rules have been adopted in accordance with Section 67-5226, Idaho Code and are necessary in order to comply with deadlines in amendments to governing law or federal programs.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because of HB 797, legislative intent.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary or proposed rule, contact DeeAnne Moore at (208) 334-5795.

Anyone can submit written comments regarding this rule. All written comments and data concerning the rule must be directed to the undersigned and must be postmarked on or before October 25, 2000.

DATED this 1st day of August, 2000.

Sherri Kovach
Administrative Procedures Coordinator
DHW - Division of Legal Services
450 West State Street, 10th Floor
P.O. Box 83720, Boise, Idaho 83720-0036
(208) 334-5564 phone, (208) 332-7347 fax

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0309-0009

120. REHABILITATIVE SERVICES -- DEVELOPMENTAL DISABILITIES ~~CENTERS~~ AGENCIES.

The Department will pay for rehabilitative services pursuant to 42 CFR 440.130(d), including medical or remedial services provided by facilities which have entered into a provider agreement with the Department and are licensed as developmental disabilities ~~centers~~ agencies by the ~~Division of Medicaid, Bureau of Facility Standards~~ Division of Family and Community Services, Bureau of Developmental Disabilities. Effective July 1, 1995, all recipients not currently receiving services from a Developmental Disabilities ~~Center~~ Agency shall do so only as part of an Individual Support Plan (ISP) developed by the client and his targeted service coordinator, if one is selected. If the client chooses not to select a targeted service coordinator, the Developmental Disabilities ~~Center~~ Agency (DDCA) must ensure an ~~ISP Individual Program Plan~~ is developed ~~and submitted to the Regional ACCESS Unit. Recipients receiving services from a Developmental Disabilities Center effective July 1, 1995, shall do so only as a part of an ISP developed by the client and his targeted service coordinator, if one is selected, at the time of their annual review and in no case later than June 30, 1996. If the client chooses not to select a targeted service coordinator, the DDC~~ must ensure an ISP is developed and submitted to the Regional ACCESS Unit. Clients who are Home and Community Based Services Waiver recipients who want and need DDCA services shall develop an ISP with their targeted service coordinator and submit that plan to the Regional ACCESS Unit for authorization. Educational services, other than those "related services" found in 34 CFR 300.13 and provided to all eligibles under the State Medical Plan, are the responsibility of the public schools and are not eligible for Medicaid payments. Covered "related services" include: audiology; psychotherapy services; physician services; developmental and occupational therapy; physical therapy; speech pathology and transportation necessary to obtain other covered services. (7-1-95)(7-1-00)T

01. Evaluation And Diagnostic Services. ~~Evaluation and diagnostic services are not required for adults who obtain services from the center as part of an ISP developed with a targeted service coordinator.~~ Prior to delivery of service, current and accurate comprehensive evaluations or specific skill assessment shall be completed or obtained as necessary to effectively plan the consumer's program. Evaluations and assessments shall reflect the current status of the consumer. (7-1-95)(7-1-00)T

a. When required medical/social, psychological, speech and hearing, physical, developmental, and occupational therapy evaluations must meet the requirements of IDAPA 16.04.11, "Rules ~~and Minimum Standards~~ Governing Developmental Disabilities ~~Centers~~ Agencies," with the following exceptions: (7-1-95)(7-1-00)T

i. For children being served in a Developmental Disabilities ~~Center~~ Agency under Part ~~HC~~ of IDEA (Individuals with Disabilities Education Act), the above evaluations must meet the requirements in Title 16, Chapter 1, Idaho Code, "Early Intervention Services" and the Idaho State Plan for Early services Intervention of the Individuals with Developmental Disabilities Education Act; or (5-4-94)(7-1-00)T

ii. For children being served in a Developmental Disabilities ~~Center~~ Agency under Part B of IDEA, the above evaluations must meet Section 33-201, Idaho Code, "School Age," and IDAPA 08.02.03, "Rules Governing Thoroughness". (5-4-94)(7-1-00)T

b. Twelve (12) hours is the maximum Medicaid reimbursable time allowed for the combination of all evaluation or diagnostic services provided in any calendar year. (10-6-88)

02. Treatment Services. Home, community and ~~based as well as~~ center based services ~~based treatment services~~ must be recommended by a physician or other practitioner of the healing arts and provided in accordance with objectives as specified in an ISP submitted to the Regional ACCESS Unit. (7-1-95)(7-1-00)T

a. The treatment services must meet the requirements of IDAPA 16.04.11, "Rules ~~and Minimum Standards for~~ Governing Developmental Disabilities ~~Centers~~ Agencies," with the following exceptions: (5-4-94)(7-1-00)T

i. For children being served in a Developmental Disabilities ~~Center~~ Agency under Part ~~HC~~ of IDEA, treatment services must meet the requirements in Title 16, Chapter 01, Idaho Code, "Early Intervention Services" and the Idaho State Plan for Early Intervention of the Individuals with Developmental Disabilities Education Act; or (5-4-94)(7-1-00)T

ii. For children being served in a Developmental Disabilities ~~Center~~ Agency under Part B of IDEA,

treatment services must meet Section 33-201, Idaho Code, "School Age," and IDAPA 08.02.03, "Rules Governing Thoroughness". ~~(5-4-94)~~(7-1-00)T

b. Psychotherapy services limited to a maximum of forty-five (45) hours in a calendar year, and include: (7-1-95)

i. Individual psychotherapy; (7-1-95)

ii. Group psychotherapy; (7-1-95)

iii. Family-centered psychotherapy which must include the recipient and one (1) other family member at any given time. (7-1-95)

c. Speech and hearing therapy services are limited to two hundred fifty (250) treatment sessions per calendar year. (7-1-95)

d. Physical therapy services are limited ~~to one hundred (100) treatment visits per calendar year in~~ accordance with Section 140 of these rules. ~~(7-1-95)~~(7-1-00)T

e. Developmental and occupational therapy services alone or in combination are limited to a maximum of thirty (30) hours per week. ~~(7-1-95)~~(7-1-00)T

f. Collateral contact with individuals directly involved with the recipient of service to expand rehabilitative services into the client's living location. Such contacts will be included in the limitations of hours of treatment service reimbursed by Medicaid. Contacts with such persons for the purpose of future placement, interagency and intra-agency case monitoring, staffings and social service activities are not allowable for Medicaid payment. (10-6-88)

g. Only one (1) type of therapy service will be reimbursed during a single time period by the Medicaid program. No therapy services will be reimbursed during periods when the recipient is being transported to and from the ~~center~~ agency. ~~(10-6-88)~~(7-1-00)T

03. Optional Services. (11-22-91)

a. Consultation for the purpose of prescribing, monitoring, and/or administering medications. These consultations shall be: (11-22-91)

i. Provided by a physician or licensed nurse practitioner in direct face-to-face contact with the client; and (11-22-91)

ii. Incorporated into the client's Individual Support Plan with the type, amount, and duration of the service specified. (7-1-95)

b. Nursing services for the purpose of supervising, monitoring, and/or administering medication within the limits of the Nurse Practice Act, Section 54-1402(d), Idaho Code. These services shall be: (11-22-91)

i. Ordered and supervised by a physician; and (11-22-91)

ii. Provided by licensed and qualified nursing personnel in direct face-to-face contact with the client; and (11-22-91)

iii. Incorporated into the client's Individual Support Plan with the type, amount, and duration of the service specified. (7-1-95)

c. Psychiatric evaluations and services for the purpose of establishing a diagnosis, identifying client strengths and needs, and recommending and/or implementing interventions to address each need. These evaluations and services shall be: (11-22-91)

- i. Conducted by a physician in direct face-to-face contact with the client; and (11-22-91)
- ii. Incorporated into the client's Individual Support Plan with the type, amount, and duration of service specified. (7-1-95)

04. Requirements For ~~Centers~~ Agencies. ~~Centers~~ Agencies must be licensed as Developmental Disabilities ~~Centers~~ Agencies by the Department. Loss of licensure by an ~~center~~ agency will be cause for termination of all Medicaid program payment for services and termination of the ~~center's~~ agency's provider agreement. (~~11-22-91~~)(7-1-00)T

- 05. Excluded Services.** The following services are excluded for Medicaid payments: (10-6-88)
- a. Vocational services; and (10-6-88)
 - b. Educational services; and (10-6-88)
 - c. Recreational services. (10-6-88)

06. Payment Procedures. Payment for ~~center~~ agency services must be in accordance with rates established by the Department. (~~11-10-81~~)(7-1-00)T

- a. Providers of services must accept as payment in full the Department's payment for such services and must not bill a MA recipient for any portion of any charges. (11-10-81)
- b. Third party payment resources, such as Medicare and private insurance, must be exhausted before the Department is billed for services provided to an eligible recipient. Proof of billing other third party payors is required. (11-10-81)

(BREAK IN CONTINUITY OF SECTIONS)

140. PHYSICAL THERAPY SERVICES.

The Department will pay for physical therapy rendered by or under the supervision of a licensed physical therapist if such services are ordered by the attending physician as part of a plan of care. (7-1-96)

01. Service Description. The following modalities, therapeutic procedures, tests, and measurements as described in the Physical Medicine and Rehabilitation Subsection and the Neurology and Neuromuscular Procedures Subsection of the Physician's Current Procedural Terminology (CPT), published by the American Medical Association, P.O. Box 10950, Chicago, Illinois 60610, most current edition, are reimbursable for physical therapists. (7-1-96)

a. Modalities are any physical agent applied to produce therapeutic changes to biological tissue. These include the application of thermal, acoustic, light, mechanical or electrical energy. CPT procedure code range 97032 through 97036 require direct, one to one, patient contact by the therapist. CPT procedure code range 97010 through 97028 may be performed under the supervision of the physical therapist. Any modality which is not contained in these procedure code ranges must be billed using CPT code 97039 for an unlisted modality, and requires authorization by the Department prior to payment. In this case, physician and therapist information documenting the medical necessity of the modality requested for payment must be provided in writing to the Bureau of Medicaid Policy and Reimbursement. (7-1-96)

b. Therapeutic procedures are the application of clinical skills, services, or both that attempt to improve function. All therapeutic procedures require the therapist to have direct, one to one, patient contact. CPT procedure code range 97110 through 97541, and 97770, but excluding CPT procedure code 97124, massage, are eligible for Medicaid payment. HCPCS code G0169 is also covered. Any procedure not described by these procedure

codes must be billed using CPT procedure code 97139 as an unlisted procedure, and requires authorization by the Department prior to payment. In this case, physician and therapist documentation of the medical necessity of the therapeutic procedure must be provided in writing to the Bureau of Medicaid Policy and Reimbursement.

~~(7-1-96)~~(7-1-00)T

c. The provision of tests or measurements as described by CPT procedure codes 97700 through 97750 may be reimbursed. The physical therapist may be reimbursed for the technical component of muscle testing, joint range of motion, electromyography or nerve velocity determinations as described in CPT procedure codes 95831 through 95904 when ordered by a physician. (7-1-96)

d. The equipment used by the physical therapists to provide services is up to the discretion of the therapist and physician. All therapeutic equipment used by the therapist is included in the fee for service payment and no separate charge may be made to either the Medicaid program or client. (7-1-99)

02. Physician Orders. All physical therapy must be ordered by a physician and such orders must include at a minimum, the service to be provided, frequency, and, where applicable, the duration of each therapeutic session. In the event that services are required for extended periods, these services must be reordered as necessary, but at least every thirty (30) days for all patients except those receiving home health agency services and patients with chronic conditions which require on-going physical therapy. Physical therapy provided by home health agencies must be included in the home health plan of care and be reordered not less often than every sixty (60) days. Individuals with chronic medical conditions, as documented by physician, may be reordered up to every six (6) months. Documentation including the physician orders, care plans, progress or other notes documenting each assessment, therapy session and testing or measurement results must be maintained in the files of the therapist. The absence of such documentation is cause for recoupment of Medicaid payment. (7-1-99)

03. Payment Procedures. Payment procedures are as follows: (7-1-96)

a. Each recipient is limited to ~~one hundred~~ twenty-five (40025) visits of outpatient physical therapy during any calendar year. The Department may authorize additional visits if such services are determined to be medically necessary. Visits to outpatient departments of hospitals and ~~from home health services provided by school districts, developmental disability agencies,~~ or independent physical therapists providing physical therapy are included in the limit on the total outpatient physical therapy visits. ~~(3-22-93)~~(7-1-00)T

~~b. Home health agencies must send a copy of the patient's attending physician's order for physical therapy services to the Department with their claims. (7-1-96)~~

~~#b.~~ Physical therapy rendered by home health agencies must have, at least every sixty (60) days, physician recertification, in writing, that those services were medically necessary. This information must be on the copy of the physician's order submitted with the claim. (7-1-96)

~~#.~~ Physical therapy provided by home health agencies will be paid at a rate per visit as described in Section 105 and subject to the home health visit limitations contained in Section 105.01.c. ~~(12-31-91)~~(7-1-00)T

c. Physical therapists identified by Medicare as independent practitioners and enrolled as Medicaid providers will be paid on a fee-for-service basis. The maximum fee paid will be based upon the Department's fee schedule. Only these practitioners can bill the Department directly for their services. (7-1-96)

d. Physical therapy rendered on-site to hospital inpatients or outpatients will be paid at a rate not to exceed the payment determined as reasonable cost using Title XVIII (Medicare) standards and principles. (3-22-93)

e. Physical therapy rendered by nursing home facilities to outpatients will be paid at a rate not to exceed the payment determined as reasonable cost using Title XVIII (Medicare) standards and principles. (7-1-85)

f. Payment for physical therapy rendered to inpatients in long-term care facilities is made directly to the facilities as part of their operating costs. (7-1-85)

g. Payment for physical therapy ordered in ~~an Adult and Child Development Center~~ Developmental

Disability Agency or its equivalent, according to Section 120, will be made directly to that center. Payment will be based upon the Department's fee schedule for those services. ~~(12-31-91)~~(7-1-00)T

04. Excluded Services. Services excluded from Medicaid program coverage include, group exercise therapy, group hydrotherapy, and biofeedback services. (7-1-99)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE
16.03.09 - RULES GOVERNING THE MEDICAL ASSISTANCE PROGRAM

DOCKET NO. 16-0309-0010

NOTICE OF TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The temporary rule is effective July 1, 2000.

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 Section(s) 56-202(F), Idaho Code.

PUBLIC HEARING SCHEDULE: Pursuant to Section 67-5222(2), Idaho Code, 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 October 18, 2000.

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 non-technical explanation of the substance and purpose of the proposed rulemaking:

The changes in these rules implement SB 1365. The major points are: All PCS and Attendant providers will be employees of an agency. CNA requirements is modified to allow other training. PCS supervision by MD and RN expanded. Numerous technical changes to standardize terminology.

TEMPORARY RULE JUSTIFICATION: The temporary rule has been adopted in accordance with Section 67-5226, Idaho Code and is necessary in order to comply with deadlines in amendments to governing law or federal programs.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was conducted. The Division of Medicaid met with PCS, Residential Care Industries, CO-AD and LINC as well as with Regional staff.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary or proposed rule, contact DeeAnne Moore at (208) 364-1840.

Anyone can submit written comments regarding this proposed rule. All written comments and data concerning the rule must be directed to the undersigned and must be postmarked on or before October 25, 2000.

DATED this 15th day of August, 2000.

Sherri Kovach
Administrative Procedures Coordinator
DHW - Division of Legal Services
450 West State Street, 10th Floor
P.O. Box 83720
Boise, Idaho 83720-0036
(208) 334-5564 phone, (208) 332-7347 fax

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0309-0010

003. DEFINITIONS.

For the purposes of these rules, the following terms will be used, as defined below: (11-10-81)

01. Abortion. The medical procedure necessary for the termination of pregnancy endangering the life of the woman, or the result of rape or incest, or determined to be medically necessary in order to save the health of the woman. This Subsection is effective retroactively from October 1, 1993. (2-17-94)

02. Access Unit (ACCESS). Access to Care Coordination, Evaluation, Services and Supports. A regional multidisciplinary, transdivisional unit that has the responsibility of determining eligibility, authorizing services, and assuring quality for services and supports for individuals with developmental disabilities. (7-1-95)

03. Activities Of Daily Living (ADL). The performance of basic self-care activities in meeting an individual's needs for sustaining him in a daily living environment, including, but not limited to, bathing, washing, dressing, toileting, grooming, eating, communication, continence, mobility, and associated tasks. (7-1-00)T

034. Ambulatory Surgical Center (ASC). Any distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization, and which is certified by the U.S. Department of Health and Human Services as an ASC. (7-1-97)

05. Bureau. ~~The Bureau of Medicaid Policy and Reimbursement within the Division of Medicaid, Idaho Department of Health and Welfare, which has the responsibility for administration of the Medical Assistance Program for the state of Idaho.~~ **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 IADLs. These services may include, but are not limited to, 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. (7-1-97)(7-1-00)T

06. Bureau Of Systems And Operations Authorized Provider. ~~A Bureau of the Division of Medicaid charged with the responsibility of investigation and seeking prosecution of cases involving Medicaid fraud~~ licensed nurse practitioner, clinical nurse specialist, or physician assistant. (7-1-97)(7-1-00)T

047. Bill. The itemized cost of all services provided to one (1) ~~recipient~~ participant on a single claim form. (11-10-81)(7-1-00)T

078. Buy-In Coverage. The amount the State pays for Part B of Title C XVIII on behalf of the A/R. (11-10-81)

089. Category I Sanctions. Less severe administrative sanctions, which can be employed concurrently, which neither require notification nor are subject to appeal unless specifically allowed. (11-10-81)

0910. Category II Sanctions. Severe administrative sanctions which are appealable as provided for in IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings". (7-1-97)

101. Central Office. The administrative headquarters for the Idaho Department of Health and Welfare which are located in the State Office Building (State Towers), 450 West State Street, Boise, Idaho 83720. (11-10-81)

112. Certified Registered Nurse Anesthetist (CRNA). A Registered Nurse qualified by advanced training in an accredited program in the specialty of nurse anesthesia to manage the care of the patient during the administration of anesthesia in selected surgical situations. (7-1-97)

123. Claim. An itemized bill for services rendered to one (1) ~~recipient~~ participant by a provider submitted on any of the following Department claim forms: (11-10-81)(7-1-00)T

a. DHW PH 3-80, "Physician Invoice" or such other claim form as may be prescribed by the

- Department; or (11-10-81)
- b. DHW 03-80, "Title XIX Pharmacy Claim"; or (11-10-81)
 - c. DHW-AD78, "Adjustment Request"; or (11-10-81)
 - d. DHW OP REV 4-80, "Hospital Out-patient"; or (11-10-81)
 - e. DHW IP 3-80, "Hospital In-patient"; or (11-10-81)
 - f. DHW 0137, "Attending Dentist's Statement"; or (11-10-81)
 - g. DHW NH 3-80, "Nursing Home Statement"; or (11-10-81)
 - h. HW-0034 "Consent Form" for sterilization procedures. (11-10-81)
- 134. Collateral Contacts.** Contacts made with a parent, guardian, or other individual having a primary relationship to the patient by an appropriately qualified treatment professional. The contact must be ordered by a physician, contained in the treatment plan, directed at the medical treatment of the patient, and documented in the progress notes or continuous service record. (10-6-88)
- 145. Community Living Home.** A licensed ICF/MR facility of eight (8) beds or less that has converted to a group home to provide residential habilitation services to developmentally disabled waiver recipients. Room and board is not included in the reimbursement rate. (7-1-95)
- 156. Contraception.** The provision of drugs or devices to prevent pregnancy. (1-16-80)
- 167. Department.** The state of Idaho Department of Health and Welfare (DHW). (11-10-81)
- 178. Director.** The Director of the Idaho Department of Health and Welfare. (11-10-81)
- 189. Durable Medical Equipment (DME).** Equipment other than prosthetics or orthotics which 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 MA ~~recipient~~ participant. ~~(1-1-86)~~(7-1-00)T
- 192. Educational Services.** Services which are provided in buildings, rooms or areas designated or used as a school or as educational facilities; which are provided during the specific hours and time periods in which the educational instruction takes place in the normal school day and period of time for these students; and which are included in the individual educational plan for the ~~recipient~~ participant or required by federal and state educational statutes or regulations; are not "related services" as listed in Sections 119 and 120 of these rules; and such services are provided to school age individuals as defined in Section 33-201, Idaho Code. ~~(7-1-99)~~(7-1-00)T
- 201. Eligibility Manuals.** IDAPA 16.03.01, "Rules Governing Eligibility for Medicaid for Families and Children," and IDAPA 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind and Disabled". ~~(7-1-97)~~(7-1-00)T
- 212. Emergency.** Any situation arising in the medical condition of a patient, which, after applying the prevailing medical standards of judgement and practice within the community requires immediate medical intervention. All obstetrical deliveries are considered emergencies. (10-29-92)
- 223. Endangerment Of Life.** A condition where, in the opinion of two (2) licensed physicians, a pregnant woman may die or suffer severe and long lasting physical health damage if the fetus is carried to term. (1-16-80)
- 234. Health Authority.** An authorized official of any of the seven (7) Idaho District Health Departments or their satellite centers. (1-16-80)

245. Home Health Services. Services ordered by a physician and performed by a licensed nurse, registered physical therapist, or home health aide as defined in IDAPA 16.03.07, Subsection 002.11, "Rules for ~~Proprietary~~ Home Health Agencies". ~~(7-1-97)~~(7-1-00)T

256. 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. (11-10-81)

267. In-State Care. Medical services provided within the Idaho border or in counties bordering Idaho are considered to be in-state, excluding long term care. (2-5-93)

278. Inspection Of Care Team (IOCT). An interdisciplinary team which provides inspection of care in intermediate care facilities for the mentally retarded approved by the Department as providers of care for eligible medical assistance ~~recipients~~ participants. Such a team is composed of: ~~(7-1-94)~~(7-1-00)T

- a. At least one (1) registered nurse; and (7-1-94)
- b. One (1) qualified mental retardation professional; and when required, one (1) of the following: (7-1-94)
 - i. A consultant physician; or (7-1-94)
 - ii. A consultant social worker; or (7-1-94)
 - iii. When appropriate, other health and human services personnel responsible to the Department as employees or consultants. (7-1-94)

29. Instrumental Activities Of Daily Living (IADL). Those activities performed in supporting the activities of daily living, including, but not limited, to managing money, preparing meals, shopping, light housekeeping, using the telephone, or getting around in the community. (7-1-00)T

- 2830. Interested Physician.** (11-10-81)
- a. A physician who performs a Medicaid funded abortion for a fee; or (11-10-81)
 - b. A physician who is related by blood or marriage to another physician performing a Medicaid funded abortion. (11-10-81)

2931. Intermediate Care Facility Services. Those services furnished in an intermediate care facility as defined in 42 CFR 440.150, but excluding services provided in a Christian Science Sanatorium. ~~(11-10-81)~~(7-1-00)T

302. Law Enforcement Authority. An agency recognized by the state of Idaho in enforcement of established state and federal statutes. (11-10-81)

33. 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. (7-1-00)T

34. 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. (11-10-81)

325. Licensed Psychologist. An individual who is licensed to practice psychology under Chapter 23, Title 54, Idaho Code. (10-6-88)

336. Licensed, Qualified Professionals. Individuals licensed, registered, or certified by national

certification standards in their respective discipline, or otherwise qualified within the state of Idaho. (11-10-81)

347. Lock-In Program. An administrative sanction, required of ~~recipients~~ participant found to have misused the services provided by the Medical Assistance Program, requiring the ~~recipient~~ participant to select one (1) provider in the identified area(s) of misuse to serve as the primary provider. ~~(11-10-81)~~(7-1-00)T

358. Medical Care Treatment Plan. The problem list, clinical diagnosis, and treatment plan of care administered by or under the direct supervision of a physician. (11-10-81)

362. Medical Necessity. A service is medically necessary if: (7-1-98)

a. It is reasonably calculated to prevent, diagnose, or treat conditions in the client that endanger life, cause pain, or cause functionally significant deformity or malfunction; and (7-1-98)

b. There is no other equally effective course of treatment available or suitable for the client requesting the service which is more conservative or substantially less costly. (7-1-98)

c. Medical services shall be of a quality that meets professionally recognized standards of health care and shall be substantiated by records including evidence of such medical necessity and quality. Those records shall be made available to the Department upon request. (7-1-98)

374. Medical Supplies. Items excluding drugs and biologicals and equipment furnished incident to a physician's professional services commonly furnished in a physician's office or items ordered by a physician for the treatment of a specific medical condition. These items are generally not useful to an individual in the absence of an illness and are consumable, nonreusable, disposable, and generally have no salvage value. Surgical dressings, ace bandages, splints and casts, and other devices used for reduction of fractures or dislocations are considered supplies. (11-1-86)

384. Morbid Obesity. The condition of a person who exceeds ideal weight by more than one hundred (100) pounds and who has significant medical complications directly related to weight gain. (7-1-97)

394. Non-Legend Drug. Any drug the distribution of which is not subject to the ordering, dispensing, or administering by a licensed medical practitioner. (11-10-81)

403. Nurse Midwife. A registered nurse (RN) who is currently licensed to practice in Idaho, who meets applicable standards as found in the Idaho Nurse Practice Act, Rules and Minimum Standards promulgated by the Idaho State Board of Nursing, and who meets one of the following provisions: (11-10-81)

a. Is currently certified as a Nurse Midwife by the American College of Nurse Midwives; or (11-10-81)

b. Has satisfactorily completed a formal educational program of at least one (1) academic year that: (11-10-81)

i. Prepares a RN to furnish gynecological and obstetrical care to women during pregnancy, delivery and postpartum, and care to normal newborns; (11-10-81)

ii. Upon completion, qualifies a RN to take the certification examination offered by the American College of Nurse Midwives; (11-10-81)

iii. Includes at least four (4) months, in the aggregate, of classroom instruction and a component of supervised clinical practice; and (11-10-81)

iv. Awards a degree, diploma, or certificate to persons who successfully complete the program. (11-10-81)

414. Nurse Practitioner. A registered nurse (RN) who is currently licensed to practice in this State, who

meets applicable standards as found in the Idaho Nurse Practice Act, Rules and Minimum Standards promulgated by the Idaho State Board of Nursing, and who meets one (1) of the following provisions: (11-10-81)

a. Is currently certified as a Primary Care Nurse Practitioner by the American Nurses Association or by the National Board of Pediatric Nurse Practitioners and Associates, or by the Nurses Association of the American College of Obstetricians and Gynecologists; or (11-10-81)

b. Has satisfactorily completed a formal one (1) year academic year educational program that: (11-10-81)

i. Prepares a RN to perform an expanded role in the delivery of primary care; (11-10-81)

ii. Includes at least four (4) months, in the aggregate, of classroom instruction and a component of supervised clinical practice; and (11-10-81)

iii. Awards a degree, diploma, or certificate to persons who successfully complete the program. (11-10-81)

425. Nursing Facility (NF). An institution, or distinct part of an institution, which is primarily engaged in providing skilled nursing care and related services for residents. The residents must require medical or nursing care, or rehabilitation services for injuries, disabilities, or sickness. An institution must provide, on a regular basis, health-related care and services to individuals; who because of their mental or physical condition require care and services above the level of room, board, and supervision; which are made available to them only through institutional facilities, not primarily for care and treatment of mental diseases. The institution is licensed in the state of Idaho pursuant to Section 39-1301, Idaho Code and is certified as a nursing facility pursuant to 42 CFR 405.1120 through 405.1136. (7-1-94)

436. Orthotic. Pertaining to or promoting the straightening of a deformed or distorted part. (10-1-91)

447. Orthotic And Prosthetic Professional. An individual certified or registered by the American Board for Certification in Orthotics and/or Prosthetics. (10-1-91)

48. Other Public Education Agency. Charter schools and the Idaho Infant Toddler Program. (7-1-00)T

459. Otologist. A licensed physician who specializes in the diagnosis and treatment of hearing disorders and diseases of the ear. (11-10-81)

4650. Out-Patient 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 hospital bed accommodation. (11-10-81)

4751. 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. (7-1-97)

4852. Oxygen-Related Equipment. Equipment which is utilized or acquired for the routine administration of oxygen in the home. This includes oxygen tanks, regulators, humidification nebulizers, oxygen concentrators, and related equipment. Equipment which is used solely for the administration of medication into the lungs is excluded from this definition. (11-1-86)

53. Participant. An individual who is receiving Medical Assistance. (7-1-00)T

4954. Patient. The person undergoing treatment or receiving services from a provider. (11-10-81)

55. Personal Assistance Agency. An entity that recruits, hires, fires, trains, supervises, schedules, oversees quality of work, takes responsibility for services provided, provides payroll and benefits for personal

assistants working for them, is the employer of record and in fact, and may provide fiscal intermediary services. (7-1-00)T

56. Personal Assistance Services (PAS). Services that include attendant care and personal care services. (7-1-00)T

507. Physician. A person possessing a Doctorate of Medicine degree or a Doctor of Osteopathy degree and licensed to practice medicine by a state or United States territory. (10-1-91)

548. Physician's Assistant. A person who is licensed by the Idaho Board of Medicine and who meets at least one (1) of the following provisions: (7-1-97)

a. Is currently certified by the National Commission on Certification of Physician Assistants to assist primary care physicians; or (11-10-81)

b. Has satisfactorily completed a program for preparing physician's assistants that: (11-10-81)

i. Was at least one (1) academic year in length; and (11-10-81)

ii. Consisted of supervised clinical practice and at least four (4) months, in the aggregate, of classroom instruction directed toward preparing students to deliver health care; and (11-10-81)

iii. Was accredited by the American Medical Association's Committee on Allied Health Education and Accreditation. (11-10-81)

529. Plan Of Care. A written description of medical, remedial and/or rehabilitative services to be provided to a ~~recipient~~ 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. ~~(10-6-88)~~(7-1-00)T

5360. Premium Or Subscription Charge. The per capita amount paid by the Department for each eligible MA ~~recipient~~ participant enrolled under a contract for the provisions of medical and rehabilitative care and services whether or not such a ~~recipient~~ participant receives care and services during the contract period. ~~(11-10-81)~~(7-1-00)T

5461. Property. The homestead and all personal and real property in which the ~~recipient~~ participant has a legal interest. ~~(11-10-81)~~(7-1-00)T

5562. Prosthetic Device. Replacement, corrective, or supportive devices prescribed by a physician or other licensed practitioner of the healing arts profession within the scope of his practice as defined by state law to: (10-1-91)

a. Artificially replace a missing portion of the body; or (10-1-91)

b. Prevent or correct physical deformities or malfunctions; or (10-1-91)

c. Support a weak or deformed portion of the body. (10-1-91)

d. Computerized communication devices are not covered under the definition of a prosthetic device. (7-1-99)

563. Provider. Any individual, organization or business entity furnishing medical goods or services in compliance with this chapter and who has applied for and received a provider number, pursuant to Section 020, and who has entered into a written provider agreement, pursuant to Section 040. (7-1-97)

5764. Provider Agreement. An agreement between the provider and the Department, entered into pursuant to Section 040. (12-31-91)

- ~~5865.~~ **Provider Reimbursement Manual.** IDAPA 16.03.10, “Rules Governing Provider Reimbursement in Idaho”. (7-1-97)
- ~~5966.~~ **Psychology Assistant.** An individual who practices psychology under the supervision of a licensed psychologist when required under Chapter 23, Title 54, Idaho Code, and Section H of the “Rules of the Idaho State Board of Psychologist Examiners”. (7-1-94)
- ~~60.~~ **Recipient.** *An individual who is receiving Medical Assistance.* (~~11-10-81~~)
- ~~647.~~ **Recreational Therapy (Services).** Those activities or services that are generally perceived as recreation such as, but not limited to, fishing, hunting, camping, attendance or participation in sporting events or practices, attendance at concerts, fairs or rodeos, skiing, sightseeing, boating, bowling, swimming, training for Special Olympics, and special day parties (birthday, Christmas, etc.). (10-6-88)
- ~~628.~~ **Regional Nurse Reviewer (RNR).** A registered nurse who reviews and makes determinations on applications for entitlement to and continued participation in Title XIX long term care for the Department. (7-1-94)
- ~~639.~~ **Social Security Act.** 42 USC 101 et seq., authorizing, in part, federal grants to the states for medical assistance to low-income persons meeting certain criteria. (11-10-81)
- ~~6470.~~ **Specialized Family Home.** Living situation where a maximum of two (2) waiver ~~recipients~~ participants who do not require a skilled nursing service live with a provider family of residential habilitation services. (~~7-1-95~~)(7-1-00)T
- ~~6571.~~ **Speech/Language Pathology And Audiology Services.** Diagnostic, screening, preventative, or corrective services provided by a speech pathologist or audiologist, for which a patient is referred by a physician or other practitioner of the healing arts within the scope of his or her practice under state law. Speech, hearing and language services do not include equipment needed by the patient such as communication devices or environmental controls. (7-1-99)
- ~~6672.~~ **Subluxation.** A partial or incomplete dislocation of the spine. (11-10-81)
- ~~673.~~ **Supervision.** Procedural guidance by a qualified person and initial direction and periodic inspection of the actual act, at the site of service delivery. (6-21-90)
- ~~6874.~~ **Title XVIII.** That program established by the 1965 Social Security Act authorizing funding for the Medicare Program for the aged, blind, and disabled. The term is interchangeable with “Medicare”. (11-10-81)
- ~~6975.~~ **Title XIX.** That program established by the 1965 Social Security Act authorizing the Medical Assistance Program, commonly referred to as “Medicaid”, which is jointly financed by the federal and state governments and administered by the states. The term is interchangeable with “Medicaid”. (11-10-81)
- ~~706.~~ **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 ~~recipient~~ participant of medical assistance. (~~11-10-81~~)(7-1-00)T
- ~~747.~~ **Transportation.** The physical movement of a ~~recipient~~ participant to and from a medical appointment or service by the ~~recipient~~ participant, another person, taxi or common carrier. (10-6-88)
- ~~728.~~ **Utilization Control (UC).** A program of prepayment screening and annual review by at least one (1) Regional Nurse Reviewer to determine the appropriateness of medical entitlement and the need for continued medical entitlement of applicants/~~recipients~~participants to Title XIX benefits in a NF. (~~7-1-94~~)(7-1-00)T
- ~~739.~~ **Utilization Control Team (UCT).** A team of Regional Nurse Reviewers which conducts on-site reviews of the care and services in the NFs approved by the Department as providers of care for eligible medical assistance ~~recipients~~ participants. (~~7-1-94~~)(7-1-00)T

~~7480.~~ **Vocational Services.** Services or programs which are directly related to the preparation of individuals for paid or unpaid employment. The test of the vocational nature of the service is whether the services are provided with the expectation that the ~~recipient~~ participant would be able to participate in a sheltered workshop or in the general work force within one (1) year. ~~(10-6-88)~~(7-1-00)T

(BREAK IN CONTINUITY OF SECTIONS)

146. PERSONAL CARE SERVICES.

Pursuant to Sections 39-5601 through 39-5607, Idaho Code, it is the intention of the Department to provide personal care services to eligible ~~recipients~~ participants in their personal residence in order to prevent unnecessary institutional placement, to provide for the greatest degree of independence possible, to enhance the quality of life, to encourage individual choice, and to maintain community integration. For a ~~recipient~~ participant to be eligible for personal care services, the Department must find that the ~~recipient~~ participant requires personal care services due to a medical condition which impairs their physical or mental function or independence and must find the ~~recipient~~ participant capable of being maintained safely and effectively in their own home or residence with personal care services. ~~(1-1-91)~~(7-1-00)T

01. Care And Services Provided. (1-1-91)

a. Medically oriented tasks having to do with a patient's physical or functional requirements, as opposed to housekeeping or skilled nursing care, provided in the patient's home. Such services may include, but are not limited to: (1-1-91)

i. Basic personal care and grooming to include bathing, care of the hair, assistance with clothing, and basic skin care, but excluding the irrigation or suctioning of any body cavities which require sterile procedures and the application of dressings, involving prescription, medication, and aseptic techniques; and (1-1-91)

ii. Assistance with bladder or bowel requirements which may include helping the patient to and from the bathroom or assisting the patient with bedpan routines, but excluding insertion or sterile irrigation of catheters; and (5-1-87)

iii. Assisting the patient with medications which are ordinarily self-administered, when ordered by a physician, but excluding the giving of injections or fluids into the veins, muscles, or skin, or administering of medicine; and (7-15-83)

iv. Assistance with food, nutrition, and diet activities to include the preparation of meals if incidental to medical need, as determined by a physician; and (7-15-83)

v. The continuation of active treatment training programs in the home setting to increase or maintain client independence for the developmentally disabled client. (5-1-87)

vi. Non-nasogastric gastrostomy tube feedings may be performed if authorized prior to implementation by the Department's Regional Medicaid Unit and if the following requirements are met: (2-19-92)

(1) The task is non-complex and can be safely performed in the given patient care situation; and (2-19-92)

(2) A registered nurse has assessed the patient's nursing care needs and has developed a written standardized procedure for gastrostomy tube feedings, which is individualized for the patient's characteristics and needs; and (2-19-92)

(3) Persons to whom the procedure can be delegated are identified by name. The registered nurse must provide proper instruction in the performance of the procedure, supervise a return demonstration of safe performance

of the procedure, state in writing strengths and weaknesses of the person performing the procedure, and evaluate the performance of the procedure at least monthly; and (2-19-92)

(4) Any change in the patient's status or problem relative to the procedure must be reported immediately to the registered nurse; and (2-19-92)

(5) The individualized procedure, the supervised performance of the procedure, and follow-up evaluation of the performance of the procedure must be documented in writing by the supervising RN, and must be readily available for review, preferably with the patient's record. (2-19-92)

(6) Medication previously received could be given by the personal care provider through the non-nasogastric tube unless contraindicated. (2-19-92)

vii. In addition to performing at least one (1) of the services listed in Subsections 146.01.a.i. through 146.01.a.vi., the provider may also perform the following services: (2-19-92)

(1) Such incidental housekeeping services essential to a patient's comfort and health, to include the changing of bed linens, rearranging furniture to enable the patient to move about more easily, laundry and room cleaning when incidental to the patient's treatment. Excluded are cleaning and laundry for any other occupant of the patient's residence; and (2-19-92)

(2) Accompanying the patient to clinics, physician office visits, or other trips which are reasonable for the purpose of obtaining medical diagnosis or treatment; and (7-15-83)

(3) Shopping for groceries or other household items required specifically for the health and maintenance of the patient. (2-19-92)

b. Service Limitations. The maximum amount of personal care services available to an eligible recipient participant is ~~dependent on whether services are obtained under the Home and Community-based Services waiver (HCBS waiver) or under the State Medicaid Plan Service option.~~ as follows: ~~(1-1-91)(7-1-00)T~~

i. For adults receiving services under the State Medicaid Plan option, service delivery is limited to a maximum of sixteen (16) hours per week per recipient participant. ~~(10-1-94)(7-1-00)T~~

ii. For individuals under the age of ~~twenty-one~~ eighteen (218) who meet medical necessity criteria under EPSDT, the eligible recipient participant may receive up to twenty-four (24) hours per day of service delivery under the State Plan option. ~~(10-1-94)(7-1-00)T~~

~~iii. For individuals receiving services under the HCBS waiver, the eligible recipient may receive up to twenty-four (24) hours per day of service delivery, based on the medical need for such service as documented in the plan of care and the cost effectiveness criteria under the waiver program. (1-30-94)~~

02. Place Of Service Delivery. Personal Care Services (PCS) may be provided only in a recipient's participant's personal residence. The following living situations are specifically excluded as a personal residence for the purpose of these rules: ~~(1-1-91)(7-1-00)T~~

a. Certified nursing facilities (NF) or hospitals; and (1-1-91)

b. Licensed Intermediate Care Facility for the Mentally Retarded; and (7-15-83)

c. Intensive Treatment Facility For Children as described in IDAPA 16.06.01, "Rules Governing Family and Children's Services," Section 620. (4-5-00)

d. A home receiving payment for specialized foster care, professional foster care, or group foster care. (4-5-00)

03. Services Delivered Following A Written Plan. (7-15-83)

a. All PCS are provided based on a written plan of care which is the responsibility of the ~~supervisory nurse~~ Personal Assistance Agency and the participant to prepare and is based on: ~~(7-15-83)(7-1-00)T~~

i. The physician's or authorized provider's information including the ~~physician's~~ orders; and ~~(7-15-83)(7-1-00)T~~

ii. The nurse's or QMRP's assessment and observations of the patient; and ~~(7-15-83)(7-1-00)T~~

iii. Information elicited from the ~~recipient~~ participant. ~~(7-15-83)(7-1-00)T~~

b. The plan of care must include all aspects of personal care necessary to be performed by the PCS provider, including the amount, type, and frequency of such services. ~~(7-15-83)~~

c. The plan of care will be signed and approved by the physician or authorized provider, prior to the initiation of the services by the PCS provider. ~~(7-15-83)(7-1-00)T~~

d. The plan must be revised and updated based upon treatment results or a patient's changing profile of needs as necessary, but at least annually. ~~(7-15-83)~~

04. Physician/Authorized Provider Supervision Of The Service. All Personal Care Services are provided under the order of a licensed physician or authorized provider. The physician or authorized provider must: ~~(1-1-91)(7-1-00)T~~

a. ~~Provide such medical information to the Department's Regional Medicaid Unit (RMU) as is necessary to establish that the recipient is medically eligible for NF placement for those recipients receiving PCS under the Department's Home and Community Based Services waivers. For recipients eligible for PCS under the Idaho State Plan, the physician will eCertify, in writing, that the services are medically necessary. (4-5-00)(7-1-00)T~~

b. Order all services delivered by the PCS provider. Such orders are signed and dated by the physician or authorized provider and include, at a minimum, his signature and date of approval on the ~~recipient's~~ participant's plan of care. ~~(7-15-83)(7-1-00)T~~

c. Update the plan of care, including his signature and date of approval, as necessary, but at least annually. ~~(1-1-91)~~

d. Recommend institutional placement of the ~~recipient~~ participant if he identifies that PCS, in combination with other community resources, are no longer sufficient to ensure the health or safety of the ~~recipient~~ participant. ~~(1-1-91)(7-1-00)T~~

05. Service Supervision. ~~(1-1-91)~~

a. A registered nurse or a QMRP who is not functioning as the personal care provider ~~will~~ may oversee the delivery of PCS. The need for such oversight will be identified by the RMU, and when received will include: ~~(1-1-91)(7-1-00)T~~

i. In conjunction with the PAA and attending physician or authorized provider or the RMU or its contractor the development of a plan of care for the ~~recipient~~ participant; and ~~(1-1-91)(7-1-00)T~~

ii. Review of the treatment given by the personal care provider through a review of the ~~recipient's~~ participant's PCS record as maintained by the provider and on-site interviews with the patient at least every ninety (90) days; and ~~(1-1-91)(7-1-00)T~~

iii. Reevaluation of the plan of care as necessary and obtaining physician or authorized provider approval on all changes. The entire plan is reviewed at least annually; and ~~(1-1-91)(7-1-00)T~~

iv. ~~Immediately~~ notification of the physician or authorized provider of any significant changes in the

~~recipient's~~ participant's physical condition or response to the service delivery; and ~~(1-1-91)~~(7-1-00)T

v. Provides an on-site visit to the ~~recipient~~ participant to evaluate changes of condition when requested by the PCS provider, QMRP supervisor, ~~provider agency~~ PAA, case manager, or ~~recipient~~ participant. ~~(1-1-91)~~(7-1-00)T

b. In addition to, or instead of the supervisory visit by the registered nurse, all clients who are developmentally disabled, other than those with only a physical disability, as determined by the Regional Medicaid Unit ~~will~~ may receive oversight of service delivery by a Qualified Mental Retardation Professional (QMRP) as defined in 42 CFR 483.430. Such oversight will include: ~~(8-5-91)~~(7-1-00)T

i. In conjunction with the attending physician ~~and supervisory RN~~ or authorized provider, the QMRP ~~will~~ may assist in the development of the plan of care for the ~~recipient~~ participant for those aspects of active treatment which are provided in the home by the PCS attendant. ~~(1-1-91)~~(7-1-00)T

ii. Review of the care and/or training given by the personal care provider through a review of the ~~recipient's~~ participant's PCS record as maintained by the provider, and on-site interviews with the client at least every ninety (90) days. ~~(1-1-91)~~(7-1-00)T

iii. Reevaluation of the plan of care as necessary, but at least annually. (1-1-91)

iv. An on-site visit to the ~~recipient~~ participant to evaluate any change of condition when requested by the PCS provider, ~~provider agency~~ PAA, nurse supervisor, case manager, or ~~recipient~~ participant. ~~(1-1-91)~~(7-1-00)T

06. PCS Provider Qualifications. (1-1-91)

a. Persons providing PCS: Individuals may provide PCS either as ~~PCS~~ personal assistance agency employees, or employees of record of a personal assistance agency functioning as a fiscal intermediary (FI), ~~or as independent providers~~ if they have at least one (1) of the following qualifications: ~~(4-5-00)~~(7-1-00)T

i. Registered Nurse, RN: A person currently licensed by the Idaho State Board of Nursing as a registered nurse; or (7-15-83)

ii. Licensed Practical Nurse, L.P.N.: A person currently licensed by the Idaho State Board of Nursing as a licensed practical nurse; or (7-15-83)

iii. Nursing Assistant: All nursing assistants who provide PCS to eligible individuals must appear on the Idaho State Board of Nursing's registry of certified ~~nurse aides~~ (CNA) or other training program approved by the Department. An individual who has completed a certified nurse aide training program may be granted provisional provider status for up to ninety (90) days by the Department to allow for the completion of competency testing and registry. ~~(1-30-94)~~(7-1-00)T

iv. Specially Qualified Assistant. A person who has documented training to meet the needs of a specific individual by a personal assistance agency, the participant, or the participant's family. Such training must be provided before services are delivered or reimbursed by Medicaid. (7-1-00)T

b. All persons who care for participants with a developmentally disabled ~~ability~~ clients other than those with only physical disabilities as identified by the Department's RMU will, in addition to the completion of the requirements of Subsection 146.06.a.iii., have completed one (1) of the Department approved developmental disabilities training courses, or have experience in working directly providing services to people with developmental disabilities. Providers who are qualified as QMRPs will be exempted from the Department approved developmental disabilities training course. Each region may grant temporary approval to an individual who meets all qualifications except for the required developmental disabilities training course or experience to become a PCS provider to a participant with developmentally disabled ~~ability~~ recipient if all of the following conditions are met: ~~(7-1-94)~~(7-1-00)T

i. The RMU has verified that there are no qualified providers reasonably available to provide services to client requesting services; and (7-1-94)

- ii. The provider must be 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 status; and (7-1-94)
- iii. The supervising QMRP makes monthly visits until the provider graduates from the training program. (7-1-94)
- c. Personal Assistance Agency providers must submit to the Department documentation of their worker's compensation and professional liability insurance coverage. In the case of worker's compensation, agencies will direct their sureties to provide a certificate of insurance to the Department. ~~Independent providers must submit to the Department documentation of their professional liability insurance coverage.~~ Termination of either type of insurance by the provider will be cause for termination of PCS Provider status by the Department. Personal Assistance Agency providers ~~and FIs~~ will keep copies of employee health screens in their files for review by the Department as necessary. ~~Independent providers will submit the completed health screen to the Department. Agency and independent providers' employees of fact or record will complete~~ subject themselves to a criminal history check conducted by the Department. If no criminal history is indicated on the Self-Declaration form, individuals may be authorized by the Region to provide services on a provisional basis while awaiting the results of the fingerprinting process. Such authorization may be provided after the client's safety is assured by the responsible Region. (4-5-00)(7-1-00)T
- d. Individuals providing supervision to PCS attendants. (1-1-91)
- i. RN supervisors will have a current Idaho professional nursing license (RN). (1-1-91)
- ii. Qualified Mental Retardation Professional (QMRP) supervisors will be qualified by education and training as required in 42 CFR 483.430. (1-1-91)
- ~~iii. Supervising RNs and QMRPs who are independent providers will be independent contractors and obtain any desired benefits such as life, disability and/or unemployment insurance that he may desire, maintain professional liability insurance, and report all income to the appropriate authorities, pay social security and all other state and federal taxes. (1-1-91)~~
- e. Provider agency. ~~An entity~~ personal assistance agency which has a signed provider agreement with the Department and is capable of and responsible for all of the following: (1-1-91)(7-1-00)T
- i. Recruitment, hiring, firing, training, supervision, scheduling and payroll for personal care attendants and the assurance of quality service provided by the personal care attendants; and (1-1-91)
- ii. Participation in the provision of worker's compensation, unemployment compensation and all other state and federal tax withholdings; and (8-5-91)
- iii. Maintenance of liability insurance coverage; and (1-1-91)
- iv. Provision of a licensed professional nurse (RN) ~~and or~~, where applicable, a QMRP supervisor to develop and complete plans of care and provide ongoing supervision of a ~~recipient's~~ participant's care; and (1-1-91)(7-1-00)T
- v. Assignment of a qualified personal care attendant(s) to eligible ~~recipients~~ participants after consultation with and approval of such ~~recipients~~ participants; and (1-1-91)(7-1-00)T
- vi. Assure that all PCS attendants meet the qualifications in Subsection 146.06.a.; and (12-31-91)
- vii. Billing Medicaid for services approved and authorized by the RMU; and (1-1-91)
- viii. Make referrals for PCS eligible ~~recipients~~ participants for case management services when a need for such services is identified; and (1-1-91)(7-1-00)T

- ix. Conduct such criminal background checks and health screens on new and existing employees as required in Subsection 146.10 and 146.11. (12-31-91)
- ~~will:-~~ ~~f. Independent providers. Persons who meet the training requirements in Subsection 146.06.a. and (12-31-91)~~
- ~~i. Obtain the required training, certifications, agreements, knowledge and information needed to function as an independent provider; and (1-1-91)~~
- ~~ii. Obtain any desired benefits such as life, disability and/or unemployment insurance that he may desire; and (1-1-91)~~
- ~~iii. Maintain professional liability insurance effective April 15, 1991, for certified nurse's aides, and upon completion of the certified nurse's aide course for all other providers; and (7-1-94)~~
- ~~iv. Report all income to the appropriate authorities, pay social security and all other state and federal taxes as an independent contractor; and (1-1-91)~~
- ~~v. Submit claims to the Medicaid Program for approved services; and (1-1-91)~~
- ~~vi. Provide for care by a fully trained and qualified replacement when unable to provide service; and (1-1-91)~~
- ~~vii. Provide unanticipated services that are not part of the plan of care in emergency situations; and (1-1-91)~~
- ~~viii. Participate in the background check and obtain the health screen required in Subsections 146.10 and 146.11; and (12-31-91)~~
- g.f. Fiscal intermediaries services. Independent living services provided by ~~A~~an entity which has a signed Personal Assistance provider agency agreement with the Department and meets the requirements of Subsection 669.03. (4-5-00)(7-1-00)T
- hg. When care is provided in the provider's home, acquire the appropriate level of child foster or day care licensure or certification. The provider must be licensed as defined in Section 39-1213, Idaho Code, for care of individuals under eighteen (18) years of age. Noncompliance with the above standards will be cause for termination of the provider's provider agreement. (4-5-00)(7-1-00)T
- ~~i. Utilization of independent providers. Independent providers will be utilized in the following circumstances:- (8-5-91)~~
- ~~i. When a provider agency is unavailable; or (8-5-91)~~
- ~~ii. When, based on an assessment involving the recipient, the recipient's family and the Department's regional Medicaid staff, it is determined that an independent provider will best meet the needs of the recipient. The assessment shall include consideration of the recipient's and/or family member's ability to select a provider and manage and evaluate the care he receives. (8-5-91)~~
- ~~iii. Recipients receiving PCS from an independent provider should be evaluated for the need for targeted case management from a provider agency or administrative case management from the Department. (1-1-91)~~
- ~~iv. The independent provider will not be considered an employee of the state, recipient, or RN supervisor, but will be considered an independent contractor. (1-1-91)~~
- fh. A PCS provider attendant cannot be a relative of any recipient participant to whom the provider is supplying services. (5-1-87)(7-1-00)T

- i. For the purposes of this subsection, a relative is defined as a spouse or a parent of a minor child. (1-1-91)
- ii. Nothing in this subsection shall be construed to prohibit a relative from providing PCS where Medicaid is not the payment source for such services. (1-1-91)

07. Recipient Participant Eligibility Determination. An eligible ~~recipient~~ participant may qualify for PCS coverage either under the Idaho State Medicaid Plan, ~~or the Department's Home and Community Based Services waiver. For both programs,~~ the recipient participant must be financially eligible for MA as described in Idaho Department of Health and Welfare Rules, IDAPA 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind and Disabled (AABD)". The cited chapter implements and is in accordance with the Financial Eligibility Section of the Idaho State Plan. In addition, ~~waiver recipients must meet the following requirements:~~ (12-31-91)(7-1-00)T

- a. ~~The Department's Regional Medicaid Unit must determine that:~~ (1-1-91)
 - i. ~~The recipient would qualify for nursing facility level of care as set forth in Subsections 180.03 and 180.08 if PCS were not made available; and~~ (7-1-95)
 - ii. ~~In the assessment of the RMU, the patient could be maintained in their own home or residence and receive safe and effective services through the Personal Care Service Program; and~~ (1-1-91)
 - iii. ~~In the assessment of the RMU, the average monthly Medicaid cost of providing Personal Care Services and other community services to the patient would not exceed the average Medicaid cost of nursing facility care as described below:~~ (7-1-94)

(1) ~~The average monthly Medicaid cost of personal care and other medical services paid by Medicaid will be calculated utilizing the number of visits or hours or days of PCS and medical services prescribed by the attending physician for the patient.~~ (1-1-91)

(2) ~~The average monthly Medicaid patient cost of nursing facility care will be calculated by the Bureau of Medicaid Policy and Reimbursement utilizing projected Medicaid Program expenditures for institutional care, based on the average interim rate for that type of care.~~ (7-1-95)

(3) ~~If the amount identified in Subsection 146.07.a.iii.(1) is less than the amount identified in Subsection 146.07.a.iii.(2) then the individual is eligible for PCS.~~ (1-30-94)

(4) ~~If the amount identified in Subsection 146.07.a.iii.(1) is greater than or equal to the amount identified in Subsection 146.07.a.iii.(2) then the individual is not eligible for PCS.~~ (12-31-91)

(5) Eligible ~~recipients~~ participants receiving PCS under the Idaho State Plan must have a completed UAI, medical justification, physician's or authorized provider's orders, and plan of care for such services. All services will be authorized by the RMU prior to payment for the amount and duration of services based on this information. (1-1-91)(7-1-00)T

iv. ~~Following the approval by the RMU for services under the waiver, the recipient must receive and continue to receive a waiver service. For the purposes of these rules, a waiver service is defined as personal care services in excess of sixteen (16) hours per week. A recipient who does not use a waiver service for thirty (30) consecutive days will be terminated from the waiver program.~~ (1-1-91)

b. ~~A recipient who is determined by the Department to be eligible for the Personal Care Services Program under the Home and Community Based Services waiver may elect not to utilize PCS, but may choose admission to a nursing facility.~~ (7-1-94)

e. ~~The recipient's eligibility examiner will process the application in accordance with Idaho Department of Health and Welfare Rules, IDAPA 16.03.05, "Rules Governing Eligibility for the Aged, Blind and Disabled (AABD)," as if the application was for admission to a nursing facility, except that the eligibility examiner~~

~~will forward potentially eligible applications immediately to the RMU for review together with the physician's prescription for Personal Care Services. The Medicaid application process cited above conforms to all statutory and regulatory requirements relating to the Medicaid application process.~~ (12-31-91)

~~d. The decisions of the RMU regarding the acceptance of the recipients into the PCS program will be transmitted to the eligibility examiner. The eligibility examiner will notify the applicant of the Department's determination in accordance with Idaho Department of Health and Welfare Rules, IDAPA 16.03.05, "Rules Governing Eligibility for the Aged, Blind and Disabled (AABD)," except:~~ (10-1-94)

~~i. The referring physician will be notified, in addition to the applicant, of the determination; and~~ (7-15-83)

~~ii. If the application is approved, the RMU will provide a list of personal care providers to the client, or their representatives, to select the provider of their choice.~~ (1-30-94)

08. Case Redetermination. (12-31-91)

a. Financial redetermination will be conducted pursuant to Idaho Department of Health and Welfare Rules, IDAPA 16.03.01, "Rules Governing Eligibility for Medicaid for Families and Children," and IDAPA 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind and Disabled (AABD)". Medical redetermination will be made at least annually by the RMU, or sooner at the request of the patient, the eligibility examiner, ~~PCSAA provider agency, independent~~ personal care provider, the supervising registered nurse, ~~or QMRP~~, the physician, or authorized provider. The sections cited implement and are in accordance with Idaho's approved state plan with the exception of ~~(1-30-94)(7-1-00)T~~

b. The redetermination process will assess the following factors: (7-15-83)

i. The ~~recipient's~~ participant's continued need for ~~the~~ Personal Care Services ~~Program~~; and ~~(7-15-83)(7-1-00)T~~

ii. Discharge from ~~the~~ Personal Care Services ~~Program~~; and ~~(7-15-83)(7-1-00)T~~

iii. Referral of the patient from ~~the~~ Personal Care Services ~~Program~~ to a nursing facility ~~or licensed residential care facility~~. ~~(7-1-94)(7-1-00)T~~

09. Criminal History Check. All personal care providers (case managers, RN supervisors, QMRP supervisors and personal care attendants) shall participate in a criminal history check as required by Section 39-5604, Idaho Code. The criminal history check will be conducted in accordance with IDAPA 16, Title 05, Chapter 06, "Rules Governing Mandatory Criminal History Checks". (10-1-94)

10. Health Screen. The Department will require that a health questionnaire be completed by each ~~independent provider and provider~~ personal assistance agency employee who serves as a personal care attendant. ~~Provider Personal assistance agencies and fiscal intermediaries~~ will retain this in their personnel file. ~~Independent providers will complete the questionnaires as part of the application.~~ If the applicant indicates on the questionnaire that he has a medical problem, the individual will be required to submit a statement from a physician or authorized provider that his medical condition would not prevent him from performing all the duties required of a personal care provider. Misrepresentation of information submitted on the health screen is cause for termination ~~of provider status for independent PCS providers or termination~~ of employment for agency employees. ~~(4-5-00)(7-1-00)T~~

11. PCS Record. Three (3) types of record information will be maintained on all ~~recipients~~ participants receiving PCS and are considered to be the PCS record. ~~(1-1-91)(7-1-00)T~~

a. Personal Care Provider Information. Each provider will maintain a written documentation of each visit made to a patient, and will record at a minimum the following information: (1-1-91)

i. Date and time of visit; and (1-1-91)

- ii. Services provided during the visit; and (1-1-91)
- iii. A statement of the ~~recipient's~~ participant's response to the service, including any changes noted in the ~~recipient's~~ participant's condition; and ~~(1-1-91)~~(7-1-00)T
- iv. Length of visit and unless it is determined by the RMU that the ~~recipient~~ participant is unable to do so, the record of service delivery should be verified by the ~~recipient~~ participant as evidenced by their signature on the service record; and ~~(1-1-91)~~(7-1-00)T
- v. Any changes in the treatment plan authorized by the referring physician, authorized provider or supervising registered nurse or QMRP as the result of changes in the ~~recipient's~~ participant's condition. ~~(1-1-91)~~(7-1-00)T
- vi. A copy of the information contained in Subsections 146.13.a.i. through 146.13.a.v., will be maintained in the ~~recipient's~~ participant's home unless authorized to be kept elsewhere by the RMU. Failure to maintain such documentation may result in the recoupment of funds paid for undocumented services. ~~(1-1-91)~~(7-1-00)T
- b. Plan of Care. The plan of care which is initiated by the attending physician or authorized provider, developed by the supervising RN ~~and, when appropriate,~~ or QMRP, must specify diagnosis, general treatment and the Personal Care Services which are required by the ~~recipient~~ participant. The plan will contain all elements required by Subsection 146.03 and a copy of the most current plan of care will be maintained in the ~~recipient's~~ participant's home and will be available to the PCS Attendant, Supervising RN, QMRP and, if applicable, the case manager. ~~(12-31-91)~~(7-1-00)T
- c. Oversight Information. In addition to the plan of care, at least every ninety (90) days the Supervising RN ~~and, where required,~~ or the QMRP will verify, in writing, that the services provided were consistent with the treatment plan. Any changes in the treatment plan will be documented and include the signature of the Supervising RN or QMRP. ~~(10-1-94)~~(7-1-00)T
- 12. Provider Responsibility For Notification.** It is the responsibility of the PCSAA ~~provider~~ to notify either the ~~supervising RN or the~~ RMU and physician or authorized provider when any significant changes in the ~~recipient's~~ participant's condition are noted during service delivery. Such notification will be documented in the PCSAA record. ~~(7-15-83)~~(7-1-00)T
- 13. Records Maintenance.** In order to provide continuity of services, when a ~~patient~~ participant is transferred among ~~independent~~ providers, ~~or when the independent provider changes Supervising RNs,~~ all of the foregoing ~~patient's~~ participant's records will be delivered to and held by the field office of the Department until a replacement provider ~~or Supervising RN~~ assumes the case. ~~When a patient utilizing independent PCS providers leaves the Personal Care Services Program, the records will be retained by the Department as part of the patient's closed case record. Provider agencies~~ PAAs will be responsible to retain their clients' records for ~~three~~ five (5) years following the date of service. (10-1-94)(7-1-00)T
- 14. Provider Coverage Limitations.** (4-5-00)
- a. In congregate living situations, payment is limited to one (1) claim per provider act. In no case may more time be billed than was actually spent by the provider in service delivery. (4-5-00)
- b. No provider may serve more than two (2) ~~ICF/MR level clients~~ children who are authorized for eight (8) or more hours of care per day. ~~No provider may serve more than one (1) NF level client authorized for more than eight (8) hours of care per day, unless approved by the Department under Section 39-1301(a), Idaho Code.~~ ~~(4-5-00)~~(7-1-00)T
- 15. Community Awareness Program.** The Department will establish and maintain a community awareness program that will educate Idaho citizens regarding the purpose and function of all long-term care alternatives including, but not limited to, personal ~~care~~ assistance services and individual ~~recipient~~ participant rights. This program will be developed in cooperation with other state agencies including, but not limited to, the ~~Office~~

Commission On Aging and the ~~Division of Vocational Rehabilitation~~ State Independent Living Council.
~~(1-1-91)(7-1-00)T~~

(BREAK IN CONTINUITY OF SECTIONS)

148. PROVIDER REIMBURSEMENT FOR PERSONAL ~~CARE~~ ASSISTANCE SERVICES.

01. Reimbursement Rate. Personal ~~care~~ assistance providers will be paid a uniform reimbursement rate for service as established by the Department pursuant to Section 39-5606, Idaho Code, on an annual basis. Provider claims for payment will be submitted on claim forms provided or approved by the Department. Billing instructions will be provided by the Department.
~~(1-1-91)(7-1-00)T~~

02. Calculated Fee. The fee calculated for personal care provider reimbursement includes a basic rate for services and mileage. No separate charges for mileage will be paid by the Department for non-medical ~~client~~ transportation, unless approved by the RMU under a Home and Community-Based Services (HCBS) waiver, or provider transportation to and from the ~~recipient's~~ participant's home. Fees will be calculated as follows:
~~(1-1-91)(7-1-00)T~~

a. Annually Medicaid will conduct a poll of all Idaho nursing facilities and establish the weighted average hourly rates (WAHR) for nursing facility industry employees in comparable positions (i.e. RN, QMRP, certified and non-certified ~~Nurse's aides~~) in Idaho to be used for the reimbursement rate to be effective on July 1 of that year.
~~(4-5-00)(7-1-00)T~~

b. Medicaid will then establish ~~three (3)~~ payment levels for ~~both provider~~ personal assistance agencies and independent providers for ~~PCS attendant~~ personal assistance services as follows:
~~(4-5-00)(7-1-00)T~~

i. Weekly service needs of zero to sixteen (0-16) hours under the State Medicaid Plan, or a HCBS waiver recipients zero to eight (0-8) hours/day:

Provider Personal Assistance Agencies	WAHR x 1.55	=	\$ amount/hour
Independent Providers	WAHR x 1.22 (which is a supplemental component to cover training, social security and liability insurance)	=	\$ amount/hour

~~(1-30-94)(10-1-00)T~~

ii. Extended visit, one (1) ~~recipient~~ child (eight and one-quarter (8.25) hours up to twenty-four (24) hours):

Provider Agencies and Fiscal Intermediary Personal Assistance Agencies	(WAHR x actual hours of care up to 5 hours x 1.55) plus (\$.65 x 1.55 hours on site on-call)	=	\$ amount (Maximum \$59.51 63.65)
Independent Providers Licensed Child Foster Homes	(WAHR x actual hours of care up to 5 hours x 1.22) plus (\$.65 x 1.22 x actual hours on site on-call)	=	\$ amount (Maximum \$56.43 60.36)

~~(4-5-00)(7-1-00)T~~

iii. Extended visit, two (2) ~~recipients~~ children (eight and one-quarter (8.25) hours up to twenty-four

(24) hours):

<i>Provider Agencies and Fiscal Intermediary</i> <u>Personal Assistance Agencies</u>	(WAHR x actual hours of care up to 4 hours) x (1.55 plus \$.65 x 1.55 x hours on site on-call)	=	\$ amount (Maximum \$50.73 <u>54.26</u>)
<i>Independent Providers</i> <u>Licensed Child Foster Homes</u>	(WAHR x hours actual care up to 4 hours x 1.22) plus (\$.65 x 1.22 x hours on site on-call)	=	\$ amount (Maximum \$41.44 <u>44.33</u>)

~~(4-5-00)~~(7-1-00)T

c. The attending physician or authorized provider will be reimbursed for services provided using current payment levels and methodologies for other ~~physician~~ services provided to eligible ~~recipients~~ participants.
~~(1-1-91)~~(7-1-00)T

d. The supervisory RN and QMRP will be reimbursed at a per visit amount established by the Department for supervisory visits. Client evaluations and Care Plan Development will be reimbursed at a rate established by the Department, following authorization by the RMU. (1-1-91)

i. The number of supervisory visits by the RN ~~and~~ or QMRP to be conducted per calendar quarter will be approved as part of the PCS care plan by the RMU. ~~(1-1-91)~~(7-1-00)T

ii. Additional evaluations or emergency visits in excess of those contained in the approved care plan will be authorized when needed by the RMU. (1-1-91)

(BREAK IN CONTINUITY OF SECTIONS)

669. DEFINITIONS.

The following definitions apply to Sections 664 through 704 of the rules: (4-5-00)

~~**01.** Plan For Services (PFS). A written plan, initially developed by the RMU or its contractor for services provided under the Home and Community-Based Services Waiver. This plan must be approved by the RMU and Medicaid-reimbursable services must be contained in the plan.~~ (4-5-00)

021. Uniform Assessment Instrument (UAI). A set of standardized criteria adopted by the Department to assess functional and cognitive abilities. (4-5-00)

~~**032.** Personal Assistance Agency That Provides Fiscal Intermediary (FI) Services. An entity that acts as an intermediary between the Medicaid program and eligible waiver participants for the purposes of assisting consumers in performing tasks associated with the employment of waiver service providers. A personal assistance agency that focuses on fostering participant independence and personal control of services delivered. The core tasks of the FI are to:~~ (4-5-00)(7-1-00)T

a. To directly assure compliance with legal requirements related to employment of waiver service providers; ~~and~~ (4-5-00)(7-1-00)T

b. To offer supportive services to enable participants or families consumers to perform the required employer tasks themselves; ~~;~~ (4-5-00)(7-1-00)T

c. To bill the Medicaid program for services approved and authorized by the Department; (7-1-00)T

- d. To collect any participant participation due; (7-1-00)T
- e. To pay personal assistants and other waiver service providers for service; (7-1-00)T
- f. To perform all necessary withholding as required by state and federal labor and tax laws, rules and regulations; (7-1-00)T
- g. To offer a full range of services and perform all services contained in a written agreement between the participant and the provider; (7-1-00)T
- h. Make referrals for PCS eligible participant for case management services when a need for such services is identified; and (7-1-00)T
- i. Obtain such criminal background checks and health screens on new and existing employees of record and fact as required. (7-1-00)T

03. Fiscal Intermediary Services. Services that allow the participant receiving personal assistance services, or his designee or legal representative, to choose the level of control he will assume in recruiting, selecting, managing and dismissing his personal assistant regardless of who the employer of record is, and allows the participant control over the manner in which services are delivered. (7-1-00)T

04. Individual Service (IS) Plan. A document which outlines all services including, but not limited to, personal assistance services and IADLs, required to maintain the individual in his home and community. The plan is initially developed by the RMU or its contractor for services provided under the Home and Community-Based Services Waiver. This plan must be approved by the RMU and all Medicaid reimbursable services must be contained in the plan. (7-1-00)T

045. Provider Personal Assistance Agency Or Agency. An entity that recruits, hires, fires, trains, supervises, schedules, oversees quality of work, takes responsibility for the care given, and provides payroll, including all required withholding for federal and state tax purposes, and benefits for care providers working for them. They also bill Medicaid for services provided by employees, and collect participant contribution. ~~(4-5-00)~~(7-1-00)T

056. Employer Of Record. An entity which bills for services, withholds required taxes, and conducts other administrative activities for a waiver program participant. Such an entity is also called a personal assistance agency functioning as a fiscal intermediary. ~~(4-5-00)~~(7-1-00)T

067. Employer Of Fact. A participant or representative of a participant who hires, fires, and directs the services delivered by a waiver program provider. This individual may be a family member. (4-5-00)

078. Participant. An aged or disabled individual who requires and receives services under the Home and Community-based Waiver program (4-5-00)

670. SERVICES PROVIDED.

- 01. Services Provided Under Waiver.** Services that may be provided under the waiver are: (4-5-00)
 - a. Adult day ~~health~~ care; ~~(4-5-00)~~(7-1-00)T
 - b. Assistive technology; (4-5-00)
 - c. Assisted transportation; (4-5-00)
 - d. Attendant care; (4-5-00)
 - e. Case management; (7-1-00)T

- ef. Chore services; (4-5-00)
- fg. Adult companion; (4-5-00)
- gh. Adult residential care; (4-5-00)
- hi. Consultation; (4-5-00)
- ij. Home delivered meals; (4-5-00)
- jk. Homemaker; (4-5-00)
- kl. Home modifications; (4-5-00)
- l. ~~Personal care services in excess of the State Medicaid Plan;~~ (~~4-5-00~~)
- m. Personal emergency response system; (4-5-00)
- n. Psychiatric consultation; (4-5-00)
- o. Respite care; and (4-5-00)
- p. Skilled nursing. (4-5-00)

02. Administrative Case Management. The Department will also provide administrative case management. (4-5-00)

671. PRE-AUTHORIZATION REQUIREMENTS.

01. Pre-Authorization Requirements. All waiver services must be preauthorized by the Regional Medicaid Unit (RMU) Department. Authorization will be based on the information from: (~~4-5-00~~)(7-1-00)T

- a. The UAI; (4-5-00)
- b. The IS plan ~~for service~~ developed by the RMU Department or its contractor; and (~~4-5-00~~)(7-1-00)T
- c. Any other medical information which verifies the need for NF services in the absence of the waiver services. (4-5-00)

02. UAI Administration. The UAI will be administered, and the initial IS plan ~~for service~~ developed, by the RMU or its contractor. (~~4-5-00~~)(7-1-00)T

672. PROVIDER QUALIFICATIONS.

Each provider must have a signed provider agreement with the Department for each of the services it provides. (4-5-00)

01. Employment Status. Unless otherwise specified by the Department, each individual service provider must be an employee of record or fact of an agency, ~~or an employee of record for a FI~~. The Department may enter into provider agreements with individuals in situations where no agency exists, or no FI is willing to provide services. Such agreements will be reviewed annually to verify whether coverage by an agency or FI is still not available. (~~4-5-00~~)(7-1-00)T

02. Provider Qualifications. All providers of homemaker, respite care, adult day health, transportation, chore companion, attendant adult residential care, home delivered meals, and behavior consultants 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/activities in the Department's approved Aged and Disabled waiver ~~request~~ as approved by the Health Care Financing Administration (HCFA).

~~(4-5-00)~~(7-1-00)T

a. A waiver provider can not be a relative of any participant to whom the provider is supplying services. (7-1-00)T

b. For the purposes of Section 672, a relative is defined as a spouse or parent of a minor child. (7-1-00)T

~~**03. Personal Care Providers Qualifications.** Personal Care Providers must meet the requirements of Section 146 of these rules.~~ (4-5-00)

043. Specialized Medical Equipment Provider Qualifications. Providers of specialized medical equipment and supplies must be enrolled in the Medicaid program as participating medical vendor providers. (4-5-00)

054. Nursing Service Provider Qualifications. Nursing Service Providers must be licensed as an R.N. or L.P.N. in Idaho or be practicing on a federal reservation and be licensed in another state. (4-5-00)

~~**065. Psychiatric Consultation Provider Qualifications.** Psychiatric Consultation Providers must have:~~ (4-5-00)

a. A master's degree in a behavioral science; (4-5-00)

b. Be licensed in accordance with state law and regulations; or (4-5-00)

c. Have a bachelor's degree and work for an agency with direct supervision from a licensed or Ph.D. psychologist and have one (1) year's experience in treating severe behavior problems. (4-5-00)

06. Case Management. Case managers and case management agencies will meet the same requirements as PCS case managers specified in Section 147 unless specifically modified by another section of these rules. (7-1-00)T

07. Consultation Services. Services must be provided through ~~a~~ Personal Assistance Agency ~~or FF~~ by a person who has demonstrated skills in training participants/family members in hiring, firing, training, and supervising their own care providers. ~~(4-5-00)~~(7-1-00)T

08. Adult Residential Care Providers. The facility will 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. (4-5-00)

09. Home Delivered Meals. Providers must be a public agency or private business and must be capable of: (4-5-00)

a. Supervising the direct service; (4-5-00)

b. Providing assurance that 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; (4-5-00)

c. Delivering the meals in accordance with the plan for care, in a sanitary manner and at the correct temperature for the specific type of food; (4-5-00)

d. Maintaining documentation that the meals served are made from the highest USDA grade for each specific food served; and (4-5-00)

e. Being inspected and licensed as a food establishment by the district health department. (4-5-00)

10. Personal Emergency Response Systems. Providers must have a Land Mobile License from the Federal Communications Commission (FCC). (7-1-00)T

(BREAK IN CONTINUITY OF SECTIONS)

680. ATTENDANT CARE.

Services that involve personal and medically oriented tasks dealing with the functional needs of the participant. These services may include, but are not limited to personal care and medical tasks that can be done by unlicensed persons, or delegated to an unlicensed person by a licensed health care professional. Additionally, it may include administration of medications, ventilator care, and tube feeding. Services may occur in the participant's home, community, work, school or recreational settings. (4-5-00)

01. Responsibility For Care. ~~To utilize the services of a PAA acting as an FI. The participant or family, or legal representative~~ must be able and willing to assume responsibility for the direction of the participant's care and for personnel activities such as provider selection and supervision. ~~If the participant, family, or legal representative is unable or unwilling to assume such responsibility, then an agency employee must be utilized.~~ (4-5-00)(7-1-00)T

02. Supervision. The Department may require supervision by a health care professional if the required care is so complex that such supervision is necessary for health and safety. (4-5-00)

(BREAK IN CONTINUITY OF SECTIONS)

684. CONSULTATION.

01. Services To Participant Or Family Member. Services provided by ~~an agency or through an FI~~ PAA 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/family. (4-5-00)(7-1-00)T

02. Services To The Provider. Services to the provider are for the purpose of understanding the special needs of the participant and the role of the care giver. (4-5-00)

685. HOMEMAKER SERVICES.

01. Homemaker Services. Assistance to the participant with light housekeeping, laundry, assistance with essential errands, meal preparation, and other light housekeeping duties if there is no one else in the household capable of performing these tasks. (4-5-00)

02. Homemaker. The homemaker must be an employee of ~~record or fact of an agency or an employee of record of a fiscal intermediary.~~ (4-5-00)(7-1-00)T

(BREAK IN CONTINUITY OF SECTIONS)

692. PERSONAL CARE SERVICES UNDER THE WAIVER CASE MANAGEMENT.

~~Services which are described in Section 146 of these rules and are provided in excess of state plan limitations and the restrictions contained in Subsection 146.01.b.i. of these rules.~~ Case management includes all of the activities contained in Subsection 147.03 of these rules. Such services are designed to foster independence of the participant, and will be time limited. (4-5-00)(7-1-00)T

01. Hourly Services Care. ~~Personal care services under the waiver include limited hourly services in the home of the client only. For services in the home of the provider, see Section 694, Adult Residential Care. All services will be provided in accordance with an Individual Service Plan, which will take the place of the Individual Community Service Plan found in Subsection 147.03.b. All services will be incorporated into the Individual Service plan and authorized by the RMU.~~ (4-5-00)(7-1-00)T

02. Requirements For An FI. ~~Consumers~~ Participants of PCS will have one (1) year from the date which services begin in their geographic region, as described in Section 667 of these rules, to obtain the services of an FI and become an employee ~~of in~~ fact or to use the services of an agency unless the provisions of Subsection 670.01 are met. Provider qualifications are in accordance with Subsections 147.05 and 147.06. (4-5-00)(7-1-00)T

03. Notification By Case Manager. The case manager will notify the RMU, the PAA, as well as the medical professionals involved with the participant of any significant change in the participant's situation or condition. (7-1-00)T

693. PERSONAL EMERGENCY RESPONSE SYSTEMS (PERS).

01. Personal Emergency Response System. A system which may be provided to monitor waiver participant safety or provide access to emergency crisis intervention for emotional, medical, or environmental emergencies through the provision of communication connection systems. (4-5-00)

02. Limitations. PERS are limited to participants who: (4-5-00)

a. Rent or own their home, or live with unpaid relatives; (4-5-00)(7-1-00)T

b. Are alone for significant parts of the day; (4-5-00)

c. Have no ~~regular~~ caretaker for extended periods of time; and (4-5-00)(7-1-00)T

d. Would otherwise require extensive routine supervision. (4-5-00)

694. ADULT RESIDENTIAL CARE.

01. Adult Residential Care Services. Services are those that consist of a range of services provided in a congregate setting licensed in accordance with IDAPA 16.03.22, "Rules for Licensed Residential Care and Assisted Living Facilities in Idaho," that may include: (4-5-00)(7-1-00)T

a. Medication management; (4-5-00)

b. Assistance with activities of daily living; (4-5-00)

c. Meals, including special diets; (4-5-00)

d. Housekeeping; (4-5-00)

e. Laundry; (4-5-00)

f. Transportation; (4-5-00)

g. Opportunities for socialization; (4-5-00)

h. Recreation; and (4-5-00)

i. Assistance with personal finances (4-5-00)

02. Administration Oversight. Administrative oversight must be provided for all services provided or

available in this setting.

