PENDING RULES

COMMITTEE RULES
REVIEW BOOK

Submitted for Review Before

Senate Health & Welfare Committee

66th Idaho Legislature

Second Regular Session – 2022

Prepared by:

Office of the Administrative Rules Coordinator
Division of Financial Management

January 2022

BRAD LITTLE
Governor

ALEX J. ADAMS
Administrator

State of Idaho
DIVISION OF FINANCIAL MANAGEMENT
Executive Office of the Governor

January 10, 2022

M E M O R A N D U M

TO: **Members of the 2022 Idaho State Legislature**

FROM: **Alex J. Adams, Administrator**
Bradley A. Hunt, Rules Coordinator

SUBJECT: **Overview of Executive Agency Rulemaking in 2021**

Background. Governor Little maintains and continues to stress the importance of an efficiently functioning government along with ensuring continuity of the services citizens expect and implemented through executive administrative rules. Nearly all rules published in the Legislative Rules Review books are simply re-published because the 2021 Legislature adjourned *sine die* without passing a concurrent resolution approving any pending fee rules as specified in Section 67-5224, Idaho Code, as well as not extending any effective rule on July 1 by statute as outlined in Section 67-5292, Idaho Code. The necessary rules were re-published in the following special bulletins:

- July 21 – Temporary Rules
- October 20 – Proposed Rules
- December 22 – Pending Rules

Changes in Existing Rules. Since the vast majority of rules either expired or were not approved, there is no existing rule available to amend. Therefore, only a clean version of the rule chapter is able to be presented to the Legislature in January 2022. In some cases, rules were modified based on public comment, or to implement Executive Order 2020-01, Zero-Based Regulation (ZBR), among other reasons. Given the unprecedented volume, edits are incorporated within a single omnibus docket, or in the case of ZBR rulemaking a standalone docket, and presented as a clean rule chapter. There are several ways that legislators may view previous rules for comparison purposes:

- An archive of any rule since 1996 is available on the DFM website. This allows legislators to see the evolution of a rule over time.
- The Legislative Services Office analyzes all proposed rules. You can find their analysis of proposed rules which, in some cases, may discuss changes between previous rules and the proposed rules. These may be found on the Legislature's website.
- Changes made between the proposed and pending rule stages for omnibus rulemaking were noted in the December 22 bulletin where applicable.

Process for Approving Rules. Below, you will find a brief description on legislative actions and outcomes regarding the rules review process and contents of the Legislative Rules Review Books:

- Pending Fee Rules must be affirmatively approved by both bodies via adoption of concurrent resolution to become final.
- Pending Rules become final and effective sine die unless rejected, in whole or in part, via concurrent resolution adopted by both bodies.
    - Pending rules may be approved, in whole or in part, or rejected if determined to be inconsistent with legislative intent of the governing statute.
    - If rejected, new or amended language must be identified at a numerical or alphabetical designation within the rule and specified in the concurrent resolution.
- A link to LSO's proposed rule analysis is provided at the beginning of each docket and includes any required supporting documentation (e.g. Cost Benefit Analysis (CBA), Incorporation By Reference Synopsis (IBRS)) as part of the analysis.
- All 2022 review books can be accessed on the DFM website here.

Contact Information. If questions arise during the rules review process, please do not hesitate to contact the Rules Coordinator, Brad Hunt: Brad.Hunt@dfm.idaho.gov; 208-854-3096.

SENATE HEALTH & WELFARE COMMITTEE

ADMINISTRATIVE RULES REVIEW

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2022 Legislative Session

IDAPA 15 – OFFICE OF THE GOVERNOR
IDAHO COMMISSION ON AGING

DOCKET NO. 15-0100-2100

NOTICE OF OMNIBUS RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2022 Idaho State Legislature for final approval. The pending rule becomes final and effective upon the conclusion of the legislative session, unless the rule is approved or rejected in part by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved or rejected in part by concurrent resolution, the rule becomes final and effective upon adoption of, or 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 67-5003, Idaho Code.

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

This pending rule adopts and publishes the following rule chapters previously submitted to and reviewed by the Idaho Legislature under IDAPA 15.01, rules of the Idaho Commission on Aging:

IDAPA 15.01
- 15.01.01, *Rules Governing Senior Services and Older Americans Act Programs*;
- 15.01.02, *Rules Governing Adult Protective Services Programs*;
- 15.01.03, *Rules Governing the Ombudsman for the Elderly Program*; and
- 15.01.20, *Rules Governing Area Agency on Aging (AAA) Operations*.

There are no changes to the pending rule and it is being adopted as originally proposed. The complete text of the proposed rulemaking was published in the October 20, 2021, Special Edition of the Idaho Administrative Bulletin, Vol. 21-10SE, pages 1230-1246.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year: This rulemaking is not anticipated to have any fiscal impact on the state general fund because the FY2022 budget has already been set by the Legislature, and approved by the Governor, anticipating the existence of the rules and fees being reauthorized by this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Vicki Yanzuk, 208-577-2847.

Dated this 22nd day of December, 2021.

Judy B. Taylor, Director
Idaho Commission on Aging
P.O. Box 83720
Boise, ID 83720
Phone: 208-334-3800
Email: ICOA@aging.idaho.gov

THE FOLLOWING NOTICE PUBLISHED WITH THE OMNIBUS PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section 67-5003, Idaho Code.

PUBLIC HEARING SCHEDULE: Oral comment concerning this rulemaking will be scheduled in accordance with Section 67-5222, Idaho Code.

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

This proposed rulemaking publishes the following rule chapters previously submitted to and reviewed by the Idaho Legislature under IDAPA 15.01, rules of the Idaho Commission on Aging:

IDAPA 15.01
- 15.01.01, *Rules Governing Senior Services and Older Americans Act Programs*;
- 15.01.02, *Rules Governing Adult Protective Services Programs*;
- 15.01.03, *Rules Governing the Ombudsman for the Elderly Program*; and
- 15.01.20, *Rules Governing Area Agency on Aging (AAA) Operations*.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: None.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year: This rulemaking is not anticipated to have any fiscal impact on the state general fund because the FY2022 budget has already been set by the Legislature, and approved by the Governor, anticipating the existence of the rules being reauthorized by this rulemaking.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not feasible because engaging in negotiated rulemaking for all previously existing rules will inhibit the agency from carrying out its ability to serve the citizens of Idaho and to protect their health, safety, and welfare.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, incorporated material may be obtained or electronically accessed as provided in the text of the proposed rules attached hereto.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rules, contact Vicki Yanzuk, 208-577-2847.

Anyone may submit written comments regarding the proposed rulemaking. All written comments must be directed to the undersigned and must be delivered within twenty-one (21) days after publication of this Notice in the Idaho Administrative Bulletin. Oral presentation of comments may be requested pursuant to Section 67-5222(2), Idaho Code, and must be delivered to the undersigned within fourteen (14) days of the date of publication of this Notice in the Idaho Administrative Bulletin.

DATED this October 20, 2021.

THE FOLLOWING IS THE TEXT OF OMNIBUS PENDING DOCKET NO. 15-0100-2100

15.01.01 – RULES GOVERNING SENIOR SERVICES AND OLDER AMERICANS ACT PROGRAMS

000. LEGAL AUTHORITY.
Under authority of Section 67-5003, Idaho Code, the Idaho Commission on Aging adopts the following rules. ( )

001. TITLE AND SCOPE.

01. Title. These rules are titled IDAPA 15.01.01, "Rules Governing Senior Services and Older Americans Act Programs." ( )

02. Scope. These rules constitute minimum requirements for aging services funded under authority of Sections 67-5005 through 5008, Idaho Code, and the Older Americans Act as Amended and include a list of common terms and definitions related to Idaho's aging programs. ( )

002. -- 009. (RESERVED)

010. DEFINITIONS.

01. Act. The Idaho Senior Services Act. Programs and services established in Sections 67-5001 through 67-5011, Idaho Code. ( )

02. Aging Network. The ICOA, the AAAs, Focal Points and other providers of direct service to older individuals. ( )

03. Area Agency on Aging (AAA). Separate organizational unit within a unit of general purpose local government or public or private non-profit agency or organization agency that functions only for purposes of serving as the area agency on aging that plans, develops, and implements services for older persons within a specified geographic area. ( )

04. Assessment. An instrument utilizing uniform criteria to assess eligibility. ( )

05. Caregiver. An adult family member or another individual, who is an "informal" provider of in-home and community care to an older individual. "Informal" means that the care is not provided as part of a public or private formal service program. ( )

06. Client. Person who has met service eligibility requirements addressed in this chapter. ( )

07. Cost Sharing Payment. An established payment required from individuals receiving services under this chapter. The cost sharing payment varies by regulation and according to client's current annual household or individual income. ( )

08. Department. Idaho Department of Health and Welfare. ( )

09. Focal Point. A facility established to encourage the maximum collocation and coordination of services for older individuals. ( )

10. Formal Supports. Services provided to clients by a formally organized entity, including, but not limited to, Medicaid HCBS. ( )

11. Household. For sliding fee purposes, a "household" includes a client and any other person permanently resident in the same dwelling who share accommodations and expenses with the client. ( )

12. ICOA. Idaho Commission on Aging. ( )

13. ICOA Program Manual. Operational guidance for services and programs. ( )

14. Impairment in Activities of Daily Living (ADL). The inability to perform one or more of the following six activities of daily living without personal assistance, stand-by assistance, supervision or cues: eating, dressing, bathing, toileting, transferring in and out of bed/chair, and walking. ( )

15. Impairment in Instrumental Activities of Daily Living (IADL). The inability to perform one or more of the following eight instrumental activities of daily living without personal assistance, or stand-by assistance, supervision or cues: preparing meals, shopping for personal items, medication management, managing money, using telephone, doing heavy housework, doing light housework, and transportation ability (transportation ability refers to the individual's ability to make use of available transportation without assistance). ( )

16. Informal Supports. Supports provided by church, family, friends, and neighbors, usually at no cost to the client. ( )

17. Medicaid HCBS. Services approved under the Medicaid Waiver for the aged and disabled. ( )

18. Older Americans Act (OAA). Federal law which authorizes funding to states to provide home and community-based services for older persons. ( )

19. Program. The Idaho Senior Services and Older Americans Act programs as administered by the ICOA. ( )

20. Program Regulations. Applicable Federal statutes and regulations, the act, and these rules. ( )

21. Provider. An AAA or a person or entity capable of providing services to clients under a formal contractual arrangement including duly authorized agents and employees. ( )

22. Services. Long-term services and supports that assist clients to remain in their home and community including but not limited to: Transportation, congregate meals, in-home services, adult day care and information and assistance. ( )

011. DEMONSTRATION PROJECTS.
The Administrator has authority to operate demonstration projects under the authority of section 67-5010, Idaho Code, which may be exempt from these rules at the Administers discretion. ( )

012. PROGRAM PURPOSE.
The Idaho Senior Services Act and Older Americans Act Services are designed to provide older individuals with the assistance they need to compensate for functional or cognitive limitations with the goal of living safe, dignified, and healthy lives within the community of their choice. ( )

013. PROGRAM POLICY.

01. ICOA Program Manual. The manual is developed, modified, and updated with input from the appropriate stakeholder groups and approved by the Administrator. At the Administrator's discretion, the manual may be modified to adhere to state or federal law or regulations. ( )

02. Contracts. The ICOA may contract with Providers to deliver home and community-based services in accordance with the regulations. ( )

03. Home and Community Based Services. Services may include: ( )

a. Adult Day Care. Personal care for clients in a supervised, protective, and congregate setting during some portion of a day. Services offered in conjunction with adult day care/adult day health typically include social and recreational activities, training, counseling, and services such as rehabilitation, medications assistance and home health aide services for adult day health. ( )

b. Case Management. Case management is a service provided to clients, at the direction of the individual or a family member of the individual, to assess the needs of the person and to arrange, coordinate, and monitor an optimum package of services to meet those needs. Activities of case management include: comprehensive assessment of the individual; development and implementation of a service plan with the individual to mobilize formal and informal resources and services; coordination and monitoring of formal and informal service delivery; and periodic reassessment. ( )

c. Chore Services. Providing assistance to clients who have functional limitations that prohibit them from performing tasks such as routine yard work, sidewalk maintenance, heavy cleaning, or minor household maintenance. ( )

d. Congregate Meals. A meal provided to an eligible individual in a congregate or group setting. The meal served must meet program requirements. ( )

e. Health Promotion and Disease Prevention. Services that include health screenings and assessments; organized physical fitness activities; evidence-based health promotion programs; medication management; home injury control services; and/or information, education, and prevention strategies for chronic disease and other health conditions that would reduce the length or quality of life of the person sixty (60) or older. ( )

f. Home-Delivered Meals. Meals delivered to clients in private homes. ( )

g. Homemaker Service. Assistance with housekeeping, meal planning and preparation, essential shopping and personal errands, banking and bill paying, medication management, and, with restrictions, bathing and washing hair. ( )

h. Information and Assistance Services. Provides current information about services available within the community, conducts intake and assessment, determines the appropriate available service, and makes a referral and to the extent practicable, establishes adequate follow-up procedures. ( )

i. Legal Assistance. Advice, counseling, or representation by an attorney or by a paralegal under the supervision of an attorney. ( )

j. National Family Caregiver Program. ( )

i. Counseling. Assist caregivers in making decisions and solving problems relating to their caregiver roles. This includes counseling to individuals, support groups, and caregiver training (of individual caregivers and families). ( )

ii. Respite Care. Services which offer temporary, substitute supports or living arrangements for care recipients in order to provide a brief period of relief or rest for caregivers. ( )

iii. Supplemental services. Services provided on a limited basis to complement the care provided by caregivers. Examples of supplemental services include, but are not limited to, home modifications, assistive technologies, emergency response systems, and incontinence supplies. ( )

iv. Information Services. A service for caregivers that provides the public and individuals with information on resources and services available to the individuals within their communities. ( )

v. Access Assistance. A service that assists caregivers in obtaining access to the services and resources that are available within their communities. To the maximum extent practicable, it ensures that the individuals receive the services needed by establishing adequate follow-up procedures. ( )

k. Outreach Services. A service which actively seeks out older individuals with greatest social and economic needs with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas. ( )

l. Transportation Services. Services designed to transport clients to and from community facilities/ resources for the purposes of applying for and receiving services, reducing isolation, or otherwise promoting independence. ( )

m. Respite. Short-term, intermittent relief provided to caregivers of an ADL or IADL impaired care recipient. ( )

014. PROGRAM ELIGIBILITY.
Individuals are eligible for specific Services as established by the Older Americans Act and Idaho Senior Services Act. ( )

015. SERVICE PRIORITY.
Highest priority is given to clients in immediate jeopardy then those with the greatest degree of ADL or IADL deficits and who are lacking formal and informal supports other than a caregiver. Caregiver services are prioritized by the Administrator in accordance with the Program Regulations. ( )

016. SERVICE LIMITATIONS.

01. Cost Sharing Payments. Payments are required based on the sliding fee scale established by the Administrator in accordance with the Program Regulations. ( )

02. Service. Eligibility, denial, or termination are determined through the applicable ICOA Assessment. ( )

03. Medicaid HCBS. Clients or individuals determined by the Department to be eligible for Medicaid or Medicaid HCBS, are not eligible for Services unless the Services are determined by the Provider to be needed on an interim, emergency basis until Medicaid or Medicaid HCBS is initiated. ( )

017. -- 999. (RESERVED)

000. AUTHORITY.
Under authority of Sections 67-5003 and 39-5312, Idaho Code, the ICOA adopts the following rules. ( )

001. TITLE AND SCOPE.

01. Title. These rules are titled IDAPA 15.01.02, "Rules Governing Adult Protective Services Programs." ( )

02. Scope. These rules relate to the authority and responsibilities of Providers to administer adult protective services. ( )

002. -- 009. (RESERVED)

010. DEFINITIONS.
Any item not specifically defined below has the same meaning as those defined in Idaho Code or IDAPA 15.01.01, "15.01.01, "Rules Governing Senior Services and Older Americans Act Programs." ( )

01. Adult Protective Services (APS). Statutory protections safeguarding vulnerable adults through investigations of reports alleging abuse, neglect, self-neglect or exploitation, and arrangements for the provision of emergency or supportive services necessary to reduce or eliminate risk of harm. ( )

02. Legal Representative. A person with documented legal authority to act on behalf of another individual. ( )

03. Protective Action Plan (PAP). An individual plan addressing the remedial, social, legal, medical, educational, mental health or other services available to reduce or eliminate the risk of harm to a vulnerable adult. ( )

04. Provider. An Area Agency on Aging or a person or entity capable of providing APS under a formal contractual arrangement including duly authorized agents and employees. ( )

011. -- 019. (RESERVED)

020. POLICY STATEMENT.
The ICOA is charged by statute to provide APS services to ensure the vulnerable adult population in Idaho is protected from abuse, neglect, and exploitation. Protective services will be provided that are the least restrictive to personal freedom and ensure the maximum independence of individuals served. In protecting the vulnerable adult population, APS is also intended to provide assistance to care giving families experiencing difficulties in maintaining functionally impaired relatives in the household. ( )

021. ADMINISTRATIVE REQUIREMENTS.
In accordance with Section 67-5011, Idaho Code, the ICOA will administer APS through contracts with Area Agencies on Aging. ( )

022. PROVISION OF SERVICE REQUIREMENTS.
In accordance with Section 67-5011, Idaho Code, each Provider assumes all responsibilities cited in Title 39, Chapter 53, Idaho Code. ( )

01. Direct Provision of Service. Area Agencies on Aging will administer APS as a direct service or may subcontract the service to another Provider at the sole discretion of the Administrator. ( )

02. Contracts. Each Provider must administer APS pursuant to contracts delineating the duties and obligations of each APS program. ( )

03. Court Visitors. APS staff shall not serve as a court appointed visitor in a guardianship or conservatorship proceeding involving a proposed ward who is or has been the alleged victim in an APS investigation. ( )

023. -- 030. (RESERVED)

031. INVESTIGATIVE REQUIREMENTS.

01. Review of Allegations. Upon receipt of a report of abuse, neglect, or exploitation the Provider shall conduct a review of the allegations of such report to determine whether: ( )

a. The report was required to be made to ICOA or its contractors pursuant to Section 39-5303, Idaho Code; ( )

b. An emergency exists; and ( )

c. In cases involving resident-to-resident contact reported pursuant to Section 39-5303(A), Idaho Code, determine whether the case involves the sexual abuse, death, or serious physical injury jeopardizing the life, health, or safety of a vulnerable adult, or involves repeated physical or verbal altercations between residents, not resulting in observable physical or mental injury, but constituting an ongoing pattern of resident behavior that a facility's staff is unable to remedy through reasonable efforts. ( )

02. Need for Investigation. If, based on its review, the Provider determines that a report involves a nursing facility defined in Section 39-1301(b), Idaho Code, and was required to be made to the Department pursuant to Section 39-5303, Idaho Code, the Provider shall immediately refer the report to the Department. If, based on its review, the Provider determines that a report involving resident-to-resident contact was exempted from reporting by Section 39-5303A, Idaho Code, no further investigation need be conducted on such report. The Provider shall investigate all other reports. ( )

03. Vulnerability Determination. Upon investigating a report, the Provider shall determine whether an alleged victim is vulnerable as defined in Section 39-5302, Idaho Code. If the alleged victim is determined to be vulnerable as defined in Section 39-5302, Idaho Code, the Provider shall continue the investigation. If the alleged victim is not vulnerable as defined in Section 39-5302, Idaho Code, the case shall be closed; however, the Provider may refer the complaint to Information and Assistance, Case Management, the Ombudsman, law enforcement or other appropriate entity for investigation and resolution. ( )

04. Assessment of Alleged Victim. An alleged victim's vulnerability and associated risk factors shall be determined through the ICOA-approved standardized assessment forms. Initial interviews and assessments of an alleged victim shall be conducted by the Provider. ( )

05. Investigative Determinations. The Provider shall make one (1) of two (2) investigative determinations upon completion of an APS investigation: ( )

a. Substantiated. A report of abuse, neglect, or exploitation of a vulnerable adult by another individual is deemed substantiated when, based upon limited investigation and review, the Provider perceives the report to be credible. A substantiated report shall be referred immediately to law enforcement for further investigation and action. Additionally, the name of the individual against whom a substantiated report was filed shall be forwarded to the Department pursuant to Sections 39-5304(5) and 39-5308(2), Idaho Code, for further investigation. In substantiated cases of self-neglect, the Provider shall initiate appropriate referrals for supportive services with the consent of the vulnerable adult or his legal representative. ( )

b. Unsubstantiated. The Provider shall close the case if a report of abuse, neglect, or exploitation is not substantiated. If a report is unsubstantiated, but the Provider determines that the vulnerable adult has unmet service needs, the Provider shall initiate appropriate referrals for supportive services with consent of the vulnerable adult or their legal representative. ( )

06. Protective Action Plan. Upon substantiating a report of abuse, neglect, or exploitation of a vulnerable adult, the Provider shall develop and implement a Protective Action Plan. ( )

07. Caretaker Neglect. In investigating a report of caretaker neglect, the Provider shall take into account any deterioration of the mental or physical health of the caregiver resulting from the pressures associated with care giving responsibilities that may have contributed to the neglect of the vulnerable adult. In such cases, the Provider shall make every effort to assist the primary caregiver in accessing program services necessary to reduce the

risk to the vulnerable adult. In APS cases, in which family members are experiencing difficulties in providing twenty-four (24) hour care for a functionally impaired relative, the Provider shall make appropriate referrals to available community services to provide needed assistance. ( )

08. Adult Protective Services and Ombudsman Coordination. Providers shall ensure that APS and the Ombudsman program maintain a written agreement establishing local cooperative protocols in the investigation of complaints. ( )

09. Confidentiality. All records relating to a vulnerable adult and held by a Provider are confidential and shall only be divulged as permitted pursuant to Sections 39-5307, 39-5304(5), and 39-5308, Idaho Code. ( )

032. CASE CLOSURE.

01. Case Closure. The Provider shall close a case under the following circumstances: ( )

a. The Provider shall close a substantiated case upon a determination that an initiated PAP or law enforcement involvement has successfully reduced the risk to the vulnerable adult. ( )

b. The Provider may close a substantiated case when the vulnerable adult refuses to consent to receive services, or upon a determination that the Provider has implemented all measures available to reduce risk but has been unable to reduce risk. ( )

c. A case will be closed if the Provider determines that an allegation has been made in bad faith or for a malicious purpose. ( )