(4-5-00)

03. Written Plan. A written IS plan ~~for services~~ will be negotiated between the participant or legal representative, and a facility representative. ~~(4-5-00)(7-1-00)T~~

(BREAK IN CONTINUITY OF SECTIONS)

697. ROLE OF THE REGIONAL MEDICAID UNIT.

The RMU will provide for the administration of the UAI, and the development of the initial PFS IS plan. This will be done either by RMU staff or a contractor. The RMU will review and approve all PFS IS plans, and the will authorize Medicaid payment by type, scope, and amount. ~~(4-5-00)(7-1-00)T~~

01. Services Not In PFS The IS Plan. Services which are not in the PFS IS plan approved by the RMU are not eligible for Medicaid payment. ~~(4-5-00)(7-1-00)T~~

02. Excess Services. Services in excess of those in the approved PFS IS plan are not eligible for Medicaid payment. ~~(4-5-00)(7-1-00)T~~

03. Early Approval Date. The earliest date that services may be approved by the RMU for Medicaid payment is the date that the participant's PFS IS plan is ~~signed by the RMU or its contractor and~~ signed by the participant or his designee. ~~(4-5-00)(7-1-00)T~~

698. SERVICE DELIVERED FOLLOWING A WRITTEN INDIVIDUAL SERVICE PLAN FOR SERVICES.

All waiver services must be authorized by the RMU in the Region where the participant will be residing and provided based on a written PFS IS plan. ~~(4-5-00)(7-1-00)T~~

01. Development Of The PFS IS Plan. The initial PFS IS plan is developed by the RMU or its contractor, based on the UAI, in conjunction with: ~~(4-5-00)(7-1-00)T~~

a. The waiver participant (efforts must be made to maximize the participant's involvement in the planning process by providing him with information and education regarding his rights); and (4-5-00)

b. The guardian, when appropriate; and (4-5-00)

c. The supervising nurse or case manager, when appropriate; and (4-5-00)

d. Others identified by the waiver participant. (4-5-00)

02. Contents Of The PFS IS Plan. The PFS IS plan must include the following: ~~(4-5-00)(7-1-00)T~~

a. The specific type, amount, frequency, and duration of Medicaid reimbursed waiver services to be provided; and (4-5-00)

b. Supports and service needs that are to be met by the participant's family, friends, neighbors, volunteers, church, and other community services; and (4-5-00)

c. The providers of waiver services when known; and (4-5-00)

d. Documentation that the participant has been given a choice between waiver services and institutional placement; and (4-5-00)

e. The signature of the participant or his legal representative ~~and the RMU or its contractor~~, agreeing to the plan. ~~(4-5-00)(7-1-00)T~~

03. PPS IS Plan Revision. The plan must be revised and updated at least annually, based upon treatment results or a change in the participant's needs. ~~(4-5-00)~~(7-1-00)T

04. Authorization Of Services. All services reimbursed under the Home and Community Based Waiver must be authorized by the RMU prior to the payment of services. (4-5-00)

05. Service Supervision. The ~~IS Plan for Service~~ IS Plan for Service, which includes all waiver services, is monitored by the PAA, participant, family, and the RMU or its contractor. ~~(4-5-00)~~(7-1-00)T

699. PARTICIPANT ELIGIBILITY DETERMINATION.

Waiver eligibility will be determined by the RMU. The participant must be eligible for Medicaid as described in IDAPA 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind, and Disabled (AABD)". In addition, waiver participants must meet the following requirements. ~~(4-5-00)~~(7-1-00)T

01. Requirements For Determining Participant Eligibility. The RMU must determine that: (4-5-00)

a. The participant would qualify for NF level of care as set forth in Section 506, if the waiver services listed in Section 664 of these rules were not made available; and (3-1-00)T

b. The participant could be safely and effectively maintained in the requested/chosen community residence with appropriate waiver services. This determination must be made by the RMU. Prior to any denial of services on this basis, the ~~case manager~~ Department must verify that services to correct the concerns of the team are not available. ~~(4-5-00)~~(7-1-00)T

c. The average daily cost of waiver services and other medical services to the participant would not exceed the average daily cost to Medicaid of NF care. (4-5-00)

d. Following the approval by the RMU for services under the waiver, the participant must receive and continue to receive a waiver service as described in these rules. A participant who does not use a waiver service for thirty (30) consecutive days will be terminated from the waiver program. (4-5-00)

02. Admission To A Nursing Facility. A participant who is determined by the RMU to be eligible for services under the waiver may elect to not utilize waiver services and may choose admission to an NF. (4-5-00)

03. Redetermination Process. Case Redetermination will be conducted by the RMU or its contractor. The redetermination process will verify that the participant continues to meet NF level of care and the participant's continued need for waiver services. (4-5-00)

700. PROVIDER REIMBURSEMENT.

The criteria used in reimbursing providers for waiver services are: (4-5-00)

01. Fee For Services. Waiver service providers will be paid on a fee for service basis as established by the Department depending on the type of service provided. Adult residential care will be paid on a per diem basis, based on the number of hours and types of ~~service~~ assistance required by the participant as identified in the UAI. ~~(4-5-00)~~(7-1-00)T

02. Provider Claims. Provider claims for payment will be submitted on claim forms provided or approved by the Department. Billing instructions will be provided by the Department's payment system contractor. (4-5-00)

03. Calculation Of Fees. The fees calculated for waiver services include both services and mileage. No separate charges for mileage will be paid by the Department for provider transportation to and from the participant's home or other service delivery location when the participant is not being provided waiver or state plan transportation. (4-5-00)

701. PROVIDER RECORDS.

Records will be maintained on each waiver participant. (4-5-00)

01. Service Provider Information. Each service provider shall document each visit made or service provided to the participant, and will record at a minimum the following information: (4-5-00)

a. Date and time of visit; and (4-5-00)

b. Services provided during the visit; and (4-5-00)

c. 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 (4-5-00)

d. Length of visit, including time in and time out, if appropriate to the service provided. Unless the RMU 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. (4-5-00)

02. Original Record. The provider is required to keep the original service delivery record. A copy of the service delivery record will be maintained in the participant's living arrangement unless authorized to be kept elsewhere by the RMU. Failure to maintain documentation according to these rules shall result in the recoupment of funds paid for undocumented services. (4-5-00)

03. ~~Plan For~~ Individual Service Plan. The ~~PFS IS plan~~ initiated by the RMU or its contractor must specify which waiver services are required by the participant. The plan will contain all elements required by Subsection 698.02 and a copy of the most current ~~PFS IS 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 ~~PFS IS plan~~ and UAI will be available from the RMU to each individual service provider with a release of information signed by the participant or legal representative. ~~(4-5-00)(7-1-00)T~~

702. PROVIDER RESPONSIBILITY FOR NOTIFICATION.

The service provider is responsible to notify the ~~RMU~~, physician, ~~supervising RN~~ 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. ~~(4-5-00)(7-1-00)T~~

703. RECORDS RETENTION.

~~Provider agencies~~ PAAs, FIs, and other providers are responsible to retain their records for five (5) years following the date of service. ~~(4-5-00)(7-1-00)T~~

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE
16.03.09 - RULES GOVERNING THE MEDICAL ASSISTANCE PROGRAM

DOCKET NO. 16-0309-0011

NOTICE OF TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The temporary rule is effective October 1, 2000.

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 Section(s) 56-202(b) and 56-203(g), Idaho Code.

PUBLIC HEARING SCHEDULE: Pursuant to Section 67-5222(2), Idaho Code, 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 October 18, 2000.

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 non-technical explanation of the substance and purpose of the proposed rulemaking:

Section 56-227E, Idaho Code, effective April 14, 2000, which was enacted through S.B. 1530, recognizes two (2) types of transportation providers, commercial and non-commercial. The law provides a limitation on reimbursement for transportation of Medicaid clients when the vehicle contains five (5) or more clients; provides for a waiver based on undue hardship; declares an emergency; and provides a sunset clause of June 20, 2001. The Department of Health and Welfare, Division of Medicaid, will no longer pay non-commercial transportation providers including agency or individual transportation providers for unloaded miles. However, the reimbursement rate per mile per passenger will be at the rate the Idaho Board of Examiners reimburses state employees to use their personal vehicles, rounded up to the nearest whole cent, for up to five (5) passengers per vehicle. At present that rate is thirty-three cents (\$.33) per mile.

TEMPORARY RULE JUSTIFICATION: The temporary rule has been adopted in accordance with Section 67-5226, Idaho Code and is necessary in order to comply with deadlines in amendments to governing law or federal programs.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because the rulemaking changes were to comply with Idaho Code.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary or proposed rule, contact Kathleen Allyn at (208) 334-5747.

Anyone can submit written comments regarding this proposed rule. All written comments and data concerning the rule must be directed to the undersigned and must be postmarked on or before October 25, 2000.

DATED this 15th day of August, 2000.

Sherri Kovach
Administrative Procedures Coordinator
DHW - Division of Legal Services
450 West State Street, 10th Floor
P.O. Box 83720
Boise, Idaho 83720-0036
(208) 334-5564 phone
(208) 332-7347 fax

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0309-0011

011. — ~~013. (RESERVED)~~ INCORPORATION BY REFERENCE.

The following is incorporated by reference in this chapter of rules:

01. Board Of Examiners. “Idaho State Travel Policies and Procedures of the Idaho State Board of Examiners.” Appendices A and B, June 13, 2000. (10-1-00)T

02. Availability. The “Idaho Travel Policies and Procedures of the Idaho State Board of Examiners.” can be found 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.state.id.us>. (10-1-00)T

012. -- 013. (RESERVED).

(BREAK IN CONTINUITY OF SECTIONS)

150. TRANSPORTATION.

~~“Transportation” includes expenses for transportation, cost of meals and lodging en route to and from receiving medical care or treatment, and while receiving medical care or treatment. It also includes the cost of an attendant to accompany the recipient, if necessary, and the cost of the attendant’s transportation, meals, lodging and, if the attendant is not a member of the recipient’s family, salary. Review of “transportation” is required to insure that only necessary and reasonable expenses are paid. Certain transportation services require preapproval, and other services require review after the services have been rendered. An exception to preapproval can be made when the service was an emergency or when eligibility for Medicaid is determined after the service was provided, or when a retrospective approval is required by the Department.~~ (7-1-98)

01. Scope of Coverage And General Requirements ~~For Transportation.~~ (7-1-98)

~~a. The Department will pay for necessary transportation for a Medicaid recipient to receive medical care or treatment from providers of Medicaid approved medical services. Transportation services are subject to review by the Department or its designee prior to services being rendered, or on a retrospective basis. Transportation service review is governed by provisions of the Transportation Policies and Procedures Manual as amended. If such review identifies that a transportation service is not covered, then no Medicaid payment will be made for the transportation service. Reimbursement for transportation services originally denied by the Department or its designee will be made if such decision is reversed by the appeals process required in IDAPA 16.05.03, “Rules Governing Contested Case Proceedings and Declaratory Rulings.”~~ (1-1-00)F

~~b. The Department or its designee may authorize the transportation, meals, and lodging costs of an attendant or one (1) immediate family member to accompany the recipient, if necessary, and salary for the attendant, if he is not a member of the recipient’s family. The Department will not pay the meals or lodging costs for of a salaried attendant once the recipient being escorted is admitted to an inpatient facility. The Department will pay the meals and lodging costs of one (1) immediate family member while the recipient is an inpatient in a facility, if deemed necessary due to the recipient’s age or other factors, and authorized by the Department or its designee.~~ (7-1-98)

~~e. When lodging is required, the Department or its designee will authorize it insuring that the least expensive yet most appropriate lodging is provided. Receipts for lodging may be required by the Department.~~ (7-1-98)

~~d. For any requests for transportation costs to receive covered medical care or treatment, the Department or its designee will only authorize transportation costs to the nearest available, appropriate Medicaid~~

~~provider. In some cases, a referral from the recipient's primary care physician is also required. (7-1-98)~~

~~e. If private vehicle transportation is used, the Department will pay for such transportation at rates established by the Department. The private carrier is responsible for providing all necessary insurance at no cost to the Department. (7-1-98)~~

~~f. If other than private vehicle transportation is used, the transportation must be the least expensive yet the most appropriate form available. The Department will make payment for such transportation at rates established by the Department. The carrier is responsible for providing all necessary insurance at no cost to the Department. (7-1-98)~~

~~g. Reimbursement will be made by the Department for necessary transportation to any person, including but not limited to the recipient, or a relative or friend of the recipient. The Department will make payment to the recipient if the recipient has paid for or provided the transportation service, or to the actual provider of the transportation service. Each billing invoice must have prior authorization attached, if appropriate, and be submitted to the Department for payment. Providers must bill on a HCFA 1500 claim form. If no attachments to the claim are required, the provider may bill electronically. Payment for transportation costs will not be issued prior to the service being rendered. (7-1-98)~~

~~h. Commercial transportation companies, such as taxi, intra-city bus or van, inter-city bus or van, intrastate bus or van, interstate bus or van, airlines, car rental agencies, or lodging facilities, must not charge Medicaid recipients more than is charged to the general public for the same service. (7-1-98)~~

~~i. If the recipient has two (2) or more separate medical appointments in a day which necessitate separate trips by the same or a different transporter, the Department will pay for a round trip to transport the recipient to each appointment. (7-1-98)~~

~~j. In order for the Department to pay for transportation services, the recipient must be taking the trip to actually receive medical care or treatment from a Medicaid provider. (7-1-98)~~

~~k. The Department will not pay for transportation or lodging when those services are available and provided at no cost by organizations such as Red Cross, Easter Seal Society, Cancer Society, fraternal and church organizations, Ronald McDonald Houses, and other private or social agencies. (7-1-98)~~

~~**02. Preauthorization For Transportation To A Distant Point.** Preauthorization of transportation to a distant point, either in or out of state, is required. For purposes of these rules, a "distant point" is defined as more than ten (10) miles from the recipient's residence. The Department or its designee must determine the following: (7-1-98)~~

~~a. That adequate and comparable medical services are not available locally. When the services are available locally and/or more than one (1) service provider is within the local area, the Department's reimbursement is limited to transportation costs to the closest provider of the necessary service; and (1-1-00)F~~

~~b. That an appointment for covered medical care or treatment has been made with a provider at the distant point; and (7-1-98)~~

~~e. If applicable, that a referral has been made by the patient's attending physician. (1-16-80)~~

~~d. The Department will only authorize meals when overnight travel to a distant point is required and cooking facilities are not available. The actual cost of the meals will be authorized up to the amount set by the Department. Meals and lodging costs will not be paid if the recipient and/or the attendant stays in a private home that is not a lodging facility. (7-1-98)~~

~~**03. Scope Of Coverage And General Requirements For Ambulance Services.** Medically necessary ambulance services are reimbursable in emergency situations or when prior authorization has been obtained from the Department or its designee. Ambulance services are subject to review by the Department or its designee prior to the~~

service being rendered, and on a retrospective basis. Ambulance service review is governed by provisions of the Transportation Policies and Procedures Manual as amended. If such review identifies that an ambulance service is not covered, then no Medicaid payment will be made for the ambulance service. Reimbursement for ambulance services originally denied by the Department or its designee will be made if such decision is reversed by the appeals process required in IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings". Payment for ambulance services is subject to the following limitations: ~~(7-1-98)~~(10-1-00)T

a. If a Medicaid recipient is also a Medicare recipient, a provider must first bill Medicare for services rendered. (7-1-98)

b. If Medicare does not pay the entire bill for ambulance service, the provider is to secure an "Explanation of Benefits" (EOB) from Medicare, attach it to the appropriate claim form and submit it to the Department. (7-1-98)

c. For Medicare recipients, the Department will reimburse providers for deductible and co-insurance not to exceed the Medicaid allowed amount for the services billed. (7-1-98)

d. Before payment is made by the Department, a Medicaid recipient must utilize any available insurance benefits to pay for ambulance services. (7-1-98)

e. Ambulance services are medically necessary when an emergency condition exists. For purposes of reimbursement, an emergency condition exists when a recipient manifests acute symptoms and/or signs which, by reasonable medical judgement of the Department or its designee, represent a condition of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in death, serious impairment of a bodily function or major organ, and/or serious jeopardy to the overall health of the recipient. If such condition exists, and treatment is required at the recipient's location, or transport of the recipient for treatment in another location by ambulance is the only appropriate mode of travel, the Department will review such claims and consider authorization for emergency ambulance services. If an emergency does not exist, prior written authorization to transport by ambulance must be secured from the Department or its designee. For purposes of reimbursement, in non-emergency situations, the provider must provide justification to the Department or its designee that travel by ambulance is medically necessary due to the medical condition of the recipient, and that any other mode of travel would, by reasonable medical judgement of the Department or its designee, result in death, serious impairment of a bodily function or major organ, and/or serious jeopardy to the overall health of the recipient. (7-1-98)

f. Each billing invoice for ambulance service must have prior authorization attached, if appropriate, and be submitted to the Department for payment. Ambulance units that are not hospital-based must bill on a HCFA 1500 claim form and are reimbursed on a fee for service schedule. Hospital-based ambulance units must bill on a UB-92 claim form and are reimbursed at the hospital's outpatient reimbursement rate. If no attachments to the claim are required, the provider may bill electronically. (7-1-98)

g. All Emergency Medical Services (EMS) Providers that provide services to Medicaid recipients in Idaho must hold a current license issued by the Emergency Medical Services Bureau of the Department, and must be governed by IDAPA 16.02.03, "Rules Governing Emergency Medical Services". Ambulances based outside the state of Idaho must hold a current license issued by their states' EMS licensing authority when the transport is initiated outside the state of Idaho. Payment will not be made to ambulances that do not hold a current license. (7-1-98)

h. Only local transportation by ambulance is covered. In exceptional situations where the ambulance transportation originates beyond the locality to which the recipient was transported, payment may be made for such services only if the evidence clearly establishes that such institution is the nearest one with appropriate facilities and the service is authorized by the Department or its designee. (7-1-98)

i. Ambulance services providers cannot charge Medicaid recipients more than is charged to the general public for the same service. (7-1-98)

042. Air Ambulance Service. In some areas, transportation by airplane or helicopter may qualify as ambulance services. Air ambulance services are covered only when: (7-1-98)

- a. The point of pickup is inaccessible by land vehicle; or (11-10-81)
- b. Great distances or other obstacles are involved in getting the recipient to the nearest appropriate facility and speedy admission is essential; and (11-10-81)
- c. Air ambulance service will be covered where the recipient's condition and other circumstances necessitate the use of this type of transportation; however, where land ambulance service will suffice, payment will be based on the amount payable for land ambulance, or the lowest cost. (11-10-81)
- d. Air ambulance services must be approved in advance by the Department or its designee except in emergency situations. Emergency air ambulance services ~~must~~ shall be authorized by the Department or its designee on a retrospective basis. (~~7-1-98~~)(10-1-00)T
- e. The operator of the air service must bill the air ambulance service rather than the hospital or other facility receiving the recipient. (7-1-98)

053. Ambulance Reimbursement. (7-1-98)

- a. Base rate for ambulance services includes customary patient care equipment including such items as stretcher, clean linens, reusable devices, and reusable equipment. (11-10-81)
- b. Not to be included as a base rate and to be billed separately are charges for each nonreusable item and disposable supply, such as oxygen, triangular bandage and dressing, which may be required for the care of the recipient during transport. Oxygen will be reimbursed according to volume used by the recipient during transport. The volume must appear in the appropriate field on the claim. (7-1-98)
- c. Charges for extra attendants are not covered except for justified situations and must be authorized by the Department or its designee. (7-1-98)
- d. If a physician is in attendance during transport, he is responsible for the billing of his services. (11-10-81)
- e. Reimbursement for waiting time will not be considered unless documentation submitted to the Department or its designee identifies the length of the waiting time and establishes its medical necessity or indicates that it was physician ordered. Limited waiting time will be allowed for round trips. (7-1-98)
- f. Ambulance units are licensed by the EMS Bureau of the Department, or other states' EMS licensing authority according to the level of training and expertise its personnel maintains. At least, this level of personnel are required to be in the patient compartment of the vehicle for every ambulance trip. The Department will reimburse a base rate according to the level of ambulance license the unit has been issued. Units with Emergency Medical Technician - Basic (EMT-B) or equivalent personnel in the patient compartment of the vehicle will be reimbursed at the Basic Life Support (BLS) rate. Units with Advanced Emergency Medical Technician-Ambulance (AEMT-A) or equivalent personnel in the patient compartment of the vehicle will be reimbursed at the Intermediate Life Support (ILS) rate. Units with Emergency Medical Technician - Paramedic (EMT-P) or equivalent personnel in the patient compartment of the vehicle will be reimbursed at the Advanced Life Support (ALS) rate. In addition to the base rate, the Department will reimburse mileage. These rates are set by the Department. (7-1-98)
- g. If multiple licensed EMS providers are involved in the transport of a recipient, only the ambulance provider which actually transports the recipient will be reimbursed for the services. In situations where personnel and equipment from a licensed ALS provider boards an ILS or BLS ambulance, the transporting ambulance may bill for ALS services as authorized by the Department or its designee. In situations where personnel and equipment from a licensed ILS provider boards a BLS ambulance, the transporting ambulance may bill for ILS services as authorized by the Department or its designee. In situations where medical personnel and equipment from a medical facility are present during the transport of the recipient, the transporting ambulance may bill at the ALS level of service. The transporting provider must arrange to pay the other provider for their services. The only exception to the preceding policy is in situations where medical personnel employed by a licensed air ambulance provider boards an ALS, ILS, or BLS ground ambulance at some point, and the air ambulance medical personnel also accompany and treat the

recipient during the air ambulance trip. In this situation, the air ambulance provider may bill the appropriate base rate for the air ambulance trip, and may also bill the charges associated with their medical personnel and equipment as authorized by the Department or its designee. The ground ambulance provider may also bill for their part of the trip as authorized by the Department or its designee. (7-1-98)

h. If multiple licensed EMS providers transport a recipient for different legs of a trip, each provider must bill their base rate, mileage, and for nonreusable supplies and oxygen used, as authorized by the Department or its designee. (7-1-98)

i. If a licensed transporting EMS provider responds to an emergency situation and treats the recipient, but does not transport the recipient, the Department may reimburse for the treat and release service. The Department will reimburse the appropriate base rate and will pay for nonreusable supplies and oxygen used at the scene. This service requires authorization from the Department or its designee, usually on a retrospective basis. (7-1-98)

j. If an ambulance vehicle and crew have returned to a base station after having transported a recipient to a facility and the recipient's physician orders the recipient to be transferred from this facility to another facility because of medical need, two (2) base rate charges, in addition to the mileage, will be considered for reimbursement. If an ambulance vehicle and crew do not return to a base station and the patient is transferred from one (1) facility to another facility, charges for only one (1) base rate, waiting time, and mileage will be considered. (7-1-98)

k. Round trip charges will be allowed only in circumstances when a facility in-patient is transported to another facility to obtain specialized services not available in the facility in which the recipient is an in-patient. The transport must be to and from a facility that is the nearest one with the specialized services. (7-1-98)

l. If a licensed transporting EMS provider responds to a recipient's location and upon examination and evaluation of the recipient, finds that ~~their~~ his condition is such that no treatment or transport is necessary, the Department will pay for the response and evaluation service. This service requires authorization by the Department or its designee, usually on a retrospective basis. No payment will be made if the EMS provider responds and no evaluation is done, or the recipient has left the scene. No payment will be made for mileage, supplies or oxygen, nor will payment be made to an EMS provider who is licensed as a non-transporting provider. (~~7-1-98~~)(10-1-00)T

151.—~~154.~~ (~~RESERVED~~) NON-EMERGENCY TRANSPORTATION.

01. General Coverage For Non-Emergency Transportation. Non-emergency transportation is all transportation that is not of an emergency nature, including non-medical transportation under waiver programs. An emergency is a condition described in Subsection 150.01.e. Medicaid will reimburse non-emergency transportation by commercial or non-commercial transportation providers under the following circumstances and limitations: (10-1-00)T

a. The travel is essential to get to or from a medically necessary service or a waiver service covered by Medicaid; and (10-1-00)T

b. The person for whom services are billed is actually transported for all the distance billed; and (10-1-00)T

c. The mode of transportation is the lowest in cost to the Medicaid program that is appropriate to the medical needs of the client; and (10-1-00)T

d. The transportation is to the nearest medical or waiver service provider appropriate to perform the needed services, and transportation is by the most direct route practicable. Reimbursement will be limited to the distance of the most direct route practicable; and (10-1-00)T

e. Other modes of transportation, including personal vehicle, assistance by family, friends and charitable organizations, are unavailable or impractical under the circumstances; and (10-1-00)T

f. The travel is authorized by the Department prior to the transportation; and (10-1-00)T

g. Authorization for the travel is requested from the Department at least twenty-four (24) hours in advance of the travel to the medical appointment or waiver service excluding Saturdays, Sundays, and state holidays; and (10-1-00)T

h. The transporter has completed and signed a current Medicaid provider agreement; and (10-1-00)T

i. Travel is not covered by the service to which the client is being transported; and (10-1-00)T

j. Transportation is paid on a reimbursement basis only; payment will not be issued prior to delivery of the service. (10-1-00)T

02. Exceptions. Despite the preceding rules, Medicaid will cover transportation services under the following circumstances: (10-1-00)T

a. Transportation services may be retroactively approved when a client is found retroactively eligible, the transportation service falls within the period of retroactive eligibility, and the transporter was a Medicaid transportation provider at the time of the transport for which reimbursement is sought. (10-1-00)T

b. If the trip distance is less than twenty-one (21) miles, prior approval for non-commercial transport is not necessary. For Subsection 151.02, a trip is the distance a transporter carries a client in the course of a day. Therefore, the total mileage of a round-trip transport that takes place within one (1) day will be considered in determining whether this exception applies. Even though prior approval is not required, the transporter shall maintain all records as described in Subsection 152.02.d. of these rules. This exception is not available to commercial providers. (10-1-00)T

c. Reimbursement for non-commercial transportation will be limited as required by Section 56-227E, Idaho Code, and as expressed in Subsection 152.02.b. (10-1-00)T

03. Services Incidental To Travel. Medicaid will reimburse for the reasonable cost actually incurred of meals, lodging, a personal assistant and other necessary services incidental to travel, only under the following conditions: (10-1-00)T

a. Approval of the service is requested from the Department at least twenty-four (24) hours in advance of the travel. Excluding Saturdays, Sundays, and state holidays. (10-1-00)T

b. The reasonable cost of meals actually incurred in transit will be approved when necessary, when there is no other practical means of obtaining food, and only when an overnight stay is required to receive the service. Reimbursement shall not exceed the amount allowed for state employees in travel status. The Idaho State Travel and Procedures of the Idaho State Board of Examiners, Appendices are incorporated by reference in this chapter. (10-1-00)T

c. The reasonable cost actually incurred for lodging will be approved when the round trip and the needed medical service, in practicality, can not be completed in the same day. The travel must entail a one (1) way distance of at least two hundred (200) miles, or a normal one (1) way travel time of at least four (4) hours. The incidental travel expenses of a family member or other companion will be covered when medical necessity or the vulnerability of the individual requires accompaniment for safety, and no less-costly alternative is available. Lodging reimbursement will not be paid when the stay is in the home of a relative or acquaintance. (10-1-00)T

152. REQUIREMENTS OF NON-EMERGENCY TRANSPORTATION PROVIDERS.

01. Commercial Transportation Provider. A commercial transportation provider is an entity in the business of transportation that is organized to provide, that publicly holds itself out to provide, and that actually provides personal transportation services to the general public. By "holding itself out" to the general public, the provider vigorously and diligently solicits riders from the general populace, as opposed to primarily serving riders from one (1) or more congregate living facilities. By "actually providing" services to the general public, the provider's riders include substantial numbers of persons whose travel is funded by a source other than Medicaid. (10-1-00)T

a. Payment conditioned on prior approval. Medicaid will reimburse commercial transportation services only when approved at least twenty-four (24) hours in advance of the services, as provided in Subsection 151.01.f., or under the exception stated in Subsection 151.02.a. (10-1-00)T

b. Minimum qualifications. Each commercial transportation provider must, at minimum, meet the following standards: (10-1-00)T

i. Maintain all certifications and licenses for drivers and vehicles required by all public transportation laws, regulations, ordinances that apply to the transportation provider. (10-1-00)T

ii. Adhere to all laws, rules and regulations applicable to transportation providers of that type, including those requiring liability insurance. Liability insurance will be carried in an amount to cover at least five hundred thousand dollars (\$500,000) personal injury and five hundred thousand dollars (\$500,000) property damage per occurrence. (10-1-00)T

iii. Enter into a Medicaid provider agreement and enrollment application. (10-1-00)T

c. Records. Each commercial provider shall maintain the following records for a minimum of five (5) years. (10-1-00)T

i. Prior authorization documents. (10-1-00)T

ii. Name of client and Medicaid ID number. (10-1-00)T

iii. Date, time and geographical point of pick-up for each client trip. (10-1-00)T

iv. Date, time and geographical point of drop-off for each client trip. (10-1-00)T

v. Identification of the vehicle(s) and driver(s) transporting each client on each trip, and total miles for the trip. (10-1-00)T

02. Non-Commercial Transportation Provider. Any transportation provider that does not meet the definition of a commercial transportation provider is a non-commercial transportation provider. Non-commercial transportation services may be performed by an agency or by an individual provider. Agency transporters are entities that provide transportation as well as at least one other service to one or more Medicaid clients. Individual transporters are non-commercial providers who transport a family member, acquaintance or other person in a personal vehicle. If the Medicaid clients being transported are also clients of the transportation provider for services such as residential care, mental health, developmental therapy or other services, the provider will be considered a non-commercial provider with respect to those clients, even if the provider otherwise qualifies as a commercial transporter. A provider will be considered non-commercial with respect to any Medicaid clients transported if those clients are being transported to or from another service in which the provider has any ownership or control or if the arrangement to provide transportation is not an arm's length transaction. (10-1-00)T

a. Limitation on reimbursement per vehicle. Reimbursement for non-commercial transportation will be limited to no more than five (5) Medicaid eligible passengers per vehicle during any trip or leg of a trip. (10-1-00)T

b. Hardship exception. The Department may grant an exception on the basis of hardship, in order for a provider to be reimbursed for more than five (5) passengers at a time. The provider must submit information to show at minimum that its costs of vehicle operation exceed the five (5)-passenger reimbursement rate. In evaluating requests for exception, the Department will consider factors such as alternative forms of services and transportation available in the area, the cost of alternatives, the appropriateness of the vehicles utilized and the benefit to clients. The Department may limit the exception including the amount of additional reimbursement and the time duration of the exception. (10-1-00)T

c. Minimum qualifications. Each non-commercial transportation provider must, at minimum, meet

the following standards: (10-1-00)T

i. Continuously maintain liability insurance that covers passengers. For agency providers, coverage must be at least one-hundred thousand (\$100,000) per individual and three-hundred thousand (\$300,000) each incident. Individual providers must carry at least the minimum liability insurance required by Idaho law. If an agency permits employees to transport clients in employees' personal vehicles, the agency must ensure that adequate insurance coverage is carried to cover those circumstances. (10-1-00)T

ii. Obtain and maintain all licenses and certifications required by government to conduct business and to operate the types of vehicles used to transport clients. Agencies shall maintain documentation of appropriate licensure for all employees who operate vehicles. (10-1-00)T

iii. Adhere to all laws, rules, and regulations applicable to drivers and vehicles of the type used. (10-1-00)T

iv. Enter into a Medicaid enrollment application and provider agreement. (10-1-00)T

d. Records. Each non-commercial transportation provider shall, at the time of transport, collect the following information, and shall maintain it for a minimum of five (5) years: (10-1-00)T

i. Client name and Medicaid ID number for each trip. (10-1-00)T

ii. Date, time, geographical point of pick-up and odometer reading at pick-up for each client trip. (10-1-00)T

iii. Date, time, geographical point of drop-off and odometer reading at drop-off for each client trip. (10-1-00)T

iv. Mileage each client was transported for each trip billed. (10-1-00)T

v. Identification of the vehicle and driver transporting each client on each trip. (10-1-00)T

vi. Notice of prior authorization, when required. (10-1-00)T

03. Claims For Travel-Related Services. All claims for travel-related services must be supported by receipts, or other verification of the date, place, the amount of and the nature of services that were performed. Medicaid will not pay for claimed services that are not verifiable by contemporaneous documentation. (10-1-00)T

04. Submission Of Transportation Claims. All transportation claims shall be on a HCFA 1500 Claim form and shall include a trip-related authorization number where prior authorization is required. Payment shall not be made in advance of the service being rendered. (10-1-00)T

153. REIMBURSEMENT RATES.

01. Commercial Transportation. Payment shall be at the rate charged by the provider to a third party with billing requirements comparable to the Medicaid program or, if there is no comparable third party, at the rate charged to the general public plus a reasonable administrative charge. The provider must demonstrate that the administrative charge is an amount proportional to the additional administrative costs attributable to providing services to Medicaid clients. (10-1-00)T

02. Non-Commercial Providers -- Agency And Individual. Payment for each Medicaid passenger shall be at the rate, rounded up to the nearest whole cent, the Idaho Board of Examiners will reimburse state employees to use their personal vehicles on state business, to a maximum of five (5) passengers per trip or leg of a trip. (10-1-00)T

154. (RESERVED).

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE
16.03.09 - RULES GOVERNING THE MEDICAL ASSISTANCE PROGRAM

DOCKET NO. 16-0309-0012

NOTICE OF TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The temporary rule is effective September 1, 2000.

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 Section(s) 56-202(f), Idaho Code.

PUBLIC HEARING SCHEDULE: Pursuant to Section 67-5222(2), Idaho Code, 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 October 18, 2000.

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 non-technical explanation of the substance and purpose of the proposed rulemaking:

Changes to the rule will be made as required by legislative intent, generic drugs will be dispensed by the pharmacy unless prior authorized by the Department. In Section 817, technical changes were made to clarify the language.

TEMPORARY RULE JUSTIFICATION: The temporary rule has been adopted in accordance with Section 67-5226, Idaho Code and is necessary in order to comply with deadlines and amendments to governing law or federal programs.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because the rule changes are to comply with legislative intent.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary or proposed rule, contact Gary Duerr at (208) 364-1829.

Anyone can submit written comments regarding this proposed rule. All written comments and data concerning the rule must be directed to the undersigned and must be postmarked on or before October 25, 2000.

DATED this 15th day of August, 2000.

Sherri Kovach
Administrative Procedures Coordinator
DHW - Division of Legal Services
450 West State Street, 10th Floor
P.O. Box 83720
Boise, Idaho 83720-0036
(208) 334-5564 phone, (208) 332-7347 fax

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0309-0012

806. PAYMENT FOR COVERED DRUGS.

Payment will be made, as provided in Section 817, only to pharmacies ~~licensed by the Idaho Board of Pharmacy and~~ registered with the Department as a provider for the specific location where the service was performed. An out of the state pharmacy shipping or mailing a prescription into Idaho must have a valid mail order license issued by the Idaho Board of Pharmacy and be properly enrolled as a Medicaid provider. ~~(4-5-00)~~(9-1-00)T

(BREAK IN CONTINUITY OF SECTIONS)

812. ADDITIONAL COVERED DRUG PRODUCTS.

Additional drug products will be allowed as follows: (4-5-00)

- 01. Therapeutic Vitamins.** Therapeutic vitamins may include: (4-5-00)
 - a. Injectable vitamin B12 (cyanocobalamin and analogues); (4-5-00)
 - b. Vitamin K and analogues; (4-5-00)
 - c. Pediatric legend vitamin-fluoride preparations; (4-5-00)
 - d. Legend prenatal vitamins for pregnant or lactating women; (4-5-00)
 - e. Legend folic acid; (4-5-00)
 - f. Oral legend drugs containing folic acid in combination with Vitamin B12 and/or iron salts, without additional ingredients; and (4-5-00)
 - g. Legend vitamin D and analogues. (4-5-00)
- 02. Prescriptions For Nonlegend Products.** Prescriptions for nonlegend products may include: (4-5-00)
 - a. Insulin; (4-5-00)
 - b. Disposable insulin syringes and needles; (4-5-00)
 - c. Oral iron salts; and (4-5-00)
 - d. Permethrin. (4-5-00)
- 03. Prior Authorization Drugs.** Prior authorization for drugs is as follows: (4-5-00)
 - a. Medications requiring prior authorization include: (4-5-00)
 - i. Amphetamines and related CNS stimulants; (4-5-00)
 - ii. Growth hormones; (4-5-00)
 - iii. Retinoids. (4-5-00)
 - iv. Brand name drugs when an acceptable generic form exists. (9-1-00)T
 - b. Some medications excluded in Section 811 may be accepted for other medically approved indications, provided that prior authorization is obtained. (4-5-00)

c. The prior authorization procedure is initiated by the prescriber who shall submit the dated and signed request to the Department. This request shall include: ~~(4-5-00)~~(9-1-00)T

- i. Recipient name; (4-5-00)
- ii. Medicaid identification number; (4-5-00)
- iii. Date of birth; (4-5-00)
- iv. Diagnosis; (4-5-00)
- v. Specific drug; (4-5-00)
- vi. Strength and dosage; (4-5-00)
- vii. Statement of medical necessity as to why this drug is needed versus other therapies; and (4-5-00)
- viii. Duration of therapy desired, not to exceed twelve (12) months. (4-5-00)

d. The Department will determine coverage based on this request, and will notify the client, prescriber, and pharmacy, if known. Specific details on the prior authorization procedure can be found in the pharmacy guidelines issued by the Department. (4-5-00)

(BREAK IN CONTINUITY OF SECTIONS)

817. PAYMENT PROCEDURES.

The following protocol shall be followed for proper reimbursement. (4-5-00)

01. Filing Claims. Pharmacists shall file claims electronically with Department approved software or by submitting the appropriate claim form to the fiscal contractor. Upon request, the contractor will provide pharmacies with a supply of claim forms. The form shall include information described in the pharmacy guidelines issued by the Department. (4-5-00)

02. Claim Form Review. Each claim form ~~is~~ may be subject to review by a contract claim examiner, a pharmaceutical consultant, or a medical consultant. ~~(4-5-00)~~(9-1-00)T

03. Billed Charges. A pharmacy's billed charges are not to exceed the usual and customary charges defined as the lowest charge by the provider to the general public for the same service including advertised specials. (4-5-00)

04. Reimbursement. Reimbursement to pharmacies shall be limited to the lowest of the following: (4-5-00)

a. Federal Upper Limit (FUL), as established by the Health Care Financing Administration (HCFA), of the U.S. Department of Health and Human Services, plus the dispensing fee assigned by the Department; (4-5-00)

b. State Maximum Allowable Cost (SMAC), as established by the Department, plus the assigned dispensing fee; (4-5-00)

c. Estimated Acquisition Cost (EAC), as established by the Department following negotiations with representatives of the Idaho pharmacy profession defined as an approximation of the net cost of the drug and a reasonable operating margin, plus the assigned dispensing fee; or (4-5-00)

d. The pharmacy's usual and customary charge to the general public as defined in Subsection 817.03.

(4-5-00)

05. Dispensing Fees. Only one (1) dispensing fee per month will be allowed for the dispensing of each maintenance drug to any recipient as an outpatient or a resident in a care facility except: (4-5-00)

a. Multiple dispensing of topical and injectable medication when dispensed in manufacturer's original package sizes, unless evidence exists, as determined by the Department, that the quantity dispensed does not relate to the prescriber's order; (4-5-00)

b. Multiple dispensing of oral liquid maintenance medication if a reasonable quantity, as determined by the Department, is dispensed at each filling; (4-5-00)

c. Multiple dispensing of tablets or capsules if the quantity needed for a thirty-four (34) day supply is excessively large or unduly expensive, in the judgment of the Department; or (4-5-00)

d. When the dose is being titrated for maximum therapeutic response with a minimum of adverse effects. (4-5-00)

06. Remittance Advice. Claims are processed by computer, and payments are made directly to the pharmacy or its designated bank through electronic claims transfer. A remittance advice with detailed information of each claim transaction will accompany each payment made by the Department. (4-5-00)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE
16.03.14 - RULES GOVERNING MINIMUM STANDARDS FOR HOSPITALS IN IDAHO

DOCKET NO. 16-0314-0001
NOTICE OF PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has proposed rulemaking. The action is authorized pursuant to Section(s) 39-1307, 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 October 18, 2000

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 non-technical explanation of the substance and purpose of the proposed rulemaking:

At present this rule has been found to place an unnecessary burden on hospitals by requiring prescribers to be physically present within twenty-four hours to sign the order. The revisions will allow prescribers greater flexibility while maintaining the quality of medical services provided.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was conducted with the Hospital Association and the Idaho Medical Association.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Sylvia Creswell at (208) 364-1863.

Anyone can submit written comments regarding this proposed rulemaking. All written comments and data concerning the rule must be directed to the undersigned and delivered on or before October 25, 2000.

DATED this 7th day of August, 2000.

Sherri Kovach
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THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0314-0001

250. MEDICAL STAFF.

The hospital shall have an active medical staff organized under bylaws approved by the governing body and responsible to the governing body for the quality of all medical care provided the patients, and for the professional practices and ethical conduct of the members. (10-14-88)

01. Medical Staff Qualifications And Privileges. All medical staff members shall be qualified legally and professionally, for the privileges which they are granted. (10-14-88)

a. Privileges shall be granted only on the basis of individual training, competence, and experience. (10-14-88)

b. The medical staff, with governing body approval, shall develop and implement a written procedure for determining qualifications for medical staff appointment, and for determining privileges. (10-14-88)

c. The governing body shall approve medical staff privileges within the limits of the hospital's capabilities for providing qualified support staff and equipment in specialized areas. (10-14-88)

02. Medical Staff Appointments And Reappointments. Medical staff appointments and reappointments shall be made by the governing body upon the recommendation of the active medical staff, or a committee of the active staff. (10-14-88)

a. Appointments to the medical staff shall include a written delineation of all privileges including surgical procedures, and governing body approval shall be documented. (10-14-88)

b. Reappointments to the medical staff shall be made at least every two (2) years with appropriate documentation indicating governing body approval. (10-14-88)

c. Reappointment procedures shall include a means of increasing or decreasing privileges after consideration of the member's physical and mental capabilities. (10-14-88)

d. The medical staff and administration with approval of the governing body shall develop a written procedure for temporary or emergency medical staff privileges. (10-14-88)

03. Required Hospital Functions. Each hospital shall have a mechanism in place to perform the following functions: (10-14-88)

a. Coordinate all activities of the medical staff; and (10-14-88)

b. Develop a hospital formulary and procedures for the choice and control of all drugs used in the hospital; and (10-14-88)

c. Establish procedures to prevent and control infections in the hospital; and (10-14-88)

d. Develop and monitor standards of medical records contents; and (10-14-88)

e. Maintain communications between medical staff and the governing body of the hospital; and (10-14-88)

f. Review clinical work of the medical staff. (10-14-88)

04. Documentary Evidence Of Medical Staff Activities. The medical staff or any committees of the staff shall meet as often as necessary, but at least twice annually, to assure implementation of the required functions in Subsection 250.03. Minutes of all meetings of the medical staff or any committees of the staff shall be maintained. (12-31-91)

05. Medical Staff Bylaws, Rules, And Regulations. These shall specify at least the following: (10-14-88)

a. A description of the medical staff organization which includes: (10-14-88)

i. Officers and their duties; and (10-14-88)

- ii. Staff committees and their responsibilities; and (10-14-88)
- iii. Frequency of staff and committee meetings; and (10-14-88)
- iv. Agenda for all meetings and the type of records to be kept. (10-14-88)
- b. A statement of the necessary qualifications for appointment to the staff, and the duties and privileges of each category of medical staff. (10-14-88)
- c. A procedure for appointment, granting and withdrawal of privileges. (10-14-88)
- d. A mechanism for hearings and appeals of decisions regarding medical staff membership and privileges. (10-14-88)
- e. A statement regarding attendance at staff meetings. (10-14-88)
- f. A statement of qualifications and a procedure for delineation of clinical privileges for all categories of nonphysician practitioners. (10-14-88)
- g. A requirement for keeping accurate and complete medical records. (10-14-88)
- h. A requirement that all tissue surgically removed will be delivered to a pathologist for a report on such specimens, unless the medical staff, in consultation with the pathologist, adopts uniform exceptions to sending tissue specimens to the laboratory for analysis. (10-14-88)
- i. A statement requiring a history and physical, and preoperative diagnosis previous to surgery. (10-14-88)
- j. A requirement that consultation is necessary with unusual cases, except in emergencies. Unusual cases shall be defined by the hospital medical staff. (10-14-88)

06. Review Of Policies And Procedures. The medical staff shall review and approve all policies and procedures directly related to medical care. (10-14-88)

07. Dentists And Podiatrists. If dentists and podiatrists are appointed to the medical staff, the bylaws shall specifically refer to services performed by such professionals, and shall specify at least the following: (10-14-88)

- a. Patients admitted for dental or podiatry service shall be under the general care of a physician member of the active staff. (10-14-88)
- b. All medical staff requirements and procedure for privileges shall be followed for dentists and podiatrists. (10-14-88)

08. Dating Of Bylaws. Bylaws shall be dated and signed by the current officers of the medical staff or the committee of the whole. (10-14-88)

09. Medical Orders. Written, verbal and telephone orders from persons authorized to give medical orders under Idaho law shall be accepted by those health care practitioners empowered to do so under Idaho law and written hospital policies and procedures. Verbal and telephone orders shall contain the name of the person giving the order, the first initial and last name and professional designation of the health care practitioners receiving the order. The order(s) shall be promptly signed and dated or electronically authenticated by the prescribing practitioner. (10-14-88)()

(BREAK IN CONTINUITY OF SECTIONS)

330. PHARMACY SERVICE.

The hospital shall provide an organized pharmaceutical service that is administered in accordance with accepted professional principles and appropriate federal, state, and local laws. (10-14-88)

01. Organization And Supervision. Pharmacy services shall be under the overall direction of a pharmacist who is licensed in Idaho and is responsible for developing, coordinating, and supervising all pharmaceutical services in the hospital. (10-14-88)

a. The director of the pharmaceutical service, whether a full, part-time or a consultant member of the staff, shall be responsible to the chief executive officer or his designee. (10-14-88)

b. The pharmacist shall be responsible for the supervision of the hospital drug storage area in which drugs are stored and from which drugs are distributed. (10-14-88)

c. If trained pharmacy assistants, pharmacy students, or pharmacy interns are employed, they shall work under the direct supervision of a pharmacist. (10-14-88)

d. If the director of the pharmaceutical service is part-time, sufficient time shall be provided by the pharmacist to fulfill the responsibilities of the director of pharmaceutical services. (10-14-88)

e. The director of the pharmaceutical service shall be responsible for maintaining records of the transactions of the pharmacy as required by law and as necessary to maintain adequate control and accountability of all drugs. This includes a system of control and records for the requisitioning and dispensing of drugs and supplies to nursing units and to other department/services of the hospital, as well as records of all prescription drugs dispensed to the patient. (10-14-88)

f. The pharmacist shall periodically check drugs and drug records in all locations in the hospital where drugs are stored, including but not limited to nursing stations, emergency rooms, outpatient departments, operating suites. (10-14-88)

02. Staffing. The pharmaceutical service shall be staffed by a sufficient number of qualified personnel in keeping with the size and scope of services offered by the hospital. (10-14-88)

a. The services of a pharmacist shall be sufficient to meet the needs of the patients and to ensure that the established medication distribution system is functioning according to hospital policy. (10-14-88)

b. A pharmacist shall be available on premises or on call at all times. (10-14-88)

03. Scope Of Services. (10-14-88)

a. The scope of pharmaceutical service shall be consistent with the needs of the patients and include a program for the control and accountability of drug products throughout the hospital. A pharmacy and therapeutics committee or its equivalent composed of members of the medical staff, the director of pharmaceutical services, the director of nursing services, hospital administration and other health disciplines as necessary, shall develop written policies and procedures for drug selection, preparation, dispensing, distribution, administration, control, and safe and effective use. Refer to Subsections 250.03 and 250.04. (12-31-91)

04. Policies And Procedures. Written policies and procedures shall be developed by the pharmacy and therapeutics committee or its equivalent to govern the pharmaceutical services provided by the hospital. (10-14-88)

a. Policies and procedures shall be reviewed revised and amended as necessary, and dated to indicate the time of last review. (10-14-88)

b. Written policies and procedures that are essential for patient safety, and for the control and

accountability of drugs, shall be in accordance with acceptable professional practices and applicable federal, state and local laws. (10-14-88)

- c. Policies and procedures shall include, but are not limited to the following: (10-14-88)
- i. There shall be a drug recall procedure that can be readily implemented; and (10-14-88)
- ii. All medications not specifically prescribed as to time or number of doses shall be controlled by automatic stop orders or other methods; and (10-14-88)

iii. Drugs shall be dispensed and administered only upon written or verbal order of a member of the medical staff authorized to prescribe. Verbal orders for drugs shall be given only to those health care practitioners empowered to accept orders under Idaho law and written hospital policies and procedures. Verbal or telephone orders shall be promptly signed and dated or electronically authenticated by the prescriber ~~within twenty-four (24) hours~~. The person accepting the verbal or telephone orders shall meet the procedures set forth in Subsection 250.402; and ~~(12-31-91)()~~

iv. If patients bring their own drugs into the hospital, these drugs shall not be administered unless they are identified by the pharmacist and a physician's order is written to administer these specific drugs. If the drug(s) that the patient brought to the hospital is (are) not to be used while he is hospitalized, it (they) shall be packaged, sealed, stored, and returned to the patient at the time of discharge; and (10-14-88)

v. Self-administration of medications by patients shall not be permitted unless specifically ordered by the physician; and (10-14-88)

vi. Investigational drugs shall be used only under the supervision of the principal investigator and after approval for use by the pharmacy and therapeutics committee; and (10-14-88)

vii. Acts of drug compounding, packaging, labeling, and dispensing, shall be restricted to the pharmacist or to his designee under supervision; and (10-14-88)

viii. The labeling of drugs and biologicals shall be based on currently accepted professional principles, applicable federal, state, and local laws, and include the appropriate accessory and cautionary instructions, as well as the expiration date when applicable. Only the pharmacist or authorized pharmacy personnel under the supervision of the pharmacist shall make labeling changes; and (10-14-88)

ix. Discontinued drugs, outdated drugs, or containers with worn, illegible, or missing labels shall be returned to the pharmacy for proper disposition; and (10-14-88)

x. Only approved drugs and biologicals shall be used. (See definition.) A list or formulary of approved drugs shall be maintained in the hospital. (10-14-88)

05. Space, Equipment, And Facilities. Space, equipment and supplies provided for the professional and administrative functions of the pharmaceutical service shall be appropriate to ensure patient safety through proper storage, compounding, and dispensing of drugs. (10-14-88)

a. The organized pharmaceutical service of the hospital shall have the necessary equipment and physical facilities for compounding and dispensing drugs, and where indicated, radiopharmaceuticals and parenteral preparations. (10-14-88)

b. There shall be special storage areas throughout the hospital for photosensitive and thermolabile products, and for controlled substances requiring special security. (10-14-88)

c. Up-to-date pharmaceutical reference materials shall be provided to furnish the medical and nursing staffs with current information concerning drugs. (10-14-88)

06. Safe Handling Of Drugs. In addition to the rules listed below, written policies and procedures

which govern the safe dispensing and administration of drugs shall be developed by the pharmacy and therapeutics committee with the cooperation and the approval of the medical staff. (10-14-88)

- a. The pharmacist shall review the prescriber's original order or a direct copy thereof; and (10-14-88)
- b. The pharmacist shall develop a procedure for the safe mixture of parenteral products; and (10-14-88)
- c. All medications shall be administered by trained personnel in accordance with accepted professional practices and any laws and regulations governing such acts; and (10-14-88)
- d. Each dose of medication administered shall be properly recorded as soon as administered in the patient's medication record which is a separate and distinct part of the patient's medical record; and (10-14-88)
- e. Drug reactions and medication errors shall be reported to the attending physician and pharmacist in accordance with hospital policy. (10-14-88)

07. Inservice/Continuing Education. The pharmacist shall provide inservice/continuing education for medical and nursing staff at least once quarterly. (10-14-88)

08. Security. The pharmacist is responsible for the drug storage security elements of the designated areas. Access to the pharmacy shall be gained only by him and by individuals designated by him. All prescribed medications shall be under lock and schedule II drugs shall be double-locked. (10-14-88)

09. Unit Dose Drug Distribution. Unit dose procedures, if employed, shall be practiced in accordance with accepted standards of labeling, quality control, and accountability. (10-14-88)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE
16.04.05 - RULES GOVERNING RESPITE CARE SERVICES

DOCKET NO. 16-0405-0001 (REPEAL)

NOTICE OF PENDING RULE

EFFECTIVE DATE: These rules have been adopted by the agency and are now pending review by the 2001 Idaho State Legislature for final adoption. The pending rule becomes final and effective upon adjournment of the legislature, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224(5)(a) and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

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 39-4701 et Seq., Idaho Code.

DESCRIPTIVE SUMMARY: The pending rule is being adopted as proposed and is being repealed in its entirety. The original text of the proposed rule was published in the Idaho Administrative Bulletin, July 5, 2000, Volume 00-7, page 35.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Paul Swatsenbarg at (208) 334-5512.

DATED this 1st day of August, 2000.

Sherri Kovach
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IDAPA 16
TITLE 04
Chapter 05

RULES GOVERNING RESPITE CARE SERVICES

There are no substantive changes from the proposed rule text.

The complete text of the proposed rule was published in the Idaho Administrative Bulletin, [Volume 00-7, July 5, 2000, page 35.](#)

This rule has been adopted as a pending rule by the Agency and is now pending review and adoption by the 2001 Idaho State Legislature as a final rule.

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE
16.04.09 - RULES GOVERNING DEVELOPMENTAL DISABILITIES
IN-HOME FINANCIAL ASSISTANCE

DOCKET NO. 16-0409-0001 (REPEAL)

NOTICE OF PENDING RULE

EFFECTIVE DATE: These rules have been adopted by the agency and are now pending review by the 2001 Idaho State Legislature for final adoption. The pending rule becomes final and effective upon adjournment of the legislature, unless the rule is approved, rejected, amended or modified by concurrent resolution in accordance with Section 67-5224(5)(a) and 67-5291, Idaho Code. If the pending rule is approved, amended or modified by concurrent resolution, the rule becomes final and effective upon adoption of the concurrent resolution or upon the date specified in the concurrent resolution.

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 39-4701 et Seq., Idaho Code.

DESCRIPTIVE SUMMARY: The pending rules are being adopted as proposed. The original text of the proposed rules was published in the Idaho Administrative Bulletin, July 5, 2000, Volume 00-7, page 36.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the pending rule, contact Paul Swatsenbarg at (208) 334-5512.

DATED this 1st day of August, 2000.

Sherri Kovach
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IDAPA 16
TITLE 04
Chapter 09

RULES GOVERNING DEVELOPMENTAL DISABILITIES
IN-HOME FINANCIAL ASSISTANCE

There are no substantive changes from the proposed rule text.

The complete text of the proposed rule was published in the Idaho Administrative Bulletin, [Volume 00-7, July 5, 2000, page 36.](#)

This rule has been adopted as a pending rule by the Agency and is now pending review and adoption by the 2001 Idaho State Legislature as a final rule.

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE
16.04.10 - RULES GOVERNING COMMUNITY SERVICES BLOCK GRANT PROGRAM
DOCKET NO. 16-0410-0001 (REPEAL)
NOTICE OF TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The temporary rule is effective October 1, 2000.

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 Section(s) 56-1004, Idaho Code.

PUBLIC HEARING SCHEDULE: Pursuant to Section 67-5222(2), Idaho Code, 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 October 18, 2000.

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 non-technical explanation of the substance and purpose of the proposed rulemaking:

Repeal of the entire chapter is necessary due to Federal Law changes as contained in the 1998 Federal CSBG Reauthorization. The chapter is being rewritten in Docket No. 16-0410-0002.

TEMPORARY RULE JUSTIFICATION: The temporary rule has been adopted in accordance with Section 67-5226, Idaho Code and is necessary in order to comply with deadlines in amendments to governing law or federal programs and to confer a benefit.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because the rulemaking is to comply with federal programs.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary or proposed rule, contact Patti Campbell at (208) 334-5815.

Anyone can submit written comments regarding this proposed rule. All written comments and data concerning the rule must be directed to the undersigned and must be postmarked on or before October 25, 2000.

DATED this 3rd day of August, 2000.

Sherri Kovach
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THIS CHAPTER IS BEING REPEALED IN ITS ENTIRETY.

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE
16.04.10 - RULES GOVERNING COMMUNITY SERVICES BLOCK GRANT PROGRAM

DOCKET NO. 16-0410-0002

NOTICE OF TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The temporary rule is effective October 1, 2000.

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 Section(s) 56-1004, Idaho Code.

PUBLIC HEARING SCHEDULE: Pursuant to Section 67-5222(2), Idaho Code, 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 October 18, 2000.

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 non-technical explanation of the substance and purpose of the proposed rulemaking:

Re-write of the entire chapter is to comply with 1998 Federal law changes contained in the 1998 Federal Community Services Block Grant Re-authorization.

TEMPORARY RULE JUSTIFICATION: The temporary rule has been adopted in accordance with Section 67-5226, Idaho Code and is necessary in order to comply with deadlines in amendments to governing law or federal programs and to confer a benefit.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because the rulemaking is to comply with federal programs.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary or proposed rule, contact Patti Campbell at (208) 334-5815.

Anyone can submit written comments regarding this proposed rule. All written comments and data concerning the rule must be directed to the undersigned and must be postmarked on or before October 25, 2000.

DATED this 3rd day of August, 2000.

Sherri Kovach
Administrative Procedures Coordinator
DHW - Division of Legal Services
450 West State Street, 10th Floor
P.O. Box 83720
Boise, Idaho 83720-0036
(208) 334-5564 phone
(208) 332-7347 fax

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0410-0002

IDAPA 16
TITLE 04
Chapter 10

16.04.10 - RULES GOVERNING THE COMMUNITY SERVICES BLOCK GRANT PROGRAM

000. LEGAL AUTHORITY.

Sections 56-202 and 56-203, Idaho Code, authorize the Idaho Department of Health and Welfare to enter into contracts with the federal government to carry out the purposes of the Community Services Block Grant Act. (10-1-00)T

001. TITLE AND SCOPE.

01. Title. These rules are cited as Idaho Department of Health and Welfare, IDAPA 16.04.10, "Rules Governing the Community Services Block Grant Program." (10-1-00)T

02. Scope. These rules provide standards for the administration of the Community Services Block Grant Program, as authorized by the Community Services Block Grant Act, as amended. (10-1-00)T

002. WRITTEN INTERPRETATIONS.

003. ADMINISTRATIVE APPEALS.

Appeals are governed by Idaho Department of Health and Welfare Rules, IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings". (10-1-00)T

004. INCORPORATION BY REFERENCE.

There are none in this chapter.

005. DEFINITIONS.

01. Community Action Agency. A private, non-profit organization serving the low-income population in specified counties of the state with which the Idaho Department of Health and Welfare has contracted for the provision of CSBG services. (10-1-00)T

02. Department. The Idaho Department of Health and Welfare. (10-1-00)T

03. Earned Income. Cash or in-kind payment derived from employment or self-employment. Receipt of a service, benefit or durable goods instead of wages is in-kind income. Earned income is gross earnings before deductions for taxes or any other purposes. (10-1-00)T

04. Eligible Entity. A private, non-profit organization which is a community action agency or a migrant or seasonal farm worker organization receiving CSBG funding before October 27, 1998, or designated by the Department as an eligible entity for an unserved area after October 27, 1998, and which is governed by a tripartite board, as defined in Subsection 005.06. (10-1-00)T

05. Low-Income And Poor Participants. Those persons receiving or eligible to receive CSBG services who live in households having an income at or below one hundred twenty-five percent (125%) of poverty. (10-1-00)T

06. Tripartite Board. A board, selected by an eligible entity, which participates in the development, planning, implementation, and evaluation of the community services block grant program, composed as follows: (10-1-00)T

a. One-third (1/3) of the board members are elected public officials, currently holding office, or their

representatives. Appointed public officials or their representatives will meet this requirement if the number of elected officials available and willing to serve is less than one-third (1/3) of the board membership. (10-1-00)T

b. At least one-third (1/3) of the board members are representatives of low-income individuals and families, living in the neighborhoods they serve, chosen by democratic selection procedures. (10-1-00)T

c. The remaining board members are officials or members of business, industry, labor, religious, law enforcement, education, or other major groups and interests in the community served. (10-1-00)T

07. Unearned Income. Income received from sources other than employment or self-employment, such as Social Security, unemployment insurance, and workers' compensation. (10-1-00)T

006. ABBREVIATIONS.

01. CSBG. Community Services Block Grant. (10-1-00)T

02. HHS. The United States Department of Health and Human Services. (10-1-00)T

03. SEOG. Supplemental Education Opportunity Grants. (10-1-00)T

007. -- 126. (RESERVED).

127. INCOME ELIGIBILITY REQUIREMENTS.

Assistance under this program is limited to participant households with countable income at or below one hundred twenty-five percent (125%) of the Poverty Guidelines updated annually in the Federal Register by the US Department of Health and Human Services under the authority of 42 U.S.C. 9902(s), effective thirty (30) days after publication. (10-1-00)T

01. Countable Income. All earned and unearned income is counted in determining eligibility, unless specifically excluded by rule. (10-1-00)T

02. Income Not Counted. For eligibility purposes, the following types of income are not counted. (10-1-00)T

a. Benefit payments from Medicare Insurance. (10-1-00)T

b. State cash assistance payments. (10-1-00)T

c. Child care subsidy payments. (10-1-00)T

d. Private loans made to the participant or the household. (10-1-00)T

e. Assets withdrawn from a personal bank account. (10-1-00)T

f. Sale of real property. (10-1-00)T

g. Lump sum payments from an IRA. (10-1-00)T

h. Income tax refunds. (10-1-00)T

i. Income from capital gains. (10-1-00)T

j. Infrequent, irregular or unpredictable income from gifts or lottery winnings of less than one hundred dollars (\$100). (10-1-00)T

k. Wages or allowances paid to a live-in attendant for care of a disabled person. (10-1-00)T

- l. Interest posted to a bank account. (10-1-00)T
- m. Monies for educational purposes from NSDL, college work-study programs, state student incentive grants, SEOG, Pell, guaranteed student loans and supplemental grants funded under Title IV, A-2. (10-1-00)T
- n. Monies from the VA-GI Bill for Education. (10-1-00)T
- o. Department of Health and Welfare adoption subsidies. (10-1-00)T
- p. Compensation to volunteers under the Older Americans Act or Foster Grandparent Program, including Green Thumb and Vista volunteers, and the Title V Senior Employment Program. (10-1-00)T
- q. Payments made by a third party, non-household member for the household, such as for child care, energy assistance, shelter, food and clothing assistance. (10-1-00)T
- r. Value of food stamps or donated food. (10-1-00)T
- s. Utility allowance. (10-1-00)T

128. NONFINANCIAL ELIGIBILITY REQUIREMENTS.

An individual must be an Idaho resident at the time of application for CSBG services, but there is no durational requirement. Citizenship is not a condition of eligibility. (10-1-00)T

129. SERVICE AREAS.

Idaho has seven (7) service areas for fund distribution purposes, as listed in Subsections 129.01 through 129.07.

- (10-1-00)T
- 01. Region I.** The counties of Benewah, Bonner, Boundary, Kootenai, and Shoshone. (10-1-00)T
- 02. Region II.** The counties of Clearwater, Idaho, Latah, Lewis, and Nez Perce. (10-1-00)T
- 03. Region III.** The counties of Adams, Boise, Canyon, Gem, Payette, Valley, and Washington. (10-1-00)T
- 04. Region IV.** The counties of Ada, Elmore, and Owyhee. (10-1-00)T
- 05. Region V.** The counties of Blaine, Camas, Cassia, Gooding, Jerome, Lincoln, Minidoka, and Twin Falls. (10-1-00)T
- 06. Region VI.** The counties of Bannock, Bear Lake, Bingham, Caribou, Franklin, Oneida, and Power. (10-1-00)T
- 07. Region VII.** The counties of Bonneville, Butte, Clark, Custer, Fremont, Jefferson, Lemhi, Madison, and Teton. (10-1-00)T

130. -- 149. (RESERVED).

150. PROHIBITED ACTIVITIES.

CSBG funds may not be used for the following activities: (10-1-00)T

- 01. Construction.** Without a waiver from the Secretary of HHS, funds may not be used to purchase or improve land, or to purchase, construct, or permanently improve (other than low-cost residential weatherization or other energy-related home repairs) any building or other facility. (10-1-00)T
- 02. Political Activities.** Funds may not be used for political purposes, sponsoring or conducting candidate meetings, voter registration activity or voter transportation, or other political activities. (10-1-00)T

03. Lobbying. Funds may not be used to influence the passage or defeat of legislation. (10-1-00)T

151. -- 199. (RESERVED).

200. FUNDING DISTRIBUTION.

The seven (7) CSBG service areas will each receive base funding of six percent (6%) of Idaho's CSBG allocation. Seasonal and migrant farmworker organizations will receive funding which in total equals seven percent (7%) of Idaho's CSBG allocation. After deducting state administrative expenses and funds for statewide activities, the seven (7) service areas will receive the remaining funds, based on the ratio of Idaho's low-income population residing within each service area. (10-1-00)T

201. CONTINUATION OF FUNDING.

The Department will not terminate or reduce the funding of any eligible entity that received CSBG funding in the previous fiscal year below the proportional share of funding received, unless, after providing notice and an opportunity for a hearing, the Department determines that cause exists for such termination or reduction, subject to review by the Secretary of HHS. (10-1-00)T

202. FUNDING TERMINATION OR REDUCTIONS.

The term "cause" is defined in Subsections 202.01 and 202.02. (10-1-00)T

01. Funding Reduction. With respect to a funding reduction, the term "cause" includes a statewide redistribution of funds to respond to the results of the most recent census or other appropriate data, the designation of a new eligible entity, or severe economic dislocation. Cause may also include the failure of an eligible entity to comply with the terms of an agreement or a State plan, or to meet a State monitoring requirement. (10-1-00)T

02. Termination. With respect to funding termination, the term "cause" includes the failure of an eligible entity to comply with the terms of an agreement or a State plan, or to meet a State monitoring requirement. (10-1-00)T

203. Designation And Redesignation Of Eligible Entities In Unserved Areas.

01. Qualified Organization In Or Near Area. The following organizations may apply for and be designated as eligible entities to provide services in any geographic area which stops being served by an eligible entity. (10-1-00)T

a. An eligible entity or other private, nonprofit organization in the unserved area, capable of providing a broad range of services designed to eliminate poverty and foster self-sufficiency, and that meets the requirements of this program. (10-1-00)T

b. A private, nonprofit eligible entity located adjacent to or near the unserved area that is already providing related services in the unserved area. If designated, such entity would have to add additional board members to ensure adequate representation of the unserved area. (10-1-00)T

02. Special Consideration. An organization with demonstrated effectiveness in meeting the goals and purposes of this program will receive the designation. Eligible entities providing related services in the unserved area, consistent with the needs identified by a community-needs assessment, may be given priority. (10-1-00)T

03. No Qualified Organization In Or Near Area. A political subdivision of the State may serve as an eligible entity for the area if no qualified private, nonprofit organization is available. The entity must administer the program through a tripartite board, as defined in Subsection 004.06, or through another approved mechanism to assure decision making and participation by low-income individuals in the development, planning, implementation, and evaluation of this program. (10-1-00)T

204. -- 299. (RESERVED).

300. APPLICATION PROCESS.

Applications will be received by the Department of Health and Welfare, Division of Welfare, P.O. Box 83720, 450 W.

State Street, Boise ID, 83720-0036, no later than 5 p.m., ninety (90) days before the beginning of the federal fiscal year. Projects shall be designed and funded to operate for one (1) twelve-month (12) period. (10-1-00)T

301. -- 374. (RESERVED).

375. APPLICATION.

An original and one (1) copy of an application shall be submitted to the Department's Division of Welfare and shall include the following items: (10-1-00)T

- 01. Face Sheet.** CSBG Application Face Sheet, describing general information about the entity and the application. (10-1-00)T
- 02. Budget.** A budget for the period of the grant, on forms provided by the Department. (10-1-00)T
- 03. Causes Of Poverty.** The results of the most recent community-needs assessment. (10-1-00)T
- 04. Service Plan.** A description of how the agency will carry out the program. (10-1-00)T
- 05. Work Program.** Services to be performed and estimated number of participants. (10-1-00)T
- 06. Client Characteristics Report.** Demographic data on participants. (10-1-00)T
- 07. Outcome Measures.** How the entity will determine the success of services. (10-1-00)T
- 08. Assurances And Certifications.** Pledge by the entity to meet program requirements. (10-1-00)T

376. -- 399. (RESERVED).

400. AUDIT.

Projects funded by CSBG shall be subject to an annual audit, of a scope and depth defined by the Department. The Department may join with other interested parties to obtain a single audit of the eligible entity. (10-1-00)T

401. -- 599. (RESERVED).

600. CORRECTIVE ACTION, TERMINATION, OR REDUCTION OF FUNDING.

01. Determination. If an eligible entity fails to comply with the terms of an agreement or the State plan, to provide services, or to meet appropriate standards, goals, and other requirements, including performance objectives, the Department shall inform the entity of the deficiency to be corrected and may take one (1) or more of the following steps. (10-1-00)T

- a. Require the entity to correct the deficiency. (10-1-00)T
- b. Offer training and technical assistance, if appropriate, to help correct the deficiency, and submit a report to HHS describing the training and technical assistance offered or stating the reasons why it was not offered. (10-1-00)T

c. If feasible, allow the entity sixty (60) days to develop and implement a quality improvement plan to correct the deficiency within a reasonable period of time. (10-1-00)T

d. After providing adequate notice and an opportunity for a hearing, initiate proceedings to terminate the designation of or reduce the funding of the eligible entity unless the entity corrects the deficiency. (10-1-00)T

02. Review. The Secretary of HHS may review any decision to terminate the designation or reduce the funding of an eligible entity. (10-1-00)T

601. -- 699. (RESERVED).

700. COMMUNITY FOOD AND NUTRITION PROGRAM.

Funds may be used to coordinate private and public food assistance resources, where such coordination is inadequate, to better serve low-income populations; to assist low-income communities to identify potential sponsors of child nutrition programs and to initiate such programs in underserved or unserved areas; and to develop innovative approaches to meet the nutrition needs of low-income individuals. (10-1-00)T

701. -- 996. (RESERVED).

997. CONFIDENTIALITY OF RECORDS.

Any disclosure of information obtained by the Department is subject to the restrictions contained in Idaho Department of Health and Welfare Rules, IDAPA 16.05.01, "Rules Governing the Protection and Disclosure of Department Records". (10-1-00)T

998. -- 999. (RESERVED).

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE
16.04.14 - RULES GOVERNING LOW INCOME HOME ENERGY ASSISTANCE PROGRAM
DOCKET NO. 16-0414-0001
NOTICE OF TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The temporary rule is effective October 1, 2000.

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 Section(s) 56-1004 (1), Idaho Code.

PUBLIC HEARING SCHEDULE: Pursuant to Section 67-5222(2), Idaho Code, 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 October 18, 2000.

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 non-technical explanation of the substance and purpose of the proposed rulemaking:

- 1) Added to the chapter, Catastrophic Illness Costs as criteria for program eligibility.
- 2) Revises "Rights to a Hearing" from Sections 300 and 503 to Section 200.
- 3) Revises the formula for computing Low Income Home Energy Assistance program benefits.

TEMPORARY RULE JUSTIFICATION: The temporary rule has been adopted in accordance with Section 67-5226, Idaho Code and is necessary in order to comply with deadlines in amendments to governing law or federal programs and to confer a benefit.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because the changes are to comply with amendments to governing law.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary or proposed rule, contact Patti Campbell at (208) 334-5815.

Anyone can submit written comments regarding this proposed rule. All written comments and data concerning the rule must be directed to the undersigned and must be postmarked on or before October 25, 2000.

DATED this 8th day of August, 2000.

Sherri Kovach
Administrative Procedures Coordinator
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450 West State Street, 10th Floor
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Boise, Idaho 83720-0036
(208) 334-5564 phone, (208) 332-7347 fax

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0414-0001

101. ELIGIBLE ACTIVITIES.

Funds made available through the LIHEAP grant will be used as follows: (7-1-99)

01. Home Utility And Bulk Fuel Costs. These costs include those incurred by the eligible participant household for electricity, natural gas and bulk fuel for home energy needs, but does not include costs incurred for telephone, water, trash or sewer. (7-1-99)

02. Emergency Crisis Intervention Costs. A portion of the LIHEAP grant funds are reserved for home heating supply shortages experienced by the participant household or a weather-related emergency which threatens the health or lives of an area's inhabitants such that the Governor declares a state of emergency. (7-1-99)

03. Catastrophic Illness Costs. Households with income exceeding eligibility guidelines may be eligible due to catastrophic illness. The household's unreimbursed medical expenses from the previous twelve (12) months are subtracted from the household's gross income for the same period. If the household then meets income guidelines, the Department makes a final eligibility determination. (10-1-00)T

034. Low-Cost Residential Weatherization. Funds reserved for weatherization services to low-income households pursuant to Department of Energy, Weatherization Assistance Program Regulations, when in accordance with federal LIHEAP Regulations. (7-1-99)

102. PARTICIPANT RIGHTS.

The participant has rights protected by federal and state laws and Department rules. The Department or their designee must inform the participant of their rights during the application process and eligibility determination, as follows: (7-1-99)

01. Right To Apply. Any participant household wishing to apply must be given the opportunity, without delay, to apply for LIHEAP benefits. All participants must apply in writing. (7-1-99)

02. Right To A Hearing. Rules governing hearing rights are contained in Idaho Department of Health and Welfare Rules, IDAPA 16.05.03, *Sections 300, et seq., and Section 503*, "Rules Governing Contested Cases and Declaratory Rulings". (7-1-99)(10-1-00)T

03. Civil Rights. The rights of participant households must be respected under the U.S. and Idaho Constitutions, the Social Security Act, Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, and all other relevant provisions of federal and state law, including the avoidance of practices which violate a person's privacy or subjection to harassment. (7-1-99)

(BREAK IN CONTINUITY OF SECTIONS)

204. BENEFIT DETERMINATION.

Eligible participant households will have their LIHEAP benefit determined using Subsections 204.01 through 204.03 of these rules. (4-5-00)

01. Actual Consumption Method. The actual consumption method is used if the eligible participant household heats their residence with either natural gas or electricity and have resided in the residence for one (1) year or longer. Use table 204.01 to determine the base benefit under the Actual Consumption Method. The minimum base benefit is one hundred three dollars (\$103). The maximum base benefit is five hundred fifty dollars (\$550).

TABLE 204.01 ACTUAL CONSUMPTION METHOD	
Step 1.	List the annual consumption cost, excluding July, August and September, furnished by the energy supplier.
Step 2.	<u>Determine if the eligible participant household resides in subsidized housing. If so, the base benefit is always low burden. Skip Step 3 in this case, and go to Step 4.</u>

TABLE 204.01 ACTUAL CONSUMPTION METHOD	
Step 23 .	Divide the annual consumption cost from Step 1 by annualized countable income reported by the household. This gives the percentage of energy burden. 0% to 5% energy burden is low. 6% to 10% energy burden is average. 11% and above energy burden is high.
Step 34 .	If the percentage of energy burden from Step 23 is low, multiply the annual consumption cost from Step 1 by 251 % to determine the base benefit. If the percentage of energy burden from Step 23 is average, multiply the annual consumption cost from Step 1 by 3026 % to determine the base benefit. If the percentage of energy burden from Step 23 is high, multiply the annual consumption cost from Step 1 by 3329 % to determine the base benefit.

~~(4-5-00)~~(10-1-00)T

02. Average Annual Cost Method. The average annual cost method is used when the eligible participant household's actual consumption cost is unknown, or they use a heating source other than electricity or natural gas. Average cost is established based on information gathered from energy suppliers throughout the state. Average cost is published in the annual heating cost chart, available from the Department of Health and Welfare, Bureau of Policy, Grants Unit. The county of residence and source of home energy identify the average cost from the chart. Use table 204.02 to determine the base benefit under the Average Annual Cost Method.

TABLE 204.02 AVERAGE ANNUAL COST METHOD	
Step 1.	Identify the household's average annual heating cost from the annual heating cost chart available from the Department of Health and Welfare, Bureau of Policy, Grants Unit.
<u>Step 2.</u>	<u>Determine if the eligible participant household resides in subsidized housing. If so, the base benefit is always low burden. Skip Step 3 in this case, and go to Step 4.</u>
Step 23 .	Divide the average annual heating cost from Step 1 by annualized countable income reported by the household. This gives the percentage of energy burden. 0% to 5% energy burden is low. 6% to 10% energy burden is average. 11% and above energy burden is high.
Step 34 .	If the percentage of energy burden from Step 23 is low, multiply the annual average heating cost from Step 1 by 251 % to determine the base benefit. If the percentage of energy burden from Step 23 is average, multiply the annual average heating cost from Step 1 by 3026 % to determine the base benefit. If the percentage of energy burden from Step 23 is high, multiply the annual average heating cost from Step 1 by 3329 % to determine the base benefit.