02. Suspense File. Closed cases will be maintained in a suspense file until formal action is completed by law enforcement and/or the courts in the following instances: ( )

a. Cases referred by the Provider to law enforcement for criminal investigation and prosecution as determined necessary by the law enforcement agency. ( )

b. Cases referred by the Provider for guardianship/conservatorship proceedings. ( )

033. -- 999. (RESERVED)

15.01.03 – RULES GOVERNING THE OMBUDSMAN FOR THE ELDERLY PROGRAM

000. LEGAL AUTHORITY.
Under authority set forth in the OAA and Title 67, Chapter 50, Idaho Code, Section 67-5009, ICOA adopts the following rules. ( )

001. TITLE AND SCOPE.

01. Title. These rules are titled IDAPA 15.01.03, "Rules Governing the Ombudsman for the Elderly Program." ( )

02. Scope. These rules relate to the authority, responsibility, and designation of the ombudsman program. ( )

002. -- 009. (RESERVED)

010. DEFINITIONS.
Any item not specifically defined below has the same meaning as those defined in IDAPA 15.01.01, "Rules Governing Senior Services Program," and the Older Americans Act (OAA), Section 711, and Title 67, Chapter 50, Idaho Code. ( )

01. Access. Right to enter long-term care facility upon notification of person in charge. ( )

02. Affected Parties. Long-term care facilities, state or county departments or agencies, or others against whom a complaint has been lodged. ( )

03. Area III. Planning and service area made up of: Canyon, Valley, Boise, Gem, Elmore, Washington, Ada, Adams, Payette, and Owyhee counties. ( )

04. Complainant. The local ombudsman or any individual or organization who registers a complaint with the local ombudsman. ( )

05. Complaint Investigation/Resolution. Activities related to receiving, analyzing, researching, observing, interviewing, verifying or resolving a complaint through advocacy, facilitation, conciliation, mediation, negotiation, representation, referral, follow-up, or education. ( )

06. Complaints. Allegations made by or on behalf of eligible clients, whether living in long-term care facilities or in the community. ( )

07. Designation. Process by which the Office approves the location of local ombudsman programs within AAAs and delegates to such programs the authority to carry out the purposes of the program. ( )

08. Local Ombudsman. An individual associated with a designated local Ombudsman for the Elderly Program, who performs the duties of ombudsman. ( )

09. Long-Term Care Facility. Skilled nursing facilities as defined in IDAPA 16.03.02, Subsection 002.33, "Skilled Nursing Facilities," and residential assisted living facilities as defined in IDAPA 16.03.22, "Residential Assisted Living Facilities." ( )

10. Non-Jurisdictional Complaints. Complaints made by or on behalf of residents of long-term care facilities who are under the age of sixty (60) or complaints concerning persons outside the statutory jurisdiction of an ombudsman. ( )

11. Office. Office of the State Ombudsman for the Elderly pursuant to Title 67, Chapter 50, Idaho Code, Section 67-5009. ( )

12. Resident. Resident as defined in IDAPA 16.03.22, "Residential Assisted Living Facilities." ( )

011. -- 019. (RESERVED)

020. ADMINISTRATIVE REQUIREMENTS.
Each AAA local ombudsman program shall meet all administrative requirements as cited in OAA, Section 712 (a), and Title 67, Chapter 50, Idaho Code, Section 67-5009, unless granted a waiver by the Office. ( )

01. Procedures. All local ombudsmen shall follow procedures outlined in the Office Procedures Manual. ( )

02. Space. Each AAA shall provide space assuring privacy for local ombudsmen to hold confidential meetings. ( )

03. Supervision. Local ombudsmen shall operate under the direct supervision of the Office for all complaint handling activities and are considered subdivisions of the Office. ( )

04. Forms. All local ombudsmen shall utilize standardized forms provided by the Office. ( )

05. Conflict of Interest. AAAs shall ensure that the local ombudsmen are not part of an organization that: ( )

a. Is responsible for licensing and certifying skilled nursing or residential assisted living facilities under IDAPA 16.03.22, "Residential Assisted Living Facilities"; ( )

b. Provides skilled nursing or living care or is an association of such a provider; or ( )

c. May impair the ability of the local ombudsmen to investigate and resolve complaints objectively and independently. ( )

06. Travel Funds. Each AAA shall provide travel funds for the local ombudsman program to carry out activities related to complaint investigations. ( )

07. Program Report. All local ombudsman programs shall comply with the Office's reporting requirements. ( )

08. Program Reviews. Each AAA shall submit to a program review of local ombudsman programs at reasonable intervals deemed necessary by the Office. ( )

09. Adult Protection and Ombudsman Coordination. Each AAA shall ensure that Adult Protection staff and the local ombudsman maintain a written agreement establishing cooperative protocols in the investigation of complaints. ( )

10. State Agreements. All local programs shall honor and carry out state-level agreements between the Office and other agencies of government. ( )

021. STAFFING.
Pursuant to the OAA, Section 712, in order to meet minimum requirements established for the position of local ombudsman, each AAA shall seek applicants having the following qualifications. ( )

01. Minimum Qualifications. Any person hired to fill the position of local ombudsman on or after July 1, 1998, shall have: ( )

a. A Bachelor's degree or equivalent; ( )

b. Minimum of one (1) year's experience working with the elderly; ( )

c. Ability to effectively communicate verbally and in writing; ( )

d. Knowledge of long-term care issues and resources; ( )

e. Demonstrated ability to interpret and apply relevant local, state and federal laws, rules, regulations, and guidelines; ( )

f. Demonstrated ability to work independently; ( )

g. Demonstrated skill in interviewing techniques; and ( )

h. Demonstrated ability to collect data, conduct interviews and to form conclusions. ( )

02. Hiring. The Office shall be included in the process of interviewing and selecting applicants for the local ombudsman position. The AAA shall make the final selection from the top three (3) applicants. ( )

022. -- 030. (RESERVED)

031. DESIGNATION OF AUTHORITY OF AAA.
The Office shall designate an entity as a local ombudsman. ( )

01. Designation of Authority. Each AAA shall directly provide, through a contract agreement with the ICOA, a local ombudsman program employing at least one (1) full-time local ombudsman whose function is to carry out the duties of the Office. AAAs I, II, IV, V and VI shall employ one (1) full-time local ombudsman; AAA III shall employ two (2) full-time local ombudsmen. An AAA may petition the Office in writing for a waiver of this requirement. ( )

02. Grounds for Revocation or Termination. In revoking a designated local ombudsman program, the Office shall provide due process in accordance with applicable law and IDAPA 04.11.01, Section 000, et seq., "Idaho Rules of Administrative Procedure of the Attorney General." ( )

a. Following termination of a local ombudsman program, the Office shall perform the duties of the local program and withdraw funding for the local program for the remainder of the funding period. ( )

b. An AAA's appeal of the Office's termination of its local ombudsman program shall be governed by the Adjudicatory Rules of Practice and Procedures in Claims Relating to Contracts and Grants Funded under Title III, OAA. ( )

032. HANDLING OF COMPLAINTS.
The Office has jurisdiction to accept, identify, investigate, and resolve complaints made by, or on behalf of, persons aged sixty (60) or older, living in the community or in long-term care facilities. The Office and the local ombudsmen shall ensure that persons aged sixty (60) or older have regular and timely access to services provided through the Office. The Office shall represent the interests of older persons before governmental agencies and seek to protect the health, safety, welfare and rights of older persons. ( )

01. Non-Jurisdictional Complaints. Local ombudsmen may respond to complaints made by or on behalf of under age sixty (60) long-term care residents where such action will: ( )

a. Benefit other residents; or ( )

b. Provide the only viable avenue of assistance available to the complainant. ( )

02. Conflict of Interest. Local ombudsmen shall refer to the Office any complaint involving AAA staff or contractors. ( )

03. Complaints. Complaints concerning local ombudsmen, or relative to a local ombudsman's official duties, shall be directly referred to the Office. The Office, upon completing an investigation of such complaint, shall provide findings and recommendations to the AAA. ( )

04. Guardianship. The local ombudsmen shall not serve as an ex-officio or appointed member of any Board of Community Guardian, nor file an affidavit to the court for guardianship. ( )

05. Court Visitor. The local ombudsmen shall not act as court visitor in any guardianship/ conservatorship proceeding concerning a past or current client. ( )

06. Legal Documents. Local ombudsmen shall not, in their capacity as ombudsmen, act as a notary or a witness of signatures for legal documents. ( )

033. ACCESS.
The Office shall ensure that representatives of the Office have access to long-term care facilities and residents as well as appropriate access to medical and social records, and resident representative contact information needed to investigate complaints. ( )

01. Visitation. For visitation purposes, local ombudsmen shall have access to long-term care facilities during regular business hours. Visiting local ombudsmen shall: ( )

a. Notify the person in charge upon entering the facility; ( )

b. Be allowed to visit common areas of the facility and the rooms of residents if consent is given by the resident; and ( )

c. Communicate privately and without restriction with any resident who consents to the communication. ( )

02. Investigation. Local ombudsmen shall have access to long-term care facilities at any time for the purpose of conducting investigations. A local ombudsman conducting an investigation shall: ( )

a. Notify the person in charge upon entering the facility; ( )

b. Be allowed to visit common areas of the facility and the rooms of residents if consent is given by the resident; ( )

c. Seek out residents who consent to communicate privately; ( )

d. Communicate privately and without restriction with any resident who consents to the communication; and ( )

e. Inspect a resident's records under conditions set forth in the OAA, Section 712. ( )

f. Inspect facility administrative records, policies, and documents that are accessible to the resident and general public. ( )

03. Privacy. Local ombudsmen shall have statutory authority to visit facilities and residents in facilities unescorted by facility personnel. See Section 67-5009, Idaho Code. ( )

04. HIPAA. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule, 45 CFR 164, subparts A and E, does not preclude release by the facility of resident private health information or other resident identifying information to the Office. ( )

034. -- 040. (RESERVED)

041. WRITTEN CONSENT.
The Office shall ensure appropriate access to review medical and social records of a resident. (See OAA, Section 712) ( )

01. Resident Written Consent. Access to confidential records requires the written consent of the resident or legal representative. ( )

02. Lack of Consent. If the client is unable to provide written or oral consent, or the legal representative is unavailable to provide consent, the local ombudsman, with approval of the Office may inspect available client records, including medical records that are necessary for investigation of a complaint. ( )

03. Consent Refused. If a local ombudsman has been refused access to records by legal representative but has reasonable cause to believe that the legal representative is not acting in the best interest of the client, the local ombudsman may, with the approval of the Office, inspect client records, including medical records. ( )

04. Requirements for Informing Client or Resident. The local ombudsman shall inform the complainant or resident regarding: ( )

a. Who will receive the information; ( )

b. What information will be disclosed; and ( )

c. The purpose for which the information is being disclosed. ( )

042. CONFIDENTIALITY.
The Office shall be the custodian of all local ombudsman program records including, but not limited to, records and files containing personal information relative to complainants and residents of long-term care facilities. Requests for release of confidential information shall be submitted to the Office for approval or denial. Release of information shall be granted pursuant to OAA, Section 721(e). ( )

01. Storage of Records. Client records shall be maintained in locked storage. Case records inactive for two (2) years or longer may be expunged. As required by law, release of these records shall be limited to persons authorized by the Office. ( )

02. Performance Evaluations. For performance evaluation purposes, direct supervisors shall have access to client files maintained by local ombudsmen. ( )

03. Confidential Records. Records to be safeguarded include, but are not limited to, long-term care and community-based complaint files including: ( )

a. Notes of interviews with complainants and clients or collateral contacts; ( )

b. All copies of residents' medical records or diagnoses; ( )

c. All records relevant to complaint investigations; ( )

d. All memoranda generated by the Office or by another agency office during the evaluation and resolution of a complaint; ( )

e. All photographs, video tapes, tape recordings, etc. pertaining to complaint investigation; ( )

f. All memoranda or letters generated during evaluation or resolution of a complaint; ( )

g. Written documentation that parties affected by ombudsman opinions or recommendations have been notified; and ( )

h. Information containing unverified complaints about long-term care facility owners, administrators, staff or other persons involved in the long-term care system or in other service programs. ( )

04. Request for Anonymity. The ombudsman shall honor a resident's or complainant's request to remain anonymous. If investigation of a complaint requires that a resident's or complainant's name be divulged in order for the investigation to proceed, the ombudsman shall so inform the resident or complainant. If the resident or complainant insists on maintaining anonymity, the ombudsman may terminate the investigation. ( )

043. DISCLOSURE.
The Office is the only entity authorized to disclose ombudsmen program files, records, or information. Identifying information of any resident or complainant shall be disclosed only with proper consent or in response to a court order.

The Office, in its sole discretion, may delegate the disclosure of ombudsman program files, records, or information to a local ombudsman. ( )

01. Court Order. Identifying information of a resident, complainant, or both may be disclosed, with or without the consent of the resident, complainant, or both, pursuant to a court order issued by a court of competent jurisdiction. ( )

02. Resident Consent. Without a court order, identifying information of a resident shall be disclosed only if the resident or his representative communicates informed consent to the disclosure and the consent is given in writing, orally, visually or through the use of auxiliary aids and services; and such consent is documented by a representative of the Office in accordance with procedures. ( )

03. Complainant Consent. Without a court order, identifying information of a complainant shall be disclosed only if the complainant communicates informed consent to the disclosure and the consent is given in writing, orally, visually or through the use of auxiliary aids and services; and such consent is documented by a representative of the Office in accordance with procedures. ( )

044. -- 999. (RESERVED)

000. AUTHORITY.
Under authority of Section 67-5003, Idaho Code, the ICOA adopts the following rules. ( )

001. TITLE AND SCOPE.

01. Title. These rules are titled IDAPA 15.01.20, "Rules Governing Area Agency on Aging (AAA) Operations." ( )

02. Scope. These rules relate to the authority, responsibilities, and designation of AAAs. ( )

002. -- 009. (RESERVED)

010. DEFINITIONS.
Any item not specifically defined below has the same meaning as those defined in IDAPA 15.01.01, "Rules Governing Senior Services and Older Americans Act Programs." ( )

01. Area Plan. Plan describing aging programs and services which an AAA is required to submit to the Idaho Commission on Aging, in accordance with the OAA, in order to receive OAA funding. ( )

02. Contract. A legally binding, written agreement between two (2) or more parties which outlines the terms and provisions to which both parties agree. ( )

03. Planning and Service Area (PSA). ICOA designated geographical area within Idaho for which an AAA is responsible. ( )

011. -- 019. (RESERVED)

020. PLANNING AND SERVICE AREA (PSA) DESIGNATION.
The ICOA has divided the state into PSAs in accordance with Section 305 of the OAA, as amended. ( )

021. AAA.

01. AAA Designation. The ICOA shall accept applications for AAA designation in accordance with Section 305 of the OAA. ( )

02. Revocation of AAA Designation. The ICOA may revoke the designation of an AAA as specified in OAA and the federal regulations thereunder. ( )

03. Denial of AAA Designation. Any organization denied AAA designation through a competitive bidding process may appeal the decision to the Administrator of ICOA. ( )

04. Limit on the Number of Area Agencies and PSA's. In order to maximize funding for services that directly benefit the elderly, the number of PSAs and AAAs is limited to no more than six (6). ( )

022. AAA BUDGET FORMS AND REVISIONS.

01. Budget Forms. Each AAA shall submit, on forms provided by the ICOA, a budget for agency operations. The AAA shall maintain sufficiently detailed budget and expenditure records to respond to requests for information from the ICOA, U.S. Administration for Community Living, legislators, or the general public. ( )

02. Budget Revisions. Requests for approval of budget revisions shall be made in writing to the ICOA: ( )

a. In order to process transfers between Title III programs; ( )

b. To reflect holdbacks or midyear increases in state or federal spending; or ( )

c. If there is a change in spending which exceeds ten percent (10%) of any line item in the comprehensive budget summary. ( )

023. -- 040. (RESERVED)

041. AAA RESPONSIBILITIES.
On behalf of all older persons in the PSA, the AAA shall assume the lead role relative to aging issues. In accordance with the OAA and all pertinent federal regulations, the AAA shall serve as the public advocate for the development and enhancement of comprehensive, coordinated community-based service systems within each community throughout the PSA. ( )

042. CONTRACT MANAGEMENT REQUIREMENTS.
AAAs shall adhere to all applicable federal contracting and procurement requirements in awarding subcontracts. ( )

01. Non-Profit Agency Contractors. AAAs may subcontract with private, non-profit agencies that are incorporated as 501(c)(3) organizations. ( )

02. AAA Provider Subcontracts. All subcontracts between the AAA and service providers shall contain sufficient program and financial information to ensure all activities comply with the Area Plan, the OAA, federal regulations, the SS Act, and the rules of the ICOA. ( )

03. Contracts Term. Each AAA may award multi-year subcontracts not to exceed four (4) years. ( )

a. Each AAA shall maintain documentation satisfactory to ICOA that justifies the reason(s) a multi-year subcontract was awarded. Justification for a multi-year subcontract may include, but is not limited to, the following: ( )

i. More than one (1) year is necessary to complete the project or service; ( )

ii. More than one (1) year is necessary to justify substantial cost savings; or ( )

iii. A multi-year subcontract award is necessary to allow a provider the opportunity to increase and demonstrate capacity to operate a particular service. ( )

b. No AAA shall continue a multi-year subcontract unless the results of evaluation justify continuance of the subcontract. ( )

04. AAA Provider Appeals. AAAs shall develop fair and impartial hearing procedures and provide an opportunity for a hearing for any organization denied a subcontract with the AAA. ( )

043. -- 050. (RESERVED)

051. AREA ADVISORY COUNCILS ON AGING.

01. Establishment of Council. The AAA shall establish an advisory council in accordance with the requirements of the OAA, as amended, and all pertinent federal regulations. ( )

02. Council Meetings. Each advisory council shall meet at least two (2) times each year. ( )

03. Conflict of Interest. AAA employees, or members of the immediate families of AAA employees, shall not serve on the advisory council. ( )

04. By-Laws. The advisory council shall adopt and operate according to by-laws. ( )

052. AREA PLANS.
Each AAA shall submit a four (4) year area plan to the ICOA by close of business January 1, 2002, and by October 15 every four (4) years thereafter. Annual updates shall be submitted by October 15 of each year. The area plan and annual updates shall be submitted in a uniform format prescribed by the ICOA to meet the requirements of the OAA and all pertinent federal regulations. ( )

053. SERVICE PRIORITY AND APPEALS.

01. Service Priority. Pursuant to the OAA, each AAA shall ensure that all service providers prioritize service delivery to those older individuals having the greatest economic and social need, with particular attention to low-income minority individuals and individuals residing in rural areas. ( )

02. Denial or Termination of Service. AAAs shall develop fair and impartial hearing procedures and provide an opportunity for a hearing for any individual who is denied or terminated from a service. ( )

054. ELIGIBILITY.
Individuals are eligible for services as established by the Older Americans Act and the Idaho Senior Services Act. ( )

055. AAA ASSESSMENTS OF PROVIDERS.
Every other year each AAA shall conduct, at a minimum, one (1) on-site assessment of each of its providers that receives fifty thousand dollars ($50,000) or more in combined federal and state funds during a contract year. Such assessments shall comply with the terms of the AAA contract with the ICOA and be on file for ICOA review. ( )

056. REPORTING REQUIREMENTS.

01. Reporting Forms. Each AAA shall submit to the ICOA such reports as are specified by the ICOA, in such format and on such schedule as is established by the ICOA, in fulfillment of all federal and state requirements. ( )

02. Verification of Service Provider Reports. The AAAs shall conduct ongoing verification of service provider reports. ( )

03. Reporting Deficiencies. If reports are late, incorrect, or incomplete, the ICOA shall withhold funds from the AAA, in accordance with terms of the contract between the ICOA and the AAA, until a correct report is received by the ICOA. ( )

057. CIVIL RIGHTS.
Neither the AAAs nor their providers shall violate any state or federal law regarding civil rights and shall provide all services and functions funded by the ICOA, affected by rule of the ICOA or provided for by contract with the ICOA without discrimination on the basis of race, color, national origin, age, gender, physical or mental impairment, or on any other basis prohibited by law. ( )

058. -- 065. (RESERVED)

066. FINANCIAL MANAGEMENT.

01. Regulations. Area agencies and service providers shall meet the financial management requirements of 45 CFR, 74 and 92. ( )

02. Allowable Costs. Allowable costs are delineated in the OAA, and 45 CFR, Part 75. These cost principles shall apply to the expenditure of federal funds, as well as any state or local funds which are reported as match for federal funds. In-kind contributions shall benefit the program for which they are reported as match. No expenditure may be used as match if it has been or will be counted as match for another award of federal or state funds. ( )

03. Audits. All AAAs and service providers shall be audited in accordance with the Single Audit Act of 1996 and OMB Circular A-133 as amended. ( )

067. -- 999. (RESERVED)

IDAPA 15 – OFFICE OF THE GOVERNOR
COMMISSION FOR THE BLIND AND VISUALLY IMPAIRED

DOCKET NO. 15-0200-2100

NOTICE OF OMNIBUS RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2022 Idaho State Legislature for final approval. The pending rule becomes final and effective upon the conclusion of the legislative session, unless the rule is approved or rejected in part by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved or rejected in part by concurrent resolution, the rule becomes final and effective upon adoption of, or 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 Sections 67-5407(d)(e) and 67-5408, Idaho Code.

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

This pending rule adopts and publishes the following rule chapters previously submitted to and reviewed by the Idaho Legislature under IDAPA 15.02, rules of the Commission for the Blind and Visually Impaired:

IDAPA 15.02
- 15.02.01, *Rules Governing the Rehabilitation Programs*; and
- 15.02.30, *Business Enterprise Program*.

The text of the pending rule has been amended in accordance with Section 67-5227, Idaho Code. The complete text of the proposed rule was published in the October 20, 2021 Idaho Administrative Bulletin, Vol. 21-10SE, pages 1247-1266.

The text changes in the pending rule are non-substantive, and result in a further reduction in word count:
- Grammatical error corrected;
- Redundant language removed;
- Title of ICBVI staff corrected.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year: This rulemaking is not anticipated to have any fiscal impact on the state general fund because the FY2022 budget has already been set by the Legislature, and approved by the Governor, anticipating the existence of the rules and fees being reauthorized by this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Mike Walsh (208) 334-3220.

Dated this 22nd day of December, 2021.

Mike Walsh, PhD, CRC
Rehabilitation Services Chief
Idaho Commission for the Blind and Visually Impaired
341 West Washington
PO Box 83720
Boise, ID 83720-0012
Phone: (208) 334- 3220
Fax: (208) 334-2963
Email: mike.walsh@icbvi.idaho.gov

THE FOLLOWING NOTICE PUBLISHED WITH THE OMNIBUS PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 67-5407(d)(e) and 67-5408, Idaho Code.

PUBLIC HEARING SCHEDULE: Oral comment concerning this rulemaking will be scheduled in accordance with Section 67-5222, Idaho Code.

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

This proposed rulemaking publishes the following rule chapters previously submitted to and reviewed by the Idaho Legislature under IDAPA 15.02, rules of the Commission for the Blind and Visually Impaired:

IDAPA 15.02
- 15.02.01, *Rules Governing the Rehabilitation Programs*; and
- 15.02.30, *Business Enterprise Program*.

In addition, this proposed rulemaking combines the following three rule chapters (15.02.02 Vocational Rehabilitation Services, 15.02.03 Rules Governing the Independent Living Program, and 15.02.04 Rules Governing the Prevention of Blindness and Sight Restoration Program) into one chapter entitled 15.02.01 Rules Governing the Rehabilitation Programs, Subchapters A, B, and C, respectively.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: None.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year: This rulemaking is not anticipated to have any fiscal impact on the state general fund because the FY2022 budget has already been set by the Legislature, and approved by the Governor, anticipating the existence of the rules being reauthorized by this rulemaking.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not feasible because engaging in negotiated rulemaking for all previously existing rules will inhibit the agency from carrying out its ability to serve the citizens of Idaho and to protect their health, safety, and welfare.

Negotiated rulemaking conducted outside of this omnibus rulemaking under dockets 15-0202-2101 and 15-0203-2101 published in the June 2, 2021 Idaho Administrative Bulletin, Vol. 21-6, pages 50-53, and affects the following rule chapters included in this proposed rulemaking: 15.02.02, Vocational Rehabilitation Services and 15.02.03, Rules Governing the Independent living Program.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, incorporated material may be obtained or electronically accessed as provided in the text of the proposed rules attached hereto.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rules, contact Mike Walsh (208) 334-3220.

Anyone may submit written comments regarding the proposed rulemaking. All written comments must be directed to the undersigned and must be delivered within twenty-one (21) days after publication of this Notice in the Idaho Administrative Bulletin. Oral presentation of comments may be requested pursuant to Section 67-5222(2), Idaho Code, and must be delivered to the undersigned within fourteen (14) days of the date of publication of this Notice in the Idaho Administrative Bulletin.

DATED this October 20, 2021.

Substantive changes have been made to the pending rule.
Italicized red text **indicates changes between the text of the proposed rule as adopted in the pending rule.**

THE FOLLOWING IS THE TEXT OF OMNIBUS PENDING DOCKET NO. 15-0200-2100

15.02.01 – RULES GOVERNING THE REHABILITATION PROGRAMS

000. LEGAL AUTHORITY.
This chapter is adopted in accordance with Sections 67-5407 and 67-5408, Idaho Code. ( )

001. SCOPE.
The provisions of these rules establish procedures, requirements, and implement program changes necessitated by the Rehabilitation Act of 1973, as amended, which address the provisions of vocational rehabilitation services to the blind and visually impaired population of Idaho. These rules also establish the procedure and practice requirements governing the provision of services under the Independent Living Program. These rules also include the procedure and practice requirements governing the provision of services under the Prevention of Blindness and Sight Restoration Program. ( )

002. INCORPORATION BY REFERENCE.
The following federal laws and regulations are incorporated by reference into the rules of this chapter and copies are available at the Commission's office: ( )

01. 29 U.S.C. Section 701, et seq., Rehabilitation Act of 1973 as amended through Public Law 114-95, enacted December 10, 2015. ( )

02. 34 CFR 361, 363, 364, 367 and 397. ( )

03. Workforce Innovation and Opportunity Act (WIOA), Public Law 113-128, enacted July 22, 2014. ( )

003. – 009. (RESERVED)

010. DEFINITIONS.

01. Blind or Visually Impaired. A person whose visual acuity with correcting lenses is not better than twenty/two hundred (20/200) in the better eye; or a person whose vision in the better eye is restricted to a field which subtends an angle of not greater than twenty (20) degrees; or a person who is functionally blind; or a person who is without any sight. ( )

02. Commission. Idaho Commission for the Blind and Visually Impaired. ( )

03. Comparable Benefits and Services. Any benefit or service that exists under any other programs that is available to the client. Examples are, but not limited to, Medicaid, Medicare, private health insurance, and medical indigence programs for medication. ( )

04. Functionally Blind. A person with a visual impairment that constitutes or results in a substantial impediment to employment or substantially limits one (1) or more major life activities. This is determined by a qualified, rehabilitation professional, not a physician. ( )

05. Immediate Danger of Blindness. The status of an individual or client who is in danger of becoming blind or visually impaired within two (2) years. ( )

06. Independent Living Services. Services that reduce the impact of functional limitations on the ability of a client to achieve independence in the home or community. ( )

07. Most Significant Disability. Meets the criteria as Significant Disability as found in the Rehabilitation Act of 1973, as amended, and defined in 34 CFR 361.5(c)(29), and is further defined as: Having a severe physical, mental, cognitive, or sensory impairment that seriously limits four (4) or more functional capacities (such as mobility, communication, self-care, self-direction, interpersonal skills, work tolerance or work skills) in terms of an employment outcome, and whose vocational rehabilitation can be expected to require multiple vocational rehabilitation services over an extended period of time. ( )

08. Prevention of Blindness and Sight Restoration Services. Treatment or surgery to prevent

blindness or restore vision to clients without financial resources to procure such services for themselves. ( )

09. Vocational Rehabilitation (VR) Service or Services. Services that reduce the impact of functional limitations on the ability of a client to achieve an employment outcome and are offered on a statewide basis to individuals who are blind or visually impaired or functionally blind, subject to eligibility. ( )

011. – 099. (RESERVED)

SUBCHAPTER A – VOCATIONAL REHABILITATION SERVICES (Rules 100 Through 199)

100. INFORMATION, REFERRAL, AND APPLICATION FOR VR SERVICES.
Any person or entity may refer an individual to the Commission for services. ( )

01. Contact by the Commission. Each referred individual must be seen or contacted by Commission staff within three (3) working days of the referral's receipt by scheduling an initial appointment, or documentation in a case note of telephone contact or email contact. Staff will inform the referral of application requirements and information necessary to initiate an assessment for determining eligibility. ( )

02. Right to Apply. All individuals have the right to apply for VR Services and to have a decision made regarding their eligibility for such services. ( )

03. Availability and Residence Requirements. Individuals must be available and legally permitted to join the labor market prior to eligibility determination. Residence requirements will not exclude any individual present in the state from vocational rehabilitation services. Individuals must have legal status in the United States and be authorized to work. ( )

04. Work Status and Identity Documentation. Documents that establish work status (employment eligibility) and identity must be consistent with Form I-9, Immigration and Naturalization Services (Form I-9, Employment Eligibility Verification). ( )

101. ELIGIBILITY.

01. Eligibility Requirements. Eligibility of a client for vocational rehabilitation services is based upon a determination that: ( )

a. The client is blind or visually impaired; ( )

b. The client's blindness or visual impairment constitutes or results in a substantial impediment to employment; and ( )

c. There is a reasonable expectation that vocational rehabilitation services will benefit the client in terms of securing, retaining, or regaining employment. ( )

d. The client has a disability priority which can include no significant disability (D), significant disability (SD), or most significant disability (MSD). ( )

102. COMPARABLE BENEFITS.
Eligible clients are to identify and use all available comparable benefits that may be available during the development of the Individualized Plan for Employment. Services that are exempt from this requirement are identified in 34 CFR 361.53(b). ( )

103. PURCHASING REQUIREMENTS.
All services and purchases will follow federal, state, and agency purchasing guidelines. Client services require written Authorization for Purchase (AFP) prior to the initiation of the purchased service. An authorization will be issued on or before the beginning date of service. If services are provided without an approved authorization, the Commission reserves the right to deny the vendor's invoice. ( )

104. PURCHASING STANDARDS.
The Commission pays usual, customary, and reasonable charges for services. In accordance with 34 CFR 361.50, the Commission has established a fee schedule for client services and levels of purchasing authority for Counselors. Exceptions to the upper limits established in the fee schedule need to be approved by the Rehabilitation Services Chief. Services that will meet the client's need at the least cost to the Commission will be the service considered for planning purposes. ( )

105. – 149. (RESERVED)

150. CLIENT APPEALS.

01. Informal Dispute Resolution. Within fifteen (15) calendar days of notification of the contested action, lack of action or decision, the client may make a written request to the Rehabilitation Services Chief that an informal dispute resolution be held, stating the reason for the review. ( )

a. The Rehabilitation Services Chief will inform the client in writing as to the time, place, and date of the informal dispute resolution. The client may choose to represent himself or may have a representative speak on his behalf. ( )

b. The Rehabilitation Services Chief will make a decision regarding the specifics of the informal dispute resolution. This decision will be in written form, and it will be sent to the client. ( )

02. Mediation. The request will be made in writing to the Rehabilitation Services Chief stating the reason for the review. The mediation must take place within sixty (60) days of client's request. ( )

03. Impartial Due Process Hearing. An impartial due process hearing can be held without an informal dispute resolution or mediation or if the client is dissatisfied with the result of the informal dispute resolution or mediation. The impartial due process hearing will deal with the issues involved in the original informal dispute resolution or mediation if one took place. The request for an impartial due process hearing will be made in writing to the Administrator within fifteen (15) calendar days of the Rehabilitation Services Chief's decision from the informal dispute resolution or the mediation proceedings. The hearing by an impartial hearing officer must be held within sixty (60) days of a request by the client unless both parties agree to a specified delay. ( )

151. ORDER OF SELECTION.

01. Prioritizing Services. In the event that the Commission lacks the personnel or financial resources to provide the full range of services to all eligible individuals, the following Order of Selection (OOS) will be used to prioritize service provisions. Students with disabilities, as defined by 34 CFR 361.5(c)(51), who received pre-employment transition services prior to eligibility determination and assignment to a priority category will continue to receive such services. All clients who have an Individualized Plan for Employment will continue to be served. Priority will be given to eligible individuals as follows: ( )

a. Priority 1. Eligible individuals with the Most Significant Disabilities. ( )

b. Priority 2. Eligible individuals with Significant Disabilities. ( )

c. Priority 3. All other eligible individuals with Disabilities. ( )

02. Inability to Serve. If the Commission cannot serve all eligible individuals within a priority category, individuals will be released from the statewide waitlist based on priority category and date of application. ( )

03. Exemption. Employed individuals, who are eligible for VR services and require immediate equipment or services to maintain their employment, are exempt from the OOS policy, as authorized in the Rehabilitation Act, as amended by WIOA, 34 CFR 361.36(a)(3)(v). ( )

152. – 199. (RESERVED)

SUBCHAPTER B – INDEPENDENT LIVING PROGRAM (Rules 200 Through 299)

200. PROVISION OF SERVICES ON A STATEWIDE BASIS AND APPLICATION.

01. Services. Independent Living Services are offered on a statewide basis to eligible individuals who are blind or visually impaired. ( )

02. Application. To apply for Independent Living Services, an individual must meet with a Rehabilitation Teacher and complete an application for Independent Living Services. An individual is considered to have applied for Independent Living Services with the Commission when that individual has signed an application for Independent Living Services, including completion and signature of required forms relating to independent living rights and responsibilities and to the release and exchange of information. ( )

201. ELIGIBILITY.
Eligibility of a client for Independent Living Services is based upon a determination that: ( )

01. Blind or Visually Impaired. The client is blind or visually impaired; ( )

02. Ability to Function. The client's blindness or visual impairment substantially limits the client's ability to function in the family or community; ( )

03. Result of Services. Provision of Independent Living Services will improve the client's ability to function, continue functioning, or move toward functioning independently in the family or community; and ( )

04. Residency. The client is a resident of the state of Idaho. ( )

202. INDEPENDENT LIVING PLAN.

01. Plan Development. For those clients determined eligible for Independent Living Services, an Independent Living Plan will be jointly developed by the client and a Rehabilitation Teacher, unless waived by the client in writing. ( )

02. Plan Contents. The plan will include the Independent Living goals and objectives, Independent Living Services to be provided, including start and end dates, costs, comparable benefits and services, client financial participation and any other elements deemed necessary by the Rehabilitation Teacher. ( )

203. PURCHASING STANDARDS AND REQUIREMENTS.
There is no fee assessed for Independent Living Services provided to the client by the Rehabilitation Teacher. However, where the provision of Independent Living Services includes the purchase of aids, appliances, assistive technology, computer hardware and software, and other purchased services or devices, the client's ability to pay will be taken into consideration with the expectation that the client will contribute toward or pay for the required service. The Commission will expend no more than five hundred dollars ($500) per client. Any exceptions to this rule are only granted upon review and approval of the Independent Living Coordinator. All purchases will follow federal, state, and agency purchasing guidelines. ( )

204. – 299. (RESERVED)

SUBCHAPTER C – THE PREVENTION OF BLINDNESS AND SIGHT RESTORATION PROGRAM (Rules 300 Through 999)

300. PROVISION OF SERVICES ON A STATEWIDE BASIS.
Prevention of Blindness and Sight Restoration Services are offered on a statewide basis to individuals who are Blind or Visually Impaired or who are in immediate danger of Blindness, subject to eligibility and available funding. To

apply, individuals must meet with a vocational rehabilitation assistant from the Commission to complete and sign an application. ( )

301. ELIGIBILITY.
Eligibility of a client for Prevention of Blindness and Sight Restoration Services is based upon a determination by the Commission that a client is blind or visually impaired, functionally blind, or in immediate danger of blindness and that the client is without financial resources to procure services for themselves. Clients must also meet *the following* requirements*:* *( )*

01. Demonstration of Financial Need. Only clients without financial resources to procure Services for themselves are eligible for Prevention of Blindness and Sight Restoration Services. Clients will undergo a financial needs assessment with Commission staff to determine whether financial eligibility requirements are met. ( )

02. Residency Requirements. In order to be eligible for Prevention of Blindness and Sight Restoration Services, a client must demonstrate the following residency requirements: ( )

a. If client is not a United States citizen, client must provide proof of *their* legal presence as a registered alien in the United States. *( )*

b. Residence in the state of Idaho for a minimum of six (6) months; and ( )

c. Presence in the state of Idaho at the time of provision of Prevention of Blindness and Sight Restoration Services. ( )

302. – 349. (RESERVED)

350. PAYMENT FOR NECESSARY EXPENSES.
The Commission's payment of necessary expenses associated with provision of Prevention of Blindness and Sight Restoration Services to eligible clients is subject to availability of funds during any single state fiscal year. In the event available funds for Prevention of Blindness and Sight Restoration Services are exhausted prior to the end of any single state fiscal year, eligible clients are placed on a waiting list until such time as funding is available to resume Prevention of Blindness and Sight Restoration Services. ( )

01. Upper Limits. *T*he Commission will pay no more than five thousand dollars ($5,000) per eligible client for necessary expenses incurred for Prevention of Blindness and Sight Restoration Services during each eligible client's lifetime participation in the Blind Prevention and Sight Restoration Program. *( )*

02. Comparable Benefits and Services. Eligible clients must apply for and secure any comparable benefits and services which shall be applied towards payment of necessary expenses incurred for Prevention of Blindness and Sight Restoration Services before any expenditure of Commission funds. ( )

03. Exceptions. Any exceptions to the individual lifetime limit per eligible client set forth in Subsection 350.01 of these rules are only granted upon approval of the *Independent Living Coordinator*. *( )*

351. – 999. (RESERVED)

000. LEGAL AUTHORITY.
The Idaho Legislature has designated the Commission for the Blind and Visually Impaired as the sole licensing agency under the provisions of the Randolph-Sheppard vending stand act pursuant to Section 67-5411, Idaho Code, and has given to the Board of the Idaho Commission for the Blind and Visually Impaired the legislative power to promulgate rules by the provisions of Section 67-5407(e), Idaho Code. ( )

001. TITLE AND SCOPE.

01. Title. These rules are titled IDAPA 15.02.30, "Business Enterprise Program." ( )

02. Scope. These rules specify the conditions and standards under which the Business Enterprise Program facilities are operated. ( )

002. -- 009. (RESERVED)

010. DEFINITIONS.
Unless otherwise indicated in these rules, terms below are defined as follows: ( )

01. Administrator. The Administrator of the Commission. ( )

02. Agreement. An agreement between the Program and an operator for the operation of a vending facility as a primary location. ( )

03. Benefits. Retirement or pension plans, health insurance contributions, and paid sick and vacation leave available only to operators. (See 34 CFR 395.8.) ( )

04. Blind Person. A person who, after examination by a physician skilled in diseases of the eye or by an optometrist, whichever such person selects, has been determined to have the following (see 34 CFR 395.1(c)): ( )

a. Not more than twenty/two hundred (20/200) central visual acuity in the better eye with correcting lenses; or ( )

b. An equally disabling loss of the visual field as evidenced by a limitation to the field of vision in the better eye to such a degree that its widest diameter subtends an angle of no greater than twenty (20) degrees. ( )

05. Certified. Having successfully completed the Commission-approved training program established by the Program as a requirement for licensing. (See Section 150 of these rules.) ( )

06. Commission. The Idaho Commission for the Blind and Visually Impaired. ( )

07. Committee. The Idaho Blind Merchants Committee (IBMC). ( )

08. Contract. A contract with a licensee or other qualified individual for the operation of a vending facility. Contracts are of limited duration. ( )

09. Contract Facility. A facility operated under a contract by a licensee or other party. ( )

10. Facility. A vending enterprise defined as: ( )

a. Automatic vending machines, cafeterias, snack bars, cart service, shelters, counters, and such other appropriate auxiliary equipment which may be operated by blind licensees and which is necessary for the sale of newspapers, periodicals, confections, tobacco products, foods, beverages, and other articles or services dispensed automatically or manually and prepared on or off the premises in accordance with all applicable health laws, and including the vending or exchange of chances for any lottery authorized by state law and conducted by an agency of a state within such a state. (See 34 CFR 395.1(x)); or ( )

b. Restaurants, cafeterias, snack bars, and goods and services customarily offered in connection with any of the foregoing, and includes vending machines dispensing foods when operated independently or in conjunction with such facilities. (See Section 67-6903, Idaho Code); or ( )

c. Any type of business which the Supervisor finds is consistent with and furthers the policies, goals, and objectives of the Program. ( )

11. License. A written instrument issued by the state licensing agency to a blind person, authorizing such person to operate a vending facility on federal or other property. (See 34 CFR 395.1(i).) ( )

12. Licensee. A blind person licensed by the state licensing agency to operate a vending facility on federal or other property. (See 34 CFR 395.1(b).) ( )

13. Operator. A licensee assigned to and operating a primary location. ( )

14. Permit. The official approval given a state licensing agency by a department, agency or instrumentality in control of the maintenance, operation, and protection of federal property, or person in control of other property, whereby the state licensing agency is authorized to establish a vending facility. (See 34 CFR 395.1(o).) ( )

15. Primary Location. A single building or group of buildings operated as a vending facility pursuant to an agreement. ( )

16. Probation. A conditional status wherein a vendor has a specified period of time to correct identified problems before an agreement or contract may be terminated. ( )

17. Program. The Business Enterprise Program (BEP), provided for by the Randolph-Sheppard Act to give priority to the blind in need of economic opportunities. (See 34 CFR 395.1(p) and Title 67, Chapter 69, Idaho Code.) ( )

18. Property Manager. The individual or entity in charge of administering vending contracts or permits in federal, state, or local government buildings or private buildings. ( )

19. Satellite. An ancillary site separate from a primary location granted to an operator as part of an agreement. ( )

20. Set Aside Funds. Funds which accrue to a state licensing agency from an assessment against the net proceeds of each vending facility in the state's vending facility program and any income from vending machines on federal property which accrues to the state licensing agency. (See 34 CFR 395.1(s).) ( )

21. State Licensing Agency. The Commission which has been designated by the Secretary of Education to issue licenses to blind persons for the operation of vending facilities on federal and other property. (See 34 CFR. 395.1(v).) ( )

22. Supervisor. The BEP individual who administers the Program. ( )

23. Suspension. Temporary withdrawal by the Supervisor of privileges granted by a license, agreement or contract during which time a vendor may not continue to operate a facility. ( )

24. Vendor. A licensee who operates a primary location with or without satellites, pursuant to an agreement, or who operates a contract facility pursuant to a contract. ( )

011. PURPOSE.

The purpose of the Program is to provide remunerative employment opportunities for blind individuals who have an interest in and aptitude for operating a facility, to demonstrate alternative techniques for coping with blindness, and to educate the public regarding the ability of blind individuals to independently operate businesses. The Supervisor is responsible for the administration of the Program and reports to the Administrator. The Program shall be coordinated with other vocational rehabilitation programs of the Commission. ( )

012. -- 029. (RESERVED)

030. LICENSES.

01. Issuance of Licenses. Licenses shall be issued for an indefinite period of time and shall be issued only to persons who are determined by the Program to be: ( )

a. Blind, as defined in Subsection 010.04 of these rules; and ( )

b. Citizens of the United States; and ( )

c. Certified by the Program as qualified and trained to operate a facility. ( )

02. Inactive License. If a licensee, who is not an operator, fails for more than one (1) year to bid for a facility, the license of such licensee shall become inactive. ( )

03. Reactivation. A license can be reactivated upon written request to the Supervisor. The Supervisor may require a licensee to repeat the certification requirements to reactivate a license. ( )

031. -- 039. (RESERVED)

040. TERMINATION AND SUSPENSION OF LICENSES.

01. Grounds for Termination. Licenses are subject to termination after fifteen (15) days' notice if the Program finds: ( )

a. That the facility is not being operated in accordance with Commission rules, the terms and conditions governing the permit, or the terms and conditions of the agreement or contract (See Section 140 of these rules.); ( )

b. That the licensee no longer meets the definition of blind person as set out in Subsection 010.04 of these rules; ( )

c. That the licensee has received a medically documented diagnosis that will result in prolonged incapacity of the licensee and a continuing inability to operate a facility; ( )

d. That the licensee has withdrawn from the Program by submitting written notification to the Supervisor; ( )

e. That the licensee has made unauthorized use of retirement account funds; or ( )

f. That the licensee engages in conduct or allows a condition to exist for which the licensee has previously been placed on probation, or which has previously led to the suspension of the license. ( )