~~(4-5-00)~~(10-1-00)T

03. Adjusting LIHEAP Benefit. For both actual consumption and average annual cost methods, add an adjusted benefit of twenty-five dollars (\$25) to the base benefit if the eligible participant household contains at least one (1) of the following: (4-5-00)

- a. Child under six (6) years of age. (4-5-00)
- b. Individual with disabilities as declared on the LIHEAP application form. (4-5-00)
- c. Individual sixty (60) years of age or older. (4-5-00)
- d. Household contains more than one (1) member. (4-5-00)

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE
16.05.03 - RULES GOVERNING CONTESTED CASES PROCEEDINGS
AND DECLARATORY RULINGS

DOCKET NO. 16-0503-0001 (REPEAL)

NOTICE OF PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has proposed rulemaking. The action is authorized pursuant to Section(s) 16-107, 56-133, 56-135, 56-202, 56-203, 56-204A, 56-216, 56-1003, 56-1004, and 56-1005, 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 October 18, 2000.

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 non-technical explanation of the substance and purpose of the proposed rulemaking:

Current contested case rules are unnecessarily complex, lengthy, and do not accurately reflect where programs are in the Department of Health and Welfare divisions. The entire chapter is being repealed in this docket and re-written in docket no. 16-0503-0002.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was conducted with Department Administrators and the Deputy Attorney General offices in the Regions and at Central.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rules, contact Jeanne Goodenough at (208) 334-5537.

Anyone can submit written comments regarding this rulemaking. All written comments and data concerning the rule must be directed to the undersigned and delivered on or before October 25, 2000.

DATED this 15th day of August, 2000.

Sherri Kovach
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DHW - Legal Services Division
450 West State Street - 10th Floor
P.O. Box 83720
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THIS CHAPTER IS BEING REPEALED IN ITS ENTIRETY.

IDAPA 16 - DEPARTMENT OF HEALTH AND WELFARE
16.05.03 - RULES GOVERNING CONTESTED CASES PROCEEDINGS
AND DECLARATORY RULINGS

DOCKET NO. 16-0503-0002

NOTICE OF PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has proposed rulemaking. The action is authorized pursuant to Section(s) 16-107, 56-133, 56-135, 56-202, 56-203, 56-204A, 56-216, 56-1003, 56-1004, and 56-1005, 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 October 18, 2000

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 non-technical explanation of the substance and purpose of the proposed rulemaking:

Current contested case rules are unnecessarily complex, lengthy, and do not accurately reflect where programs are in the Department of Health and Welfare divisions. The entire chapter is being repealed in docket no. 16-0503-0001 and re-written in this docket. A re-write of the chapter will allow for simplification and streamlining of our hearing process, and correction of program references.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was conducted with Department Administrators and the Deputy Attorney General offices in the Regions and at Central.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rules, contact Jeanne Goodenough at (208) 334-5537.

Anyone can submit written comments regarding this rulemaking. All written comments and data concerning the rule must be directed to the undersigned and delivered on or before October 25, 2000.

DATED this 15th day of August, 2000.

Sherri Kovach
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THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0503-0002

IDAPA 16
TITLE 05
Chapter 03

16.05.03 - RULES GOVERNING CONTESTED CASE PROCEEDINGS
AND DECLARATORY RULINGS

000. LEGAL AUTHORITY.

The Idaho Legislature has granted the Director of the Department of Health and Welfare and the Board of Health and Welfare the power and authority to conduct contested case proceedings and issue declaratory rulings, and to adopt rules governing such proceedings pursuant to Sections 16-107, 56-133, 56-135, 56-202, 56-203, 56-204A, 56-216, 56-1003, 56-1004, and 56-1005, Idaho Code. ()

001. TITLE AND SCOPE.

01. Title. These rules are to be cited fully as Idaho Department of Health and Welfare Rules, IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings". ()

02. Scope. These rules establish standards for petitions for rulemaking and declaratory rulings, and the conduct of contested cases. Contested cases include appeals from providers of medical assistance and other services, and appeals relating to individuals' benefits administered through the Division of Welfare, child support license suspension hearings, denial of a criminal history exemption, and tobacco citations pursuant to Sections 39-5705 and 39-5708, Idaho Code. ()

002. WRITTEN INTERPRETATIONS.

There are none for this chapter of rules. ()

003. ADMINISTRATIVE APPEALS.

All contested cases shall be governed by the provisions of this chapter. The Board of Health and Welfare and the Director of the Department of Health and Welfare find that the provisions of IDAPA 04.11.01.000, et seq., "Idaho Rules of Administrative Procedure of the Attorney General," are inapplicable for contested cases involving the programs administered by the Department, because of the specific requirements of federal and state law regarding hearing processes, and the complexity of the rules at IDAPA 04.11.01, "Idaho Rules of Administrative Procedure of the Attorney General". ()

004. INCORPORATION BY REFERENCE.

There are none in this chapter of rules. ()

005. ADMINISTRATIVE PROCEDURES SECTION.

Petitions for adoption of rules, petitions for declaratory rulings, and appeals shall be filed with: Administrative Procedures Section, 10th Floor, 450 West State Street, P.O. Box 83720, Boise, ID 83720-0036. Phone: (208) 334-5564. FAX: 332-7347. ()

006. -- 009. (RESERVED).

010. DEFINITIONS AND ABBREVIATIONS.

01. Appellant. A person or entity who files an appeal of Department action or inaction. ()

02. Board. The Idaho Board of Health and Welfare. ()

03. Department. The Idaho Department of Health and Welfare. ()

04. Director. The Director of the Department of Health and Welfare. ()

05. Hearing Officer. The person designated to preside over a particular hearing and any related proceedings. ()

06. IPV. Intentional program violation. ()

07. Intervenor. Any person, other than an appellant or the Department, who requests to be admitted as a party in an appeal. ()

08. Party. An appellant, the Department and an intervenor, if intervention is permitted. ()

011. -- 039. (RESERVED).

040. PETITION FOR ADOPTION OF RULES.

Pursuant to Section 67-5230, Idaho Code, any person may file a written petition with the Administrative Procedures Section requesting the promulgation, amendment, or repeal of a rule. The petition shall include a name, address and phone number to which the Department may respond; list the rule in question and explain the reasons for the petition; and include the suggested language of the rule. The Director shall initiate rulemaking proceedings or deny the petition in writing within twenty-eight (28) days. ()

041. -- 049. (RESERVED).

050. PETITION FOR DECLARATORY RULING.

Pursuant to Section 67-5232, Idaho Code, any person may file a written petition to the Director through the Administrative Procedures Section for a declaratory ruling as to the applicability of any statute or rule of the Department to an actual set of facts involving that person. ()

051. CONTENTS OF PETITION FOR DECLARATORY RULING.

A petition for a declaratory ruling shall identify that it is a request for a declaratory ruling pursuant to this section; the specific statute, or rule with respect to which the declaratory ruling is requested; a complete description of the situation for which the declaratory ruling is requested; and the specific ruling requested. The petition shall include the date of the petition, the name, address and phone number of the petitioner and whether the petition is made on behalf of a corporation or organization. The petition shall identify the manner by which the statute or rule interferes with, impairs, or threatens to interfere with or impair the legal rights, duties, licenses, immunities, interests or privileges of the petitioner. ()

052. DISPOSITION OF PETITION FOR DECLARATORY RULING.

The Director shall issue a final declaratory ruling in writing within seventy (70) days after receipt of the petition or within such additional time as may be required. The Director may decline to issue a declaratory ruling in the following circumstances: ()

01. Incomplete. When a petition fails to meet the requirements set forth in Section 051 of these rules; ()

02. Contested Case. When the issue set forth in the petition would be more properly addressed as a contested case, such as where there is a reasonable dispute as to the relevant facts, or where witness credibility is an issue; ()

03. No Legal Interest. When the petition fails to state a sufficient or cognizable legal interest to confer standing; ()

04. Others Affected. When the issue presented would substantially affect the legal rights, license, privileges, immunities, or interests of parties other than petitioners; or ()

05. Beyond Authority. When the ruling requested is beyond the authority of the Department. ()

053. -- 099. (RESERVED).

100. DEPARTMENT RESPONSIBILITY.

When a decision is appealable, the Department shall advise the individual or provider in writing of the right and method to appeal and the right to be represented. ()

101. FILING OF APPEALS.

Appeals shall be filed in writing and shall state the appellant's name, address and phone number, and the remedy requested, except that appeals of action relating to Division of Welfare programs listed in Section 200 of these rules may be made verbally by an individual or representative. Appeals should be accompanied by a copy of the decision that is the subject of the appeal. Unless otherwise provided by statute or these rules, individuals who are aggrieved by a Department decision shall have twenty-eight (28) days from the date of the decision is mailed to file an appeal. ()

102. NOTICE OF HEARING.

All parties in an appeal shall be notified of a hearing at least ten (10) days in advance, or within such time period as may be mandated by law. The hearing officer may provide a shorter advance notice upon request of a party or for good cause. The notice shall identify the time, place and nature of the hearing; a statement of the legal authority under which the hearing is to be held; the particular sections of any statutes and rules involved; the issues involved; and the right to be represented. The notice shall identify how and when documents for the hearing will be provided to all parties. ()

103. PREHEARING CONFERENCE.

The hearing officer may, upon written or other sufficient notice to all interested parties, hold a prehearing conference to formulate or simplify the issues; obtain admissions or stipulations of fact and documents; identify whether there is any additional information that had not been presented to the Department with good cause; arrange for exchange of proposed exhibits or prepared expert testimony; limit the number of witnesses; determine the procedure at the hearing; and to determine any other matters which may expedite the orderly conduct and disposition of the proceeding. ()

104. SUBPOENAS.

At the request of a party, the hearing officer may issue subpoenas for witnesses or documents, consistent with Sections 120 and 134 of these rules. ()

105. DISPOSITION OF CASE WITHOUT A HEARING.

Any contested case may be resolved without a hearing on the merits of the appeal by stipulation, settlement, motion to dismiss, summary judgment, default, withdrawal, for lack of jurisdiction, or if an appeal is not filed within the time limits set forth in these rules. ()

106. DEFAULT.

If a party fails to appear at a scheduled hearing or at any stage of a contested case without good cause, the hearing officer may enter a proposed default order against that party. The default order shall be set aside if the appellant provides good cause for not appearing within seven (7) days of service of the order. ()

107. INTERVENTION.

Persons other than the original parties to an appeal who are directly and substantially affected by the proceeding may participate if they first secure an order from the hearing officer granting leave to intervene. The granting of leave to intervene shall not be construed to be a finding or determination that the intervenor is or may be a party aggrieved by any ruling, order or decision of the Department for purposes of judicial review. ()

108. -- 119. (RESERVED).

120. DISCOVERY.

Except for hearings involving Section 56-1005(5), Idaho Code, prehearing discovery shall be limited to obtaining the names of witnesses and copies of documents the opposing party intends to offer as exhibits. The hearing officer may order disclosure of this information if a party refuses to comply after receiving a written request. Nothing in Section 120 shall limit the authority of the Director provided in Section 56-227C, Idaho Code. ()

121. BRIEFING SCHEDULE.

A hearing officer may require briefs to be filed by the parties, and establish a reasonable briefing schedule. ()

122. FILING OF DOCUMENTS IN AN APPEAL.

All documents intended to be used as exhibits shall be filed with the hearing officer. Such documents shall be provided to every party at the time they are filed with the hearing officer, in person or by first class mail. Service by mail is complete when the document, properly addressed and stamped, is deposited in the United States or Statehouse mail. A certificate showing delivery to all parties shall accompany all documents when they are filed with the hearing officer. ()

123. REPRESENTATION.

Any party in a contested case proceeding may be represented by legal counsel, at the party's own expense. An individual in an appeal involving benefits may also be represented by a non-attorney. ()

124. REPRESENTATION OF INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES.

Unless an individual, authorized representative or attorney provides a written declaration to the contrary, eligible individuals with developmental disabilities or mental illness shall be deemed to be represented by the state Protection and Advocacy System established pursuant to 42 USC 6041, et seq., and 42 USC 10801 et seq., and designated by the Governor. The protection and advocacy system shall have access to records of such individuals maintained by any program or institution of the Department if the individual is unable to authorize the system to have such access, or does not have a legal guardian, conservator or other legal representative. Service of documents shall be made on the protection and advocacy system and the individual. Unless the protection and advocacy system provides written notification to the Department that it will not be representing the individual, the system shall be an authorized representative. ()

125. INTERPRETERS.

If necessary, an interpreter shall be provided by the Department. ()

126. -- 129. (RESERVED).

130. OPEN HEARINGS.

All contested case hearings are open to the public, unless ordered closed in the discretion of the hearing officer due to the sensitive nature of the hearing. Witnesses may testify by telephone or other electronic means, provided the examination and responses are audible to all parties. ()

131. AUTHORITY OF HEARING OFFICER.

The hearing officer shall consider only information that was available to the Department at the time the decision was made. If appellant shows that there is additional relevant information that was not presented to the Department with good cause, the hearing officer shall remand the case to the Department for consideration. No hearing officer shall have the jurisdiction or authority to invalidate any federal or state statute, rule, regulation, or court order. No hearing officer shall substitute his judgment for that of Department officials on matters of substance or policy, nor shall any hearing officer retain jurisdiction on any matter after it has been remanded to the Department. ()

132. BURDEN OF PROOF - INDIVIDUAL BENEFIT CASES.

The Department has the burden of proof if the action being appealed is to limit, reduce or terminate services or benefits; establish an overpayment or disqualification; revoke or limit a license; or to contest a tobacco violation pursuant to Sections 39-5705 and 39-5708, Idaho Code. The appellant has the burden of proof on all other issues, including establishing eligibility for a program, service or license; seeking an exemption required due to criminal history or abuse registry information; or seeking to avoid license suspension for failure to pay child support. ()

133. BURDEN OF PROOF - PROVIDER CASES.

The Department has the burden of proof if the action being appealed is to revoke or limit a license, certification, or provider agreement; or to impose a penalty. The appellant has the burden of proof on all other issues, including establishing entitlement to payment. ()

134. EVIDENCE.

Pursuant to Section 67-5251, Idaho Code, the hearing shall be informal and technical rules of evidence shall not

apply, except that irrelevant, immaterial, incompetent, unduly repetitious evidence, evidence excludable on constitutional or statutory grounds, or evidence protected by legal privilege shall be excluded. Hearsay evidence shall be received if it is relevant to a matter in dispute and is sufficiently reliable that prudent persons would commonly rely on it in the conduct of their affairs, or corroborates competent evidence. Any part of the evidence may be received in written form if doing so will expedite the hearing without substantially prejudicing the interest of any party. Documentary evidence may be received in the form of copies or excerpts if the original is not readily available. Unless otherwise stated in statute, rule, or regulation, the evidentiary standard shall be proof by a preponderance of the evidence. ()

135. DISCRETIONARY JUDICIAL NOTICE.

Notice may be taken of judicially cognizable facts by the hearing officer or authority on its own motion or on motion of a party. In addition, notice may be taken of generally recognized technical or scientific facts within the Department's specialized knowledge. Parties shall be notified either before or during the hearing, or by reference in preliminary reports or otherwise, of the material noticed including any staff memoranda or data, and the parties shall be afforded an opportunity to contest the material so noticed. The Department's experience, technical competence, and specialized knowledge may be utilized in the evaluation of the evidence. ()

136. MANDATORY JUDICIAL NOTICE.

01. Judicial Notice. The hearing officer shall take judicial notice, on its own motion or on the motion of any party, of the following materials: ()

02. Admissible, Valid, And Enforceable Materials. The following are admissible, valid and enforceable: ()

- a. Rules of the Department and other state agencies; ()
- b. Federal regulations; ()
- c. State plans of the Department; ()
- d. The Constitutions and statutes of the United States and Idaho; ()
- e. Public records; and ()
- f. Such other materials that a court of law must judicially notice. ()

137. HEARING RECORD.

The hearing officer shall arrange for a record to be made of a hearing. The hearing shall be recorded unless a party requests a stenographic recording by a certified court reporter, in writing, at least seven (7) days prior to the date of hearing. The record shall be transcribed at the expense of the party requesting a transcript and prepayment or guarantee of payment may be required. Once a transcript is requested, any party may obtain a copy at the party's own expense. The Department shall maintain the complete record of each contested case for a period of not less than six (6) months after the expiration of the last date for judicial review, unless otherwise provided by law. ()

138. DECISION AND ORDER.

A preliminary order shall be issued by the hearing officer not later than thirty (30) days after the case is submitted for decision. The order shall include specific findings on all major facts at issue; a reasoned statement in support of the decision; all other findings and recommendations of the hearing officer; a preliminary decision affirming, reversing or modifying the action or decision of the Department, or remanding the case for further proceedings; and the procedures and time limits for filing requests for review of the order. Unless otherwise provided by a statute governing a particular program, motions for reconsideration of a preliminary order shall not be accepted. ()

139. -- 149. (RESERVED).

150. REVIEW OF PRELIMINARY ORDERS BY DEPARTMENT.

In cases under the jurisdiction of the Department, either party may file a request for review with the Administrative

Procedures Section not later than fourteen (14) days from the date the preliminary order was mailed. The request shall identify all legal and factual bases of disagreement with the preliminary order. The Director or designee shall allow for briefing by the parties and shall determine whether oral argument will be allowed. The Director or designee shall determine whether a transcript of the hearing is needed and if so, one shall be provided by the party who requests review of the preliminary order. A final decision shall be issued within fifty-six (56) days after the matter has been submitted for decision. ()

151. PETITION FOR REVIEW BY BOARD OF HEALTH AND WELFARE.

In cases under the jurisdiction of the Board, either party may file a petition for review with the Administrative Procedures Section not later than twenty-eight (28) days from the date the preliminary order was mailed. The Administrative Procedures Section shall establish a schedule for the submission of briefs and if allowed, oral argument. Appellant shall provide a transcript of the hearing before the hearing officer unless the appeal involves only questions of law. ()

152. FINAL ORDER.

The Board, Director or designee may affirm, modify, or reverse the order, or remand the matter to the hearing officer for further proceedings. The decision shall inform the parties of the procedure and time limits for filing appeals with the district court. Motions for reconsideration of a final order shall not be accepted. ()

153. SERVICE OF PRELIMINARY AND FINAL ORDERS.

Orders shall be deemed to have been served when copies thereof are mailed to all parties of record or their attorneys. ()

154. MAINTENANCE OF ORDERS.

All final orders of the Board or the Director shall be maintained by the Administrative Procedures Section and made available for public inspection for at least six (6) months, or until all appeals are concluded, whichever is later. ()

155. EFFECT OF PETITION FOR JUDICIAL REVIEW.

The filing of a petition for judicial review shall not stay compliance with a final order or suspend the effectiveness of the order, unless otherwise ordered or mandated by law. ()

156. -- 198. (RESERVED).

199. SPECIFIC CONTESTED CASE PROVISIONS.

The following sections set forth special requirements of various Department programs, which supersede the general provisions of these rules insofar as they are different or inconsistent. Sections 200 through 254 pertain to the programs in the Division of Welfare; Sections 300 and 301 pertain to the Division of Medicaid; and Sections 400 through 402 pertain to the Division of Health. ()

200. DIVISION OF WELFARE APPEALS.

The provisions of this section of rules govern the conduct of individual benefit hearings to determine eligibility for benefits or services in the Division of Welfare, including IDAPA 16.03.05, "Rules Governing Eligibility for Aid to the Aged, Blind and Disabled," IDAPA 16.03.08, "Rules Governing Temporary Assistance for Families in Idaho," IDAPA 16.03.04, "Rules Governing the Food Stamp Program in Idaho," IDAPA 16.06.12, "Rules Governing Idaho Child Care Program," IDAPA 16.04.14, "Rules Governing the Low Income Energy Assistance Program," IDAPA 16.04.02, "Idaho Telecommunication Service Assistance Program Rules," IDAPA 16.04.12, "Rules Governing Individual and Family Grant Programs," and IDAPA 16.03.01, "Rules Governing Eligibility for Medicaid for Families and Children." ()

201. TIME FOR FILING APPEAL.

A decision issued by the Department in a Division of Welfare program shall be final and effective unless an individual or representative appeals within thirty (30) days from the date the decision was mailed, except that a recipient or applicant for Food Stamps shall have ninety (90) days to appeal. An individual or representative may also appeal when the Department delays in making an eligibility decision or making payment beyond the limits specified in the particular program within thirty (30) days after the action would have been taken if the Department had acted in a timely manner. ()

202. INFORMAL CONFERENCE.

An appellant or representative has the right to request an informal conference with the Department or Community Action Agency before the hearing date. This conference may be used to resolve the issue informally or to provide the appellant with information about the hearing or actions. The conference will not affect the appellant's right to a hearing or the time limits for the hearing. After the conference, the hearing shall be held unless the appellant withdraws the appeal, or the Department withdraws the action contested by the appellant. ()

203. WITHDRAWAL OF AN APPEAL.

An appellant or representative may withdraw an appeal upon written request to the hearing officer. ()

204. TIME LIMITS FOR COMPLETING HEARINGS.

The Department shall conduct the hearing relating to an individual's benefits and take action within ninety (90) days from the date the hearing request is received. When the hearing request concerns the computed amount of the Community Spouse Resource Allowance, the hearing shall be held within thirty (30) days from the date the hearing request is received. The Department shall expedite hearing requests from appellants such as migrant farm workers who are planning to move before the hearing decision would normally be reached. An applicant for benefits or services in the Individual and Family Grant Program who is dissatisfied with the administrative panel's determination of eligibility or grant amount may appeal not later than fourteen (14) days from mailing of the determination. ()

205. APPEAL OF AUTOMATIC ADJUSTMENTS.

An appeal shall be dismissed if the hearing officer determines that the sole issue is an automatic grant adjustment, change in rule that affects benefit amount or eligibility, or reduction of Medicaid services under state or federal law. ()

206. CONSOLIDATED HEARING.

When there are multiple appeals or a group appeal involving similar issues of law, rules, or policy, the hearing officer shall hold a consolidated hearing. ()

207. POSTPONEMENT OF FOOD STAMP HEARINGS.

An appellant may request, and shall be granted a postponement of a hearing, not to exceed thirty (30) days. The time limit for the Department's response shall be extended for as many days as the hearing is postponed. ()

208. -- 249. (RESERVED).

250. FOOD STAMPS DISQUALIFICATION HEARINGS.

A disqualification hearing shall be scheduled when the Department has evidence that an individual has allegedly committed one (1) or more acts of intentional program violations (IPV). ()

251. COMBINING DISQUALIFICATION HEARING AND BENEFIT HEARING.

The hearing officer shall consolidate a hearing regarding benefits or overpayment and a disqualification hearing if the issues are the same or related. The appellant shall be notified that the hearings will be combined. ()

252. RIGHT NOT TO TESTIFY.

The hearing officer shall advise the appellant that he may refuse to answer questions during a disqualification hearing. ()

253. FAILURE TO APPEAR.

If an appellant or representative fails to appear at a disqualification hearing or cannot be located, the hearing shall be conducted in his absence. The Department shall present proof that advance notice of the hearing was mailed to the appellant's last known address. The hearing officer shall consider the evidence and determine if an IPV occurred based solely on the information provided by the Department. The appellant has ten (10) days from the date of the scheduled hearing to show good cause for failure to appear. If an IPV had been established, but the hearing officer determines the appellant had good cause for not appearing, the previous decision shall be void and a new hearing shall be conducted. The previous hearing officer may conduct the new hearing. ()

254. STANDARD FOR DETERMINING INTENTIONAL PROGRAM VIOLATIONS.

The determination that an intentional program violation has been committed shall be established by clear and

convincing evidence that the appellant committed or intended to commit an IPV. ()

255. -- 299. (RESERVED).

300. DIVISION OF MEDICAID - REQUEST FOR ADMINISTRATIVE REVIEW.

An action relating to licensure or certification, billing or reimbursement shall be final and effective unless the provider or facility requests in writing an administrative review within twenty-eight (28) days after the notice is mailed. The request shall be signed by the licensed administrator of the facility or by the provider, identify the challenged decision, and state specifically the grounds for its contention that the decision was erroneous. The parties shall clarify and attempt to resolve the issues at the review conference. If the Department determines that additional documentation is needed to resolve the issues, a second session of the conference may be scheduled. A written decision by the Department shall be furnished to the facility or provider. ()

301. SCOPE OF HEARING.

If the Department's decision after the administrative review is appealed, only issues and documentation that were presented in the administrative review shall be admissible in the appeal hearing. ()

302. -- 399. (RESERVED).

400. DIVISION OF HEALTH -- LABORATORIES.

A notice of grounds for denial, suspension, revocation or renewal shall become final and effective unless the applicant or responsible party files a written appeal by registered or certified mail within fourteen (14) days of receipt of the notice. A hearing shall be held not more than twenty-eight (28) days from receipt of the appeal. The applicant or responsible person shall receive at least fourteen (14) days of notice of the hearing date. If the Department finds that the public health, safety or welfare imperatively requires emergency action, and incorporates the findings to that effect in its notice of denial, suspension or revocation, summary suspension of the approval may be ordered. ()

401. REPORTABLE DISEASES.

An order or restriction as specified in IDAPA 16.02.10, Subsections 015.05 through 015.10, "Idaho Reportable Diseases," shall become final and effective unless an appeal is filed within five (5) working days after the effective date of the order or restriction. ()

01. Conduct Of Hearing. The Department may take whatever precautions and make whatever arrangements are necessary for the conduct of such hearing to insure that the health of participants and the public is not jeopardized. ()

02. Review. Any person directly affected by an order or restriction may file exceptions to the Director's determination, which shall be reviewed by the Board. The order or restriction shall remain effective unless rescinded by the Board. ()

402. FOOD ESTABLISHMENTS.

A notice of action or intended action to deny, suspend, revoke, or fail to renew a license shall become final and effective unless an appeal is filed with the appropriate health district by the applicant or license holder within fourteen (14) days of receipt of the notice. The health district shall conduct an administrative review and issue a decision, which shall become final and effective unless an appeal is filed with the Department within fourteen (14) days. If an appeal is received timely, a hearing shall be scheduled and a decision issued within twenty-one (21) days of receipt of the appeal. ()

403. -- 999. (RESERVED).

IDAPA 17 - INDUSTRIAL COMMISSION
17.04.05 - ACCREDITATION OF ASBESTOS PROFESSIONALS
EMPLOYED IN SCHOOL PROJECTS

DOCKET NO. 17-0405-0001 (REPEAL)

NOTICE OF PROPOSED RULE

AUTHORITY: In compliance with Section 67-5220(1), Idaho Code, notice is hereby given that this agency proposed rule-making. The action is authorized pursuant to Section(s) 72-508, 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 October 18, 2000.

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 non-technical explanation of the substance and purpose of the proposed rulemaking:

IDAPA 17.04.05, was originally promulgated pursuant to Executive Order 89-5. Last session the legislative committee asked the Commission to research the statutory authority for certain provisions of the rule. In researching this, the Commission found that the Executive Order under which the rule was originally promulgated expired without renewal and there is no statutory authority remaining for the rule. The accreditation of asbestos professionals is required by the federal Environmental Protection Act. The state program is duplicating the federal program and the statutory basis for this at the state level no longer exists. Therefore, the Commission wishes to repeal the rule in its entirety.

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

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because the research of the Commission's statutory authority in this matter was requested by a member of the legislature in his official capacity and the Executive Order under which the rule was originally promulgated has expired without the creation of statutory authority for the program.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Gary Stivers, Director, Industrial Commission, (208)334-6050.

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, 2000.

DATED this 22nd day of August, 2000.

Patricia S. Ramey, Commission Secretary
Industrial Commission
317 Main Street, 2nd Floor East
P. O. Box 83720, Boise, Idaho 83720-0041
Phone: (208)334-6000
Fax: (208)334-5145

THIS CHAPTER IS BEING REPEALED IN ITS ENTIRETY.

IDAPA 17 - INDUSTRIAL COMMISSION

17.07.01 - SAFETY RULES FOR ELEVATORS AND ESCALATORS - GENERAL REQUIREMENTS

DOCKET NO. 17-0701-0001

NOTICE OF PROPOSED RULE

AUTHORITY: In compliance with Section 67-5220(1), Idaho Code, notice is hereby given that this agency proposed rulemaking. The action is authorized pursuant to Section(s) 72-508, 72-720, 72-721, 72-722, and 72-723, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rule-making will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 18, 2000.

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 non-technical explanation of the substance and purpose of the proposed rulemaking:

These amendments are proposed to update the state's safety standards for elevators, escalators, and moving walkways to comply with changes in the national elevator standards which are adopted by reference in IDAPA 17.07.01.004. There is a need to add to definitions and clarify the state rules based on the national standards. IDAPA 17.07.02 through 04 are being repealed and incorporated into IDAPA 17.07.01 to eliminate redundancy and improve the continuity of the rules.

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

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rule-making was not conducted because substantive changes were made due to updates in the national safety standards. The other changes were clerical in nature.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Mike Poulin, Industrial Safety Supervisor, Division of Building Safety, (208)334-3950, extension 315.

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, 2000.

DATED this 31st day of July, 2000.

Patricia S. Ramey
Commission Secretary
Industrial Commission
317 Main Street, 2nd Floor East
P. O. Box 83720
Boise, Idaho 83720-0041
Phone: (208)334-6000/Fax: (208)334-5145

THE FOLLOWING IS THE TEXT OF DOCKET NO. 17-0101-0001

17.07.01 - SAFETY RULES FOR ELEVATORS, ~~AND~~ ESCALATORS
~~—GENERAL REQUIREMENTS, AND MOVING WALKS~~

001. TITLE AND SCOPE.

01. Title. These rules shall be cited as IDAPA 17.07.01, “Safety Rules for Elevators, ~~and~~ Escalators—
~~General Requirements,~~” and Moving Walks”. ()

02. Scope. These rules shall be applicable to all persons engaged in the design, construction, installation, operation, inspection, testing, maintenance, alteration ~~and~~ or repair of elevators, dumbwaiters, moving walks, material lifts, wheelchair lifts, stairway chair-lifts, and escalators. (7-1-97)()

(BREAK IN CONTINUITY OF SECTIONS)

004. ~~(RESERVED)~~ INCORPORATION BY REFERENCE.

- 01.** ANSI/ASME A17.1. - 1996 edition with addenda, Safety Code for Elevators and Escalators. ()
- 02.** ANSI/ASME A17.2.1. - 1996 edition with addenda, Inspector’s Manual for Electric Elevators. ()
- 03.** ANSI/ASME A17.2.2. - 1997 edition with addenda, Inspector’s Manual for Hydraulic Elevators. ()
- 04.** ANSI/ASME A17.2.3. - 1994 edition with addenda, Inspector’s Manual for Escalators and Moving Walks. ()
- 05.** ANSI/ASME A17.3. - 1996 edition with addenda, Existing Elevators and Escalators. ()
- 06.** ANSI/ASME A17.4. - 1991 edition, Emergency Evacuation of Passengers from Elevators. ()
- 07.** ANSI/ASME A17.5. - 1996 edition, Standard for Elevator and Escalator Electrical Equipment. ()
- 08.** ANSI/ASME A10.4. - 1990 edition, Safety Requirements for Personnel Hoists and Employee Elevators for Construction and Demolition of Operations. ()
- 09.** ANSI A117.1, Section 407. - 1998 edition, Accessible and Usable Buildings and Facilities, Elevators. ()
- 10.** ANSI A18.1. - 1999 edition, Safety Standards for Platform Lifts and Stairway Chairlifts. ()

005. ~~INCLUSIVE GENDER OFFICE ADDRESS AND HOURS.~~

~~For all sections and subsections of these rules, the terms and references used in the masculine include the feminine and vice versa, as appropriate. The standards incorporated by reference herein are available for review at the Division of Building Safety, 277 North Sixth Street, Boise, Idaho, between the hours of 8 a.m. and 5 p.m., except Saturday, Sunday and legal holidays.~~ (7-1-97)()

006. ~~SEVERABILITY.~~

~~The sections and subsections of these rules are severable. If any rule, or part thereof, or the application of such rule, or the application of such rule to any person or circumstance is declared invalid, that invalidity does not affect the~~

~~validity of any remaining portion.~~

~~(7-1-97)~~

0076. -- 009. (RESERVED).

010. DEFINITIONS.

- 01. Alteration.** ~~Is a~~ A change to equipment other than maintenance, repair, or replacement. (7-1-97)(____)
- 02. Approved.** Acceptable to the authority having jurisdiction. (7-1-97)
- 03. Authority Having Jurisdiction.** The State of Idaho, Division of Building Safety. (7-1-97)
- 04. Authorized Personnel.** Persons who have been instructed in the operation and/or maintenance of the equipment designated by the owner to use or maintain the equipment. (7-1-97)
- 05. Building Code.** The latest state adopted version of the Uniform Building Code. (7-1-97)
- 06. Certified.** A certification by a testing laboratory, a professional engineer, a manufacturer, or a contractor that a device or an assembly conforms to the requirements of the Safety Code for Elevators and Escalators (ASME A17.1). (7-1-97)
- 07. Competent Person.** A person who is capable of identifying existing and predictable hazards and who has authorization to take prompt corrective action to eliminate them. (7-1-97)
- 08. Department.** ~~Is~~ The Division of Building Safety. (7-1-97)(____)
- 09. Designated Attendant.** ~~Is where~~ A person who operates an elevator ~~operation~~ that is controlled from the inside of the car. (7-1-97)(____)
- 10. Designated Level.** ~~Is~~ The main floor or other level that best serves the needs of emergency personnel for firefighting or rescue purposes. (7-1-97)(____)
- 11. Director.** ~~Is~~ The administrator of the Division of Building Safety. (7-1-97)(____)
- 12. Dumbwaiter.** ~~Is a~~ A hoisting and lowering mechanism equipped with a car of limited size which moves in guide rails and serves two (2) or more landings, and classified by the following types: (7-1-97)(____)
- a. Hand dumbwaiter. ~~Is a~~ A dumbwaiter utilizing manual energy to move the car. (7-1-97)(____)
- b. Power dumbwaiter. ~~Is a~~ A dumbwaiter utilizing energy other than gravitational or manual to move a car. (7-1-97)(____)
- c. Electric dumbwaiter. ~~Is a~~ A power dumbwaiter where the energy is applied by means of an electric driving machine. (7-1-97)(____)
- d. Hydraulic dumbwaiter. ~~Is a~~ A power dumbwaiter where the energy is applied, by means of a liquid under pressure, in a cylinder equipped with a plunger or piston. (7-1-97)(____)
- e. Direct plunger hydraulic dumbwaiter. ~~Is a~~ A hydraulic dumbwaiter having a plunger or cylinder directly attached to the car frame or platform. (7-1-97)(____)
- f. Electro-Hydraulic Dumbwaiter. ~~Is a~~ A direct plunger dumbwaiter where liquid is pumped under pressure directly into the cylinder by a pump driven by an electric motor. (7-1-97)(____)
- g. Maintained pressure hydraulic dumbwaiter. ~~Is a~~ A direct plunger dumbwaiter where liquid under pressure is available at all times for transfer into the cylinder. (7-1-97)(____)

h. Roped Hydraulic Dumbwaiter. ~~Is-a~~ A dumbwaiter having its piston connected to the car with wire rope. (7-1-97)(____)

i. Under-counter dumbwaiter. ~~Is-a~~ A dumbwaiter which has its top terminal landing located underneath a counter. (7-1-97)(____)

13. Earthquake Protective Devices. A device or group of devices which serve to regulate the operation of an elevator or group of elevators in a predetermined manner during or after an earthquake. (7-1-97)

14. Elevator. A hoisting and lowering mechanism, equipped with a car or platform, which moves in guide rails and serves two (2) or more landings and is classified by the following types: (7-1-97)

a. Freight elevator. ~~Is-a~~ An elevator used primarily for carrying freight and on which only the operator and the persons necessary for unloading and loading the freight are permitted to ride. (7-1-97)(____)

b. Gravity elevator. ~~Is-a~~ An elevator utilizing gravity to move the car. (7-1-97)(____)

c. Hand elevator. ~~Is-a~~ An elevator utilizing manual energy to move the car. (7-1-97)(____)

d. Inclined elevator. ~~Is-a~~ An elevator which travels at an angle of inclination of seventy (70) degrees or less from the horizontal. (7-1-97)(____)

e. Multi-deck elevator. ~~Is-a~~ An elevator having two (2) or more compartments located one immediately above the other. (7-1-97)(____)

f. Observation elevator. ~~Is-a~~ An elevator designed to permit exterior viewing by passengers while the car is traveling. (7-1-97)(____)

g. Passenger elevator. ~~Is-a~~ An elevator used primarily to carry persons other than the operator and persons necessary for unloading and loading. (7-1-97)(____)

h. Power elevator. ~~Is-a~~ An elevator utilizing energy other than gravity or manual to move the car. (7-1-97)(____)

i. Electric elevator. ~~Is-a~~ A power elevator where the energy is applied by means of an electric driving machine. (7-1-97)(____)

j. Hydraulic elevator. ~~Is-a~~ A power elevator where the energy is applied; by means of a liquid under pressure; in a cylinder equipped with a plunger or piston. (7-1-97)(____)

k. Direct plunger hydraulic elevator. ~~Is-a~~ A hydraulic elevator having a plunger or cylinder directly attached to the car frame or platform. (7-1-97)(____)

l. Electro-hydraulic elevator. ~~Is-a~~ A direct plunger elevator where liquid is pumped under pressure directly into the cylinder by a pump driven by an electric motor. (7-1-97)(____)

m. Limited-use/limited application elevator. ~~Is-a~~ A power passenger elevator where the use and application is limited by size, capacity, speed, and rise, intended principally to provide vertical transportation for people with physical disabilities. (7-1-97)(____)

n. Maintained pressure hydraulic elevator. ~~Is-a~~ A direct plunger elevator where liquid under pressure is available at all times for transfer into the cylinder. (7-1-97)(____)

o. Personnel hoist. A mechanism and its related hoistway for use in connection with the construction, alteration, on-going maintenance, or demolition of a building, structure, or other work. It is used for hoisting and lowering workers or materials or both, and is equipped with a car that moves vertically on guide members. (____)

~~op.~~ Roped hydraulic elevator. ~~Is-a~~ A hydraulic elevator having its plunger or piston connected to the car with wire ropes or indirectly coupled to the car by means of wire ropes and sheaves. (7-1-97)(____)

~~pq.~~ Rack and pinion elevator. ~~Is-a~~ A power elevator with or without a counterweight which is supported, raised, and lowered by a motor or motors which drive a pinion or pinions on a stationary rack mounted in the hoistway. (7-1-97)(____)

~~qr.~~ Screw column elevator. ~~Is-a~~ A power elevator having an uncounter-weighted car which is supported, raised, and lowered by means of a screw thread. (7-1-97)(____)

~~rs.~~ Private residence elevator. ~~Is-a~~ A power passenger elevator which is limited in size, capacity, rise, and speed, and is installed in a single family private residence or in a multiple dwelling as a means of access to an individual private residence. (7-1-97)(____)

~~st.~~ Rooftop elevator. ~~Is-a~~ A power passenger or freight elevator operating between a landing at roof level and one (1) landing below. It opens onto the exterior roof level of the building through a horizontal opening. (7-1-97)(____)

~~tu.~~ Sidewalk elevator. ~~Is-a~~ An elevator of the freight type operating between a landing in a sidewalk or other exterior area and the floors below the sidewalk or grade level. It opens onto the exterior area through a horizontal opening. (7-1-97)(____)

~~uv.~~ Special purpose personnel elevator. ~~Is-a~~ An elevator which is limited in size, capacity, and speed, and permanently installed in structures such as grain elevators, radio antenna, bridge towers, underground facilities, dams, power plants, and similar structures to provide vertical transportation of authorized personnel and their tools and equipment only. (7-1-97)(____)

~~vw.~~ Construction elevator. ~~Is-a~~ An elevator being used temporarily, only for construction purposes. (7-1-97)(____)

15. Enforcing Authority. The Industrial Commission, state of Idaho. (7-1-97)

16. Escalator. A power driven, inclined, continuous stairway used for raising or lowering passengers. (7-1-97)

17. Hoistway Enclosure. The fixed structure, consisting of vertical walls or partitions, which isolates the hoistway from all other areas or from an adjacent hoistway and in which the hoistway doors and door assemblies are installed. (7-1-97)

18. Inspection and Tests. (7-1-97)

a. Acceptance. The initial inspection and tests of new or altered equipment by a competent person and witnessed by a State Inspector to check for compliance with the applicable code requirements. (7-1-97)

b. Periodic. Routine inspection and tests plus additional detailed examination and operation of equipment at specified intervals performed by a competent person and witnessed by a State Inspector to check for compliance with the applicable code requirements. (7-1-97)

c. Routine. The examination and operation of equipment at specified intervals by a competent person to check for compliance with applicable code requirements. (7-1-97)

19. Installation. A complete elevator, dumbwaiter, escalator, lift, inclined lift, or moving walk including its hoistway, hoistway enclosures and related construction, and all machinery and equipment for its operation. (7-1-97)

a. Existing installation. An installation that has been completed or was under construction prior to the

effective date of the adoption of the latest applicable ASME standard. (7-1-97)

b. New installation. Any installation not classified as an existing installation by definition, or an existing elevator, dumbwaiter, escalator, lift, inclined lift, or moving walk moved to a new location subsequent to the effective date of the adoption of the latest applicable ASME standard. (7-1-97)

20. Installation Placed Out Of Service. An installation ~~who's~~ on which the power feed lines have been disconnected from the mainline disconnect switch ~~and~~. (7-1-97)()

a. An electric elevator, dumbwaiter, or lift ~~who's~~ on which the suspension ropes have been removed, whose car and counterweights rest at the bottom of the hoistway, and ~~whose~~ the hoistway doors have been permanently barricaded or sealed in the closed position on the hoistway side. (7-1-97)()

b. A hydraulic elevator, dumbwaiter, or lift ~~whose~~ on which the car rests at the bottom of the hoistway; when provided with suspension ropes and counterweights, the suspension ropes have been removed and the counterweights rest at the bottom of the hoistway. ~~and~~ whose the hoistway doors are permanently barricaded or sealed in the closed position on the hoistway side. (7-1-97)()

c. An escalator or moving walk ~~whose~~ on which the entrances have been permanently barricaded. (7-1-97)()

21. Labeled. Equipment or materials to which the manufacturer has ~~been~~ attached a label, symbol, or other identifying mark of an independent certifying organization with authority to perform product evaluation, ~~that maintains and to perform~~ periodic inspection of the production of labeled equipment or materials, ~~and by whose labeling~~ By affixing the label the manufacturer indicates the equipment or materials compliance with appropriate standards or performance in a specified manner. (7-1-97)()

22. Listed. Equipment or materials included in a list published by an independent certifying organization ~~concerned~~ with authority to perform product evaluation ~~that maintains and to perform~~ periodic inspection of the production of listed equipment or materials, ~~and whose listing~~ The certifying organization states whether ~~that the listed~~ equipment or material meets appropriate standards or has been tested and found suitable for use in a specified manner. (7-1-97)()

23. Main Floor. The floor providing normal egress from the building. (7-1-97)

24. Maintenance. A process of routine examination, lubrication, cleaning, adjustment, and replacement of parts for the performance in accordance with applicable Code requirements. (7-1-97)

25. Material Lift. A hoisting and lowering mechanism not normally classified as an elevator, equipped with a platform, serving two (2) or more landings for the purpose of transporting materials only (no persons), which may be manually or automatically operated from outside the hoistway. ()

26. Moving Walk. A type of passenger-carrying device on which passengers stand or walk, and which the passenger-carrying surface remains parallel to its direction of motion and is uninterrupted. ()

257. Penetrate A Floor. To pass through or pierce a floor in such a way that the opening has a continuous perimeter and is provided only to allow equipment to pass through the floor. (7-1-97)

268. Phase I Emergency Recall. The ~~operation of an elevator wherein it~~ first phase of an emergency during which an elevator is automatically or manually recalled to a specific landing and removed from normal service ~~because of~~ due to the activation of a fire detection device. (7-1-97)()

279. Phase II Emergency In-Car Operation. The operation and control of an elevator by firefighters ~~where the operation of the elevator is under their control~~ during an emergency. (7-1-97)()

2830. Pit. That portion of a hoistway extending from the sill level of the lowest landing to the floor at the bottom of the hoistway. (7-1-97)

2931. Private Residence. A separate dwelling or a separate apartment in a multiple dwelling which is occupied only by the members of a single family unit. (7-1-97)

302. Repair. The process of rehabilitation or replacement of parts that are basically the same as the original for the purpose of ensuring performance in accordance with the applicable code requirements. (7-1-97)

313. Replacement. The substitution of a device or component in its entirety with a new unit that is basically the same as the original for the purpose of ensuring performance in accordance with the applicable code requirements. (7-1-97)

324. Weather Proof. So constructed or protected that exposure to the weather will not interfere with the successful operation of the equipment. (7-1-97)

(BREAK IN CONTINUITY OF SECTIONS)

012. -- ~~99019.~~ (RESERVED).

020. GENERAL REQUIREMENTS.

01. Compliance With Code And Rules. All new elevators, dumbwaiters, moving walks, material lifts, wheelchair lifts, stairway chair-lifts, and escalators, unless otherwise exempted by these rules, to be installed or operated in the state of Idaho shall be designed, constructed, installed, operated, and inspected in accordance with the applicable ANSI/ASME code, the latest addenda, and these rules. ()

02. State Registration Number. All elevators, dumbwaiters, moving walks, material lifts, wheelchair lifts, stairway chair-lifts, and escalators, unless otherwise exempted by these rules, shall have a state of Idaho registration number permanently affixed to the equipment. ()

03. Manual Shutoff Valve. All hydraulic elevators shall have a manual shutoff valve in the supply line to the hydraulic cylinder located in the elevator machine room. ()

04. Pressure Gage Installations. All hydraulic elevators shall have a hydraulic nipple type H-1 located between the hydraulic oil pump and the machine room manual shutoff valve to standardize pressure gage installations. ()

05. Emergency Unlocking Devices. Hoistway door unlocking provisions and devices shall be provided for use by authorized and emergency personnel for each elevator car at every landing where there is an entrance. ()

06. Main Line Disconnect Or Shunt Trip. A fused or circuit breaker elevator main line disconnect shall be located in the appropriate elevator machine room for the elevator being controlled. Where used, shunt trips shall be located in the appropriate elevator machine room for the elevator being controlled. ()

021. NOTIFICATION REQUIREMENTS.

01. Prior To Installation, Major Alterations, Or Repairs. Before any major alteration or repairs are made to an existing elevator, dumbwaiter, moving walk, material lift, wheelchair lift, stairway chair-lift, and or escalator, unless otherwise exempted by these rules, or before the installation of any new elevator, dumbwaiter, moving walk, material lift, wheelchair lift, stairway chair-lift, or escalator, unless otherwise exempted by these rules, notice of such installation, major alteration, or repairs must be given in writing to the Idaho Division of Building Safety. ()

02. Accidents. When an accident occurs involving an elevator, dumbwaiter, moving walk, material lift,

wheelchair lift, stairway chair-lift, or escalator, unless otherwise exempted by these rules, the owner, user, or designated representative shall promptly notify the Division of Building Safety and submit a detailed report of the accident. ()

022. EXEMPTIONS.

01. Private Residences. Elevators, dumbwaiters, moving walks, material lifts, wheelchair lifts, stairway chair-lifts, and escalators in private residences are exempt from these rules. ()

02. Federal Government. Elevators, dumbwaiters, moving walks, material lifts, wheelchair lifts, stairway chair-lifts, and escalators in buildings or on premises owned by the Federal Government are exempt from these rules. ()

03. Designated Representatives Of The Division. Designated representatives of the Division of Building Safety are exempt from the ASME OEL-1 requirements. ()

023. EMERGENCY EVACUATION OF PASSENGERS FROM ELEVATORS.

01. Guide For Training And Performing Emergency Evacuation. ANSI/ASME A17.4 - 1991, Emergency Evacuation of Passengers from Elevators, shall be used as a guide for conducting training and performing emergency evacuation of passengers from an elevator. ()

02. Supervision. Whenever possible the evacuation of passengers from an elevator car shall be conducted under the direct supervision of elevator personnel. ()

03. Training Required. Only trained personnel shall attempt emergency evacuation of passengers from an elevator. ()

04. Elevator Owner's Responsibility. The owner of an elevator shall ensure that there are properly trained personnel capable of performing emergency evacuation of passengers from an elevator. ()

05. Equipment For Rescue Personnel. Rescue personnel shall have the proper tools and equipment ready for use prior to attempting emergency evacuation of passengers from an elevator. ()

06. Elevator Door Keys. Specialized elevator door keys shall be used by and available to properly trained personnel. ()

024. ELEVATOR MACHINE ROOM/MECHANICAL SPACES.

01. Access. Only elevator personnel and authorized personnel shall have access to the elevator machine room and mechanical spaces. ()

02. Storage. No non-elevator related materials shall be stored in elevator machine room and mechanical spaces. ()

03. Non-Elevator Utilities. No non-elevator related utilities shall be installed or run through elevator machine room and mechanical spaces. ()

025. ELEVATOR PITS/HOISTWAYS.

01. Maintenance. For fire, sanitation and safety concerns, all elevator pits shall be kept free of trash, debris, and water. ()

02. Non-Elevator Utilities. No non-elevator related utilities shall be installed or run through an elevator hoistway/pit. ()

026. INSPECTIONS.

Elevators installed or operated in the state of Idaho, unless otherwise exempted by these rules, shall have an inspection in accordance with the ANSI/ASME standards incorporated by reference in Subsections 004.01, 004.02, or 004.03 of these rules. The following types of inspections are required. ()

01. Acceptance Inspection. An acceptance inspection shall be conducted by a competent person representing the owner and witnessed by a designated representative of the Division of Building Safety for all new or altered elevators, unless otherwise exempted by these rules. ()

02. Routine Inspection. A routine inspection shall be conducted annually by a competent person representing the owner for all elevators, dumbwaiters, moving walks, material lifts, wheelchair lifts, stairway chairlifts, and escalators, unless otherwise exempted by these rules, utilizing forms provided by the Division of Building Safety. ()

03. Periodic Inspection. Periodic inspections shall be conducted every five (5) years by a competent person representing the owner and witnessed by a designated representative of the Division of Building Safety for all elevators, unless otherwise exempted by these rules. ()

027. CERTIFICATE TO OPERATE ELEVATOR.

An elevator, unless otherwise exempted by these rules, shall not be placed into operation until an inspection has been performed and a Certificate to Operate has been issued by the Division of Building Safety. ()

01. Inspection Prior To Issuance. A Certificate to Operate may be issued only if, after a thorough inspection, the designated representative of the Division of Building Safety finds that the elevator meets the required safety standards. If the elevator is found to be unsafe, the representative shall prohibit the use of the elevator until it is made safe. (See Figure 027.01, Appendix I) ()

02. Term Of Certificate. A Certificate to Operate shall be in effect for five (5) years, provided that the elevator continues to meet the requirements of the appropriate codes. ()

03. Revocation Of Certificate. The Certificate to Operate shall remain the property of the state of Idaho and may be revoked at any time if the elevator fails to meet the requirements of the appropriate codes. ()

028. TEMPORARY CERTIFICATE TO OPERATE.

A temporary certificate to operate is effective for sixty (60) days and may be issued to allow use of the elevator while non-critical non-conformances are corrected. Before the expiration of sixty (60) days, the elevator shall be reinspected and a permanent Certificate to Operate shall be issued, or the elevator shall be put out of service. (See Figure 028, Appendix II) ()

029. INSPECTION REPORTS.

Inspection reports must be filed as follows: ()

01. Inspection Witnessed By Division. Whenever an inspection is conducted by a competent person representing the owner and witnessed by a designated representative of the Division of Building Safety, a copy of the inspection report shall be filed with the Division and a copy sent to the owner or the owner's representative for corrective actions as required. ()

02. Inspection By Owner's Representative. Whenever an inspection is conducted by a competent person representing the owner, a copy of the inspection report shall be filed with the Division. ()

030. REMUNERATION.

Competent persons, referred to in Sections 026 and 029, shall be considered to be employees of the owner or the owner's representative and shall receive no salary from, nor shall any of their expenses be paid by the state of Idaho. ()

031. CONSTRUCTION, REPAIR, ALTERATION, OR DISMANTLING.

01. Training And Experience Requirements. Only persons who are qualified by virtue of training and experience shall construct, repair, alter, or dismantle elevators, dumbwaiters, moving walks, material lifts, wheelchair lifts, stairway chair-lifts, and escalators. EXCEPTION: an apprentice while under the direct supervision of a qualified journeyman. ()

02. Barricades And Signs. Elevators, dumbwaiters, moving walks, material lifts, wheelchair lifts, stairway chair-lifts, and escalators that are under maintenance, repair, inspection, alteration, construction, being dismantled, or are otherwise out of service shall have their points of entry appropriately barricaded and signed. Additionally mechanical rooms/ spaces or controllers shall be appropriately signed. ()

03. Safety Devices. ()

a. No person shall attempt to remove or do any work on any safety device until the elevator, dumbwaiter, moving walk, material lift, wheelchair lift, stairway chair-lift, or escalator is removed from service. ()

b. No person shall alter any safety device in any manner to render it ineffective except as part of a required test or during an inspection procedure. ()

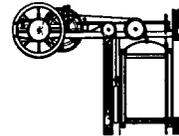
032. -- 999. (RESERVED).

APPENDIX I

FIGURE 027.01 - A SAMPLE OF A CERTIFICATE TO OPERATE



State of Idaho
INDUSTRIAL COMMISSION
and
DIVISION OF BUILDING SAFETY



ELEVATOR
CERTIFICATE TO OPERATE

ELEVATOR (SN): _____ EXPIRES: _____

LOCATED AT: _____

MAY BE OPERATED FOR A PERIOD OF FIVE YEARS FROM THE DATE OF ISSUE SO LONG AS THE ELEVATOR CONTINUES TO MEET ALL APPLICABLE CODE REQUIREMENTS. THIS CERTIFICATE REMAINS THE PROPERTY OF THE STATE OF IDAHO AND CAN BE REVOKED AT ANY TIME THE ELEVATOR FAILS TO COMPLY WITH THE APPROPRIATE CODES.

ISSUED BY: _____ DATE: _____

POST THIS CERTIFICATE IN A CONSPICUOUS PLACE IN THE ELEVATOR MACHINE ROOM
(CERTIFICATE MUST BE POSTED UNDER GLASS OR SIMILARLY PROTECTED)

IS-004

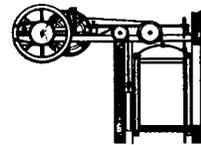
6/96

APPENDIX II

FIGURE 028, SAMPLE OF A TEMPORARY CERTIFICATE TO OPERATE



State of Idaho
INDUSTRIAL COMMISSION
and
DIVISION OF BUILDING SAFETY



ELEVATOR
TEMPORARY
CERTIFICATE TO OPERATE

SAMPLE

ELEVATOR (SN): _____ EXPIRES: _____

LOCATED AT: _____

MAY BE OPERATED FOR A PERIOD NOT TO EXCEED 60-DAYS BY WHICH TIME ALL NOTED INSPECTION REPORT NONCONFORMANCES SHALL BE CORRECTED AND THE ELEVATOR REINSPECTED OR TAKEN OUT OF SERVICE.

ISSUED BY: _____ DATE: _____

IS-004 POST THIS CERTIFICATE IN A CONSPICUOUS PLACE IN THE ELEVATOR MACHINE ROOM 6/96

IDAPA 17 - INDUSTRIAL COMMISSION
17.07.02 - SAFETY STANDARDS FOR CONSTRUCTION AND OPERATION
OF ELEVATORS - ADMINISTRATION
DOCKET NO. 17-0702-0001 (REPEAL)
NOTICE OF PROPOSED RULE

AUTHORITY: In compliance with Section 67-5220(1), Idaho Code, notice is hereby given that this agency proposed rulemaking. The action is authorized pursuant to Section(s) 72-508, 72-720, 72-721, 72-722, and 72-723, 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 October 18, 2000.

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five a(5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is a non-technical explanation of the substance and purpose of the proposed rule-making:

IDAPA 17.07.02 is repealed and incorporated into IDAPA 17.07.01 in order to eliminate redundancy and improve the continuity of the rules.

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

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because substantive changes were made due to updates in the national safety standards. The other changes were clerical in nature.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Mike Poulin, Industrial Safety Supervisor, Division of Building Safety, (208)334-3950, extension 315.

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, 2000.

DATED this 31st day of July, 2000.

Patricia S. Ramey
Commission Secretary
Industrial Commission
317 Main Street, 2nd Floor East
P. O. Box 83720
Boise, Idaho 83720-0041
Phone: (208)334-6000
Fax: (208)334-5145

THIS CHAPTER IS BEING REPEALED IN ITS ENTIRETY.

IDAPA 17 - INDUSTRIAL COMMISSION
17.07.03 - SAFETY STANDARDS FOR ELEVATORS AND ESCALATORS - INSPECTIONS
DOCKET NO. 17-0703-0001 (REPEAL)
NOTICE OF PROPOSED RULE

AUTHORITY: In compliance with Section 67-5220(1), Idaho Code, notice is hereby given that this agency proposed rulemaking. The action is authorized pursuant to Section(s) 72-508, 72-720, 72-721, 72-722, and 72-723, 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 October 18, 2000.

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five a(5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is a non-technical explanation of the substance and purpose of the proposed rulemaking:

IDAPA 17.07.03 is repealed and incorporated into IDAPA 17.07.01 in order to eliminate redundancy and improve the continuity of the rules.

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

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because substantive changes were made due to updates in the national safety standards. The other changes were clerical in nature.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Mike Poulin, Industrial Safety Supervisor, Division of Building Safety, (208)334-3950, extension 315.

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Phone: (208)334-6000
Fax: (208)334-5145

THIS CHAPTER IS BEING REPEALED IN ITS ENTIRETY.

IDAPA 17 - INDUSTRIAL COMMISSION
17.07.04 - SAFETY STANDARDS FOR ELEVATORS AND ESCALATORS
- CONSTRUCTION, REPAIR, ALTERATION, OR DISMANTLING

DOCKET NO. 17-0704-0001 (REPEAL)

NOTICE OF PROPOSED RULE

AUTHORITY: In compliance with Section 67-5220(1), Idaho Code, notice is hereby given that this agency proposed rulemaking. The action is authorized pursuant to Section(s) 72-508, 72-720, 72-721, 72-722, and 72-723, 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 October 18, 2000.

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five a(5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is a non-technical explanation of the substance and purpose of the proposed rulemaking:

IDAPA 17.07.04 is repealed and incorporated into IDAPA 17.07.01 in order to eliminate redundancy and improve the continuity of the rules.

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

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because substantive changes were made due to updates in the national safety standards. The other changes were clerical in nature.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Mike Poulin, Industrial Safety Supervisor, Division of Building Safety, (208)334-3950, extension 315.

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, 2000.

DATED this 31st day of July, 2000.

Patricia S. Ramey
Commission Secretary
Industrial Commission
317 Main Street, 2nd Floor East
P. O. Box 83720
Boise, Idaho 83720-0041
Phone: (208)334-6000
Fax: (208)334-5145

THIS CHAPTER IS BEING REPEALED IN ITS ENTIRETY.

IDAPA 18 - DEPARTMENT OF INSURANCE
18.01.30 - INDIVIDUAL DISABILITY AND GROUP SUPPLEMENTAL DISABILITY
INSURANCE MINIMUM STANDARDS RULE

DOCKET NO. 18-0130-0001 (REWRITE)

NOTICE OF PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has proposed rule making. These rules are proposed pursuant to the authority vested in the Director of the Department of Insurance under Title 41, Chapter 2, 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 October 18, 2000.

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 address below.

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

This rule sets forth prohibited policy provisions, minimum standards for benefits, disclosure requirements and replacement requirements for various types of individual disability insurance policies and group supplemental disability insurance policies sold in Idaho. The proposed rule will replace the current rule governing standards for individual disability insurance policies and is based on the most recent model rule adopted by National Association of Insurance Commissioners.

NEGOTIATED RULEMAKING: pursuant to IDAPA 04.11.01.811, negotiated rulemaking was conducted. The Notice of Negotiated Rulemaking was published in the Idaho Administrative Bulletin, February 2, 2000, Volume No. 00-2, page 23.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning these proposed rules, contact Joan Krosch at (208) 334-4250.

Anyone may submit written comments regarding these rules. All written comments and data concerning the rule must be directed to the undersigned and must be received on or before October 25, 2000.

Dated this 22nd day of August, 2000.

Mary L. Hartung, Director
Idaho Department of Insurance
700 West State Street - 3rd Floor
P.O. Box 83720
Boise, ID 83720-0043
Telephone No. (208) 334-4250

THE FOLLOWING IS THE TEXT OF DOCKET NO. 16-0130-0001

IDAPA 18
TITLE 01
Chapter 30

**18.01.30 - INDIVIDUAL DISABILITY AND GROUP SUPPLEMENTAL
DISABILITY INSURANCE MINIMUM STANDARDS RULE**

000. LEGAL AUTHORITY.

This rule is issued pursuant to the authority vested in the director under Chapter 42, Title 41, Idaho Code, and Chapter 52, Title 67-5220(1), Idaho Code. ()

001. TITLE AND SCOPE.

01. Title. This rule shall be cited in full as Idaho Department of Insurance Rules, IDAPA 18.01.30, "Individual Disability and Group Supplemental Disability Insurance Minimum Standards Rule". ()

02. Scope. The purpose of this rule is to implement Chapter 42, Title 41, Idaho Code, and, to this extent not in conflict with federal law, to standardize and simplify the terms and coverages of individual disability insurance policies, and group supplemental health insurance consisting of group disability policies and certificates providing hospital confinement indemnity, accident only, specified disease, specified accident or limited benefit health coverage. This rule is also intended to facilitate public understanding and comparison of coverage, to eliminate provisions contained in individual accident and sickness insurance policies and group supplemental health insurance that may be misleading or confusing in connection with the purchase of the coverages or with the settlement of claims, and to provide for full disclosure in the marketing and sale of individual accident and sickness insurance policies and group supplemental health insurance. This rule is also intended to provide for disclosure in the sale of dental and vision plans. ()

03. Application. This rule applies to all individual accident and sickness insurance policies and group supplemental health policies and certificates, including short-term plans, delivered or issued for delivery in this state on and after the effective date of this rule that are not specifically exempted from the rule. ()

a. This rule shall apply to dental plans and vision plans only as specified. ()

b. This rule shall not apply to: ()

i. Individual policies or contracts issued pursuant to a conversion privilege under a policy or contract of group or individual insurance when the group or individual policy or contract includes provisions that are inconsistent with the requirements of this rule. ()

ii. Policies issued to employees or members as additions to franchise plans in existence on the effective date of this rule. ()

iii. Medicare supplement policies subject to Chapter 44, Title 41, Idaho Code, Medicare Supplement Insurance Minimum Standards, and IDAPA 18.01.54, "Rule to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act". () ()

iv. Long-term care insurance policies subject to Chapter 46, Title 41, Idaho Code, Long Term Care Insurance, and IDAPA 18.01.60, "Long-Term Care Insurance Minimum Standards". ()

v. Civilian Health and Medical Program of the Uniformed Services, Chapter 55, Title 10 of the United States Code, (CHAMPUS) supplement insurance policies. ()

04. Other Rules Applicable. The requirements contained in this rule shall be in addition to any other applicable rules previously adopted. ()

002. WRITTEN INTERPRETATIONS.

In accordance with Section 67-5201, Idaho Code, this agency may have written statements that pertain to the interpretation of the rules of the chapter, or to the documentation of compliance with the rules of this chapter. These documents will be available for public inspection and copying at cost at this agency. ()

003. ADMINISTRATIVE APPEALS.

All contested cases will be governed by the provisions of Chapter 2, Title 41, Idaho Code, Chapter 52, Title 67, Idaho Code, and IDAPA 04.11.01, "Idaho Rules of Administrative Procedure of the Attorney General". ()

004. DEFINITIONS.

Except as provided in this rule, an individual accident and sickness insurance policy or group supplemental health insurance policy delivered or issued for delivery to any person in this state and to which this rule applies shall contain definitions respecting the matters set forth below that comply with the requirements of Section 004. ()

01. Accident. "Accident," "accidental injury," and "accidental" shall be defined to employ "result" language and shall not include words that establish an accidental means test or use words such as "external, violent, visible wounds" or similar words of description or characterization. ()

a. The definition shall not be more restrictive than the following: "injury" or "injuries" means accidental bodily injury sustained by the insured person that is the direct cause of the condition for which benefits are provided, independent of disease or bodily infirmity or any other cause, and that occurs while the insurance is in force. ()

b. The definition may provide that injuries shall not include injuries for which: ()

i. Benefits are provided under workers' compensation, employers' liability, or similar law; or ()

ii. Under a motor vehicle no-fault plan, unless prohibited by law; or ()

iii. Injuries occurring while the insured person is engaged in any activity pertaining to a trade, business, employment or occupation for wage or profit. ()

02. Convalescent Nursing Home. "Convalescent nursing home," "extended care facility," or "skilled nursing facility" shall be defined in relation to its status, facility and available services. ()

a. A definition of the home or facility shall not be more restrictive than one requiring that it: ()

i. Be operated pursuant to law; ()

ii. Be approved for payment of Medicare benefits or be qualified to receive approval for payment of Medicare benefits, if so requested; ()

iii. Be primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a duly licensed physician; ()

iv. Provide continuous twenty-four (24) hours per day nursing service by or under the supervision of a registered nurse; and ()

v. Maintain a daily medical record of each patient. ()

b. The definition of the home or facility may provide that the term shall not be inclusive of: ()

i. A home, facility or part of a home or facility used primarily for rest; ()

ii. A home or facility for the aged or for the care of drug addicts or alcoholics; or ()

iii. A home or facility primarily used for the care and treatment of mental diseases or disorders, or for custodial or educational care. ()

03. Hospital. May be defined in relation to its status, facilities and available services or to reflect its accreditation by the Joint Commission on Accreditation of Healthcare Organizations. ()

a. The definition of the term “hospital” shall not be more restrictive than one requiring that the hospital: ()

i. Be an institution licensed to operate as a hospital pursuant to law; ()

ii. Be primarily and continuously engaged in providing or operating, either on its premises or in facilities available to the hospital on a prearranged basis and under the supervision of a staff of licensed physicians, medical, diagnostic and major surgical facilities for the medical care and treatment of sick or injured persons on an in-patient basis for which a charge is made; and ()

iii. Provide twenty-four (24) hour nursing service by or under the supervision of registered nurses. ()

b. The definition of the term “hospital” may state that the term shall not be inclusive of the following, unless the facility otherwise meets the qualifications set forth at Subsection 004.03.a. of this rule: ()

i. Convalescent homes or, convalescent, rest, or nursing facilities; ()

ii. Facilities affording primarily custodial, educational, or rehabilitory care; ()

iii. Facilities for the aged, drug addicts, or alcoholics; or ()

iv. A military or veterans’ hospital, a soldiers’ home or a hospital contracted for or operated by any national government or government agency for the treatment of members or ex-members of the armed forces, except for services rendered on an emergency basis where a legal liability for the patient exists for charges made to the individual for the services. ()

04. Medicare. Means The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended. ()

05. Mental Or Nervous Disorders. Shall not be defined more restrictively than a definition including neurosis, psychoneurosis, psychosis, or mental or emotional disease or disorder of any kind. ()

06. Nurse. May be defined so that the description of nurse is restricted to a type of nurse, such as registered nurse, a licensed practical nurse, or a licensed vocational nurse. If the words “nurse,” “trained nurse” or “registered nurse” are used without specific instruction, then the use of these terms requires the insurer to recognize the services of any individual who qualifies under the terminology in accordance with the applicable statutes or administrative rules of the licensing or registry board of the state of Idaho. ()

07. One Period Of Confinement. Means consecutive days of in-hospital service received as an in-patient, or successive confinements when discharge from and readmission to the hospital occurs within a period of time not more than ninety (90) days or three times the maximum number of days of in-hospital coverage provided by the policy to a maximum of one hundred eighty (180) days. ()

08. Partial Disability. Shall be defined in relation to the individual’s inability to perform one or more but not all of the “major,” “important” or “essential” duties of employment or occupation, or may be related to a percentage of time worked or to a specified number of hours or to compensation. ()

09. Physician. May be defined by including words such as “qualified physician” or “licensed physician.” The use of these terms requires an insurer to recognize and to accept, to the extent of its obligation under the contract, all providers of medical care and treatment when the services are within the scope of the provider’s

licensed authority and are provided pursuant to applicable laws. ()

10. Preexisting Condition. Shall not be defined more restrictively than the following: ()

a. A health benefit plan shall not deny, exclude or limit benefits for a covered individual for covered expenses incurred more than twelve (12) months following the effective date of the individual's coverage due to a preexisting condition. A health benefit plan shall not define a preexisting condition more restrictively than: ()

i. A condition that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care or treatment during the six (6) months immediately preceding the effective date of coverage; ()

ii. A condition for which medical advice, diagnosis, care or treatment was recommended or received during the six (6) months immediately preceding the effective date of coverage; or ()

iii. A pregnancy existing on the effective date of coverage. ()

b. A health benefit plan shall waive any time period applicable to a preexisting condition exclusion or limitation period with respect to particular services for the period of time an individual was previously covered by qualifying previous coverage to the extent such previous coverage provided benefits with respect to such services, provided that the qualifying previous coverage was continuous to a date not more than sixty-three (63) days prior to the effective date of the new coverage. ()

c. An individual carrier shall not modify a health benefit plan with respect to an individual or dependent through riders, endorsements, or otherwise, to restrict or exclude coverage for certain diseases or medical conditions otherwise covered by the health benefit plan. ()

11. Residual Disability. Shall be defined in relation to the individual's reduction in earnings and may be related either to the inability to perform some part of the "major," "important," or "essential duties" of employment or occupation, or to the inability to perform all usual business duties for as long as is usually required. A policy that provides for residual disability benefits may require a qualification period, during which the insured must be continuously totally disabled before residual disability benefits are payable. The qualification period for residual benefits may be longer than the elimination period for total disability. In lieu of the term "residual disability," the insurer may use "proportionate disability" or other term of similar import that in the opinion of the director adequately and fairly describes the benefit. ()

12. Sickness Or Illness. Shall not be defined to be more restrictive than the following: "Sickness (or Illness) means sickness or disease of an insured person that first manifests itself after the effective date of insurance and while the insurance is in force. The definition may be further modified to exclude sickness or disease for which benefits are provided under a worker's compensation, occupational disease, employers' liability or similar law." ()

13. Total Disability. Shall be defined in accordance with the following limitations: ()

a. A general definition of total disability shall not be more restrictive than one requiring that the individual who is totally disabled not be engaged in any employment or occupation for which he or she is or becomes qualified by reason of education, training or experience, and is not in fact engaged in any employment or occupation for wage or profit. ()

b. Total disability may be defined in relation to the inability of the person to perform duties but may not be based solely upon an individual's inability to: ()

i. Perform "any occupation whatsoever," "any occupational duty," or "any and every duty of his occupation"; or ()

ii. Engage in a training or rehabilitation program. ()

c. An insurer may require the complete inability of the person to perform all of the substantial and

material duties of his or her regular occupation or words of similar import. An insurer may require care by a physician other than the insured or a member of the insured's immediate family. ()

005. INCORPORATION BY REFERENCE.

01. Copies. Copies of these documents may be obtained from the Idaho Department of Insurance, 700 W. State Street, 3rd Floor, PO Box 83720, Boise, Idaho 83702-0043, or from the Internet website at www.doi.state.id.us under the "Consumer Assistance" link. ()

02. Documents Incorporated By Reference. The following sections of the April 1999 version of the NAIC Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Act are incorporated by reference into these rules: ()

- a. Basic Hospital Expense Coverage. ()
- b. Basic Medical-Surgical Expense Coverage. ()
- c. Basic Hospital/Medical-surgical Expense Coverage. ()
- d. Hospital Confinement Indemnity Coverage. ()
- e. Individual Major Medical Expense Coverage. ()
- f. Disability Income Protection Coverage. ()
- g. Accident Only Coverage. ()
- h. Specified Disease Or Specified Accident Coverage. ()
- i. Limited Benefit Health Coverage. ()
- j. Dental Plans. ()
- k. Vision Plans. ()
- l. Notice To Applicant Regarding Replacement Of Accident And Sickness Insurance (direct sales). ()
- m. Notice To Applicant Regarding Placement Of Accident And Sickness Insurance (other than direct sales). ()

006. -- 010. (RESERVED).