02. Notice of Termination. Notice shall be in writing, specify the grounds upon which the notice of termination is based; and advise the operator of his right to administrative review and a full evidentiary hearing. ( )

03. Request for Review Not a Stay. A timely filed request for administrative review shall not stay the termination of the license. ( )

04. Termination. The termination becomes effective following the fifteen (15) day notice period unless the vendor seeks administrative review, in which case the license may be suspended and any contract or agreement may be terminated pending completion of the administrative review, full evidentiary hearing, and subsequent appeals. Until the review process has been concluded, the Program shall operate the facility. At the conclusion of the review process, should the vendor prevail, the Program shall restore all rights and benefits to the vendor including compensation for the period of termination calculated at a weekly rate determined by averaging the net income for the facility for the prior federal fiscal year. ( )

05. Suspension. The Supervisor has the authority to suspend the license of a vendor whose conduct may jeopardize a permit or the Program. ( )

a. The Supervisor shall notify the vendor in writing of the suspension and identify the specific deficiencies and the time allowed for the vendor to take corrective action. If no resolution has been made at the end of the specified time, the Supervisor shall issue a notice of termination. ( )

b. If the Supervisor and a vendor, whose license has been suspended, cannot agree on arrangements for a temporary replacement vendor, the procedures set out in Section 180 of these rules shall be followed to resolve the matter. ( )

06. Probation. The Supervisor has the authority to place a vendor who is not in compliance with the terms of an agreement or contract on probation. The Supervisor shall notify the vendor in writing of the probation and identify the specific deficiencies and the time allowed for the vendor to take corrective action. If no resolution has been made at the end of the specified time, the Supervisor shall issue a notice of termination. ( )

07. Improvement Plans. If the Supervisor receives a set aside report from a vendor that indicates no profit has been realized during two (2) consecutive months or three (3) months in a fiscal year the Supervisor shall review the situation and, with the vendor, devise a plan with measurable objectives and timetables for improvement. Should the facility not show a reasonable profit during the three (3) subsequent months the Supervisor may issue a notice of termination or the facility may be contracted or closed. ( )

041. -- 049. (RESERVED)

050. SELECTION OF OPERATORS.

01. Notification of Opening. The Supervisor shall notify all licensees and prospective operators, all commissioners and counselors of the Commission of all facility openings in writing. The notice of openings shall also be posted on the Commission web site. The notice shall state the facility location, the application procedure, and the deadline for application. The notice shall also solicit interest in operating the facility on a contract, in the event it is not awarded as a primary location. Interested parties will be provided specific information about the openings upon request. ( )

02. Qualification of Bidders. A bidder for a primary location shall be: ( )

a. Licensed by the Commission; ( )

b. Current with Program payments, including monthly set asides and any other monies due the Program; and ( )

c. In good standing and not have been placed on probation or had his license suspended within the last calendar year. ( )

03. No Qualified Bidders. If no applications are received from qualified bidders' licensees who expressed an interest in operating the facility as a contract facility will be given priority in the selection of a contractor. If no licensee is awarded the facility, the Supervisor may award a contract to any qualified individual. ( )

04. Application. An application shall be in the form of a written letter to the Supervisor and include a statement of qualifications and pertinent experience. ( )

05. Selection Process. ( )

a. The Supervisor shall appoint a panel to review all applications and conduct interviews. ( )

b. The panel shall consist of the Supervisor who serves as chair, a representative of the Committee

selected by the Committee chair, and one (1) person from field services. The person from field services shall not have had a client relationship with the applicants. ( )

c. The panel shall review all written applications and interview at least the top five (5) candidates, using the same format and interview questions. All members of the panel must be physically present during the interviews. ( )

d. A weighted evaluation form shall be used by each panel member. Selection criteria shall be consistent with the job requirements of that facility. Points shall be given by each interviewer to each candidate in the various categories assessed. A composite score shall be tabulated for each candidate. ( )

e. The Supervisor shall make a final selection from the two (2) candidates with the highest total points. If the candidate with the highest score is not selected, the Supervisor must provide an explanation in writing to the highest scoring candidate upon request. ( )

f. If no bidder is awarded operation of the facility, the Supervisor may grant it on a contract to a licensee or other qualified individual. ( )

06. Notification of Decision. The Supervisor shall notify all applicants in writing of the final decision. ( )

07. Records. The Supervisor shall maintain a record of all proceedings. ( )

08. Transfer and Promotion. The procedure for transfer and promotion shall be the same as for original selection of vendors. ( )

051. -- 059. (RESERVED)

060. ACCESS TO PROGRAM AND FINANCIAL INFORMATION.
Each licensee in the Program shall be provided access to all Program financial data relevant to the operation of the Program, including annual financial reports, provided that such disclosure does not violate applicable federal or state laws pertaining to the disclosure of confidential information. Insofar as practical, such data shall be made available in suitable alternative format. At the request of a licensee, qualified staff of the Program shall arrange a convenient time to assist in the interpretation of the financial data. ( )

061. -- 069. (RESERVED)

070. EQUIPMENT, INITIAL STOCK AND BUSINESS EXPENSES.

01. Program Responsibility. The Program assumes full responsibility for providing each facility established under the Program with adequate equipment and initial stock of merchandise. ( )

02. Initial Stock of Merchandise. An initial stock of merchandise shall be provided by the Supervisor. The Supervisor shall determine the quantity of the initial stock, which shall be enough for at least one (1) full week of operation. The vendor shall account for the value of the initial stock when the operation is concluded. ( )

03. Vending Machine Contracts. The Program shall negotiate contracts with vending companies for installation or location of vending machines in or to be assigned to facilities. ( )

04. Insurance. All vendors shall be responsible for obtaining general liability, product liability, and worker's compensation insurance. Proof of insurance must be sent to the Supervisor prior to the start of operation and within ten (10) days of policy renewal date. ( )

071. MAINTENANCE AND REPLACEMENT OF EQUIPMENT.
The Program shall maintain or cause to be maintained all equipment in a safe and satisfactory working condition. Replacement in lieu of repair shall be a decision of the Supervisor. It is the vendor's responsibility to report any incident resulting in damage, breakage, theft, defacement, or malfunction of equipment or fixtures as soon as

possible. Vendors are authorized to arrange for minor repairs or replacement of small equipment where the total cost does not exceed three hundred dollars ($300). Repair shall be deemed unauthorized when the repair or replacement is attributable to negligent actions by the vendor or when the equipment or fixtures are not the maintenance responsibility of the Program. ( )

072. OPERATOR OWNERSHIP OF VENDING FACILITIES.
The Commission does not vest title to equipment and stock in an operator. ( )

073. -- 099. (RESERVED)

100. SETTING ASIDE OF FUNDS.

01. Set Aside. The Commission may set aside, or cause to be set aside, from the net profit of the operation of facilities, funds for the purposes of maintenance and replacement and purchase of equipment. ( )

02. Other Purposes Allowed by the Randolph-Sheppard Act. The Commission reserves the right to use set aside funds for other purposes as permitted in accordance with the provisions of the Randolph-Sheppard Act and federal rules and regulations. ( )

03. Approval by the United States Department of Education. The funds set aside for those specified purposes shall not exceed the amount determined reasonable by the Rehabilitation Services Administration Commissioner, U.S. Department of Education. ( )

04. Record of Expenditures. The charge for each of the program purposes cited shall be determined on the basis of records of expenditures made for each of these purposes over a reasonable period of time with allowances for improving services, fluctuations in costs and program expansion. Adequate records shall be maintained to support the charges for each of the purposes cited. ( )

05. Increases. At no time shall the set aside charges be increased without prior consultation with the Committee. ( )

06. Review of Schedule of Funds. The schedule of funds to be set aside shall be reviewed periodically by the Supervisor and the Committee. After reviewing the accounting records and other criteria pertinent to the administration of the Program, it may be necessary to revise the set aside payment schedule. ( )

07. Income with No Program Operator. Vending machine income received from federal sites where there is no licensed Program operator shall be used for those purposes designated by the Committee in accordance with 34 CFR 395.8. ( )

101. DISTRIBUTION AND USE OF INCOME FROM VENDING MACHINES ON FEDERAL PROPERTY.

01. Limitations. No limitation shall be imposed on income from vending machines combined to create a facility when such facility is maintained, serviced or operated by a program vendor. ( )

02. Vending Machine Income. The Program shall manage vending machine income disbursed by a property managing department, agency or instrumentality of the United States in accordance with the requirements of 34 CFR 395.8. ( )

102. -- 119. (RESERVED)

120. OPERATOR BENEFITS.

01. Vending Machine Income. The Program shall provide licensees with information regarding benefits. Upon a majority vote of licensees, the Program may retain vending machine income from federal property in accordance with 34 CFR 395.8(a). Such income may be used for the establishment and maintenance of retirement or pension plans, for health insurance contributions, and for the provision of paid sick leave and vacation time for

operators. Distribution of benefit payments shall be determined by a majority vote of licensees and established as policy. ( )

02. Eligibility. Only operators of a primary location pursuant to an agreement shall be eligible to receive benefits. There shall be a ninety (90) day waiting period before a new operator is eligible to receive benefits. Benefit payments will not be interrupted when an operator transfers from one primary location to another. Benefits shall be paid only after the appropriate documentation is submitted to the Program. ( )

03. Medical Insurance. If a majority of licensees determines that operators shall be reimbursed for medical insurance premiums, operators shall be responsible for acquiring their own policies. The Program shall reimburse the operator in an amount determined by the vote of licensees. Operators shall provide documentation to the Program proving payment of their premiums, prior to any reimbursement. ( )

04. Retirement and Pension Accounts. If a majority vote of licensees determines that operators shall have retirement accounts, the Program shall deposit into approved retirement accounts an amount determined by a majority vote of licensees, up to the maximum federal allowance for IRAs per year. The funds shall be deposited on a monthly basis directly into each operator's retirement account. ( )

05. Sick Leave and Vacation Funds. If a majority vote of licensees determines that operators shall have sick or vacation leave funds, or both, the Program shall remit to each operator an amount determined by a majority vote of licensees. ( )

06. Non-Fully Funded Benefits. If funds are not available for full payment of benefits, as voted by the licensees, the Program may pro-rate the payments from available funds, unless another method of disbursement of non-fully funded benefits was voted by a majority of the licensees. ( )

121. -- 129. (RESERVED)

130. AGREEMENTS/CONTRACTS.
Vendors shall enter into an agreement or a contract with the Program that specifies the rights and responsibilities of the operator and Program as they relate to the operation of a primary location and any satellites. The contract shall specify the rights and responsibilities of the licensee or qualified operator and Program as they relate to the operation of a contract facility. ( )

01. Program Responsibilities. The Program shall: ( )

a. Equip the facility for carrying out the business authorized by the permit; ( )

b. Furnish initial stocks of merchandise sufficient to enable the vendor to commence operating the business. The Program shall also furnish the vendor with an inventory list of all equipment and initial stock; ( )

c. Provide for the maintenance of the equipment and replace obsolete and worn out equipment as necessary; ( )

d. Provide, or provide for supervisory and management services as deemed appropriate by the Supervisor for efficient operation; ( )

e. Periodically audit, or cause to be audited, the vendor's records and financial data to verify the accuracy of the set aside report; and ( )

f. Provide information or make available data in suitable format at the vendor's request when possible. ( )

02. Vendor Responsibilities. The vendor shall: ( )

a. Have the facility open for business as specified in the permit. Exceptions may be approved in

advance by the Supervisor; ( )

b. Operate on a cash basis. The Program shall not be responsible for bills incurred by the vendor. The vendor is responsible for notifying suppliers that the vendor alone is responsible and shall verify that notification by use of the purveyor letter supplied by the Program; ( )

c. Be accountable to the Program for the income of the facility; ( )

d. Provide for a temporary worker in the vendor's absence because of illness, vacation, or other causes. The salary of the person who substitutes for the vendor, or that of other emergency help, shall be paid for by the vendor. The vendor shall notify the Program a reasonable time in advance of taking any voluntary leave, and as soon as possible with respect to any involuntary leave; ( )

e. Carry on the business of the facility in compliance with the permit and applicable health laws and regulations and make available to the Program copies of inspection reports; ( )

f. Maintain a neat, business-like appearance while working at the facility, and conduct business in an orderly, professional manner; ( )

g. Take proper care of the equipment and not make structural alterations or changes to the facility without written approval of the Program; ( )

h. Keep appropriate records and send a monthly report and set aside payment to the Program by the fifteenth day of the following month as required. Late reports or payments will be resolved in the manner set forth in Section 040 of these rules; ( )

i. Be responsible for the day to day management of the facility. For staffed facilities, the vendor should be present the majority of the time the facility is staffed for service to the public. For vending only facilities, the Supervisor and vendor will mutually agree on the hours that the vendor shall be at the facility, and the agreement shall become an addendum to the contract or operating agreement; and ( )

j. The vendor shall provide copies of proof of insurance as required by Subsection 070.04 of these rules. ( )

03. General Rights and Responsibilities. ( )

a. The business to be conducted shall be limited to that specified and authorized in the permit or contract between property managing agency and the Program. ( )

b. The right, title to, and interest in the equipment and initial inventories of the facility are vested in the Program. At termination of the operating agreement, a value equal to that assigned to the outgoing vendor as beginning inventory will be returned to the Program. The Program will determine what inventory will be accepted from the outgoing vendor. The outgoing vendor shall have receipts no more than ninety (90) days old to show the value of inventory. Any inventory refused by the Program will become the property of the outgoing vendor. If the takeover inventory is less than initially assigned, the outgoing vendor will pay the difference in cash. If the Program agrees to accept more inventory than was initially assigned, the Program will reimburse the outgoing vendor in cash. ( )

c. The monthly income of the vendor shall be the net profit for the period in question; the expenses shall be in accordance with the monthly set aside report as developed by the Program and the Committee. ( )

d. Rebates, commissions, or bonuses received by the vendor from suppliers shall be reported as income. Such income is not to be treated as the separate, personal income of the vendor. ( )

e. Merchandise taken from the stock in trade of the facility by the vendor for personal use shall be paid for at cost. ( )

f. The business and premises shall be covered by adequate comprehensive and product liability insurance, and any such other insurance as will protect the vendor and anyone employed by the vendor against losses and claims arising out of the conduct of the business or which are required by law. The dollar amount of insurance shall be fixed by the Program and the Committee using industry standards and state requirements as guidelines to assure up-to-date coverage. The cost of such insurance shall be a cost of operating the business of the facility and taken into account as such in determining the net proceeds of the business operation. ( )

g. After an initial commitment to operate a primary location for twelve (12) months, an agreement may be terminated at anytime by the operator with at least thirty (30) days written notice to the Program. During the initial twelve (12) month period, the operator cannot bid on other primary locations without the consent of the Supervisor. ( )

h. The operator is encouraged to hire blind persons or persons with other disabilities when feasible. ( )

i. The vendor shall report promptly to the Supervisor any unresolved complaints of the property manager. ( )

j. The vendor may, with written approval of the Supervisor, negotiate with property managers for additional facilities. ( )

k. A vendor may purchase equipment for a facility only if the purchase is approved in advance, in writing, by the Supervisor. The Program, in its sole discretion, has the first option to purchase from the vendor any equipment purchased without advance, written approval. ( )

131. -- 139. (RESERVED)

140. TERMINATION AND SUSPENSION OF AGREEMENTS/CONTRACTS.

01. Grounds for Termination. Agreements and contracts may be terminated if: ( )

a. The vendor is not operating the facility on a cash basis; ( )

b. The health and safety of the vendor, the employees, or the customers are jeopardized; ( )

c. The set aside report indicates the vendor did not show an average one thousand dollar ($1,000) net profit per month, after set aside payment, for the prior federal fiscal year; ( )

d. The vendor jeopardizes the state's investment in the facility by violating the terms of the permit, agreement or contract, or by placing the facility in danger of being closed; ( )

e. The business and premises of the facility are not covered by adequate insurance; ( )

f. The facility is not being operated in accordance with the agreement, contract, Commission rules, or with applicable federal, state, or local laws, rules, and regulations; ( )

02. Notice of Termination. The notice shall be in writing and specify the grounds upon which the notice of termination is based and advise the vendor of his right to administrative review and a full evidentiary hearing. ( )

03. Request for Review Not a Stay. A timely filed request for administrative review shall not stay the termination of an agreement or contract. ( )

04. Review. The termination becomes effective following the fifteen (15) day notice period unless the vendor seeks administrative review, in which case the License may be suspended and any contract or agreement may be terminated pending completion of the administrative review, full evidentiary hearing, and subsequent appeals. Until the review process has been concluded, the Program shall operate the facility. At the conclusion of the review

process, should the vendor prevail, the Program shall restore all rights and benefits to the vendor including compensation for the period of termination calculated at a weekly rate determined by averaging the net income for the facility for the eight (8) weeks prior to the notice of termination. ( )

05. Grounds for Suspension. Agreements and contracts may be suspended if: ( )

a. The vendor has committed any of the acts enumerated in Subsection 140.01 of these rules; or ( )

b. The property manager requests the removal of the vendor and documents the request in writing, and the Program determines that immediate removal of the vendor is in the best interest of the Program; or ( )

c. The Supervisor and the vendor cannot agree on a plan to resolve violations and improve performance. ( )

06. Notice of Suspension. A written notice of suspension shall be delivered to the vendor and shall state the reason for the suspension. Suspension may continue up to sixty (60) days. If the vendor seeks administrative review of the suspension, the suspension shall continue until the administrative review, evidentiary hearing, and subsequent proceedings have concluded. During the suspension, the facility shall be operated by the Program. At the conclusion of the review process, should the vendor prevail, the Program shall restore all rights and benefits to the vendor including compensation for the period of termination calculated at a weekly rate determined by averaging the net income for the facility for the eight (8) weeks prior to the notice of termination. ( )

07. Cancellation. An agreement or contract may be cancelled by the Program at any time should the facility cease to be a vending facility by revocation of the permit by the property manager. Cancellation under this Subsection shall not affect licensure and does not give rise to a right to administrative review, evidentiary hearing or other relief. ( )

141. -- 149. (RESERVED)

150. TRAINING PROGRAM.

01. Certification. Prior to certification, an applicant shall satisfactorily complete the training program established by the Program and any on-the-job training prescribed by the Supervisor. The training program shall have certain basic requirements but also be customized to meet the needs of each individual applicant. The training program shall include, but is not limited to: fundamentals of purchasing, inventory control, pricing, record keeping and other accounting systems; display and arrangement of merchandise and equipment; and public relations and promotion. ( )

02. In-Service Training. The Program shall provide each vendor with regular and systematic assistance and in-service training to: promote maximum returns to the vendor; maximum service to the clientele; maintenance of a clean and attractive place of business; utilization of sound business practices; and adherence to the Commission's rules, policies, and building management requirements. ( )

03. Post-Employment Services. Post-employment services may be provided to eligible vendors when necessary to assure that they maintain suitable employment within the agency's Business Enterprise Program. Eligibility for and provision of post-employment services shall be in accordance with IDAPA 15.02.02, "Vocational Rehabilitation Services." ( )

151. -- 159. (RESERVED)

160. IDAHO BLIND MERCHANT'S COMMITTEE.

01. Committee Name. The Program shall provide for a state committee of blind vendors per the Randolph-Sheppard Act (See 34 CFR 395.14.) The name of this committee is the Idaho Blind Merchants Committee (IBMC). ( )

02. Purpose of Committee. The purpose of the Committee is to: ( )

a. Actively participate with the Commission in major administrative decisions and policy and program development decisions affecting the overall administration of the Program; ( )

b. Receive and transmit to the Commission grievances at the request of vendors and serve as advocates for such vendors in connection with such grievances; ( )

c. Actively participate with the Commission in the development and administration of a system for the transfer and promotion of vendors; ( )

d. Actively participate with the Commission in the development of training and retraining programs for vendors; and ( )

e. Sponsor, with the assistance of the Commission, meetings and instructional conferences for vendors within the state. ( )

03. Bylaws. The Committee shall, by a two-thirds (2/3) majority vote, adopt bylaws, consistent with the Randolph-Sheppard Act, which govern the internal operation of the Committee. ( )

04. Committee Membership. The Committee comprises the operators of all facilities in the state. ( )

05. Executive Board. An executive board consisting of a chair, vice chair, secretary, and two (2) at large representatives shall be elected by the Committee at a regular meeting. Members of the executive board shall serve for two (2) years in their respective positions. The executive board may conduct all business of the Committee between regular meetings of the Committee. ( )

161. -- 169. (RESERVED)

170. MEETINGS OF THE COMMITTEE.

01. Annual Meetings. The Committee shall hold at least one (1) regular meeting each calendar year. ( )

02. Additional Meetings. The Committee may provide for additional meetings in its bylaws. ( )

03. Program Responsibilities. The Program shall work with the Committee chair or designated representative to coordinate the regular meetings of the Committee. At regular meetings, the Program shall give financial and overview reports, review Program rules and policies; and receive Committee recommendations for changes to the Program rules or polices. ( )

04. Expenses. Allowable expenses of not more than two (2) regular meetings per calendar year may be paid out of Program monies. Allowable expenses include meeting rooms, lodging, per diem, and transportation. The transportation arrangements shall be determined by the Supervisor. Expenses for additional meetings of the Committee may be paid by the Program at the discretion of the Supervisor after consultation with the Administrator. ( )

05. Future Meeting. The date and time for the next regular meeting shall be set prior to adjournment. ( )

06. Minutes. Minutes shall be kept by the Committee and made available to the Supervisor. Minutes shall be sent to each operator and to the Supervisor within ninety (90) days after conclusion of the meeting. The Program shall pay all reasonable costs for this service. ( )

171. -- 179. (RESERVED)

180. ADMINISTRATIVE REVIEW.

01. Request for Review. A vendor who is aggrieved by any action or failure to act arising from the operation or administration of the Program may ask for a review of the action by filing a written request with the Administrator. The written request for review, which may be filed by the vendor or a designated representative of the vendor, shall specify the matter to be reviewed and how the vendor has been aggrieved. ( )

02. Response. Upon receipt of a request for administrative review, the Administrator shall notify the Supervisor, who has fifteen (15) calendar days to file a written response to the request. A copy of the Supervisor's response shall be sent to the vendor or the vendor's designated representative. ( )