011. PROHIBITED POLICY PROVISIONS.

01. Probationary Or Waiting Period. Except as provided in Subsection 004.10 pertaining to the definition of a preexisting condition, a policy shall not contain provisions establishing a probationary or waiting period during which no coverage is provided under the policy. Accident policies shall not contain probationary or waiting periods. ()

02. Additional Coverage As Dividend. A policy or rider for additional coverage may not be issued as a dividend unless an equivalent cash payment is offered as an alternative to the dividend policy or rider. A dividend policy or rider for additional coverage shall not be issued for an initial term of less than six (6) months. ()

i. The initial renewal subsequent to the issuance of a policy or rider as a dividend shall clearly disclose that the policyholder is renewing the coverage that was provided as a dividend for the previous term and that the renewal is optional. ()

03. Return Of Premium Or Cash Value Benefit. A disability income policy or hospital confinement indemnity policy may contain a “return of premium” or “cash value benefit” so long as the return of premium or cash value benefit is not reduced by an amount greater than the aggregate of claims paid under the policy, and the insurer demonstrates that the reserve basis for the policies is adequate. No other policy subject to this rule shall provide a return of premium or cash value benefit, except return of unearned premium upon termination or suspension of coverage, retroactive waiver of premium paid during disability, payment of dividends on participating policies, or experience rating refunds. ()

04. Federally Operated Hospital. Policies providing hospital confinement indemnity coverage shall not contain provisions excluding coverage because of confinement in a hospital operated by the federal government. ()

05. Exclusions. A policy shall not limit or exclude coverage by type of illness, accident, treatment or medical condition, except as follows: ()

- a. Preexisting conditions or diseases, except for congenital anomalies of a covered dependent child; ()
- b. Mental or emotional disorders, alcoholism and drug addiction; ()
- c. Pregnancy, except for complications of pregnancy; ()
- d. Illness, treatment or medical condition arising out of: ()
 - i. War or act of war (whether declared or undeclared); participation in a felony, riot or insurrections; service in the armed forces or units auxiliary to it; ()
 - ii. Suicide (sane or insane), attempted suicide or intentionally self-inflicted injury; ()
 - iii. Aviation; ()
 - iv. With respect to short-term nonrenewable policies, interscholastic sports; and ()
 - v. With respect to disability income protection policies, incarceration. ()
- e. Cosmetic surgery, except that “cosmetic surgery” shall not include reconstructive surgery when the service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child; ()
- f. Foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet; ()
- g. Care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion, or subluxation in the human body for purposes of removing nerve interference and the effects of it, where the interference is the result of or related to distortion, misalignment or subluxation of, or in the vertebral column; ()
- h. Benefits provided under Medicare or other governmental program (except Medicaid), a state or federal worker’s compensation law, employers liability or occupational disease law, or motor vehicle no-fault law; services performed by a member of the covered person’s immediate family; and services for which no charge is normally made in the absence of insurance; ()
- i. Dental care or treatment; ()
- j. Eye glasses, hearing aids, and examination for the prescription, or fitting of them; ()

- k. Rest cures, custodial care, transportation, and routine physical examinations; and ()
- l. Territorial limitations. ()

06. Authority Of Director To Disapprove. Policy provisions precluded in Section 011 shall not be construed as a limitation on the authority of the director to disapprove other policy provisions in accordance with Chapters 21, 22 and 42 of Title 41 of the Idaho Code, or that in the opinion of the director are unjust, unfair or unfairly discriminatory to the policyholder, beneficiary or a person insured under the policy. ()

ACCIDENT AND SICKNESS MINIMUM STANDARDS FOR BENEFITS
(Sections 012 through 029)

012. ACCIDENT AND SICKNESS MINIMUM STANDARDS FOR BENEFITS.

The following minimum standards for benefits are prescribed for the categories of coverage noted in the following subsections. An individual accident and sickness insurance policy or group supplemental health insurance policy shall not be delivered or issued for delivery in this state unless it meets the required minimum standards for the specified categories or the director finds that the policies or contracts are allowable as limited benefit health insurance and the outline of coverage complies with the model outline of coverage established by the National Association of Insurance Commissioners (“NAIC”) and accessible by the Internet at www.doi.state.id.us, under the “Consumer Assistance” link, for each category of coverage noted in Sections 013 through 029. Section 012 shall not preclude the issuance of any policy or contract combining two (2) or more categories set forth in Section 41-4204(1) and 41-4204(2), Idaho Code. Limitations on coinsurance percentages set forth in this rule do not apply to out-of-network benefits offered as part of a managed care plan. ()

013. GENERAL RULES.

01. Termination Of Coverage Of Spouse Limitations. A “noncancellable,” “guaranteed renewable,” or “noncancellable and guaranteed renewable” individual accident and sickness policy shall not provide for termination of coverage of the spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than nonpayment of premium. In addition, the policy shall provide that in the event of the insured’s death, the spouse of the insured, if covered under the policy, shall become the insured. ()

a. The terms “noncancellable,” “guaranteed renewable,” or “noncancellable and guaranteed renewable” shall not be used without further explanatory language in accordance with the disclosure requirements of Section 101 of this rule. ()

b. The terms “noncancellable” or “noncancellable and guaranteed renewable” may be used only in an individual accident and sickness policy that the insured has the right to continue in force by the timely payment of premiums set forth in the policy until the age of sixty-five (65) or until eligibility for Medicare, during which period the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force. ()

c. An individual accident and sickness or individual accident-only policy that provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from accident or sickness may provide that the insured has the right to continue the policy only to age sixty (60) if, at age sixty (60), the insured has the right to continue the policy in force at least to age sixty-five (65) while actively and regularly employed. ()

d. Except as provided in Section 013 of this rule, (the term “guaranteed renewable” may be used only in a policy that the insured has the right to continue in force by the timely payment of premiums until the age of sixty-five (65) or until eligibility for Medicare and to the extent not in conflict with Health Insurance Portability and Accountability Act, HIPAA), during which period the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force, except where the insurer is able to show good cause for changing the policy provisions and obtains prior written approval from the director. The insurer may make changes in premium rates by classes. ()

02. Age And Durational Requirements. In an individual accident and sickness policy covering both husband and wife, the age of the younger spouse shall be used as the basis for meeting the age and durational requirements of the definitions of “noncancellable” or “guaranteed renewable.” However, this requirement shall not prevent termination of coverage of the older spouse upon attainment of the stated age so long as the policy may be continued in force as to the younger spouse to the age or for the durational period as specified in the policy. ()

03. Accidental Death And Dismemberment Coverage. When accidental death and dismemberment coverage is part of the individual accident and sickness insurance coverage offered under the contract, the insured shall have the option to include all insureds under the coverage and not just the principal insured. ()

04. Military Service Limitations. If a policy contains a status-type military service exclusion or a provision that suspends coverage during military service, the policy shall provide, upon receipt of written request, for refund of premiums as applicable to the person on a pro rata basis. ()

05. Pregnancy Benefit Extension. In the event the insurer cancels or refuses to renew, policies providing pregnancy benefits shall provide for an extension of benefits as to pregnancy commencing while the policy is in force and for which benefits would have been payable had the policy remained in force. ()

06. Convalescent Or Extended Care Benefits. Policies providing convalescent or extended care benefits following hospitalization shall not condition the benefits upon admission to the convalescent or extended care facility within a period of less than fourteen (14) days after discharge from the hospital. ()

07. Coverage Of Dependents. A policy’s coverage shall continue for a dependent child who is incapable of self-sustaining employment due to mental retardation or physical handicap on the date that the child’s coverage would otherwise terminate under the policy due to the attainment of a specified age for children and who is chiefly dependent on the insured for support and maintenance. The policy may require that within thirty-one (31) days of the date the company receives due proof of the incapacity in order for the insured to elect to continue the policy in force with respect to the child, or that a separate converted policy be issued at the option of the insured or policyholder. Provisions relating to coverage of dependents with mental or physical handicaps shall meet the requirements of Sections 41-2139 and 41-2203, Idaho Code. ()

08. Expenses Of Live Donor. A policy providing coverage for the recipient in a transplant operation shall also provide reimbursement of any medical expenses of a live donor to the extent that benefits remain and are available under the recipient’s policy or certificate, after benefits for the recipient’s own expenses have been paid. ()

09. Recurrent Disabilities. A policy may contain a provision relating to recurrent disabilities, but a provision relating to recurrent disabilities shall not specify that a recurrent disability be separated by a period greater than six (6) months. ()

10. Accidental Death And Dismemberment. Accidental death and dismemberment benefits shall be payable if the loss occurs within ninety (90) days from the date of the accident, irrespective of total disability. Disability income benefits, if provided, shall not require the loss to commence less than thirty (30) days after the date of accident, nor shall any policy that the insurer cancels or refuses to renew require that it be in force at the time disability commences if the accident occurred while the coverage was in force. ()

11. Specific Dismemberment Benefits. Specific dismemberment benefits shall not be in lieu of other benefits unless the specific benefit equals or exceeds the other benefits. ()

12. Accident Only Policy. An accident-only policy providing benefits that vary according to the type of accidental cause shall prominently set forth in the outline of coverage the circumstances under which benefits are payable that are lesser than the maximum amount payable under the policy. ()

13. Continuous Loss. Termination of the policy shall be without prejudice to a continuous loss that commenced while the policy or certificate was in force. The continuous total disability of the insured may be a condition for the extension of benefits beyond the period the policy was in force, limited to the duration of the benefit period, if any, or payment of the maximum benefits. ()

14. Fractures Or Dislocations. A policy providing coverage for fractures or dislocations may not provide benefits only for “full or complete” fractures or dislocations. ()

014. BASIC HOSPITAL EXPENSE COVERAGE.

A policy of accident and sickness insurance that provides coverage for a period of not less than thirty-one (31) days during a continuous hospital confinement for each person insured under the policy, for expense incurred for necessary treatment and services rendered as a result of accident or sickness for at least the following: ()

01. Daily Hospital Room And Board. Daily hospital room and board in an amount not less than the lesser of: ()

a. Eighty percent (80%) of the charges for semiprivate room accommodations; or ()

b. One hundred dollars (\$100) per day. ()

02. Miscellaneous Services. Miscellaneous hospital services for expenses incurred for the charges made by the hospital for services and supplies that are customarily rendered by the hospital and provided for use only during any one period of confinement in an amount not less than either eighty percent (80%) of the charges incurred up to at least three thousand dollars (\$3,000) or ten (10) times the daily hospital room and board benefits; and ()

03. Hospital Outpatient Services. Hospital outpatient services consisting of: ()

a. Hospital services on the day surgery is performed; ()

b. Hospital services rendered within seventy-two (72) hours after injury, in an amount not less than one hundred fifty dollars (\$150); and ()

c. X-ray and laboratory tests to the extent that benefits for the services would have been provided in an amount of less than one hundred dollars (\$100) if rendered to an in-patient of the hospital. ()

04. Combined Deductible. Benefits provided under Subsections 014.01 and 014.02 of this rule may be provided subject to a combined deductible amount not in excess of one hundred dollars (\$100). ()

015. BASIC MEDICAL-SURGICAL EXPENSE COVERAGE.

A policy of accident and sickness insurance that provides coverage for each person insured under the policy for the expenses incurred for the necessary services rendered by a physician for treatment of an injury or sickness for at least the following: ()

01. Surgical Services. Surgical services shall be: ()

a. In amounts not less than those provided on a fee schedule based on the relative values contained in the most recent Medicare Resource Based Relative Value Scale, or as defined to the director, utilizing Current Procedure Terminology (CPT) coding or other acceptable relative value schedule, up to a maximum of at least one thousand dollars (\$1000) for one procedure; or ()

b. Not less than eighty percent (80%) of the reasonable charges. ()

02. Anesthesia Services. Anesthesia services, consisting of administration of necessary general anesthesia and related procedures in connection with covered surgical service rendered by a physician other than the physician (or the physician assistant) performing the surgical services in an amount not less than: ()

a. Eighty percent (80%) of the reasonable charges; or ()

b. Fifteen percent (15%) of the surgical service benefit. ()

03. In-Hospital Medical Services. In-hospital medical services, consisting of physician services

rendered to a person who is a bed patient in a hospital for treatment of sickness or injury other than that for which surgical care is required, in an amount not less than: ()

- a. Eighty percent (80%) of the reasonable charges; or ()
- b. Fifty dollars (\$50) per day for not less than twenty-one (21) days during one period of confinement. ()

016. BASIC HOSPITAL/MEDICAL-SURGICAL EXPENSE COVERAGE.

A combined coverage and must meet the requirements of both Sections 014 and 015. ()

017. HOSPITAL CONFINEMENT INDEMNITY COVERAGE.

01. Hospital Confinement Indemnity Coverage. A policy of accident and sickness insurance that provides daily benefits for hospital confinement on an indemnity basis in an amount not less than forty dollars (\$40) per day and not less than thirty-one (31) days during each period of confinement for each person insured under the policy. ()

02. Preexisting Condition Limitation. Coverage shall not be excluded due to a preexisting condition for a period greater than twelve (12) months following the effective date of coverage of an insured person unless the preexisting condition is specifically and expressly excluded. ()

03. No Coordination Of Benefits. Benefits shall be paid regardless of other coverage. ()

018. INDIVIDUAL MAJOR MEDICAL EXPENSE COVERAGE.

01. Major Medical Expense Coverage. An accident and sickness insurance policy that provides hospital, medical and surgical expense coverage, to an aggregate maximum of not less than five hundred thousand dollars (\$500,000); coinsurance percentage per year per covered person not to exceed fifty percent (50%) of covered charges, provided that the coinsurance out-of-pocket maximum combined with any deductibles shall not exceed four percent (4%) of the aggregate maximum limit under the policy for each covered person; a deductible stated on a per person, per family, per illness, per benefit period, or per year basis, or a combination of these bases not to exceed four percent (4%) of the aggregate maximum limit under the policy for each covered person for at least: ()

- a. Daily hospital room and board expenses subject only to limitations based on average daily cost of the semiprivate room rate in the area where the insured resides; ()
- b. Miscellaneous hospital services; ()
- c. Surgical services; ()
- d. Anesthesia services; ()
- e. In-hospital medical services; and ()
- f. Out-of-hospital care, consisting of physicians' services rendered on an ambulatory basis where coverage is not provided elsewhere in the policy for diagnosis and treatment of sickness or injury, diagnostic x-ray, laboratory services, radiation therapy, and hemodialysis ordered by a physician. ()

02. Additional Benefits. Individual major medical expense coverage must also provide not fewer than three (3) of the following additional benefits: ()

- a. In-hospital private duty registered nurse services; ()
- b. Convalescent nursing home care; ()
- c. Diagnosis and treatment by a radiologist or physiotherapist; ()

- d. Rental of special medical equipment, as defined by the insurer in the policy; ()
- e. Artificial limbs or eyes, casts, splints, trusses or braces; ()
- f. Treatment for functional nervous disorders, and mental and emotional disorders; or ()
- g. Out-of-hospital prescription drugs and medications. ()

03. Deductible Application. If the policy is written to complement underlying basic hospital expense and basic medical-surgical expense coverage, the deductible may be increased by the amount of the benefits provided by the underlying coverage. ()

04. Benefit Requirements. The minimum benefits required by Subsection 018.01 may be subject to all applicable deductibles, coinsurance and general policy exceptions and limitations. A major medical expense policy may also have special or internal limitations for prescription drugs, nursing facilities, intensive care facilities, mental health treatment, alcohol or substance abuse treatment, transplants, experimental treatments, mandated benefits required by law and those services covered under Subsection 018.02. Except as authorized by Subsection 018.04 through the application of special or internal limitations, a major medical expense policy must be designed to cover, after any deductibles or coinsurance provisions are met, the usual, customary and reasonable charges, as determined consistently by the carrier and as subject to prior written approval by the director or another rate agreed to between the insurer and provider, for covered services up to the lifetime policy maximum. ()

019. DISABILITY INCOME PROTECTION COVERAGE.

A policy that provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from either sickness or injury or a combination of them that: ()

01. Periodic Payments. Provides that periodic payments that are payable at ages after sixty-two (62) and reduced solely on the basis of age are at least fifty percent (50%) of amounts payable immediately prior to sixty-two (62); ()

02. Elimination Period. Contains an elimination period no greater than: ()

- a. Ninety (90) days in the case of a coverage providing a benefit of one year (1) or less; ()
- b. One hundred and eighty (180) days in the case of coverage providing a benefit of more than one (1) year but not greater than two (2) years; or ()
- c. Three hundred sixty five (365) days in all other cases during the continuance of disability resulting from sickness or injury; ()

03. Payable Time Period During Disability. Has a maximum period of time for which it is payable during disability of at least six (6) months. No reduction in benefits shall be put into effect because of an increase in Social Security or similar benefits during a benefit period. ()

04. One Elimination Period. Where a policy provides total disability benefits and partial disability benefits, only one (1) elimination period may be required. ()

020. ACCIDENT ONLY COVERAGE.

A policy that provides coverage, singly or in combination, for death, dismemberment, disability or hospital and medical care caused by accident. Accidental death and double dismemberment amounts under the policy shall be at least one thousand dollars (\$1000) and a single dismemberment amount shall be at least five hundred dollars (\$500). ()

021. SPECIFIED DISEASE COVERAGE.

01. Specified Disease Coverage. Pays benefits for the diagnosis and treatment of a specifically named

disease or diseases. A specified disease policy must meet the following rules and one (1) of the following sets of minimum standards for benefits, as defined in Section 021 for cancer only polices, or other specified disease coverage. ()

a. Insurance covering cancer only or cancer in conjunction with other conditions or diseases must meet the standards of Sections 024, 025, or 027 of this rule. ()

b. Insurance covering specified diseases other than cancer must meet the standards of Sections 023 or 027 of this rule. ()

02. General Rules. Except for cancer coverage provided on an expense-incurred basis, either as cancer-only coverage or in combination with one or more other specified diseases, the following rules shall apply to specified disease coverages in addition to all other requirements imposed by this rule. In cases of conflict Subsections 021.02.a. through 021.02.l., shall govern: ()

a. Policies covering a single specified disease or combination of specified diseases may not be sold or offered for sale other than as specified disease coverage under Section 021 of this rule. ()

b. Any policy issued pursuant to Section 021 of this rule that conditions payment upon pathological diagnosis of a covered disease shall also provide that if the pathological diagnosis is medically inappropriate, a clinical diagnosis will be accepted instead. ()

c. Notwithstanding any other provision of this rule, specified disease policies shall provide benefits to any covered person not only for the specified diseases but also for any other conditions or diseases, directly caused or aggravated by the specified diseases or the treatment of the specified disease. ()

d. Individual accident and sickness policies containing specified disease coverage shall be guaranteed renewable. ()

e. No policy issued pursuant to Section 021 shall contain a waiting or probationary period greater than thirty (30) days. A specified disease policy may contain a waiting or probationary period following the issue or reinstatement date of the policy or certificate in respect to a particular covered person before the coverage becomes effective as to that covered person. ()

f. An application or enrollment form for specified disease coverage shall contain a statement above the signature of the applicant or enrollee that a person to be covered for specified disease is not also covered by any Title XIX program (Medicaid, or any similar name). The statement may be combined with any other statement for which the insurer may require the applicant's or enrollee's signature. ()

g. Payments may be conditioned upon an insured person's receiving medically necessary care, given in a medically appropriate location, under a medically accepted course of diagnosis or treatment. ()

h. Benefits for specified disease coverage shall be paid regardless of other coverage. ()

i. After the effective date of the coverage (or applicable waiting period, if any) benefits shall begin with the first day of care or confinement if the care or confinement is for a covered disease even though the diagnosis is made at some later date. The retroactive application of the coverage may not be less than ninety (90) days prior to the diagnosis. ()

j. Policies providing expense benefits shall not use the term "actual" when the policy only pays up to a limited amount of expenses. Instead, the term "charge" or substantially similar language should be used that does not have the misleading or deceptive effect of the phrase "actual charges". ()

k. Preexisting condition shall not be defined to be more restrictive than the following: "Preexisting condition means a condition for which medical advice, diagnosis, care or treatment was recommended or received from a physician within the six (6) month period preceding the effective date of coverage of an insured person." ()

1. Coverage for specified diseases will not be excluded due to a preexisting condition for a period greater than twelve (12) months following the effective date of coverage of an insured person unless the preexisting condition is specifically excluded. ()

022. HOSPICE CARE.

01. Hospice Care. A facility licensed, certified or registered in accordance with state law that provides a formal program of care that is: ()

- a. For terminally ill patients whose life expectancy is less than six (6) months; ()
- b. Provided on an inpatient or outpatient basis; and ()
- c. Directed by a physician. ()

02. Optional Benefit. Hospice care is an optional benefit. However, if a specified disease insurance product offers coverage for hospice care, it shall meet the following minimum standards: ()

- a. Eligibility for payment of benefits when the attending physician of the insured provides a written statement that the insured person has a life expectancy of six (6) months or less; ()
- b. A fixed-sum payment of at least fifty dollars (\$50) per day; and ()
- c. A lifetime maximum benefit limit of at least ten thousand dollars (\$10,000). ()

03. Non-Terminally Ill Patients. Hospice care does not cover non-terminally ill patients who may be confined in a: ()

- a. Convalescent home; ()
- b. Rest or nursing facility; ()
- c. Skilled nursing facility; ()
- d. Rehabilitation unit; or ()
- e. Facility providing treatment for persons suffering from mental diseases or disorders or care for the aged or substance abusers. ()

023. NON-CANCER COVERAGES.

The following minimum benefits standards apply to non-cancer coverages: ()

01. Minimum Benefit Standards For Non-Cancer Coverages. Coverage for each insured person for a specifically named disease (or diseases) with a deductible amount not in excess of two hundred fifty dollars (\$250) and an overall aggregate benefit limit of not less than ten thousand dollars (\$10,000) and a benefit period of not less than two (2) years for at least the following incurred expenses: ()

- a. Hospital room and board and any other hospital furnished medical services or supplies; ()
- b. Treatment by a legally qualified physician or surgeon; ()
- c. Private duty services of a registered nurse (R.N.); ()
- d. X-ray, radium and other therapy procedures used in diagnosis and treatment; ()
- e. Professional ambulance for local service to or from a local hospital; ()

- f. Blood transfusions, including expense incurred for blood donors; ()
- g. Drugs and medicines prescribed by a physician; ()
- h. The rental of an iron lung or similar mechanical apparatus; ()
- i. Braces, crutches, and wheel chairs as are deemed necessary by the attending physician for the treatment of the disease; ()
- j. Emergency transportation if in the opinion of the attending physician it is necessary to transport the insured to another locality for treatment of the disease; and ()
- k. May include coverage of any other expenses necessarily incurred in the treatment of the disease. ()

02. Benefit Limits For Specifically Named Disease. Coverage for each insured person for a specifically named disease (or diseases) with no deductible amount, and an overall aggregate benefit limit of not less than twenty five thousand dollars (\$25,000) payable at the rate of not less than fifty dollars (\$50) a day while confined in a hospital and a benefit period of not less than five hundred (500) days. ()

024. CANCER-ONLY OR COMBINATION POLICIES.

A policy that provides coverage for each insured person for cancer-only coverage or in combination with one (1) or more other specified diseases on an expense incurred basis for services, supplies, care, and treatment of cancer, in amounts not in excess of the usual and customary charges, with a deductible amount not in excess of two hundred fifty dollars (\$250), and an overall aggregate benefit limit of not less than ten thousand dollars (\$10,000) and a benefit period of not less than three (3) years shall provide at least the following minimum provisions: ()

01. Qualified Physician Or Surgeon. Treatment by, or under the direction of, a legally qualified physician or surgeon; ()

02. X-Ray And Therapy Procedures. X-ray, radium chemotherapy and other therapy procedures used in diagnosis and treatment; ()

03. Hospital. Hospital room and board and any other hospital furnished medical services or supplies; ()

04. Blood Transfusions. Blood transfusions and their administration, including expense incurred for blood donors; ()

05. Prescription Medicines. Drugs and medicines prescribed by a physician; ()

06. Ambulance Services. Professional ambulance for local service to or from a local hospital; ()

07. Private Duty Nurse. Private duty services of a registered nurse provided in a hospital; ()

08. Medical Equipment. Braces, crutches, and wheelchairs deemed necessary by the attending physician for the treatment of the disease; ()

09. Emergency Transportation To Referral Treatment Facility. Emergency transportation if in the opinion of the attending physician it is necessary to transport the insured to another locality for treatment of the disease; and ()

10. Home Health Care And Treatment. Home health care that is necessary care and treatment provided at the insured person's residence by a home health care agency or by others under arrangements made with a home health care agency. The program of treatment shall be prescribed in writing by the insured person's attending physician, who shall approve the program prior to its start. The physician must certify that hospital confinement

would be otherwise required. A “home health care agency” is an agency approved under Medicare, or is licensed to provide home health care under applicable state law, or meets all of the following requirements: ()

- a. It is primarily engaged in providing home health care services; ()
- b. Its policies are established by a group of professional personnel (including at least one (1) physician and one (1) registered nurse); ()
- c. A physician or a registered nurse provides supervision of home health care services; ()
- d. It maintains clinical records on all patients; and ()
- e. It has a full time administrator. ()

11. Home Health Care. Home health care includes, but is not limited to: ()

- a. Part-time or intermittent skilled nursing services provided by a registered nurse or a licensed practical nurse; ()
- b. Part-time or intermittent home health aide services that provide supportive services in the home under the supervision of a registered nurse or a physical, speech, or hearing occupational therapists; ()
- c. Physical, occupational, or speech and hearing therapy; and ()
- d. Medical supplies, drugs, and medicines prescribed by a physician and related pharmaceutical services, and laboratory services to the extent the charges or costs would have been covered if the insured person had remained in the hospital. ()

12. Therapy. therapy includes physical, speech, hearing, and occupational therapy; ()

13. Special Equipment. Special equipment including hospital bed, toilette, pulleys, wheelchairs, aspirator, chux, oxygen, surgical dressings, rubber shields, colostomy, and ileostomy appliances; ()

14. Prosthetic Devices. Prosthetic devices including wigs and artificial breasts; ()

15. Non-Custodial Services. Nursing home care for non-custodial services; and ()

16. Reconstructive Surgery. Reconstructive surgery when deemed necessary by the attending physician. ()

025. PER DIEM CANCER COVERAGES.

The following minimum benefits standards apply to cancer coverages written on a per diem indemnity basis. These coverages shall offer insured persons: ()

01. Minimum Benefit Payment Based On Hospital Confinement. A fixed-sum payment of at least one hundred dollars (\$100) for each day of hospital confinement for at least three hundred sixty five (365) days; ()

02. Minimum Benefit Payment Based On Out-Patient Services. A fixed-sum payment equal to one-half (1/2) the hospital inpatient benefit for each day of hospital or nonhospital outpatient surgery, chemotherapy and radiation therapy, for at least three hundred sixty-five (365) days of treatment; and ()

03. Minimum Benefit Payment Based On Administration Of Plasma Or Blood Donor. A fixed-sum payment of at least fifty dollars (\$50) per day for blood and plasma, which includes their administration whether received as an inpatient or outpatient for at least three hundred sixty five (365) days of treatment. ()

026. NURSING HOME BENEFITS.

Benefits tied to confinement in a skilled nursing home or to receipt of home health care are optional. If a policy offers these benefits, they must equal the following: ()

01. Minimum Benefit Standards Based On Nursing Home Confinement. A fixed-sum payment equal to one-fourth (1/4) the hospital in-patient benefit for each day of skilled nursing home confinement for at least one hundred (100) days. ()

02. Minimum Benefit Standards Based On Home Health Care. A fixed-sum payment equal to one-fourth (1/4) the hospital in-patient benefit for each day of home health care for at least one hundred (100) days. ()

03. Benefit Payments. Benefit payments shall begin with the first day of care or confinement after the effective date of coverage if the care or confinement is for a covered disease even though the diagnosis of a covered disease is made at some later date (but not retroactive more than thirty (30) days from the date of diagnosis) if the initial care or confinement was for diagnosis or treatment of the covered disease. ()

04. Restrictions Or Limitations. Notwithstanding any other provision of this rule, any restriction or limitation applied to the benefits in Subsections 026.01. and 026.02. of this rule, whether by definition or otherwise, shall be no more restrictive than those under Medicare. ()

027. LUMP SUM INDEMNITY COVERAGE.

The following minimum benefits standards apply to lump-sum indemnity coverage of any specified disease: ()

01. Indemnity Benefit, Specific Disease. These coverages must pay indemnity benefits on behalf of insured persons of a specifically named disease or diseases. The benefits are payable as a fixed, one-time payment made within thirty (30) days of submission to the insurer of proof of diagnosis of the specified disease. Dollar benefits shall be offered for sale only in even increments of one thousand dollars (\$1,000). ()

02. Equal Coverage. Where coverage is advertised or otherwise represented to offer generic coverage of a disease or diseases, the same dollar amounts shall be payable regardless of the particular subtype of the disease with one exception. In the case of clearly identifiable subtypes with significantly lower treatments costs, lesser amounts may be payable so long as the policy clearly differentiates that subtype and its benefits. ()

028. SPECIFIED ACCIDENT COVERAGE.

A policy that provides coverage for a specifically identified kind of accident (or accidents) for each person insured under the policy for accidental death or accidental death and dismemberment combined, with a benefit amount not less than one thousand dollars (\$1,000) for double dismemberment and five hundred dollars (\$500) for single dismemberment. ()

029. LIMITED BENEFIT HEALTH COVERAGE.

01. Limited Benefit Plan. A policy or contract, other than a policy or contract covering only a specified disease or diseases, that provides benefits that are less than the minimum standards for benefits required under Sections 014, 015 through 018, 020, and 028 of this rule. Limited Benefit Health Coverage policies or contracts may be delivered or issued for delivery in this state only if an outline of coverage meeting the requirements of this rule for "Limited Benefit Health Coverage" is completed and delivered as required by Subsection 101.01.n. of this rule and the policy or certificate is clearly labeled as a limited benefit policy or certificate as required by Subsection 101.01.a. A policy covering a single specified disease or combination of diseases shall meet the requirements of Section 021 of this rule, and shall not be offered for sale as a "limited coverage." ()

02. Limited Benefit Plan Exceptions. Subsection 029.02 does not apply to policies designed to provide coverage for long-term care or to Medicare supplement insurance, as defined in Chapter 46, Title 41, Idaho Code, "Long-Term Care Insurance" and Chapter 44, Title 41, Idaho Code, "Medicare Supplement Insurance Minimum Standards." ()

030. -- 100. (RESERVED).

101. REQUIRED DISCLOSURE PROVISIONS.

01. General Rules. ()

a. All applications for coverages specified in Sections 014 through 018, 020, 028, and 029 of this rule shall contain a prominent statement by type, stamp or other appropriate means in either contrasting color or in boldface type at least equal to the size type used for the headings or captions of sections of the application and in close conjunction with the applicant's signature block on the application as follows: "The (policy) (certificate) provides limited benefits. Review your (policy) (certificate) carefully." ()

b. All applications for dental plans shall contain a prominent statement by type, stamp or other appropriate means in either contrasting color or in boldface type at least equal to the size type used for the headings or captions of sections of the application and in close conjunction with the applicant's signature block on the application as follows: "The (policy) (certificate) provides dental benefits only. Review your (policy) (certificate) carefully." ()

c. All applications for vision plans shall contain a prominent statement by type, stamp or other appropriate means in either contrasting color or in boldface type at least equal to the size type used for the headings or captions of sections of the application and in close conjunction with the applicant's signature block on the application as follows: "The (policy) (certificate) provides vision benefits only. Review your (policy) (certificate) carefully." ()

d. Each policy of individual accident and sickness insurance and group supplemental health insurance shall include a renewal, continuation or nonrenewal provision. The language or specification of the provision shall be consistent with the type of contract to be issued. The provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state the duration, where limited, of renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed. ()

e. Except for riders or endorsements by which the insurer effectuates a request made in writing by the policyholder or exercises a specifically reserved right under the policy, all riders or endorsements added to a policy after date of issue or at reinstatement or renewal that reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the policyholder. After date of policy issue, any rider or endorsement that increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to in writing signed by the policyholder, except if the increased benefits or coverage is required by law. The signature requirements in this paragraph apply to group supplemental health insurance certificates only where the certificate holder also pays the insurance premium. ()

f. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy or certificate. ()

g. A policy or certificate that provides for the payment of benefits based on standards described as "usual and customary," "reasonable and customary," or words of similar import shall include a definition of the terms and an explanation of the terms in its accompanying outline of coverage. ()

h. If a policy or certificate contains any limitations with respect to preexisting conditions, the limitations shall appear as a separate paragraph of the policy or certificate and be labeled as "Preexisting Condition Limitations". ()

i. All accident-only policies and certificates shall contain a prominent statement on the first page of the policy or certificate, in either contrasting color or in boldface type at least equal to the size of type used for headings or captions of sections in the policy or certificate, a prominent statement as follows: "Notice to Buyer: This is an accident-only (policy) (certificate) and it does not pay benefits for loss from sickness. Review your (policy) (certificate) carefully." ()

j. Accident-only policies or certificates that provide coverage for hospital or medical care shall

contain the following statement in addition to the Notice to Buyer required by Subsection 101.01.i.: “This (policy) (certificate) provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses.” ()

k. All policies and certificates, except single-premium nonrenewable policies and as otherwise provided in this paragraph, shall have a notice prominently printed on the first page of the policy or certificate or attached to it stating in substance that the policyholder or certificate holder shall have the right to return the policy or certificate within ten (10) days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the policyholder or certificate holder is not satisfied for any reason. ()

l. If age is to be used as a determining factor for reducing the maximum aggregate benefits made available in the policy or certificate as originally issued, that fact shall be prominently set forth in the outline of coverage. ()

m. If a policy or certificate contains a conversion privilege, it shall comply, in substance, with the following: ()

i. The caption of the provision shall be “Conversion Privilege” or words of similar import. ()

ii. The provision shall indicate the persons eligible for conversion, the circumstances applicable to the conversion privilege, including any limitations on the conversion, and the person by whom the conversion privilege may be exercised. ()

iii. The provision shall specify the benefits to be provided on conversion or may state that the converted coverage will be as provided on a policy form then being used by the insurer for that purpose. ()

n. Outlines of coverage delivered in connection with policies defined as “Hospital Confinement Indemnity Coverage” in Section 017, “Specified Disease Coverage” in Subsection 012.09, or “Limited Benefit Health Coverage” in Section 029 of this rule to persons eligible for Medicare by reason of age shall contain the information for hospital confinement indemnity providing limited benefits (supplemental benefits) and Accident-Only Coverage as set forth in the model outlines of coverage found on the Department of Insurance Internet web-site at www.doi.state.id.us, “Consumer Assistance” link. In addition, the following language shall be printed on or attached to the first page of the outline of coverage: “THIS IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the ‘Guide to Health Insurance for People With Medicare’ available from the company.” ()

i. An insurer shall also deliver to persons eligible for Medicare any notice required under IDAPA 18.01.54, Section 019, “Rule to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act”. ()

o. All specified disease policies and certificates shall contain on the first page or attached to it in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the policy or certificate a prominent statement as follows: “Notice to Buyer: This is a specified disease (policy) (certificate). This (policy) (certificate) provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses. Read your (policy) (certificate) carefully with the outline of coverage.” ()

p. All hospital confinement indemnity policies and certificates shall display prominently by type, stamp, or other appropriate means on the first page of the policy or certificate, or attached to it, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the policy or certificate the following: “Notice to Buyer: This is a hospital confinement indemnity (policy) (certificate). This (policy) (certificate) provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses.” ()

q. All limited benefit health policies and certificates shall display prominently by type, stamp or other appropriate means on the first page of the policy or certificate, or attached to it, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the policy or certificate the

following: “Notice to Buyer: This is a limited benefit health (policy) (certificate). This (policy) (certificate) provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses.” ()

r. All basic hospital expense policies and certificates shall display prominently by type, stamp or other appropriate means on the first page of the policy or certificate, or attached to it, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the policy or certificate the following: “Notice to Buyer: This is a basic hospital expense (policy) (certificate). This (policy) (certificate) provides limited benefits and should not be considered a substitute for comprehensive health insurance coverage.” ()

s. All basic medical-surgical expense policies and certificates shall display prominently by type, stamp, or other appropriate means on the first page of the policy or certificate, or attached to it, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the policy or certificate the following: “Notice to Buyer: This is a basic medical-surgical expense (policy) (certificate). This (policy) (certificate) provides limited benefits and should not be considered a substitute for comprehensive health insurance coverage.” ()

t. All basic hospital/medical-surgical expense policies and certificates shall display prominently by type, stamp or other appropriate means on the first page of the policy or certificate, or attached to it, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the policy or certificate the following: “Notice to Buyer: This is a basic hospital/medical-surgical expense (policy) (certificate). This (policy) (certificate) provides limited benefits and should not be considered a substitute for comprehensive health insurance coverage.” ()

u. All dental plan policies and certificates shall display prominently by type, stamp or other appropriate means on the first page of the policy or certificate, or attached to it, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the policy or certificate the following: “Notice to Buyer: This (policy) (certificate) provides dental benefits only.” ()

v. All vision plan policies and certificates shall display prominently by type, stamp or other appropriate means on the first page of the policy or certificate, or attached to it, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the policy or certificate the following: “Notice to Buyer: This (policy) (certificate) provides vision benefits only.” ()

02. Outline Of Coverage Requirements. Outlines of coverage required under this rule will conform to the model outlines of coverage as set forth at the Idaho Department of Insurance web-site, www.doi.state.id.us, under the consumer assistance link. ()

a. An insurer shall deliver an outline of coverage to an applicant or enrollee in the sale of individual accident and sickness insurance, group supplemental health insurance, dental plans and vision plans as required by Section 41-4205, Idaho Code, that conforms to Subsection 013.03 of this rule. ()

b. If an outline of coverage was delivered at the time of application or enrollment and the policy or certificate is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate must accompany the policy or certificate when it is delivered and contain the following statement in no less than twelve (12) point type, immediately above the company name: “NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon (application) (enrollment), and the coverage originally applied for has not been issued.” ()

c. The appropriate outline of coverage for policies or contracts providing hospital coverage that only meet the standards of Section 014 shall be that statement contained in the model outline of coverage for Basic Hospital Expense Coverage, as set forth at the Department of Insurance Internet website, www.doi.state.id.us. The appropriate outline of coverage for policies providing coverage that meets the standards of both Sections 014 and 015, shall be the statement contained in the model outline-of coverage for Basic Hospital/Medical-Surgical Expense Coverage, as set forth at the Department web-site. The appropriate outline of coverage for policies providing coverage that meets the standards of both Sections 014 and 017, or Sections 016 and 017, or Sections 014, 015, and 017 shall be the statement contained in the model outline of coverage for Individual Major Medical Expense Coverage as set forth at the Department web-site. ()

d. In any case where the prescribed outline of coverage is inappropriate for the coverage provided by the policy or certificate, an alternate outline of coverage shall be submitted to the director for prior written approval. ()

102. -- 200. (RESERVED).

201. REQUIREMENTS FOR REPLACEMENT OF INDIVIDUAL ACCIDENT AND SICKNESS INSURANCE.

01. Application Form. An application form shall include a question designed to elicit information as to whether the insurance to be issued is intended to replace any other accident and sickness insurance presently in force. A supplementary application or other form to be signed by the applicant containing the question may be used. ()

02. Required Notice. Upon determining that a sale will involve replacement, an insurer, or its agent shall furnish the applicant, prior to issuance or delivery of the policy, the "Notice To Applicant Regarding Replacement Of Accident And Sickness Insurance," taking into consideration the requirement for direct response or other than direct response. A direct response insurer shall deliver to the applicant upon issuance of the policy, the notice described in Section 201. ()

202. -- 999. (RESERVED).

IDAPA 18 - DEPARTMENT OF INSURANCE
18.01.30 - INDIVIDUAL ACCIDENT AND SICKNESS DISABILITY
INSURANCE MINIMUM STANDARDS ACT

DOCKET NO. 18-0130-0002 (REPEAL)

NOTICE OF PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has proposed rulemaking. These rules are proposed pursuant to the authority vested in the Director of the Department of Insurance under Title 41, Chapter 2, 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 October 18, 2000.

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 address below.

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

The rule is being repealed in its entirety and will be replaced with a new rule setting forth requirements for individual disability insurance policies based on the most recent model rule proposed by the National Association of Insurance Commissioners.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was conducted. The Notice of Negotiated Rulemaking was published in the Idaho Administrative Bulletin, February 2, 2000, Volume No. 00-2, page 23.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning these proposed rules, contact Joan Krosch at (208) 334-4250.

Anyone may submit written comments regarding this proposed rulemaking. All written comments and data concerning the rule must be directed to the undersigned and must be received on or before October 25, 2000.

Dated this 22nd day of August, 2000.

Mary L. Hartung
Director
Idaho Department of Insurance
700 West State Street - 3rd Floor
P.O. Box 83720
Boise, ID 83720-0043
Telephone No. (208) 334-4250

THIS CHAPTER IS BEING REPEALED IN ITS ENTIRETY.

IDAPA 18 - DEPARTMENT OF INSURANCE
18.01.44 - SCHEDULE OF FEES, LICENSES AND MISCELLANEOUS CHARGES

DOCKET NO. 18-0144-0001

NOTICE OF PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has proposed rule making. These rules are proposed pursuant to the authority vested in the Director of the Department of Insurance under Title 41, Chapters 2 and 4, 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 October 18, 2000.

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 address below.

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

These amendments provide that overpayments in excess of \$200 will not be made unless a written request is made by the payor in order to reduce the administrative burden associated with multiple refunds of relatively small payments; extraordinary exam costs will not be considered to be included in the continuation fee and may be imposed by the director to allow the department to pass unforeseen exam costs on to a company; a continuation fee will be imposed on domestic risk retention groups only; and the continuation fee for purchasing groups will be \$100.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because the changes are relatively minor yet affect various types of parties who would be difficult to assemble for negotiated rulemaking, and the refund problems started to arise after July 1, 2000.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning these proposed rules, contact Robert C. Murphy at (208) 334-4250.

Anyone may submit written comments regarding these rules. All written comments and data concerning the rule must be directed to the undersigned and must be received on or before October 25, 2000.

Dated this 22nd day of August, 2000.

Mary L. Hartung, Director
Idaho Department of Insurance
700 West State Street - 3rd Floor
P.O. Box 83720
Boise, ID 83720-0043
Telephone No. (208) 334-4250

THE FOLLOWING IS THE TEXT OF DOCKET NO. 18-0144-0001

020. INSURER FEES.

01. Annual Continuation Fee. All insurers and other entities (set forth in Section 020) licensed, listed, or otherwise approved to do business in the state of Idaho shall pay an annual continuation fee. (7-1-00)

a. The annual continuation fee shall be due on March 1st each year and shall provide for payment of the insurer's fees due through the last day of February next proceeding. (7-1-00)

b. The annual continuation fee shall be charged at the time the insurer applies for admission to do business in the state of Idaho. If the application is approved, the fee paid shall cover the insurer's fees through the last day of February next proceeding. (7-1-00)

02. Fee For Insurers. For all insurance companies receiving a certificate of authority pursuant to Chapter 3, Title 41, Idaho Code, the amount of the annual continuation fee shall be as follows: (7-1-00)

a. If insurer's surplus as regards policyholders at the preceding December 31 is less than ten million dollars (\$10,000,000) - One thousand dollars (\$1,000). (7-1-00)

b. If insurer's surplus as regards policyholders at the preceding December 31 is ten million (\$10,000,000) or more, but less than one hundred million (\$100,000,000) - Two thousand five hundred dollars (\$2,500). (7-1-00)

c. If insurer's surplus as regards policyholders at the preceding December 31 is on hundred million (\$100,000,000) or greater - Four thousand five hundred dollars (\$4,500). (7-1-00)

03. Fees Of Other Entities. For the following entities, the amount of the annual continuation fee shall be: ()

~~a.~~ Five hundred dollars (\$500): (~~7-1-00~~)()

~~ai.~~ Accredited reinsurers, listed pursuant to Section 41-514(1)(b), Idaho Code. (7-1-00)

~~aii.~~ Trusteed reinsurers, listed pursuant to Section 41-514(1)(d), Idaho Code. (7-1-00)

~~aiii.~~ Authorized surplus line insurers. (7-1-00)

~~aiii.~~ County mutual insurers. (7-1-00)

~~ae.~~ Fraternal benefit societies. (7-1-00)

~~af.~~ Hospital and/or professional service corporations. (7-1-00)

~~ag.~~ Hospital liability trusts. (7-1-00)

~~axiii.~~ Self funded employee health care plans. (7-1-00)

~~ay.~~ Domestic Risk retention groups. (~~7-1-00~~)()

~~axi.~~ Petroleum clean water trusts. (7-1-00)

~~axii.~~ Rating organizations. (7-1-00)

~~axiii.~~ Advisory organizations. (7-1-00)

~~b.~~ One hundred dollars (\$100): ()

~~aj.~~ Purchasing groups. (7-1-00)

04. What Payment Of Fee Shall Cover. Payment of the annual continuation fee shall be deemed to be payment of all fees that would ordinarily be paid to the Department by the insurer or entity during the relevant year, including, but not limited to, the following: (7-1-00)

- a. Certificate of authority renewal, license renewal, and annual registration. (7-1-00)
- b. Arson, Fire and Fraud. (7-1-00)
- c. Annual statement filing. (7-1-00)
- d. Filing of policy rates and forms. (7-1-00)
- e. Agent appointment and renewal of appointment. (7-1-00)
- f. Filings under Chapter 38, Title 41, Idaho Code, Acquisition of control and insurance holding company systems. (7-1-00)
- g. Filing of amendments to Articles of Incorporation. (7-1-00)
- h. Filing of amendments to Bylaws. (7-1-00)
- i. Amendments to Certificate of Authority. (7-1-00)
- j. Filing of notice of significant transactions pursuant to Section 41-345, Idaho Code. (7-1-00)
- k. Quarterly statement filing. (7-1-00)
- l. Examination expenses, except for those set forth in Subsection 020.05.g. ~~(7-1-00)~~()

05. Fees Not Included. Payment of the annual continuation fee will not exempt the insurer or entity from the following: (7-1-00)

- a. Fees for application for producer license. (7-1-00)
- b. Costs incurred by the Department for investigation of an applicant for producer license. (7-1-00)
- c. Attorney's fees and costs incurred by the Department when allowed pursuant to Idaho Code. (7-1-00)
- d. Costs incurred for experts and consultants when allowed by Idaho Code. (7-1-00)
- e. Penalties or fines levied by or payable to the Department of Insurance. (7-1-00)
- f. All fees set forth under Section 040. (7-1-00)
- g. Extraordinary exam fees, including but not limited to, out-of-state exam fees, costs associated with an exam that is not an ordinary three to five (3 to 5) year financial exam, special actuarial reviews, and costs that are otherwise out of the ordinary as determined by the director. ()

06. Failure To Pay Fee. Failure to pay the annual continuation fee on or before March 1st each year shall be treated as failure to pay the continuation fee and will result in expiration of the insurer's or entity's authority to do business in the state of Idaho pursuant to Section 41-324, Idaho Code. (7-1-00)

07. Reinstatement Fee. The reinstatement fee referenced in Section 41-324(3), Idaho Code, shall be the amount referenced above for the insurer or entity continuation fee. (7-1-00)

(BREAK IN CONTINUITY OF SECTIONS)

051. OVERPAYMENTS.

Overpayments of published fees will be returned only when such overpayments exceed ~~twenty~~ two hundred dollars (\$200), or upon written request of the payor. ~~(7-1-00)~~()

IDAPA 18 - DEPARTMENT OF INSURANCE
18.01.60 - LONG-TERM CARE INSURANCE MINIMUM STANDARDS
DOCKET NO. 18-0160-0001
NOTICE OF PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has proposed rule making. These rules are proposed pursuant to the authority vested in the Director of the Department of Insurance under Title 41, Chapter 2, 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 October 18, 2000.

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 address below.

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

Amends the existing rule governing sales of long-term care insurance to add requirements for disclosure to consumers by long-term care insurance sellers of rating practices, including rate increase history, sets forth information to be included in disclosures to consumers and requires signed acknowledgement by consumer, amends loss ratio standards, sets forth additional filing requirements, adds standards governing premium rates and rate increases, provides for reimbursement of unnecessary rate increases, and sets forth requirements for actuarial certifications. The proposed rule is based on changes to the model long-term care insurance rule adopted by the National Association of Insurance Commissioners.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because the changes are part of a model rule developed by the National Association of Insurance Commissioners with input from affected parties at the national level.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning these proposed rules, contact Joan Krosch at (208) 334-4250.

Anyone may submit written comments regarding these rules. All written comments and data concerning the rule must be directed to the undersigned and must be received on or before October 25, 2000.

Dated this 22nd day of August, 2000.

Mary L. Hartung, Director
Idaho Department of Insurance
700 West State Street - 3rd Floor
P.O. Box 83720
Boise, ID 83720-0043
Telephone No. (208) 334-4250

THE FOLLOWING IS THE TEXT OF DOCKET NO. 18-0160-0001

001. TITLE AND SCOPE.

01. Title. This rule shall be cited in full as Idaho Department of Insurance Rule, IDAPA 18.01.60, rule to implement the “Long-Term Care Insurance Minimum Standards”. (4-5-00)

02. Purpose. The purpose of this rule is to promote the public interest, to promote the availability of long-term care insurance coverage, to protect applicants for long-term care insurance, as defined, from unfair or deceptive sales or enrollment practices, to facilitate public understanding and comparison of long-term care insurance coverages, and to facilitate flexibility and innovation in the development of long-term care insurance. (4-5-00)

03. Scope And Applicability. Except as otherwise specifically provided, this rule applies to all long-term care insurance policies including qualified long-term care insurance contracts and life insurance policies that accelerate benefits for long-term care delivered or issued for delivery in this state on or after the effective date by Insurers, Fraternal Benefit Societies, Managed Care Organizations and all similar organizations; certain provisions of this rule apply only to qualified long-term care insurance. Additionally, this rule is intended to apply to policies having indemnity benefits that are triggered by activities of daily living and sold as disability income insurance, if: (4-5-00)()

a. The benefits of the disability income policy are dependent upon or vary in amount based on the receipt of long-term care services; ()

b. The disability income policy is advertised, marketed or offered as insurance for long-term care services; or ()

c. Benefits under the policy may commence after the policyholder has reached Social Security’s normal retirement age unless benefits are designed to replace lost income or pay for specific expenses other than long-term care services. ()

(BREAK IN CONTINUITY OF SECTIONS)

004. DEFINITIONS.

For the purpose of this rule, no long-term care insurance policy delivered or issued for delivery in this state shall use the terms set forth below, unless the terms are defined in the policy. In relation to the Qualified Long-Term Care plans, such definitions must satisfy definitions as amended by the U.S. Treasury Department and the following requirements: (4-5-00)

01. Activities Of Daily Living. At least bathing, continence, dressing, eating, toileting, and transferring. (4-5-00)

02. Acute Condition. The individual is medically unstable. Such an individual requires frequent monitoring by medical professionals, such as physicians and registered nurses, in order to maintain his health status. (4-5-00)

03. Adult Day Care. A program for six (6) or more individuals, of social and health-related services provided during the day in a community group setting for the purpose of supporting frail, impaired elderly or other disabled adults who can benefit from care in a group setting outside the home. (4-5-00)

04. Bathing. Washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower. (4-5-00)

05. Cognitive Impairment. A deficiency in a person’s short or long-term memory, orientation as to person, place and time, deductive or abstract reasoning, or judgment as it relates to safety awareness. (4-5-00)

06. Continence. The ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag). (4-5-00)

07. Dressing. Putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs. (4-5-00)

08. Eating. Feeding oneself by getting food into the body from a receptacle (such as a plate, cup, or table) or by a feeding tube or intravenously. (4-5-00)

09. Exceptional Increase. Means only those increases filed by an insurer as exceptional for which the director determines the need for the premium rate increase is justified due to changes in Idaho laws or rules applicable to long-term care coverage, or due to increased and unexpected utilization that affects the majority of insurers of similar products. ()

a. Except as provided in Section 020, Premium Rate Schedule Increases, exceptional increases are subject to the same requirements as other premium rate schedule increases. ()

b. The director may request a review by an independent actuary or a professional actuarial body of the basis for a request that an increase be considered an exceptional increase. ()

c. The director, in determining that the necessary basis for an exceptional increase exists, shall also determine any potential offsets to higher claims costs. ()

~~09~~**10. Hands-On Assistance.** Physical assistance (minimal, moderate, or maximal) without which the individual would not be able to perform the activity of daily living. (4-5-00)

~~10~~**11. Home Health Care Services.** Medical and non-medical services, provided to ill, disabled, or infirm persons in their residences. Such services may include homemaker services, assistance with activities of daily living, and respite care services. (4-5-00)

12. Incidental. As used in Subsection 020.10, the value of the long-term care benefits provided is less than ten percent (10%) of the total value of the benefits provided over the life of the policy. These values shall be measured as of the date of issue. ()

~~13~~**13. Medicare.** “The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended,” or “Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof,” or words of similar import. (4-5-00)

124. Mental Or Nervous Disorder. Shall not be defined to include more than neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder. (4-5-00)

~~135~~**135. Personal Care.** The provision of hands-on services to assist an individual with activities of daily living. (4-5-00)

16. Qualified Actuary. Means a member in gooding standing of the American Academy of Actuaries. ()

17. Similar Policy Forms. Means all of the long-term care insurance policies and certificates issued by an insurer in the same long-term care benefit classification as the policy form being considered. Certificates of groups that meet the definition in Section 41-4603(4)(a), Idaho Code, are not considered similar to certificates or policies otherwise issued as long-term care insurance, but are similar to other comparable certificates with the same long-term care benefit classifications. For purposes of determining similar policy forms, long-term care benefit classifications are defined as follows: ()

a. Institutional long-term care benefits only; ()

b. Non-institutional long-term care benefits only; or ()

c. Comprehensive long-term care benefits. ()

148. Skilled Nursing Care, Intermediate Care, Personal Care, Home Care, And Other Services. Defined in relation to the level of skill required, the nature of the care and the setting in which care must be delivered. (4-5-00)

159. Toileting. Getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene. (4-5-00)

~~1620.~~ **Transferring.** Moving into or out of a bed, chair, or wheelchair. (4-5-00)

~~1721.~~ **All Providers Of Services.** Including but not limited to Skilled Nursing Facility, Extended Care Facility, Intermediate Care Facility, Convalescent Nursing Home, Personal Care Facility, and Home Care Agency. Such services shall be defined in relation to the services and facilities required to be available and the licensure or degree status of those providing or supervising the services. The definition may require that the provider be appropriately licensed or certified. (4-5-00)

005. POLICY PRACTICES AND PROVISIONS.

01. Renewability. The terms “guaranteed renewable” and “noncancellable” shall not be used in any individual long-term care insurance policy without further explanatory language in accordance with the disclosure requirements of Section 009 of this rule. (4-5-00)

a. A policy issued to an individual shall not contain renewal provisions other than “guaranteed renewable” or “noncancellable”. (4-5-00)

b. The term “guaranteed renewable” may be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums and when the insurer has no unilateral right to make any change in any provision of the policy or rider while the insurance is in force, and cannot decline to renew, except that rates may be revised by the insurer on a class basis. (4-5-00)

c. The term “noncancellable” may be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums during which period the insurer has no right to unilaterally make any change in any provision of the insurance or in the premium rate. (4-5-00)

d. The term “level premium” may only be used when the insurer does not have the right to change the premium for a specified period for the life of the policy. ()

~~de.~~ In addition to the other requirements of Subsection 005.01, a qualified long-term care insurance contract shall be guaranteed renewable, within the meaning of Section 7702B(b)(1)(C) of the Internal Revenue Code of 1986 as amended. (4-5-00)

02. Limitations And Exclusions. A policy may not be delivered or issued for delivery in this state as long-term care insurance if the policy limits or excludes coverage by type of illness, treatment, medical condition or accident, except as follows: (4-5-00)

a. Preexisting conditions or diseases; (4-5-00)

b. Mental or nervous disorders; however, this shall not permit exclusion or limitation of benefits on the basis of Alzheimer’s Disease; (4-5-00)

c. Alcoholism and drug addiction; (4-5-00)

d. Illness, treatment, or medical condition arising out of: (4-5-00)

i. War or act of war (whether declared or undeclared); (4-5-00)

- ii. Participation in a felony, riot, or insurrection; (4-5-00)
- iii. Service in the armed forces or units auxiliary thereto; (4-5-00)
- iv. Suicide (sane or insane), attempted suicide, or intentionally self-inflicted injury; or (4-5-00)
- v. Aviation (this exclusion applies only to non-fare-paying passengers). (4-5-00)
- e. Treatment provided in a government facility (unless otherwise required by law), services for which benefits are available under Medicare or other governmental program (except Medicaid), any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law, services provided by a member of the covered person's immediate family, and services for which no charge is normally made in the absence of insurance; (4-5-00)
- f. Expenses for services or items available or paid under another long-term care insurance or health insurance policy; or (4-5-00)
- g. In the case of a qualified long-term care insurance contract, expenses for services or items to the extent that the expenses are reimbursable under Title XVIII of the Social Security Act or would be so reimbursable but for the application of a deductible or coinsurance amount. (4-5-00)
- h. Subsection 005.02 is not intended to prohibit exclusions and limitations by type of provider or territorial limitations. (4-5-00)

03. Extension Of Benefits. Termination of long-term care insurance shall be without prejudice to any benefits payable for institutionalization if the institutionalization began while the long-term care insurance was in force and continues without interruption after termination. The extension of benefits beyond the period the long-term care insurance was in force may be limited to the duration of the benefit period, if any, or to payment of the maximum benefits and may be subject to any policy waiting period, and all other applicable provisions of the policy. (4-5-00)

04. Continuation Or Conversion. (4-5-00)

a. Group long-term care insurance issued in this state on or after the effective date of Section 005 shall provide covered individuals with a basis for continuation or conversion of coverage. (4-5-00)

b. For the purposes of Section 005, "a basis for continuation of coverage" means a policy provision that maintains coverage under the existing group policy when the coverage would otherwise terminate and which is subject only to the continued timely payment of premium when due. Group policies that restrict provision of benefits and services to, or contain incentives to use certain providers or facilities, may provide continuation benefits that are substantially equivalent to the benefits of the existing group policy. The director shall make a determination as to the substantial equivalency of benefits, and in doing so, shall take into consideration the differences between managed care and non-managed care plans, including, but not limited to, provider system arrangements, service availability, benefit levels and administrative complexity. (4-5-00)

c. For the purposes of Section 005, "a basis for conversion of coverage" means a policy provision that an individual whose coverage under the group policy would otherwise terminate or has been terminated for any reason, including discontinuance of the group policy in its entirety or with respect to an insured class, and who has been continuously insured under the group policy (and any group policy which it replaced) for at least six (6) months immediately prior to termination, shall be entitled to the issuance of a converted policy by the insurer under whose group policy he or she is covered, without evidence of insurability. (4-5-00)

d. For the purposes of Section 005, "converted policy" means an individual policy of long-term care insurance providing benefits identical to or benefits determined by the director to be substantially equivalent to or in excess of those provided under the group policy from which conversion is made. Where the group policy from which conversion is made restricts provision of benefits and services to, or contains incentives to use certain providers or facilities, the director, in making a determination as to the substantial equivalency of benefits, shall take into consideration the differences between managed care and non-managed care plans, including, but not limited to,

provider system arrangements, service availability, benefit levels and administrative complexity. (4-5-00)

e. Written application for the converted policy shall be made and the first premium due, if any, shall be paid as directed by the insurer not later than thirty-one (31) days after termination of coverage under the group policy. The converted policy shall be issued effective on the day following the termination of coverage under the group policy and shall be renewable annually. (4-5-00)

f. Unless the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy from which conversion is made. Where the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy replaced. (4-5-00)

g. Continuation of coverage or issuance of a converted policy shall be mandatory, except where: (4-5-00)

i. Termination of group coverage resulted from an individual's failure to make any required payment of premium or contribution when due; or (4-5-00)

ii. The terminating coverage is replaced not later than thirty-one (31) days after termination, by group coverage effective on the day following the termination of coverage: (4-5-00)

(1) Providing benefits identical to or benefits determined by the director to be substantially equivalent to or in excess of those provided by the terminating coverage; and (4-5-00)

(2) The premium for which is calculated in a manner consistent with the requirements of Subsection 005.06. (4-5-00)

h. Notwithstanding any other provision of Section 005, a converted policy issued to an individual who at the time of conversion is covered by another long-term care insurance policy that provides benefits on the basis of incurred expenses, may contain a provision that results in a reduction of benefits payable if the benefits provided under the additional coverage, together with the full benefits provided by the converted policy, would result in payment of more than one hundred percent (100%) of incurred expenses. The provision shall only be included in the converted policy if the converted policy also provides for a premium decrease or refund which reflects the reduction in benefits payable. (4-5-00)

i. The converted policy may provide that the benefits payable under the converted policy, together with the benefits payable under the group policy from which conversion is made, shall not exceed those that would have been payable had the individual's coverage under the group policy remained in force and effect. (4-5-00)

j. Notwithstanding any other provision of Section 005, an insured individual whose eligibility for group long-term care coverage is based upon his relationship to another person shall be entitled to continuation of coverage under the group policy upon termination of the qualifying relationship by death or dissolution of marriage. (4-5-00)

k. For the purposes of Section 005 a "managed-care plan" is a health care or assisted living arrangement designed to coordinate patient care or control costs through utilization review, case management or use of specific provider networks. (4-5-00)

05. Discontinuance And Replacement. If a group long-term care policy is replaced by another group long-term care policy issued to the same policyholder, the succeeding insurer shall offer coverage to all persons covered under the previous group policy on its date of termination. Coverage provided or offered to individuals by the insurer and premiums charged to persons under the new group policy: (4-5-00)

a. Shall not result in an exclusion for preexisting conditions that would have been covered under the group policy being replaced; and (4-5-00)

b. Shall not vary or otherwise depend on the individual's health or disability status, claim experience or use of long-term care services. (4-5-00)

06. Premium Changes. (4-5-00)

a. The premium charged to an insured shall not increase due to either: (4-5-00)

i. The increasing age of the insured at ages beyond sixty-five (65); or (4-5-00)

ii. The duration the insured has been covered under the policy. (4-5-00)

b. The purchase of additional coverage shall not be considered a premium rate increase, but for purposes of the calculation required under Section 0245, the portion of the premium attributable to the additional coverage shall be added to and considered part of the initial annual premium. (~~4-5-00~~)()

c. A reduction in benefits shall not be considered a premium change, but for purpose of the calculation required under Section 0245, the initial annual premium shall be based on the reduced benefits. (~~4-5-00~~)()

07. Electronic Enrollment For Group Policies. (4-5-00)

a. In the case of a group defined in Section 41-4603(4)(a), Idaho Code, any requirement that a signature of an insured be obtained by an agent or insurer shall be deemed satisfied if: (4-5-00)

i. The consent is obtained by telephonic or electronic enrollment by the group policyholder or insurer. A verification of enrollment information shall be provided to the enrollee; (4-5-00)

ii. The telephonic or electronic enrollment provides necessary and reasonable safeguards to assure the accuracy, retention, and prompt retrieval of records; and (4-5-00)

iii. The telephonic or electronic enrollment provides necessary and reasonable safeguards to assure that the confidentiality of individually identifiable information, "privileged information," is maintained. (4-5-00)

b. The insurer shall make available, upon request of the director, records that will demonstrate the insurer's ability to confirm enrollment and coverage amounts. (4-5-00)

006. INCORPORATION OF DOCUMENTS BY REFERENCE.

01. Forms. An insurer shall use the forms published on the Department of Insurance Internet Website www.doi.state.id.us, select the link, "Consumer Assistance," to comply with the disclosure requirements of Subsection 009.10.a. and Subsection 009.10.b., which forms are incorporated herein by this reference. ()

02. NAIC Model Regulation For Long-Term Care Insurance Minimum Standards Appendices B, C, and D. Copies Of NAIC Model Regulation For Long-Term Care Insurance Minimum Standards Appendices B, C, and D can be found at the Idaho Department of Insurance Home page, www.doi.state.id.us, select SHIBA (Senior Health Insurance Benefits Advisors) under the Consumer Assistance link, which appendices are hereby incorporated by reference. To obtain a hard copy of the required illustrations based on the NAIC Model Regulation, contact SHIBA at the Idaho Department of Insurance (208) 334-4250. ()

~~006.~~—007. (RESERVED).

(BREAK IN CONTINUITY OF SECTIONS)

009. REQUIRED DISCLOSURE PROVISIONS.

01. Renewability. Individual long-term care insurance policies shall contain a renewability provision. ()

a. The provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state ~~that the duration, where limited, of renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed~~ coverage is guaranteed renewable or noncancellable. This provision shall not apply to policies that do not contain a renewability provision, and under which the right to nonrenew is reserved solely to the policyholder. (4-5-00)()

b. A long-term care insurance policy or certificate, other than one where the insurer does not have the right to change the premium, shall include a statement that the premium rates may change. ()

02. Riders And Endorsements. Except for riders or endorsements by which the insurer effectuates a request made in writing by the insured under an individual long-term care insurance policy, all riders or endorsements added to an individual long-term care insurance policy after date of issue or at reinstatement or renewal that reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the individual insured. After the date of policy issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to in writing signed by the insured, except if the increased benefits or coverage are required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy, rider or endorsement. (4-5-00)

03. Payment Of Benefits. A long-term care insurance policy that provides for the payment of benefits based on standards described as “usual and customary,” “reasonable and customary,” or words of similar import shall include a definition of these terms and an explanation of the terms in its accompanying outline of coverage. (4-5-00)

04. Limitations. If a long-term care insurance policy or certificate contains any limitations with respect to preexisting conditions, the limitations shall appear as a separate paragraph of the policy or certificate and shall be labeled as “Preexisting Condition Limitations”. (4-5-00)

05. Other Limitations Or Conditions On Eligibility For Benefits. A long-term care insurance policy or certificate containing any limitations or conditions for eligibility other than those prohibited in this rule shall set forth a description of the limitations or conditions, including any required number of days of confinement, in a separate paragraph of the policy or certificate and shall label such paragraph “Limitations or Conditions on Eligibility for Benefits”. (4-5-00)

06. Disclosure Of Tax Consequences. With regard to life insurance policies that provide an accelerated benefit for long-term care, a disclosure statement is required at the time of application for the policy or rider and at the time the accelerated benefit payment request is submitted that receipt of these accelerated benefits may be taxable, and that assistance should be sought from a personal tax advisor. The disclosure statement shall be prominently displayed on the first page of the policy or rider and any other related documents. Subsection 009.06 shall not apply to qualified long-term care insurance contracts. (4-5-00)

07. Benefit Triggers. Activities of daily living and cognitive impairment shall be used to measure an insured’s need for long-term care and shall be described in the policy or certificate in a separate paragraph and shall be labeled “Eligibility for the Payment of Benefits”. Any additional benefit triggers shall also be explained. If these triggers differ for different benefits, explanation of the trigger shall accompany each benefit description. If an attending physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this too shall be specified. (4-5-00)

08. Qualified Contracts. A qualified long-term care insurance contract shall include a disclosure statement in the policy and in the outline of coverage as contained in Section 027 that the policy is intended to be a qualified long-term care insurance contract. (4-5-00)

09. Non-Qualified Contracts. A non-qualified long-term care insurance contract shall include a

disclosure statement in the policy and in the outline of coverage as contained in Section 027 that the policy is not intended to be a qualified long-term care insurance contract. (4-5-00)

- 10. Required Disclosure of Rating Practices to Consumers.** ()
- a. Subsection 009.10 shall apply as follows: ()
- i. Except as provided in Subsection 009.10.a.ii., Subsection 009.10 applies to any long-term care policy or certificate issued in this state on or after July 1, 2001. ()
- ii. For certificates issued on or after the effective date of this amended rule under a group long-term care insurance policy as defined in Section 41-4603(4)(a), Idaho Code, which policy was in force at the time this amended rule became effective, the provisions of Subsection 009.10 shall apply on the policy anniversary following January 1, 2002. ()
- b. Other than policies for which no applicable premium rate or rate schedule increases can be made, insurers shall provide all of the information listed in Subsection 009.10.b. to the applicant at the time of application or enrollment, unless the method of application does not allow for delivery at that time. In such a case, an insurer shall provide all information listed in Subsection 009.10.b. to the applicant no later than at the time of delivery of the policy or certificate. ()
- i. A statement that the policy may be subject to rate increases in the future: ()
- ii. An explanation of potential future premium rate revisions, and the policyholder's or certificateholder's option in the event of a premium rate revision: ()
- iii. The premium rate or rate schedules applicable to the applicant that will be in effect until a request is made for an increase; and ()
- iv. A general explanation for applying premium rate or rate schedule adjustments that shall include, a description of when premium rate or rate schedule adjustments will be effective (e.g., next anniversary date, next billing date, etc.); and the right to a revised premium rate or rate schedule as provided in Subsection 009.10.b.ii., if the premium rate or rate schedule is changed. ()
- c. Information regarding each premium rate increase on this policy form or similar forms over the past ten (10) years for this state or any other state that, at a minimum, identifies: ()
- i. The policy forms for which premium rates have been increased; ()
- ii. The calendar years when the form was available for purchase; and ()
- iii. The amount or percent of each increase. The percentage may be expressed as a percentage of the premium rate prior to the increase, and may also be expressed as minimum and maximum percentages if the rate increase is variable by rating characteristics. ()
- d. The insurer may, in a fair manner, provide additional explanatory information related to the rate increases. ()
- e. An insurer shall have the right to exclude from the disclosure premium rate increases that only apply to blocks of business acquired from other nonaffiliated insurers or the long-term care policies acquired from other nonaffiliated insurers when those increases occurred prior to acquisition. ()
- f. If an acquiring insurer files for a rate increase on a long-term care policy form acquired from nonaffiliated insurers or a block of policy forms acquired from nonaffiliated insurers on or before the later of the effective date of Subsection 009.10 or the end of a twenty-four (24) month period following the acquisition of the block of policies, the acquiring insurer may exclude that rate increase from the disclosure. However, the nonaffiliated selling company shall include the disclosure of that rate increase in accordance with Subsection 009.10.c. ()

g. If the acquiring insurer in Subsection 009.10.f. above files for a subsequent rate increase, even within the twenty-four (24) month period, on the same policy form acquired from nonaffiliated insurers or block of policy forms acquired from nonaffiliated insurers referenced in Subsection 009.10.f., the acquiring insurer must make all disclosures required by Subsection 009.10.c., including disclosure of the earlier rate increase referenced in Subsection 009.10.f. ()

h. An applicant shall sign an acknowledgement at the time of application, unless the method of application does not allow for signature at that time, that the insurer made the disclosure required under Subsections 009.10.a. and 009.10.b. If because of the method of application the applicant cannot sign an acknowledgement at the time of application, the applicant shall sign no later than at the time of delivery of the policy or certificate. ()

i. An insurer shall use the forms published on the Department of Insurance Internet Website www.doi.state.id.us and select the link, "Consumer Assistance," to comply with the disclosure requirements of Subsection 009.10.a. and Subsection 009.10.b. ()

j. An insurer shall provide notice of an upcoming premium rate schedule increase to all policyholders or certificateholders, if applicable, at least thirty (30) days prior to the implementation of the premium rate schedule increase by the insurer. The notice shall include the information required by Subsection 009.10.b., when the increase is implemented. ()

(BREAK IN CONTINUITY OF SECTIONS)

015. LICENSING.

No agent or broker is authorized to ~~market, sell, solicit, or otherwise contact a person for the purpose of marketing long-term care insurance unless the agent has demonstrated his knowledge of long-term care insurance and the appropriateness of such insurance by passing a test required by this state and maintaining appropriate licenses negotiate with respect to long-term care insurance except as authorized by Title 41, Chapter 10, Licensing Requirements And Procedures.~~ (4-5-00)()

(BREAK IN CONTINUITY OF SECTIONS)

018. LOSS RATIO.

Section 018 shall apply to all (group and individual) long-term care insurance policies or certificates except those covered under Sections 019 and 020 of this rule. ()

01. Expected Loss Ratios. Benefits under long-term care insurance policies shall be deemed reasonable in relation to premiums provided the expected loss ratio is at least sixty percent (60%), calculated in a manner which provides for adequate reserving of the long-term care insurance risk. In evaluating the expected loss ratio, due consideration shall be given to all relevant factors, including: (4-5-00)

- a. Statistical credibility of incurred claims experience and earned premiums; (4-5-00)
- b. The period for which rates are computed to provide coverage; (4-5-00)
- c. Experienced and projected trends; (4-5-00)
- d. Concentration of experience within early policy duration; (4-5-00)
- e. Expected claim fluctuation; (4-5-00)
- f. Experience refunds, adjustments or dividends; (4-5-00)

- g. Renewability features; (4-5-00)
- h. All appropriate expense factors; (4-5-00)
- i. Interest; (4-5-00)
- j. Experimental nature of the coverage; (4-5-00)
- k. Policy reserves; (4-5-00)
- l. Mix of business by risk classification; and (4-5-00)
- m. Product features such as long elimination periods, high deductibles and high maximum limits. (4-5-00)

02. Policies That Accelerate Benefits. Subsection 018.01 shall not apply to life insurance policies that accelerate benefits for long-term care. A life insurance policy that funds long-term care benefits entirely by accelerating the death benefit is considered to provide reasonable benefits in relation to premiums paid, if the policy complies with all of the following provisions: (4-5-00)

a. The interest credited internally to determine cash value accumulations, including long-term care, if any, are guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy; (4-5-00)

b. The portion of the policy that provides life insurance benefits meets the nonforfeiture requirements of Section 41-1927, Idaho Code, Standard Nonforfeiture Law – Life Insurance. (4-5-00)

c. The policy meets the disclosure requirements of Sections 41-4605(9), 41-4605(10), and 41-4605(11), Idaho Code. (4-5-00)

d. An actuarial memorandum is filed with the insurance department that includes: (4-5-00)

i. A description of the basis on which the long-term care rates were determined; (4-5-00)

ii. A description of the basis for the reserves; (4-5-00)

iii. A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance; (4-5-00)

iv. A description and a table of each actuarial assumption used. For expenses, an insurer must include percent of premium dollars per policy and dollars per unit of benefits, if any; (4-5-00)

v. A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives; (4-5-00)

vi. The estimated average annual premium per policy and the average issue age; (4-5-00)

vii. A statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used and, if used, the statement shall include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and (4-5-00)

viii. A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values and reserves on the underlying life insurance policy, both for active lives and those in long-term care claim status. (4-5-00)

019. FILING REQUIREMENT.

Prior to an insurer or similar organization offering group long-term care insurance to a resident of this state pursuant to Section 41-4604, Idaho Code, Extraterritorial Jurisdiction – Group Long-Term Care Insurance, it shall file with the director evidence that the group policy or certificate thereunder has been approved by a state having statutory or regulatory long-term care insurance requirements substantially similar to those adopted in this state. (4-5-00)

01. Initial Filing Requirements. ()

- a. Subsection 019.01 applies to any long-term care policy issued in this state on or after July 1, 2001. ()
- b. An insurer will provide the information listed in Subsection 019.01 to the director thirty (30) days prior to making the long-term care insurance form available for sale. ()
- c. A copy of the disclosure documents required in Section 009. ()
- d. An actuarial certification consisting of at least the following: ()
 - i. A statement that the initial premium rate schedule is sufficient to cover anticipated costs under moderately adverse experience and that the premium rate schedule is reasonably expected to be sustainable over the life of the form with no future premium increases anticipated; ()
 - ii. A statement that the policy design and coverage provided have been reviewed and taken into consideration; ()
 - iii. A statement that the underwriting and claims adjudication processes have been reviewed and taken into consideration. ()
- e. A complete description of the basis for contract reserves that are anticipated to be held under the form, to include: ()
 - i. Sufficient detail or sample calculations provided so as to have a complete depiction of the reserve amounts to be held; ()
 - ii. A statement that the assumptions used for reserves contain reasonable margins for adverse experience; ()
 - iii. A statement that the net valuation premium for renewal years does not increase (except for attained-age rating where permitted); and ()
 - iv. A statement that the difference between the gross premium and the net valuation premium for renewal years is sufficient to cover expected renewal expenses; or if such a statement cannot be made, a complete description of the situations where this does not occur; ()
 - v. An aggregate distribution of anticipated issues may be used as long as the underlying gross premiums maintain a reasonably consistent relationship; ()
 - vi. If the gross premiums for certain age groups appear to be inconsistent with this requirement, the director may request a demonstration under Subsection 019.02 based on a standard age distribution; and ()
 - vii. A statement that the premium rate schedule is not less than the premium rate schedule for existing similar policy forms also available from the insurer except for reasonable differences attributable to benefits; or, ()
 - viii. A comparison of the premium schedules for similar policy forms that are currently available from the insurer with an explanation of the differences. ()

02. Actuarial Demonstration. The director may request an actuarial demonstration that benefits are reasonable in relation to premiums. The actuarial demonstration shall include either premium and claim experience on similar policy forms, adjusted for any premium or benefit differences, relevant and credible data from other studies, or both. ()

a. In the event the director requests additional information under this provision, the period referred to in Subsection 019.01 of this section does not include the period of time during which the insurer is preparing the requested information. ()

020. PREMIUM RATE SCHEDULE INCREASES.

01. Premium Rate Increases. This Section 020 shall apply as follows: ()

a. Except as provided in Subsection 020.01.b., this section applies to any long-term care policy or certificate issued in this state on or after July 1, 2001. ()

b. For certificates issued on or after the effective date of this amended rule under a group long-term care insurance policy as defined in Section 41-4603 (4)(a), Idaho Code, which policy was in force at the time this amended rule became effective, the provisions of this section shall apply on the policy anniversary following January 1, 2002. ()

c. An insurer shall provide notice of a pending premium rate schedule increase, including an exceptional increase, to the director at least thirty (30) days prior to the notice to the policyholders and shall include: ()

i. Information required by Section 009. ()

d. Certification by a qualified actuary that: ()

i. If the requested premium rate schedule increase is implemented and the underlying assumptions, which reflect moderately adverse conditions, are realized, no further premium rate schedule increases are anticipated; and ()

ii. The premium rate filing is in compliance with the provisions of this Section 020. ()

02. Actuarial Memorandum. An actuarial memorandum justifying the rate schedule change request that includes: ()

a. Lifetime projections of earned premiums and incurred claims based on the filed premium rate schedule increase; and the method of assumptions used in determining the projected values, including reflection of any assumptions that deviate from those used for pricing other forms currently available for sale: ()

i. Annual values for the past five (5) years preceding and the three (3) years following the valuation date shall be provided separately; ()

ii. The projections shall include the development of the lifetime loss ratio, unless the rate of increase is an exceptional increase; ()

iii. The projections shall demonstrate compliance with Subsection 020.03, and ()

iv. For exceptional increases: ()

(1) The projected experience should be limited to the increases in claims expenses attributable to the approved reasons for the exceptional increase; and ()

(2) In the event the director determines as provided in Subsection 004.09.b. that offsets may exist, the

insurer shall use appropriate net projected experience. ()

b. Disclosure of how reserves have been incorporated in this rate increase will trigger contingent benefit upon lapse. ()

c. Disclosure of the analysis performed to determine why a rate adjustment is necessary, which pricing assumptions were not realized and why, and what other actions taken by the company have been relied on by the actuary. ()

d. A statement that policy design, underwriting and claims adjudication practices have been taken into consideration; and in the event that it is necessary to maintain consistent premium rates for new certificates and certificates receiving a rate increase, the insurer will need to file composite rates reflecting projections of new certificates. ()

e. A statement that renewal premium rate schedules are not greater than new business premium rate schedules except for differences attributable to benefits, unless sufficient justification is provided to the director; and sufficient information for review of the premium rate schedule increase by the director. ()

03. Premium Rate Schedule Increases. All premium rate schedule increases shall be determined in accordance with the following requirements: ()

a. Exceptional increases shall provide that seventy percent (70%) of the present value of projected additional premiums from the exceptional increase will be returned to policyholders in benefits. ()

b. Premium rate schedule increases shall be calculated such that the sum of the accumulated value of incurred claims, without the inclusion of active life reserves, and the present value of future projected incurred claims, without the inclusion of active life reserves, will not be less than the sum of the following: ()

i. The accumulated value of the initial earned premium times fifty eight percent (58%); ()

ii. Eighty-five percent (85%) of the accumulated value of prior premium rate schedule increases on an earned basis; ()

iii. The present value of future projected initial earned premiums times fifty-eight percent (58%); and ()

iv. Eighty-five percent (85%) of the present value of future projected premiums not in Subsection 020.03.b.iii. on an earned basis. ()

c. In the event that a policy form has both exceptional and other increases, the values in Subsections 020.03.b.ii. and 020.03.b.iv., will also include seventy percent (70%) for exceptional rate increase amounts. ()

d. All present and accumulated values used to determine rate increases shall use the maximum valuation interest rate for contract reserves as specified in IDAPA 18.01.68, "Minimum Reserve Standards For Individual And Group Health Insurance Contracts." Appendix A, IIA. The actuary shall disclose as part of the actuarial memorandum the use of any appropriate averages. ()

04. Projections Filed For Review. For each rate increase that is implemented, the insurer shall file for review by the director updated projections, as defined in Subsection 020.02.a., annually for the following three (3) years and include a comparison of actual results to projected values. The director may extend the period to greater than three (3) years if actual results are not consistent with projected values from prior projections. For group insurance policies that meet the conditions in Subsection 020.11, the projections required by this Subsection 020.04 shall be provided to the policyholder in lieu of filing with the director. ()

05. Revised Premium Rate. If any premium rate in the revised premium rate schedule is greater than 200 percent (200%) of the comparable rate in the initial premium schedule, lifetime projections, as defined in Subsection 020.02.a., shall be filed for review by the director every five (5) years following the end of the required

period in Subsection 020.04. For group insurance policies that meet the conditions in Subsection 020.13, the projections required by Subsection 020.05 shall be provided to the policyholder in lieu of filing with the director. ()

06. Actual and Projected Experience. If the director has determined that the actual experience following a rate increase does not adequately match the projected experience and that the current projections under moderately adverse conditions demonstrate that incurred claims will not exceed proportions of the premium specified in Subsection 020.03, the director may require the insurer to implement any of the following: ()

a. Premium rate schedule adjustments; or ()

i. Other measures to reduce the difference between the projected and actual experience. ()

b. In determining whether the actual experience adequately matches the projected experience, consideration should be given to Subsection 020.02.d., if applicable. ()

07. Contingent Benefit Upon Lapse. If the majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse, the insurer shall file: ()

a. A plan, subject to director approval, for improved administration or claims processing designed to eliminate the potential for further deterioration of the policy form requiring further premium rate schedule increases, or both, or to demonstrate that appropriate administration and claims processing have been implemented or are in effect. If the director should determine that such appropriate administration and claims processing functions have not been addressed, provisions of Subsection 08 may be applied; and ()

b. The original anticipated lifetime loss ratio, and the premium rate schedule increase that would have been calculated according to Subsection 020.03 had the greater of the original anticipated lifetime loss ratio or fifty-eight percent (58%) been used in the calculations described in Subsections 020.03.b.i. and 020.03.b.iii. ()

08. Additional Rate Increase Filings. For a rate increase filing that meets the following criteria, the director shall review, for all policies included in the filing, the projected lapse rates and past lapse rates during the twelve (12) months following each increase to determine if significant adverse lapse has occurred or is anticipated: ()

a. The rate increase is not the first rate increase requested for the specific policy form or forms; ()

b. The rate increase is not an exceptional increase; and ()

c. The majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse. ()

d. In the event significant adverse lapse has occurred, is anticipated in the filing or is evidenced in the actual results as presented in the updated projections provided by the insurer following the requested rate increase, the director may determine that a rate spiral exists. Following the determination that a rate spiral exists, the director may require the insurer to offer, without underwriting, to all in force insureds subject to the rate increase option to replace existing coverage with one or more reasonably comparable products being offered by the insurer or its affiliates. The offer shall: ()

i. Be subject to the approval of the director; ()

ii. Be based on actuarially sound principles, but not be based on attained age; and ()

iii. Provide that the maximum benefits under any new policy accepted by an insured shall be reduced by comparable benefits already paid under the existing policy. ()

e. The insurer shall maintain the experience of all the replacement insureds separate from the ()

experience of insureds originally issued the policy forms. In the event of a request for a rate increase on the policy form, the rate increase shall be limited to the lesser of: ()

- i. The maximum rate increase determined based on the combined experience; and ()
- ii. The maximum rate increase determined based only on the experience of the insureds originally issued the form plus ten percent (10%). ()

09. Persistent Practice Of Inadequate Rate Filings. If the director determines that the insurer has exhibited a persistent practice of filing inadequate initial premium rates for long-term care insurance, the director may, in addition to the provisions of Subsection 020.08 of this section, prohibit the insurer from either of the following: ()

- a. Filing and marketing comparable coverage for a period of up to five (5) years; or ()
- b. Offering all other similar coverages and limiting marketing of new applications to the products subject to recent premium rate schedule increases. ()

10. Exceptions. Subsections 020.01 and 020.09 shall not apply to policies for which the long-term care benefits provided by the policy are incidental, as defined in Subsection 004.12, if the policy complies with all of the following provisions: ()

- a. The interest credited internally to determine cash value accumulations, including long-term care, if any, are guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy; ()
- b. The portion of the policy that provides insurance benefits other than long-term care coverage meets the nonforfeiture requirements as applicable in any of the following: ()
 - i. Section 41-1927, Idaho Code, Standard Nonforfeiture Law-Life Insurance; ()
 - ii. Section 41-1927A, Idaho Code, Standard Nonforfeiture Law for Individual Deferred Annuities; ()
 - iii. IDAPA 18.01.16, Subsection 018.02, "Variable Contracts". ()

11. Exceptions For Disclosure And Performance Standards. The policy meets the disclosure requirements of Sections 41-4605(9), 41-4605(10) and 41-4605(11), Idaho Code, pertaining to the Disclosure and Performance Standards for Long-term Care Coverage. ()

12. Exception If Actuarial Memorandum Filed Which Includes Defined Information. An actuarial memorandum is filed with the Department of Insurance that includes: ()

- a. A description of the basis on which the long-term care rates were determined; ()
- b. A description of the basis for the reserves; ()
- c. A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance; ()
- d. A description and a table of each actuarial assumption used. For expenses, an insurer must include percent of premium dollars per policy and dollars per unit of benefits, if any; ()
- e. A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives; ()
- f. The estimated average annual premium per policy and the average issue age; ()

g. A statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used and, if used, the statement shall include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and ()

h. A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values and reserves on the underlying insurance policy, both for active lives and those in long-term care claims status. ()

13. Exceptions For Association Plans. Premium Rate Schedule Increases Subsections 020.06 and 020.08 shall not apply to group insurance policies as defined in Section 41-4603(4)(a), Idaho Code, where: ()

a. The policies insure two hundred fifty (250) or more persons and the policyholder has five thousand (5,000) or more eligible employees of a single employer; or ()

b. The policyholder, and not the certificateholders, pay a material portion of the premium, which shall not be less than twenty percent (20%) of the total premium for the group in the calendar year prior to the year a rate increase is filed. ()

0201. FILING REQUIREMENTS FOR ADVERTISING.

01. Filing And Retention. Every Insurer, Fraternal Benefit Society, Managed Care Organization, or other similar organization providing long-term care insurance or benefits in this state shall provide a copy of any long-term care insurance advertisement intended for use in this state whether through written, radio, or television medium to the Director of Insurance of this state for review and approval by the Director. In addition, all advertisements shall be retained by the insurer or other entity for at least five (5) years from the date the advertisement was first used; or until the filing of the next regular report of examination of the insurer, whichever is the longer period of time. (4-5-00)

02. Exemptions. The director may exempt from these requirements any advertising form or material when, in the director's opinion, this requirement may not be reasonably applied. (4-5-00)

0202. STANDARDS FOR MARKETING.

01. General Provisions. Every Insurer, Fraternal Benefit Society, Managed Care Organization or other similar organization marketing long-term care insurance coverage in this state, directly or through its agents, shall: (4-5-00)

a. Establish marketing procedures and agent training requirements to assure that any marketing activities, including any comparison of policies by its agents will be fair and accurate. (~~4-5-00~~)()

b. Establish marketing procedures to assure excessive insurance is not sold or issued. (4-5-00)

c. Display prominently by type, stamp or other appropriate means, on the first page of the outline of coverage and policy the following: "Notice to buyer: This policy may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations". (4-5-00)

d. Provide copies of the disclosure forms required in Subsection 009.10. ()

e. Provide an explanation of contingent benefit upon lapse as provided for in Subsection 025.04.b. ()

f. Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for long-term care insurance already has accident and sickness or long-term care insurance and the types and

amounts of any such insurance, except that in the case of qualified long-term care insurance contracts, an inquiry into whether a prospective applicant or enrollee for long-term care insurance has accident and sickness insurance is not required. (4-5-00)

eg. ~~Every insurer or entity marketing long-term care insurance shall e~~Establish auditable procedures for verifying compliance with Subsection 02~~+~~2.01. (4-5-00)(____)

f~~l~~. ~~If the state in which the policy or certificate is to be delivered or issued for delivery has a senior insurance counseling program approved by the director, the insurer shall, a~~At solicitation, provide written notice to the prospective policyholder and certificate holder that Senior Health Insurance Benefits Advisors/SHIBA the program is available and the name, address and telephone number of the program. (4-5-00)(____)

g. For long-term care insurance policies and certificates, use the terms “noncancellable” or “level premium” only when the policy or certificate conforms to Subsection 005.01.c. of this rule. (4-5-00)

02. Prohibited Practices. In addition to the practices prohibited in Chapter 13, Title 41, Idaho Code, Trade Practices and Frauds, the following acts and practices are prohibited: (4-5-00)(____)

a. Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on or convert any insurance policy, or to take out a policy of insurance with another insurer. (4-5-00)

b. High pressure tactics. Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance. (4-5-00)

c. Cold lead advertising. Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company. (4-5-00)

d. Misrepresentation. Misrepresenting a material fact in selling or offering to sell a long-term care insurance policy. (4-5-00)

03. Associations. With respect to the obligations set forth in Subsection 02~~+~~2.03, the primary responsibility of an association, as defined in Section 41-4603(4)(b), Idaho Code, when endorsing or selling long-term care insurance shall be to educate its members concerning long-term care issues in general so that its members can make informed decisions. Associations shall provide objective information regarding long-term care insurance policies or certificates endorsed or sold by such associations to ensure that members of such associations receive a balanced and complete explanation of the features in the policies or certificates that are being endorsed or sold. Subsection 02~~+~~2.03 shall not apply to qualified long-term care insurance contracts. (4-5-00)(____)

a. The insurer shall file with the insurance department the following material: (4-5-00)

i. The policy and certificate; (4-5-00)

ii. A corresponding outline of coverage; and (4-5-00)

iii. All advertisements to be utilized. (4-5-00)

b. The association shall disclose in any long-term care insurance solicitation: (4-5-00)

i. The specific nature and amount of the compensation arrangements (including all fees, commissions, administrative fees and other forms of financial support) that the association receives from endorsement or sale of the policy or certificate to its members; and (4-5-00)

ii. A brief description of the process under which the policies and the insurer issuing the policies were

- selected. (4-5-00)
- c. If the association and the insurer have interlocking directorates or trustee arrangements, the association shall disclose that fact to its members. (4-5-00)
- d. The board of directors of associations selling or endorsing long-term care insurance policies or certificates shall review and approve the insurance policies as well as the compensation arrangements made with the insurer. (4-5-00)
- e. The association shall also: (4-5-00)
- i. At the time of the association's decision to endorse, engage the services of a person with expertise in long-term care insurance not affiliated with the insurer to conduct an examination of the policies, including its benefits, features, and rates, and update the examination thereafter in the event of material change; (4-5-00)
- ii. Actively monitor the marketing efforts of the insurer and its agents; and (4-5-00)
- iii. Review and approve all marketing materials or other insurance communications used to promote sales or sent to members regarding the policies or certificates. (4-5-00)
- iv. Subsections 02~~7~~2.03.e.i. and 02~~7~~2.03.e.iii. shall not apply to qualified long-term care insurance contracts. (~~4-5-00~~)()
- f. No group long-term care insurance policy or certificate may be issued to an association unless the insurer files with the state insurance department the information required in Section 02~~7~~2. (~~4-5-00~~)()
- g. The insurer shall not issue a long-term care policy or certificate to an association or continue to market such a policy or certificate unless the insurer certifies annually that the association has complied with the requirements set forth in Section 02~~7~~2. (~~4-5-00~~)()
- h. Failure to comply with the filing and certification requirements of Section 02~~7~~2 constitutes an unfair trade practice in violation of Chapter 13, Title 21, Idaho Code, Trade Practices and Frauds. (~~4-5-00~~)()

02~~3~~3. SUITABILITY.

01. Life Insurance Policies That Accelerate Benefits. Section 02~~2~~3 shall not apply to life insurance policies that accelerate benefits for long-term care. (~~4-5-00~~)()

02. General Provisions. Every Insurer, Fraternal Benefit Society, Managed Care Organization or other similar organization marketing long-term care insurance (the "issuer") shall: (4-5-00)

- a. Develop and use suitability standards to determine whether the purchase or replacement of long-term care insurance is appropriate for the needs of the applicant; (4-5-00)
- b. Train its agents in the use of its suitability standards; and (4-5-00)
- c. Maintain a copy of its suitability standards and make them available for inspection upon request by the director. (4-5-00)

03. Determination Of Standards. To determine whether the applicant meets the standards developed by the issuer; (4-5-00)

- a. The agent and issuer shall develop procedures that take the following into consideration: (4-5-00)
- i. The ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage; (4-5-00)

ii. The applicant's goals or needs with respect to long-term care and the advantages and disadvantages of insurance to meet these goals or needs; and (4-5-00)

iii. The values, benefits, and costs of the applicant's existing insurance, if any, when compared to the values, benefits and costs of the recommended purchase or replacement. (4-5-00)

b. The issuer and an agent, if involved, shall make reasonable efforts to obtain the information set out in Subsection 0223.03.a. The efforts shall include presentation to the applicant, at or prior to application, the "Long-Term Care Insurance Personal Worksheet". The personal worksheet used by the issuer shall contain, at a minimum, the information in the format contained in the NAIC Model Regulations in Appendix B, in not less than twelve (12) point type. The issuer may request the applicant to provide additional information to comply with its suitability standards. A copy of the issuer's personal worksheet shall be filed with the director. (~~4-5-00~~)(____)

i. Copies of NAIC Model Regulations for Long-Term Care Insurance Minimum Standards Appendixes B, C, and D can be found at the Idaho Department of Insurance Home page, www.doi.state.id.us, select SHIBA (Senior Health Insurance Benefits Advisors) under Consumer Assistance link, see attachments to the NAIC Model Regulation implementing the Long-Term Care Insurance Minimum Standards. To obtain a copy of the required illustrations based on the NAIC Model Regulation, contact SHIBA at the Idaho Department of Insurance (208) 334-4250. (4-5-00)

c. A completed personal worksheet shall be returned to the issuer prior to the issuer's consideration of the applicant for coverage, except the personal worksheet need not be returned for sales of employer group long-term care insurance to employees and their spouses. (4-5-00)

d. The sale or dissemination outside the company or agency by the issuer or agent of information obtained through the personal worksheet in the NAIC Model Regulations, Appendix B is prohibited. (4-5-00)

04. Appropriateness. The issuer shall use the suitability standards it has developed pursuant to Section 0223 in determining whether issuing long-term care insurance coverage to an applicant is appropriate. (~~4-5-00~~)(____)

05. Use Of Standards. Agents shall use the suitability standards developed by the issuer in marketing long-term care insurance. (4-5-00)

06. Disclosure Form. At the same time as the personal worksheet is provided to the applicant, the disclosure form entitled "Things You Should Know Before You Buy Long-Term Care Insurance" shall be provided. The form shall be in the format contained in the NAIC Model Regulations, Appendix C, in not less than twelve (12) point type. (4-5-00)

07. Rejection And Alternatives. If the issuer determines that the applicant does not meet its financial suitability standards, or if the applicant has declined to provide the information, the issuer may reject the application. In the alternative, the issuer shall send the applicant a letter similar to the NAIC Model Regulations, Appendix D. However, if the applicant has declined to provide financial information, the issuer may use some other method to verify the applicant's intent. Either the applicant's returned letter or a record of the alternative method of verification shall be made part of the applicant's file. (4-5-00)

08. Reporting. The issuer shall report annually to the director the total number of applications received from residents of this state, the number of those who declined to provide information on the personal worksheet, the number of applicants who did not meet the suitability standards, and the number of those who chose to confirm after receiving a suitability letter. (4-5-00)

0234. PROHIBITION AGAINST PREEXISTING CONDITIONS AND PROBATIONARY PERIODS IN REPLACEMENT POLICIES OR CERTIFICATES.

If a long-term care insurance policy or certificate replaces another long-term care policy or certificate, the replacing insurer shall waive any time periods applicable to preexisting conditions and probationary periods in the new long-term care policy for similar benefits to the extent that similar exclusions have been satisfied under the original policy. (4-5-00)

0245. NONFORFEITURE BENEFIT REQUIREMENT.

01. Life Insurance Policies That Accelerate Benefits. Section 0245 does not apply to life insurance policies or riders containing accelerated long-term care benefits. ~~(4-5-00)~~(____)

02. Nonforfeiture Benefits. To comply with the requirement to offer a nonforfeiture benefit pursuant to the provisions of Section 41-4607, Idaho Code, every Insurer, Fraternal Benefit Society, Managed Care Organization, or other similar organization marketing long-term care insurance coverage in this state shall satisfy the following: (4-5-00)

a. A policy or certificate offered with nonforfeiture benefits shall have coverage elements, eligibility, benefit triggers and benefit length that are the same as coverage to be issued without nonforfeiture benefits. The nonforfeiture benefit included in the offer shall be the benefit described in Subsection 0245.04.d. ~~(4-5-00)~~(____)

b. The offer shall be in writing if the nonforfeiture benefit is not otherwise described in the Outline of Coverage or other materials given to the prospective policyholder. (4-5-00)

03. Contingent Benefit. If the offer required to be made under Section 41-4607, Idaho Code, is rejected, the insurer shall provide the contingent benefit upon lapse described in Section 0245. ~~(4-5-00)~~(____)

04. Rejection Of Offer. After rejection of the offer required under Section 41-4607, Idaho Code, as it pertains to nonforfeiture benefits, for individual and group policies without nonforfeiture benefits issued after the effective date of Section 0245, the insurer shall provide a contingent benefit upon lapse. ~~(4-5-00)~~(____)

a. In the event a group policyholder elects to make the nonforfeiture benefit an option to the certificate holder, a certificate shall provide either the nonforfeiture benefit or the contingent benefit upon lapse. (4-5-00)

b. The contingent benefit on lapse shall be triggered every time an insurer increases the premium rates to a level which results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth within Subsection 0245.04 based on the insured's issue age, and the policy or certificate lapses within one hundred twenty (120) days of the due date of the premium so increased. Unless otherwise required, policyholders shall be notified at least thirty (30) days prior to the due date of the premium reflecting the rate increase.

Table: Issue Age - Percent Increase Over Initial Premium

Issue Age	Percent Increase Over Initial Premium	Issue Age	Percent Increase Over Initial Premium
29 and under	200%	72	36%
30-34	190%	73	34%
35-39	170%	74	32%
40-44	150%	75	30%
45-49	130%	76	28%
50-54	110%	77	26%
55-59	90%	78	24%
60	70%	79	22%
61	66%	80	20%
62	62%	81	19%
63	58%	82	18%
64	54%	83	17%
65	50%	84	16%
66	48%	85	15%
67	46%	86	14%
68	44%	87	13%
69	42%	88	12%
70	40%	89	11%
71	38%	90 and over	10%

(4-5-00)()

c. On or before the effective date of a substantial premium increase as defined in Subsection 0245.04.b., the insurer shall: (4-5-00)()

i. Offer to reduce policy benefits provided by the current coverage without the requirement of additional underwriting so that required premium payments are not increased; (4-5-00)

ii. Offer to convert the coverage to a paid-up status with a shortened benefit period in accordance with the terms of Subsection 0245.04.d. This option may be elected at any time during the one hundred twenty (120) day period referenced in Subsection 0245.04.b.; and (4-5-00)()

iii. Notify the policyholder or certificate holder that a default or lapse at any time during the one hundred twenty (120) day period referenced in Subsection 0245.04.b. shall be deemed to be the election of the offer to convert in Subsection 0245.04.c.ii. (4-5-00)()

d. Benefits continued as nonforfeiture benefits, including contingent benefits upon lapse, are described in Subsection 0245.04.d.: (4-5-00)()

i. For purposes of this Subsection 0245.04.d., attained age rating is defined as a schedule of premiums

starting from the issue date which increases age at least one percent (1%) per year prior to age fifty (50), and at least three percent (3%) per year beyond age fifty (50); ~~(4-5-00)~~(____)

ii. For purposes of Subsection 0245.04.d., the nonforfeiture benefit shall be of a shortened benefit period providing paid-up long-term care insurance coverage after lapse. The same benefits (amounts and frequency in effect at the time of lapse but not increased thereafter) will be payable for a qualifying claim, but the lifetime maximum dollars or days of benefits shall be determined as specified in Subsection 0245.04.d.iii.; ~~(4-5-00)~~(____)

iii. The standard nonforfeiture credit will be equal to one hundred percent (100%) of the sum of all premiums paid, including the premiums paid prior to any changes in benefits. The insurer may offer additional shortened benefit period options, as long as the benefits for each duration equal or exceed the standard nonforfeiture credit for that duration. However, the minimum nonforfeiture credit shall not be less than thirty (30) times the daily nursing home benefit at the time of lapse. In either event, the calculation of the nonforfeiture credit is subject to the limitation of Subsection 0245.04.e.; ~~(4-5-00)~~(____)

iv. The nonforfeiture benefit ~~and the contingent benefit upon lapse~~ shall begin not later than the end of the third year following the policy or certificate issue date; The contingent benefit upon lapse shall be effective during the first three (3) years as well as thereafter. ~~(4-5-00)~~(____)

v. Notwithstanding Subsection 0245.04.d.iv. ~~except that~~ for a policy or certificate ~~with a contingent benefit upon lapse or a policy or certificate~~ with attained age rating, the nonforfeiture benefit shall begin on the earlier of: ~~(4-5-00)~~(____)

(1) The end of the tenth year following the policy or certificate issue date; or (4-5-00)

(2) The end of the second year following the date the policy or certificate is no longer subject to attained age rating. (4-5-00)

vi. Nonforfeiture credits may be used for all care and services qualifying for benefits under the terms of the policy or certificate, up to the limits specified in the policy or certificate. (4-5-00)

e. All benefits paid by the insurer while the policy or certificate is in premium paying status and in the paid-up status will not exceed the maximum benefits which would be payable if the policy or certificate had remained in premium paying status. (4-5-00)

f. There shall be no difference in the minimum nonforfeiture benefits as required under Section 0245 for group and individual policies. ~~(4-5-00)~~(____)

g. The requirements set forth in Section 0245 shall become effective twelve (12) months after adoption of this provision and shall apply as follows: ~~(4-5-00)~~(____)

i. Except as provided in Subsection 0245.04.g.ii., the provisions of Section 0245 apply to any long-term care policy issued in this state on or after the effective date of this rule. ~~(4-5-00)~~(____)

ii. For certificates issued on or after the effective date of this Section 0245, under a group long-term care insurance policy as defined in Section 41-4603(4)(a), Idaho Code, which policy was in force at the time this rule became effective, the provisions of Section 0245 shall not apply. ~~(4-5-00)~~(____)

h. Premiums charged for a policy or certificate containing nonforfeiture benefits or a contingent benefit on lapse shall be subject to the loss ratio requirements of Section 018 treating the policy as a whole. (4-5-00)

i. To determine whether contingent nonforfeiture upon lapse provisions are triggered under Subsection 0245.04.b., a replacing insurer that purchased or otherwise assumed a block or blocks of long-term care insurance policies from another insurer shall calculate the percentage increase based on the initial annual premium paid by the insured when the policy was first purchased from the original insurer. ~~(4-5-00)~~(____)

- j. Nonforfeiture benefits for qualified long-term care insurance contracts that are level premium contracts shall meet the following requirements: (4-5-00)
- i. The nonforfeiture provision shall be appropriately captioned; (4-5-00)
 - ii. The nonforfeiture provision shall provide a benefit available in the event of a default on the payment of any premiums and shall state that the amount of the benefit may be adjusted subsequent to being initially granted only as necessary to reflect changes in claims, persistency and interest as reflected in changes in rates for premium paying contracts approved by the Secretary of the Treasury for the same contract form; and (4-5-00)
 - iii. The nonforfeiture provision shall provide at least one (1) of the following: (4-5-00)
 - (1) Reduced paid-up insurance; (4-5-00)
 - (2) Extended term insurance; (4-5-00)
 - (3) Shortened benefit period; or (4-5-00)
 - (4) Other similar offerings approved by the Director. (4-5-00)

0256. STANDARDS FOR BENEFIT TRIGGERS.

01. Conditions Of Benefits Payment. A long-term care insurance policy shall condition the payment of benefits on a determination of the insured's ability to perform activities of daily living and on cognitive impairment. Eligibility for the payment of benefits shall not be more restrictive than requiring either a deficiency in the ability to perform not more than three (3) of the activities of daily living or the presence of cognitive impairment. (4-5-00)

02. Activities Of Daily Living. Insurers may use activities of daily living to trigger covered benefits in addition to those contained in Subsection 0256.02 as long as they are defined in the policy. Activities of daily living shall include at least the following as defined in Section 004 and in the policy. ~~(4-5-00)~~(____)

- a. Bathing; (4-5-00)
- b. Continence; (4-5-00)
- c. Dressing; (4-5-00)
- d. Eating; (4-5-00)
- e. Toileting; and (4-5-00)
- f. Transferring. (4-5-00)

03. Additional Provisions. An insurer may use additional provisions for the determination of when benefits are payable under a policy or certificate; however the provisions shall not restrict, and are not in lieu of, the requirements contained in Subsections 0256.01 and 0256.02. ~~(4-5-00)~~(____)

04. Determinations Of Deficiency. For purposes of Section 0256 the determination of a deficiency shall not be more restrictive than: ~~(4-5-00)~~(____)

- a. Requiring the hands-on assistance of another person to perform the prescribed activities of daily living; or (4-5-00)
- b. If the deficiency is due to the presence of a cognitive impairment, supervision or verbal cueing by another person is needed in order to protect the insured or others. (4-5-00)

05. Assessments. Assessments of activities of daily living and cognitive impairment shall be performed by licensed or certified professionals, such as physicians, nurses or social workers. (4-5-00)

06. Appeals. Long-term care insurance policies shall include a clear description of the process for appealing and resolving benefit determinations. (4-5-00)

07. Effective Date. The requirements set forth in Section 0256 shall be effective within twelve (12) months of the effective date of the rule and shall apply as follows: (~~4-5-00~~)(____)

a. Except as provided in Subsection 0256.07.b. the provisions of Section 0256 apply to a long-term care policy issued in this state on or after the effective date of the rule. (~~4-5-00~~)(____)

b. For certificates issued on or after the effective date of Section 0256, under a group long-term care insurance policy as defined in Section 41-4603(4)(a), Idaho Code, that was in force at the time this rule became effective, the provisions of Section 0256 shall not apply. (~~4-5-00~~)(____)

0267. ADDITIONAL STANDARDS FOR BENEFIT TRIGGERS FOR QUALIFIED LONG-TERM CARE INSURANCE CONTRACTS.

01. Definitions. For purposes of Section 0267 the following definitions apply: (~~4-5-00~~)(____)

a. Qualified long-term care services means services that meet the requirements of Section 7702B(b) of the Internal Revenue Code of 1986, as amended, as follows: necessary diagnostic, preventive, therapeutic, curative, treatment, mitigation, and rehabilitative services and maintenance or personal care services which are required by a chronically ill individual, and are provided pursuant to a plan of care prescribed by a licensed health care practitioner. (4-5-00)

b. Chronically ill individual has the meaning prescribed for this term by Section 7702B(c)(2) of the Internal Revenue Code of 1986, as amended. Under this provision, a chronically ill individual means any individual who has been certified by a licensed health care practitioner as:

i. Being unable to perform (without substantial assistance from another individual) at least two (2) activities of daily living for a period of at least ninety (90) days due to a loss of functional capacity; or (4-5-00)

ii. Requiring substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment. (4-5-00)

c. The term chronically ill individual shall not include an individual otherwise meeting these requirements unless within the preceding twelve (12) month period a licensed health care practitioner has certified that the individual meets these requirements. (4-5-00)

d. Licensed health care practitioner means a physician, as defined in Section 1861(R)(1) of the Social Security Act, and a registered professional nurse, licensed social worker, or other individual who meets requirements prescribed by the Secretary of the Treasury. (4-5-00)

e. Maintenance or personal care services means any care, the primary purpose of which is the provision of needed assistance with any of the disabilities, the existence of which leads to the conclusion that the individual is a chronically ill individual (including the protection from threats to health and safety due to severe cognitive impairment). (4-5-00)

02. The Chronically Ill. A qualified long-term care insurance contract shall pay for qualified long-term care services received by a chronically ill individual provided pursuant to a plan of care prescribed by a licensed health care practitioner. (4-5-00)

03. Payments And Conditions. A qualified long-term care insurance contract shall condition the payment of benefits on a determination of the insured's inability to perform activities of daily living for an expected period of at least ninety (90) days due to a loss of functional capacity; or to severe cognitive impairment, as described

in Subsection 0267.06.b. (and as described under regulations or other guidance developed by the Secretary of the Treasury). An insured will be considered to have met a condition of payment if, within the preceding twelve (12) month period, a licensed health care practitioner has certified that the insured has met the requirements and the provider has prescribed the qualified long-term care insurance services pursuant to a plan of care. ~~(4-5-00)~~(____)

04. Certifications By Professionals. Certifications regarding activities of daily living and cognitive impairment required pursuant to Subsection 0267.03 shall be performed by licensed or certified professionals, such as physicians, registered professional nurses, licensed social workers, or other individuals who meet requirements prescribed by the Secretary of the Treasury. ~~(4-5-00)~~(____)

05. Certifications By Carrier. Certification required pursuant to Subsection 0267.03 may be performed by the carrier as is reasonably necessary with respect to a specific claim, except that when a licensed health care practitioner has certified that an insured is unable to perform activities of daily living for an expected period of at least ninety (90) days due to a loss of functional capacity and the insured is in claim status, the certification may not be rescinded and additional certifications may not be performed until after the expiration of the ninety (90) day period. ~~(4-5-00)~~(____)

06. Standards. For the purposes of Section 0267, determinations of functional capacity and severe cognitive impairment shall be based on the following standards: ~~(4-5-00)~~(____)

a. For loss of functional capacity, requiring the substantial assistance of another person to perform the prescribed activities of daily living; or (4-5-00)

b. For severe cognitive impairment, requiring substantial supervision by another person to protect the insured from threats to health and safety. (4-5-00)

07. Appeals. Qualified long-term care contracts shall include a clear description of the process for appealing and resolving benefit determinations. (4-5-00)

0278. STANDARD FORMAT OUTLINE OF COVERAGE.

Section 0278 of the rule implements, interprets and makes specific, the provisions of Section 41-4605(7)(a), Idaho Code, in prescribing a standard format and the content of an outline of coverage. ~~(4-5-00)~~(____)

01. Format. The outline of coverage shall be a freestanding document, using no smaller than ten (10) point type. Text that is capitalized or underscored in the standard format outline of coverage may be emphasized by other means that provide prominence equivalent to the capitalization or underscoring. (4-5-00)

02. Content. The outline of coverage shall contain no material of an advertising nature. (4-5-00)

03. Standard Form. Use of the text and sequence of text of the standard format outline of coverage is mandatory, unless otherwise specifically indicated. Format for outline of coverage may be found on the Idaho Department of Insurance Home Page website, www.doi.state.id.us, select SHIBA (Senior Health Insurance Benefits Advisors) under Consumer Assistance link, see attachments to the NAIC Model Regulation implementing the Long-Term Care Insurance Minimum Standards. (4-5-00)

0289. REQUIREMENT TO DELIVER SHOPPER'S GUIDE.

01. Approved Format. A long-term care insurance shopper's guide in the format developed by the National Association of Insurance Commissioners, or a guide developed or approved by the director, shall be provided to all prospective applicants of a long-term care insurance policy or certificate. (4-5-00)

a. In the case of agent solicitations, an agent must deliver the shopper's guide prior to the presentation of an application or enrollment form. (4-5-00)

b. In the case of direct response solicitations, the shopper's guide must be presented in conjunction with any application or enrollment form. (4-5-00)

02. Exceptions. Life insurance policies or riders containing accelerated long-term care benefits are not required to furnish the above-referenced guide, but shall furnish the policy summary required under Section 41-4605(9), Idaho Code, Disclosure and Performance Standards for Long-Term Care Insurance. (4-5-00)

02930. PENALTIES.

In addition to any other penalties provided by the laws of this state any insurer and any agent found to have violated any requirement of ~~this state relating to the rule of long term care insurance or the marketing of such insurance~~ IDAPA 18.01.60, "Long-Term Care Insurance Minimum Standards," shall be subject to an administrative penalty ~~fine~~ of up to three (3) times the amount of any commissions paid for each policy involved in the violation or up to ten thousand dollars (\$10,000), whichever is greater. (~~4-5-00~~)(____)

0301. -- 999. (RESERVED).

**IDAHO DEPARTMENT OF ADMINISTRATION
OFFICE OF THE ADMINISTRATIVE RULES COORDINATOR**

**IDAPA 21 - DIVISION OF VETERANS SERVICES -
DEPARTMENT OF SELF-GOVERNING AGENCIES**

DOCKET NO. 21-0100-0001

**NOTICE OF LEGISLATIVE ACTION AND CORRECTION TO PREVIOUS NOTICE OF
LEGISLATIVE ACTION PUBLISHED UNDER DOCKET NO. 15-0700-0001**

**REGARDING HOUSE BILL 437 RELATING TO THE TRANSFER OF THE DIVISION OF VETERANS
SERVICES FROM THE DEPARTMENT OF HEALTH AND WELFARE TO THE
DEPARTMENT OF SELF-GOVERNING AGENCIES**

CORRECTION: The Notice of Legislative Action, published under Docket No. 15-0700-0001, explaining HB 437 which transferred the Division of Veterans Services from the Department of Health and Welfare to the Department of Self-governing Agencies, inadvertently placed the Division of Veterans Services under the Office of the Governor. It also incorrectly assigned the Division the agency identification number IDAPA 15, which identifies the Office of the Governor. That Notice of Legislative Action, which contained this error, was published in the July 5, 2000, Idaho Administrative Bulletin, pages 34 and 35. This Notice is being published to correct this mistake and to remove the Division from the Office of the Governor and properly reposition it under the Department of Self-governing Agencies. It is also correcting the agency identification number to IDAPA 21 which will now identify the Division of Veterans Services. The action of the previous Notice is, therefore, null and void and is hereby replaced by this Notice of Legislative Action.

EFFECTIVE DATE: The effective date of this action is July 1, 2000.

AUTHORITY: In compliance with Sections 67-5203 and 67-5220, Idaho Code, notice is hereby given by the Office of the Administrative Rules Coordinator that the Fifty-fifth Legislature in the Second Regular Session - 2000, passed House Bill No. 437 which amends existing law to establish the Division of Veterans Services in the Department of Self-governing Agencies and to remove the responsibility for veterans and veterans services from the Department of Health and Welfare.

DESCRIPTIVE SUMMARY: The following is a statement in nontechnical language of the substance of the notice and the legislative action:

This notice is being published to correct mistakes made in the previously published Notice of Legislative Action relating to this same matter. House Bill 437 amends Sections 65-201, Idaho Code, to establish the Division of Veterans Services in the Department of Self-governing Agencies and to remove the responsibility for veterans and veterans services from the Department of Health and Welfare.

This notice, in accordance with Section 67-5203, Idaho Code, complies with the Legislative intent of House Bill No. 437 by repositioning the Division of Veterans Services to the Department of Self-governing Agencies. The Division and the administrative rules under its authority, which were indexed under IDAPA 16, TITLE 07, (Department of Health and Welfare), are now given the agency designation IDAPA 21 and will be indexed as IDAPA 21, TITLE 01.

Concurrently with the publication of this notice, all of the administrative rules under the authority of the Division of Veterans Services are being repromulgated in this Bulletin.

ASSISTANCE ON QUESTIONS: For assistance on questions concerning this notice contact Joni Harkless at the Division of Veterans Services at (208) 334-3513 or Dennis Stevenson at the Office of Administrative Rules at (208) 332-1820.

DATED this 28th day of August, 2000.

Rick Thompson, Administrative Rules Coordinator
Department of Administration, Office of Administrative Rules
P.O. Box 83720, Boise, ID 83720-0306
Phone: (208) 332-1820 / Fax: (208) 334-2395

IDAPA 21 - DIVISION OF VETERANS SERVICES

21.01.01 - RULES GOVERNING ELIGIBILITY FOR ADMISSION, RESIDENCY AND MAINTENANCE CHARGES IN IDAHO STATE VETERANS HOMES - DOMICILIARY CARE

DOCKET NO. 21-0101-0001 (REPEAL)

NOTICE OF TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is July 1, 2000.

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 Section 65-202 and 66-907, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking are scheduled for:

**Thursday, October 12, 2000, 7:00 p.m. to 9:00 p.m.
West Conference Room J. R. Williams Building
700 W. State, Boise, Idaho**

The hearing site 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:

This chapter must be repealed to facilitate the Division of Veterans Services' move from the Department of Health and Welfare to the Department of Self-governing Agencies. This move resulted from amendments to Idaho Code Sections 39-106, 65-201, 65-202, 65-204, 66-901, 66-906, 66-907, and 67-2601. These amendments were contained in H0437 which passed the 2000 Idaho Legislature and was signed by the Governor on March 27, 2000. This chapter is being rewritten under Docket No. 21-0101-0002 which is being published in this Bulletin following this Notice.

TEMPORARY RULE JUSTIFICATION: Pursuant to Sections 67-5226(1)(b) and 67-5226(1)(c), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate for the following reasons:

Compliance with deadlines in amendments to governing law or federal programs.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: Not applicable.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because this action is necessary to comply with amendments to governing law.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Joni Harkless at (208) 334-3513.

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 October 25, 2000.

DATED this 17th day of August, 2000.

Gary Bermeosolo, Administrator
Division of Veterans Services
320 Collins Road, Boise, ID 83702
Phone: (208) 334-3513 / Fax: (208) 334-2627

THIS CHAPTER IS BEING REPEALED IN ITS ENTIRETY.

IDAPA 21 - DIVISION OF VETERANS SERVICES
21.01.01 - RULES GOVERNING ADMISSION, RESIDENCY, AND MAINTENANCE
CHARGES IN IDAHO STATE VETERANS HOMES AND DIVISION OF
VETERANS SERVICES ADMINISTRATIVE PROCEDURE

DOCKET NO. 21-0101-0002 (REWRITE)

NOTICE OF TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is July 1, 2000.

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 Section 65-202 and 66-907, Idaho Code; Title 38, Chapter 1, Section 101(2), United States Code; and U.S. Department of Veterans Affairs 38 CFR, Parts 17, 51, and 58.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking are scheduled for:

Thursday, October 12, 2000
7:00 p.m. to 9:00 p.m.
West Conference Room J. R. Williams Building
700 W. State, Boise, Idaho

The hearing site 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:

This chapter replaces IDAPA 21.01.01, 21.01.02, and 21.01.03 (formerly IDAPA 16.07.01, 16.07.02, and 16.07.03) which are being repealed to facilitate the Division of Veterans Services' move from the Department of Health and Welfare to the Department of Self Governing Agencies. This move resulted from amendments to Sections 39-106, 65-201, 65-202, 65-204, 66-901, 66-906, 66-907, and 67-2601, Idaho Code. These amendments were contained in H0437 which passed the 2000 Idaho Legislature and was signed by the Governor on March 27, 2000. This chapter also contains the Division's provisions for contested cases which were previously provided for in the Department of Health and Welfare Rules, IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings". Other changes include those required for compliance with U.S. Department of Veterans Affairs regulations and some general clean-up.

TEMPORARY RULE JUSTIFICATION: Pursuant to Sections 67-5226(1)(b) and 67-5226(1)(c), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate for the following reasons:

Compliance with deadlines in amendments to governing law or federal programs.

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

This chapter outlines the monthly maintenance charge for residency in an Idaho State Veterans Home.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because this action is necessary to comply with amendments to governing law or federal programs.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Joni Harkless at (208) 334-3513.

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 October 25, 2000.

DATED this 17th day of August, 2000.

Gary Bermeosolo, Administrator
Division of Veterans Services
320 Collins Road, Boise, ID 83702
Phone: (208) 334-3513 / Fax: (208) 334-2627

THE FOLLOWING IS THE TEXT OF DOCKET NO. 21-0101-0002

IDAPA 21
TITLE 01
Chapter 01

21.01.01 - RULES GOVERNING ADMISSION, RESIDENCY, AND MAINTENANCE
CHARGES IN IDAHO STATE VETERANS HOMES AND DIVISION OF
VETERANS SERVICES ADMINISTRATIVE PROCEDURE.

000. LEGAL AUTHORITY.

The Administrator of the Division of Veterans Services with the advice of the Veterans Affairs Commission is authorized by the Idaho Legislature to establish rules governing requirements for admission to Idaho State Veterans Homes and to establish rules governing charges for residency, pursuant to Sections 65-202, 65-204 and 66-907, Idaho Code. (7-1-00)T

001. TITLE AND SCOPE.

01. Title. These Rules shall be cited as IDAPA 21.01.01, "Rules Governing Admission, Residency, and Maintenance Charges in Idaho State Veterans Homes and Division of Veterans Services Administrative Procedure". (7-1-00)T

02. Scope. These rules contain provisions for determining eligibility for admission and for establishing charges for residency in Idaho State Veterans Homes, together with rules of administrative procedure before the Idaho Veterans Affairs Commission. (7-1-00)T

002. WRITTEN INTERPRETATIONS.

There are no written interpretations for this Chapter. (7-1-00)T

003. ADMINISTRATIVE APPEALS.

Administrative procedure and appeals pursuant to this Chapter are governed by Section 982, et seq. (7-1-00)T

004. POLICY.

Through the facilities and services available at Idaho State Veterans Homes, the Division of Veterans Services will provide necessary care for honorably discharged eligible veterans. No applicant will be denied admission on the basis of sex, race, color, age, political or religious opinion or affiliation, national origin, or lack of income, nor will any care or other benefit at a Home be provided in a manner, place, or quality different than that provided for other residents with comparable disabilities and circumstances. However, if residents are financially able to do so, they must contribute to the cost of their care, with allowances made for retention of funds for their personal needs. (7-1-00)T

005. DEFINITIONS AND ABBREVIATIONS.

For the purposes of the rules contained in this Chapter, the following terms are used as defined: (7-1-00)T

01. Applicant. A person who has expressed interest in applying for residency in an Idaho State

Veterans Home. (7-1-00)T

02. Bona Fide Resident. A person who maintains a principal or primary home or place of abode in the state of Idaho coupled with the present intent to remain at that home or abode and return to it after any period of absence pursuant to Section 66-901, Idaho Code. (7-1-00)T

03. Commission. The Idaho Veterans Affairs Commission. (7-1-00)T

04. County Service Officer. A person appointed by the county to provide assistance to veterans in accordance with Section 65-601, Idaho Code. (7-1-00)T

05. Department. The Idaho Department of Self Governing Agencies. (7-1-00)T

06. Division. Division of Veterans Services in the Idaho Department of Self Governing Agencies. (7-1-00)T

07. Division Administrator. The Administrator of the Division of Veterans Services in the Department of Self Governing Agencies, or his designee. The chief officer of the Division of Veterans Services. (7-1-00)T

08. Home Administrator. Administrator of an Idaho State Veterans Home. The chief officer of each respective Veterans Home. (7-1-00)T

09. Home. An Idaho State Veterans Home. (7-1-00)T

10. Idaho State Veterans Home. Pursuant to Section 66-901, Idaho Code, a Home for eligible veterans. (7-1-00)T

11. Legal Dependents. The mother, father, spouse, or minor children of an applicant/resident who, by reason of insufficient financial resources, or non-minor children who because of disease, handicap or disability, must have financial support from the applicant/resident in order to maintain themselves. (7-1-00)T

12. Liquid Assets. Those assets which can be liquidated for cash within a reasonable period of time including, but not limited to, money market certificates, certificates of deposit, stocks and bonds, and some tax shelter investments. (7-1-00)T

13. Maintenance Charge. A charge made for care and residence at an Idaho State Veterans Home, based upon the current established rate. (7-1-00)T

14. Net Income. That income used to compute charges after allowable deductions have been made. (7-1-00)T

15. Resident. A veteran who is a resident of an Idaho State Veterans Home. (7-1-00)T

16. VA. United States Department of Veterans Affairs. (7-1-00)T

17. Veteran. Shall have the meaning established in Section 65-203, Idaho Code. (7-1-00)T

006. -- 049. (RESERVED).

050. ADMINISTRATIVE POWERS.

The Home Administrator has full authority in the management of a Home, subject to review by the Division Administrator and Commission. A Home Administrator can, in the execution of his duties, delegate certain responsibilities to his staff. When requested by the Division Administrator, the Home Administrator will attend regular and special meetings of the Commission. (7-1-00)T

01. Representative Powers. The Division Administrator is authorized to represent the Commission in all official transactions between the Veterans Homes and other departments of Idaho state government. (7-1-00)T

02. Investigation Powers. Upon receipt of an application for residency and for the duration of residency of any resident, the Division of Veterans Services is authorized to conduct an investigation to determine the total value of the property and assets of the applicant/resident to determine his ability to pay maintenance charges established in this chapter pursuant to Section 66-907, Idaho Code. (7-1-00)T

03. Inspection Powers. Inspection of the rooms and facilities of a Home, as well as of the dress and appearance of all residents, can be conducted at any time by the Home Administrator. (7-1-00)T

04. Emergency Powers. In an emergency, the Home Administrator is authorized to use his judgment in matters not specifically covered by a statute, order, rule, or policy. (7-1-00)T

051. -- 074. (RESERVED).

075. ADMINISTRATIVE DUTIES.

The Home Administrator will enforce all orders and rules and implement all policies of the Division in the administration of a Home. (7-1-00)T

01. Management Of Records. The Home Administrator must maintain accurate fiscal and resident records. (7-1-00)T

a. Nursing care records. Records relating to each nursing care resident of a Home will be kept in accordance with Idaho Department of Health and Welfare Rules, IDAPA 16.03.02, "Rules and Minimum Standards for Skilled Nursing and Intermediate Care Facilities in Idaho". (7-1-00)T

b. Residential care records. Records relating to each residential care resident of a Home will be kept in accordance with Idaho Department of Health and Welfare Rules, IDAPA 16.03.22, "Rules for Residential and Assisted Living Facilities in Idaho". (7-1-00)T

c. Domiciliary care records. Records relating to each domiciliary care resident of a Home will include: (7-1-00)T

i. Date of admission; (7-1-00)T

ii. Period of residency; (7-1-00)T

iii. Age; (7-1-00)T

iv. Residence; (7-1-00)T

v. Military organization in which the veteran served; (7-1-00)T

vi. Evidence of other eligibility requirements; (7-1-00)T

vii. "Acknowledgment of Conditions Leading to Discharge" form; and (7-1-00)T

viii. "Residents Bill of Rights" form. (7-1-00)T

d. Fiscal records. The Home Administrator must account for Home funds expended on behalf of designated residents or for the benefit of the Home. (7-1-00)T

02. Response To Complaints. The Home Administrator will respond in writing to any written and signed complaint made by a resident pursuant to Section 300. (7-1-00)T

076. -- 099. (RESERVED).

100. ELIGIBILITY REQUIREMENTS.

An applicant/resident must be a veteran of the armed forces and must satisfy the following requirements, pursuant to Sections 66-901 and 66-907, Idaho Code: (7-1-00)T

01. Idaho Residency. The applicant must be a bona fide resident of the state of Idaho at the time of admission to a Home. (7-1-00)T

02. Incompetent Applicants. Applicants who are considered incompetent must provide copies of guardianship or power of attorney. (7-1-00)T

03. Necessity Of Required Services. Applicants must meet the requirements for the level of care for which they apply. (7-1-00)T

a. Nursing care. To be eligible to receive nursing care in a state veterans home, applicants must be referred by a VA physician or a physician currently licensed by the Idaho Board of Medicine to practice medicine or surgery in the state of Idaho. (7-1-00)T

b. Residential care. Each applicant must submit to a physical examination performed at the VA Medical Center or by the clinical specialist assigned to a Home and meet the physical limitation requirements for residential care. The applicant must be unable to earn a living and have no adequate means of support due to wounds, old age, or physical or mental disabilities. However, each residential care resident must ambulate independently or with the aid of a wheelchair, walker, or similar device and be capable of performing at the time of admission, and for the duration of his residency, all of the following with minimal assistance: (7-1-00)T

- i. Making his bed daily; (7-1-00)T
- ii. Maintaining his room in a neat and orderly manner at all times; (7-1-00)T
- iii. Keeping all clothing clean through proper laundering; (7-1-00)T
- iv. Observing cleanliness in person, dress and living habits and dressing himself; (7-1-00)T
- v. Bathing or showering frequently; (7-1-00)T
- vi. Shaving daily or keeping his mustache or beard neatly groomed; (7-1-00)T
- vii. Proceeding to and returning from the dining room and feeding himself; (7-1-00)T
- viii. Securing medical attention on an ambulatory basis and managing medications; (7-1-00)T
- ix. Maintaining voluntary control over body eliminations or control by use of an appropriate prosthesis; and (7-1-00)T
- x. Making rational decisions as to his desire to remain or leave the Home. (7-1-00)T

c. Domiciliary care. Each applicant must submit to a physical examination performed at the VA Medical Center or by the clinical specialist assigned to a Home and meet the physical limitation requirements for domiciliary care. The applicant must be unable to earn a living and have no adequate means of support due to wounds, old age, or physical or mental disabilities. However, each domiciliary care resident must be able to ambulate independently and must be capable of performing at the time of admission, and for the duration of his residency, all of the following without assistance: (7-1-00)T

- i. Making his bed daily; (7-1-00)T
- ii. Maintaining his room in a neat and orderly manner at all times; (7-1-00)T
- iii. Keeping all clothing clean through proper laundering; (7-1-00)T

- iv. Observing cleanliness in person, dress and living habits and dressing himself; (7-1-00)T
- v. Bathing or showering frequently; (7-1-00)T
- vi. Shaving daily or keeping his mustache or beard neatly groomed; (7-1-00)T
- vii. Proceeding to and returning from the dining room and feeding himself; (7-1-00)T
- viii. Securing medical attention on an ambulatory basis and managing medications; (7-1-00)T
- ix. Maintaining voluntary control over body eliminations or control by use of an appropriate prosthesis; and (7-1-00)T
- x. Making rational and competent decisions as to his desire to remain or leave the Home. (7-1-00)T

04. Placement Restriction. A Home shall not accept applicants or continue to extend care to residents for whom the facility does not have the capability or services to provide an appropriate level of care. (7-1-00)T

05. Financial Statement. Each applicant must file a signed, dated statement with the Home Administrator containing a report of income from all sources and a report of all liquid assets which will be used to determine the amount of the maintenance charge which is required in accordance with Section 66-907, Idaho Code, and IDAPA 21.01.01, "Rules Governing Admission, Residency, and Maintenance Charges in Idaho State Veterans Homes and Division of Veterans Services Administrative Procedure". (7-1-00)T

06. Social Security Benefits. If eligible for Social Security benefits, the applicant/resident and spouse must apply for those benefits unless waived by the Home Administrator. (7-1-00)T

07. Medicare Coverage. If eligible for Medicare parts "A" and "B," the applicant/resident must elect to participate, unless participation is waived by the Home Administrator. (7-1-00)T

08. Income Limitation. (7-1-00)T

a. Nursing Care. None. (7-1-00)T

b. Residential and Domiciliary Care. An applicant whose total monthly net income, at the time of his application for residency, exceeds the current maximum annual rate of VA pension for a single veteran pursuant to Public Law 95-588 divided by twelve (12) cannot be admitted unless granted a waiver by the Home Administrator. This waiver must include a statement from a VA Medical Center physician indicating the veteran is in "need of continuing medical care". (7-1-00)T

09. VA Pension - Nursing Care. Unless waived by the Home Administrator, a nursing care applicant/resident must be eligible for, apply for, and/or be in receipt of a VA disability pension in accordance with Public Law 95-588. Such waivers may be considered only when the applicant/resident has signed a statement indicating he is unable to defray the necessary expenses of the medical care for which he is applying and arrangements are made to secure medical services not provided by VA. (7-1-00)T

101. -- 149. (RESERVED).

150. APPLICATION PROCEDURE.

01. Availability Of Application Forms. Forms to apply for residence in a Home are available: (7-1-00)T

a. From any Idaho State Veterans Home; (7-1-00)T

b. From any county service officer; or (7-1-00)T

c. From any active post or barracks service officer of veterans organizations. (7-1-00)T

02. Submission Of Application. An application may be submitted to the administrative offices of an Idaho State Veterans Home. (7-1-00)T

03. Application Processing. Completed applications will be processed no later than three (3) working days from receipt. (7-1-00)T

04. Waiting List. An applicant who is approved for admission for whom a vacancy does not exist will be placed on a waiting list and accepted on a first come, first serve basis dependent on the Home's ability to provide a level of care consistent with the needs of the applicant. The Home Administrator may award "priority status" to prospective Home residents resulting in their names being placed near the top of the Home waiting list, provided they have completed all preadmission requirements and meet one (1) or more of the following criteria: (7-1-00)T

a. Veterans who served during any war or conflict officially engaged in by the government of the United States. (7-1-00)T

b. Previous residents of Idaho State Veterans Homes who have been discharged for therapeutic treatment or to live in a lesser level of care or in an independent setting and whose discharge plan indicates a readmission priority. (7-1-00)T

c. Current Home residents who demonstrate a need for a level of care provided by an Idaho State Veterans Home and who would benefit from maintaining a stable environment. (7-1-00)T

d. Receive special consideration as per the request of the medical director because of his desire to provide a very specific continuum of care. (7-1-00)T

05. Provision if Application Rejected. An applicant whose application has been rejected and who feels he meets the eligibility requirements can request a hearing in accordance with the procedures specified in Section 982, et seq. (7-1-00)T

151. -- 199. (RESERVED).

200. CONDITIONS FOR ADMISSION.

01. Denial Of Admission. Admission may be denied to an otherwise eligible applicant for any reason for which an admitted resident could be involuntarily discharged. (7-1-00)T

02. Assignment Of Personal Property. Prior to admission to an Idaho State Veterans Home, an eligible applicant must agree that while he is a resident of a Home he will assign the following, under the conditions specified: (7-1-00)T

a. Pursuant to Section 66-906, Idaho Code, all personal property owned, money held, or assets to which he is entitled at the time of his death -- unless disposed of by will or rightfully claimed within five (5) years of the death of the resident by an heir or person named in the resident's will -- must be assigned to the Division Administrator at the time of application for the sole use and benefit of a Home. (7-1-00)T

b. Upon discharge or voluntary departure from a Home, and after written notification is sent to the resident, all personal property owned or money deposited with the Home which is unclaimed by the former resident will be converted for the sole use and benefit of a Home as specified below: (7-1-00)T

i. Personal property unclaimed within thirty (30) days of departure or discharge will be made available to needy Home residents or disposed of at public auction or private sale and the proceeds deposited with the state; or (7-1-00)T

ii. Money deposited with the Home will be retained and deposited with the state; however, said money

may be claimed by the former resident within five (5) years of departure or discharge. (7-1-00)T

201. WEAPONS.

Weapons including, but not limited to, firearms, ammunition, straight razors, and knives with two (2) edged blades or blades longer than three (3) inches are not allowed. (7-1-00)T

202. ACKNOWLEDGMENT OF CONDITIONS LEADING TO DISCHARGE.

Upon admission to an Idaho State Veterans Home, each resident will be advised in writing of the conditions under which immediate discharge will occur, as specified in Subsection 350.01. Each resident must acknowledge receipt of this information by signature, and that acknowledgment will be a permanent part of each resident's file. (7-1-00)T

203. LIABILITY.

An Idaho State Veterans Home will not be responsible for loss or damage to residents' clothing, personal property, sensory aids, dentures, or prosthetic devices. (7-1-00)T

204. -- 299. (RESERVED).

300. CONDUCT OF RESIDENTS.

Each resident must comply with applicable rules in this Chapter and with any order or directive of the Home Administrator. All complaints made by the residents concerning food, quarters, ill treatment, neglect, abusive language, or other violations of any rule or standard applicable to the Home, or complaints against the operation of a Home may be made either verbally or in writing to the Home Administrator. (7-1-00)T

01. No Operation Of Motor Vehicles By Nursing And Residential Care Residents. The operation or storage of privately owned motor vehicles by nursing and residential care residents is prohibited on Home property. (7-1-00)T

02. Operation Of Motor Vehicles By Domiciliary Residents. Each authorized domiciliary care resident who drives a motor vehicle onto the grounds of a Home must adhere to the following: (7-1-00)T

a. Requirements: (7-1-00)T

i. Must possess a valid driver's license; (7-1-00)T

ii. Vehicle must have a current motor vehicle registration; (7-1-00)T

iii. Operator must be insured against liability and property damage in accordance with Idaho law; and (7-1-00)T

iv. Must park only in assigned spaces. (7-1-00)T

b. Prohibitions. Nonoperable motor vehicles and motor vehicle repairs are not permitted on the grounds of a Home. (7-1-00)T

03. Housekeeping. (7-1-00)T

a. Housekeeping services for nursing care residents shall be provided by the Home. (7-1-00)T

b. Each residential and domiciliary care resident must adhere to the following requirements (residential care residents may need minimal assistance): (7-1-00)T

i. Making his bed daily; (7-1-00)T

ii. Maintaining his room in a neat and orderly manner at all times; and (7-1-00)T

iii. Assuring that all clothing is appropriately marked, stored and kept clean through proper laundering. (7-1-00)T

- c. All residents are prohibited from: (7-1-00)T
 - i. Washing clothes or other articles which present a health or safety hazard in resident rooms or bathrooms; (7-1-00)T
 - ii. Using electrical devices, including televisions, radios, recorders, and shavers, until they have been certified by Home maintenance staff as being safe for use; (7-1-00)T
 - iii. Entering the kitchen, laundry, shop or mechanical spaces without permission; and (7-1-00)T
 - iv. Interfering or tampering with the heating, refrigeration or air conditioning systems, televisions, lighting, appliances, plumbing, or mechanical equipment at the Home without authorization. (7-1-00)T
- 04. Personal Conduct.** Each resident must adhere to the following: (7-1-00)T
 - a. Requirements: (7-1-00)T
 - i. Observing cleanliness in person, dress and in living habits; (7-1-00)T
 - ii. Bathing or showering frequently; (7-1-00)T
 - iii. Observing the smoking policies of a Home; (7-1-00)T
 - iv. Residential and domiciliary care residents must retire to a recreation area or utilize an individual bed light if desiring to read between 10 p.m. and 6:30 a.m. during which time all room overhead lights are turned off; (7-1-00)T
 - b. Prohibitions: (7-1-00)T
 - i. Creating a disturbance or using intoxicating beverages or nonprescribed controlled substances in the buildings or on the grounds (unless prescribed by a physician); (7-1-00)T
 - ii. Marking or writing on the walls of a building, or damaging the grounds or any other property; (7-1-00)T
 - iii. Using profanity or exhibiting vulgar behavior in the Home or in any other public place; (7-1-00)T
 - iv. Becoming involved in quarrels, persistent dissension or criticism of others; (7-1-00)T
 - v. Lending money to, or borrowing money from, another resident or an employee of the Home; (7-1-00)T
 - vi. Smoking in an unauthorized area; (7-1-00)T
 - vii. Taking food (other than fresh fruit for consumption within a reasonable time period), condiments, dishes or utensils from the dining room; (7-1-00)T
 - viii. Cooking or using heating devices in residents' rooms or other unauthorized areas; (7-1-00)T
 - ix. Storing flammable or combustible material including, but not limited to, gasoline, butane, solvents, and acetone on Home grounds. (7-1-00)T

301. -- 349. (RESERVED).

350. PENALTIES FOR RESIDENTIAL AND NURSING CARE RESIDENTS.

Upon determination that a resident has failed to comply with an order or rule of a Home or the Division, the Home

Administrator must notify the resident, in writing, of pending disciplinary action which can include: (7-1-00)T

01. Discharge. A resident may be discharged from the Home for a period of time to be determined by the Home Administrator: (7-1-00)T

a. Upon determination by the Home Administrator that an emergency exists, a resident may be immediately discharged. (7-1-00)T

b. If the Home Administrator determines that a resident has committed one (1) or more of the following acts, the resident will be given notice in accordance with Subsection 982.03 and after fifteen (15) days discharged from the Home: (7-1-00)T

i. Possession of a lethal weapon of any kind or possession of wine, beer, liquor, controlled substance or medication unless prescribed by the resident's primary care physician; (7-1-00)T

ii. Excessive or habitual intoxication; (7-1-00)T

iii. Disturbing the peace; (7-1-00)T

iv. Striking or threatening another person; (7-1-00)T

v. Willful destruction or wrongful appropriation of state or another person's property; (7-1-00)T

vi. Commission of a felony; (7-1-00)T

vii. Abusive language or gestures or intentional assault or battery; (7-1-00)T

viii. Willful disobedience or persistent violations of Home rules; (7-1-00)T

ix. Refusal or failure to pay established charges (see Sections 880 through 980); (7-1-00)T

x. Any pattern of behavior that infringes upon the rights of another person; (7-1-00)T

xi. Unauthorized absences from the Home. (7-1-00)T

02. Restriction. A resident may be restricted to the Home for a period of time to be determined by the Home Administrator. (7-1-00)T

351. PENALTIES FOR DOMICILIARY RESIDENTS.

Upon determination that a resident has failed to comply with an order or rule of a Home or the Division, the Home Administrator must notify the resident, in writing, of pending disciplinary action which can include: (7-1-00)T

01. Discharge. A resident may be discharged from the Home for a period of time to be determined by the Home Administrator: (7-1-00)T

a. If the Home Administrator determines that a domiciliary resident has committed one (1) or more of the following acts, the resident will be given notice in accordance with Subsection 982.03 and immediately discharged from the Home. (7-1-00)T

i. Possession of wine, beer, liquor, controlled substance or a lethal weapon of any kind in the Home; (7-1-00)T

ii. Excessive intoxication; (7-1-00)T

iii. Disturbing the peace; (7-1-00)T

iv. Striking or threatening another person; (7-1-00)T

- v. Willful destruction or wrongful appropriation of state or another person's property; (7-1-00)T
 - vi. Commission of a felony; (7-1-00)T
 - vii. Abusive language or gestures, assault or battery. (7-1-00)T
 - b. The resident will be given notice of his eventual discharge in accordance with Subsection 982.03 for any of the following acts: (7-1-00)T
 - i. Habitual intoxication; (7-1-00)T
 - ii. Willful disobedience or persistent violations of Home rules; (7-1-00)T
 - iii. Refusal or failure to pay established charges (see Sections 880 through 980); (7-1-00)T
 - iv. Any pattern of behavior that infringes upon the rights of another person; (7-1-00)T
 - v. Unauthorized absences. (7-1-00)T
- 02. Restriction.** A resident may be restricted to the Home for a period of time to be determined by the Home Administrator. (7-1-00)T

352. UNAUTHORIZED ABSENCES -- RESIDENTIAL AND DOMICILIARY CARE.

01. Unauthorized Absences Prohibited. For residential and domiciliary care residents, no more than three (3) unauthorized absences may be accumulated in a thirty (30) day period. If more than three (3) unauthorized absences are accumulated, the resident will be discharged for a period of thirty (30) days. (7-1-00)T

02. Yearly Maximum. The maximum number of unauthorized absences allowable in a one (1) year period is twelve (12). Any resident who exceeds twelve (12) unauthorized absences in one (1) year will be discharged for a period of up to one (1) year. (7-1-00)T

03. Readmission Requirements. Residents discharged pursuant to this Rule must reapply for admission and are subject to the same restrictions and conditions as other applicants. (7-1-00)T

353. -- 850. (RESERVED).

851. AVAILABLE SERVICES.

The Division of Veterans Services will attempt to make available the following services. (7-1-00)T

- 01. Nursing Care.** The Division of Veterans Services will attempt to make available the services listed below for nursing care residents: (7-1-00)T
- a. Barber/Beauty Shop. (7-1-00)T
 - b. Chaplain. (7-1-00)T
 - c. Dental Hygiene. (7-1-00)T
 - d. Dietitian. (7-1-00)T
 - e. Financial Counseling. (7-1-00)T
 - f. Lab. (7-1-00)T
 - g. Laundry. (7-1-00)T

- h. Nursing. (7-1-00)T
- i. Pharmaceutical. (7-1-00)T
- j. Physical Therapy. (7-1-00)T
- k. Physician. (7-1-00)T
- l. Referral. (7-1-00)T
- m. Respiratory Therapy. (7-1-00)T
- n. Security. (7-1-00)T
- o. Social Work. (7-1-00)T
- p. Speech Therapy. (7-1-00)T
- q. Therapeutic Recreation. (7-1-00)T
- r. Transportation. (7-1-00)T
- s. Volunteer Support. (7-1-00)T
- t. X-Ray. (7-1-00)T

02. Residential And Domiciliary Care. The Division of Veterans Services will attempt to make available the services listed below for residential and domiciliary care residents: (7-1-00)T

- a. Barber/Beauty Shop. (7-1-00)T
- b. Chaplain. (7-1-00)T
- c. Dietitian. (7-1-00)T
- d. Financial Counseling. (7-1-00)T
- e. Laundry. (7-1-00)T
- f. Nursing (limited). (7-1-00)T
- g. Referral. (7-1-00)T
- h. Security. (7-1-00)T
- i. Social Work. (7-1-00)T
- j. Therapeutic Recreation. (7-1-00)T
- k. Transportation. (7-1-00)T
- l. Volunteer Support. (7-1-00)T

852. -- 879. (RESERVED).

880. FINANCIAL CONDITION OF APPLICANTS/RESIDENTS.

Each applicant/resident or his legal representative must submit a signed and dated financial statement to the Home Administrator on which his income and liquid assets from all sources are reported. The statement must also indicate whether the applicant/resident is responsible for the support of any legal dependent who should be considered in fixing the amount of monthly charges. If changes occur in the applicant's/resident's income or liquid assets, it shall be the applicant's/resident's responsibility to submit an accurate financial statement immediately. (7-1-00)T

01. Investigation Of Financial Condition. The Division of Veterans Services is authorized to investigate the financial condition of applicants/residents to determine their ability to pay maintenance charges. An applicant/resident may be required to provide a power of attorney or a release of information to the Home Administrator in order to assist in investigating his financial condition and to aid in securing any benefits for which he may be eligible. (7-1-00)T

02. Retroactive Income. In the event an applicant/resident is awarded retroactive income from any source, he is responsible to report this award to the Home Administrator. He is then required to pay his maintenance charge retroactive to the effective date of income. (7-1-00)T

881. -- 914. (RESERVED).

915. MAINTENANCE CHARGES.

Upon becoming a resident of an Idaho State Veterans Home, each resident is liable for the payment of a maintenance charge as well as expenses for supplies, medication, equipment, and services (other than basic services for the assigned level of care) that are not provided or paid for by VA, Medicaid, Medicare, or other insurance unless otherwise determined by the Home Administrator. Residents living in a Home for any part of a month must pay for each day, based on the actual number of days in the month, at that fraction of their total charge. Refusal or failure to pay the established maintenance charge or related expenses is cause for discharge from the Home. (7-1-00)T

- 01. Charges.** Charges will be computed, based on the following factors: (7-1-00)T
- a. If the resident has an income, those items used to compute the charge will include: (7-1-00)T
 - i. Social Security benefits; (7-1-00)T
 - ii. Retirement benefits; (7-1-00)T
 - iii. Income from annuities; (7-1-00)T
 - iv. Insurance benefits; (7-1-00)T
 - v. Rental from property; (7-1-00)T
 - vi. Farm income; (7-1-00)T
 - vii. VA pensions or compensations; (7-1-00)T
 - viii. Tax refunds; and (7-1-00)T
 - ix. Income from any and all other sources. (7-1-00)T
 - b. If the resident is single, incompetent, and has liquid assets in excess of five hundred dollars (\$500), he will be assessed the current maximum charge until those assets are reduced to less than five hundred dollars (\$500). (7-1-00)T
 - c. If the resident is single, competent, and has liquid assets in excess of fifteen hundred dollars (\$1,500), he will be assessed the current maximum charge until those assets are reduced to less than fifteen hundred dollars (\$1,500). (7-1-00)T

d. Joint income will be used in computing charges for married persons. If the resident has dependents who rely upon him for financial support, the amount of liquid assets will not be drawn upon after they have declined to a level of five thousand dollars (\$5,000). (7-1-00)T

02. Exclusions From Income Or Payment. The only exclusions in computing monthly charges will be: (7-1-00)T

a. Those funds which a resident receives from the sale of hobby/craft items constructed and sold as part of a Home occupational therapy program; or (7-1-00)T

b. Those unusual expenses specified below, which are incurred after the resident's admission to a Home and are approved by the Home Administrator, up to a maximum monthly allowance which is established pursuant to Section 980: (7-1-00)T

i. Prosthetic, orthopedic, and paraplegic appliances; (7-1-00)T

ii. Sensory aids; (7-1-00)T

iii. Wheelchairs; (7-1-00)T

iv. Therapy services; (7-1-00)T

v. Hospital, medical, surgical expenses and bills for prescription drugs incurred and paid by the individual in the current month and documented by a paid receipt. (7-1-00)T

c. Reasonable medical insurance premiums, as paid, with documentation of payment. Other insurance premiums are excluded from consideration; or (7-1-00)T

d. An allowance established pursuant to Section 980 for retention by a resident for personal needs; (7-1-00)T

e. That amount necessary for a resident of a Home to contribute to the support of a legal dependent where proof of actual payment is documented. A monthly allowance will be established for a spouse or additional dependents pursuant to Section 980. (These allowances take into consideration housing and utility costs.) (7-1-00)T

03. Income Eligibility Limits. (7-1-00)T

a. Nursing Care. None. (7-1-00)T

b. Residential and Domiciliary Care. A resident's total monthly net income, from all sources, may not exceed the current maximum annual rate of VA pension for a single veteran pursuant to Public Law 95-588 divided by twelve (12) unless waived by the Home Administrator in accordance with Subsection 100.08. (7-1-00)T

c. While in residence at a Home, a domiciliary resident may seek outside employment and receive income so that his total monthly net income from all sources will exceed the current maximum annual rate of VA pension for a single veteran pursuant to Public Law 95- 588 divided by twelve (12) for a one (1) month transitional period. At the end of this one (1) month transitional period, the resident will be discharged. (7-1-00)T

04. Continued Eligibility. (7-1-00)T

a. Nursing Care. A resident may continue to be eligible for residency in a Home, regardless of income changes, if the conditions defined in Subsection 100.09 continue to be met. (7-1-00)T

b. Residential and Domiciliary Care. If a resident's net monthly income exceeds the income eligibility limit after admission to the Home, the resident may appeal to the Home Administrator for a waiver of the income eligibility limit which may be granted for good cause. Consideration for good cause must include "need for continuing medical care" as documented by a VA Medical Center physician. (7-1-00)T

05. Charges. (7-1-00)T

a. Nursing Care. After allowable deductions, a resident will be assessed a fee equal to the remaining portion of his net monthly income up to the maximum charge. The maximum monthly maintenance charge is based on historical costs that are adjusted to include anticipated costs and an inflation factor. Changes to the maximum charge are made pursuant to Section 980. (7-1-00)T

b. Residential Care. After allowable deductions, a resident will be assessed a fee of seventy-five percent (75%) of the remaining portion of his net monthly income up to the maximum charge. The maximum monthly maintenance charge shall be seventy-five percent (75%) of the current maximum annual rate of VA pension for a single veteran pursuant to Public Law 95-588 divided by twelve (12). (7-1-00)T

c. Domiciliary Care. After allowable deductions, a resident will be assessed a fee of sixty percent (60%) of the remaining portion of his net monthly income up to the maximum charge. The maximum monthly maintenance charge shall be sixty percent (60%) of the current maximum annual rate of VA pension for a single veteran pursuant to Public Law 95-588 divided by twelve (12). (7-1-00)T

06. Payment Schedule. Maintenance charges are due the first of each month for the preceding month, and must be paid in full by the resident or guardian on or before the tenth (10) day of the month. Payments may be made either by cash or by check, and a receipt will be issued. (7-1-00)T

07. Security Deposit. A deposit of one hundred dollars (\$100) will be required upon admission to a Home, unless waived by the Home Administrator. This deposit will be held until the resident leaves. Any debts or liabilities on behalf of the resident will be offset against this deposit at that time. After payment of any debts or liabilities, the remaining balance of the deposit will be returned to the outgoing resident. (7-1-00)T

08. Leave Of Absence Or Hospitalization. No reduction in charges will be made for leave of absence or hospitalization and each day will count as if the resident were present at a Home. Also, in the case of a leave of absence in excess of four (4) days or a hospital stay in excess of ten (10) days, the resident will be charged the current VA per diem rate for each absent day unless waived by the Home Administrator. (7-1-00)T

916. -- 949. (RESERVED).

950. FINANCIAL GROUNDS FOR REJECTION OR DISCHARGE.

The following circumstances may be considered as grounds for rejection of an application for residency or for revocation of residency and subsequent discharge. (When an application is rejected or a resident discharged, the applicant/resident will be given written notification of his intended application rejection or his discharge, in accordance with the provisions in Subsection 982.03.) (7-1-00)T

01. Disposal Of Assets. If the Home Administrator determines that an applicant/resident has disposed of assets following or within one (1) year preceding initial application for residency, which would have the effect of reducing his maintenance charge, such action can lead to rejection of the application or discharge from a Home. (7-1-00)T

02. Failure To Pay Maintenance Charge. Refusal or failure to pay the established maintenance charge can be cause for discharge from a Home. If the resident is so discharged, or leaves a Home voluntarily, he will not be eligible for readmission to a Home until all indebtedness to the Home is paid in full, or acceptable arrangements have been made with the Home Administrator for repayment. (7-1-00)T

03. Failure To Pay For Services. (7-1-00)T

a. Residents who are excluded from receiving free services from a VA Medical Center may elect to purchase such services through a sharing agreement or contract between a Home and a VA Medical Center or an outside provider when such sharing agreement or contract exists. In those cases where sharing agreement or contract costs are borne by a Home, the resident must reimburse the Home for the costs of services provided. (7-1-00)T

b. Failure to reimburse a Home or a service provider within ten (10) days after receipt of a bill for services provided under a sharing agreement or contract may result in a resident's discharge from the Home. (7-1-00)T

951. -- 979. (RESERVED).

980. MONTHLY CHARGES AND ALLOWANCES.

01. Nursing Care. Pursuant to Section 66-907, Idaho Code, maximum monthly charges and allowances are established by the Division Administrator with the advice of the Commission. A schedule of charges and allowances will be available in the business office of each Home. Charges and allowances will be reviewed from time to time by the Division Administrator and the Commission. (7-1-00)T

a. Changes to Charges and Allowances. Members of the public may comment on proposed changes at meetings of the Commission when changes are considered. (7-1-00)T

b. Notification and Posting. When changes are made to charges or allowances, residents and/or their families or sponsors will receive written notification and changes will be posted in the business office of each Home a minimum of thirty (30) days prior to the effective date of the change. (7-1-00)T

02. Residential And Domiciliary Care. Pursuant to Section 66-907, Idaho Code, maximum monthly charges and allowances are established by the Division Administrator with the advice of the Commission. A schedule of charges and allowances will be available in the business office of the Boise Veterans Home. Allowances will be reviewed from time to time by the Division Administrator and the Commission. (7-1-00)T

a. Changes to Charges and Allowances. Pursuant to Subsections 915.05.b. and 915.05.c., monthly charges for residential and domiciliary care will be adjusted automatically when a change is made to the current maximum annual rate of VA pension for a single veteran pursuant to Public Law 95-588 divided by twelve (12). Relative to monthly allowances, members of the public may comment on proposed changes at meetings of the Commission when changes are considered. (7-1-00)T

b. Notification and Posting of Changes to Allowances. When changes are made to allowances, residents or their families or sponsors will receive written notification, and changes will be posted in the business office of the Boise Veterans Home a minimum of thirty (30) days prior to the effective date of the change. (7-1-00)T

981. APPEAL PROCEDURE.

Upon notification to a resident of restriction to or discharge from a Home by the Home Administrator, the resident may request a hearing in accordance with the provisions in Section 982, "Provisions for Contested Cases". Any additional violation of Home rules by a resident while on notice for disciplinary action will be treated independent of any pending appeal. (7-1-00)T

982. PROVISIONS FOR CONTESTED CASES.

01. Inapplicability Of Idaho Rules Of Administrative Procedure Of The Attorney General. All contested cases shall be governed by the provisions of these rules. The Veterans Affairs Commission and Administrator of the Division of Veterans Services find that the provisions of IDAPA 04.11.01.000, et seq., "Idaho Rules of Administrative Procedure of the Attorney General," are inapplicable and inappropriate for contested cases before the Veterans Affairs Commission, because of the specific and unique requirements of federal and state law regarding notices, hearing processes, procedural requirements, time lines, and other provisions requiring the Division to adopt its own procedures pursuant to Section 67-5206(5)(b), Idaho Code, and hereby affirmatively promulgate and adopt alternative procedures and elect not to be governed by any of the provisions of IDAPA 04.11.01.000, et seq., "Idaho Rules of Administrative Procedure of the Attorney General". (7-1-00)T

02. Hearing Rights. Through compliance with these rules, residents and applicants have the following rights to a hearing: (7-1-00)T

a. If a resident of a Home is notified of pending disciplinary action, including restriction or discharge,

the resident will be afforded an opportunity for a hearing with the Veterans Affairs Commission. A resident of a Home must attempt to resolve the violations stated on the notice of action through verbal discussions with the Home Administrator or his designee prior to submission of a written request for a hearing before the Commission.

(7-1-00)T

b. If an application for residency in a Home is rejected, the applicant may request a hearing before the Veterans Affairs Commission.

(7-1-00)T

c. If an application for emergency relief is denied, the applicant may request a hearing before the Veterans Affairs Commission.

(7-1-00)T

03. Notice Of Action. The Home Administrator or his designee must notify the applicant/resident of any action to be taken regarding rejection of an application or restriction to or discharge from a Home.

(7-1-00)T

a. The notice of intended action must be in writing.

(7-1-00)T

b. The notice must state the following:

(7-1-00)T

i. The reason for the impending action and a reference to the pertinent rules under which the action is being brought or decision has been made;

(7-1-00)T

ii. The effective date of the action;

(7-1-00)T

iii. The applicant's/resident's right to request a hearing according to the provisions in Section 982; and

(7-1-00)T

iv. The procedure for requesting a hearing before the Commission, as provided in Subsection 982.05.

(7-1-00)T

c. The following notification deadlines are established for Domiciliary Care only:

(7-1-00)T

i. Restriction or discharge notices must be sent to the resident three (3) days prior to the intended effective date of the action, except under the conditions noted in Subsection 351.01.a.

(7-1-00)T

ii. Notification of findings of ineligibility for residency will be mailed to the applicant within three (3) working days after receipt of the completed application citing the reasons for rejection.

(7-1-00)T

d. The following notification deadlines are established for Residential Care only:

(7-1-00)T

i. Restriction or discharge notices must be sent to the resident fifteen (15) days prior to the intended effective date of the action, except under the conditions noted in Subsection 350.01.a.

(7-1-00)T

ii. Notification of findings of ineligibility for residency will be mailed to the applicant within three (3) working days after receipt of the completed application citing the reasons for rejection.

(7-1-00)T

e. The following notification deadlines are established for Nursing Care only:

(7-1-00)T

i. Restriction or discharge notices must be sent to the resident fifteen (15) days prior to the intended effective date of the action, except under the conditions noted in Subsection 350.01.a.

(7-1-00)T

ii. Notification of findings of ineligibility for residency will be mailed to the applicant within three (3) working days after receipt of the completed application citing the reasons for rejection.

(7-1-00)T

04. Notice Of Denial Of Emergency Relief. The Veterans Services Program Supervisor or his designee must notify the applicant of the denial of his application for emergency relief.

(7-1-00)T

a. The notice of denial must be in writing.