03. Filing Objections, Replies, and Decisions. Upon receipt of the response from the Supervisor, the vendor or the vendor's designated representative has fifteen (15) calendar days in which to file any objections or make reply, after which time the Administrator shall, in good faith, evaluate the materials submitted and issue a written decision within fifteen (15) calendar days. The vendor or the vendor's designated representative may request an evidentiary hearing in accordance with Subsection 190.01 of these rules if the decision issued by the Administrator fails to resolve the vendor's grievance(s). ( )

181. -- 189. (RESERVED)

190. FULL EVIDENTIARY HEARING.

01. Request. The Commission shall provide a vendor an opportunity for a full evidentiary hearing. The vendor or the vendor's designated representative may request a full evidentiary hearing following the receipt of an unfavorable decision issued by the Administrator pursuant to Subsection 180.03 of these rules. The written request shall be delivered to the Administrator, with a copy to the Committee chair, within fifteen (15) calendar days of the aggrieved party's receipt of the Administrator's decision. ( )

02. Suspension. If the conduct of the vendor places the facility or permit in jeopardy, the Supervisor may suspend or terminate the agreement or contract pending the decision of the full evidentiary hearing. ( )

03. Time and Place of Hearing. The evidentiary hearing shall be held in the Commission headquarters at a mutually convenient time. ( )

04. Time Limit. The hearing procedure shall be limited to ninety (90) calendar days, beginning on the date the request for hearing is filed by the vendor. The time limit may be extended due to illness of the vendor or delay in obtaining evidence because of circumstances beyond the control of the vendor or the Program. ( )

05. Hearing Officer. The Administrator shall appoint a hearing officer to conduct the evidentiary hearing and issue a report. ( )

06. Hearing Notice. A notice of the hearing date shall be provided to the vendor at least twenty-one (21) calendar days prior to the date set for the hearing. ( )

07. Legal Counsel. The vendor may arrange to have legal counsel or other representation. Such counsel shall be at the expense of the vendor. ( )

08. Evidence. The hearing officer shall make a reasonable effort to obtain the most credible evidence of fact in the case, and the rules of evidence do not apply. ( )

09. Conduct of Hearing. Each party shall be given an opportunity to present its case, examine and cross-examine witnesses, present argument, and rebut evidence. ( )

10. Transcripts. A transcript of the proceedings shall be made available to the parties upon request. The Program shall pay all transcript costs associated with the conduct of the hearing. ( )

11. Report of Facts, Findings, Conclusion, and Recommended Decision. ( )

a. The hearing officer shall submit a report to the Administrator within twenty-one (21) calendar days after the hearing. This report shall include: the issues and relevant facts adduced at the hearing; applicable provisions of law, rules, and Commission policy; findings of fact and conclusions of law with respect to issues; and the reasons and basis thereof. ( )

b. The report shall also set forth any action necessary to resolve the issue and a recommended decision. ( )

12. Service of Report. The report shall be served on the Administrator and all parties to the hearing. ( )

13. Written Comments, Arguments, and Exceptions. Parties to the hearing may, within fifteen (15) calendar days of the date the report was received in the Administrator's office, file written comments, arguments, and exceptions to the report with the Administrator. Comments, arguments, and exceptions received in a timely fashion become a part of the record and shall be considered by the Administrator in making a final decision. ( )

14. Exclusive Record for Decision. The transcript of testimony, exhibits, and all papers and documents filed shall constitute an exclusive record for decision. ( )

15. Decision. The final decision of the Administrator shall be mailed to the vendor within thirty (30) days of receipt of the hearing officer's report. ( )

191. -- 199. (RESERVED)

200. ARBITRATION.
If a Vendor is dissatisfied with a decision rendered after a full evidentiary hearing, the vendor may request that an arbitration panel be convened by filing a complaint with the Secretary of the U.S. Department of Education in accordance with 34 CFR 395.13. ( )

201. -- 209. (RESERVED)

210. EXPLANATION TO VENDORS OF RIGHTS AND RESPONSIBILITIES.
The Program shall furnish to each vendor copies of documents relevant to the operation of the facility, including rules and procedures, a written description of the arrangements for providing services, the agreement and permit covering the operation of the facility, and shall provide explanation of these documents upon request by the vendor. ( )

211. -- 219. (RESERVED)

220. DISCRIMINATION.
The Program shall not discriminate against any applicant, licensee or vendor on the basis of gender, race, age, creed, color, religion, physical or mental handicap, sexual orientation, or national origin. ( )

221. -- 999. (RESERVED)

IDAPA 16 – DEPARTMENT OF HEALTH AND WELFARE

DOCKET NO. 16-0000-2100

NOTICE OF OMNIBUS RULEMAKING – ADOPTION OF PENDING RULE

LINK: LSO Rules Analysis Memo

EFFECTIVE DATE: This rule has been adopted by the agency and is now pending review by the 2022 Idaho State Legislature for final approval. The pending rule becomes final and effective upon the conclusion of the legislative session, unless the rule is approved or rejected in part by concurrent resolution in accordance with Section 67-5224 and 67-5291, Idaho Code. If the pending rule is approved or rejected in part by concurrent resolution, the rule becomes final and effective upon adoption of, or 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 Sections 6-2604, 16-107, 16-1623, 16-2403, 16-2404, 16-2406, 16-2423, 16-2433, 31-3503C, 37-121, 39-242, 39-605, 39-906, 39-909, 39-910, 39-1003, 39-1118, 39-1301 through 39-1314, 39-1306, 39-1307, 39-1307A, 39-1307B, 39-1603, 39-2401(2), 39-3133, 39-3140, 39-3308, 39-3508, 39-4505(2), 39-4601 et seq., 39-4605, 39-4801, 39-5209, 39-5403, 39-5508, 39-5704, 56-133, 56-135, 56-201 et seq., 56-202, 56-202(b), 56-203, 56-204A, 56-209, 56-216, 56-221, 56-222, 56-227, 56-239, 56-250 through 257, 56-260 through 56-266, 56-1001, 56-1003, 56-1004, 56-1004A, 56-1005, 56-1007, 56-1009, 56-1011 through 56-1023, 54-1119, 56-1610, 66-317, Idaho Code, and 45 CFR Parts 260 - 265, Parts 400 and 401, by Section 412E, Title IV, Pub. L. 96-212, and Medicare Prescription Drug Improvement and Modernization Act of 2003, P.L. 108-173, Section 231, Section 1937 of the Social Security Act, the Low-Income Home Energy Assistance Act of 1981, 42 U.S.C Sections 8621 to 8629, 42 USC 5101 et seq., and 7 USC 7501 et seq.

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

This pending rule adopts and publishes the following rule chapters previously submitted to and reviewed by the Idaho Legislature under IDAPA 16, rules of the Department of Health And Welfare. Changes in the pending rule are indicated beneath their respective rule chapter below:

IDAPA 16

- 16.01.02, *Emergency Medical Services (EMS) - Rule Definitions*;
- 16.01.03, *Emergency Medical Services (EMS) - Agency Licensing Requirements* –
  - Added statement regarding prehospital support;
- 16.01.05, *Emergency Medical Services (EMS) - Education, Instructor, and Examination Requirements*;
- 16.01.06, *Emergency Medical Services (EMS) - Data Collection and Submission Requirements*;
- 16.01.12, *Emergency Medical Services (EMS) - Complaints, Investigations, and Disciplinary Actions*;
- 16.02.02, *Idaho Emergency Medical Services (EMS) Physician Commission*;
- 16.02.06, *Quality Assurance for Idaho Clinical Laboratories*;
- 16.02.10, *Idaho Reportable Diseases*;
- 16.02.11, *Immunization Requirements Licensed Daycare Facility Attendees*;
- 16.02.12, *Newborn Screening*;
- 16.02.15, *Immunization Requirements for Idaho School Children*;
- 16.02.19, *Idaho Food Code*;
- 16.02.23, *Indoor Smoking*;
- 16.02.24, *Clandestine Drug Laboratory Cleanup*;
- 16.03.01, *Eligibility for Health Care Assistance for Families and Children*;
- 16.03.02, *Skilled Nursing Facilities*;
- 16.03.04, *Idaho Food Stamp Program*;
- 16.03.05, *Eligibility for Aid to the Aged, Blind, and Disabled (AABD)*;
- 16.03.06, *Refugee Medical Assistance*;
- 16.03.07, *Home Health Agencies*;
- 16.03.08, *Temporary Assistance for Families in Idaho (TAFI)*;
- 16.03.09, *Medicaid Basic Plan Benefits*;
- 16.03.10, *Medicaid Enhanced Plan Benefits*;

- 16.03.11, *Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID)*;
- 16.03.13, *Consumer-Directed Services*;
- 16.03.14, *Hospitals*;
- 16.03.17, *Medicare/Medicaid Coordinated Plan Benefits*;
- 16.03.21, *Developmental Disabilities Agencies (DDA) –*
  - Added minor clarifications, updates to participant record requirements, and new Section (407) regarding Termination Procedures;
- 16.03.24, *The Medically Indigent Program*;
- 16.03.25, *Idaho Medicaid Promoting Interoperability (PI) Program*;
- 16.04.14, *Low-Income Home Energy Assistance Program (LIHEAP)*;
- 16.04.17, *Residential Habilitation Agencies*;
- 16.05.01, *Use and Disclosure of Department Records*;
- 16.05.03, *Contested Case Proceedings and Declaratory Rulings*;
- 16.05.04, *Idaho Council on Domestic Violence and Victim Assistance Grant Funding –*
  - Section 002 - Incorporation by Reference was removed;
- 16.05.07, *The Investigation & Enforcement of Fraud, Abuse, & Misconduct*;
- 16.06.05, *Alleged Medical Neglect of Disabled Infants*;
- 16.06.12, *Idaho Child Care Program (ICCP)*;
- 16.06.13, *Emergency Assistance for Families and Children*;
- 16.07.17, *Substance Use Disorders Services*;
- 16.07.19, *Certification of Peer Support Specialists and Family Support Partners*;
- 16.07.25, *Prevention of Minors' Access to Tobacco Products*;
- 16.07.33, *Adult Mental Health Services*;
- 16.07.37, *Children's Mental Health Services*; and
- 16.07.39, *Designated Examiners and Dispositioners*.

The text of the pending rule has been amended in accordance with Section 67-5227, Idaho Code. The complete text of the proposed rule was published in the October 20, 2021, Special Edition of the Idaho Administrative Bulletin, Vol. 21-10SE, pages 1332-2359.

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

This rulemaking is not anticipated to have any fiscal impact on the state general fund because the FY2022 budget has already been set by the Legislature, and approved by the Governor, anticipating the existence of the rules being reauthorized by this rulemaking.

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning this pending rule, contact Administrative Rules Unit, dhwrules@dhw.idaho.gov, 450 W State St., 10 Floor, Boise, ID, 83720.

Dated this 22nd day of December, 2021.

Tamara Prisock
DHW – Administrative Rules Unit
450 W. State Street – 10th Floor
P.O. Box 83720
Boise, ID 83720-0036
phone: (208) 334-5500
fax: (208) 334-6558
e-mail: dhwrules@dhw.idaho.gov

THE FOLLOWING NOTICE PUBLISHED WITH THE OMNIBUS PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 6-2604, 16-107, 16-1623, 16-2403, 16-2404, 16-2406, 16-2423, 16-2433, 31-3503C, 37-121, 39-242, 39-605, 39-906, 39-909, 39-910, 39-1003, 39-1118, 39-1301 through 39-1314, 39-1306, 39-1307, 39-1307A, 39-1307B, 39-1603, 39-2401(2), 39-3133, 39-3140, 39-3308, 39-3508, 39-4505(2), 39-4601 et seq., 39-4605, 39-4801, 39-5209, 39-5403, 39-5508, 39-5704, 56-133, 56-135, 56-201 et seq., 56-202, 56-202(b), 56-203, 56-204A, 56-209, 56-216, 56-221, 56-222, 56-227, 56-239, 56-250 through 257, 56-260 through 56-266, 56-1001, 56-1003, 56-1004, 56-1004A, 56-1005, 56-1007, 56-1009, 56-1011 through 56-1023, 54-1119, 56-1610, 66-317, Idaho Code, and 45 CFR Parts 260 - 265, Parts 400 and 401, by Section 412E, Title IV, Pub. L. 96-212, and Medicare Prescription Drug Improvement and Modernization Act of 2003, P.L. 108-173, Section 231, Section 1937 of the Social Security Act, the Low-Income Home Energy Assistance Act of 1981, 42 U.S.C Sections 8621 to 8629, 42 USC 5101 et seq., and 7 USC 7501 et seq.

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

*** VIRTUAL PUBLIC HEARING ***

Wednesday, November 3, 2021
1:30 p.m. - 3:00 p.m. MT

WebEx INFORMATION
WebEx Phone: +1-415-655-0003 US Toll
+1-720-650-7664 United States Toll (Denver)

Meeting Number (Access Code): 1771 50 9424
Meeting password: jCCJZByA374 (52259292 from phones and video systems)

WebEx Link:
https://idhw.webex.com/idhw/j.php?MTID=m913d0dbdc824d0d160ece7dc7f06249f

DO NOT CALL IN PRIOR TO 10 MINUTES BEFORE THE START OF THE MEETING

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

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

This proposed rulemaking publishes the following rule chapters previously submitted to and reviewed by the Idaho Legislature under IDAPA 16, rules of the Department of Health And Welfare:

IDAPA 16
- 16.01.02, *Emergency Medical Services (EMS) - Rule Definitions*;
- 16.01.03, *Emergency Medical Services (EMS) - Agency Licensing Requirements* – Revisions provide a waiver process to clinical level agency licensure model to allow part-time Advance Life Support or Intermediate Life Support coverage for prehospital ambulances struggling with staffing issues, or agencies that sometimes have personnel available who can offer more advanced patient care services;

- 16.01.05, *Emergency Medical Services (EMS) - Education, Instructor, and Examination Requirements* – Rewritten according to Executive Order 2020-01;
- 16.01.06, *Emergency Medical Services (EMS) - Data Collection and Submission Requirements*;
- 16.01.12, *Emergency Medical Services (EMS) - Complaints, Investigations, and Disciplinary Actions*;
- 16.02.02, *Idaho Emergency Medical Services (EMS) Physician Commission*;
- 16.02.06, *Quality Assurance for Idaho Clinical Laboratories*;
- 16.02.10, *Idaho Reportable Diseases*;
- 16.02.11, *Immunization Requirements Licensed Daycare Facility Attendees*;
- 16.02.12, *Newborn Screening*;
- 16.02.15, *Immunization Requirements for Idaho School Children*;
- 16.02.19, *Idaho Food Code*;
- 16.02.23, *Indoor Smoking* – Rewritten according to Executive Order 2020-01;
- 16.02.24, *Clandestine Drug Laboratory Cleanup*;
- 16.03.01, *Eligibility for Health Care Assistance for Families and Children*;
- 16.03.02, *Skilled Nursing Facilities*;
- 16.03.04, *Idaho Food Stamp Program*;
- 16.03.05, *Eligibility for Aid to the Aged, Blind, and Disabled (AABD)*;
- 16.03.06, *Refugee Medical Assistance* – Rewritten according to Executive Order 2020-01;
- 16.03.07, *Home Health Agencies* – Rewritten according to Executive Order 2020-01;
- 16.03.08, *Temporary Assistance for Families in Idaho (TAFI)*;
- 16.03.09, *Medicaid Basic Plan Benefits*;
- 16.03.10, *Medicaid Enhanced Plan Benefits*;
- 16.03.11, *Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID)*;
- 16.03.13, *Consumer-Directed Services*;
- 16.03.14, *Hospitals*;
- 16.03.17, *Medicare/Medicaid Coordinated Plan Benefits*;
- 16.03.21, *Developmental Disabilities Agencies (DDA)* – Rewritten according to Executive Order 2020-01;
- 16.03.24, *The Medically Indigent Program*;
- 16.03.25, *Idaho Medicaid Promoting Interoperability (PI) Program*;
- 16.04.14, *Low-Income Home Energy Assistance Program (LIHEAP)*;
- 16.04.17, *Residential Habilitation Agencies*;
- 16.05.01, *Use and Disclosure of Department Records*;
- 16.05.03, *Contested Case Proceedings and Declaratory Rulings*;
- 16.05.04, *Idaho Council on Domestic Violence and Victim Assistance Grant Funding*;
- 16.05.07, *The Investigation & Enforcement of Fraud, Abuse, & Misconduct* – Rewritten according to Executive Order 2020-01;
- 16.06.05, *Alleged Medical Neglect of Disabled Infants*;
- 16.06.12, *Idaho Child Care Program (ICCP)*;
- 16.06.13, *Emergency Assistance for Families and Children* – Rewritten according to Executive Order 2020-01;
- 16.07.17, *Substance Use Disorders Services* – Rewritten according to Executive Order 2020-01;
- 16.07.19, *Certification of Peer Support Specialists and Family Support Partners*;
- 16.07.25, *Prevention of Minors' Access to Tobacco Products*;
- 16.07.33, *Adult Mental Health Services*;
- 16.07.37, *Children's Mental Health Services*; and
- 16.07.39, *Designated Examiners and Dispositioners* – Rewritten according to Executive Order 2020-01.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: None.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year: This rulemaking is not anticipated to have any fiscal impact on the state general fund because the FY2022 budget has already been set by the Legislature, and approved by the Governor, anticipating the existence of the rule(s) being reauthorized by this rulemaking.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not feasible because engaging in negotiated rulemaking for all previously existing rules will inhibit the agency from carrying out its ability to serve the citizens of Idaho and to protect their health, safety, and welfare.

Negotiated rulemaking conducted outside of this omnibus rulemaking affects the following rule chapters included in this proposed rulemaking listed below with their respective negotiated rulemaking docket number:

- 16.01.05, EMS - Education, Instructor, and Exam, 16-0105-2101, Vol. 21-4, pages 30-31, and Vol. 21-5, pages 17-18
- 16.03.06, Refugee Medical Assistance, 16-0306-2101, Vol. 21-4, pages 34-35
- 16.03.07, Home Health Agencies, 16-0307-2101, Vol. 21-3, pages 27-28, and Vol. 21-4, pages 36-37
- 16.03.09, Medicaid Basic Plan Benefits, 16-0309-2101, Vol. 21-5, pages 22-23
- 16.03.21, Developmental Disabilities Agencies, 16-0321-2101, Vol. 21-2, pages 28-30, Vol. 21-3, pages 29-30, and Vol. 21-4, pages 38-39
- 16.05.07, Investigation and Enforcement of Fraud, Abuse, and Misconduct, 16-0507-2101, Vol. 21-4, pages 42-43
- 16.06.13, Emergency Assistance for Families and Children, 16-0613-2101, Vol. 21-5, pages 24-25
- 16.07.17, Substance Use Disorders Services, 16-0717-2101, Vol. 21-2, pages 31-32
- 16.07.39, Designated Examiners and Dispositioners, 16-0739-2101, Vol. 21-2, pages 33-34

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, incorporated material may be obtained or electronically accessed as provided in the text of the proposed rules attached hereto.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rules, contact Administrative Rules Unit, dhwrules@dhw.idaho.gov, 450 W State St., 10 Floor, Boise, ID, 83720.

Anyone may submit written comments regarding the proposed rulemaking. All written comments must be directed to the undersigned and must be delivered within twenty-one (21) days after publication of this Notice in the Idaho Administrative Bulletin.

DATED this 20th day of October, 2021.