(7-1-00)T

- b. The notice must state the following: (7-1-00)T
 - i. The reason for denial and a reference to the pertinent rules under which the denial was made; and (7-1-00)T
 - ii. The applicant's right to request a hearing according to the provisions in these rules; and (7-1-00)T
 - iii. The procedure for requesting a hearing before the Commission, as provided in Subsection 982.05. (7-1-00)T
- c. Notice of denial of emergency relief will be mailed to the applicant within three (3) working days after receipt of the completed application. (7-1-00)T

05. Requesting A Hearing. (7-1-00)T

a. A request for a hearing from a resident or an applicant for residency in an Idaho State Veterans Home must be submitted through the Home Administrator to the Division Administrator for possible resolution or scheduling before the Commission. A resident's request must contain a description of what effort he has taken to satisfy the requirements of Subsection 982.02.a. Any hearing conducted in accordance with these provisions will be held during either a regular or special meeting of the Commission. (7-1-00)T

b. A request for a hearing from an applicant for emergency relief must be submitted through the Veterans Services Program Supervisor to the Division Administrator for possible resolution or scheduling before the Commission. Any hearing conducted in accordance with these provisions will be held during either a regular or special meeting of the Commission. (7-1-00)T

c. A request for a hearing must be in writing and signed by the applicant/resident. (7-1-00)T

d. A request for a hearing must be submitted within three (3) days of receipt of the written notice of action or denial. (7-1-00)T

e. Pending a hearing, benefits will be continued or held in abeyance as follows: (7-1-00)T

i. Benefits for domiciliary care residents will be continued if the hearing request is made before the effective date of action and within three (3) days of receipt of the notice. No action will be taken by the Home Administrator pending receipt of the written decision of the Commission following the hearing, except under the conditions noted in Subsection 351.01.a. (7-1-00)T

ii. Benefits for residential care residents will be continued if the hearing request is made before the effective date of action and within three (3) days of receipt of the notice. No action will be taken by the Home Administrator pending receipt of the written decision of the Commission following the hearing, except under the conditions noted in Subsection 350.01.a. (7-1-00)T

iii. Benefits for nursing care residents will be continued if the hearing request is made before the effective date of action and within three (3) days of receipt of the notice. No action will be taken by the Home Administrator pending receipt of the written decision of the Commission following the hearing, except under the conditions noted in Subsection 350.01.a. (7-1-00)T

iv. Benefits for emergency relief applicants will not be granted until the Commission renders a written decision following the hearing. (7-1-00)T

983. PREHEARING PROVISIONS.

The following general provisions are applicable to those phases of all contested case proceedings which occur before the hearing is conducted unless precluded by statute or rule. (7-1-00)T

01. Limitation Of Time Periods. In the event there is no other specific provision in these rules or in

the Idaho Code, a resident, applicant, or other person aggrieved by any final decision of the agency shall have thirty-five (35) days to file an appeal of any adverse order or notice of decision of the Division, Division Administrator, or Home Administrator. (7-1-00)T

02. Notice Of Hearing. All parties in a contested case proceeding shall be afforded an opportunity for a hearing after reasonable notice, or within such time period as may be mandated by law. The hearing shall be arranged by the Division Administrator. The notice shall include: (7-1-00)T

- a. A statement of the time, place and nature of the hearing; (7-1-00)T
- b. A statement of the legal authority under which the hearing is to be held; (7-1-00)T
- c. A reference to the particular sections of any statutes and rules involved; (7-1-00)T
- d. A statement of the issues involved; (7-1-00)T
- e. A statement that all documents relied upon by the Veterans Affairs Commission to make its order or notice of decision, or otherwise related to the issues involved in the hearing and relied upon by any party, are to be filed with the Division Administrator and that each party must serve its own documents unless otherwise stated by law; (7-1-00)T
- f. A statement that all parties may be represented by counsel; and (7-1-00)T
- g. A statement concerning advance requests for hearing transcripts pursuant to Subsection 983.08. (7-1-00)T

03. Prehearing Conference. The Division Administrator or Veterans Affairs Commission may, upon written or other sufficient notice to all interested parties, hold a prehearing conference for the following purposes: (7-1-00)T

- a. To formulate or simplify the issues; (7-1-00)T
- b. To obtain admissions or stipulations of fact and of documents; (7-1-00)T
- c. To arrange for exchange of proposed exhibits or prepared expert testimony; (7-1-00)T
- d. To limit the number of witnesses; (7-1-00)T
- e. To determine the procedure at the hearing; and (7-1-00)T
- f. To determine any other matters which may expedite the orderly conduct and disposition of the proceeding. (7-1-00)T

04. Disposition Of Case Without A Hearing. Unless precluded by law, disposition without a hearing may be made of any contested case by stipulation, agreed settlement, consent order, motions to dismiss, summary judgment, or default. (7-1-00)T

05. Withdrawal Of Appeal. The initiating party at any time may withdraw from any contested case proceeding upon serving written notice of withdrawal to the Division Administrator. (7-1-00)T

06. Withdrawal Of Attorney Or Representative. Any attorney or other person representing a party in a contested case proceeding who wants to withdraw from such proceeding must immediately notify, in writing, the Division Administrator, and all involved parties. (7-1-00)T

07. Intervention. Persons, other than the original parties to the proceeding, who are directly and substantially affected by the proceeding, may intervene if they first secure an order from the Division Administrator granting leave to intervene. (7-1-00)T

- a. Granting of Leave to Intervene. The granting of leave to intervene or to otherwise appear in any matter or proceeding shall not be construed to be a finding or determination that such party will or may be a party aggrieved by any ruling, order or decision of the agency for purposes of judicial review or appeal. (7-1-00)T
- b. Form and Content of Petitions. Petitions for leave to intervene must be in writing and must clearly: (7-1-00)T
- i. Identify the proceeding in which it is sought to intervene, setting forth the name and address of the Intervenor; (7-1-00)T
- ii. Make a clear and concise statement of the direct and substantial interest of the Intervenor in such proceeding and the relationship of the Intervenor to the other parties; (7-1-00)T
- iii. State the manner in which such Intervenor will be affected by such proceeding, outlining the matters and things relied upon by such Intervenor as a basis for his request to intervene in such cause; (7-1-00)T
- iv. If affirmative relief is sought, the Petition must contain a clear and concise statement of relief sought and the basis thereof; and (7-1-00)T
- v. A statement as to the nature and quantity of evidence the Intervenor will present if such Petition is granted. (7-1-00)T
- c. Filing of Petitions. All Petitions must be filed with the Division Administrator. Petitions to intervene and proof of service thereof on all other parties of record must be filed within seven (7) days after receiving notice of the proceeding, or if no notice is received, not less than fourteen (14) days prior to the date set for hearing and, if filed thereafter, must state a substantial reason for such delay; otherwise the Petition will not be considered. (7-1-00)T

08. Hearing Record. The Veterans Affairs Commission or the Division Administrator will arrange for a record to be made of the contested case hearing. The record must be a verbatim record and it will be magnetically recorded by two (2) recording devices, unless a party requests a stenographic recording by a certified court reporter, in writing, at least seven (7) days prior to the date of hearing. The record shall be transcribed at the expense of the party requesting a transcription, and prepayment or guarantee of payment may be required. Once a transcription is requested, any party may obtain a copy at the party's own expense. The recorded proceedings will be provided to the Division Administrator for inclusion into the record. The Division shall maintain an official record of each contested case for a period of not less than six (6) months after the expiration of the last date for judicial review, unless otherwise provided by law. The record shall include all notices of proceedings, pleadings, motions, briefs, petitions and intermediate rulings, evidence received or considered, any oral or written statements allowed by the Commission, statement of matters officially noticed, offers of proof and objections and rulings thereon, the recording of the proceedings or any transcript of all or part of the proceedings, staff memoranda or data submitted to the Commission in connection with the proceeding, and any recommended order, preliminary order, final order or order on reconsideration. (7-1-00)T

09. Subpoenas. The Commission may compel the attendance of specific persons and the production of specific documents, materials, or objects at any contested case proceeding by subpoena issued by the Division Administrator. (7-1-00)T

10. Stipulations. The parties to a contested case proceeding may stipulate as to any fact at issue, either by written stipulation or by oral statement shown upon the record. Any such stipulation shall be binding upon all parties so stipulating and may be considered by the Commission. The Commission may require proof by evidence of any facts stipulated to, notwithstanding the stipulation of the parties. (7-1-00)T

11. Rules Of Civil Procedure. As contested case proceedings and hearings are informal, the Idaho Rules of Civil Procedure shall not apply. The Commission shall provide the procedure at the hearing, as required by the provisions of Section 67-5242(3), Idaho Code. (7-1-00)T

12. Discovery. Prehearing discovery shall be strictly limited to obtaining the names of witnesses and copies of documents the opposing party intends to offer or present at the hearing. The Commission may order disclosure of this information if a party refuses to comply after receiving a written request. (7-1-00)T

13. Briefing Schedule. The Commission may require briefs and written memoranda to be filed by the parties, and may establish a reasonable briefing schedule. (7-1-00)T

14. Informal Disposition. Unless otherwise prohibited by statute or rule, the Commission may decline to initiate a contested case. Informal disposition may be made of any contested case by negotiation, stipulation, agreed settlement or consent order, which informal settlement is encouraged. The parties may stipulate as to the facts, reserving their right to appeal to a court of competent jurisdiction on issues of law. The Commission may request such additional information as may be required to decide whether to initiate or to decide a contested case. If the Commission declines to initiate or decide a contested case, a brief statement of the reasons for that decision will be furnished to all persons or parties involved. This disposition of a contested case by informal disposition shall be a final agency action pursuant to Section 67-5241, Idaho Code. (7-1-00)T

984. HEARING PROVISIONS.

The following general provisions are applicable to those phases of all contested case proceedings which occur during the hearing unless precluded by statute or rule. (7-1-00)T

01. Classification Of Proceedings. Proceedings before the Veterans Affairs Commission will be classified according to their nature, the relief sought, the need for proof, and the requirements of due process. (7-1-00)T

02. Formal Complaints And Petitions. Complaints and Petitions must be in writing and shall set forth clearly and concisely the grounds of the complaint and a statement of the facts, actions or things done or omitted. Facts constituting such acts or omissions, together with citations, statutes, or rules involved, should be stated, together with the dates on which the acts or omissions occurred. The initial pleading of each party must provide the name and the address of the Complainant or Petitioner or representative, together with the name, address and telephone number of his attorney, if any, upon the complaint or Petition. Service of documents on the named representative or attorney is valid service upon the party for all purposes. (7-1-00)T

03. Computation Of Time. In computing any period of time relating to a contested case proceeding, the first day of the period is not to be included. The last day of the period is to be included unless it is a Saturday, Sunday or legal holiday, in which case the period runs until 5 p.m. of the next working day, unless otherwise provided by law. (7-1-00)T

04. Service Of Documents. Documents concerning contested case proceedings must be served as follows: (7-1-00)T

a. All pleadings, briefs and subsequent papers must be served upon every party of record concurrently with the filing with the Division Administrator. (7-1-00)T

b. All notices and orders required to be served, other than the initial complaint or Petition, must be served in person or by first-class mail. (7-1-00)T

c. The initial complaint or Petition must be served in person or by certified mail. (7-1-00)T

d. Service by first-class or certified mail will be deemed complete when the document, properly addressed and stamped, is deposited in the United States mail. The postmark shall be the determinant date for all time lines. (7-1-00)T

e. Proof of service must accompany all documents when they are filed with the Hearing Coordinator. (7-1-00)T

05. Commission Authority. The Commission shall, in the context of each proceeding and unless precluded by law, have the discretion, power and authority to: (7-1-00)T

- a. Determine the order of presentation; (7-1-00)T
 - b. Grant or deny Petitions reconsideration; (7-1-00)T
 - c. Determine the need, if any, for consolidation; (7-1-00)T
 - d. Rule on all evidentiary questions; (7-1-00)T
 - e. Rule on motions and objections and dispose of procedural requests; (7-1-00)T
 - f. Determine the need for prehearing conferences, recesses, adjournments, hearings on motions and postponements; (7-1-00)T
 - g. Administer oaths and affirmations; (7-1-00)T
 - h. Examine witnesses; (7-1-00)T
 - i. Issue subpoenas or request orders in the form of subpoenas as provided by law; (7-1-00)T
 - j. Prescribe general rules of hearing decorum and conduct; (7-1-00)T
 - k. Regulate the course of the proceeding; (7-1-00)T
 - l. Formulate a reasoned statement in support of the decision. Findings of fact should be set forth in statutory language and shall be accompanied by a concise and explicit statement of the underlying facts of record supporting the findings. (7-1-00)T
 - m. Perform any functions including those set forth in Sections 67- 5241 through 67- 5251, Idaho Code; and (7-1-00)T
 - n. All other functions specifically authorized by statute or rule. (7-1-00)T
 - o. The Commission shall not have the jurisdiction or authority to invalidate any federal or state statute, rule, or regulation. (7-1-00)T
- 06. Ex Parte Consultations.** Ex parte communications between the Commission and any party to a contested case proceeding are precluded pursuant to Section 67-5253, Idaho Code. (7-1-00)T
- 07. Representation By Counsel.** Any party in a contested case proceeding may be represented by counsel, at the party's own expense. (7-1-00)T
- 08. Open Hearings.** All contested case hearings must be open to the public, unless precluded by law. Unless otherwise permitted by the Commission, hearings shall be held during regular meetings of the Commission and will be arranged by the Division Administrator. (7-1-00)T
- 09. Testimony Under Oath.** All testimony to be considered, with the exception of matters officially noticed or entered by stipulation, must be given under oath, as administered by the Commission or other authority authorized to administer oaths. (7-1-00)T
- 10. Appearance And Representation.** Any party to a proceeding may appear and be heard in person or may authorize an attorney to represent the party at the party's own expense. Unless otherwise expressly allowed by these rules, with the prior approval of the Commission, a party may be assisted, but not represented, by a friend or relative. When a party chooses to appear in person and does not speak or understand the English language, an interpreter shall be allowed to interpret under oath. The interpreter shall not be allowed to act as a representative of the party and shall act at the party's own expense. (7-1-00)T

11. Default. If a party fails to appear at a scheduled hearing or at any stage of a contested case without good cause and reasonable notice to the Commission and to all other parties, the Commission may enter a notice of proposed default order against the nonappearing party. A default order may be altered or set aside upon petition filed within seven (7) days of service of the order showing sufficient good cause stating the grounds relied on, and providing reasonable notice to all parties. (7-1-00)T

12. Order Of Presentation. At any contested case hearing, the party having the burden of proof (usually the Petitioner or Complainant) shall be the first to present testimony unless the Commission determines otherwise. Unless otherwise determined, in advance, by the Commission, the burden of proof shall be preponderance of the evidence. (7-1-00)T

13. Evidence. Pursuant to Section 67-5251, Idaho Code, the hearing shall be informal and technical rules of evidence shall not apply, except that irrelevant, immaterial, incompetent, duly repetitious evidence, or evidence excludable on constitutional or statutory grounds protected by the rules of privilege recognized by law may be excluded. Hearsay evidence may be received if it is relevant to or corroborates competent evidence, but shall not be the sole basis for any finding of fact. Any part of the evidence may be received in written form if doing so will expedite the hearing without substantially prejudicing the interest of any party. Documentary evidence may be received in the form of copies or excerpts if the original is not readily available. (7-1-00)T

14. Testimony By Telephone Or Other Electronic Means. With the prior approval of the Commission, witnesses may testify by telephone or other electronic means, provided the examination and responses are audible to all parties. (7-1-00)T

15. Official Notice. (7-1-00)T

a. **Discretionary Notice.** Notice may be taken of judicially cognizable facts by the Commission on its own motion or on motion of a party. In addition, notice may be taken of generally recognized technical or scientific facts within the Commission's specialized knowledge. Parties shall be notified either before or during the hearing, or by reference in preliminary reports or otherwise, of the material noticed including any staff memoranda or data, and the parties shall be afforded an opportunity to contest the material so noticed. The Commission's experience, technical competence, and specialized knowledge may be utilized in the evaluation of the evidence. (7-1-00)T

b. **Mandatory Notice.** For all hearings, the Commission must take official notice of the following materials on its own motion or on the motion of any party. Objections going to such notice must become a part of the record. For the purposes of the hearing, it is established as true without proof that the following are admissible, valid and enforceable: (7-1-00)T

i. Rules of the Division and other state agencies; (7-1-00)T

ii. Federal regulations; (7-1-00)T

iii. The constitution and statutes of the United States and Idaho; (7-1-00)T

iv. Public records; and (7-1-00)T

v. Such other materials that a court of law must judicially notice. (7-1-00)T

16. Contents Of The Record. Pursuant to Section 67-5249(2), Idaho Code, the record in a contested case proceeding shall be kept by the Division Administrator, on behalf of the Commission, and must include the following: (7-1-00)T

a. All notices, pleadings, motions and rulings; (7-1-00)T

b. All evidence received or considered; (7-1-00)T

c. A statement of all matters officially noticed; (7-1-00)T

- d. A record of testimony and offers of proof, objections and rulings thereon; (7-1-00)T
- e. A record of proposed findings and exceptions; (7-1-00)T
- f. Any decision, opinion, or report by the Commission; (7-1-00)T
- g. All staff memoranda or data submitted to the Commission in connection with consideration of the case; (7-1-00)T
- h. All briefs or memoranda submitted by any party; and (7-1-00)T
- i. Any recommended order, preliminary order, final order, or order on reconsideration. (7-1-00)T

17. Judicial Review. In accordance with Section 67-5271, Idaho Code, a party which has exhausted all administrative remedies available within the Division may seek judicial review. Proceedings for judicial review shall be instituted in accordance with Sections 67-5270 and 5273, Idaho Code. (7-1-00)T

985. POST HEARING PROVISIONS.

The following provisions are applicable to those phases of all contested case proceedings which occur after the hearing has been conducted: (7-1-00)T

01. Submission Of Decision And Order. The Commission's decision and final order shall be served upon all parties personally or by mail. (7-1-00)T

02. Service Of Decisions And Orders. Decisions and orders shall be deemed to have been served when copies thereof are mailed to all parties of record or their attorneys by the Division Administrator. (7-1-00)T

03. No Motions For Reconsideration. Unless otherwise provided by law or these rules, motions for reconsideration shall not be permitted. (7-1-00)T

04. Public Inspection. All final decisions and orders of the Commission must be maintained by the Division Administrator and made available for public inspection after service on the parties. (7-1-00)T

05. Effect Of Petition For Judicial Review. The filing of a petition for judicial review shall not stay compliance with the decision and order or suspend the effectiveness of the decision and order, unless otherwise ordered or mandated by law. (7-1-00)T

986. -- 999. (RESERVED).

IDAPA 21 - DIVISION OF VETERANS SERVICES

21.01.02 - RULES GOVERNING ELIGIBILITY FOR ADMISSION, RESIDENCY AND MAINTENANCE CHARGES IN IDAHO STATE VETERANS HOMES - RESIDENTIAL CARE

DOCKET NO. 21-0102-0001 (REPEAL)

NOTICE OF TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is July 1, 2000.

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 Section 65-202 and 66-907, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking are scheduled for:

**Thursday, October 12, 2000, 7:00 p.m. to 9:00 p.m.
West Conference Room J. R. Williams Building
700 W. State, Boise, Idaho**

The hearing site 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:

This chapter must be repealed to facilitate the Division of Veterans Services' move from the Department of Health and Welfare to the Department of Self Governing Agencies. This move resulted from amendments to Idaho Code Sections 39-106, 65-201, 65-202, 65-204, 66-901, 66-906, 66-907, and 67-2601. These amendments were contained in H0437 which passed the 2000 Idaho Legislature and was signed by the Governor on March 27, 2000. Parts of this chapter are being rewritten and incorporated into Docket No. 21-0101-0002 which is being published in this Bulletin.

TEMPORARY RULE JUSTIFICATION: Pursuant to Sections 67-5226(1)(b) and 67-5226(1)(c), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate for the following reasons:

Compliance with deadlines in amendments to governing law or federal programs.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: Not applicable.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because this action is necessary to comply with amendments to governing law.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Joni Harkless at (208) 334-3513.

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 October 25, 2000.

DATED this 17th day of August, 2000.

Gary Bermeosolo, Administrator
Division of Veterans Services
320 Collins Road, Boise, ID 83702
Phone: (208) 334-3513 Fax: (208) 334-2627

THIS CHAPTER IS BEING REPEALED IN ITS ENTIRETY.

IDAPA 21 - DIVISION OF VETERANS SERVICES
21.01.02 - RULES GOVERNING EMERGENCY RELIEF FOR VETERANS
DOCKET NO. 21-0102-0002 (REWRITE)
NOTICE OF TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is July 1, 2000.

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 Section 65-202, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking are scheduled for:

Thursday, October 12, 2000, 7:00 p.m. to 9:00 p.m.
West Conference Room J. R. Williams Building
700 W. State, Boise, Idaho

The hearing site 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:

This chapter replaces IDAPA 21.01.04 (formerly IDAPA 16.07.04), which is being repealed to facilitate the Division of Veterans Services' move from the Department of Health and Welfare to the Department of Self Governing Agencies. This move resulted from amendments to Sections 39-106, 65-201, 65-202, 65-204, 66-901, 66-906, 66-907, and 67-2601, Idaho Code. These amendments were contained in H0437 which passed the 2000 Idaho Legislature and was signed by the Governor on March 27, 2000. Changes also include some general clean-up.

TEMPORARY RULE JUSTIFICATION: Pursuant to Sections 67-5226(1)(b) and 67-5226(1)(c), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate for the following reasons:

Compliance with deadlines in amendments to governing law or federal programs.

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

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because this action is necessary to comply with amendments to governing law.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Joni Harkless at (208) 334-3513.

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 October 25, 2000.

DATED this 17th day of August, 2000.

Gary Bermeosolo, Administrator
Division of Veterans Services
320 Collins Road
Boise, ID 83702
Phone: (208) 334-3513
Fax: (208) 334-2627

THE FOLLOWING IS THE TEXT OF DOCKET NO. 21-0102-0002

IDAPA 21
TITLE 01
Chapter 02

21.01.02 - RULES GOVERNING EMERGENCY RELIEF FOR VETERANS

000. LEGAL AUTHORITY.

The Idaho Legislature has given the Administrator of the Division of Veterans Services the authority to promulgate rules governing the standards pertaining to the Veterans Services Emergency Relief Program, pursuant to Sections 65-201, 65-202, 65-203, 65-204 and 65-207, Idaho Code. (7-1-00)T

001. TITLE AND SCOPE.

01. Title. These rules shall be cited as IDAPA 21.01.02, "Rules Governing Emergency Relief for Veterans". (7-1-00)T

02. Scope. These rules contain the provisions for accepting, evaluating, granting, and denying requests for emergency relief and provisions related to Veterans Service Officers. (7-1-00)T

002. WRITTEN INTERPRETATIONS.

There are no written interpretations for this Chapter. (7-1-00)T

003. ADMINISTRATIVE APPEALS.

Contested case appeals shall be governed by Division of Veterans Services Rules, IDAPA 21.01.01, "Rules Governing Admission, Residency, and Maintenance Charges in Idaho State Veterans Homes and Division of Veterans Services Administrative Procedure," Sections 982, et seq. (7-1-00)T

004. POLICY.

There exists in this state a need to provide assistance in the way of the actual necessities of life such as food, fuel, shelter, and clothing in a time of temporary emergency need to honorably discharged veterans meeting basic eligibility criteria and their dependents. A statewide network of qualified veterans service officers is required to ensure that destitute and disabled veterans and dependents are receiving earned United States Department of Veterans Affairs benefits thus lessening the demand for veterans emergency relief or other welfare programs. (7-1-00)T

005. SUBMISSION OF APPLICATION.

Persons authorized to submit emergency relief applications on behalf of applicants include post and county service officers and public welfare employees. Additionally, any person in need of emergency assistance may submit an application on his own behalf. (7-1-00)T

006. BASIC ELIGIBILITY.

The applicant must be a(n): (7-1-00)T

01. Bona Fide Resident. At the time of application, the applicant must provide proof that he maintains a principal or primary place of abode in the state of Idaho coupled with the present intent to remain at that home or abode and return to it after any period of absence. (7-1-00)T

02. Armed Forces Veteran. Pursuant to Section 65-203, Idaho Code, a person who actually served during any war or conflict officially engaged in by the government of the United States and was discharged, under honorable conditions, after ninety (90) or more days of military service or was separated from military service earlier because of service-connected disability. (7-1-00)T

007. PERSONS TO RECEIVE RELIEF -- CLASSIFICATIONS.

Emergency relief grants may be made by the Idaho Division of Veterans Services to veterans and their dependents who come under the following classifications: (7-1-00)T

01. Destitute Veterans. Those persons meeting the basic eligibility criteria who demonstrate a state of extreme emergency need resulting from an accident or catastrophic event which has occurred within ninety (90) days of the date of the application for emergency relief. (7-1-00)T

02. Disabled Veterans. Those persons meeting the basic eligibility criteria who demonstrate a state of extreme emergency need who are unemployed as the result of a disabling condition which has occurred within ninety (90) days of the date of application for emergency relief. (7-1-00)T

03. Surviving Spouse and Dependent Children. Surviving spouses and dependent children of once eligible veterans who meet the criteria of Subsections 007.01 or 007.02. (7-1-00)T

008. PURPOSE OF GRANTS.

Relief grants are provided to eligible individuals for the purchase of food, fuel, shelter, and other necessities of daily living in a time of temporary emergency need. No grants will be made to a potential recipient who refuses to take advantage of available government benefits or federal-state-local relief. Applicants will be required to obtain certification that they have applied for available assistance programs. Emergency relief funds may not be used to duplicate assistance from other sources. (7-1-00)T

009. PERMISSIBLE RELIEF.

Amounts of grants will depend upon facts and conditions as shown on the application submitted. In no case will a grant exceed one thousand dollars (\$1,000). All grants are subject to the availability of funds. (7-1-00)T

010. PAYMENT PROCESS.

When it has been verified that a request for relief is valid, the request for funds is processed for payment by the State Controller's Office, and a state warrant is issued to the individual. (7-1-00)T

011. PROPORTIONATE GRANTS.

A grant amount will be determined in proportion to the extent of the emergency and the length of time assistance is required. (7-1-00)T

012. ACCUMULATION OF GRANTS.

Grant recipients may receive only one (1) grant in a six (6) month period. The total of all grants awarded to a veteran and his dependents shall not exceed one thousand dollars (\$1,000). (7-1-00)T

013. INVESTIGATION.

Applicants must agree to permit investigation of their financial, domestic and employment status as may be related to the emergency need. Personal and private information on an application is confidential, and the applicant must sign the application if he is available and capable. A relative may file an application on behalf of the petitioner if the petitioner is not available or is unable to file the application. Each application should include a full report on the financial and home conditions pertinent to the applicant, together with recommendations of the investigator making the report. Temporary emergency or destitution must be clearly shown in the investigator's report. Incorrect or falsified information may constitute basis for denial of grant including future relief. (7-1-00)T

014. VETERANS SERVICE OFFICER SUPPORT.

Veterans service officers, whether of the counties or the recognized veterans service organizations, must have a current knowledge and understanding of United States Department of Veterans Affairs programs to adequately serve the citizens of the state in the recovery of earned veterans benefits. (7-1-00)T

01. Training. The Division of Veterans Services will conduct a minimum of three (3) regional training conferences each year in support of the statewide service officer program. (7-1-00)T

02. Reimbursement. Eligible counties and service organizations sending service officers to scheduled

training sessions may apply to the Division of Veterans Services for reimbursement of travel expenses for one (1) participant. Payment will not be provided for expenses reimbursed by other sources and shall be limited to one (1) regional training conference per year. (7-1-00)T

03. Rate of Reimbursement. Reimbursement of travel expenses shall be for mileage and meals and at the same rate as established by the State Board of Examiners. (7-1-00)T

04. Requests for Reimbursement. All requests for reimbursement must be submitted from an official county officer or from an administrative officer of a congressionally chartered veterans service organization. Requests for reimbursement shall be submitted in a format as prescribed by the Division of Veterans Services. Requests must be submitted within thirty (30) days after the conclusion of a training conference. All reimbursements are subject to the availability of funds. (7-1-00)T

05. Validation. Request for reimbursement shall be validated by cross-referencing attendance lists from service officer training conferences. (7-1-00)T

015. -- 999. (RESERVED).

IDAPA 21 - DIVISION OF VETERANS SERVICES

21.01.03 - RULES GOVERNING ELIGIBILITY FOR ADMISSION, RESIDENCY AND MAINTENANCE CHARGES IN IDAHO STATE VETERANS HOMES - NURSING CARE

DOCKET NO. 21-0103-0001 (REPEAL)

NOTICE OF TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is July 1, 2000.

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 Section 65-202 and 66-907, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking are scheduled for:

Thursday, October 12, 2000, 7:00 p.m. to 9:00 p.m.
West Conference Room J. R. Williams Building
700 W. State, Boise, Idaho

The hearing site 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:

This chapter must be repealed to facilitate the Division of Veterans Services' move from the Department of Health and Welfare to the Department of Self Governing Agencies. This move resulted from amendments to Idaho Code Sections 39-106, 65-201, 65-202, 65-204, 66-901, 66-906, 66-907, and 67-2601. These amendments were contained in H0437 which passed the 2000 Idaho Legislature and was signed by the Governor on March 27, 2000. Parts of this chapter are being rewritten and incorporated into Docket No. 21-0101-0002 which is being published in this Bulletin.

TEMPORARY RULE JUSTIFICATION: Pursuant to Sections 67-5226(1)(b) and 67-5226(1)(c), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate for the following reasons:

Compliance with deadlines in amendments to governing law or federal programs.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: Not applicable.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because this action is necessary to comply with amendments to governing law.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Joni Harkless at (208) 334-3513.

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 October 25, 2000.

DATED this 17th day of August, 2000.

Gary Bermeosolo, Administrator
Division of Veterans Services
320 Collins Road, Boise, ID 83702
Phone: (208) 334-3513 / Fax: (208) 334-2627

THIS CHAPTER IS BEING REPEALED IN ITS ENTIRETY.

IDAPA 21 - DIVISION OF VETERANS SERVICES
21.01.03 - RULES GOVERNING MEDICAID QUALIFIED UNITS IN
IDAHO STATE VETERANS HOMES

DOCKET NO. 21-0103-0002 (REWRITE)

NOTICE OF TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is July 1, 2000.

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 Section 65-202 and 66-907, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking are scheduled for:

Thursday, October 12, 2000, 7:00 p.m. to 9:00 p.m.
West Conference Room J. R. Williams Building
700 W. State, Boise, Idaho

The hearing site 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:

This chapter is necessary to facilitate the requirement that the Idaho State Veterans Homes become Medicaid-certified which was contained in H0799. H0799 was passed by the 2000 Idaho Legislature and signed by the Governor on April 14, 2000.

TEMPORARY RULE JUSTIFICATION: Pursuant to Sections 67-5226(1)(b) and 67-5226(1)(c), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate for the following reasons:

Compliance with deadlines in amendments to governing law or federal programs.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: This chapter requires that all new Idaho State Veterans Home nursing care residents, including re-admitted residents, must apply for and become eligible for Medicaid benefits or pay the Homes' maximum monthly nursing care charge. Those individuals who cannot or choose not to qualify for Medicaid shall be required to pay for services in full from other than Medicaid funds.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because this action is necessary to comply with amendments to governing law or federal programs.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Joni Harkless at (208) 334-3513.

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 October 25, 2000.

DATED this 17th day of August, 2000.

Gary Bermeosolo, Administrator
Division of Veterans Services
320 Collins Road
Boise, ID 83702
Phone: (208) 334-3513
Fax: (208) 334-2627

THE FOLLOWING IS THE TEXT OF DOCKET NO. 21-0103-0002

IDAPA 21
TITLE 01
Chapter 03

21.01.03 - RULES GOVERNING MEDICAID QUALIFIED UNITS
IN IDAHO STATE VETERANS HOMES.

000. LEGAL AUTHORITY.

The Administrator of the Division of Veterans Services, with the advice of the Veterans Affairs Commission, is authorized by the Idaho Legislature to establish rules governing requirements for admission to Idaho State Veterans Homes and to establish rules governing charges for residency, pursuant to Sections 65-202, 65-204 and 66-907, Idaho Code. The legislature has also directed the Division of Veterans Services to make state veterans homes Medicaid eligible facilities. (7-1-00)T

001. TITLE AND SCOPE.

01. Title. These Rules shall be cited as IDAPA 21.01.03, "Rules Governing Medicaid Qualified Units in Idaho State Veterans Homes". (7-1-00)T

02. Scope. The provisions of this Chapter add to, but do not replace other rules governing the Idaho State Veterans Homes. These rules are intended to add those provisions necessary and advisable to facilitate Medicaid eligibility for the Veterans Homes. To the extent there is a conflict between these rules and other rules governing the Veterans Homes, these rules supersede and have priority over such other rules. (7-1-00)T

03. Relationship To Policies And Procedures. The policies and procedures found within the Division of Veterans Services' policy and procedure manual are intended for the uniform guidance of employees and management of the Veterans Homes and to provide certain minimum standards of conduct by employees. However, such policies and procedures are neither contractual in nature nor, unlike these rules, do they have the force and effect of law. Management personnel, within the scope of their duties and employment, may deviate from the division's policies and procedures manual when the health and safety of Veterans Home residents, or special or unique circumstances, reasonably warrant such deviation. (7-1-00)T

002. WRITTEN INTERPRETATIONS.

There are no written interpretations for this Chapter. (7-1-00)T

003. ADMINISTRATIVE PROVISIONS.

Contested case appeals shall be governed by Division of Veterans Services Rules, IDAPA 21.01.01, "Rules Governing Admission, Residency, and Maintenance Charges in Idaho State Veterans Homes and Division of Veterans Services Administrative Procedure," Sections 982, et seq. (7-1-00)T

004. POLICY.

While those who are residents of the Veterans Homes on June 30, 2000, and before, are strongly encouraged to apply for Medicaid benefits, when such benefits may be available to them, it is the policy of the Division of Veterans Services, that participation in the Medicaid program shall be voluntary. Unless required by the legislature, no resident, who was continually a resident on and after June 30, 2000, shall be required, against their will, to participate in the Medicaid program. (7-1-00)T

005. MEDICAID ELIGIBILITY.

On and after July 1, 2000, all new nursing care residents at the Idaho State Veterans Homes, including re-admitted residents, must either apply for and become eligible for Medicaid benefits, or must pay the maximum monthly

nursing care charge as it may be established from time to time. Eligibility for Medicaid benefits is determined entirely by the Idaho Department of Health and Welfare and its agents. Those who cannot, or choose not to, qualify for Medicaid shall be required to pay for services in full from other than Medicaid funds. This requirement may be waived by the Division Administrator, in his sole discretion, should its application be unfair or cause an undue hardship. Care and services for those residents who are Medicaid eligible shall be billed to and paid by Medicaid following the date the respective Veterans Home becomes a qualified Medicaid facility. (7-1-00)T

006. DEFINITIONS.

Unless otherwise provided herein, the definitions set forth in IDAPA 21.01.01, "Rules Governing Admission, Residency, and Maintenance Charges in Idaho State Veterans Homes and Division of Veterans Services Administrative Procedure," shall apply herein. (7-1-00)T

007. CALCULATION OF MAXIMUM CHARGES.

The maximum monthly nursing care charge at the Idaho State Veterans Homes shall be established by the Division Administrator with the advice of the Veterans Affairs Commission. Said amount shall be uniform for all three (3) Veterans Homes. (7-1-00)T

008. -- 999. (RESERVED).

IDAPA 21 - DIVISION OF VETERANS SERVICES
21.01.04 - RULES GOVERNING EMERGENCY RELIEF FOR VETERANS
DOCKET NO. 21-0104-0001 (REPEAL)
NOTICE OF TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is July 1, 2000.

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 Section 65-202, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking are scheduled for:

Thursday, October 12, 2000, 7:00 p.m. to 9:00 p.m.
West Conference Room J. R. Williams Building
700 W. State, Boise, Idaho

The hearing site 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:

This chapter must be repealed to facilitate the Division of Veterans Services' move from the Department of Health and Welfare to the Department of Self Governing Agencies. This move resulted from amendments to Idaho Code Sections 39-106, 65-201, 65-202, 65-204, 66-901, 66-906, 66-907, and 67-2601. These amendments were contained in H0437 which passed the 2000 Idaho Legislature and was signed by the Governor on March 27, 2000. This chapter is being rewritten under Docket No. 21-0102-0002 which is being published in this Bulletin.

TEMPORARY RULE JUSTIFICATION: Pursuant to Sections 67-5226(1)(b) and 67-5226(1)(c), Idaho Code, the Governor has found that temporary adoption of the rule is appropriate for the following reasons:

Compliance with deadlines in amendments to governing law or federal programs.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: Not applicable.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because this action is necessary to comply with amendments to governing law.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Joni Harkless at (208) 334-3513.

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 October 25, 2000.

DATED this 17th day of August, 2000.

Gary Bermeosolo, Administrator
Division of Veterans Services
320 Collins Road, Boise, ID 83702
Phone: (208) 334-3513 Fax: (208) 334-2627

THIS CHAPTER IS BEING REPEALED IN ITS ENTIRETY.

IDAPA 22 - IDAHO STATE BOARD OF MEDICINE

**22.01.01 - RULES OF THE BOARD OF MEDICINE FOR LICENSURE TO PRACTICE MEDICINE
AND SURGERY AND OSTEOPATHIC MEDICINE AND SURGERY**

DOCKET NO. 22-0101-0001

NOTICE OF PROPOSED RULE

AUTHORITY: In compliance with Sections 67-5224 and 67-5226, Idaho Code, notice is hereby given that this agency has proposed rulemaking. The action is authorized pursuant to Section 54-1806 (2), 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 October 18, 2000.

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 statement in nontechnical language of the substance of the proposed rule:

This rule change is required to comply with a recent Idaho Supreme Court decision stating that sections of current rules that define sexual relations with patients as a standard of care violation exceed the statutory authority of the agency. Clarification is added to a section of the rules relating to physical or mental illness to comply with federal Americans with Disabilities Act requirements. References to an agency that performed foreign medical school site reviews are removed, as the agency no longer performs that function. Reference to annual license issue and renewal are removed to allow two-year licensure. Interview language is changed to reflect change to statute (HB215).

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: NONE

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because the rulemaking is being done to comply with Idaho Supreme Court decision and federal guidelines.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Nancy M. Kerr, Idaho State Board of Medicine, (208) 327-7000.

Anyone can submit written comments regarding this proposed rule. All written comments and data concerning the rule must be directed to the undersigned and must be postmarked on or before October 25, 2000.

DATED this 11th day of August 2000.

Nancy M. Kerr
Executive Director
Idaho State Board of Medicine
1755 Westgate Drive
PO Box 83720
Boise, Idaho 83720-0058
(208) 327-7000, Fax (208) 327-7005

THE FOLLOWING IS THE TEXT OF DOCKET NO. 22-0101-0001

000. LEGAL AUTHORITY.

Pursuant to ~~Idaho Code~~, Sections 54-1806(2), 54-1806(11), and Section 54-1806A, Idaho Code, the Idaho State Board of Medicine is authorized to promulgate rules to govern the practice of Medicine in Idaho. ~~(7-1-93)~~(____)

(BREAK IN CONTINUITY OF SECTIONS)

051. LICENSURE BY WRITTEN EXAMINATION.

01. Application. Each applicant must have graduated from an acceptable school of medicine and completed one (1) year of postgraduate training approved by the Liaison Committee on Graduate Medical Education, the American Osteopathic Association or the Board, and shall submit completed written application to the Board on forms prescribed by the Board seventy-five (75) days prior to the written examination date, together with the application and examination fees. The application form shall be verified and shall require the following: (7-1-93)

a. The education background of the applicant including his college education, medical school education and postgraduate training; (7-1-93)

b. A certificate of graduation from an acceptable school of medicine, and evidence of satisfactory completion of postgraduate training; (7-1-93)

c. The disclosure of any criminal charges, convictions or guilty pleas against the applicant other than minor traffic offenses; (7-1-93)

d. The current mental and physical condition of the applicant, together with disclosure of any previous physical or mental illness which impacts the applicant's ability to practice medicine; ~~(7-1-93)~~(____)

e. The disclosure of any past or pending medical malpractice actions against the applicant, and the settlements, if any, of such claims; (7-1-93)

f. The disclosure of any disciplinary action by any state board of medicine, medical society, professional society, hospital or institution staff; (7-1-93)

g. The disclosure of the refusal to issue a license to practice medicine by any other state; (7-1-93)

h. References; (7-1-93)

i. An unmounted photograph of the applicant, three inches by three inches (3" x 3"), taken not more than one (1) year prior to the date of the application; (7-1-93)

j. A certified copy of the applicant's fingerprints on forms supplied by the board which shall be forwarded to the Idaho Department of Law Enforcement to the FBI Identification Division for a criminal history record check; (7-1-93)

k. Such other information or examinations as the Board deems necessary to identify and evaluate the applicant's credentials and competency. (7-1-93)

02. Examination. Each applicant must pass an examination conducted by or acceptable to the Board which shall thoroughly test the applicant's fitness to practice medicine. If an applicant fails to pass the examination on two (2) separate occasions, the applicant shall not be eligible to take the examination for at least one (1) year, and before taking the examination again, the applicant must make a showing to the Board that he has successfully engaged in a course of study for the purpose of improving his ability to engage in the practice of medicine. Applicants who fail two (2) separate examinations in another state, territory, or district of the United States or Canada, must make the same showing of successful completion of a course of study prior to examination for licensure. (7-1-93)

03. Interview. Each applicant ~~shall~~ may be personally interviewed by the Board or a designated committee of the Board. The interview shall include a review of the applicant's qualifications and professional credentials. (7-1-93)(____)

04. Applicants. All applicants must appear to be examined or receive their license within one (1) year unless extended by the Board after filing an application. (7-1-93)

052. LICENSURE BY WRITTEN EXAMINATION FOR GRADUATES OF MEDICAL SCHOOLS LOCATED OUTSIDE OF THE UNITED STATES AND CANADA.

01. Foreign Graduate. In addition to meeting the requirements of Section 051, graduates of medical schools located outside of the United States and Canada must submit to the Board: (3-19-99)

a. An original certificate from the Educational Commission for Foreign Medical School Graduates or must submit documentation that the applicant has passed the examination either administered or recognized by the Educational Commission for Foreign Medical School Graduates; and IDAPA 22.01.01. (7-1-93)

b. Evidence directly from the foreign medical school which establishes to the satisfaction of the Board that the foreign medical school meets the standards for medical educational facilities set forth in Subsection 052.02; and (3-19-99)

c. An Affidavit from the foreign medical school that to its knowledge no state of the United States has refused to license its graduates on the grounds that the school fails to meet reasonable standards for medical education facilities. (7-1-93)

d. A complete transcript from the medical school showing the courses taken and grades received. (7-1-93)

02. Requirements. A foreign medical school must meet and comply with the following requirements: (7-1-93)

a. The degree issued must be comparable to the degrees issued by medical schools located within the United States or Canada. (7-1-93)

b. If the foreign medical school issued its first M.D. degrees after 1975, the school must ~~complete a standard questionnaire and~~ provide a site visit or documented evidence of equivalent evaluation efforts acceptable to the Board is required. (7-1-93)(____)

c. If the foreign medical school issued valid degrees prior to 1975, the Board, in its discretion may require ~~completion of a standard questionnaire~~; a site visit; ~~or both~~. (7-1-93)(____)

d. A site visit of the school, when required, must be financed by the school. The visiting team shall consist of at least one (1) member of the Board; one (1) consultant, a clinical medical educator acceptable to the Board; one (1) consultant, a basic science educator acceptable to the Board; such administrative support personnel as deemed necessary. The school will be required to pay consultant fees and expenses. (7-1-93)

e. The Board may waive the site visit requirement if: (7-1-93)

i. ~~A visiting team of the Federation of State Medical Boards has visited the campus and makes the results of its study available to the Board; or~~ (7-1-93)

ii. Information assembled by a similarly or comparably constituted site visit team is available from another state licensing board; or (7-1-93)

iii. In the case of review for renewal of approval. (7-1-93)

~~f. The standard questionnaire will be the questionnaire of the Federation of State Medical Boards of the United States, Inc., covering legal authority to operate, ownership, history of operation, enrollment, programs, fees, educational program, administration, student characteristics, clinical teaching facilities, student affairs, faculty, finances, plant, library, basic sciences, graduate education, continuing education, research, and such other information as may be relevant. (7-1-93)~~

g. All schools approved by the Board will be subject to review of approval as deemed necessary by the Board, taking into consideration need and feasibility. (7-1-93)

h. The Board will review all available information in considering approval, including investigative reports by other states, national and international agencies, and may consider the comparative performance of graduates with those of other schools on standard examination. (7-1-93)

03. Postgraduate Training. The foreign medical school graduate must submit documentation that the applicant has satisfactorily completed three (3) years of postgraduate training in a program which is located in the United States or Canada, which is approved for such training by the Liaison Committee on Graduate Medical Education and which is conducted under the direction of an acceptable school of medicine; provided however, applicants who do not have an ECFMG certificate must also submit documentation that their three (3) years of postgraduate training included at least one (1) academic year of supervised clinical training conducted under the direction of an acceptable school of medicine. (7-1-93)

04. ECFMG. The certificate from the Educational Commission for Foreign Medical School Graduates is not required if the applicant holds a license to practice medicine which was issued prior to 1958 in one (1) of the states of the United States and which was obtained by written examination. (7-1-93)

05. English Language. The foreign medical student applicant must be able to speak, write and read the English language. (7-1-93)

(BREAK IN CONTINUITY OF SECTIONS)

076. LICENSURE BY ENDORSEMENT.

01. Endorsement. A license to practice medicine may be granted by endorsement without written examination to an applicant (including an applicant who has graduated from a foreign medical school) who submits a completed written application to the Board on forms furnished by the Board, together with the necessary application fee. The application form shall be verified and in addition to the information required by Section 051 or Subsection 052.02, as applicable, the following additional information shall be required: (3-19-99)

- a. The employment history and practice location of the applicant; (7-1-93)
- b. Each state in which the applicant has applied for a license to practice medicine; (7-1-93)
- c. Each state wherein the applicant is licensed to practice medicine. (7-1-93)

02. Qualifications. The applicant must also have any one (1) of the following qualifications: (7-1-93)

- a. The applicant is a diplomat of the National Board of Medical Examiners or the National Board of Examiners for Osteopathic Physicians and Surgeons; (7-1-93)
- b. The applicant holds a valid, unrevoked, unsuspended license to practice medicine and surgery, or osteopathic medicine and surgery in a state, territory or district of the United States or Canada obtained after an equivalent written examination as required by Subsection 051.02; (3-19-99)
- c. The applicant has earned a D.O. degree issued after January 1, 1963, and holds a valid, unrevoked,

unsuspended license to practice osteopathic medicine and surgery in an unlimited state, territory or district of the United States, which in the Board's opinion maintains standards equivalent to Idaho. The term "unlimited state" means a state where a composite examining board exists, where medical doctors and osteopaths take the same examination, and where a license to practice osteopathy includes authorization to practice unlimited medicine and surgery, these requirements being in effect at the time of licensure. (7-1-93)

03. Interview. Each applicant ~~shall~~ may be personally interviewed by the Board or a designated committee of the Board. The interview shall include a review of the applicant's qualifications and professional credentials. (~~7-1-93~~)(____)

04. Health Care Standards. In reviewing the application or conducting the applicant's interview, the Board shall determine whether the applicant possesses the requisite qualifications to provide the same standard of health care as provided by licensed physicians in this state. If the Board is unable to reach such a conclusion through the application and interview, it shall conduct further written or oral examination, or both, to establish such qualifications. (7-1-93)

a. If further written examination is required, the Board may require passage of Part 2 of the Federation Licensing Examination (FLEX) or the Specialty Purpose Examination (SPEX) prepared by the Federation of State Medical Boards of the United States. (7-1-93)

b. If further oral examination is required, the Board may utilize either of two (2) oral examinations: (7-1-93)

i. A test administered by a member of the Board testing responses to clinical situations; or (7-1-93)

ii. A test prepared by a physician practicing in the appropriate specialty, consisting of no less than twelve (12) questions selected to determine current clinical awareness. (7-1-93)

c. The Board will require further written or oral examination when in its judgement the need is apparent, including but not limited to the following circumstances: (7-1-93)

i. Graduate of a foreign medical school not accredited by the Liaison Committee on Medical Education; (7-1-93)

ii. Applicant whose background investigation reveals evidence of impairment or competency deficit; (7-1-93)

iii. When the applicant has not been in active practice for a period exceeding one (1) year, or when practice has been significantly interrupted; (7-1-93)

iv. When the applicant has not written a recognized examination intended to determine ability to practice medicine within a period of five (5) years preceding application; (7-1-93)

v. When the applicant received initial licensure on the basis of an examination not listed in Section 051 of this policy; or (3-19-99)

vi. When there is any reason whatsoever to question the identity of the applicant. (7-1-93)

d. Oral Examinations will be administered by at least two (2) physicians, licensed in Idaho, at least one (1) a member of the Board. (7-1-93)

05. Failure To Pass Examination. (7-1-93)

a. When an applicant fails to pass the oral examination, he may be offered an opportunity to take a current clinical written examination acceptable to the Board. (7-1-93)

b. When an applicant fails to achieve a passing score in the clinical written examination, he may be

offered an opportunity to write the Federation Licensing Examination, whether or not he has previously written this examination. (7-1-93)

c. Each applicant who has failed a licensing examination, a current competency written examination, or the Board oral examination, will be required to appear for a personal interview with the Board at a regularly scheduled meeting. (7-1-93)

(BREAK IN CONTINUITY OF SECTIONS)

078. INACTIVE LICENSE.

01. Converted License. Any license issued by the Board may be converted to an inactive license on the condition that the licensee will not engage in the practice of medicine in this state. An inactive license fee shall be collected by the Board. (7-1-93)

02. Issuance Of Inactive License. Any applicant who is entitled to be issued a license to practice medicine may be issued, upon request, an inactive license to practice medicine on the condition that he will not engage in the practice of medicine in this state. An inactive license fee shall be collected by the Board. (7-1-93)

03. Annually Renewed. Inactive licenses shall be issued for a period ~~up to~~ of not less than one (1) year or more than five (5) years and such licenses shall be renewed ~~annually~~ upon payment of an inactive license renewal fee. The inactive license certificate shall set forth its date of expiration. (7-1-93)(____)

04. Inactive To Active License. An inactive license may be converted to an active license to practice medicine by application to the Board and payment of required fees. Before the license will be converted the applicant must account for the time during which an inactive license was held. The Board may, in its discretion, require a personal interview. (7-1-93)

079. LICENSES.

01. Licensure Expiration. Each license to practice medicine shall be issued for a period of not less than one (1) year ~~and~~ or more than five (5) years. Each license shall set forth its expiration date on the face of the certificate. The Board may condition the issuance of such a license for the full term upon the occurrence of events specified by the Board and the Board may extend a license for an intermediate period of time. (7-1-93)(____)

02. Renewal. Each license to practice medicine may be renewed prior to its expiration date by the payment of a renewal fee to the Board and by completion of a renewal form provided by the Board. In order to be eligible for renewal, a licensee must provide a current address to the Board and must notify the Board of any change of address during the renewal period. Licenses not renewed by their termination date shall be canceled. (4-2-93)

03. Reinstatement. Licenses canceled for nonpayment of ~~yearly~~ renewal fees may be reinstated by filing a reinstatement application on forms prescribed by the Board and upon payment of a reinstatement fee. (7-1-93)(____)

04. Relicensure. Persons whose licenses have been canceled for a period of more than five (5) years, shall be required to make application to the Board as new applicants for licensure. (7-1-93)

(BREAK IN CONTINUITY OF SECTIONS)

101. ADDITIONAL GROUNDS FOR SUSPENSION, REVOCATION OR DISCIPLINARY SANCTIONS.

01. Discipline. In addition to the statutory grounds for medical discipline set forth in Idaho Code, Section 54-1814, every person licensed to practice medicine or registered as an extern, intern, resident or physician's assistant is subject to discipline by the board upon any of the following grounds: (7-1-93)

02. Unethical Advertising. Advertising the practice of medicine in any unethical or unprofessional manner, includes but is not limited to: (7-1-93)

a. Using advertising or representations likely to deceive, defraud or harm the public. (7-1-93)

b. Making a false or misleading statement regarding his or her skill or the efficacy or value of the medicine, treatment or remedy prescribed by him or her at his or her direction in the treatment of any disease or other condition of the body or mind. (7-1-93)

03. Standard Of Care. Providing health care which fails to meet the standard of health care provided by other qualified physicians in the same community or similar communities, includes but is not limited to: (7-1-93)

a. Being found mentally incompetent or insane by any court of competent jurisdiction. (7-1-93)

b. Engaging in practice or behavior that demonstrates a manifest incapacity or incompetence to practice medicine. (7-1-93)

c. Allowing another person or organization to use his or her license to practice medicine. (7-1-93)

~~d. Commission of any act of sexual contact, misconduct, exploitation or intercourse with a patient or former patient or related to the licensee's practice of medicine. (7-1-93)~~

~~i. Consent of the patient shall not be a defense. (3-19-99)~~

~~ii. Section 101 does not apply to sexual contact between a medical care provider and the provider's spouse or a person in a domestic relationship who is also a patient. (3-19-99)~~

~~iii. A former patient includes a patient for whom the physician has provided medical services or prescriptions within the last twelve (12) months. (3-19-99)~~

~~iv. Sexual or romantic relationships with former patients beyond that period of time may also be a violation if the physician uses or exploits the trust, knowledge, emotions or influence derived from the prior professional relationship with the patient. (3-19-99)~~

~~ed. Prescribing, selling, administering, distributing or giving any drug legally classified as a controlled substance or recognized as an addictive or dangerous drug to himself or herself or to a spouse, child or stepchild. (3-19-99)~~

~~fe. Violating any state or federal law or regulation relating to controlled substances. (7-1-93)~~

~~gf. Directly promoting surgical procedures or laboratory tests that are unnecessary and not medically indicated. (7-1-93)~~

~~hg. Failure to transfer pertinent and necessary medical records to another physician when requested to do so by the subject patient or by his or her legally designated representative. (7-1-93)~~

04. Conduct. Engaging in any conduct which constitutes an abuse or exploitation of a patient arising out of the trust and confidence placed in the physician by the patient, includes but is not limited to: (7-1-93)

a. Obtaining any fee by fraud, deceit or misrepresentation. (7-1-93)

b. Employing abusive billing practices. (7-1-93)

- c. Failure to transfer pertinent and necessary medical records to another physician when requested to do so by the subject patient or by his or her legally designated representative. (7-1-93)
- d. Commission of any act of sexual contact, misconduct, exploitation or intercourse with a patient or former patient or related to the licensee's practice of medicine. (7-1-93)
 - i. Consent of the patient shall not be a defense. (3-19-99)
 - ii. Section 101 does not apply to sexual contact between a medical care provider and the provider's spouse or a person in a domestic relationship who is also a patient. (3-19-99)
 - iii. A former patient includes a patient for whom the physician has provided medical services or prescriptions within the last twelve (12) months. (3-19-99)
 - iv. Sexual or romantic relationships with former patients beyond that period of time may also be a violation if the physician uses or exploits the trust, knowledge, emotions or influence derived from the prior professional relationship with the patient. (3-19-99)

IDAPA 23 - IDAHO BOARD OF NURSING
23.01.01 - RULES OF THE IDAHO BOARD OF NURSING
DOCKET NO. 23-0101-0001
NOTICE OF PROPOSED RULE

AUTHORITY: In compliance with Section 67-5220(1), Idaho Code, notice is hereby given that this agency has proposed rulemaking. The action is authorized pursuant to Section 54-1404(a), 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 October 18, 2000.

The hearings 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:

The proposed rulemaking is a clarification of existing rules for temporary licensure, license renewal and reinstatement, the rules dealing with graduates of nursing schools located outside the United States or its territories, and the rules governing nurse apprentices and others exempted from licensure by the Board. The rules include changes in fees and a provision for a returned check fee. New rules create a framework for the issuance of licenses and wallet certificates, and clarify that, with the exception of advanced practice professional nurses, one individual may hold only one license at any time. Several rules are being eliminated or combined with others in a general housekeeping effort.

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

Renewal/reinstatement fees are being increased by \$5; licensure fees are being increased \$15 for licensed professional and licensed practical nurses and \$50 for advanced practice professional nurses; the endorsement licensure fee is increased by \$10; the temporary license fee by \$10; the limited license fee by \$10; the license verification fee by \$15; and the advanced practice authorization fee by \$40. The fees charged for evaluation of educational programs are being revised to allow charges of up to \$250 for nursing education programs and \$500 for programs offered by commercial establishments.

NEGOTIATED RULEMAKING: Pursuant to IDAPA 04.11.01.811, negotiated rulemaking was not conducted because of the nature of the proposed changes.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Sandra Evans, Executive Director, at (208) 334-3110.

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, 2000.

DATED this 22nd day of August 2000.

Sandra Evans
Executive Director
Idaho Board of Nursing
280 N. 8th St., Ste. 210
P. O. Box 83720
Boise, ID 83720-0061
Telephone: (208) 334-3110
Facsimile: (208) 334-3262

THE FOLLOWING IS THE TEXT OF DOCKET NO. 23-0101-0001

000. LEGAL AUTHORITY.

~~This chapter is adopted in accordance with Section 54-1404(9) and 54-1402(d), Idaho Code, the Board of Nursing shall make, adopt and publish rules pursuant to Chapter 52, Title 67, Idaho Code, as may be necessary or appropriate to carry out the provisions and purposes of the Nursing Practice Act. (7-1-93)()~~

(BREAK IN CONTINUITY OF SECTIONS)

002. PHILOSOPHY AND OBJECTIVES INCORPORATION BY REFERENCE.

~~There are no documents that have been incorporated by reference into these rules. ()~~

- ~~**01. Philosophy.** The Idaho Board of Nursing believes that: (7-1-93)~~
- ~~a. Nursing is an essential social service that meets health care needs of clients in various settings in our society. (5-21-79)~~
 - ~~b. Adequate health care is a right of every individual. The primary means that the Board of Nursing has to assure the consumer access to competent practitioners is the licensing process, the approval of educational programs and the improvement of practice through governing procedures. (11-28-84)~~
 - ~~c. Clients have the right to be active participants in the planning and evaluating of their health care. (11-28-84)~~
 - ~~d. The Board of Nursing contributes to the protection of the consumer by ensuring that nurses practice within their respective scopes of preparation. (11-28-84)~~
 - ~~e. In order for practitioners to remain competent and current, there must be a commitment to continuing education. (5-21-79)~~
 - ~~f. Research is an essential component of nursing that describes, explains, or predicts phenomena. (11-28-84)~~
 - ~~g. Research findings contribute to the body of nursing knowledge. (11-28-84)~~
 - ~~h. Consultation services for faculty and schools of nursing, nursing service administrators, and practitioners of nursing are an integral part of the Board of Nursing's mandate. (5-21-79)~~
 - ~~i. Because of the complexity of the health care delivery system and the role changes that are occurring in the various health professions, it is essential that effective communication be maintained with local, state, and national nursing organizations, health agencies, governmental units, schools of nursing and health care providers. (5-21-79)~~
- ~~**02. Objectives.** The Idaho Board of Nursing, as an advocate for consumers of health care, will: (7-1-93)~~
- ~~a. Implement the Nursing Practice Act by promulgating and enforcing rules to protect the public health, safety, and welfare. (7-1-93)~~
 - ~~b. Determine criteria for the evaluation and approval of programs preparing practitioners of nursing. (11-28-84)~~

- ~~e. Establish standards for nursing practice to assure the safety of patients/clients and promote quality care. (5-21-79)~~
- ~~d. Collaborate with other agencies in the development, implementation, and evaluation of programs designed to meet specific health care needs in Idaho. (11-28-84)~~
- ~~e. Promote the maintenance and enhancement of knowledge and skills essential for assuring competent nursing practice. (5-21-79)~~
- ~~f. Establish the standards and implement the process necessary for initial and continuing licensure to practice nursing. (5-21-79)~~
- ~~g. Conduct, facilitate, and evaluate research that will promote safe, quality health care. (7-1-93)~~
- ~~h. Implement research findings that will contribute to the safety and well-being of the consumers of nursing care. (11-28-84)~~

003. WRITTEN INTERPRETATIONS.

In accordance with Sections 54-1401 through 54-1416~~7~~, Idaho Code, this Board has written statements which pertain to the interpretation of the rules of this chapter, or to the documentation of compliance with the rules of this chapter. These documents are available for public inspection ~~and copying at cost~~ at the Board office. (7-1-93)()

(BREAK IN CONTINUITY OF SECTIONS)

005. PUBLIC RECORDS.

~~The records associated with the~~ Board of Nursing records are subject to the provisions of the Idaho Public Records Act, Title 9, Chapter ~~13~~, Idaho Code. (7-1-93)()

006. OFFICE--OFFICE HOURS--MAILING ADDRESS AND STREET ADDRESS INFORMATION.

- 01. Street Address. The offices of the Board of Nursing are located at 280 North Eighth Street, Boise, Idaho. ()
- 02. Mailing Address. The mailing address of the Board is P.O. Box 83720, Boise, Idaho 83720-0061. ()
- 03. Telephone Number. The telephone number of the Board is (208) 334-3110. ()
- 04. Telecommunications. A TDD or telecommunications device for the deaf is available at (800) 377-3529. ()
- 05. Facsimile. The Board's FAX number is (208) 334-3262. (7-1-93)()
- 06. Electronic Address. The Board's web address is www2.state.id.us/ibn/ibnhome.htm. ()

007. FILING OF DOCUMENTS.

All ~~filings for~~ written communications and documents that are intended to be part of an official record for decision in a rulemaking or contested cases must be filed with the executive director of the Board of Nursing. One (1) original is sufficient for submission to the hearing officer, with one (1) copy for the Board of Nursing and one (1) copy submitted to the opposing party. Whenever documents are filed by facsimile transmission (FAX), originals shall be deposited in the mail the same day or hand delivered the following business day to the hearing officer or the Board of Nursing, and opposing parties. (7-1-93)()

008. CHANGES IN NAME AND ADDRESS -- ADDRESS FOR NOTIFICATION PURPOSES.

01. Change Of Name. Whenever a change of licensee name occurs, the board must be immediately notified of the change. Documentation confirming the change of name must be provided to the board on request. ()

02. Change Of Address. Whenever a change of licensee mailing address occurs, the board must be immediately notified of the change. ()

03. Address For Notification Purposes. The most recent mailing address on record with the board will be utilized for purposes of all written communication with the licensee including, but not limited to, notification of renewal and notices related to disciplinary actions. ()

~~008.~~ 009. (RESERVED).

(BREAK IN CONTINUITY OF SECTIONS)

040. TEMPORARY LICENSE.

01. Issued At Discretion Of Board. Temporary licenses are issued at the discretion of the Board. (6-1-78)

02. Applicant For Licensure By Interstate Endorsement - Current Licensure In Another State. A temporary license may be issued to an applicant for interstate endorsement on proof of current licensure in good standing in another state, ~~filing of the completed application form, and payment of the required fees~~ satisfactory documentation of employment within the three (3) years immediately preceding application, and compliance with the requirements of Section 242 of these rules. (6-1-78)()

03. ~~Idaho Graduates~~ - Applicant For Licensure By Examination. A temporary license to practice nursing until notification of examination results may be issued to an applicant for Idaho licensure following graduation from an ~~Idaho approved~~ nursing education program recognized by the professional licensing board for nursing of any state or territory of the United States, and compliance with Section 221 of these rules. (6-11-93)()

04. ~~Out-Of-State Graduates - Examination.~~ ~~A temporary license to practice nursing until notification of examination results may be issued to an applicant following graduation from a nursing education program in another state or territory of the United States.~~ (6-11-93)

05. ~~Out-Of-State Graduates - Endorsement.~~ ~~A temporary license to practice nursing until notification of examination results may be issued to a graduate of an approved nursing education program in another state or territory of the United States.~~ (6-11-93)

06a. ~~Limitation Of Practice - New Graduates.~~ The practice of nursing by new graduates holding temporary licensure shall be limited as follows: (11-28-84)()

a.i. Direct supervision by a ~~registered~~ licensed professional nurse must be provided. (11-28-84)()

b.ii. Charge responsibilities may not be assumed. (11-28-84)

b. Terms of temporary licenses issued to examination candidates are as follows: ()

i. Temporary licenses will be issued for a period of no more than three (3) months. ()

- ii. Temporary licenses are not renewable. ()
- 074. Unsuccessful Examination Candidates.** (6-11-93)
- a. An applicant who fails to pass the licensing examination shall not be eligible for further temporary licensure. ~~(6-11-93)~~()
- b. ~~Failure candidates who~~ In the event that such applicant subsequently passes the licensing examination after ~~eighteen~~ twelve (12) months or more have elapsed following completion of the educational program, ~~will be issued~~ a temporary license with conditions may be issued until verification of clinical competence is received. ~~(6-11-93)~~()
- 085. Applicants ~~Who Have Been Inactive~~ Not In Active Practice.** A temporary license with specific terms and conditions may be issued to a person who has not actively engaged in the practice of nursing in any state for more than three (3) years immediately prior to the application for licensure or to an applicant whose completed application indicates the need for confirmation of the applicant's ability to practice safe nursing. ~~Conditions may include, but need not be limited to:~~ ~~(11-28-84)~~()
- a. ~~Completion of a Board approved educational program including clinical experience for re-entry into practice.~~ ~~(11-28-84)~~
- b. ~~Working under direct supervision for a specified length of time in an agency approved by the Board.~~ ~~(11-28-84)~~
- e. ~~Obtaining reports from the employing agency on the performance of the applicant.~~ ~~(6-1-78)~~
- 096. Applicants From Other Countries.** Upon final evaluation of the completed application, the Board may, at its discretion, issue a temporary license to a graduate from a nursing education program outside of the United States or its territories, pending notification of results of the licensing examination. (6-11-93)
- ~~10. Reinstatement Applicants. A temporary license may be issued to a person whose license has lapsed for more than one (1) year, but less than three (3) years, upon receipt of the completed application, the census questionnaire, and the required fees. (11-28-84)~~
- ~~11. Reinstatement Applicants Currently Licensed In Another State. A temporary license may be issued to persons whose Idaho licenses have lapsed for more than one year, upon receipt of the completed application, the census questionnaire, proof of current licensure in another state, and the required fees. (11-28-84)~~
- 1207. Fee.** The applicant must pay the temporary license fee, as prescribed in Subsection 901.03 of these rules. (7-1-93)

(BREAK IN CONTINUITY OF SECTIONS)

- 060. ~~RENEWAL OF LICENSE AND REINSTATEMENT OF A LAPSED LICENSE~~ RENEWAL.**
All licenses must be renewed as prescribed in the Section 54-14101, Idaho Code. ~~(7-1-93)~~()
- 01. Renewal Application - Licensed Professional Nurse.** A renewal application ~~with census questionnaire~~ will be mailed to every currently licensed professional nurse, at the address on record with the Board, on or before July 1 of every odd-numbered year. ~~(11-28-84)~~()
- 02. Renewal Application - Licensed Practical Nurse.** A renewal application ~~with census questionnaire~~ will be mailed to every currently licensed practical nurse, at the address on record with the Board, on or before July 1 of every even-numbered year. ~~(6-1-78)~~()

03. Renewal Application - Advanced Practice Professional Nurse. A renewal application will be mailed to every advanced practice professional nurse, at the address on record with the Board, on or before July 1 of every odd-numbered year. ()

034. Final Date To Renew. The original signed renewal application, ~~completed census questionnaire,~~ and renewal fee as prescribed in Section 900 of these rules, must be submitted to the Board and post-marked not later than August 31 of the appropriate renewal year. (7-1-93)()

045. Date License Lapsed. Licenses not renewed prior to September 1 of the appropriate year will be lapsed and therefore invalid. (11-28-84)

056. Effective Period. Renewed ~~certificates~~ licenses shall be effective for a two (2) year period, from September 1 of the renewal year. (7-1-93)()

~~**06. Performance Evaluation. Prior to renewal of a license, the Board may require a recent performance evaluation if the Board has evidence of a prior or current problem which could affect an individual's physical or mental health or competence.**~~ (5-21-89)

061. LATE RENEWAL OR REINSTATEMENT OF A LAPSED LICENSE.

01. Reinstatement Within One Year (Late Renewal). A person whose license has lapsed for failure to pay the renewal fee by the specified date may apply for reinstatement within one (1) year by: (7-1-93)()

- a. Filing a completed ~~census questionnaire~~ renewal application; and (11-28-84)()
- b. Payment of the verification of records fee and the renewal fee as prescribed in Subsection 900.03 of these rules. (7-1-93)

02. Reinstatement After One Year. ~~After one (1) year, but less than three (3) years, A~~ a person whose license has lapsed for failure to pay the renewal fee by the specified date may apply for reinstatement ~~after more than one (1) year~~ by: (7-1-93)()

- a. Filing a completed reinstatement application; and (6-1-78)()
- b. ~~Filing a census questionnaire; and~~ (6-1-78)
- e**b.** Payment of the verification of records fee and the renewal fee as prescribed in Subsection 900.03 of these rules; and (7-1-93)
- d**c.** ~~Enabling~~ Providing evidence satisfactory to the Board to obtain a satisfactory nursing employer reference if of the applicant's was employed during the five (5) years immediately preceding application ability to practice safely and competently. (7-1-93)()

03. Reinstatement After Three Years. After three (3) years, a person whose license has lapsed for failure to timely pay the renewal fee may apply for reinstatement by: ()

- a. Filing a completed application; and ()
- b. Payment of the verification of records fee and the renewal fee as prescribed in Subsection 900.03 of these rules; and ()
- c. Complying with the requirements of Subsection 040.07 of these rules; and ()
- d. Providing evidence satisfactory to the Board of the applicant's ability to practice safely and competently. ()

062. -- 074~~5~~. (RESERVED).

075. EXCEPTIONS IN LICENSURE LAW.

In accordance with Section 54-1411, Idaho Code, licensure to practice nursing shall not be required, nor shall the practice of nursing be prohibited for: (6-1-78)

~~01. **Emergency.** Persons assisting in an emergency; or~~ (6-1-78)

~~02. **Students.** Students enrolled in approved nursing education programs performing functions incident to formal instruction; or~~ (6-1-78)

~~03. **Government Employees.** Nurses licensed by another state, territory or country and employed by the United States Government performing official duties; or~~ (6-1-78)

~~04. **Religious Tenets.** Persons rendering nursing services or care of the sick when done in connection with the practice of the religious tenets of any church by adherents thereof; or~~ (6-1-78)

~~05. **Correctional Institutions.** Medical attendants of the Department of Corrections at its correctional institutions.~~ (6-1-78)

076. PERSONS EXEMPTED BY BOARD.

Licensure to practice nursing shall not be required, nor shall the practice of nursing be prohibited for persons exempted by the Board including: (11-28-84)

~~01. **Non-Resident Nurses.** Non-resident nurses, currently licensed in good standing in another state, who are practicing in Idaho on the basis of one (1) temporary engagement not to exceed thirty (30) days in length, including but not limited to transport teams, Red Cross Bloodmobile personnel, nurses presenting educational programs; or other non-resident nurses performing temporary nursing services of an emergency nature, which services are of a general public benefit.~~ (7-1-93)

021. Technicians. Technicians who are enrolled in Board-recognized programs of training or who are registered or certified by Board-recognized appropriate national bodies and are employed in state licensed or certified health care facilities, performing within the ordinary and customary roles in their field. (6-1-78)

~~032. **Non-Resident Nurses-Enrolled In Courses.** Non-resident nurses currently licensed in good standing in another state, who are in Idaho on a temporary basis because of enrollment in or presentation a short term Board-approved course of instruction recognized or approved by the Board and who are performing functions under supervision incident to formal instruction.~~ (5-21-89)(____)

043. Family Members And Others. (7-1-93)

a. Family members providing care to a person to whom they are related by blood, marriage, adoption, legal guardianship or licensed foster care. (5-21-89)

b. Non-family members who provide gratuitous care to a person on a temporary basis in order to give respite to family members who regularly provide care to that person. (5-21-89)

c. Live-in domestics, housekeepers and companions, provided they do not represent themselves as nor receive compensation as licensed nurses or other nursing care providers and so long as any health care provided is incidental to the services for which they are employed. *Live-in aides placed by an organized health care agency and live-in nursing students may not administer medications by injection, but may only assist with medications as defined by the Board of Nursing.* (5-21-89)(____)

054. Nurse Apprentice. A nurse apprentice is a currently enrolled nursing student who is employed for remuneration in a non-licensed capacity by a Board approved health care agency. *Nurse Apprentice I is a nursing student who has satisfactorily completed a basic nursing fundamentals course. Nurse Apprentice II is a nursing student who has satisfactorily completed one (1) academic year of an approved professional nursing education*

- ~~program.~~ (7-1-93)(____)
- 06a. Qualifications.** Applicants for ~~N~~nurse ~~A~~pprentice ~~I/II~~ shall: (6-20-92)(____)
- ~~a~~i. Be enrolled in an accredited/approved nursing education program that is substantially equivalent to Idaho's approved programs for practical/professional nursing. (6-20-92)
- ~~b~~ii. Be in good academic standing at the time of application and notify the Board of any change in academic standing. (6-20-92)
- ~~e~~iii. Meet the employing agency's health care ~~agency~~ skills validation requirements. (6-20-92)(____)
- ~~d~~iv. ~~Perform only those functions approved by the Board of Nursing and not endanger patients by exceeding the Board-approved scope of practice or by exceeding own knowledge base~~ Satisfactorily complete a basic nursing fundamentals course. (6-20-92)(____)
- ~~e.~~ ~~Adhere to employing agency policies.~~ (6-20-92)
- ~~f.~~ ~~Follow agency procedure for refusing an assignment when there is concern for patient safety and welfare.~~ (6-20-92)
- ~~g~~v. ~~Wear a name badge and~~ Use obvious designations that identify ~~him~~ the applicant as a nurse apprentice ~~I/II~~. (7-1-93)(____)
- 07b. Application.** A completed application for ~~N~~nurse ~~A~~pprentice ~~I/II~~ shall consist of: (6-20-92)(____)
- ~~a~~i. Completed application form provided by the Board, to include a fee of ten dollars (\$10); and (7-1-93)
- ~~b~~ii. Verification of satisfactory completion of a basic nursing fundamentals course ~~for Nurse Apprentice I, and verification of completion of nursing coursework included in one (1) academic year of an approved professional nursing education program for Apprentice II;~~ and (6-20-92)(____)
- ~~e~~iii. Validation of successful demonstration of skills from a nursing education program; and (6-20-92)(____)
- ~~d~~iv. Verification of on-going good academic standing in nursing education program ~~at end of each semester/quarter of enrollment.~~ (6-20-92)(____)
- 08c. Application Approval.** An individual whose application is approved shall be issued a letter identifying the individual as a ~~N~~nurse ~~A~~pprentice ~~I/II~~ for a designated time period. ~~The letter may be reissued upon verification of on-going good academic standing in a nursing education program at the end of each semester/quarter of enrollment.~~ (6-20-92)(____)
- 09d. Scope Of Practice – Nurse Apprentice I.** A ~~N~~nurse ~~A~~pprentice ~~I~~ may, under ~~registered~~ licensed professional nurse supervision, perform all functions approved by the Board of Nursing for ~~auxiliary workers and, in addition, may empty hemovac and assist with oxygen therapy by mask or cannula~~ unlicensed assistive personnel as set forth in Subsection 400.04. (7-1-93)(____)
- 10. Scope Of Practice – Nurse Apprentice II.** A ~~Nurse Apprentice II~~ may, under ~~registered nurse~~ supervision, perform all ~~Nurse Apprentice I~~ functions and, in addition may: (7-1-93)
- ~~a.~~ ~~Assist mothers with breast feeding.~~ (6-20-92)
- ~~b.~~ ~~Suction infants with bulb syringe.~~ (6-20-92)
- ~~e.~~ ~~Catheterize using straight catheter.~~ (6-20-92)

- ~~d. Check for circulation, sensation, movement. (6-20-92)~~
- ~~e. Change non-sterile/sterile dressings. (6-20-92)~~
- ~~f. Apply moist/dry dressings or wet to dry dressings. (6-20-92)~~
- ~~g. Provide hemovac care. (6-20-92)~~
- ~~h. Apply ostomy appliances. (6-20-92)~~
- ~~i. Discontinue peripheral IV. (6-20-92)~~
- ~~j. Collect urine specimen from an indwelling catheter. (6-20-92)~~
- ~~k. Collect specimen from wound drainage. (6-20-92)~~
- ~~l. Remove sutures and staples. (6-20-92)~~
- ~~m. Suction oral, nasal, pharyngeal passages (no tracheal suctioning). (6-20-92)~~
- ~~n. Administer gastrostomy feedings through an established tube. (6-20-92)~~
- ~~o. Assess Homan's sign. (6-20-92)~~
- ~~**II. Employer Qualifications.** Applicants for employers of Nurse Apprentice I/II shall: (6-20-92)~~
 - ~~a. Submit completed application for Board review. (6-20-92)~~
 - ~~b. Develop written procedures/descriptions required by the Board. (6-20-92)~~
 - ~~e. Have Board approval to participate as an agency that employs Nurse Apprentices I/II. (6-20-92)~~
 - ~~d. Submit an annual report to the Board for continuing approval. (6-20-92)~~
- ~~**205. Employer Application. ()**~~
 - ~~a. A completed application for health care agencies wishing to employ ~~N~~nurse ~~A~~pprentices ~~II~~ shall consist of: (6-20-92)()~~
 - ~~a.i. Completed application form provided by the Board; and (6-20-92)~~
 - ~~b.ii. Job descriptions for ~~A~~pprentice-~~II~~; and (6-20-92)()~~
 - ~~c.iii. A written plan for orientation and skill validation; and (6-20-92)~~
 - ~~d.iiii. The name of the ~~registered~~ licensed professional nurse who shall be accountable and responsible for the coordination or management of the nurse apprentice program; and (6-20-92)()~~
 - ~~e.v. Assurance that a ~~fully~~-licensed ~~registered~~ professional nurse is ~~present on-site~~ readily available when nurse apprentice is working. (6-20-92)()~~
 - ~~f.vi. A written procedure for the nurse apprentice who is asked to perform a task that could jeopardize a patient and who declines to perform the task; and (6-20-92)()~~
 - ~~g.vii. A fee of ~~twenty-five~~ one hundred dollars (\$~~25~~100). (7-1-93)()~~

~~13. Approval By Board.~~

~~(7-1-93)~~

~~a.~~ Following application review, the Board may grant approval to a health care agency to employ ~~nurse apprentice~~ ~~for~~ for a period of up to one (1) year. ~~(6-20-92)()~~

~~b.~~ To insure continuing compliance with Board requirements, each approved agency shall submit an annual report to the Board on forms provided by the Board. Based on their findings, the Board may grant continuing approval annually for an additional one (1) year period. (6-20-92)

~~c.~~ At any time, if the employing agency fails to inform the Board of changes in conditions upon which approval was based or otherwise fails to comply with established requirements, the Board may notify the agency of withdrawal of approval. (6-20-92)

(BREAK IN CONTINUITY OF SECTIONS)

260. QUALIFICATIONS FOR LICENSURE OF GRADUATES OF ~~FOREIGN~~ SCHOOLS OF NURSING LOCATED OUTSIDE THE UNITED STATES OR ITS TERRITORIES.

A graduate from a nursing education program outside of the United States or its territories must: ~~(6-1-78)()~~

01. ~~Screening Examination.~~ Pass ~~a screening~~ examination(s), approved by the Board, which ~~tests for~~ demonstrate nursing knowledge and ~~knowledge of written~~ English proficiency; ~~and.~~ ~~(8-31-82)()~~

02. ~~Minimum Requirements Education Credentials.~~ Have education qualifications that are substantially equivalent to Idaho's minimum requirements at the time of application; ~~and.~~ ~~(11-28-84)()~~

03. License. Hold a license in good standing from a country outside the United States or its territories; ~~and.~~ ~~(6-1-78)()~~

04. ~~Licensing Examination.~~ Take ~~the same~~ licensing examination ~~as that administered in Idaho~~ required in Subsection 263.01 and achieve the score determined as passing for that examination by the Board, ~~unless the applicant was licensed in another state or territory of the United States prior to 1965.~~ ~~(6-11-93)()~~

05. ~~Applicants Licensed In Another State Or Territory.~~ Graduates of schools of nursing located outside the United States or its territories who are licensed in a state or territory who meet the requirements of Section 240 may be processed as applicants for licensure by endorsement from another state. ()

261. APPLICATION FOR LICENSURE OF GRADUATES OF ~~FOREIGN~~ SCHOOLS OF NURSING LOCATED OUTSIDE THE UNITED STATES OR ITS TERRITORIES.

A completed application for licensure by a graduate of a nursing education program outside of the United States or its territories must include the following: ~~(7-1-93)()~~

01. ~~Screening Examination Scores Verification.~~ ~~Prior to the submission of an application, an official copy of the applicant's screening examination scores must be received by the Board~~ Verification of demonstrated nursing knowledge and English proficiency; and ~~(7-1-91)()~~

02. Application Form. Completed notarized application form provided by the Board; and (6-1-78)

03. Official Transcript. Official transcript from the applicant's nursing education program, and certified translation if original transcript is not in English or ~~a~~ completed ~~Commission on Graduates of Foreign Nursing Schools (CGFNS) transcript~~ equivalence credentials form (A-2) issued by an organization acceptable to the Board; and ~~(7-1-91)()~~

04. Verification of Licensure. Verification of licensure from state, province, or country of applicant's original licensure; and (6-1-78)

05. **Employment Reference.** One (1) satisfactory nursing employment reference from the ~~five~~ three (3) year period immediately preceding the application; and (7-1-91)()

06. **Fee.** Payment of the ~~F~~fee for licensure by examination ~~as prescribed in Subsection 901.01 of these~~ rules. (7-1-93)()

(BREAK IN CONTINUITY OF SECTIONS)

263. EXAMINATION AND RE-EXAMINATION OF GRADUATES OF FOREIGN SCHOOLS OF NURSING.

01. **Applicants For Professional Nurse Or Practical Nurse Licensure.** Applicants must successfully take the approved examination for professional nurse licensure or for practical nurse licensure, as applied for and approved. (6-11-93)

~~02. **Passing Score.** The passing score for each examination series or form will be determined by the Board.~~ (6-1-78)

~~03. **Retaking Examination.** Candidates who do not pass an examination will be notified of the procedure for applying to retake.~~ (6-11-93)

~~04. **Retake Fee.** The retake fee as prescribed in Subsection 901.01, of these rules, must be received or post-marked on or before the specified deadline dates.~~ (7-1-93)

~~052. **Examination Written Previously.** Foreign ~~g~~Graduates of schools of nursing located outside the United States or its territories, who have successfully taken the State Board Test Pool Examination, or the National Council Licensure Examination, or the Computerized Adapted Test administered by the National Council of State Boards of Nursing may be processed as applicants for licensure by endorsement from another state in the United States.~~ (7-1-93)()

(BREAK IN CONTINUITY OF SECTIONS)

264. -- ~~269~~70. (RESERVED).

~~270. **ADVANCED PRACTICE PROFESSIONAL NURSING.**~~

~~01. **Scope.** In accordance with Section 54-1404(a), Idaho Code, these rules are implemented by the Board of Nursing in order to define and regulate advanced practice professional nursing, including the practice categories of certified nurse-midwife, clinical nurse specialist, nurse practitioner, and registered nurse-anesthetist.~~ (7-1-99)

~~02. **Purpose.** The purpose of these rules is to promote, preserve and protect public health, safety, and welfare by:~~ (7-1-99)

~~a. Distinguishing the scope of practice of the advanced practice professional nurse from the scope of practice of the licensed professional nurse;~~ (7-1-99)

~~b. Defining the specific categories of advanced practice professional nursing, including titles;~~ (7-1-99)

~~e. Authorizing practice according to the advanced practice professional nurse's demonstrated initial~~

~~and continuing competence;~~ (7-1-99)

~~d. Providing a mechanism to assure safe practice by qualified competent individuals; and~~ (7-1-99)

~~e. Prohibiting unqualified persons from engaging in advanced practice professional nursing.~~ (7-1-99)

(BREAK IN CONTINUITY OF SECTIONS)

900. RENEWAL AND REINSTATEMENT FEES.

Fees will be assessed for renewal of ~~professional and practical nurse~~ licensure; and for late renewal or reinstatement of a lapsed license; ~~Any~~ person submitting the renewal application and fee post-marked later than August 31 shall be considered delinquent and the license lapsed and therefore invalid: (5-21-89)(____)

01. Licensed Professional Nurse Renewal Fee. Licensed professional nurses will be assessed a renewal fee of ~~forty-five~~ fifty dollars (\$450) due by August 31 of each odd-numbered year; and (7-1-91)(____)

02. Licensed Practical Nurse Renewal Fee. Licensed practical nurses will be assessed a renewal fee of ~~forty-five~~ fifty dollars (\$450) due by August 31 of each even-numbered year; and (7-1-91)(____)

03. Advanced Practice Professional Nurse. Licensed advanced practice professional nurses will be assessed a renewal fee of fifty dollars (\$50) due by August 31 of each odd-numbered year; and (____)

~~04. Late Renewal/Or Reinstatement Fee.~~ Advanced practice professional nurses, Pprofessional nurses, and practical nurses requesting a late renewal or reinstatement of a lapsed license will be assessed a fee of ~~twenty~~ thirty-five dollars (\$235) for records verification ~~plus the~~ and a ~~forty-five~~ fifty dollars (\$450) renewal fee which will be due upon application. (7-1-91)(____)

~~04. Restricted Or Limited License For Disability Renewal Fee.~~ Licensed nurses who have been issued a restricted, non-practicing license or a limited license for disability must renew the license as specified in Subsections 900.01 and 900.02 above, and will be assessed a renewal fee of forty-five dollars (\$45). (7-1-93)

05. Delay In Processing. Processing of renewal applications not accompanied by cash, cashier's check, ~~or~~ a money order, or other guaranteed funds may be delayed in order to allow clearance of personal checks through the licensee's bank. (7-1-91)(____)

901. LICENSURE FEES.

Fees will be assessed for licensure of professional and practical nurses by examination and endorsement, and for temporary licenses and verification of licensure to another state. (6-1-78)

01. Licensure By Examination. A fee will be assessed applicants for licensure by examination ~~of professional and practical nurses~~ as follows: (8-31-82)(____)

a. Professional nurse applicants ~~will be assessed a fee of seventy five dollars (\$75) which will due upon application;~~ ninety dollars (\$90). (7-1-91)(____)

b. Practical nurse applicants ~~will be assessed a fee of sixty dollars (\$60) which will be due upon application;~~ seventy-five dollars (\$75). (7-1-91)(____)

~~02. Advanced Practice Professional Nurses.~~ A person rewriting an examination will be assessed a forty dollars (\$40) processing fee which will be due upon application. Advanced practice professional nurse applicants: ninety dollars (\$90). (7-1-91)(____)

~~d. A fee of fifty dollars (\$50) will be assessed for proctoring for licensure out-of-state which will be~~

~~due upon application.~~

~~(7-1-91)~~

023. Licensure By Endorsement. ~~A~~ The fee ~~will be~~ assessed for licensure by endorsement of licensed professional and licensed practical nurses: will be eighty-five dollars (\$85). ~~(11-28-84)(____)~~

~~a. Licensed professional nurses will be assessed a fee of seventy-five dollars (\$75) which will be due upon application.~~ ~~(7-1-91)~~

~~b. Licensed practical nurses will be assessed a fee of seventy-five dollars (\$75) which will be due upon application.~~ ~~(7-1-91)~~

034. Temporary License Fee. Professional and practical nurses requesting a temporary license will be assessed a fee of ~~fifteen~~ twenty-five dollars (\$25) which will be due upon application. ~~(7-1-88)(____)~~

045. Limited License Fee. ~~A fee will be assessed for issuance of a limited license.~~ ~~(7-1-88)~~

~~a.~~ Persons who are issued a limited license following disciplinary action or temporary voluntary surrender of a license will be assessed a fee of ~~ninety~~ one hundred dollars (\$9100) which will be due upon issuance of the limited license. ~~(7-1-91)(____)~~

056. Verification Of Licensure Fee. Licensed professional and licensed practical nurses requesting verification of licensure to another state will be assessed a fee of ~~fifteen~~ thirty dollars (\$1530) which will be due upon request. ~~(7-1-88)(____)~~

~~067. Verification Of Approval To Write Licensing Examination. Professional and practical nurse applicants requesting verification of acceptance to write the licensing examination will be assessed a fee of ten dollars (\$10) which will be due upon request. Authorization Fee. Advance practice professional nurses will be assessed an authorization fee of fifty dollars (\$50) which will be due upon application.~~ ~~(7-1-91)(____)~~

~~07. Duplicate License Fee. Licensed professional and licensed practical nurses requesting a duplicate of their current certificate will be assessed a fee of ten dollars (\$10) which shall be due upon application.~~ ~~(7-1-91)~~

902. ADVANCED PRACTICE PROFESSIONAL NURSE LICENSURE FEES (RESERVED).
~~A fee will be assessed for advanced practice professional nurse licensure, renewal, and late renewal.~~ ~~(7-1-99)~~

~~01. Initial Licensure Fee. A fee of ninety dollars (\$90) will be assessed for initial licensure of an advanced practice professional nurse which will be due upon application.~~ ~~(7-1-99)~~

~~02. Renewal Fee. Advanced practice professional nurses will be assessed a renewal fee of fifty dollars (\$50) which will be due biennially, with the license renewal.~~ ~~(7-1-99)~~

~~03. Late Renewal Fee. Advanced practice professional nurses will be assessed a renewal fee of twenty-five dollars (\$25) which will be due upon application.~~ ~~(7-1-99)~~

~~04. Authorization Fee. Advance practice professional nurses will be assessed an authorization fee of fifty dollars (\$50) which will be due upon application.~~ ~~(7-1-99)~~

903. EDUCATION PROGRAM FEES.

01. Evaluation Of Nursing Education Programs. A fee ~~of not to exceed~~ one hundred two hundred fifty dollars (~~\$10250~~) per day will be assessed for survey and evaluation of nursing education programs which will be due ~~prior to approval of the program~~ at the time the evaluation is requested. ~~(7-1-91)(____)~~

02. Evaluation Of Courses Of Instruction. A fee ~~of not to exceed~~ two hundred fifty five hundred dollars (~~\$2500~~) will be assessed for approval of courses of instruction related to nursing that are offered by commercial establishments. ~~Such~~ This fee ~~is to compensate for administrative costs and expenses incident to review and evaluation of the course and shall be due prior to the review of the course~~ will be due at the time the evaluation is

requested.

(11-28-84)()

(BREAK IN CONTINUITY OF SECTIONS)

905. ~~EARNED FEES NO REFUNDS.~~

~~All fees are earned fees upon receipt and are not refundable either in whole or in part.~~

(8-31-87)()

906. RETURNED CHECK FEE.

There will be a twenty-five dollar (\$25) fee assessed for any check returned to the agency for any reason.

()

907. LICENSES AND WALLET CERTIFICATES.

01. Duplicate Wallet Certificates. Duplicate wallet certificates will be issued where the original wallet certificate has been lost or destroyed. Applicants requesting a duplicate wallet certificate must pay a ten dollar (\$10) application fee.

()

02. Revised Wallet Certificates. Revised wallet certificates will be issued to reflect a change in name. Applicants requesting a revised wallet certificate must pay a ten dollar (\$10) application fee.

()

03. Duplicate Licenses.

()

a. Duplicate licenses are reproductions of original licenses.

()

b. Applicants requesting a duplicate license must pay a ten dollar (\$10) application fee.

()

c. Original licenses may not be revised.

()

908. ONLY ONE LICENSE - EXCEPTION.

A licensee may hold only one (1) active renewable license to practice nursing at any time except that licensed advanced practice professional nurses must also be licensed to practice as licensed professional nurses.

()

9069. -- 998. (RESERVED).

999. ADMINISTRATIVE FINE.

01. Fine Assessment. An administrative fine not to exceed one hundred dollars (\$100) for each ~~count~~ ~~or~~ separate offense of practicing nursing without current licensure, ~~approval, or registration~~, may be assessed as a condition of reinstatement of a license, or the issuance of a temporary or renewable license, ~~approval, or registration.~~

(7-1-88)()

~~01. Fine Assessment. Fines will be assessed as follows:~~

(7-1-93)

~~a. Fifteen (15) - Thirty (30) days of unlicensed practice - fifty dollars (\$50).~~

(7-1-93)

~~b. Thirty-one (31) - Sixty (60) days of unlicensed practice - seventy-five dollars (\$75).~~

(7-1-93)

~~c. More than sixty (60) days of unlicensed practice - one hundred dollars (\$100).~~

(7-1-93)

02. Fine Payment. Fines shall be payable by cash, cashier's check, ~~or~~ money order, or other guaranteed funds.

(11-28-84)()

IDAPA 24 - BUREAU OF OCCUPATIONAL LICENSES
24.01.01 - RULES OF THE BOARD OF ARCHITECTURAL EXAMINERS
DOCKET NO. 24-0101-0001
NOTICE OF PROPOSED RULE

AUTHORITY: In compliance with Sections 67-5220(1), Idaho Code, notice is hereby given that this agency has proposed rulemaking. The action is authorized pursuant to Section 54-312, 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 October 18, 2000.

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:

Add section on Incorporation By Reference; add the address of the Board; change the photograph required for application from 2"X3" to passport photograph; adopt the qualifications outlined in the 2000-2001 NCARB Handbook for Interns and Architects; and establish the qualifications for examination based on experience in lieu of an architectural degree.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Dee Ann Randall, (208) 334-3233.

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 October 25, 2000.

DATED this 21st day of August, 2000.

Dee Ann Randall
Owyhee Plaza
1109 Main Street, Suite 220
Boise, Idaho 83702
(208) 334-3233
(208) 334-3945 (FAX)

THE FOLLOWING IS THE TEXT OF DOCKET NO. 24-0101-0001

004. INCORPORATION BY REFERENCE (Rule 4).

The document titled 2000-2001 NCARB Handbook for Interns and Architects, dated September 2000, referenced in Subsection 300.01.e., is herein incorporated by reference and can be obtained at the office of the Bureau. ()

005. ADDRESS OF THE IDAHO BOARD OF ARCHITECTURAL EXAMINERS (Rule 5).

Bureau of Occupational Licenses, Owyhee Plaza, 1109 Main Street, Suite 220, Boise, Idaho 83702. ()

0046. -- 009. (RESERVED).

(BREAK IN CONTINUITY OF SECTIONS)

300. APPLICATION (Rule 300).

01. Licensure By Examination. (7-1-93)

a. Application for examination shall be made on the uniform application form adopted by the Board and furnished to the applicant by the Executive Secretary of the Board. (3-18-99)

b. Applicants shall secure and furnish all information required by the uniform application form and shall include the following: (7-1-93)

i. Certified transcript of all subjects and grades received for all college courses taken. (7-1-93)

ii. If graduated from a college or university, furnish certification of graduation and a certified transcript of all work completed. (7-1-93)

iii. Furnish statement or statements, of all actual architectural or other applicable experience signed by the person under whose supervision the work was performed, giving kind and type of work done, together with dates of employment. (7-1-93)

iv. A recent ~~two inch by three inch (2" x 3")~~ passport photograph taken within the previous year for identification purposes. (7-1-93)()

v. In addition to the above required information, an applicant having credits or a degree or degrees from any college or university shall furnish the Board a certified statement from each above institution stating by what accrediting group, if any, such credits or degree or degrees are accredited. (7-1-93)

c. Application shall not be presented to the Board or evaluated by the Board until all required information is furnished and the required fee is paid. (7-1-93)

d. To be considered by the Board, properly completed applications must be received by the Executive Secretary at least thirty (30) days prior to the first day of the month in which the Board will meet. (7-1-98)

e. Qualifications of Applicants. All applicants for the Architectural Registration Examination (ARE) shall possess the minimum qualifications required by the ~~current 2000-2001~~ NCARB ~~h~~Handbook for ~~architects and~~ ~~Interns and Architects, dated September 2000~~, where such Handbook for Interns and Architects does not conflict with Idaho law. After June 1, 1993, all applicants for the ARE must have completed the Intern Development Program (IDP) requirements. Qualification for examination based upon experience. The Board may allow an applicant without an architecture degree to sit for the architecture examination upon determining that such applicant has attained the knowledge and skill approximating that attained by graduation from an accredited architecture curriculum including the submission of a record of eight (8) years or more of experience in architecture work of a character deemed satisfactory by the Board. Two (2) years of the eight (8) or more years of experience may be accepted if determined that such experience is directly related to architecture under the direct supervision of a registered engineer (practicing as a structural, civil, mechanical or electrical engineer in the field of building construction) or a registered landscape architect. At least six (6) years of such experience must be obtained while working under the direct supervision of a licensed architect. (4-5-00)()

02. Licensure By Endorsement - Blue Cover. (7-1-97)

a. General requirements. Application shall be accompanied by a current blue cover dossier compiled by the NCARB certifying that the applicant has satisfactorily passed the standard NCARB examinations, or NCARB authorized equivalent and shall include letters, transcripts, and other documents substantiating all statements relative to education and experience made in said application as required by the Board. (7-1-97)

b. Seismic knowledge requirements for endorsement applicants. Each applicant for license under endorsement to practice architecture in the state of Idaho shall submit evidence of his skill and knowledge in seismic design and such evidence shall be submitted and signed by the applicants acknowledged before a notary public, and shall contain one of the following statements: (7-1-97)

i. "I have passed the examinations in Building Construction and Structural Design of the Western Conference of State Architectural Registration Boards in June 1963 or since and/or the NCARB in 1965 or since." (7-1-97)

ii. "I am registered in the State of _____ in 20____, where competence in seismic was a requirement for registration since _____, 20____." (7-1-93)

iii. Certification of the successful completion of the seismic seminar approved by the National Conference of Architectural Registration Boards. (7-1-93)

c. All applicants shall attach to their statement a certification from the State architectural registration agency of the cited state attesting the adequacy of the cited seismic examination. (7-1-93)

03. Licensure By Endorsement - Equivalency. (7-1-97)

a. Application shall be made on the uniform application form adopted by the Board and furnished to the applicant by the Executive Secretary of the Board. (7-1-97)

b. Applicant shall comply with all requirements set forth in Subsections 300.01, 300.02.b.i., 300.02.b.ii., 300.02.b.iii., and 300.02.c. (7-1-97)

c. Applicant shall provide proof of holding a current and valid license issued by another state, a licensing authority recognized by the Board. (7-1-97)

d. Applicant shall provide proof of satisfactorily passing the NCARB examinations or NCARB authorized equivalent examination, as determined by the Board. (7-1-97)

IDAPA 24 - BUREAU OF OCCUPATIONAL LICENSES
24.03.01 - RULES OF THE STATE BOARD OF CHIROPRACTIC PHYSICIANS

DOCKET NO. 24-0301-0001
NOTICE OF PROPOSED RULE

AUTHORITY: In compliance with Sections 67-5220(1), Idaho Code, notice is hereby given that this agency has proposed rulemaking. The action is authorized pursuant to Section 54-707, 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 October 18, 2000.

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:

Change the peer review compensation schedule from the number of document pages to the dollar amount of the claim.

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

This change does not establish new or increased fees. The cost of the Peer Review process is paid largely by insurance companies and third-party providers. The changes will clarify the method of calculating the fees for review. Section 54-715, Idaho Code, authorizes the Peer Review Committee.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Dee Ann Randall, (208) 334-3233.

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 October 25, 2000.

DATED this 21st day of August, 2000.

Dee Ann Randall
Owyhee Plaza
1109 Main Street, Suite 220
Boise, Idaho 83702
(208) 334-3233
(208) 334-3945 (FAX)

THE FOLLOWING IS THE TEXT OF DOCKET NO. 24-0301-0001

600. CHIROPRACTIC PEER REVIEW (Rule 600).

01. Purpose And Composition Of Peer Review Committee. There is hereby established a Peer Review Committee, the members of which will function at the will of the Idaho State Board of Chiropractic Physicians. (7-1-98)

a. The purpose of the Peer Review Committee is to review those matters relative to the appropriateness, quality, utilization, and cost of chiropractic care in the state of Idaho. (7-1-98)

b. The Committee will be comprised of a chairman and a minimum of five (5) members, all of whom will be appointed by the members of the Board, and all of whom will serve at the pleasure of the Board. They may be removed from the Committee by vote of the Board, at any time, without cause. (7-1-98)

c. The Board will appoint one (1) of its members to act as a liaison between the Board and the Committee. This liaison will serve at the pleasure of the Board and may be removed by the Board, at any time, without cause. (7-1-98)

02. Definitions. (7-1-98)

a. "Board" means the Idaho State Board of Chiropractic Physicians. (7-1-98)

b. "Patient" means an individual who has received treatment from an Idaho licensed chiropractor, or who has received treatment under the supervision or direction of an Idaho licensed chiropractor, which treatment is within the scope of practice for a chiropractor within the state of Idaho. (7-1-98)

c. "Peer Review" means an evaluation performed by members of the Committee, which review will include the appropriateness, quality, utilization, and cost of chiropractic services and ethical performance of chiropractic care. (7-1-98)

d. "Peer Review Committee Members" shall mean those individuals appointed by the Board to serve on the Peer Review Committee. (7-1-98)

e. "Individual Reviewers" means those individual members of the Committee who are designated by the chairman of the Committee to conduct a peer review evaluation of any particular matter. (7-1-98)

03. Committee Criteria. (7-1-98)

a. Requirements for Membership: To be considered for appointment to the Committee, an applicant shall: (7-1-98)

i. Hold a current Idaho license to practice chiropractic, which license is in good standing and which has never been the subject of a formal disciplinary action in any jurisdiction; (7-1-98)

ii. Be actively engaged in the practice of chiropractic for the past four (4) years, with the most recent two (2) of those years having been spent in Idaho. (7-1-98)

b. Appointment Process: Each year the Board will notify all Idaho licensed chiropractors of the process and deadlines by which they may self-submit for membership on the Committee. (7-1-98)

i. The submissions will be maintained on file for one (1) year; after which time they will be discarded without notice to the applicants. (7-1-98)

ii. The Board will notify those individuals who are named to the Committee of their appointment. (7-1-98)

c. Limitations of Peer Review Committee Members. While serving on the Peer Review Committee, a member shall not: (7-1-98)

i. Solicit to do independent medical examinations and/or reviews for insurance companies, attorneys or other third parties; (7-1-98)

ii. Utilize any designation or other reference to Committee membership on any advertisement,

including telephone book, office, letterhead, or any other place. (7-1-98)

d. Reimbursement: Committee members will be afforded expense reimbursement in accordance with state employee travel regulations upon Board approval. (7-1-98)

04. Standards. (7-1-98)

a. In conducting any review, the Committee will utilize the Guidelines for Chiropractic Quality Assurance and Practice Parameters, Proceedings of the Mercy Center Consensus Conference, and Procedural/Utilization Facts, Chiropractic/Physical Therapy Treatment Standards, a Reference Guide, 5th Edition, Robert E. Olson, D.C. (7-1-98)

b. The reviewing chiropractors will be expected to utilize their own experience and other reference sources in ascertaining the reasonableness and appropriateness of care provided. (7-1-98)

05. Who May Utilize The Services Of The Committee. A request for peer review may be submitted to the Committee by a patient, the patient's legal representative, an insurer or other third-party payor or health care provider, or the treating chiropractic physician. (7-1-98)

06. Form Of Request. A request for peer review must be submitted to the Committee on forms available from the Board offices. (7-1-98)

07. Fees For Review. The following fees will be assessed: (7-1-98)

a. If review is requested by a patient: no charge. (7-1-98)

b. If review is requested by a treating physician, an insurer or third party provider: (7-1-98)

i. One hundred twenty-five dollars (\$125) for a review of ~~records and documents consisting of twenty-five (25) pages~~ claims in the amount of one thousand dollars (\$1,000) or less; (7-1-98)()

ii. Two hundred fifty dollars (\$250) for a review of ~~records and documents consisting of more than twenty-five (25) pages and up to fifty (50) pages~~ claims in the amount of one thousand one dollars (\$1,001) or more and not exceeding three thousand dollars (\$3,000); (7-1-98)()

iii. Three hundred fifty dollars (\$350) for a review of ~~records and documents consisting of more than fifty (50) pages and up to one hundred (100) pages~~ claims in the amount of three thousand one dollars (\$3,001) or more; (7-1-98)()

iv. ~~For every increment above one hundred (100) pages, of one (1) to fifty (50) more pages, one hundred dollars (\$100).~~ (7-1-98)

c. Payment for reviews by the insurer or third-party provider is required prior to implementation of any review process. (7-1-98)

08. Procedures For Review. (7-1-98)

a. All reviews will be blind reviews. The identity of the patient, treating physician, and any insurer or third-party payor for the services will be unknown to the individual reviewers. (7-1-98)

b. Peer review will be conducted only upon request. The opportunity for participation in the review will be made available to the non-requesting party or parties. With the exception of the treating chiropractic physician, there is no requirement of participation in the peer review process. (7-1-98)

c. Reviews will be conducted by three (3) individual reviewers, to be chosen from the membership of the Committee by the chairman. (7-1-98)

d. The individual reviewers will conduct their evaluation, reach an agreement as to the outcome, and report that outcome to the chairman. If any of the parties desire to appeal this decision, they may notify the chairman who will appoint one (1) new reviewer to conduct an evaluation and report the outcome to the chairman. There will be no further rights to appeal. Decisions of the individual reviewer will not be subject to challenge. (7-1-98)

e. The chairman will provide regular reports to the Board liaison. If it is the opinion of the reviewers that a licensed chiropractic physician has violated any of the laws and rules governing continued licensure, the Committee chairman will notify the Board liaison, immediately. The liaison will then refer the matter for further investigation and potential disciplinary action by the Board. (7-1-98)

IDAPA 24 - BUREAU OF OCCUPATIONAL LICENSES
24.04.01 - RULES OF THE IDAHO BOARD OF COSMETOLOGY
DOCKET NO. 24-0401-0001
NOTICE OF TEMPORARY AND PROPOSED RULE

EFFECTIVE DATE: The effective date of the temporary rule is June 5, 2000.

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 Section 54-821, 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 October 18, 2000.

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:

Waives the thirty (30) day application deadline for applicants who fail the examination on the first attempt; provides for nail technology and esthetics instructors, this change would extend certain requirements for examination of instructors to include persons providing nail technology, esthetics or electrology instruction; allows instructor applicants who fail the examination on the first attempt to re-examine without additional training.

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

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the temporary and proposed rule, contact Dee Ann Randall, (208) 334-3233.

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 October 25, 2000.

DATED this 21st day of August, 2000.

Dee Ann Randall
Owyhee Plaza
1109 Main Street, Suite 220
Boise, Idaho 83702
(208) 334-3233
(208) 334-3945 (FAX)

THE FOLLOWING IS THE TEXT OF DOCKET NO. 24-0401-0001

200. APPLICATIONS (Rule 200).

01. Application For License By Examination. Application for license by examination shall be made on forms furnished by the board and must be received in that office at least thirty (30) days prior to the date of

examination. (7-1-97)

02. Applications Must Be Complete To Be Accepted. To be complete applications must meet the following criteria: (7-1-97)

a. Applications from students educated in-state must be accompanied by records of instruction, a signed and notarized Certificate of Graduation, proof of tenth grade education or equivalent, and acceptable verification of applicants age upon registration in school, together with the required fees. Do not send original diploma to the board. A copy will be acceptable. (7-1-97)

b. Applications from an apprentice must be accompanied by records of instruction and a certificate of graduation, from a licensed establishment and the required fees. (7-1-97)

c. Applicants not completing their education in Idaho must document other state licensure, provide verification of practical experience, and submit the required fees. (7-1-97)

03. Fees Which May Be Refunded. If a license is not issued, the license fee may be refunded, providing a permit has not been issued. Examination fees are not refundable. (7-1-97)

04. Deadline Date For Filing. Applications which are not fully completed, in accordance with Rule 200~~2~~, and the fees paid thirty (30) days prior to the examination~~2~~, will be held over until the next scheduled examination. Those applicants who fail any portion of the examination on their first attempt may submit an application with the required fee for re-examination, and if said application and fee is received by the board office prior to the next scheduled examination, the thirty (30) day application deadline shall be waived. ~~(7-1-97)~~(6-5-00)T

(BREAK IN CONTINUITY OF SECTIONS)

600. ~~COSMETOLOGY, ELECTROLOGY~~ INSTRUCTOR RULES (Rule 600).

01. Requirements For Instructor License. (7-1-97)

a. Application for an instructor license shall be made on forms furnished by the board and accompanied with the required fees. (7-1-97)

b. Section 54-805(2)(8), Idaho Code, provides for twelve (12) semester college credit hours or equivalent, as approved by the board, or successful completion of the examination required by board rules. Credit hours must be obtained from the Education Department, Speech Communications Department or from the Psychology/Sociology Department and other credit at the discretion of the Board. (7-1-97)

c. Equivalent: (7-1-97)

i. Teaching seminars directed to cosmetology, nail technology, esthetics or electrology must be approved by the board. Fourteen (14) clock hours is equivalent to one (1) semester college credit hour in an approved seminar. Verification of satisfactory completion must be submitted to the board for their approval. ~~(7-1-99)~~(6-5-00)T

ii. Verified satisfactory teaching as a qualified instructor from another state three (3) of the previous five (5) years immediately prior to application. (7-1-97)

d. Experience Requirements for Instructor Applicant (Reference Section 54-805(2)(8), Idaho Code). Five (5) years experience is deemed "immediately preceding" if obtained during the seven (7) year period immediately preceding application for licensure. (7-1-97)

e. An electrologist with fewer than five (5) years' experience as a licensed electrologist must complete three (3) months, five hundred (500) hours of teacher's training in a cosmetology school approved to teach

electrology as set forth in Subsection 550.08. (7-1-99)

02. Examination Dates And Places. (7-1-97)

a. Instructor examinations will be held in conjunction with the board meeting in Boise on the Tuesday following the first (1st) Monday of February, June and October. (7-1-97)

b. The dates and places of examination are subject to change. (7-1-97)

03. Termination. All application records in the bureau of applicants who have not qualified for reexamination within five (5) years of notification of failure in any examination under the Cosmetology Law will be terminated and destroyed. (7-1-97)

04. Scope And Requirement Of Examination For License. (7-1-97)

a. Examination will consist of both a practical and written examination. The written examination will be in two parts: a national theory examination and an Idaho jurisprudence examination. (7-1-97)

b. Mannequin shall be used in lieu of model. (7-1-97)

c. Examinee ~~would~~ will be required to demonstrate to the board ability to teach cosmetology, nail technology, esthetics, or electrology services. One subject to be assigned when accepted for examination and a subject to be drawn at the time of the examination. ~~(7-1-97)~~(6-5-00)T

d. Supplies required for the instructor's examination. Bring sufficient materials and supplies to demonstrate in assigned category. (7-1-97)

05. Instructor Reexamination. To be eligible, an applicant must obtain two hundred (200) hours additional ~~training~~ instruction in a school of cosmetology, nail technology, esthetics, or electrology as a student instructor. This requirement will not apply to those applicants failing the examination for the first time. ~~(7-1-97)~~(6-5-00)T

06. Requirements For Student Instructor. (7-1-97)

a. A student instructor shall file an application on forms provided by the board before beginning training and shall at all times be under the direct supervision of a licensed instructor. (7-1-97)

b. The time spent as a student instructor to meet instructor licensure requirements will not be credited to the years experience required for an instructor license. (7-1-97)

c. One (1) year experience may be obtained within a school upon completion of instructor training. (7-1-97)

d. Six (6) months is considered to be one thousand (1,000) hours of training. Three (3) months is considered to be five hundred (500) hours of training. (7-1-97)

07. Student Registration. Schools are required to register all students with the board prior to providing any instruction. Student registration fee must be submitted at time of registration. (7-1-97)

08. Record Of Training. The number of required operations on a monthly Record Form and Student Record of Instruction Form are as follows: (The first numbers are required operations for six (6) months/one thousand (1,000) hours of training; the second numbers are required operations for three (3) months/five hundred (500) hours of training.) (7-1-97)

a. Lesson Planning - twenty-five/ten (25/10). (7-1-99)

b. Audio Visual Aid Preparation - twenty-five/ten (25/10). (7-1-99)

- c. Theory Class. Teach twenty-five (25) classes/Teach ten (10) classes. (7-1-99)
- d. Practical Demonstrations - twenty-five/ten (25/10). (7-1-99)
- e. Testing and Evaluation Theory. - Fifteen (15) theory/five (5) theory. (7-1-99)
- f. Testing and Evaluation. - Fifteen (15) practical/five (5) practical. (7-1-99)
- g. Clinic Floor Supervision - Seven hundred/three hundred (700/300). (7-1-99)
- h. Related Subjects - One hundred fifty/fifty-five (150/55). (7-1-99)
- i. Counseling. (7-1-97)
- ii. Record Keeping. (7-1-97)
- iii. Business and Reception. (7-1-97)

IDAPA 24 - BUREAU OF OCCUPATIONAL LICENSES
24.04.01 - RULES OF THE IDAHO BOARD OF COSMETOLOGY
DOCKET NO. 24-0401-0002
NOTICE OF PROPOSED RULE

AUTHORITY: In compliance with Sections 67-5220(1), Idaho Code, notice is hereby given that this agency has proposed rulemaking. The action is authorized pursuant to Section 54-821, 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 October 18, 2000.

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:

Adopts definitions from Idaho Code, clarifies definitions of "Record of Instruction" and "First Aid Kit"; separate Esthetics from Electrology; replaces references to "registration" & "certificate" with "license" or "permit"; clarifies action resulting from default of student loan; clarifies endorsement requirements; requires jurisprudence exam for endorsement applicants; deletes Work Permits; changes reference to the education requirement from 10th grade to required high school education; clarifies application requirement; replaces references to "training" with "instruction"; clarifies electrology instruction hour requirements; increases esthetics and nail technology instruction hour requirements; allows applicants who fail the examination on the first attempt to re-examine without additional training; specifies uses of human models and mannequins during examination; defines records of training, deletes monthly requirement for student records, and outlines requirements; defines attendance policy and clarifies student records requirements; defines student probationary period; and clarifies requirements for instructor training.

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

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Dee Ann Randall, (208) 334-3233.

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 October 25, 2000.

DATED this 21st day of August, 2000.

Dee Ann Randall
Owyhee Plaza
1109 Main Street, Suite 220
Boise, Idaho 83702
(208) 334-3233
(208) 334-3945 (FAX)

THE FOLLOWING IS THE TEXT OF DOCKET NO. 24-0401-0002

010. DEFINITIONS (Rule 10).

These rules expressly adopt all definitions set forth in Section 54-802, Idaho Code, in addition to the following:

- ()
01. **Gender.** Any reference to a gender shall mean both masculine and feminine. (7-1-97)
02. **Board.** The Idaho Board of Cosmetology as prescribed in Section 54-802, Idaho Code. (7-1-97)
03. **Bureau.** The Bureau of Occupational Licenses, Section 67-2601, Idaho Code. By authority delegated in written agreement, the Bureau of Occupational Licenses will act as the agent of the Board, in assisting the Board to carry out its duties as outlined in law and rule. (7-1-97)
04. **Chief.** The Bureau Chief of the Bureau of Occupational Licenses as established by Section 67-2602, Idaho Code. (7-1-97)
05. **Current License.** An unexpired license in good standing. (7-1-97)
06. **Establishment.** A licensed cosmetological establishment. (7-1-97)
07. **Record Of Instruction.** The final documentation submitted of total hours and operations completed by a student that is maintained by a school or, in the case of an apprentice, the instructor, ~~detailing the total hours and operations completed by a student.~~ (7-1-97)()
08. **Certificate Of Graduation.** A signed, notarized statement from a school or, in the case of an apprentice, the instructor, which indicates that the student has fulfilled all requirements of that school or apprenticeship and is eligible for examination. (7-1-97)
09. **Rules.** The rules of the board. (7-1-97)
10. **School.** A licensed school of cosmetology. (7-1-97)
11. **School Of Electrology/~~Esthetics.~~** A licensed school of cosmetology approved to teach electrology/~~esthetics.~~ (7-1-97)()
12. **Endorsement Certification.** In accordance with Section 54-812, Idaho Code. (7-1-97)
13. **Hospital Grade.** Hospital grade means a sanitizing agent registered by the Environmental Protection Agency as an effective germicidal/bactericidal, fungicidal, and virucidal disinfectant when used in accordance with the manufacturer's instructions. (7-1-97)
14. **First-Aid Kit.** First-aid kit means a ~~commercially~~ packaged and identifiable assortment of medical supplies, including adhesive bandages, skin antiseptic, ~~bio-hazard disposable container,~~ disposable gloves, and gauze, which may be used for cleaning and protecting blood spills and other minor emergency traumas of the human body. (7-1-99)()

(BREAK IN CONTINUITY OF SECTIONS)

100. BOARD QUALIFICATIONS - PROCEDURES - MEETINGS - POLICIES. (Rule 100).

01. **Board Member Qualifications.** (7-1-97)
- a. The Cosmetology board member shall meet the requirements set forth in Section 54-829, Idaho Code. (7-1-97)

- b. Cosmetology school representative: To be eligible for appointment to the Cosmetology Board the individual must: (7-1-97)
- i. Currently hold a license as a cosmetologist in this state; and (7-1-97)
 - ii. For the three (3) years immediately preceding appointment meet the following requirements: (7-1-97)
 - (1) Monetary interest in school ownership; and (7-1-97)
 - (2) Actively involved in school management. (7-1-97)
- c. Electrologist/~~Esthetician~~ board member qualification requirements - the Electrology/~~esthetics~~ board member shall: (7-1-97)(____)
- i. Be at least twenty-five (25) years of age; and (7-1-97)
 - ii. Be a resident of this state for at least five (5) years prior to appointment; and (7-1-97)
 - iii. Have been engaged in the practice of electrology/~~esthetics~~ for at least three (3) years immediately preceding appointment; and (7-1-97)(____)
 - iv. Be a licensed electrologist/~~esthetician~~ under the provisions of this act. (7-1-97)(____)
- 02. Board Meetings - Dates - Places.** (7-1-97)
- a. The board shall meet at least three (3) times a year in regular session beginning on the first Monday of February, June and October. (7-1-97)
 - b. Board meetings will be held in Boise, Idaho, at the Bureau. (7-1-97)
 - c. Dates and places of board meetings may be changed and other meetings scheduled by the action of a majority of the board. (7-1-97)

(BREAK IN CONTINUITY OF SECTIONS)

125. FEES (Rule 125).

Fees are established in accord with Section 54-818, Idaho Code, as follows: (7-1-97)

- 01. Original ~~Registrations~~ Permits, Licenses, And Annual Renewals.** (7-1-97)(____)
- a. Cosmetological establishment, original ~~registration~~ license - Fifty dollars (\$50). (7-1-97)(____)
 - b. Cosmetological establishment, annual renewals - Thirty-five dollars (\$35). (3-18-99)
 - c. Retail cosmetics Dealer, original ~~registration~~ license - Fifty dollars (\$50). (7-1-97)(____)
 - d. Retail cosmetics dealer, annual renewals - Thirty-five dollars (\$35). (3-18-99)
 - e. Makeover or glamour photography business, original ~~registration~~ license - Fifty dollars (\$50). (3-18-99)(____)
 - f. Makeover or glamour photography business, annual renewals - Thirty-five dollars (\$35). (3-18-99)

- g. Domestic school of cosmetology, original ~~registration~~ license - Five hundred dollars (\$500). (7-1-97)(____)
- h. Domestic school of cosmetology, annual renewals - One hundred fifty dollars (\$150). (7-1-97)
- i. Registered cosmetologist, original license/annual renewals - Twenty-five dollars (\$25). (3-18-99)
- j. Nail technician, original license/annual renewals - Twenty-five dollars (\$25). (3-18-99)
- k. Apprentice, original license (no renewal fees required) - Twenty dollars (\$20). (7-1-97)
- l. Student certificate (registration) (no renewal fees required) - Twenty dollars (\$20). (7-1-97)
- m. Instructor, original license/annual renewals - Thirty dollars (\$30). (3-18-99)
- n. Student instructor ~~certificate~~ permit - Twenty-five dollars (\$25). (7-1-97)(____)
- o. Electrologist, original license/annual renewals - Twenty-seven dollars (\$27). (3-18-99)
- p. Esthetician, original license/annual renewals - Twenty-seven dollars (\$27). (3-18-99)
- q. Endorsement fee - One hundred dollars (\$100). (7-1-97)(____)
- ~~r. Interim certificate when endorsement denied, also constitutes examination - Seventy-five dollars (\$75). (3-18-99)~~
- ~~st. Temporary license permit to practice, demonstrate and teach - Ten dollars (\$10). (7-1-97)(____)~~
- 02. Examination Fees.** (7-1-97)
- a. As a registered cosmetologist - Seventy-five dollars (\$75). (3-18-99)
- b. As a nail technician - Seventy-five dollars (\$75). (3-18-99)
- c. As an instructor - Seventy-five dollars (\$75). (3-18-99)
- d. As an electrologist - Seventy-five dollars (\$75). (3-18-99)
- e. As an esthetician - Seventy-five dollars (\$75). (3-18-99)
- 03. Fees Shall Not Be Prorated Or Returnable.** Fees shall not be prorated or returnable. (7-1-97)
- ~~**04. All Certificates Expire December 31.** All certificates expire December 31. (7-1-97)~~
- 054. Default.** When the board is notified by a ~~lending facility~~ financial institution or its assignee, that a person holding a registration, permit, or license is in student loan default, no registration, permit, or license may be issued or renewed until proper documentation is received from the ~~lending~~ financial institution or its assignee, that said default has been satisfied by the regulations set forth by the U.S. Department of Education. Reference Section 54-816(9), Idaho Code. (7-1-97)(____)

(BREAK IN CONTINUITY OF SECTIONS)

150. REQUIREMENTS FOR LICENSURE BY ENDORSEMENT (Rule 150).

01. Filing Application. Applicants for license by endorsement under the provisions of Section 54-812, Idaho Code, shall file an application on forms provided by the board; and (7-1-97)

a. Furnish proof of current license in another state, territory, possession or country, having requirements equal to the requirements of Idaho; or (7-1-97)

b. Document ~~completion of~~ by sworn affidavit attesting to having worked in a cosmetology establishment for three (3) years of practical experience under licensure within the five (5) years immediately preceding application. (7-1-97)()

02. Certification Of Licensure. Certification of licensure must be completed and signed by the licensing agency of the other state, territory, possession or country, and filed in the office of the board with the application for license and required fee. (7-1-97)

03. Application Must Be Accompanied By Proof Of Meeting Educational Requirements. Application for license by endorsement must be accompanied by proof of the applicant having met the educational requirements as set forth in Section 54-805, Idaho Code, ~~and satisfactory completion of at least two (2) years of high school (tenth grade), or equivalent education.~~ (7-1-97)()

04. Submit Proof Of Birth. Endorsement applicants must furnish a copy of their birth certificate or other acceptable proof of birth. (7-1-97)

05. Application Must Be Accompanied By Endorsement Fee And Original License Fee. Applications for license by endorsement must be accompanied by the endorsement fee and the original license fee. If the board finds that the applicant is ineligible for license by endorsement, but is eligible for license by examination, ~~a refund may be made of the endorsement fee in excess of the required~~ shall be utilized as the examination fee, and the applicant permitted to take the examination. (7-1-97)()

06. ~~Endorsement May Be~~ Jurisprudence Examination Required. The board ~~may~~ shall require all applicants for endorsement to pass the Idaho jurisprudence examination as noted under Section 450 prior to licensure by endorsement. (7-1-99)()

151. -- 174. (RESERVED).

~~**175. WORK PERMITS (Rule 175).**~~

~~When an original application for license by examination, or by endorsement, is accepted by the board as being fully completed, in accordance with the requirements of the Idaho Cosmetology Law and these Rules, a permit to work may be issued. (7-1-97)~~

~~**01. Only One Permit May Be Issued.** Only one (1) permit may be issued under any circumstances to any individual. A permit holder may work only when under the immediate personal supervision of a practitioner currently licensed in Idaho whose license embraces that particular category for which the work permit is issued. (7-1-97)~~

~~**02. Validity Of Work Permits.** Work permits will be valid only until the scheduled examination results have been released. Upon failure of any portion of an examination, no work permit will be issued. Unexcused failure to sit for the scheduled examination will invalidate the work permit and no further permits will be issued. (7-1-97)~~

176. APPLICATION AND FEE FOR PERMIT TO DEMONSTRATE OR TEACH COSMETOLOGY. (Rule 176).

Application and fee for permit to demonstrate or teach cosmetology shall be made by the sponsoring agent on forms furnished by the board and must be received in that office at least seven (7) days prior to the date of demonstration or instruction. The applicant shall include the name, address, license number, and the state, territory, possession, or country of licensure, and a ten dollar (\$10) fee for each person who shall ~~practice~~, demonstrate, or instruct. Said demonstration or instruction shall not commence until the permit is received by the applicant. The permit shall be

available for inspection by the board or its agent at the location of said demonstration or instruction. The applicant shall be required to inform each person of the sanitary rules for shops and schools prior to said demonstration, or instruction. (7-1-97)(____)

(BREAK IN CONTINUITY OF SECTIONS)

200. APPLICATIONS (Rule 200).

01. Application For License By Examination. Application for license by examination shall be made on forms furnished by the board and must be received ~~in that office~~ by the board at least thirty (30) days prior to the date of examination. (7-1-97)(____)

02. Applications Must Be Complete To Be Accepted. To be complete applications must meet the following criteria: (7-1-97)

a. Applications from students educated in-state must be accompanied by records of instruction, a signed and notarized ~~C~~certificate of ~~G~~graduation, proof of ~~tenth-grade~~ the required high school education (pursuant to Section 54-805, Idaho Code) or equivalent, and acceptable verification of applicants age upon registration in school, together with the required fees. Do not send original diploma to the board. A copy will be acceptable. (7-1-97)(____)

b. Applications from an apprentice must be accompanied by records of instruction and a notarized certificate of graduation, from a licensed establishment and the required fees. (7-1-97)(____)

c. Applicants not completing their education in Idaho must document other state territory, possession, or country licensure, provide verification of practical experience, and submit the required fees. (7-1-97)(____)

d. Applicants that cannot provide documentation of current licensure in another state, territory, possession, or country must provide certified documentation of instruction received directly from the applicable regulatory agency. (____)

03. Fees Which May Be Refunded. If a license is not issued, the license fee may be refunded, providing a permit has not been issued. Examination fees are not refundable. (7-1-97)

04. Deadline Date For Filing. Applications which are not fully completed, in accordance with Rule 200. and the fees paid thirty (30) days prior to the examination will be held over until the next scheduled examination. (7-1-97)

(BREAK IN CONTINUITY OF SECTIONS)

250. ESTABLISHING EQUIVALENCY IN LIEU OF ~~TENTH-GRADE~~ THE REQUIRED HIGH SCHOOL EDUCATION (Rule 250).

The Board will accept the following tests as being equivalent in lieu of ~~a tenth-grade~~ the required high school education (pursuant to Section 54-805, Idaho Code). (7-1-97)(____)

01. GED Test. The General Educational Development (G.E.D.) Tests approved by the Department of Education, when an applicant receives an average cutting score of not less than ~~thirty~~ forty-five (345), with no category below a cutting score of ~~thirty~~ forty (340). (7-1-97)(____)

02. CPAt Test. The CPAt (Career Programs Assessment test), when an applicant receives a ~~cutting~~ score of ~~thirty-five percent~~ (35%) approved by the U.S. Department of Education as meeting the equivalency requirement. (7-1-97)(____)

(BREAK IN CONTINUITY OF SECTIONS)

301. COSMETOLOGICAL ESTABLISHMENT CHANGES IN - OWNERSHIP - LOCATION - LICENSURE REQUIREMENTS (Rule 301).

01. Change Of Ownership Or Location. Whenever a change of ownership or fixed location of a establishment occurs, an original ~~registration~~ license fee must be paid and compliance with all rules concerning a new establishment met, before a new license will be issued. LICENSE IS NOT TRANSFERABLE. (7-1-97)()

02. Board Must Be Informed Of All Changes. The board must be informed in writing of any and all changes of ownership of establishments. (7-1-97)

03. Deletion Of An Owner. Deletion of an owner in a multiple ownership may be effected by filing a written statement with the board signed by the person withdrawing and/or the remaining owner(s). (7-1-97)

04. Transfer Of Owner. If the transfer involves change of corporate structure or deleting one (1) or more owners, a written notarized statement signed by all former owners as registered with the board shall be accepted. If the existing establishment license has expired, the procedure as set forth in Subsection 300.01 shall be followed. (7-1-97)

05. Addition Of An Owner. Addition of an owner to multiple ownership constitutes a change in ownership and the requirements for a new establishment apply. (7-1-97)

06. Supervision In An Establishment. A properly licensed establishment must operate under proper supervision, refer to Section 54-803, Idaho Code. (7-1-97)

(BREAK IN CONTINUITY OF SECTIONS)

400. REQUIREMENTS FOR LICENSURE BY EXAMINATION - GENERAL. (Rule 400).

01. Requirements. Applicants for license by examination must complete an application (Refer to Rule 200) and file it with the board, along with a completed certificate of graduation submitted to the board by the school. (7-1-97)

02. If Applicant Is From Another State. If applicant is from another state, territory, possession, or country, and is ineligible for license by endorsement, proof of having a current license in good standing and ~~training~~ instruction equivalent to the foregoing requirements must be submitted to the board (Refer to Rule 200). (7-1-97)()

401. COSMETOLOGY REQUIREMENTS FOR LICENSURE BY EXAMINATION. (Rule 401).

01. Filing Of Record Of Instruction. Applicant must file Record of Instruction covering: ~~cosmetology~~ two thousand (2,000) hours, ~~apprentice~~ of instruction as a student, or four thousand (4,000) hours of instruction as an apprentice. (7-1-97)()

02. Credit For ~~Training~~ Instruction. Credit for ~~training~~ instruction as a student or apprentice will be given for each year of practical experience under licensure in another state, territory, possession, or country as follows: (7-1-97)()

a. ~~Cosmetologist~~: Two hundred (200) hours; as ~~an apprentice~~ student, or four hundred (400) hours as an apprentice. (7-1-97)()

b. Credit will be allowed only on six (6) month experience increments. (7-1-97)

03. Hours Credit Toward Licensure. (7-1-97)

a. A licensed nail technician shall be given credit of two hundred fifty (250) hours toward the required two thousand (2000) hours for a cosmetology course or five hundred (500) hours toward the required four thousand (4,000) hours as a cosmetology apprentice. (7-1-97)

b. A licensed esthetician shall be given credit of two hundred fifty (250) hours toward the required two thousand (2000) hours for a cosmetology course. (7-1-97)

c. A nail technician student (not licensed) may receive eighty percent (80%) of accumulated hours, but no more than two hundred fifty (250) hours, as credit toward a student cosmetology course. (7-1-97)

d. An esthetician student (not licensed) may receive eighty percent (80%) of accumulated hours, but no more than two hundred fifty (250) hours as credit toward a student cosmetology course. (7-1-97)

(BREAK IN CONTINUITY OF SECTIONS)

407. ELECTROLOGY REQUIREMENTS FOR LICENSURE BY EXAMINATION (Rule 407).

01. Filing Of Record Of Instruction. Applicant must file Record of Instruction covering eight hundred (800) hours, ~~apprentice as a student, or~~ one thousand six hundred (1600) hours as an apprentice. (7-1-97)(____)

02. Credit Given For ~~Training~~ Instruction. Credit given for ~~training~~ instruction will be eighty (80) hours as a student, ~~or will be eighty (80) hours; as an apprentice;~~ one hundred sixty (160) hours as an apprentice, for each year of practical experience under licensure in another state, territory, possession, or country. (7-1-99)(____)

03. Credit For Experience. Credit for experience will be allowed only in full six (6) month increments. (7-1-99)

(BREAK IN CONTINUITY OF SECTIONS)

413. ESTHETICS REQUIREMENTS FOR LICENSURE BY EXAMINATION (Rule 413).

01. Filing of Record of Instruction. Applicant must file Record of Instruction covering ~~five~~ nine hundred (~~5~~900) hours as a student, or one thousand eight hundred (1800) hours as an apprentice. (7-1-97)(____)

02. Credit Given For ~~Training~~ Instruction. Credit given for ~~training~~ instruction as a student will be ~~five~~ nine (~~5~~90) hours as a student, or one hundred eighty (180) hours as an apprentice, for each year of practical experience under licensure in another state, territory, possession, or country. (7-1-99)(____)

03. Six Month Allowance For Credit. Credit for experience will be allowed only in full six (6) month increments. (7-1-99)

(BREAK IN CONTINUITY OF SECTIONS)

419. NAIL TECHNOLOGY REQUIREMENTS FOR LICENSURE BY EXAMINATION (Rule 419).

01. Filing Of Record Of Instruction. Applicant must file Record of Instruction covering ~~three~~ six hundred (~~360~~) hours as a student, or twelve hundred (1200) as an apprentice. (7-1-97)()

02. Credit Given For ~~Training~~ Instruction. Credit given for ~~training~~ instruction as a student will be ~~thirty~~ sixty (~~360~~) hours as a student, or one hundred twenty (120) hours as an apprentice, for each year of practical experience under licensure in another state, territory, possession or country. (7-1-97)()

03. Six Month Allowance For Credit. Credit will be allowed only on six (6) month experience increments. (7-1-97)

04. Hours Credit Toward Licensure. (7-1-97)

~~a. A licensed nail technician shall be given credit of two hundred fifty (250) hours toward the required two thousand (2000) hours for a cosmetology course or five hundred (500) hours toward the required four thousand (4,000) hours as a cosmetology apprentice. (7-1-97)~~

~~b. One seventh (1/7) of cosmetology student training hours may be credited toward nail technology training instruction requirements. (7-1-97)()~~

(BREAK IN CONTINUITY OF SECTIONS)

451. COSMETOLOGY LICENSURE EXAMINATION (Rule 451).

01. Written Examination. The written examination will cover both theory and Idaho jurisprudence. Theory will include all phases of the art of cosmetology, hair dressing, manicuring and pedicuring, facial massage, and sanitation. (7-1-98)

02. The Practical Examination. The practical examination will be the NIC examination. (7-1-98)

03. Practical Examination Additional ~~Training~~ Instruction. Additional ~~training~~ instruction required to qualify for practical reexamination shall be as follows: (7-1-97)()

a. Applicant failing below seventy-five percent (75%) will not be required to complete any additional ~~training~~ instruction prior to the first reexamination. (7-1-98)()

b. Upon failing the practical examination on a second attempt and all subsequent attempts, applicant must complete a minimum of four hundred (400) hours of additional ~~training~~ instruction. (7-1-98)()

04. Written Examination Additional ~~Training~~ Instruction. Additional ~~training~~ instruction required to qualify for the written reexamination shall be as follows: (7-1-97)()

a. Applicant failing below seventy-five percent (75%) in either the theory or Idaho jurisprudence examination will not be required to complete any additional ~~training~~ instruction prior to the first reexamination. (7-1-98)()

b. On reexamination, applicant failing below seventy-five percent (75%) in either or both the theory and Idaho jurisprudence examination may qualify for reexamination by taking not less than forty (40) hours of additional ~~training~~ instruction in theory and Idaho jurisprudence, in a curriculum approved by the board, in an Idaho licensed school, and complying with all other requirements for reexamination. (7-1-98)()

(BREAK IN CONTINUITY OF SECTIONS)

457. ELECTROLOGY EXAMINATION (Rule 457).

01. The Written Examination. The written examination will cover all phases of the art of electrology and sanitation. (7-1-99)

02. The Practical Examination. The practical examination will cover: (7-1-97)

a. Electrology: Preparation and sanitation of equipment and supplies, epilation, adjusting and control of machine, after treatment and personal appearance, attitude, sanitation. (7-1-97)

03. Additional ~~training~~ Instruction. Additional ~~training~~ instruction required to qualify for reexamination shall be as follows: (7-1-97)()

a. Applicant failing below seventy-five percent (75%) will not be required to complete any additional instruction prior to the first reexamination. ()

~~a~~b. Additional ~~training~~ instruction required to qualify for practical reexamination shall be twenty percent (20%) of the hour requirement for original examination. (7-1-97)()

~~b~~c. Additional ~~training~~ instruction required to qualify for the written reexamination shall be not less than forty (40) hours in theory and Idaho jurisprudence, in a curriculum approved by the board, in an Idaho licensed school, and complying with all other requirements for reexamination. (7-1-97)()

(BREAK IN CONTINUITY OF SECTIONS)

463. ESTHETICS EXAMINATION (Rule 463).

01. The Written Examination. The written examination will cover all phases of the art of skin care and sanitation. (7-1-97)

02. The Practical Examination. The practical examination will cover preparation, cleansing/basic facial, massage, makeup and personal appearance, attitude, sanitation. (7-1-97)

03. Additional ~~training~~ Instruction. Additional ~~training~~ instruction required to qualify for reexamination shall be as follows: (7-1-97)()

a. Applicant failing below seventy-five percent (75%) will not be required to complete any additional instruction prior to the first reexamination. ()

~~a~~b. Additional ~~training~~ instruction required to qualify for practical reexamination shall be twenty percent (20%) of the hour requirement for original examination. (7-1-97)()

~~b~~c. Additional ~~training~~ instruction required to qualify for the written reexamination shall be not less than forty (40) hours in theory and Idaho jurisprudence, in a curriculum approved by the board, in an Idaho licensed school, and complying with all other requirements for reexamination. (7-1-97)()

(BREAK IN CONTINUITY OF SECTIONS)

469. NAIL TECHNOLOGY EXAMINATION (Rule 469).

01. The Written Examination. The written examination will cover all phases of the art of manicuring, artificial nails and sanitation. (7-1-97)

02. The Practical Examination. The practical examination will include a complete basic manicure on one (1) hand, sculptured nails (with form), tips (finished), nail overlay with fabric. (7-1-97)

03. Additional ~~Training~~ Instruction. Additional ~~training~~ instruction required to qualify for reexamination shall be as follows: (7-1-97)()

a. Additional ~~training~~ instruction required to qualify for the practical reexamination shall be twenty percent (20%) of the hour requirement for original examination. (7-1-97)()

b. Additional ~~training~~ instruction required to qualify for the written reexamination shall be not less than forty (40) hours in theory and Idaho jurisprudence, in a curriculum approved by the board, in an Idaho licensed school, and complying with all other requirements for reexamination. (7-1-97)()

c. Additional ~~training~~ instruction will not be required ~~when more than one (1) section of the practical examination is failed or an applicant fails a portion of the examination more than once~~ those applicants failing the examination for the first time. (7-1-97)()

~~d. Additional training required to qualify for the written reexamination shall be not less than forty (40) hours in theory and Idaho jurisprudence, in a curriculum approved by the board, in an Idaho licensed school, and complying with all other requirements for reexamination. (7-1-97)~~

(BREAK IN CONTINUITY OF SECTIONS)

479. MODELS FOR THE COSMETOLOGY EXAMINATION (Rule 479).

~~01. Human Models. Human models must be people to whom makeup may be applied. (7-1-97)~~

~~02. Model/Mannequin With Hair Of At Least Four Inches. Model/mannequin must have hair at least four (4) inches long, sufficient length to be cut. No model/mannequin shall have hair longer than shoulder length. (7-1-97)~~

~~03. Live, Human Models. Live, Human models are mandatory for the facial and manicure/artificial nail application portions of the cosmetology examination. (7-1-97)()~~

~~04. Mandatory Mannequins For Hair Color Portion Examination. Except as set forth in Rule 479.01, Mannequins are mandatory for the hair color all portions of the cosmetology examination and must be treated in all respects, the same as a live model. (7-1-97)()~~

(BREAK IN CONTINUITY OF SECTIONS)

500. RULES OF SCHOOLS OF COSMETOLOGY (Rule 500).

Section 54-808, Idaho Code, provides for the rules of schools of cosmetology. Supplementing this section, the board adopts the following rules: (7-1-97)

01. Application Before Opening And Operating A School. No school of cosmetology will be opened and/or operated until the board has issued its approval and a valid license has been received by the school. See Section 54-806, Idaho Code. Application for a school license shall be made on forms furnished by the board. The fully

completed application to operate a school, with the required fee, shall be submitted to the board. (7-1-97)(____)

a. As soon as practicable, upon receipt of said application, the board or its designated agent, will cause the school to be inspected. Based on this inspection, a recommendation for the issuance or rejection of a license will be made and a decision entered, within a reasonable time not to exceed thirty (30) days, after said application has been received. (7-1-97)

b. All new schools applying for license must have one thousand eight hundred (1,800) square feet of space. Schools approved to teach electrology refer to Rule 550. (7-1-99)

c. All new schools must be separated completely from establishments ~~with~~ and have no connecting entrances. (7-1-97)(____)

02. Adequate Space. Schools provide adequate space for the number of students to be trained in said schools. An additional forty (40) square feet of floor space shall be provided in excess of the minimum one thousand eight hundred (1800) square feet required for each student enrolled over twenty (20) students. (7-1-97)

03. Annual Review Of Curriculum And Catalog. Schools must provide a curriculum and catalog to the board. Schools must provide a curriculum and catalog to the board for review on an annual basis. Curricula must be submitted at the time of license renewal. If there are no changes in the curriculum or catalog during the previous year, the school may submit a letter of explanation to the board. (7-1-97)

04. Minimum Two Hundred Hours Of Instruction. Student cosmetologists. Student cosmetologists may not be permitted to render any clinical service to patrons until students have completed at least two hundred (200) hours of instruction, nor clinical services considered to be possibly harmful or detrimental to patrons, such as tints, hair-coloring, permanent waves and similar services, until the student has completed three hundred (300) hours of instruction. (7-1-97)

05. Records Required. Records required of schools of cosmetology: (7-1-97)

a. Schools shall maintain ~~monthly~~ records for each student as established by schools' policy and procedures which will show: daily attendance and academic grades of instructional progress. (7-1-97)(____)

~~i. Daily hours spent in classroom recitation and study. (7-1-97)~~

~~ii. Daily hours spent in instructional and practical training. (7-1-97)~~

~~iii. Theory grade, practical grade, sanitation grades, daily number of requirements completed. (7-1-97)~~

b. Monthly Progress records shall be signed and dated by the student and ~~instructor~~ school official. A copy of the signed and dated monthly record shall be provided to the student. The school shall maintain the ~~monthly~~ records for a period of two (2) years following completion or termination of the student training instruction. These records are subject to inspection by the board at any time. (7-1-97)(____)

~~e. The number of operations and hours accumulated on the monthly record forms are to be totaled and transferred to the Record of Instruction Form, showing the day of the month beginning and the day of the month ending the monthly period of time. (7-1-97)~~

~~dc.~~ When a student's course of training instruction at a school has been completed or terminated, the completed operations, and number of ~~classroom~~ hours and practical training of instruction are to be ~~totaled~~ recorded by the school on the Record of Instruction Form. This form is to be filed with the board by the school within ~~thirty~~ sixty (~~30~~) days of the completion or termination of training instruction, or a letter of explanation shall be filed with the board by the school as to why student's ~~hours are~~ Record of Instruction is not verified being filed by the school. (7-1-97)(____)

~~ed.~~ Schools shall maintain on the premises proof of student meeting education requirements. Schools

must maintain proof of student having satisfactorily completed two (2) years of high school (tenth grade) or having equivalent education. If student is a high school graduate, schools may accept a photostatic copy of the high school diploma or transcript. A letter written on high school stationary, signed by an officer of the high school, may be accepted to verify student's satisfactory completion of the tenth grade and eligibility to commence the eleventh grade. (7-1-97)

fe. Proof of age must be submitted. Schools must maintain on their premises proof of students compliance with minimum age requirement. Acceptable proof of birth date will be a copy of the student's birth certificate, a passport, military identification, drivers license or other similar form of documentation. (7-1-97)

f. Schools shall have a written (published) attendance policy. When a school is determining student hours for their course of instruction, a school may define its attendance policy to include one hundred percent (100%) attendance for the course length or may allow excused absences for not more than ten percent (10%) of the course length for satisfactory completion. ()

06. Record Of Training Instruction. ~~A record of The operations to be recorded on the monthly record form and the Student Record of Instruction Form performed by students are~~ completed by each student shall be maintained and include the following: (7-1-97)()

- a. Creative hair styling which shall include hair styles, wet sets/styling, thermal styles, fingerwaving, braiding/free styling ~~three hundred thirty five (335);~~ (7-1-97)()
- b. Scalp Treatments ~~ten (10);~~ (7-1-97)()
- c. Permanent Waves (All Methods) ~~ninety (90);~~ (7-1-97)()
- d. Haircutting/shaping which shall include scissor and razor/clipper ~~one hundred (100);~~ (7-1-97)()
- e. Bleaching ~~ten (10);~~ (7-1-97)()
- f. Tinting ~~thirty five (35);~~ (7-1-97)()
- g. Semi Permanent/Temporary Color ~~twenty (20);~~ (7-1-97)()
- h. Frosting/Hilites ~~ten (10);~~ (7-1-97)()
- i. Facials which shall include plain, makeup and arches ~~forty five (45);~~ (7-1-97)()
- j. Manicures which shall include plain and oil ~~forty (40);~~ (7-1-97)()
- k. Pedicures ~~five (5);~~ and (7-1-97)()
- l. Artificial Nails ~~five (5).~~ (7-1-97)()

07. Discontinuance Of School. If a school discontinues to operate as a school, records of instruction covering all students attending said school at the time of discontinuance or prior thereto, must be filed in the office of the board. (7-1-97)

08. Out-Of-State Applicants. Applicants who have received training instruction in out-of-state schools and who wish to complete training instruction in an Idaho school are required to file with the board prior to applying for examination a copy of the record of instruction from the out of state school(s). For purposes of this section, the record of instruction will be a statement which gives detailed information regarding operations and hours of training instruction, and which is to be verified by the licensing agency or school(s) in the state in which the training instruction was obtained. (7-1-99)()

09. Student Registration. Schools are required to register all students with the board within five (5)

days of beginning ~~training~~ instruction (post office cancellation date will be accepted). Student registration fee must be submitted at time of registration. (7-1-97)()

10. Outside School Activities. Schools may allow a student credit for no more than thirty (30) hours per term for outside activities during the course of their ~~training~~ instruction. These hours must be approved by the instructor. (7-1-97)()

11. Probation For New Students. All students shall be required to serve a probationary period subsequent to registration with the Board in a school of cosmetology. Students must maintain acceptable attendance, satisfactory progress in their instruction, and/or pass an examination at the end of the probationary period. If the student can not maintain these requirements, a written certified notification by the school shall be submitted to the board and the students registration shall become void immediately with no refund of fees. ()

a. The probationary period for students in an approved program of less than an academic year of nine hundred (900) hours and/or less than fifteen (15) weeks shall be a minimum of five percent (5%) of course length. ()

b. The probationary period for students, in an approved program greater than an academic year of nine hundred (900) hours and/or more than thirty (30) weeks shall be a minimum of ten percent (10%) of course length. ()

(BREAK IN CONTINUITY OF SECTIONS)

550. RULES FOR COSMETOLOGY SCHOOLS APPROVED TO TEACH ELECTROLOGY (Rule 550). Section 54-802(n) provides for the teaching of electrology in cosmetology schools. (7-1-99)

01. Board Approval. The board may approve a school to teach electrology who makes application on forms provided by the board and who meets all the requirements set forth in the cosmetology law and these rules. Approval of curriculum must be submitted on a separate application. Approval may be suspended or terminated by the board for the school's failure to meet any one or more of the minimum requirements set forth in the cosmetology law and rules to teach electrology. (7-1-99)

02. Minimum Square Footage. Schools provide a minimum of three hundred (300) square feet of designated floor space per six (6) students. (7-1-97)

03. Required Equipment. Each school shall have the following equipment, which is considered the minimum equipment necessary for the proper instruction of students. This amount of equipment is based on six (6) students. (7-1-97)

- a. Work stations equal to seventy-five percent (75%) of total enrollment. (7-1-97)
- b. Two (2) brands of machines (one (1) with three (3) method capability) Galvanic, Thermolysis, and Blend. (7-1-97)
- c. Two (2) treatment tables and adjustable technician chairs. (7-1-97)
- d. Two (2) swing arm lamps with magnifying lens. (7-1-97)
- e. Two (2) magnifying glasses. (7-1-97)
- f. Tweezers. (7-1-97)
- g. One (1) basin with approved water source. (7-1-97)

- h. Necessary sanitation equipment for implements. (7-1-97)
- i. Closed storage cabinet. (7-1-97)

04. Kit. Each student to be issued a basic kit containing: two (2) tweezers, disposable probes, eye shields, disposable gloves, before treatment solution, after treatment lotion, hair pins or clippies, one (1) sharps container. (7-1-99)

05. Electrologist Instructor/Student Ratio. Schools have at least one (1) licensed electrologist instructor for every six (6) students or portion thereof, being trained therein. (7-1-99)

06. Records Required. Records required of cosmetology schools approved to teach electrology shall be maintained in accordance with the records required for schools of cosmetology. (7-1-99)(____)

- a. Students must complete a course of ~~training~~ instruction which includes a total of eight hundred (800) hours. (7-1-99)(____)

SUBSECTION 550.06.b. IS BEING MOVED TO SUBSECTION 550.07.b.

07. Record Of Training Instruction. ~~The A recorded of all operations on the monthly record form and the Student Record of Instruction Form performed completed by each students are as follows shall be maintained and include the following: (The first numbers are required minimum hours of theory; the second numbers are required minimum clinical hours.)~~ (7-1-97)(____)

- a. Permanent Removal of Hair (Electrology). (7-1-97)
- i. Bacteriology, sanitation and sterilization, safety precautions, anatomy, and physiology ~~—fifty five (55).~~ (7-1-99)(____)
- ii. Electricity which shall include the nature of electrical current, principles of operating electrical devices and the various safety precautions used when operating electrical equipment ~~—fifteen (15).~~ (7-1-99)(____)
- iii. Electrolysis which shall include the use and study of galvanic current ~~—fifteen/twenty (15/20).~~ (7-1-99)(____)
- iv. Thermolysis which shall include the use and study of high frequency current automatic and manual ~~fifteen/fifty (15/50).~~ (7-1-99)(____)
- v. A combination of high frequency and galvanic currents ~~—fifteen/thirty (15/30).~~ (7-1-99)(____)
- vi. The study and cause of hypertrichosis ~~—fifteen (15).~~ (7-1-99)(____)
- vii. ~~Additional training of up to two hundred (200) hours may be taken in bookkeeping, salesmanship and public relations.~~ (7-1-97)
- b. Students may not render any clinical services to patrons until completing at least eighty (80) hours of instruction in electrology. (7-1-99)

(BREAK IN CONTINUITY OF SECTIONS)

560. RULES FOR COSMETOLOGY SCHOOLS TEACHING ESTHETICS (Rule 560).
Section 54-802 (p), Idaho Code, provides for the teaching of esthetics in cosmetology schools. (7-1-97)

- 01. Board Approval.** The board may approve a school to teach esthetics who makes application on

forms provided by the board and who meets all the requirements set forth in the cosmetology law and these rules. Approval of curriculum must be submitted on a separate application. Approval may be suspended or terminated by the board for the school's failure to meet any one or more of the minimum requirements set forth in the cosmetology law and rules to teach esthetics. (7-1-97)

02. Records Required. Records required of schools teaching esthetics shall be maintained in accordance with the records required for schools of cosmetology. (7-1-97)()

a. Students must complete a course of training instruction which includes: ~~Two hundred fifty (250) clinical hours; Two hundred fifty (250) theory hours,~~ for a total of five nine hundred (5900) hours. (7-1-97)()

b. Students may not render any clinical services to patrons until completing at least sixty (60) hours of instruction in esthetics. (7-1-97)

c. The recorded operations ~~on the monthly record form and the Student Record of Instruction Form performed by students are as follows: (The first numbers are required minimum hours of theory; the second numbers are required minimum clinical hours.)~~ completed by each student shall be maintained and include the following: (7-1-97)()

i. Massage and Manipulation application of lotions, creams, etc. ~~thirty/sixty (30/60).~~ (7-1-99)()

ii. Cosmetics ~~thirty/sixty (30/60).~~ (7-1-99)()

iii. Machine Application: use of mechanical or electrical equipment ~~forty/eighty (40/80).~~ (7-1-99)()

(55). iv. Bacteriology, Sanitation and sterilization, safety precautions, anatomy and physiology ~~fifty-five (7-1-99)()~~

v. ~~Additional Training sixty (60).~~ (7-1-99)

vi. Eyebrow arch and hair removal ~~fifteen/twenty (15/20).~~ (7-1-99)()

vii. ~~Special field sciences fifteen/thirty (15/30).~~ (7-1-99)

03. Basic Kit. Each student shall be issued a basic skin care and cosmetic kit containing: (7-1-99)

a. ~~Basic skin care kit:~~ (7-1-99)

i. ~~Cleansing lotion~~ (7-1-99)

ii. ~~Toner;~~ (7-1-99)

iii. ~~Moisturizer;~~ (7-1-99)

iv. ~~Massage cream/oil;~~ (7-1-99)

v. ~~Two (2) facial sponges;~~ (7-1-99)

vi. ~~Five (5) spatulas;~~ (7-1-99)

vii. ~~One (1) masque brush;~~ (7-1-99)

viii. ~~Protective eye covers;~~ (7-1-99)

ix. ~~Head and body drape; and~~ (7-1-99)

- ~~x. Facial bowl; (7-1-99)~~
- ~~b. Basic cosmetic kit; (7-1-99)~~
- ~~i. Foundation base; (7-1-99)~~
- ~~ii. Translucent powder; (7-1-99)~~
- ~~iii. Eye pencil; (7-1-99)~~
- ~~iv. Lip pencil; (7-1-99)~~
- ~~v. Eyeshadow; (7-1-99)~~
- ~~vi. Mascara; (7-1-99)~~
- ~~vii. Blush; (7-1-99)~~
- ~~viii. Lip color; (7-1-99)~~
- ~~ix. Lip brush; (7-1-99)~~
- ~~x. Eyebrow brush; (7-1-99)~~
- ~~xi. Two (2) cosmetic sponges; (7-1-99)~~
- ~~xii. Mascara applicator brush; (7-1-99)~~
- ~~xiii. Make up cape; and (7-1-99)~~
- ~~xiiii. Mirror. (7-1-99)~~

(BREAK IN CONTINUITY OF SECTIONS)

570. RULES FOR COSMETOLOGY SCHOOLS TEACHING NAIL TECHNOLOGY (Rule 570).

Section 54-802 (d), Idaho Code, provides for the teaching of nail technology in cosmetology schools. (7-1-97)

01. Board Approval. The board may approve a school to teach nail technology who makes application on forms provided by the board and who meets all the requirements set forth in the cosmetology law and these rules. Approval of curriculum must be submitted on a separate application. Approval may be suspended or terminated by the board for the school's failure to meet any one or more of the minimum requirements set forth in the cosmetology law and rules to teach nail technology. (7-1-97)

02. Records Required. Records required of schools teaching nail technology shall be maintained in accordance with the records required for schools of cosmetology. (7-1-97)()

a. Students may not render any clinical services to patrons until the student has completed at least forty (40) hours of instruction. All work done on patrons must be completed by students and supervised by instructors. (7-1-97)

03. Record Of Training. The ~~A~~ recorded ~~of~~ operations ~~on the monthly record form and the Student Record of Instruction Form performed by students are formed nails ten (10) sets, finished tips ten (10) sets, wraps and mends ten (10) sets, basic manicure fifty (50), pedicure five (5); completed by each student shall be maintained of the following:~~ (7-1-97)()

- a. Form nails; ()
- b. Finished tips; ()
- c. Wraps and mends; and ()
- d. Basic manicures and pedicures. ()

(BREAK IN CONTINUITY OF SECTIONS)

600. ~~COSMETOLOGY, ELECTROLOGY~~ INSTRUCTOR RULES (Rule 600).