Substantive changes have been made to the pending rule.
Italicized red text **indicates changes between the text of the proposed rule as adopted in the pending rule.**

THE FOLLOWING IS THE TEXT OF OMNIBUS PENDING DOCKET NO. 16-0000-2100

16.01.02 – EMERGENCY MEDICAL SERVICES (EMS) – RULE DEFINITIONS

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

001. TITLE AND SCOPE.

01. Title. These rules are titled IDAPA 16.01.02, "Emergency Medical Services (EMS) – Rule Definitions." ( )

02. Scope. These rules contain the definitions used throughout the Emergency Medical Services chapters of rules adopted by the Department. Those chapters include: ( )

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

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

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

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

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

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

002. -- 009. (RESERVED)

010. DEFINITIONS AND ABBREVIATIONS A THROUGH B.
For the purposes of the Emergency Medical Services (EMS) chapters of rules, the following definitions apply: ( )

01. Advanced Emergency Medical Technician (AEMT). An AEMT is a person who: ( )

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

b. Is licensed by the Department under Sections 56-1011 through 56-1023, Idaho Code; ( )

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

d. Practices under the supervision of a physician licensed in Idaho. ( )

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

03. Advanced Practice Registered Nurse. A person who meets all the applicable requirements and is

licensed to practice as an Advanced Practice Registered Nurse under Sections 54-1401 through 54-1418, Idaho Code. ( )

04. **Advertise**. Communication of information to the public, institutions, or to any person concerned, by any oral, written, graphic means including handbills, newspapers, television, radio, telephone directories, billboards, or electronic communication methods. ( )

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

06. **Affiliating EMS Agency**. The licensed EMS agency, or agencies, under which licensed personnel are authorized to provide patient care. ( )

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

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

09. **Air Medical**. A service type available to a licensed air medical EMS agency that meets the requirements in IDAPA 16.01.03, "Emergency Medical Services (EMS) - Agency Licensing Requirements." ( )

10. **Air Medical Response**. The deployment of an aircraft licensed as an air ambulance to an emergency scene intended for the purpose of patient treatment and transportation. ( )

11. **Air Medical Support**. A service type available to a licensed air medical EMS agency that meets the requirements in IDAPA 16.01.03, "Emergency Medical Services (EMS) - Agency Licensing Requirements." ( )

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

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

14. **Ambulance Agency**. An agency licensed by the Department under Sections 56-1011 through 56-1023, Idaho Code, and IDAPA 16.01.03, "Emergency Medical Services (EMS) - Agency Licensing Requirements," operated with the intent to provide personnel and equipment for medical treatment at an emergency scene, during transportation or during transfer of persons experiencing physiological or psychological illness or injury who may need medical attention during transport. ( )

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

16. **Applicant**. Any organization that is requesting an agency license under Sections 56-1011 through

56-1023, Idaho Code, and IDAPA 16.01.03, "Emergency Medical Services (EMS) - Agency Licensing Requirements," including the following: ( )

a. An organization seeking a new license; ( )

b. An existing agency that intends to: ( )

i. Change the level of licensed personnel it utilizes; ( )

ii. Change its geographic coverage area (except by agency annexation); or ( )

iii. Begin or discontinue providing patient transport services. ( )

17. Assessment. The evaluation of a patient by EMS licensed personnel intending to provide treatment or transportation to that patient. ( )

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

19. Board. The Idaho Board of Health and Welfare. ( )

011. DEFINITIONS AND ABBREVIATIONS C THROUGH E.
For the purposes of the Emergency Medical Services (EMS) chapters of rules, the following definitions apply: ( )

01. Call Volume. The number of requests for service that an agency either anticipated or responded to during a designated period of time. ( )

02. Candidate. Any individual who is requesting an EMS personnel license under Sections 56-1011 through 56-1023, Idaho Code, IDAPA 16.01.07, "Emergency Medical Services (EMS) - Personnel Licensing Requirements." ( )

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

04. Certification. A credential issued by a designated certification body for a specified period of time indicating that minimum standards have been met. ( )

05. Certified EMS Instructor. An individual approved by the Department, who has met the requirements in IDAPA 16.01.05, "Emergency Medical Services (EMS) -- Education, Instructor, and Examination Requirements," to provide EMS education and training. ( )

06. CoAEMSP. Committee on Accreditation of Educational Programs for the Emergency Medical Services Professions. ( )

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

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

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

10. Consolidated Emergency Communications System. Facilities, equipment, and dispatching services directly related to establishing, maintaining, or enhancing a 911 emergency communications service defined in Section 31-4802, Idaho Code. ( )

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

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

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

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

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

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

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

18. Department. The Idaho Department of Health and Welfare. ( )

19. Director. The Director of the Idaho Department of Health and Welfare or their designee. ( )

20. Division. The Division of Public Health, Idaho Department of Health and Welfare. ( )

21. Emergency. A medical condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the person's health in serious jeopardy, or in causing serious impairments of bodily function or serious dysfunction of any bodily organ or part. ( )

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

23. Emergency Medical Responder (EMR). An EMR is a person who: ( )

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

b. Is licensed by the Department under Sections 56-1011 through 56-1023, Idaho Code; ( )

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

d. Practices under the supervision of a physician licensed in Idaho. ( )

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

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

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

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

d. Offer, advertise, or attempt to respond as described in Subsection 011.24.a. through 011.24.c. of this rule. ( )

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

26. Emergency Medical Technician (EMT). An EMT is a person who: ( )

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

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

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

d. Practices under the supervision of a physician licensed in Idaho. ( )

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

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

29. EMS Bureau. The Bureau of Emergency Medical Services (EMS) & Preparedness of the Idaho Department of Health and Welfare. ( )

30. EMS Education Program. The institution or agency holding an EMS education course. ( )

31. EMS Education Program Director. The individual responsible for an EMS educational program or programs. ( )

32. EMS Education Program Objectives. The measurable outcome used by the program to determine student competencies. ( )

33. EMS Medical Director. A physician who supervises the medical activities of licensed personnel affiliated with an EMS agency. ( )

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

35. EMS Response. A response to a request for assistance that would involve the medical evaluation or treatment of a patient, or both. ( )

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

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

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

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

04. Ground Transport Time. The total elapsed time calculated from departure of the ambulance from the scene to arrival of the ambulance at the patient destination. ( )

05. Hospital. A facility in Idaho licensed under Sections 39-1301 through 39-1314, Idaho Code, and defined in Section 39-1301(a)(1), Idaho Code. ( )

06. Instructor. Person who assists a student in the learning process and meets the requirements to obtain instructor certification. ( )

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

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

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

10. License. A document issued by the Department to an agency or individual authorizing specified activities and conditions as described under Sections 56-1011 through 56-1023, Idaho Code. ( )

11. Licensed Personnel. Those individuals who are licensed by the Department as Emergency Medical Responders (EMR), Emergency Medical Technicians (EMT), Advanced Emergency Medical Technicians

(AEMT), and Paramedics. ( )

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

13. Local Incident Management System. The local system of interagency communications, command, and control established to manage emergencies or demonstrate compliance with the National Incident Management System. ( )

14. Medical Supervision Plan. The written document describing the provisions for medical supervision of licensed EMS personnel. ( )

15. National Emergency Medical Services Information System (NEMSIS). NEMSIS is the national repository used to store national EMS data. NEMSIS sets the uniform data conventions and structure for the Data Dictionary. NEMSIS collects and provides aggregate data available for analysis and research through its technical assistance center accessed at . ( )

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

17. Non-transport Agency. An agency licensed by the Department, operated with the intent to provide personnel or equipment for medical stabilization at an emergency scene, but not intended to be the service that will actually transport sick or injured persons. ( )

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

19. Nurse Practitioner. An Advanced Practice Registered Nurse, licensed in the category of Nurse Practitioner, as defined in IDAPA 24.34.01, "Rules of the Idaho Board of Nursing." ( )

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

01. Optional Module. Optional modules (OMs) are skills identified by the EMS Physician Commission that exceed the floor level Scope of Practice for EMS personnel and may be adopted by the agency medical director. ( )

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

03. Paramedic. A paramedic is a person who: ( )

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

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

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

d. Practices under the supervision of a physician licensed in Idaho. ( )

04. Paramedicine. Providing emergency care to sick and injured patients at the advanced life support

(ALS) level with defined roles and responsibilities to be credentialed at the Paramedic level. ( )

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

06. Patient. A sick, injured, incapacitated, or helpless person who is under medical care or treatment. ( )

07. Patient Assessment. The evaluation of a patient by EMS licensed personnel intending to provide treatment or transportation to that patient. ( )

08. Patient Care. The performance of acts or procedures under emergency conditions in responding to a perceived individual need for immediate care in order to prevent loss of life, aggravation of physiological or psychological illness, or injury. ( )

09. Patient Movement. The relatively short distance transportation of a patient from an off-highway emergency scene to a rendezvous with an ambulance or air ambulance. ( )

10. Patient Transport. The transportation of a patient by ambulance or air ambulance from a rendezvous or emergency scene to a medical care facility. ( )

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

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

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

14. Prehospital. A setting where emergency medical care is provided prior to or during transport to a hospital. ( )

15. Psychomotor Exam. Practical demonstration of skills learned during an EMS education course. ( )

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

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

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

19. Skills Proficiency. The process overseen by an EMS agency medical director to verify competency in psychomotor skills. ( )

20. State Health Officer. The Administrator of the Division of Public Health. ( )

21. Summative Evaluation. End of topic or end of course evaluation that covers both didactic and

practical skills application. ( )

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

a. Establishing standing orders and protocols; ( )

b. Reviewing performance of licensed personnel; ( )

c. Providing instructions for patient care via radio or telephone; and ( )

d. Other oversight. ( )

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

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

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

014. -- 999. (RESERVED)

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

001. TITLE AND SCOPE.

01. Title. These rules are titled IDAPA 16.01.03, "Emergency Medical Services (EMS) – Agency Licensing Requirements." ( )

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

002. INCORPORATION BY REFERENCE.

01. Minimum Equipment Standards for Licensed EMS Services. The Board of Health and Welfare has adopted the "Minimum Equipment Standards for Licensed EMS Services," edition 2016, version 1.0, as its standard for minimum equipment requirements for licensed EMS Agencies and incorporates it by reference. Copies of these standards may be obtained from the Department, see http://www.idahoems.org. ( )

02. Time Sensitive Emergency System Standards Manual. The Board of Health and Welfare has adopted the "Time Sensitive Emergency System Standards Manual," Edition 2020-1, as its standard for certifying EMS Agencies as TSE Designated EMS Agencies. Copies of these standards may be obtained from the Department, see https://tse.idaho.gov/. ( )

003. -- 009. (RESERVED)

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

011. -- 074. (RESERVED)

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

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

077. -- 099. (RESERVED)

EMS AGENCY GENERAL LICENSURE REQUIREMENT
(Sections 100 - 199)

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

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

( )

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

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

03. Transfer of Patient From Out-of-State Medical Facility. The organization is: ( )

a. Transferring a patient from an out-of-state medical facility to a medical facility in Idaho. The organization may return the patient to the point of origin; or ( )

b. Transferring a patient from an out-of-state medical facility through the state of Idaho. ( )

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

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

b. Transporting a patient to a rendezvous with another ambulance. ( )

102. SERVICES PROVIDED BY A LICENSED EMS AGENCY.
An EMS agency can provide only those services that are within the agency's service type, clinical level, and operational declarations stated on the most recent license issued by the Department, except when the agency has a planned deployment agreement described in Section 603 of these rules. ( )

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

104. -- 199. (RESERVED)

EMS AGENCY LICENSURE MODEL
(Sections 200 - 299)

200. EMS AGENCY-- LICENSING MODEL.

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

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

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

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

( )

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

01. Ground Agency Service Types. ( )

a. Non-transport. ( )

b. Ambulance. ( )

02. Air Medical Agency Service Types. ( )

a. Air Medical. ( )

b. Air Medical Support. ( )

202. EMS AGENCY -- CLINICAL LEVELS.
An EMS agency is licensed at one (1) or more of the following clinical levels depending on the agency's highest level of licensed personnel and life support services advertised or offered. ( )

01. Non-transport: ( )

a. EMR/BLS; ( )

b. EMT/BLS; ( )

c. AEMT/ILS; or ( )

d. Paramedic/ALS. ( )

02. Ambulance: ( )

a. EMR (with Ambulance Certification)/BLS; ( )

b. EMT/BLS; ( )

c. AEMT/ILS; ( )

d. Paramedic/ALS; or ( )

e. Paramedic/ALS Critical Care. ( )

03. Air Medical: ( )

a. Paramedic/ALS; or ( )

b. Paramedic/ALS Critical Care. ( )

04. Air Medical Support; ( )

a. EMT/BLS; ( )

b. AEMT/ILS; or ( )

c. Paramedic/ALS. ( )

203. EMS AGENCY -- LICENSE DURATION.
Each EMS agency must identify the license duration for each license type. License durations are: ( )

01. Ongoing. The agency is licensed to provide EMS personnel and equipment for an ongoing period of time and plans to renew its license on an annual basis. ( )

02. Limited. The agency is licensed to provide EMS personnel and equipment for the duration of a specific event or a specified period of time with no expectation of renewing the agency license. ( )

03. Seasonal. The agency is licensed to provide EMS personnel and equipment for the duration of time each year that corresponds to the seasonal activity that the agency supports. ( )

204. GROUND EMS AGENCY -- OPERATIONAL DECLARATIONS.
An agency providing ground services is licensed with one (1) or more of the following operational declarations depending on the services that the agency advertises or offers. ( )

01. Prehospital. The prehospital operational declaration is available to an agency that: ( )

a. Has primary responsibility for responding to calls for EMS within their designated geographic coverage area; and ( )

b. Is dispatched to prehospital emergency medical calls by a consolidated emergency communications system. ( )

02. Prehospital Support. The prehospital support operational declaration is available to an agency that: ( )

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

b. Is dispatched to prehospital emergency medical calls by a consolidated emergency communications system. ( )

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

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

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

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

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

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

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

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

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

206. -- 209. (RESERVED)

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

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

a. Prehospital; ( )

b. Prehospital Support; or ( )

c. Standby. ( )

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

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

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

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

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

212. NON-TRANSPORT EMS AGENCY -- PATIENT MOVEMENT.
A non-transport agency is an agency that is not intended for patient transport and cannot advertise ambulance

services. A non-transport agency can move a patient by vehicle only when: ( )

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

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

a. EMT level or higher; or ( )

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

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

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

213. -- 299. (RESERVED)

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

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

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

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

03. Personnel Requirements for Prehospital ALS. A licensed Paramedic must be present whenever prehospital, prehospital support, or air medical transport ALS services are provided. ( )

301. AMBULANCE EMS AGENCY -- PERSONNEL REQUIREMENTS.
Each ambulance agency must ensure that there are two (2) crew members on each patient transport or transfer. The crew member providing patient care, at a minimum, must be a licensed EMR with an ambulance certification or a licensed EMT. ( )

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

01. Personnel for Air Medical Agency. An Air Medical agency must ensure that each flight includes at a minimum, one (1) licensed registered nurse and one (1) Paramedic. Based on the patient's need, an exception for transfer flights may include a minimum of one (1) licensed respiratory therapist and one (1) licensed registered nurse,

or two (2) licensed registered nurses. ( )

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

303. CRITICAL CARE -- PERSONNEL REQUIREMENTS.
Each ambulance or air medical agency that advertises the provision of critical care clinical capabilities must affiliate and deploy EMS personnel trained and credentialed to provide all critical care skills described in IDAPA 16.02.02, "Idaho Emergency Medical Services (EMS) Physician Commission." ( )

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

305. AMBULANCE-BASED CLINICIANS -- PERSONNEL REQUIREMENTS.

01. Ambulance-Based Clinician Certified by Department. An EMS agency that advertises or provides out-of-hospital patient care by affiliating and utilizing a currently licensed registered nurse, advanced practice registered nurse, or physician assistant, as defined in IDAPA 16.01.02, "Emergency Medical Services (EMS) - Rule Definitions," must ensure that those individuals maintain a current ambulance-based clinician certificate issued by the Department. See Section 306 of these rules for exceptions to this requirement. ( )

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

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

b. Documentation that the individual has successfully completed an ambulance-based clinician course; or ( )

c. Documentation that the individual has successfully completed an EMT course. ( )

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

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

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

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

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

307. -- 399. (RESERVED)

EMS AGENCY VEHICLE REQUIREMENTS
(Sections 400 - 499)

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

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

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

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

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

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

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

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

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

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

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

prior to being put back in service. ( )

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

04. Vehicle Inspection Records. Each EMS agency must keep records of all emergency response vehicle safety inspections. These records must be made available to the Department upon request. ( )

404. -- 499. (RESERVED)

EMS AGENCY REQUIREMENTS AND WAIVERS
(Sections 500 - 599)

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

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

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

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

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

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

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

a. A modification request of an operational nature will be reviewed by EMSAC; ( )

b. A modification request of a clinical nature will be reviewed by the EMSPC; and ( )

c. A modification request that has both operational and clinical considerations will be reviewed by both. ( )

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

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

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

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

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

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

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

502. -- 509. (RESERVED)

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

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

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

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

511. EMS AGENCY -- DISPATCH REQUIREMENTS.
Each EMS agency must have a twenty-four (24) hour dispatch arrangement. ( )

512. -- 519. (RESERVED)

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

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

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

02. Not on Daily Basis Per Year. The community, setting, industrial site, or event being served by the

agency does not exist on a three hundred sixty-five (365) day per year basis. ( )

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

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

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

01. Submit Petition for Waiver. The controlling authority of an existing non-transport agency desiring a waiver of the twenty-four (24) hour response requirement must submit a petition for waiver to the Department. ( )

02. Waiver Declared on Initial Application. The controlling authority of an applicant non-transport agency desiring a waiver of the twenty-four (24) hour response requirement must declare the request for waiver on the initial application for agency licensure to the Department. ( )

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

a. A description of the hours or days the geographic area is populated. ( )

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

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

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

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

c. A staffing and deployment plan identifying the agency’s response capabilities and back up plans for services to the community when the agency is unavailable. ( )

d. A description of the collaboration that exists with all other EMS agencies providing services within the applicant’s geographic response area. ( )

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

523. -- 524. (RESERVED)

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

01. Undue Hardship on Community. The provision of twenty-four (24) hour response would cause

an undue hardship on the community being served by the agency. ( )

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

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

01. Submit Petition for Waiver. The controlling authority of an existing ambulance or air medical agency desiring a waiver of the twenty-four (24) hour response requirement must submit a petition for waiver to the Board. ( )

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

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

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

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

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

527. -- 529. (RESERVED)

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

531. -- 534. (RESERVED)

535. EMS AGENCY -- RECORDS, DATA COLLECTION, AND SUBMISSION REQUIREMENTS.
Each EMS agency must comply with the records, data collection, and submission requirements under IDAPA 16.01.06, "Emergency Medical Services (EMS) -- Data Collection and Submission Requirements." ( )

536. -- 599. (RESERVED)

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

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

601. EMS AGENCY -- PATIENT CARE INTEGRATION.

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

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

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

603. EMS AGENCY -- PLANNED DEPLOYMENT AGREEMENTS.
Each EMS agency that utilizes a planned deployment must develop a cooperative planned deployment agreement between the EMS agencies. The agreement must include the following: ( )

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

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

03. Geographic Locations and Services. The agreement must provide the geographic locations and the services to be provided by the planned deployment. ( )

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

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

06. Patient Integration of Care. The agreement must provide patient integration of care by each EMS agency covered by the planned deployment. ( )

07. Patient Transport. The agreement must provide for patient transport considerations by each EMS agency covered by the planned deployment. ( )

08. Medical Supervision. The agreement must have provisions for medical supervision of each EMS agency covered by the planned deployment. ( )

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

604. -- 649. (RESERVED)

650. AIR MEDICAL EMS AGENCY -- REQUIRED POLICIES.
Each air medical EMS agency must have the following policies on file with the Department: ( )

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

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

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

a. Consider the licensed EMS agency destination protocol and medical supervision received; ( )

b. Be made available to licensed EMS agencies that utilize their services; ( )

c. Honor patient preference if: ( )

i. The requested facility is capable of providing the necessary medical care; and ( )

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

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

a. Designation of a safety officer; ( )

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

c. Post-Accident Incident Plan; ( )

d. Fitness for Duty Requirements; ( )

e. Annual Air Medical Resource Management Training; ( )

f. Procedures for allowing a crew member to decline or abort a flight; ( )

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

h. A procedure to review each flight for safety concerns and report those concerns to the safety committee. ( )

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

a. Altitude physiology; ( )

b. Stressors of flight; ( )

c. Air medical resource management; ( )

d. Survival; ( )

e. Navigation; and ( )

f. Aviation safety issues including emergency procedures. ( )

651. -- 699. (RESERVED)

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

700. EMS AGENCY -- CRITERIA TO REQUEST AN AIR MEDICAL RESPONSE.
Each ground EMS agency must establish written criteria for the agency's licensed EMS personnel that provides

decision-making guidance for requesting an air medical response to an emergency scene. This criteria must be approved by the agency's medical director. The following conditions must be included in the criteria: ( )

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

a. The patient has a penetrating or crush injury to head, neck, chest, abdomen, or pelvis; ( )

b. Neurological presentation suggestive of spinal cord injury; ( )

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

d. Fracture or dislocation with absent distal pulse; ( )

e. A glasgow coma score of ten (10) or less; ( )

f. Unstable vital signs with evidence of shock; ( )

g. Cardiac arrest; ( )

h. Respiratory arrest; ( )

i. Respiratory distress; ( )

j. Upper airway compromise; ( )

k. Anaphylaxis; ( )

l. Near drowning; ( )

m. Changes in level of consciousness; ( )

n. Amputation of an extremity; and ( )

o. Burns greater than twenty percent (20%) of body surface or with suspected airway compromise. ( )

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

a. Extremes of age; ( )

b. Pregnancy; and ( )

c. Patient "do not resuscitate" status. ( )

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

a. Availability of local hospitals and regional medical centers; ( )

b. Air medical response to the scene and transport to an appropriate hospital will be significantly shorter than ground transport time; ( )

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

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

e. As an additional resource for a multiple patient incident; ( )

f. Remote location of the patient; and ( )

g. Local destination protocols. ( )

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

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

703. EMS AGENCY -- ESTABLISHED CRITERIA FOR SIMULTANEOUS DISPATCH.
A ground EMS agency may establish criteria for simultaneous dispatch for air and ground medical response. Air medical services will not launch to an emergency scene unless requested in accordance with Subsection 720.01 of these rules. ( )

704. EMS AGENCY-- SELECTION OF AIR MEDICAL AGENCY.
Each EMS agency has the responsibility to select an appropriate air medical service EMS agency. ( )

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

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

705. -- 719. (RESERVED)

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

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

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

a. Type of incident; ( )

b. Landing zone location or GPS (latitude/longitude) coordinates, or both; ( )

c. Scene contact unit or scene incident commander, or both; ( )

d. Number of patients if known; ( )

e. Need for special equipment; ( )

f. Estimated weight of the patient; ( )

g. How to contact on scene EMS personnel; and ( )

h. How to contact the landing zone officer. ( )

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

a. The name of the requesting entity; ( )

b. Location of the landing zone; and ( )

c. Scene contact unit and scene incident commander, if known. ( )

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

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

721. -- 729. (RESERVED)

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

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

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

a. Landing zone preparation; ( )

b. Landing zone safety; and ( )

c. Communication between the ground EMS agency and the air medical agency. ( )

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

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

732. -- 799. (RESERVED)

EMS AGENCY INSPECTIONS
(Sections 800 - 899)

800. EMS AGENCY -- INSPECTIONS BY THE DEPARTMENT.

Representatives of the Department are authorized to enter an agency's facility at reasonable times to inspect an agency's vehicles, equipment, response records, and other necessary items to determine that the EMS agency is in compliance with governing Idaho statutes and administrative rules. ( )

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

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

803. -- 804. (RESERVED)

805. EMS AGENCY -- INITIAL AGENCY INSPECTION.
The Department will perform an initial inspection, which is an integral component of the application process, to ensure the EMS Agency applicant is in compliance regarding the following: ( )

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

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

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

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

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

807. -- 829. (RESERVED)

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

831. -- 839. (RESERVED)

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

841. -- 899. (RESERVED)

EMS AGENCY LICENSURE PROCESS
(Sections 900 - 999)

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

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

902. -- 970. (RESERVED)

971. LAPSED LICENSE.

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

02. Grace Period. No grace periods or extensions to an expiration date will be granted when an agency has not submitted a completed renewal application within the timeframes described in Section 950 of these rules. ( )

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

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

972. -- 979. (RESERVED)

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

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

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

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

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

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

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

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

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

02. Changes Requiring Initial Licensure Application. When an agency decides to make any of the following changes, it must submit an initial agency application to the Department and follow the initial application process described in Sections 900 through 922 of these rules: ( )

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

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

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

d. An agency that intends to add prehospital or transfer operational declarations. ( )

982. -- 989. (RESERVED)

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

991. -- 999. (RESERVED)

16.01.05 – EMERGENCY MEDICAL SERVICES (EMS) – EDUCATION, INSTRUCTOR, AND EXAMINATION REQUIREMENTS

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

001. SCOPE.
These rules include criteria and requirements for education programs conducting initial EMS education, certification of instructors, and certification examinations. Continuing education requirements are in IDAPA16.01.07, "Emergency Medical Services (EMS) -- Personnel Licensing Requirements." ( )