01. Requirements For Instructor License. (7-1-97)

a. Application for an instructor license shall be made on forms furnished by the board and accompanied with the required fees. (7-1-97)

b. Section 54-805(2)(8), Idaho Code, provides for twelve (12) semester college credit hours or equivalent, as approved by the board, or successful completion of the examination required by board rules. Credit hours must be obtained from the Education Department, Speech Communications Department or from the Psychology/Sociology Department and other credit at the discretion of the Board. (7-1-97)

c. Equivalent: (7-1-97)

i. Teaching seminars directed to cosmetology, nail technology, esthetics, or electrology must be approved by the board. Fourteen (14) clock hours is equivalent to one (1) semester college credit hour in an approved seminar. Verification of satisfactory completion must be submitted to the board for their approval. ~~(7-1-99)~~()

ii. Verified satisfactory teaching as a qualified instructor from another state three (3) of the previous five (5) years immediately prior to application. (7-1-97)

d. Experience Requirements for Instructor Applicant (Reference Section 54-805(2)(8), Idaho Code). Five (5) years experience is deemed "immediately preceding" if obtained during the seven (7) year period immediately preceding application for licensure. (7-1-97)

e. An electrologist with fewer than five (5) years' experience as a licensed electrologist must complete three (3) months, five hundred (500) hours of teacher's ~~training~~ instruction in a cosmetology school approved to teach electrology as set forth in Subsection 550.08. ~~(7-1-99)~~()

02. Examination Dates And Places. ~~(7-1-97)~~

~~a. Instructor examinations will be held in conjunction with the board meeting in Boise on the Tuesday following the first (1st) Monday of February, June and October. ~~(7-1-97)~~~~

~~b. The dates and places of examination are subject to change. ~~(7-1-97)~~()~~

03. Termination. All application records in the bureau of applicants who have not qualified for reexamination within five (5) years of notification of failure in any examination under the Cosmetology Law will be terminated and destroyed. (7-1-97)

04. Scope And Requirement Of Examination For License. (7-1-97)

a. Examination will consist of both a practical and written examination. The written examination will

be in two parts: a national theory examination and an Idaho jurisprudence examination. (7-1-97)

b. Mannequin shall be used *in lieu of model*. (7-1-97)()

c. Examinee would be required to demonstrate to the board ability to teach cosmetology, nail technology, esthetics, or electrology services. One subject to be assigned when accepted for examination and a subject to be drawn at the time of the examination. (7-1-97)()

d. Supplies required for the instructor's examination. Bring sufficient materials and supplies to demonstrate in assigned category. (7-1-97)

05. Instructor Reexamination. To be eligible, an applicant must obtain two hundred (200) hours additional ~~training~~ instruction in a school of cosmetology as a student instructor. This requirement will not apply to those applicants failing the examination for the first time. (7-1-97)()

06. Requirements For Student Instructor. (7-1-97)

a. A student instructor shall file an application on forms provided by the board before beginning ~~training~~ instruction and shall at all times be under the direct supervision of a licensed instructor. (7-1-97)()

b. The time spent as a student instructor to meet instructor licensure requirements will not be credited to the years experience required for an instructor license. (7-1-97)

c. One (1) year experience may be obtained within a school upon completion of instructor ~~training~~ instruction. (7-1-97)()

d. Six (6) months is considered to be one thousand (1,000) hours of ~~training~~ instruction. Three (3) months is considered to be five hundred (500) hours of ~~training~~ instruction. (7-1-97)()

07. Student Registration. Schools are required to register all students with the board prior to providing any instruction. Student registration fee must be submitted at time of registration. (7-1-97)

08. Records Required. Records required of schools teaching student instructors shall be maintained in accordance with the records required for schools of cosmetology. ()

089. Record Of Training Instruction. ~~The number of required~~ Records of the operations ~~on a monthly Record Form and Student Record of Instruction Form are as follows: (The first numbers are required operations for six (6) months/one thousand (1,000) hours of training; the second numbers are required operations for three (3) months/five hundred (500) hours of training.)~~ completed by each student shall be maintained of the following: (7-1-97)()

a. Lesson Planning ~~twenty five/ten (25/10)~~. (7-1-99)()

b. Audio Visual Aid Preparation ~~twenty five/ten (25/10)~~. (7-1-99)()

c. Theory Class. ~~Teach twenty five (25) classes/Teach ten (10) classes.~~ (7-1-99)()

d. Practical Demonstrations ~~twenty five/ten (25/10)~~. (7-1-99)()

e. Testing and Evaluation Theory: ~~Fifteen (15) theory/five (5) theory.~~ (7-1-99)()

f. Testing and Evaluation: ~~Fifteen (15) practical/five (5) practical.~~ (7-1-99)()

g. Clinic Floor Supervision ~~Seven hundred/three hundred (700/300)~~. (7-1-99)()

h. ~~Related Subjects One hundred fifty/fifty five (150/55)~~. (7-1-99)

- i. ~~Counseling.~~ (7-1-97)
- ii. ~~Record Keeping.~~ (7-1-97)
- iii. ~~Business and Reception.~~ (7-1-97)

(BREAK IN CONTINUITY OF SECTIONS)

700. COSMETOLOGY - ELECTROLOGY, ESTHETICS, AND NAIL TECHNOLOGY APPRENTICE TRAINING INSTRUCTION (Rule 700).

Sections 54-805(6)(c) and 54-807, Idaho Code, provide for the practice of apprentices. (7-1-99)(____)

01. Cosmetology Apprentices. There must be at least one (1) licensed cosmetology instructor and one (1) licensed cosmetologist in any cosmetological establishment at all times for each apprentice who is being trained therein. (7-1-99)

02. Electrology Apprentices. Apprentice ~~training instruction~~ must be obtained under the direct personal supervision of an electrologist instructor. An electrologist instructor may train no more than one (1) apprentice at a time. (7-1-99)(____)

03. Esthetics Apprentices. There must be at least one (1) licensed cosmetology instructor and one (1) licensed cosmetologist or licensed esthetician in any cosmetological establishment at all times for each apprentice who is being ~~trained instructed~~ therein. (7-1-99)(____)

04. Nail Technology Apprentices. There must be at least one (1) licensed cosmetology instructor and one (1) licensed cosmetologist or nail technician in any cosmetological establishment at all times for each apprentice who is being ~~trained instructed~~ therein. (7-1-99)(____)

05. Filing Application. Application for ~~license permit~~ as an apprentice must be made on forms furnished by the board. (7-1-97)(____)

06. Application For Apprentice. The application submitted for an apprentice ~~license permit~~ must list the names and license numbers of the licensed cosmetologists, electrologists, estheticians, and nail technicians employed in the establishment in which an apprentice will serve apprenticeship. (7-1-99)(____)

07. Prior To Beginning Training Instruction. Prior to beginning of ~~training instruction~~, the instructor for any apprenticeship must submit and have board approval of a curriculum for the entire apprenticeship ~~training instruction~~. (7-1-99)(____)

08. Application Must Be Accompanied By Proof Of Meeting Educational Requirements. Applications must be accompanied by proof of having satisfactorily completed two (2) years of high school (tenth grade) or having equivalent education. If applicant is a high school graduate, a photostatic copy of the high school diploma may be submitted. A letter written on high school stationery, signed by an officer of the high school, may be forwarded with the application. Such letter shall indicate that the applicant has satisfactorily completed the tenth grade and is eligible to commence the eleventh grade. Do not send original high school diploma to the board. (7-1-97)

09. Submit Proof Of Birth. Apprentices must furnish a copy of their birth certificate or other acceptable proof of birth with application. (7-1-97)

10. Apprentice License Permit. An apprentice ~~license permit~~ must be obtained from the board before ~~training instruction~~ as an apprentice begins. An original apprentice ~~license permit~~ shall be dated and valid until such time as said apprentice is no longer enrolled as an apprentice in said establishment. (7-1-99)(____)

11. **Records Required.** Establishments ~~training~~ instruction apprentices must maintain records as set forth: (7-1-97)(____)

- a. For cosmetology apprentice in Subsection 500.05. (7-1-99)
- b. For electrology apprentice in Subsection 550.06.a.i. (7-1-99)
- c. For esthetics apprentice in Subsection 560.02. (7-1-99)
- d. For nail technology apprentice in Subsection 570.02. (7-1-99)

12. **Record Of Training.** ~~The Records of the operations to be recorded on the monthly record form and the Student Record of Instruction form performed by apprentices are as set forth~~ completed by each student shall be maintained of the following: (7-1-97)(____)

- a. For cosmetology apprentice in Subsection 500.06. (7-1-97)
- b. For electrology/~~esthetic~~ apprentice in Subsection 550.07. (7-1-97)(____)
- c. For esthetics apprentice in Subsection 560.02.c. (7-1-99)
- d. For nail technology apprentice in Subsection 570.03. (7-1-99)

13. **Discontinuance Of A Course.** When an apprentice discontinues a course of study, the salon is to complete a Record of Instruction Form with the credited hours completed by the apprentice. This form is to be submitted to the board. If an apprentice discontinues a course of ~~training~~ instruction and does not transfer to another salon within sixty (60) days, the apprentice ~~license~~ permit is automatically canceled and is to be submitted to the board along with the Record of Instruction. (7-1-97)(____)

14. **Before Resuming Training Instruction.** Before resuming ~~training~~ instruction, after having discontinued a course, an apprentice must file a new application and pay an additional fee. The apprentice must receive a ~~license~~ permit before resuming ~~training~~ instruction. (7-1-97)(____)

15. **Discontinuance Of Establishment Training Instruction Apprentices.** If a licensed establishment where apprentices are being trained discontinues to operate as a salon, records of instruction covering all apprentices obtaining ~~training~~ instruction at the time of discontinuance or prior thereto, must be filed in the office of the board. (7-1-97)(____)

16. **Out Of State Apprenticeship.** Prior to commencing a course of study in an Idaho approved establishment, an apprentice applicant is required to file with the board a copy of the record of instruction from the out of state apprenticeship. For purposes of this section, the record of instruction will be a statement which gives detailed information regarding operations and hours of ~~training~~ instruction, and which is to be verified by the licensing agency or instructor(s) in the state in which the ~~training~~ instruction was obtained. (7-1-97)(____)

IDAPA 24 - BUREAU OF OCCUPATIONAL LICENSES
24.05.01 - RULES OF THE BOARD OF ENVIRONMENTAL HEALTH SPECIALIST EXAMINERS
DOCKET NO. 24-0501-0001
NOTICE OF PROPOSED RULE

AUTHORITY: In compliance with Sections 67-5220(1), Idaho Code, notice is hereby given that this agency has proposed rulemaking. The action is authorized pursuant to Section 54-2403 and 54-2405, 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 October 18, 2000.

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:

Establish the original license fee to be \$60; delete a redundancy in the reexamination fee; provide for an environmental health specialist trainee certificate fee of \$60; delete references to certificate fee.

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

Section 54-4113, Idaho Code, authorizes the Board to set fees for certificates of registration in amounts not to exceed \$60. The current fees are equal to the present statutory cap. The proposed license fee change does not increase current fees, but rather clarifies the original licensure fee. The fee for the trainee certificate is being clarified and increased to \$60 from \$5.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Dee Ann Randall, (208) 334-3233.

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 October 25, 2000.

DATED this 21st day of August, 2000.

Dee Ann Randall
Owyhee Plaza
1109 Main Street, Suite 220
Boise, Idaho 83702
(208) 334-3233
(208) 334-3945 (FAX)

THE FOLLOWING IS THE TEXT OF DOCKET NO. 24-0501-0001

400. FEES (Rule 400).

01. Fee To Accompany Application. Every application must be accompanied by the application fee together with the examination fee or reciprocity fee whichever is appropriate. (7-1-93)

- 02. Reexam Fee.** The application fee is not required when applying for reexamination unless the prior existing application has been terminated by board action and the applicant is required to submit another complete application as in the case of one applying for the first time. (7-1-93)
- 03. Fee Schedule.** As required by law, the Board has established the following fees: (7-1-93)
- a. Original license fee - Sixty dollars (\$60). ()
 - ~~a~~b. Annual renewal fee - Sixty dollars (\$60). (7-1-97)
 - ~~b~~c. Application fee - Twenty-five dollars (\$25). (7-1-93)
 - ~~c~~d. Examination/Reexamination fee - The examination/reexamination fee will equal that charged by the national examining entity together with an additional twenty-five dollar (\$25) administration fee. (7-1-97)
 - ~~d~~e. Reexamination fee - Seventy-five dollars (\$75). (7-1-93)
 - e. Reciprocity fee - Seventy-five dollars (\$75). (7-1-93)
 - f. Environmental health specialist trainee certificate fee - Five Sixty dollars (\$560). (7-1-93)()
- ~~04. Certificate Fee. The certificate fee is required when changing to Environmental Health Specialist from trainee status.~~ (7-1-93)
- 054. Fees Are Not Refundable.** Fees are not refundable. (7-1-93)

IDAPA 24 - BUREAU OF OCCUPATIONAL LICENSES
24.10.01 - RULES OF THE STATE BOARD OF OPTOMETRY
DOCKET NO. 24-1001-0001
NOTICE OF PROPOSED RULE

AUTHORITY: In compliance with Sections 67-5220(1), Idaho Code, notice is hereby given that this agency has proposed rulemaking. The action is authorized pursuant to Section 54-1509, 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 October 18, 2000.

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:

Update current examination requirements; provide that reinstatement of license canceled over five years is subject to examination at the discretion of the board; add \$10 certificate to obtain and use pharmaceutical agents fee; and update rules to reflect the change in name of the national organization administering the examination.

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

Section 54-1501, Idaho Code, authorizes the Board to issue a certificate to prescribe, administer and dispense therapeutic pharmaceutical agents. The proposed fee will be assessed one time only per applicant, to defray the costs of printing and preparing the certificate.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Dee Ann Randall, (208) 334-3233.

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 October 25, 2000.

DATED this 21st day of August, 2000.

Dee Ann Randall
Owyhee Plaza
1109 Main Street, Suite 220
Boise, Idaho 83702
(208) 334-3233
(208) 334-3945 (FAX)

THE FOLLOWING IS THE TEXT OF DOCKET NO. 24-1001-0001

175. METHOD OF APPLICATION-EXAMINATION OF APPLICANTS (Rule 175).

Applications for license shall be made on forms approved by the Board of Examiners which may be obtained and which must be filed in the office of Occupational License Bureau at Owyhee Plaza, 1109 Main Street, Suite 220, Boise, Idaho 83702, ~~by June 1, of each year.~~ (7-1-93)()

- 01. Application Fee.** The application fee must be accompanied by: (7-1-93)
- a. The required fee. (7-1-93)
 - b. An unmounted photograph three inches by three inches (3" x 3"), head and shoulders only, taken within one (1) year prior to the date of making the application. (7-1-93)
 - c. A complete transcript of credits from any college of optometry attended. (7-1-93)
 - d. A photocopy of any diplomas granted by any college of optometry. (7-1-93)
 - e. A copy of certified results establishing successful passage of the required examinations. ()

02. ~~Filing Of Documents.~~ ~~If the application is filed prior to the date of graduation, or if the required documents are otherwise unavailable, the transcripts and a copy of the diploma may be forwarded prior to the date of examination.~~ **Application Review.** Only fully completed applications accompanied by appropriate documents shall be reviewed for licensure. (7-1-93)()

03. ~~Unable To File Documents.~~ ~~Any graduate who demonstrates good cause why he has been unable to deliver a copy of the diploma or transcript of credits from a college of optometry prior to the date of examination, may take the examination but shall not receive his license until these documents are submitted and reviewed by the Board.~~ (7-1-93)

043. Exam Content. The written and the practical portions of the Idaho examination shall be all parts of the National Board of Examiners in Optometry Examination and the "Treatment and Management of Ocular Diseases" examination approved by the Association of Regulatory Boards of Optometry, Inc. (ARBO). A passing grade on ~~the National Board of Examiners in Optometry~~ both Examinations shall be necessary before obtaining a license to practice Optometry in Idaho. (7-1-93)()

(BREAK IN CONTINUITY OF SECTIONS)

250. LICENSES CANCELED FOR FAILURE TO RENEW (Rule 250).

Any person whose license to practice optometry has been canceled for failure to renew for a period in excess of ~~more than~~ five (5) years may be reinstated in accordance with the requirements of Section 67-2614, Idaho Code, ~~after~~ subject to examination by the State Board of Examiners of the State Board of Optometry ~~as is required for new applicants under Section 175 set out above~~ at its discretion. (7-1-93)()

(BREAK IN CONTINUITY OF SECTIONS)

575. FEES (Rule 575).

- 01. Annual Renewal Fee.** Annual renewal fee for license - seventy-five dollars (\$75). (7-1-97)
- 02. Annual Optometry Fund Fee.** Annual optometry fund fee - seventy-five dollars (\$75). (7-1-97)
- 03. License Application Fee.** License application fee - one hundred dollars (\$100). (7-1-93)
- 04. Certificate To Obtain And Use Pharmaceutical Agents Fee.** Certificate to obtain and use pharmaceutical agents fee - ten dollars (\$10). ()

(BREAK IN CONTINUITY OF SECTIONS)

600. BOARD CERTIFICATION OF OPTOMETRIST AUTHORIZED TO OBTAIN AND USE PHARMACEUTICAL AGENTS (Rule 600).

01. The Right To Obtain And Use Topically Applied Diagnostic Pharmaceutical Agents. The right to obtain and use topically applied diagnostic pharmaceutical agents for use in diagnosis of another in the practice of optometry as defined by Section 54-1501, Idaho Code, is subject to the following conditions set out below: (7-1-93)

a. Optometrists who have obtained a certificate from the Board of Optometry authorizing them to obtain and use topically applied diagnostic pharmaceutical agents shall obtain, from pharmacists licensed by the state of Idaho, or from any other source, and use only those agents listed below: (7-1-93)

i. Anesthetics: (7-1-93)

(1) Proparacaine 0.5%; (7-1-93)

(2) Tetracaine 0.5%; (7-1-93)

(3) Benoxinate 0.4% c fluorescein. (7-1-93)

ii. Cycloplegics: (7-1-93)

(1) Tropicamide 0.5%; (7-1-93)

(2) Cyclopentolate 0.5%; (7-1-93)

(3) Atropine 0.5%. (7-1-93)

iii. Mydriasis Reversal Agents: (7-1-93)

(1) Dapiprazole HCl 0.5%. (7-1-93)

b. The Board of Optometry shall issue a certificate to obtain and use the diagnostic drugs specifically identified and listed in this rule to any optometrist licensed to practice in Idaho who complies with both the minimum educational requirements in the subject of general and ocular pharmacology and the minimum continuing educational requirements set out below: (7-1-93)

i. Each optometrist certified to obtain and use topically applied pharmaceutical agents shall have completed courses totaling fifty-five (55) hours of actual classroom instruction in general and ocular pharmacology and emergency medical care given by an institution approved by the Council on Post Secondary Accreditation of the U.S. Department of Education or an instructor accredited and employed by such institution and which have been approved by the Board of Optometry. (7-1-93)

ii. Each optometrist certified to obtain and use topically applied pharmaceutical agents shall also have completed a refresher course in cardiopulmonary resuscitation (CPR), emergency medical care provided by the Emergency Medical Services Bureau, or equivalent program either approved or provided by the Board of Optometry, within a two (2) year period preceding issuance of the certificate by the Board of Optometry. (7-1-93)

iii. In order to maintain the certificate issued by the Board, each certified optometrist must complete a refresher course in emergency medical care described in Subsection 600.01.b.ii. above once during each two (2) year period following certification and shall list and describe the course attended and the dates of attendance upon a license renewal application form filed pursuant to Section 300. (7-1-93)

c. In order to implement this rule, the Board of Optometry may designate and approve courses of instruction given by those institutions or instructors described in Subsection 600.01.b.i. above which may be

necessary to provide practicing optometrists who have received less than fifty-five (55) hours of actual classroom instruction in general and ocular pharmacology in optometry school with the opportunity to meet the requirements of this rule. (7-1-93)

02. The Right To Prescribe, Administer And Dispense Therapeutic Pharmaceutical Agents. The right to prescribe, administer and dispense therapeutic pharmaceutical agents in the practice of optometry as defined by Section 54-1501, Idaho Code, is subject to the following conditions set out below: (11-6-93)

a. Optometrists who have obtained a certificate from the Board of Optometry authorizing them to prescribe, administer and dispense therapeutic pharmaceutical agents shall obtain, from pharmacists licensed by the State of Idaho, or from any other source, and use only those agents listed below: (11-6-93)

i. All medications for use in the treatment of the human eye and/or eyelid. (7-1-97)

ii. All over-the-counter agents. (11-6-93)

iii. Such other therapeutic pharmaceutical agents as may be approved by the Board of Optometry. (11-6-93)

b. The Board of Optometry shall issue a certificate to prescribe, administer and dispense the therapeutic medications to any optometrist licensed to practice in Idaho who complies with Subsection 600.01 and both the minimum educational and clinical experience requirements in the subject of ocular pharmacology and therapeutics and the minimum continuing educational requirements set out below: (7-1-97)

i. Completion of a minimum of one hundred (100) hours of actual classroom and clinical instruction in ocular pharmacology and therapeutics courses given by an institution or organization approved by the Council on Post-Secondary Accreditation of the U.S. Department of Education, or an Instructor employed by such institution, which have been approved by the Board of Optometry. (7-1-93)

ii. Successful passage of the "Treatment and Management of Ocular Diseases" section of the optometrist examination approved by the ~~International~~ Association of Regulatory Boards of ~~Examiners in~~ Optometry, Inc. (~~IAB~~) (ARBO). (~~11-6-93~~)()

IDAPA 24 - BUREAU OF OCCUPATIONAL LICENSES
24.15.01 - RULES OF THE IDAHO COUNSELOR LICENSING BOARD

DOCKET NO. 24-1501-0001

NOTICE OF PROPOSED RULE

AUTHORITY: In compliance with Sections 67-5220(1), Idaho Code, notice is hereby given that this agency has proposed rulemaking. The action is authorized pursuant to Section 54-3404, 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 October 18, 2000.

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:

Modify the supervised experience requirements by adding the alternatives of one-to-one consultation or one-to-two consultation with a supervisor to the existing face-to-face consultation requirement; change the required credentials of those seeking to provide qualified counseling supervision to allow supervision to be provided by a licensed professional counselor-private practice in addition to a licensed professional counselor for those applicant's supervised at anytime after July 1, 1988; add the definition of direct client contact; and replace the Board's issuance of a letter setting forth a scope of practice recommendation consistent with its evaluation of the applicant's graduate major, supervised experience and other corroborative information with a rule requiring counselors to practice only within the boundaries of their competence.

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

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Dee Ann Randall, (208) 334-3233.

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 October 25, 2000.

DATED this 21st day of August, 2000.

Dee Ann Randall
Owyhee Plaza
1109 Main Street, Suite 220
Boise, Idaho 83702
(208) 334-3233
(208) 334-3945 (FAX)

THE FOLLOWING IS THE TEXT OF DOCKET NO. 24-1501-0001

150. QUALIFICATIONS FOR LICENSED PROFESSIONAL COUNSELOR LICENSURE (Rule 150).
Licensure as a "licensed professional counselor" shall be restricted to persons who have successfully completed each of the following requirements: (7-1-97)

01. Graduate Program Requirement. A planned graduate program of sixty (60) semester hours which is primarily counseling in nature, six (6) semester hours of which are earned in an advanced counseling practicum, and including a graduate degree in a counseling field from an accredited university or college offering a graduate program in counseling. (7-1-93)

a. A planned graduate program in a counseling field shall be defined as completion of one (1) of the following: (7-1-93)

i. A counseling program accredited or approved by the National Council for accreditation of Teacher Education or a counseling program listed in the Interstate List of Approved Programs; or (7-1-93)

ii. A counseling program approved by the Council for Accreditation of Counseling and Related Educational Programs; or (7-1-93)

iii. A counseling program approved by the Council on Rehabilitation Education; or (7-1-93)

iv. A counseling program approved by the Board which shows evidence of education in the following areas: Counseling Theory, Counseling Techniques and Supervised Counseling Experience (this practicum must be 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) and at least six (6) of the following: (7-1-93)

(1) 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. (7-1-93)

(2) 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. (7-1-93)

(3) 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. (7-1-93)

(4) 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. (7-1-93)

(5) 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. (7-1-93)

(6) 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. (7-1-93)

(7) 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. (7-1-93)

(8) 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. (7-1-93)

b. A total of at least sixty (60) graduate semester hours or ninety (90) graduate quarter hours shall be required. (7-1-93)

- c. Advanced counseling practicum shall be practica taken at the graduate school level. (7-1-93)
- d. A graduate degree shall be one of the following beyond the baccalaureate level: The master's degree, the educational specialist certificate or degree, or the doctor's degree. (7-1-93)
- e. An accredited university or college shall be a college or university accredited by one (1) of the following: the Middle States Association of Colleges and Secondary Schools, the New England State Association of Colleges and Secondary Schools, the North Central Association of Colleges and Secondary Schools, the Northwest Association of Colleges and Secondary Schools, the Southern Association of Colleges and Secondary Schools, or the Western College Association. (7-1-93)

02. Supervised Experience Requirement. One thousand (1,000) hours of supervised experience in counseling acceptable to the Board. (7-1-93)

a. One thousand (1,000) hours is defined as one thousand (1,000) clock hours of experience working in a counseling setting. Supervised experience in practica and/or internships taken at the graduate level may be utilized. The supervised experience shall include a minimum of one (1) hour of face-to-face or one-to-one or one-to-two consultation with the supervisor for every twenty (20) hours of job/internship experience. (As stated under Subsection 150.01.a.iv. counseling practicum experience as opposed to job or internship experience shall be supervised at a ratio of one (1) hour of supervision for every ten (10) hours in the settings. For example: ~~(7-1-93)~~(____))

i. A person in a twenty (20) hour per week job/internship who is receiving one (1) hour of individual supervision each week would accumulate one thousand (1,000) supervised hours in fifty (50) weeks to equal the twenty to one (20/1) ratio. (7-1-93)

ii. A person in a forty (40) hour per week setting with one (1) hour of supervision per week would still require fifty (50) weeks to equal the twenty to one (20/1) ratio. (7-1-93)

iii. A person in a forty (40) hour per week setting with two (2) hours of supervision per week would accumulate the one thousand (1,000) hours at the twenty to one (20/1) supervision ratio in twenty-five (25) weeks. (7-1-93)

b. ~~The~~ If supervision was obtained prior to July 1, 1988, or in a state that does not regulate counseling, that supervision must have been provided by a qualified counselor educator as a part of a planned graduate program or by a person who holds a graduate degree beyond the baccalaureate level who is certified and/or licensed as a counselor, social worker, psychologist, or psychiatrist. Supervision by an administrative superior who is not in a counseling related profession is not acceptable to the Board. Supervision by a professional counseling peer, however, may be acceptable to the Board if the peer/supervisory relationship includes the same controls and procedures expected in an internship setting. (See Subsection 150.02.a.) For example, the relationship should include the staffing of cases, the critiquing of counseling tapes and this supervision must be conducted in a formal, professional, consistent manner on a regularly scheduled basis. Effective July 1 1988, the supervision must be provided by a Licensed Professional Counselor or a Licensed Professional Counselor-Private Practice licensed by the state of Idaho. ~~¶~~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 of Title 54, Chapter 34, Idaho Code. ~~(7-1-93)~~(____)

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 personal-social concerns, educational progress, and occupations and careers. Counseling experience may include the use of appraisal instruments, referral activities, and research findings. (7-1-93)

03. Written Examination Requirement. (7-1-93)

a. The Board requires a written examination. (7-1-93)

- b. Completion of the examination will not be required until the applicant meets the requirements presented in Subsections 150.01 and 151.02. However, an applicant may take the examination earlier if he desires. (7-1-93)
- c. The examination will be conducted at a time and place specified by the Board. (7-1-93)
- d. Successful performance on the examination will be established by the Board. (7-1-93)
- e. The first time the examination is failed the applicant may take it again the next time it is given upon application and payment of fees. If the examination has been failed twice, the individual must wait at least one (1) year before taking it a third time. The individual must wait at least one year and petition the Board for approval to take the examination the fourth time. The petition shall include evidence satisfactory to the Board that the applicant has taken additional study in the field of Counseling before approval will be granted. (7-1-93)

(BREAK IN CONTINUITY OF SECTIONS)

225. LICENSED PROFESSIONAL COUNSELOR-PRIVATE PRACTICE LICENSURE (RULE 225).

The following requirements must be met for licensed professional counselor-private practice licensure (7-1-97)

01. Private Practice Specialty Licensure. Applicants applying for private practice specialty licensure prior to January 1, 1998, must meet the criterion of having provided two thousand (2,000) hours of direct client contact since being licensed as a licensed professional counselor. Additionally, applicants must: (7-1-97)

- a. Hold a current Idaho Licensed Professional Counselor License; (7-1-97)
- b. Direct client contact is defined as face-to-face counseling in an individual or group setting. Document direct client contact by providing verification and/or practice records indicating hours of counseling; and ~~(7-1-97)~~(____) (7-1-97)
- c. Document proficiency in Diagnostic Evaluation by providing verification of successful completion of graduate course or other training/experience equivalent to a college course acceptable to the board. (7-1-97)

02. Other Requirements. After January 1, 1998 the following requirements must be met: (7-1-97)

- a. Hold a current Idaho licensed professional counselor license; and (7-1-97)
- b. Document two thousand (2,000) hours of supervised experience accumulated over a two (2) year period after licensure. (7-1-97)
 - i. A Licensed Professional Counselor-Private Practice must provide at least one thousand (1,000) hours of the supervised experience requirement; the remainder of the supervision may be provided by Psychiatrists, Counseling/Clinical Psychologists and/or Certified Social Workers-Private and Independent Practice. (7-1-97)
 - ii. The ratio for supervision will consist of one (1) hour of face-to-face, one-on-one (1/1) supervision to every thirty (30) hours of direct client contact. (7-1-97)
 - c. Document proficiency in Diagnostic Evaluation by providing verification of successful completion of graduate course or other training/experience equivalent to a college course acceptable to the board. (7-1-97)

03. Supervisors. A supervisor may supervise no more than three (3) licensed professional counselors at any one time. (7-1-97)

04. Continuing Education. Twenty (20) contact hours of continuing education, per year is required to

renew a Licensed Professional Counselor - Private Practice license. (7-1-97)

a. Documentation must be copies of verification from providers, transcripts, or certificates acceptable to the board. (7-1-97)

b. Continuing education requirement shall begin upon the second renewal of the licensed professional counselor-private practice license. Prior to renewal, documentation of the continuing education credits must be provided along with the renewal application. (7-1-97)

(BREAK IN CONTINUITY OF SECTIONS)

450. GENERAL SCOPE OF THE LICENSEE'S APPROPRIATE PRACTICE (Rule 450).

01. Board Recommendation Of Generic Scope Of Practice. While the professional counselor license could be considered generic in nature, it should not be viewed as an authorization to provide counseling services to every client population in every possible professional setting. ~~The letter which accompanies the issuance of the first license will recommend the general scope of the licensee's appropriate practice. This recommended scope of practice will be consistent with the Board's evaluation of the applicant's graduate major, supervised experience and other corroborative information.~~ Counselors are to practice only within the boundaries of competence (Code of Ethics Section C2). (7-1-93)()

02. Submission Of Additional Information For Scope Of Practice. A licensed counselor who considers the Board's recommended guidelines to be too restrictive may wish to submit additional information to acquaint the Board with new, possibly more expansive qualifications. (7-1-93)

IDAPA 24 - BUREAU OF OCCUPATIONAL LICENSES
24.17.01 - RULES OF THE STATE BOARD OF ACUPUNCTURE
DOCKET NO. 24-1701-0001
NOTICE OF PROPOSED RULE

AUTHORITY: In compliance with Sections 67-5220(1), Idaho Code, notice is hereby given that this agency has proposed rulemaking. The action is authorized pursuant to Section 54-4705, 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 October 18, 2000.

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:

Provide for the address of the Board; clarify the definitions and remove references to specific national & international groups; provide definitions for "approved acupuncture program, didactic course work, & clinical practice; delete obsolete language & define the requirements for licensure, certification, and technician; establish fees for original license \$250, original certification \$250, original technician \$150; add to inactive license "or certification" fee; include expiration and reinstatement for certificates, and refer to Chapter 67, Title 26 for expiration & reinstatement process; add certification under scope of practice; extend the change of business notice provision to 30 days from 5 days.

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

There will be no fiscal impact as the changes do not establish new or increased fees. The changes will clarify those fees authorized by Section 54-4710, Idaho Code.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Dee Ann Randall, (208) 334-3233.

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 October 25, 2000.

DATED this 21st day of August, 2000.

Dee Ann Randall
Owyhee Plaza
1109 Main Street, Suite 220
Boise, Idaho 83702
(208) 334-3233
(208) 334-3945 (FAX)

THE FOLLOWING IS THE TEXT OF DOCKET NO. 24-1701-0001

005. ADDRESS OF THE IDAHO STATE BOARD OF ACUPUNCTURE (Rule 5).
Bureau of Occupational Licenses, Owyhee Plaza, 1109 Main St., Suite 220, Boise, ID 83702. ()

0056. -- 009. (RESERVED).

010. DEFINITIONS (Rule 10).

01. Board. The State Board of Acupuncture as prescribed in Section 54-4704, Idaho Code. (3-10-00)

02. Technician Certificate. The category of license granted to a qualified applicant ~~for Acupuncture Technician who meets the requirements pursuant to Section 54-4708, Idaho Code, and other Board approved criteria.~~
(3-10-00)()

03. Certification. The category of license granted to a qualified applicant who meets the requirements ~~for full or associate membership of the American Academy of Medical Acupuncture, or fellowship of the International Academy of Medical Acupuncture, Inc. and other Board approved criteria~~ pursuant to Sections ~~54-4703 and~~ 54-4707, Idaho Code.
(3-10-00)()

04. License. Any license, certification or technician certificate issued to a qualified applicant pursuant to IDAPA 24.17.01, "Rules of the State Board of Acupuncture," promulgated by the Board, permitting said applicant to practice acupuncture in the state of Idaho. (3-10-00)

05. Practitioner. A person to whom a license, certification or technician certificate has been issued pursuant to ~~these rules~~ Title 54, Chapter 47, Idaho Code. (3-10-00)()

06. Licensure/Licensed. The category of license granted to a qualified applicant who meets ~~NCCAOM (National Certification Commission for Acupuncture and Oriental Medicine) eligibility criteria, and other Board approved criteria~~ the requirements pursuant to Sections ~~54-4703 and~~ 54-4706, Idaho Code. (3-10-00)()

07. Approved Acupuncture Program. A formal full-time acupuncture educational program that has met the standards of the Accreditation Commission for Acupuncture and Oriental Medicine or an equivalent educational body. An acupuncture program may be established as having satisfied this requirement by obtaining: ()

a. Accreditation; or ()

b. Candidacy for accreditation; or ()

c. An equivalent evaluation performed by a private, state government, or foreign government agency recognized for that purpose by the NCCAOM (National Certification Commission for Acupuncture and Oriental Medicine) Eligibility Committee. ()

08. Didactic Course Work. Educational instruction in acupuncture that is physically obtained in a classroom or laboratory setting, and when such instruction is obtained from, and in the presence of, a person credentialed as a qualified educator of acupuncture. ()

09. Clinical Practice. Practical experience in acupuncture that is physically obtained in a health care facility in order to meet the minimum requirements for licensure or certification. ()

(BREAK IN CONTINUITY OF SECTIONS)

200. QUALIFICATIONS FOR LICENSURE (Rule 200).

01. Requirements For Licensure. Applicants for licensure shall ~~meet the following requirements~~ submit a complete application, required fee, and official certified documentation of either: (3-10-00)(____)

- ~~a. Submittal of a complete application and fee. (3-10-00)~~
- ~~b. For July 1, 1999, through June 30, 2000, qualification for NCCAOM eligibility criteria for certification. (3-10-00)~~
- ~~c. After July 1, 2000, qualification for NCCAOM eligibility criteria for acupuncture certification; or (3-10-00)~~
- ~~ia. Similar requirements as approved by the Board~~ Successful completion of the requirements to be a candidate for NCCAOM certification; ~~and or (3-10-00)(____)~~
- ~~b. Graduation from an approved formal full-time acupuncture program of at least one thousand seven hundred twenty-five (1,725) hours of entry-level acupuncture education which includes a minimum of one thousand (1000) hours of didactic course work and five hundred (500) clinical hours practice; and (____)~~
- ~~ii.c. Demonstrated s~~Successful completion of an acupuncture internship, or other equivalent experience as approved by the Board; and (3-10-00)(____)
- ~~iii.d. Received Receipt of a passing grade on an NCCAOM Acupuncture certification examination; or (3-10-00)(____)~~
- ~~iv.e. Other demonstration of proficiency as uniformly required by the Board for other similarly qualified applicants for certification licensure; and (3-10-00)(____)~~
- ~~f. Successful completion of a Blood Borne Pathogen course and comprehensive examination that incorporates clean needle techniques and OSHA procedures and requirements. (____)~~

02. Requirements For Certification. Applicants for certification shall ~~meet the following requirements~~ submit a complete application, required fee and official certified documentation of either: (3-10-00)(____)

- ~~a. Submittal of a complete application and fee. (3-10-00)~~
- ~~b. For July 1, 1999, through June 30, 2000, full or associate membership of the American Academy of Medical Acupuncture or fellowship of the International Academy of Medical Acupuncture, Inc.; or (3-10-00)~~
- ~~i. Such other comparable requirements as approved by the Board; (3-10-00)~~
- ~~ea. After July 1, 2000, Successful completion of the requirements for full membership of the American Academy of Medical Acupuncture or fellowship of the International Academy of Medical Acupuncture, Inc.; or (3-10-00)(____)~~
- ~~i. Such other comparable requirements as approved by the Board; and (3-10-00)~~
- ~~b. Successful completion of a minimum of one hundred (100) hours of didactic course work, two hundred (200) hours of practice as a certified technician over a one (1) year period, twenty-five (25) case studies; and (____)~~
- ~~ii.c. Received Receipt of a passing grade on a board approved examination that measures minimum competency; or (3-10-00)(____)~~
- ~~iii.d. Other demonstration of proficiency as uniformly required by the Board for other similarly qualified applicants for certification; and (3-10-00)~~

e. Successful completion of a Blood Borne Pathogen course and comprehensive examination that incorporates clean needle techniques and OSHA procedures and requirements. ()

03. Requirements For Acupuncture Technician Certificate. Applicants for Acupuncture technician Certificate shall ~~meet the following requirements~~ submit a complete application, required fee, and official certified documentation of either: ~~(3-10-00)~~()

~~a. Submittal of a complete application and fee.~~ ~~(3-10-00)~~

~~b~~a. Successful completion of the requirements for clinical technician certificate from the International Academy of Medical Acupuncture, Inc.; or (3-10-00)

~~i. Such other comparable requirements as are approved by the Board; and~~ ~~(3-10-00)~~

b. Successful completion of a minimum of one hundred (100) hours of didactic course work within one (1) academic year; and ()

~~ii~~c. Successful completion of a Blood Borne Pathogen course and comprehensive examination that incorporates clean ~~or sterile~~ needle techniques ~~course approved by the Board~~ and OSHA procedures and requirements; and ~~(3-10-00)~~()

~~iii~~d. Receipt of a passing grade on ~~a~~ board approved examination leading to an Acupuncture Technician Certificate, or other demonstration of proficiency as may be uniformly required for other similarly qualified applicants as approved by the Board. ~~(3-10-00)~~()

(BREAK IN CONTINUITY OF SECTIONS)

300. FEES (Rule 300).

01. Application Fee. Application fee for any original license or certification – two hundred fifty dollars (\$250). ~~(3-10-00)~~()

02. Original License Fee. ()

a. Original license fee - two hundred fifty dollars (\$250). (3-10-00)

b. Original fee for Certification - two hundred fifty dollars (\$250). ()

c. Original fee for Technician Certification - one hundred fifty dollars (\$150). ()

03. Annual Renewal Fee. (3-10-00)

a. Annual renewal fee for Licensure – two hundred fifty dollars (\$250). (3-10-00)

b. Annual renewal fee for Certification – two hundred fifty dollars (\$250). (3-10-00)

c. Annual renewal fee for Technician Certification – one hundred fifty dollars (\$150). (3-10-00)

04. Inactive License. Inactive license or certification fee – fifty dollars (\$50). ~~(3-10-00)~~()

05. Non-refundable. All fees are non-refundable. (3-10-00)

06. Yearly Fees. With the exception of Subsection 300.01 and 300.02 all fees provided under these

rules are yearly fees.

(3-10-00)

301. RENEWAL OR REINSTATEMENT OF LICENSE (Rule 301).

01. Expiration Date. All Acupuncture licenses and certificates expire on June 30th of each year and must be renewed annually on or before July 1st on forms provided by the Board. Licenses and certificates not so renewed will be cancelled in accordance with Section 67-2614, Idaho Code. ~~(3-10-00)~~(____)

02. Reinstatement. Any license or certificate cancelled for failure to renew may be reinstated upon payment of a two hundred fifty dollars (\$250) ~~renewal application fee accompanied by an application and two hundred fifty dollars (\$250) license~~ reinstatement fee and in accordance with Section 67-2614, Idaho Code. ~~(3-10-00)~~(____)

(BREAK IN CONTINUITY OF SECTIONS)

400. SCOPE OF PRACTICE OF ACUPUNCTURE (Rule 400).

The Board recognizes that the practice of acupuncture is widely utilized as a treatment modality and that acupuncture may be appropriately and effectively utilized within various disciplines. The Board also finds that regulation of the scope of practice for practitioners is appropriate to protect the health, safety and welfare of the people of Idaho. Upon being granted a ~~credential~~ license or certification to practice acupuncture, a practitioner is authorized to provide only acupuncture services and treatments for which that practitioner has been appropriately trained and prepared by Board approved education or practical experience. Information contained within the application or otherwise included in the credential file maintained by the Board for that practitioner shall be 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 timely. ~~(3-10-00)~~(____)

(BREAK IN CONTINUITY OF SECTIONS)

500. USE OF BUSINESS NAME OR TRADE NAME (Rule 500).

A business name or trade name used by a practitioner shall be registered with the Board within ~~five~~ thirty (30) business days from commencement of using such name. ~~(3-10-00)~~(____)

IDAPA 24 - BUREAU OF OCCUPATIONAL LICENSES
24.18.01 - RULES OF THE REAL ESTATE APPRAISER BOARD
DOCKET NO. 24-1801-0001
NOTICE OF PROPOSED RULE

AUTHORITY: In compliance with Sections 67-5220(1), Idaho Code, notice is hereby given that this agency has proposed rulemaking. The action is authorized pursuant to Section 54-4106, 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 October 18, 2000.

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:

Increase the application for qualification fee and reciprocity application fee to \$250; increase the original certification/license fee and original certification/license fee via reciprocity to \$125; and increase the annual renewal fee to \$250.

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

Section 54-4113, Idaho Code, authorizes the Board to set fees for certification, licensure, and renewal in amounts not to exceed \$500. The proposed changes are well under the statutory cap and are necessary to insure that the Board continues to be self-supporting within the Bureau of Occupational Licenses.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Dee Ann Randall, (208) 334-3233.

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 October 25, 2000.

DATED this 21st day of August, 2000.

Dee Ann Randall
Owyhee Plaza
1109 Main Street, Suite 220
Boise, Idaho 83702
(208) 334-3233
(208) 334-3945 (FAX)

THE FOLLOWING IS THE TEXT OF DOCKET NO. 24-0801-0001

200. FEES (Rule 200).

Fees are established in accord with Section 54-4113, Idaho Code as follows:

(7-1-93)

01. Application. Application for qualification - two hundred fifty dollars (\$~~205~~0).

~~(7-1-93)~~()

- 02. Original Certification/License.** Original Certification/License - one hundred twenty-five dollars (~~\$100~~25*). (7-1-93)(____)
- 03. Certification/License Renewal.** Certification/License renewal - two hundred fifty dollars (~~\$200~~50*). (7-1-97)(____)
- 04. Reinstatement.** Reinstatement fees are as provided in Section 67-2614, Idaho Code - twenty-five dollars (\$25). (7-1-93)
- 05. Duplicate Certificate/License.** Duplicate Certificate/License - twenty-five dollars (\$25). (7-1-93)
- 06. History Record.** History record - twenty-five dollars (\$25). (7-1-93)
- 07. Application For Reciprocity.** Application for reciprocity - two hundred fifty dollars (~~\$200~~50*). (7-1-93)(____)
- 08. Original Certification/License Via Reciprocity.** Original Certification/License via reciprocity - one hundred twenty-five dollars (~~\$100~~25*). (7-1-93)(____)
- 09. Temporary Permit.** Temporary permit - one hundred dollars (\$100). (7-1-93)
- 10. Examination And Reexamination Fees.** Examination and Reexamination fees will be calculated based on the actual cost of the examination. Successful applicants will be notified of the fees at the time they are scheduled for examination. (7-1-97)
- 11. Fees Are Non-Refundable.** Fees are non-refundable. (7-1-93)
- 12. Fees Followed By “*” Means.** Proposed fees for these categories marked with an asterisk include an estimated twenty five dollars (\$25) to be submitted by the state to federal government. Title XI, Section 1109 requires each state to submit a roster listing of state certified/licensed appraisers to the Appraiser Subcommittee “no less than annually”. The state is also required to collect from such individuals who perform appraisals in federally related transactions an annual registry fee of “not more than twenty five dollars (\$25)”, such fees to be transmitted by the state to the federal government on an annual basis. (7-1-93)

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Bulletin Summary of Proposed Rulemakings

PUBLIC NOTICE OF INTENT TO PROPOSE OR PROMULGATE NEW OR CHANGED AGENCY RULES

The following agencies of the state of Idaho have published the complete text and all related, pertinent information concerning their intent to change or make the following rules in the new issue of the state Administrative Bulletin.

IDAPA 02 – DEPARTMENT OF AGRICULTURE PO Box 790, Boise, ID 83701-0790

Docket No. **02-0301-0001**, Rules Pertaining to Idaho Commercial Fertilizer Law. Repeal of chapter. Comment By: 10/25/00.

Docket No. **02-0303-0001**, Rules Governing Pesticide and Chemigation Use and Application. Adds required section and deletes obsolete one; defines record keeping and licensing requirements for dealers providing consistency with FIFRA; clarifies required worker protection standard records; imposes temperature restrictions on phenoxy herbicide; clarifies restrictions to protect pollinators in crops with blooming weeds; increases pesticide registration fees. Comment By: 10/25/00.

Docket No. **03-0403-0001**, Rules Governing Animal Industry. Specifies testing, identification and certification requirements, relative to tuberculosis, for entry of cattle, bison and domestic cervidae into Idaho; defines Chronic Wasting Disease (CWD); relative to CWD, provides requirements for importation of domestic cervidae, specifies approved tests, provides for surveillance, quarantine and management of herds, provides for qualification and certification of herds and for condemnation and depopulation of CWD infected and exposed animals and herds. Comment By: 10/25/00.

Docket No. **02-0415-0001**, Rules Governing Beef Cattle Animal Feeding Operations. Regulates the design, construction and management practices for wastewater storage and containment facilities, and nutrient management practices on beef cattle animal feeding operations; requires new feeding operations to have an approved nutrient management plan before beginning operations; requires existing feeding operations to submit a nutrient management plan to the Director of the Dept. of Agriculture by 1/1/05; provides for inspections of feeding operations and for penalties for violations. Comment By: 10/25/00.

Docket No. **02-0612-0001**, Quarantine Order No. 8-1962 Pertaining to European Pine Shoot Moth. Repeal of chapter. Comment By: 10/25/00.

Docket No. **02-0612-0002**, Idaho State Department of Agriculture Rules Pertaining to the Idaho Fertilizer Law. Prescribes definitions not covered by law; incorporates by reference certain manuals; requires registration and lists guarantees covering nutrients other than nitrogen, phosphate, and potash; describes required warning statements; prescribes proper labeling, labeling of slow release nutrients, use of investigational allowances, sampling, and guarantees concerning organic nitrogen. Comment By: 10/25/00.

Docket No. **02-0622-0001**, Noxious Weed Rules. Designates Eurasian watermilfoil as a noxious weed; adds required Sections. Comment By: 10/25/00.

IDAPA 07 – DIVISION OF BUILDING SAFETY PO Box 83720, Boise, ID 83720

Docket No. **07-0104-0001**, Rules Governing Electrical Specialty Licensing. Authority to grant waivers to qualifying applicants is being delegated to the staff. Comment By: 10/25/00.

Docket No. **07-0109-0001**, Rules Governing Readoption of Rules of Electrical Division. Repeal of chapter. Comment By: 10/25/00.

**IDAPA 08 – DEPARTMENT OF EDUCATION/BOARD OF EDUCATION
PO Box 83720, Boise, ID 83720-0037**

Docket No. **08-0102-0001**, Personnel Rules of the State Board of Education. Repeal of chapter. Comment By: 10/25/00.

Docket No. **08-0103-0001**, Financial Affairs of the State Board of Education. Repeal of chapter. Comment By: 10/25/00.

Docket No. **08-0104-0001**, Rules Governing Residency Classification. For tuition purposes, a person separated under honorable conditions from the U.S. Coast Guard who designates Idaho as his intended domicile is considered an Idaho resident. Comment By: 10/25/00.

Docket No. **08-0109-0001**, Intellectual Property and Conflict of Interest. Repeal of chapter. Comment By: 10/25/00.

Docket No. **08-0202-0001**, Rules Governing Uniformity. Incorporates by reference the 2001 version of the Idaho Department of Education Professional School Personnel Certification Standards Manual. Comment By: 10/25/00.

Docket No. **08-0202-0002**, Rules Governing Uniformity. Changes the official vehicle for the approval of teacher education programs to the National Council for Accreditation of Teacher Education (NCATE) approved Idaho Standards for Initial Certification of School Personnel. Comment By: 10/25/00.

Docket No. **08-0203-0002**, Rules Governing Thoroughness. Changes the name from “exiting” to “achievement” standards; incorporates by reference the K-8 Achievement Standards. Comment By: 10/25/00.

**IDAPA 11 – IDAHO STATE POLICE
PO Box 700, Meridian, ID 83680-0700**

Docket No. **11-1002-0001**, Rules Establishing Fees for Services – Idaho Criminal Justice Information System. Corrects the statutory authority citation; increases the name check fee. Comment By: 10/25/00.

Docket No. **11-1102-0001**, Rules of the Idaho Peace Officer Standards and Training Council for Juvenile Detention Officers. Establishes minimum standards for employment and certification of juvenile detention officers. Comment By: 10/25/00.

**IDAPA 13 – IDAHO DEPARTMENT OF FISH AND GAME
PO Box 25, Boise, ID 83707**

Docket No. **13-0104-0001**, Rules Governing Licenses. Adds required sections to the rule; removes obsolete rules; allow residents to purchase unsold nonresident tags as allowed by statutory amendment. Comment By: 10/25/00.

Docket No. **13-0104-0002**, Rules Governing Licenses. Authorizes license and tag refunds or exchanges for fire closure. Comment By: 10/25/00.

Docket No. **13-0108-0001**, Rules Governing the Taking of Big Game Animals in the State of Idaho. Amends methods of take, hunting boundaries, and controlled hunt descriptions for 2000 seasons; allows sales of leftover controlled hunt tags; creates a new nonresident deer, bear, or mountain lion tag. Comment By: 10/25/00.

Docket No. **13-0109-0001**, Rules Governing the Taking of Game Birds in the State of Idaho. Adds required sections; removes obsolete rules; makes corrections after statutory amendment. Comment By: 10/25/00.

Docket No. **13-0111-0001**, Rules Governing Fish. Adds required sections; biannual update of fishing seasons, bag limits, and possession limits; removes obsolete rules. Comment By: 10/25/00.

Docket No. **13-0115-0001**, Rules Governing the Use of Dogs. Adds required sections; increases number of nonresident permits to encourage hunting in certain areas; clarifies requirements for a hunting license and hound

hunter permit. Comment By: 10/25/00.

Docket No. **13-0116-0001**, Rules Governing the Trapping of Predatory and Unprotected Wildlife and the Taking of Furbearing Animals. Adds required sections and biennial update for setting seasons, bag, and possession limits; removes obsolete rules. Comment By: 10/25/00

Docket No. **13-0117-0001**, Rules Governing the Use of Bait for Taking Big Game Animals. Clarifies restrictions on locating bear bait near water. Comment By: 10/25/00.

Docket No. **13-0119-0001**, Rules Governing Operating, Discontinuing, and Suspending Vendors. Adds required sections; corrects obsolete language regarding military personnel obtaining resident licenses and tags. Comment By: 10/25/00.

**IDAPA 15 – OFFICE OF THE GOVERNOR - IDAHO COMMISSION ON AGING
PO Box 83720, Boise, ID 83720-0007**

Docket No. **15-0101-0002**, Rules Governing Senior Services Program. Changes definition of Case Manager to allow for a degree or equivalent and definition of Case Management to include disabled adults; deletes definition of PCS and adds definition of Medicaid HCBS Services; adds section pertaining to the conduct of in-home service workers. Comment By: 10/25/00.

Docket No. **15-0102-9902**, Rules Governing Area Agency Adult Protection Programs. Clarifies resident-to-resident abuse investigations. Comment By: 10/25/00.

Docket No. **15-0102-0001**, Rules Governing Area Agency Adult Protection Programs. Adds definition for “serious physical injury”. Comment By: 10/25/00.

Docket No. **15-0120-0001**, Rules Governing Area Agency on Aging (AAA) Operations. Changes due date for area plans and plan amendments; removes unnecessary language. Comment By: 10/25/00.

**15 – DIVISION OF HUMAN RESOURCES AND PERSONNEL COMMISSION
PO Box 83720, Boise, ID 83720-0066**

Docket No. **15-0401-0001**, Rules of the Division of Human Resources and Personnel Commission. Changes conform to statutory changes; adds definitions of “earned administrative leave” and “involuntary transfer”; clarifies veterans preference; adds voluntary probation period for certain transfers and reinstatements; clarifies use of leave for medical or optical appointments and for use of Employee Assistance Program; clarifies and makes changes in deadlines for problem-solving procedure and for enhancing consistency of performance evaluation system. Comment By: 10/25/00.

**IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE
PO Box 83720, Boise, ID 83720-0036**

Docket No. **16-0203-0001**, Rules Governing Emergency Medical Services. Updates the Incorporation by Reference; adds pediatric emergency medicine representative to EMS Advisory Committee; changes office address. Comment By: 10/25/00.

Docket No. **16-0301-0002**, Rules Governing Eligibility for Medicaid for Families and Children. Reinstates a methodology for income eligibility in which income is converted to a monthly amount and prospective budgeting is used for determining eligibility for future months. Comment By: 10/25/00.

Docket No. **16-0304-0001**, Rules Governing the Food Stamp Program in Idaho. Changes gross and net income limits, maximum monthly allotments, and Standard Utility Allowance (SUA). Comment By: 10/25/00.

Docket No. **16-0305-0002**, Rules Governing Eligibility for Aid to Aged, Blind, and Disabled. Counts a veteran's aid, attendance, and unusual medical expense payments from the VA as income in computing the participant's share in the cost of his nursing home care or HCBS. Comment By: 10/25/00.

Docket No. **16-0309-0008**, Rules Governing the Medical Assistance Program in Idaho. Deletes text referencing the maintenance of a mailing list for Medical Assistance manual updates and adds the reference for Internet access.

Comment By: 10/25/00.

Docket No. **16-0309-0009**, Medical Assistance. Conforms to HB 797 by reducing the number of unauthorized visits for Physical Therapy to 25 per calendar year and requires authorization for any visits over 25 by the Department; changes technical terminology. Comment By: 10/25/00.

Docket No. **16-0309-0010**, Medical Assistance. Implements SB 1365 by requiring that all PCS and Attendant providers be employees of an agency; modifies CNA requirements to allow other training; PCS supervision by MD and RN expanded; makes numerous technical changes to standardize terminology. Comment By: 10/25/00.

Docket No. **16-0309-0011**, Medical Assistance. Implements SB 1530 by limiting reimbursement for commercial and non-commercial transportation providers for Medicaid clients when the vehicle contains five or more clients; provides for a waiver based on undue hardship; declares an emergency; provides a sunset clause of 6/20/01; discontinues payment to non-commercial providers for unloaded miles; sets reimbursement rate per mile per passenger at \$.33 cents for up to five passengers per vehicle. Comment By: 10/25/00.

Docket No. **16-0309-0012**, Medical Assistance. Generic drugs will be dispensed by the pharmacy unless prior authorized by the Department; technical changes clarify language. Comment By: 10/25/00.

Docket No. **16-0314-0001**, Rules Governing Hospitals in the State of Idaho. Revises requirement, that prescribers be physically present within 24 hours to sign an order, to allow for greater flexibility. Comment By: 10/25/00.

Docket No. **16-0410-0001**, Rules Governing Community Services Block Grant Program. Repeal of chapter. Comment By: 10/25/00.

Docket No. **16-0410-0002**, Rules Governing Community Services Block Grant Program. Rewrite complies with federal law changes in the 1998 Federal Community Services Block Grant Re-authorization. Comment By: 10/25/00.

Docket No. **16-0414-0001**, Rules Governing the Low Income Home Energy Assistance Program. Adds "catastrophic illness costs" to program eligibility criteria; revises formula for computing program benefits. Comment By: 10/25/00.

Docket No. **16-0503-0001**, Rules Governing Contested Cases Proceedings and Declaratory Rulings. Repeal of chapter. Comment By: 10/25/00.

Docket No. **16-0503-0002**, Rules Governing Contested Cases Proceedings and Declaratory Rulings. Rewrite of chapter simplifies and streamlines the hearing process; corrects program references. Comment By: 10/25/00.

**IDAPA 17 – IDAHO INDUSTRIAL COMMISSION
PO Box 83720, Boise, ID 83720-0041**

Docket No. **17-0405-0001**, Accreditation of Asbestos Professionals Employed in School Projects. Repeal of chapter. Comment By: 10/25/00.

Docket No. **17-0701-0001**, Safety Rules for Elevators and Escalators-General Requirements. Updates state's safety standards for elevators, escalators, and moving walkways to comply with changes in the national elevator standards which are adopted by reference. Comment By: 10/25/00.

Docket No. **17-0702-0001**, Safety Standards for Construction and Operation of Elevators-Administration. Repeal of chapter. Comment By: 10/25/00.

Docket No. **17-0703-0001**, Safety Rules for Elevators and Escalators-Inspections. Repeal of chapter. Comment By: 10/25/00.

Docket No. **17-0704-0001**, Safety Rules for Elevators and Escalators-Construction, Repairs, Alterations, or Dismantling. Repeal of chapter. Comment By: 10/25/00.

**IDAPA 18 – DEPARTMENT OF INSURANCE
PO Box 83720, Boise, ID 83720-0043**

Docket No. **18-0130-0001**, Individual Accident and Sickness Disability Insurance Minimum Standards Act. Sets forth prohibited policy provisions, minimum standards for benefits, disclosure requirements, and replacement requirements for various types of individual disability insurance policies and group supplemental disability insurance policies sold in Idaho. Comment By: 10/25/00.

Docket No. **18-0130-0002**, Individual Accident and Sickness Disability Insurance Minimum Standards Act. Repeal of chapter. Comment By: 10/25/00.

Docket No. **18-0144-0001**, Schedule of Fees, Licenses, and Miscellaneous Charges. Payor must request in writing overpayments in excess of \$200; extraordinary exam costs will not be considered part of the continuation fee and director may pass them on to a company; a continuation fee will be imposed on domestic risk retention groups only; continuation fee for purchasing groups will be \$100. Comment By: 10/25/00.

Docket No. **18-0160-0001**, Long-Term Care Insurance Minimum Standards. Adds requirements for disclosure to consumers by long-term care insurance sellers of rating practices, including rate increase history; sets forth information to be included in disclosures to consumers and requires signed acknowledgement by consumer; amends loss ratio standards; sets forth additional filing requirements; adds standards governing premium rates and rate increases; provides for reimbursement of unnecessary rate increases; sets forth requirements for actuarial certifications. Comment By: 10/25/00.

**IDAPA 21 – DIVISION OF VETERANS SERVICES
320 Collins Road, Boise, ID 83702**

Docket No. **21-0101-0001**, Rules Governing Eligibility for Admission, Residency, and Maintenance Charges in Idaho

State Veterans Homes - Domiciliary Care. Repeal of chapter. Comment By: 10/25/00.

Docket No. **21-0101-0002**, Rules Governing Admission, Residency, and Maintenance Charges in Idaho State Veterans Homes and Division of Veterans Services Administrative Procedure. Rewrite conforms to amendments to state law and complies with federal regulations regarding veterans affairs and includes provisions for the Division's administrative procedures and contested cases. Comment By: 10/25/00.

Docket No. **21-0102-0001**, Rules Governing Eligibility for Admission, Residency, and Maintenance Charges in Idaho State Veterans Homes – Residential Care. Repeal of chapter. Comment By: 10/25/00.

Docket No. **21-0102-0002**, Rules Governing Emergency Relief for Veterans. Rewrite of chapter provides for accepting, evaluating, granting, and denying requests for emergency relief and provisions related to Veterans Service Officers. Comment By: 10/25/00.

Docket No. **21-0103-0001**, Rules Governing Eligibility for Admission, Residency, and Maintenance Charges in Idaho State Veterans Homes – Nursing Care. Repeal of chapter. Comment By: 10/25/00.

Docket No. **21-0103-0002**, Rules Governing Medicaid Qualified Units in Idaho State Veterans Homes. Changes conform to state law requiring the Idaho State Veterans Homes to become Medicaid-certified. Comment By: 10/25/00.

Docket No. **21-0104-0001**, Rules Governing Emergency Relief for Veterans. Repeal of chapter. Comment By: 10/25/00.

**IDAPA 22 – IDAHO STATE BOARD OF MEDICINE
PO Box 83720, Boise, ID 83720-0058**

Docket No. **22-0101-0001**, Rules of the Board of Medicine for Licensure to Practice Medicine and Surgery and Osteopathic Medicine and Surgery. Changes remove standard of care violation that define sexual relations with patients; adds rule relating to physical or mental illness to comply with ADA requirements; allows for 2 year licensure instead of annual license issue and renewal; removes obsolete language and changes interview language. Comment By: 10/25/00.

IDAPA 23 – IDAHO STATE BOARD OF NURSING

PO Box 83720, Boise, ID 83720-0061

Docket No. **23-0101-0001**, Rules of the Idaho Board of Nursing. Clarifies rules for temporary licensure, license renewal and reinstatement, graduates of nursing schools located outside the United States or its territories, and apprentices and others exempted from licensure by the Board; changes fees and adds provision for a returned check fee; creates framework for issuance of licenses and wallet certificates; clarifies that, with the exception of advanced practice professional nurses, one individual may hold only one license at any time; removes obsolete rules. Comment By: 10/25/00.

**IDAPA 24 – BUREAU OF OCCUPATIONAL LICENCES
1109 Main Street, Suite 220, Boise, ID 83702**

Docket No. **24-0101-0001**, Rules of the Board of Architectural Examiners. Adds required sections; changes application photograph size; adopts qualifications outlined in 2000-2001 NCARB Handbook for Interns and Architects; establishes exam qualifications based on experience in lieu of architectural degree. Comment By: 10/25/00.

Docket No. **24-0301-0001**, Rules of the State Board of Chiropractic Physicians. Changes peer review compensation schedule from number of document pages to dollar amount of claim. Comment By: 10/25/00.

Docket No. **24-0401-0001**, Rules of the Idaho Board of Cosmetology. Waives 30 day application deadline for applicants who fail examination on the first attempt; provides for nail technology and esthetics instructors; allows instructor applicants who fail examination on the first attempt to re-examine without additional training. Comment By: 10/25/00.

Docket No. **24-0401-0002**, Rules of the Idaho Board of Cosmetology. Clarifies definitions and changes terminology; separates esthetics from electrolysis; clarifies action resulting from student loan default; clarifies endorsement requirements; requires jurisprudence exam for endorsement applicants; eliminates work permits; changes reference to education requirement; clarifies application requirement; clarifies electrolysis instruction hour requirements; increases esthetics and nail technology instruction hour requirements; allows applicants who fail exam on first attempt to re-examine without additional training; specifies uses of human models and mannequins during exam; deletes monthly requirement for student records, and outlines requirements; defines attendance policy and student probationary period; clarifies student records and instructor training requirements. Comment By: 10/25/00.

Docket No. **24-0501-0001**, Rules of the Board of Environmental Health Specialist Examiners. Sets original license fee and a trainee certificate fee; deletes redundancy in reexamination fee and references to certificate fee. Comment By: 10/25/00.

Docket No. **24-1001-0001**, Rules of the State Board of Optometry. Updates exam requirements; gives board discretion to require exam for reinstatement of license canceled over 5 years; adds certificate to obtain and use pharmaceutical agents fee; updates name of national organization administering the exam. Comment By: 10/25/00.

Docket No. **24-1501-0001**, Rules of the Idaho Counselor Licensing Board. Modifies the supervised experience requirements; changes required credentials of those seeking to provide qualified counseling supervision; adds definition of direct client contact; and replaces Board's scope of practice letter with a rule requiring counselors to practice only within the boundaries of their competence. Comment By: 10/25/00.

Docket No. **24-1701-0001**, Rules of the State Board of Acupuncture. Clarifies and adds definitions and removes obsolete references; defines requirements for and establishes fee for licensure, certification, and technician; adds to inactive license or certification fee; includes expiration and reinstatement for certificates and process; adds certification under scope of practice; extends change of business notice provision. Comment By: 10/25/00.

Docket No. **24-1801-0001**, Rules of the Real Estate Appraiser Board. Increases fees for application for qualification, reciprocity application, original certification/license, original certification/license via reciprocity; and annual renewal fee. Comment By: 10/25/00.

**IDAPA 26 – IDAHO DEPARTMENT OF PARKS AND RECREATION
2103 Lanark, Meridian, ID 83642**

Docket No. **26-0120-0001**, Rules Governing the Administration of Park and Recreation Areas and Facilities.

Regulates operation of vehicles within state parks; prohibits interfering with state park employees duties; makes park facilities smoke free; defines liquid waste as it relates to camping; includes current Fish & Game rules on bag/creel limits. Comment By: 10/25/00.

Docket No. **26-0130-0001**, Idaho Safe Boating Rules. Specifies that persons on personal watercraft and being towed by boats must wear a personal flotation device to be considered having it readily available. Comment By: 10/25/00.

**IDAPA 27 – IDAHO BOARD OF PHARMACY
PO Box 83720, Boise, ID 83720-0067**

Docket No. **27-0101-0002**, Rules of the Idaho Board of Pharmacy. Allows transfer of prescriptions via facsimile; removes requirement for placing transfer information on original prescription for pharmacies that maintain the same information in a computer prescription database. Comment By: 10/25/00.

Docket No. **27-0101-0003**, Rules of the Idaho Board of Pharmacy. Adds the substance carisoprodol to the list of Schedule IV controlled substances. Comment By: 10/25/00.

**IDAPA 31 – IDAHO PUBLIC UTILITIES COMMISSION
PO Box 83720, Boise, ID 83720-0074**

Docket No. **31-0101-0001**, Rules of Procedure of the Idaho Public Utilities Commission. Recodifies an omitted section regarding withdrawal of pleadings. Comment By: 10/25/00.

Docket No. **31-1101-0001**, Safety and Accident Reporting Rules for Utilities Regulated by Idaho Public Utilities Commission. Updates documents incorporated by reference. Comment By: 10/25/00.

Docket No. **31-2101-0001**, The Utility Customer Relations Rules. Eliminates “guarantees” in lieu of service deposits; requires that bills be issued monthly and that utilities list their mailing addresses and toll-free telephone numbers on bills; prohibits billing for services or merchandise not ordered or authorized by consumer and specifies how partial payments are to be applied to bills; notice procedures for terminating service are clarified and simplified; eliminates reporting requirements of terminated service during winter months; allows utilities to collect reasonable deposits rather than two months’ usage as a minimum threshold billing; requires utilities to respond within 10 business days to a customer’s informal complaint. Comment By: 10/25/00.

Docket No. **31-4101-0001**, The Telephone Customer Relations Rules. Allows deposits to be credited to a customer’s account or refunded to customer; simplifies procedures for terminating telephone service; eliminates the termination of local exchange service for unexplained or large long-distance usage; reduces time telephone records are retained to 2 years; deletes obsolete references. Comment By: 10/25/00.

**IDAPA 33 – IDAHO REAL ESTATE COMMISSION
PO Box 83720, Boise, ID 83720**

Docket No. **33-0101-0003**, Rules of the Idaho Real Estate Commission. Identification numbers assigned or approved by Commission will constitute user’s signature when transmitted as part of an electronic record in the course of business with the commission. Comment By: 10/25/00.

Docket No. **33-0101-0004**, Rules of the Idaho Real Estate Commission. A flat fee of \$100 will be charged for each entity license, rather than charging additional broker license fees for multiple entity licenses. Comment By: 10/25/00.

**IDAPA 35 – IDAHO STATE TAX COMMISSION
PO Box 36, Boise, ID 83722**

Docket No. **35-0101-0001**, Income Tax Administrative Rules. Renumbers sections; corrects citations to federal and state codes; makes changes to conform to statutory changes; deletes obsolete language; changes calculation of the offset to add federal tax-exempt interest and subtract foreign dividend gross-up in computing total income; clarifies limitation of itemized deductions and addback of state income taxes and deductions allowed for college savings programs and health insurance costs for self-employed individuals; corrects calculation for the standard deduction for married individuals filing joint returns; requires an alternative method to allocation and apportionment in determining Idaho source income of real and tangible personal property and from a sole proprietorship; clarifies how an entity will report income and pay tax for officers, directors, shareholders, partners, members, or beneficiaries, and how the election is made; clarifies what qualifies as a revenue-producing enterprise due; and others. Comment By: 10/25/00.

Docket No. **35-0102-0001**, Idaho Sales and Use Tax Administrative Rules. Clarifies rental/lease property allowance when it is traded-in; removes provision limiting the credit for bad debts to only the retailer who made the original sale; deletes obsolete language and defines terminology for new technology for records retention; makes the statutory reporting requirements easier and provides options for promoters. Comment By: 10/25/00.

Docket No. **35-0103-0004**, Property Tax Administrative Rules. Renumbers sections; corrects citations to federal and state codes; makes changes to conform to statutory changes; deletes obsolete language; rewrites some definitions to be consistent with statutes and current practice; appraisal approaches, used by county assessors, were clarified to three traditional approaches; makes changes in determining eligibility for exemptions, clarifies determination of household and other taxable income. Comment By: 10/25/00.

Docket No. **35-0105-0001**, Motor Fuels Tax Administrative Rules. Adds and deletes definitions; changes reporting period to taxpayer's fiscal year or calendar year if not required to file an Idaho income tax return; allows all motor fuels to be deducted on sales to the Idaho National Guard; adds authority to grant an exemption from bonding when the distributor has provided information to show financial responsibility even when the submission is incomplete; suspends petroleum transfer fee because the insurance reserve account has reached the statutory limit. Comment By: 10/25/00.

Docket No. **35-0108-0001**, Idaho Mine License Tax Administrative Rules. Corrects a reference to the Tax Commission's Administration and Enforcement Rules. Comment By: 10/25/00.

Docket No. **35-0201-0001**, Tax Commission Administration and Enforcement Rules. Deletes obsolete language; identifies the rate of interest for calendar year 2001; changes amount charged for dishonored checks; adds Department of Treasury Financial Management Services and the governing entity of the International Fuels Tax Agreement to the list of agencies with exchange agreements. Comment By: 10/25/00.

**IDAPA 39 – IDAHO TRANSPORTATION DEPARTMENT
PO Box 7129, Boise ID 83707-1129**

Docket No. **39-0104-0001**, Rules Governing Disadvantaged Business Enterprise Program. Repeal of chapter. Comment By: 10/25/00.

Docket No. **39-0313-0001**, Rules Governing Overweight Permits. Adds 2 additional categories and restructures weight ranges for state highways. Comment By: 10/25/00.

Docket No. **39-0316-001**, Rules Governing Oversize Permits for Non-Reducible Vehicles and/or Loads. Clarifies that permit requirements for implements of husbandry used in the furtherance of a business do not apply to farm operations. Comment By: 10/25/00.

Docket No. **39-0317-0001**, Rules Governing Permits for Manufactured Homes, Modular Buildings, and Office Trailers. Conforms to state law to allow manufactured homes being transported, either prior to first sale at retail or to the initial setup location of the original purchaser, not to be registered. Comment By: 10/25/00.

Docket No. **39-0319-0001**, Rules Governing Annual Overlegal Permits. Adds 2 additional categories and restructures weight ranges for assigning more accurate weight limits on certain state highway routes. Comment By: 10/25/00.

Docket No. **39-0342-0001**, Rules Governing Use of State Right-of-Way. Adds a definition section for access management; adds sequentially ordered steps in permitting process; adds section on Access Control Types and on temporary encroachments addressing such issues as political campaign posters; adds a more detailed and comprehensive appeal process; adds Headquarters' and District office addresses. Comment By: 10/25/00.

Docket No. **39-0347-0001**, Rules Governing Certification of Local Improved Road Mileage. Conforms to statutory change by removing rule that prohibited the gating of public highways, with certain exceptions. Comment By: 10/25/00.

**IDAPA 45 – HUMAN RIGHTS COMMISSION
PO Box 83720, Boise, ID 83720**

Docket No. **45-0101-0001**, Rules of the Idaho Human Rights Commission. Identifies who may represent a party in proceedings before the Commission; and removes language prohibiting discrimination based on disabilities not presently job-related. Comment By: 10/27/00.

**IDAPA 47 – IDAHO DIVISION OF VOCATIONAL REHABILITATION
PO Box 83720, Boise, ID 83720-0096**

Docket No. **47-0101-0001**, General Administration. Adds incorporation by reference section and modifies the client appeals process section. Comment By: 10/25/00.

Docket No. **47-0102-0001**, Field Services. Adds incorporation by reference section and modifies record keeping section and client services. Comment By: 10/25/00.

Docket No. **47-0103-0001**, Management Services. Allows staff to negotiate rates of payment for services due to increased costs. Comment By: 10/25/00.

**IDAPA 48 – IDAHO DEPARTMENT OF COMMERCE
PO Box 83720, Boise, ID 83720-0093**

Docket No. **48-0101-0001**, Idaho Community Development Block Grant Program. Requires more information from ICDBG applicants on proposed projects; rewards local cash investment by increasing the competitive value of each dollar committed to proposed project; and youth centers, which can be applied for under the Public Facilities category must primarily benefit at-risk youth through various services and programs. Comment By: 10/25/00.

**IDAPA 52 – IDAHO STATE LOTTERY COMMISSION
1199 Shoreline Lane, Suite 100, Boise, ID 83702**

Docket No. **52-0102-0001**, Gaming Rules of the Idaho State Lottery Commission. Conforms to statutory changes regulating bingo raffle games. Comment By: 10/25/00.

**IDAPA 53 – DIVISION OF PROFESSIONAL-TECHNICAL EDUCATION
PO Box 83720, Boise, ID 83720-0095**

Docket No. **55-0103-0002**, Rules for Professional-Technical Schools. Identifies and sets forth the criteria and requirements for establishment and operation of a professional-technical school in Idaho that qualifies for funding under Section 33-1002G, Idaho Code. Comment By: 10/25/00.

PUBLIC HEARINGS – Public Hearings have been scheduled for the following dockets. Please refer to the Notices of each docket for scheduling information.

Department of Agriculture

Docket No. **02-0403-0002**, Rules Governing Animal Industry.

Docket No. **02-0415-0001**, Rules Governing Beef Cattle Animal Feeding Operations.

State Board of Education

Docket No. **08-0102-0001**, Personnel Rules of the State Board of Education.

Docket No. **08-0103-0001**, Financial Affairs of the State Board of Education.

Docket No. **08-0104-0001**, Rules Governing Residency Classification.

Docket No. **08-0109-0001**, Intellectual Property and Conflict of Interest.

Docket No. **08-0202-0002**, Rules Governing Uniformity.

Docket No. **08-0203-0002**, Rules Governing Thoroughness.

Division of Human Resources and Personnel Commission

Docket No. **15-0401-0001**, Rules of the Division of Human Resources and Personnel Commission.

Division of Veterans Services

Rules Governing Eligibility for Admission, Residency, and Maintenance Charges in Idaho State Veterans Homes Idaho State Veterans Homes:

Docket No. **21-0101-0001**, Domiciliary Care (Repeal),

Docket No. **21-0102-0001**, Residential Care (Repeal),

Docket No. **21-0103-0001**, Nursing Care (Repeal).
Docket No. **21-0101-0002**, Rules Governing Admission, Residency, and Maintenance Charges in Idaho State Veterans Homes and Division of Veterans Services Administrative Procedure.
Docket No. **21-0102-0002**, Rules Governing Emergency Relief for Veterans.
Docket No. **21-0103-0002**, Rules Governing Medicaid Qualified Units in Idaho State Veterans Homes.
Docket No. **21-0104-0001**, Rules Governing Emergency Relief for Veterans (Repeal).

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Idaho State Lottery Commission

Docket No. **52-0102-0001**, Gaming Rules of the Idaho State Lottery Commission.

Division of Professional-Technical Education

Docket No. **55-0103-0002**, Rules of Professional-Technical Schools.

Please refer to the Idaho Administrative Bulletin, **October 4, 2000, Volume 00-10** for notices and text of all rulemakings, public hearing schedules, Governor's executive orders, and agency contact names.

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