002. INCORPORATION BY REFERENCE.
The Department has incorporated by reference the following documents: ( )

01. Idaho EMS Education Standards, edition 2022-1. The Department has adopted the Idaho EMS Education Standards, edition 2022-1, and hereby incorporates these standards by reference. Copies may be obtained from the Department, see online at: publicdocuments.dhw.idaho.gov. ( )

02. Idaho Bureau of EMS and Preparedness EMS Education Equipment List, edition 2016-1. The Department has adopted the Idaho Bureau of EMS and Preparedness EMS Education Equipment List, edition 2016-1, and hereby incorporates these standards by reference. Copies may be obtained from the Department, see online at: publicdocuments.dhw.idaho.gov. ( )

003. -- 008. (RESERVED)

009. CRIMINAL HISTORY AND BACKGROUND CHECK REQUIREMENTS.
Certified EMS instructors must comply with the provisions in IDAPA 16.05.06, "Criminal History and Background Checks," to include: ( )

01. Initial Instructor Certification. Individuals seeking initial instructor certification must have successfully passed a criminal history and background check under the provisions in IDAPA 16.05.06, "Criminal History and Background Checks." ( )

02. Additional Criminal History and Background Check. The Department may require an updated or additional criminal history and background check at any time, without expense to the candidate, if there is cause to believe new or additional information will be disclosed. ( )

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

011. -- 075. (RESERVED)

076. ADMINISTRATIVE ACTION IMPOSED FOR EMS INSTRUCTOR CERTIFICATION.
Any EMS instructor certificate may be suspended, revoked, denied, or retained with conditions for noncompliance with these rules and documentation incorporated by reference. ( )

077. STANDARDS OF PROFESSIONAL CONDUCT FOR EMS EDUCATION PROGRAM AND EXAM PERSONNEL.
All personnel associated with an EMS education program or exam must adhere to the following standards: ( )

01. Professional Conduct. EMS education program and exam personnel maintain the knowledge necessary to competently teach curriculum and evaluate students as outlined in the Idaho EMS Education Standards. EMS education program and exam personnel refrain from performing their duties while under the influence of alcohol, any illegal substance, or a legal drug or medication causing impairment of function. ( )

02. Professional Integrity. EMS education program and exam personnel:

a. Cannot submit false information in any report, application, or documentation to the Department,

the National Registry of Emergency Medical Technicians, or any other governing, credentialing, accrediting, or certifying authority. ( )

b. Comply with state and federal laws relating to the confidentiality of student records; and ( )

c. Refrain from conduct demonstrating a professional conflict of interest during the performance of their duties as EMS educators or evaluators. ( )

03. Respectful Behavior. EMS education program and exam personnel ensure just and equitable treatment for all potential and current students and refrain from conduct involving EMS education or evaluation that is in violation of any current Idaho or federal anti-discrimination law or administrative rule. ( )

078. -- 099. (RESERVED)

EMS EDUCATION PROGRAMS
(Sections 100-199)

100. GENERAL REQUIREMENTS FOR EMS EDUCATION PROGRAMS.
EMS education programs must meet all requirements in these rules. A program may be approved by the Department if all requirements are met. Each program must be approved and in good standing in order for graduates of courses provided by a program to qualify for access to an Idaho EMS certification examination. ( )

101. INSPECTION OF EMS EDUCATION PROGRAMS.
Representatives of the Department are authorized to enter an EMS education facility at reasonable times for the purpose of assuring that an EMS education program meets the provisions of these rules. ( )

102. EMS EDUCATION PROGRAM ELIGIBILITY.
The following entities are eligible for approval as an EMS Education Program: ( )

01. EMS Agency. A licensed Idaho EMS agency, or applicant for agency licensure, that has met all of the agency licensure requirements in IDAPA 16.01.03, "Emergency Medical Services (EMS) -- Agency Licensing Requirements," with the exception of the personnel requirements in the case of an applicant agency. ( )

02. Governmental Entity. A recognized governmental entity within the State of Idaho; ( )

03. School. A proprietary, secondary, or post-secondary school as defined in Title 33, Idaho Code, and in accordance with IDAPA 08.01.11, "Registration of Post-Secondary Educational Institutions and Proprietary Schools"; or ( )

04. Hospital. An Idaho hospital as defined in IDAPA 16.03.14, "Hospitals." ( )

103. EMS EDUCATION PROGRAM APPROVAL REQUIREMENTS.
The following requirements must be met in order to be approved as an EMS Education Program: ( )

01. All Programs. All EMS educational programs must: ( )

a. Have the infrastructure elements described in the Idaho EMS Education Standards; ( )

b. Use a curriculum that meets the Idaho EMS Education Standards; ( )

c. Utilize personnel to fill the roles as defined in Section 300 of these rules; ( )

d. Provide sufficient quantities of supplies and equipment in good working order based on the curriculum and the minimum equipment list; and ( )

e. Have successfully completed a program review within the last three (3) years. ( )

02. Paramedicine Programs. Programs teaching paramedicine must be accredited by, or have a Letter of Review (LoR) from, the Committee on Accreditation of Educational Programs for the EMS Professions (CoAEMSP). A representative of the Department may attend the CoAEMSP site visit. Documentation of official correspondence between CoAEMSP and the program must be provided to the Department within thirty (30) days. ( )

104. EMS EDUCATION PROGRAM ADMINISTRATION.
Each EMS Education Program must: ( )

01. Register and Maintain Program Information with the Department and the National Certifying Body. ( )

02. Respond to all Program-Specific Department Inquiries within Fifteen (15) Days. ( )

03. Submit Supporting Documentation Requested During an Audit to the Department within Twenty-One (21) Days of the Request. ( )

04. Ensure that all Program Personnel are Familiar with and Conduct Business According to These Rules. ( )

05. Notify the Department within Fifteen (15) Days of any Sanction Taken Against an Instructor that Affects Their Ability to Teach for the Program. ( )

105. EMS EDUCATION PROGRAM COURSE ADMINISTRATION.

01. Education. To prepare students to demonstrate the expected competencies, the EMS Education Program must: ( )

a. Deliver didactic education and psychomotor training that meets the objectives of the approved curriculum; ( )

b. Establish and maintain hospital/clinical and field/internship experience agreements to ensure student access under the Idaho EMS Education Standards; ( )

c. Ensure the majority of initial education is taught by certified EMS instructors. ( )

02. Evaluation. To assure that students can demonstrate the expected competencies, the EMS Education Program must: ( )

a. Establish and enforce pass/fail criteria that include evaluation of student performance and competency during labs, didactic, clinical, and field internship training; ( )

b. Provide formative evaluations during a course to monitor the progress of students; and ( )

c. Provide a formal summative evaluation that includes a variety of clinical behaviors and judgements at the end of the course to measure the student's mastery of the objectives of the approved curriculum. ( )

106. EMS EDUCATION PROGRAM COURSE DOCUMENTATION.
Each EMS Education Program must submit the following documentation to the Department as described below, in the format provided by the Department, and retain it for a minimum of three (3) years: ( )

01. Course Registration Number (CRN) Issued by the Department. ( )

02. Course Roster. ( )

03. Course Completion Record with Completion Status and Date of Completion for all Students. ( )

04. **EMR and EMT Programs**. Results of formal summative evaluation. ( )

05. **AEMT and Paramedic Programs**. Proposed date and location of the psychomotor examination within the timeline required by the national certifying body. ( )

107. -- 199. **(RESERVED)**

CRITERIA FOR EMS EDUCATION
(Sections 200-299)

200. INITIAL EMS EDUCATION REQUIREMENTS.

01. **Consistency with Scope of Practice**. All curricula must be consistent with the Idaho scope of practice for licensed personnel as set forth in the EMS Physician Commission Standards Manual incorporated under IDAPA 16.02.02, "Idaho Emergency Medical Services (EMS) Physician Commission," which aligns with the clinical level of the course. ( )

02. **Consistency with State and National Standards**. All curricula must be consistent with Idaho EMS Education Standards incorporated under Section 004 of these rules, and the National EMS Scope of Practice Model. ( )

201. -- 299. **(RESERVED)**

EMS EDUCATION PROGRAM PERSONNEL REQUIREMENTS, QUALIFICATIONS, AND RESPONSIBILITIES
(Sections 300-399)

300. REQUIRED PERSONNEL FOR EMS EDUCATION PROGRAMS.

Each program must: ( )

01. **Program Director**. Identify an individual to serve as the program director. The program director may also serve as teaching faculty provided that faculty qualifications are met. ( )

02. **Teaching Faculty**. Identify a sufficient number of teaching faculty who meet the qualifications described below in Subsections 301.02 and 301.03 of these rules. ( )

03. **Course Physician**. Identify an individual to serve as the course physician. The course physician may also serve as teaching faculty, provided that faculty qualifications are met. ( )

301. EMS EDUCATION PROGRAM PERSONNEL QUALIFICATIONS.

01. **Program Director**. Program directors must: ( )

a. Complete an Education Program Orientation Course within the previous twenty-four (24) months. ( )

b. Have knowledge of current Idaho EMS Education Standards and the requirements for state certification and licensure. ( )

02. **Instructor**. Instructors must possess a current instructor certification issued by the Department. ( )

03. **Adjunct Faculty or Guest Lecturers**. Adjunct faculty and guest lecturers must be authorized by the course physician based on credentials, education, or expertise that corresponds to the knowledge and skill objectives they are teaching. ( )

04. **Course Physician**. Course physicians must: ( )

a. Be a Doctor of Osteopathy (DO) or Medical Doctor (MD) currently licensed to practice medicine with experience and current knowledge of emergency care of acutely ill and injured patients; and ( )

b. Have knowledge or experience in the delivery of out-of-hospital emergency care, including the proper care and transport of patients, medical direction, and quality improvement in out-of-hospital care. ( )

302. EMS EDUCATION PROGRAM PERSONNEL RESPONSIBILITIES.
An individual can have multiple personnel responsibilities, but must meet the applicable personnel requirements under Section 301 of these rules and fulfill all the responsibilities of each position they fill. ( )

01. **Program Director**. The program director's responsibilities include: ( )

a. Administrative oversight of the program; ( )

b. Ensuring that the program remains in compliance with these rules; and ( )

c. Serving as the program's point of contact for the Department, or for a national EMS certification body, or both. ( )

02. **Instructor**. The instructor's responsibilities include: ( )

a. Delivery of didactic and psychomotor education that satisfies the curriculum objectives; ( )

b. Documentation of student performance and competency under the standards defined by the program; ( )

c. Following program policies, requirements, and these rules; ( )

03. **Course Physician**. The course physician is responsible for oversight of all medical aspects of instruction. ( )

303. -- 399. (RESERVED)

EMS INSTRUCTOR CERTIFICATION
(Sections 400-499)

400. EMS INSTRUCTOR CERTIFICATION REQUIREMENTS.

01. **Instructor Certification is Required**. To serve as an EMS instructor, an individual must possess a current EMS instructor certificate issued by the Department. ( )

02. **Instructor Certification Requirements**. An individual applying for and meeting the requirements defined in this rule will be issued an initial EMS instructor certificate. For initial EMS instructor certification the individual must: ( )

a. Pass an Idaho criminal history and background check; ( )

b. Complete a Department-sponsored EMS Education Program Orientation Course within the preceding twenty-four (24) months; ( )

c. Complete a course that meets the requirements of an Adult Methodology Course. See a list of courses and required course content online at http://www.IdahoEMS.org; ( )

d. Hold a current EMS license or EMS certificate at or above the instructor level requested; and

( )

e. Have held an EMS license or EMS certificate at or above the level of instruction requested for a minimum of three (3) years. ( )

03. Duration of Certificate. EMS instructor certificates are good for up to three (3) years and are issued with an expiration date of June 30 no more than three (3) years after the date the application was approved by the Department. ( )

401. EMS INSTRUCTOR CERTIFICATE RENEWAL.
An individual applying for and meeting the EMS instructor certificate requirements defined in this rule will be issued a renewed EMS instructor certificate. An individual seeking to renew an EMS instructor certificate must: ( )

01. Submit an Application. Submit an application for EMS instructor certification renewal in the format provided by the Department prior to the expiration date of the current certificate. Certified EMS instructors may submit the renewal application and documentation to the Department up to six (6) months prior to the current expiration date of the instructor certificate. ( )

02. Teaching Time. Document twenty-four (24) hours of teaching time during the current certification period. ( )

03. Continuing Education. Complete eight (8) hours of continuing education specific to adult education during the current certification period. ( )

04. License or Certificate. Possess a current Idaho EMS personnel license, a current Idaho certificate of eligibility, or a current national certification at or above the level of instructor certificate. ( )

402. LAPSED EMS INSTRUCTOR CERTIFICATE.

01. Timely Submission. An application is considered timely when it is submitted to the Department prior to the expiration date of the EMS instructor certificate being renewed. ( )

02. Failure to Submit. An EMS instructor certificate will expire if an instructor fails to submit a complete and timely renewal application. ( )

03. No Grace Period. The Department will not grant grace periods or extensions to an expiration date. ( )

04. Application Under Review. Provided the instructor submitted a timely renewal application, an EMS instructor certificate will not lapse while under review by the Department. ( )

05. Additional Information. The Department may request additional information from the instructor to address an application that was found to be incomplete or otherwise non-compliant with these rules. The Department will send the request to the instructor's last known address. The instructor has twenty-one (21) days from the date of notification to respond to the Department after which the certificate will be considered lapsed. ( )

403. -- 499. (RESERVED)

EMS EXAMINATIONS
(Sections 500-599)

500. STANDARDIZED EMS EXAMINATIONS.
A graduate of an EMS course must successfully complete psychomotor and cognitive examinations in order to qualify for EMS personnel licensure under IDAPA 16.01.07, "Emergency Medical Services (EMS) -- Personnel Licensing Requirements." ( )

01. EMR and EMT Psychomotor Examination. The psychomotor examination requirement for

EMR and EMT course graduates can be met by any of the following: ( )

a. Pass the end-of-course examination described in Subsection 105.02.c. of these rules. ( )

b. Pass a level-appropriate Department-approved psychomotor examination. ( )

02. AEMT and Paramedic Psychomotor Examination. The psychomotor examination requirement for AEMT and Paramedic course graduates can only be met by passing a formal Department-approved psychomotor examination. ( )

03. Cognitive Examination. The cognitive examination requirement for all levels of course graduates can only be met by passing the Department-approved cognitive examination. ( )

501. EMS EXAM APPLICATIONS.
An organization other than the educational program that wishes to host a Department-approved examination must notify the Department at least sixty (60) days in advance of the proposed exam date. Educational programs must notify the Department under Section 106 of these rules. ( )

502. -- 999. (RESERVED)

16.01.06 – EMERGENCY MEDICAL SERVICES (EMS) – DATA COLLECTION AND SUBMISSION REQUIREMENTS

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

001. TITLE AND SCOPE.

01. Title. These rules are titled IDAPA 16.01.06, "Emergency Medical Services (EMS) – Data Collection and Submission Requirements." ( )

02. Scope. These rules contain the requirements for licensed EMS agencies to collect and report essential data information related to the performance, needs, and assessments of the statewide emergency medical services system. ( )

002. INCORPORATION BY REFERENCE.
The EMS Data Collection Standards Manual, Edition 2017-1, is incorporated by reference in this chapter of rules. Copies of the manual may be obtained online at http://www.idahoems.org/ or from the Bureau of Emergency Medical Services and Preparedness located at 2224 East Old Penitentiary Road, Boise, ID 83712-8249. ( )

003. CONFIDENTIALITY OF EMS RECORDS.
EMS Response records and data collected or otherwise captured by the Bureau of Emergency Medical Services and Preparedness, its agents, or designees, will be deemed to be confidential and released in accordance with applicable Department policies and applicable state and federal laws. ( )

004. -- 009. (RESERVED)

010. DEFINITIONS.

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

02. NEMSIS Data Dictionary. For the purposes of this chapter, definitions in the NEMSIS Data Dictionary apply. The NEMSIS website is at http://www.nemsis.org. ( )

011. -- 074. (RESERVED)

075. INVESTIGATION OF COMPLAINTS FOR EMS DATA COLLECTION OR SUBMISSION VIOLATIONS.
Investigation of complaints and disciplinary actions for EMS data collection and submission requirement violations are provided under IDAPA 16.01.12, "Emergency Medical Services (EMS) - Complaints, Investigations, and Disciplinary Actions." ( )

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

077. -- 099. (RESERVED)

100. EACH EMS AGENCY MUST COMPLY WITH THE FOLLOWING RECORDS, DATA COLLECTION, AND SUBMISSION REQUIREMENTS.
Each licensed EMS agency must collect and submit EMS response records to the EMS Bureau using the Idaho Prehospital Electronic Record Collections System known as PERCS. ( )

01. Records to be Maintained. Each licensed EMS agency must maintain a record that includes a Patient Care Report completed for each EMS Response. ( )

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

03. Time Frame for Submitting Records. Each licensed EMS agency must submit each month's data to the Department by the 15th of the following month in a format determined by the Department. ( )

101. -- 104. (RESERVED)

105. EMS RESPONSE RECORDS AND DATA COLLECTED.
EMS response records and data collected from licensed EMS agencies or otherwise captured by the EMS Bureau, its agents, or designees, are deemed to be confidential and can only be released in accordance with applicable Department policies, state and federal laws, and this chapter of rules. ( )

106. -- 109. (RESERVED)

110. USE OF SUBMITTED RECORDS AND DATA.
Records and data submitted to the Department, may be used by Department staff and staff or other designated agencies in the performance of its regulatory duties. ( )

01. Data Reports. Data may be compiled into reports by a licensed emergency medical service agency from the respective agency's collected records. ( )

02. Patient Care Reports. Aggregate patient care report data may be released to the public in a format reasonably calculated to not disclose the identity of the individual patient. ( )

111. -- 199. (RESERVED)

200. DATA TO BE REPORTED.
The required data and information on an EMS Response is based on the definitions and structure of National Emergency Medical Services Information System (NEMSIS). NEMSIS defined data points to be reported to the Department for each EMS Response are provided in the "EMS Data Collection Standards Manual," incorporated by reference in Section 004 of these rules. ( )

201. -- 999. (RESERVED)

16.01.12 – EMERGENCY MEDICAL SERVICES (EMS) – COMPLAINTS, INVESTIGATIONS, AND DISCIPLINARY ACTIONS

000. LEGAL AUTHORITY.
The Idaho Board of Health and Welfare is authorized under Sections 56-1005 and 56-1023, Idaho Code, to adopt rules concerning the administration of the Idaho Emergency Medical Services Act. The Director is authorized under Section 56-1003, Idaho Code, to supervise and administer an emergency medical service program. The EMS Bureau is authorized under Section 56-1022, Idaho Code, to manage complaints and investigations, and implement license actions against EMS personnel and agencies, that includes levying fines against an EMS agency. ( )

001. TITLE AND SCOPE.

01. Title. These rules are titled IDAPA 16.01.12, "Emergency Medical Services (EMS) – Complaints, Investigations, and Disciplinary Actions." ( )

02. Scope. These rules provide for the management of complaints, investigations, enforcement, and disciplinary actions by the EMS Bureau for personnel and agency licensure and certification, and educational programs and instructor approval. ( )

002. -- 009. (RESERVED)

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

011. -- 074. (RESERVED)

075. PEER REVIEW TEAM.
The EMS Bureau may elect to conduct a peer review for an alleged statute or rule violation when it determines that a peer review is an appropriate action. The EMS Bureau will determine who serves on a peer review team. ( )

076. MEMBERS OF A PEER REVIEW TEAM.
The peer review team will consist of four (4) team members selected by the EMS Bureau as appropriate to the case being considered from the following: ( )

01. Licensed Personnel. EMS personnel licensed at, or above, the license level of the subject; or ( )

02. Agency Administrator. EMS agency administrator; or ( )

03. Training Officer. EMS agency training officer; or ( )

04. Course Coordinator. Course coordinator of an EMS Bureau-approved education program or course; or ( )

05. Instructor. EMS Bureau-certified EMS instructor; and ( )

06. Chairman of Peer Review Team. Each peer review team will be chaired by a licensed Idaho EMS physician as follows: ( )

a. An Idaho EMS Physician Commissioner for cases involving EMS personnel; or ( )

b. An Idaho EMS agency medical director for cases involving an EMS agency; or ( )

c. An Idaho EMS Bureau-approved education program or course sponsoring physician for cases involving educators who are not licensed EMS personnel. ( )

077. QUALIFICATIONS REQUIRED OF A PEER REVIEW TEAM MEMBER.
An individual, serving as a member of an EMS peer review team, must have successfully completed an orientation to EMS-related statute, rules and procedures and have signed confidentiality and conflict of interest agreements provided by the EMS Bureau. ( )

078. -- 099. (RESERVED)

REPORTING OF COMPLAINTS AND SUSPECTED VIOLATIONS
(Sections 100-199)

100. COMPLAINT SUBMITTED WHEN A VIOLATION IS SUSPECTED.
Complaints must be submitted in writing on a complaint intake form found online at: http://www.idahoems.org. ( )

101. -- 109. (RESERVED)

110. REPORTING SUSPECTED VIOLATION.

01. Suspected Violations. Any person may report a suspected violation of any law or rule governing EMS. ( )

02. Report Violation. To report a suspected violation, contact the EMS Bureau, see online at: http://www.idahoems.org. ( )

111. ANONYMOUS COMPLAINTS.
Anonymous complaints are accepted; however, the inability to collect further information from the complainant may hinder the progress of the investigation. ( )

112. -- 199. (RESERVED)

INVESTIGATION OF COMPLAINTS AND SUSPECTED VIOLATIONS
(Sections 200-299)

200. EMS BUREAU INITIATES OFFICIAL INVESTIGATION.
An official investigation will be initiated when the any of the following occurs: ( )

01. Complaint with Allegations. A complaint with an allegation that, if substantiated, would be in violation of any law or rule governing EMS. ( )

02. Discovery of Potential Violation of Statute or Administrative Rule. EMS Bureau staff or other authorities discover a potential violation of any law or rule governing EMS. ( )

201. -- 209. (RESERVED)

210. VIOLATIONS THAT MAY RESULT IN ADMINISTRATIVE ACTIONS.
The EMS Bureau may impose administrative actions, including denial, revocation, suspension, or retention under conditions specified in Sections 300 through 399 of these rules. Administrative actions may be imposed on any of the following: the holder of, or an applicant or candidate for, an EMS license, certificate, education program approval, or recognition. Administrative actions may be imposed on any of the previously mentioned for any action, conduct, or failure to act that is inconsistent with the professionalism, standards, or both, established by statute or rule. ( )

211. -- 219. (RESERVED)

220. REFUSAL TO PARTICIPATE IN AN INVESTIGATION.
The refusal to participate by the subject will not prohibit full investigation or a peer review, nor prevent potential administrative license action. ( )

221. -- 229. (RESERVED)

230. SURRENDER OR LAPSE OF LICENSE.
Surrender or lapse of a license will not prohibit full investigation with the potential consequence of EMS Bureau imposing a formal administrative license action or fine. ( )

231. -- 239. (RESERVED)

240. INVESTIGATION CONFIDENTIALITY.

01. Informal Resolution. Informal resolution of complaints or non-compliance by guidance or negotiated resolution is not public information. ( )

02. Administrative License Action. Preliminary investigations and documents supplied or obtained in connection with them are confidential until a formal notice of administrative license action is issued. ( )

241. -- 249. (RESERVED)

250. NOTICE OF THE FINAL DISPOSITION OF AN INVESTIGATION.

01. Subject. The EMS Bureau will send notification to the last known address of the subject of the disposition of the investigation, including any pending or current administrative actions. ( )

02. Other Jurisdiction for EMS Personnel. A copy of administrative action imposed on EMS personnel will be sent to each agency of affiliation, agency medical director, the National Practitioners Data Base, and the National Registry of Emergency Medical Technicians. ( )

03. Other Jurisdictions for EMS Agencies. A copy of administrative action or nature of fines imposed on EMS agencies will be sent to the agency governing authorities and the agency medical director. ( )

04. Other Jurisdictions for Educational Programs or Instructors. A copy of any administrative action imposed on an EMS educational program or instructor may be sent to the state Board of Education, the sponsoring physician, the Committee on Accreditation of Educational Programs for the Emergency Medical Services Professions (CoAEMSP), and the National Registry of Emergency Medical Technicians (NREMT). ( )

251. -- 299. (RESERVED)

DISCIPLINARY AND CORRECTIVE ACTIONS
(Sections 300-399)

300. ACTIONS RESULTING FROM INVESTIGATIONS.
The following actions may be imposed upon the subject of an investigation by the EMS Bureau without peer review: ( )

01. Letter of Guidance. The EMS Bureau may issue a letter of guidance, directing the subject of the investigation to the standards, rules, educational resources, or local jurisdiction for resolution of minor non-compliance issues where no injury or threat of harm to the public, profession, or EMS system occurred. The subject of the investigation must show a willingness to become compliant and correct the issue within thirty (30) days of receipt of the personnel guidance letter. ( )

02. Warning Letter. The EMS Bureau may issue a warning letter for a first offense where an unlicensed individual is providing patient care in violation of Section 56-1020, Idaho Code. ( )

03. Negotiated Resolution. The EMS Bureau may negotiate a resolution with the subject of an investigation where allegations of misconduct or medical scope of practice non-compliance, if found to be true, did not cause, or is not likely to cause, injury or harm to the public, profession, or EMS system. The issue must be resolved and corrected within thirty (30) days of the negotiated resolution or settlement agreed to by both the subject of the investigation and the EMS Bureau. ( )

a. Negotiated resolution participants will include the subject of the investigation, EMS Bureau staff and other parties deemed appropriate by the EMS Bureau. ( )

b. During the negotiated resolution process, the subject of the investigation may be offered specific remediation or disciplinary action by consent, which, if agreed to, will resolve the matter with no further right to appeal unless stipulated and agreed to at the time that the remediation or disciplinary action is agreed upon. ( )

c. When the remediation or disciplinary action is not agreed to by consent of both the subject of the investigation and the EMS Bureau, the matter may then be referred to a peer review. ( )

301. -- 319. (RESERVED)

320. PEER REVIEW.
The EMS Bureau may elect to conduct a peer review for alleged statute or rule violations when it determines that a peer review is an appropriate action, or a negotiated resolution or settlement agreement described in Section 300 of these rules, is not reached. The peer review is conducted as follows: ( )

01. Review of Case by Peer Review Team. The peer review team reviews the case details, subject's background, affiliation, licensure history, associated evidence, and documents, and then considers aggravating and mitigating circumstance as follows: ( )

a. Aggravating circumstances can include: prior or multiple offenses, vulnerability of victim, obstruction of the investigation, and dishonesty. ( )

b. Mitigating circumstances can include: absence of prior offenses, absence of dishonest or selfish motive, timely effort to rectify situation, interim successful rehabilitation, misdirection per agency protocol, or medical direction. ( )

02. Subject Given Opportunity to Respond. The subject of the investigation will be given the opportunity to respond in writing, by teleconference, or at the option of the EMS Bureau, in person to the alleged violation. ( )

03. Evaluation of Evidence. The peer review team will evaluate the evidence and make a majority decision of the finding for each alleged statute, rule, or standards violation, including any additional detected violations. ( )

04. Recommend Action. The peer review team will recommend actions to the EMS Bureau. If subject is found to have violated statutes, rules, or standards, the recommendations may include the following: ( )

a. Administrative license action, time frames, conditions, and fines, if imposed, on an EMS agency; ( )

b. Administrative license action, time frames, and conditions, if imposed, on EMS personnel; or ( )

c. Administrative action, time frames, conditions, and fines, if imposed, on an EMS approved education program or instructor certificate. ( )

321. -- 329. (RESERVED)

330. ADMINISTRATIVE ACTIONS.
The EMS Bureau may impose the following administrative actions: ( )

01. Deny Application. The EMS Bureau may deny an application for an EMS personnel license, EMS certificate of eligibility, EMS personnel limited recognition, EMS agency license, EMS education program approval, or an EMS instructor certification: ( )

a. When the application is not complete or the applicant does not meet the eligibility requirements

provided in Sections 56-1011 through 56-1023, Idaho Code, IDAPA 16.01.07, "Emergency Medical Services (EMS) -- Personnel Licensing Requirements," IDAPA 16.02.02, "Idaho Emergency Medical Services (EMS) Physician Commission," or IDAPA 16.01.05, "Emergency Medical Services (EMS) -- Education, Instructor, and Examination Requirements"; or ( )

b. For any reason that would justify an administrative action according to Section 210 of these rules. ( )

02. Refuse to Renew. The EMS Bureau may refuse to renew an EMS personnel license, EMS personnel certificate of eligibility, EMS agency license, EMS education program approval, or EMS instructor certification: ( )

a. When the renewal application is not complete or does not meet the eligibility requirements provided in Sections 56-1011 through 56-1023, Idaho Code, and IDAPA 16.01.03, "Emergency Medical Services (EMS) -- Agency Licensing Requirements," IDAPA 16.01.05, "Emergency Medical Services (EMS) -- Education, Instructor, and Examination Requirements," 16.01.07, "Emergency Medical Services (EMS) -- Personnel Licensing Requirements," or IDAPA 16.02.02, "Idaho Emergency Medical Services (EMS) Physician Commission"; or ( )

b. Pending final outcome of an investigation or criminal proceeding when criminal charges or allegations indicate an imminent danger or threat to the health, safety, or well-being of persons or property; or ( )

c. For any reason that would justify an administrative action according to Section 210 of these rules. ( )

03. Retain with Probationary Conditions. The EMS Bureau may allow the holder of an EMS personnel license, EMS certificate of eligibility, EMS personnel limited recognition, EMS agency license, EMS education program approval, or EMS instructor certification to retain a license, approval, or certificate as agreed to in a negotiated resolution, settlement, or with conditions imposed by the EMS Bureau. ( )

04. Suspend. The EMS Bureau may suspend an EMS personnel license, EMS certificate of eligibility, EMS personnel limited recognition, EMS agency license, EMS education program approval, or EMS instructor certification for: ( )

a. A period of time up to twelve (12) months, with or without conditions; or ( )

b. Pending final outcome of an investigation or criminal proceeding when criminal charges or allegations indicate an imminent danger or threat to the health, safety, or well-being of persons or property. ( )

05. Revoke. The EMS Bureau may revoke an EMS personnel license, EMS certificate of eligibility, EMS personnel limited recognition, EMS agency license, EMS education program approval, or EMS instructor certification when: ( )

a. A peer review team recommends revocation; or ( )

b. The license or certificate holder is found to no longer be eligible for criminal history clearance per IDAPA 16.05.06, "Criminal History and Background Checks." ( )

c. The EMS Bureau will notify the city, fire district, hospital district, ambulance district, dispatch center, and county in which an EMS agency provides emergency prehospital response upon revocation of an EMS agency license. ( )

06. Review of Administrative Actions by the EMS Physician Commission. The EMS Physician Commission must review, at their next available meeting, administrative actions taken by the Department as described in Subsections 330.01 through 330.05 of this rule. ( )

331. -- 339. (RESERVED)

340. VIOLATIONS THAT MAY RESULT IN FINES BEING IMPOSED ON EMS AGENCY.
In addition to administrative license actions provided in Section 56-1022, Idaho Code, and these rules, a fine may be imposed by the EMS Bureau upon recommendation of a peer review team on a licensed EMS agency as a consequence of agency violations. Fines may be imposed for the following violations: ( )

01. Operating An Unlicensed EMS Agency. Operating without a license required in IDAPA 16.01.03, "Emergency Medical Services (EMS) -- Agency Licensing Requirements," including: ( )

a. Failure to obtain an initial license; ( )

b. Failure to obtain a license upon change in ownership; or ( )

c. Failure to renew a license and continues to operate as an EMS agency. ( )

02. Unlicensed Personnel Providing Patient Care. Allowing an unlicensed individual to provide patient care without first obtaining an EMS personnel license required in IDAPA 16.01.07, "Emergency Medical Services (EMS) -- Personnel Licensing Requirements," at the appropriate level for the EMS agency. ( )

03. Failure to Respond. Failure of the EMS agency to respond to a 911 request for service within the agency primary response area in a typical manner of operations when dispatched to a medical illness or injury, under licensure requirements in IDAPA 16.01.03, "Emergency Medical Services (EMS) -- Agency Licensing Requirements," except when the responder reasonably determines that: ( )

a. There are disaster conditions; ( )

b. Scene safety hazards are present or suspected; or ( )

c. Law enforcement assistance is necessary to assure scene safety, but has not yet allowed entry to the scene. ( )

04. Unauthorized Response by EMS Agency. Responding to a request for service which deviates from or exceeds those authorized by the EMS agency license requirements in IDAPA 16.01.03, "Emergency Medical Services (EMS) -- Agency Licensing Requirements." ( )

05. Failure to Allow Inspections. Failure to allow the EMS Bureau or its representative to inspect the agency facility, equipment, records, and other licensure requirements provided in IDAPA 16.01.03, "Emergency Medical Services (EMS) -- Agency Licensing Requirements." ( )

06. Failure To Correct Unacceptable Conditions. Failure of the EMS agency to correct unacceptable conditions within the time frame provided in a negotiated resolution settlement, or a warning letter issued by the EMS Bureau. Including the following: ( )

a. Failure to maintain an EMS vehicle in a safe and sanitary condition; ( )

b. Failure to have available minimum EMS Equipment; ( )

c. Failure to correct patient or personnel safety hazards; or ( )

d. Failure to retain an EMS agency medical director: ( )

07. Failure to Report Patient Care Data. Failure to submit patient care data as required in IDAPA 16.01.03, "Emergency Medical Services (EMS) -- Agency Licensing Requirements." ( )

341. FINES IMPOSED ON EMS AGENCY.
In addition to administrative license action allowed by statute and rule, a fine may be imposed by the EMS Bureau

upon the recommendation of a peer review team. Fines are imposed on licensed EMS agency as a consequence of agency licensure violations. ( )

01. Maximum Amount of a Fine. A fine may not exceed one thousand dollars ($1000) for each specified violation. ( )

02. Fines Levied After Peer Review. The EMS Bureau may levy a fine against an EMS agency following a peer review that has a majority decision on finding and outcomes, and includes a fine be imposed as part of the recommended action. ( )

03. Table for Maximum Fine Amount. The maximum amount of a fine that may be imposed on an EMS agency for certain violations listed in Section 330 of these rules are provided in the table below:

EMS AGENCY FINE AMOUNT FOR VIOLATIONS Section 341.03		
Rule Violation Subsection	**TYPE OF VIOLATION**	**Maximum Fine (each violation)**
340.01.	**Operating an Unlicensed EMS Agency.** **a.** Failure to obtain an initial license: **b.** Failure to obtain a license upon change of ownership: **c.** Failure to successfully renew a license:	 $1000 $ 500 $ 500
340.02.	**Unlicensed EMS Personnel Providing Patient Care.**	$ 500
340.03.	**Failure to Respond.**	$ 750
340.04.	**Unauthorized Response by EMS Agency.** Licensed EMS agency responds to a request for service which deviates from or exceeds those authorized by the EMS agency license.	$ 500
340.05.	**Failure to Allow an Inspection of an EMS Agency.**	$ 500
340.06.	**Failure to Correct Unacceptable Conditions.** **a.** Failure to maintain an EMS vehicle in a safe and sanitary condition: **b.** Failure to have available minimum EMS equipment: **c.** Failure to correct patient or personnel safety hazards: **d.** Failure to retain an EMS agency medical director:	 $ 250 $ 250 $ 250 $ 500
340.07.	**Failure to Report Patient Care Data.**	$ 500

( )

342. COLLECTED FINES.
Money collected from EMS agency fines will be deposited into the Emergency Medical Services Fund III provided for in Section 56-1018B, Idaho Code, a dedicated fund account for the purpose of providing grants to acquire vehicles and equipment for use by emergency medical services personnel in the performance of their duties. ( )

343. -- 349. (RESERVED)

350. REINSTATEMENT FOLLOWING REVOCATION.
An application of any revoked license, certificate, or educational program approval, may be filed with the EMS Bureau no earlier than one (1) year from the date of the revocation. ( )

01. Peer Review for Reinstatement. The EMS Bureau will conduct a peer review to consider the reinstatement application. ( )

02. Recommendation of Peer Review Team. The peer review team will make a recommendation to the EMS Bureau to accept or reject the application for reinstatement. ( )

03. Reinstatement Determination. The EMS Bureau will accept or reject the reinstatement application based on the peer review team recommendation and other extenuating circumstances. ( )

a. Reinstatement of a revoked EMS personnel license is subject to the lapsed license reinstatement requirements in IDAPA 16.01.07, "Emergency Medical Services (EMS) -- Personnel Licensing Requirements." ( )

b. Reinstatement of a revoked EMS agency license will be subject to an initial agency application requirements in IDAPA 16.01.03, "Emergency Medical Services (EMS) -- Agency Licensing Requirements." ( )

351. -- 999. (RESERVED)

000. LEGAL AUTHORITY.
Under Sections 56-1013A and 56-1023, Idaho Code, the Idaho Emergency Medical Services (EMS) Physician Commission is authorized to promulgate these rules for the purpose of establishing standards for scope of practice and medical supervision for licensed personnel, air medical, ambulance services, and nontransport agencies licensed by the Department of Health and Welfare. ( )

001. TITLE AND SCOPE.

01. Title. The title of these rules is IDAPA 16.02.02, "Idaho Emergency Medical Services (EMS) Physician Commission." ( )

02. Scope. The scope of these rules is to define the allowable scope of practice, acts, and duties that can be performed by persons licensed as emergency medical services personnel by the Department of Health and Welfare Bureau of Emergency Medical Services and Preparedness and to define the required level of supervision by a physician. ( )

002. INVESTIGATIONS.

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

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

003. INCORPORATION BY REFERENCE.
The Idaho Emergency Medical Services (EMS) Physician Commission has adopted the Idaho Emergency Medical Services (EMS) Physician Commission Standards Manual, edition 2020-1, and hereby incorporates this Standards Manual by reference. Copies of the manual may be obtained on the Internet at https://healthandwelfare.idaho.gov/about-dhw/boards-councils-committees/ems-physician-commission or from the Bureau of Emergency Medical Services and Preparedness located at 2224 East Old Penitentiary Road, Boise, ID, 83712-8249, whose mailing address is P.O. 83720, Boise, Idaho 83720-0036. ( )

004. EMS COMPLAINTS.
The provisions of IDAPA 16.01.12, "Emergency Medical Services (EMS) -- Complaints, Investigations, and Disciplinary Actions," govern the confidentiality of the investigation of complaints regarding licensed EMS personnel. ( )

005. -- 009. (RESERVED)

010. DEFINITIONS.
In addition to the applicable definitions in Section 56-1012, Idaho Code, and IDAPA 16.01.02, "Emergency Medical Services (EMS) -- Rule Definitions," the following terms are used in this chapter as defined below: ( )

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

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

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

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

05. Emergency Medical Services (EMS). Under Section 56-1012(12), Idaho Code, emergency

medical services or EMS is aid rendered by an individual or group of individuals who do the following: ( )

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

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

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

d. Offer, advertise, or attempt to respond as described in Section 56-1012(12), (a) through (c), Idaho Code. ( )

e. Aid rendered by a ski patroller, as described in Section 54-1804(1)(h), Idaho Code, is not EMS. ( )

06. Emergency Medical Services (EMS) Bureau. The Bureau of Emergency Medical Services (EMS) and Preparedness of the Idaho Department of Health and Welfare. ( )

07. Emergency Medical Services (EMS) Physician Commission. The Idaho Emergency Medical Services Physician Commission as created under Section 56-1013A, Idaho Code, hereafter referred to as "the Commission." ( )

08. EMS Agency. An organization licensed by the EMS Bureau to provide emergency medical services in Idaho. ( )

09. EMS Medical Director. A physician who supervises the medical activities of licensed personnel affiliated with an EMS agency. ( )

10. Hospital. A facility in Idaho licensed under Sections 39-1301 through 39-1314, Idaho Code, and defined in Section 39-1301(a)(1), Idaho Code. ( )

11. Hospital Supervising Physician. A physician who supervises the medical activities of licensed EMS personnel while employed or utilized for delivery of services in a hospital. ( )

12. Indirect (Off-Line) Supervision. The medical supervision, provided by a physician, to licensed EMS personnel who are providing medical care including EMS system design, education, quality management, patient care guidelines, medical policies, and compliance. ( )

13. License. A license issued by the EMS Bureau to an individual for a specified period of time indicating that minimum standards corresponding to one (1) of several levels of EMS proficiency have been met. ( )

14. Licensed EMS Personnel. Individuals who possess a valid license issued by the EMS Bureau. ( )

15. Medical Clinic. A place devoted primarily to the maintenance and operation of facilities for outpatient medical, surgical, and emergency care of acute and chronic conditions or injury. ( )

16. Medical Clinic Supervising Physician. A physician who supervises the medical activities of licensed EMS personnel while employed or utilized for delivery of services in a medical clinic. ( )

17. Medical Supervision. The advice and direction provided by a physician, or under the direction of a physician, to licensed EMS personnel who are providing medical care, including direct and indirect supervision. ( )

18. Medical Supervision Plan. The written document describing the provisions for medical supervision of licensed EMS personnel. ( )

19. Nurse Practitioner. An Advanced Practice Professional Nurse, licensed in the category of Nurse Practitioner, as defined in IDAPA 24.34.01, "Rules of the Idaho Board of Nursing." ( )

20. Out-of-Hospital. Any setting outside of a hospital, including inter-facility transfers, in which the provision of emergency medical services may take place. ( )

21. Physician. In accordance with Section 54-1803, Idaho Code, a person who holds a current active license issued by the Board of Medicine to practice medicine and surgery, osteopathic medicine and surgery, or osteopathic medicine in Idaho and is in good standing with no restriction upon, or actions taken against, their license. ( )

22. Physician Assistant. A person who meets all the applicable requirements to practice as a licensed physician assistant under Title 54, Chapter 18, Idaho Code, and IDAPA 24.33.02, "Rules for the Licensure of Physician Assistants." ( )

011. -- 094. (RESERVED)

095. GENERAL PROVISIONS.

01. Practice of Medicine. This chapter does not authorize the practice of medicine or any of its branches by a person not licensed to do so by the Board of Medicine. ( )

02. Patient Consent. The provision or refusal of consent for individuals receiving emergency medical services is governed by Title 39, Chapter 45, Idaho Code. ( )

03. System Consistency. All EMS medical directors, hospital supervising physicians, and medical clinic supervising physicians must collaborate to ensure EMS agencies and licensed EMS personnel have protocols, policies, standards of care, and procedures that are consistent and compatible with one another. ( )

096. -- 099. (RESERVED)

100. GENERAL DUTIES OF EMS PERSONNEL.

01. General Duties. General duties of EMS personnel include the following: ( )

a. Licensed EMS personnel must possess a valid license issued by the EMS Bureau equivalent to or higher than the scope of practice authorized by the EMS medical director, hospital supervising physician, or medical clinic supervising physician. ( )

b. Licensed EMS personnel must only provide patient care for which they have been trained, based on curricula or specialized training approved according to IDAPA 16.01.07, "Emergency Medical Services (EMS) -- Personnel Licensing Requirements," or additional training approved by the hospital or medical clinic supervising physician. ( )

c. Licensed EMS personnel must not perform a task or tasks within their scope of practice that have been specifically prohibited by their EMS medical director, hospital supervising physician, or medical clinic supervising physician. ( )

d. Licensed EMS personnel that possess a valid credential issued by the EMS medical director, hospital supervising physician, or medical clinic supervising physician are authorized to provide services when representing an Idaho EMS agency, hospital, or medical clinic and under any one (1) of the following conditions: ( )

i. When part of a documented, planned deployment of personnel resources approved by the EMS

medical director, hospital supervising physician, or medical clinic supervising physician; or ( )

ii. When, in a manner approved by the EMS medical director, hospital supervising physician, or medical clinic supervising physician, administering first aid or emergency medical attention in accordance with Section 5-330 or 5-331, Idaho Code, without expectation of remuneration; or ( )

iii. When participating in a training program approved by the EMS Bureau, the EMS medical director, hospital supervising physician, or medical clinic supervising physician. ( )

02. Scope of Practice. ( )

a. The Commission maintains an "EMS Physician Commission Standards Manual" that: ( )

i. Establishes the scope of practice of licensed EMS personnel; and ( )

ii. Specifies the type and degree of medical supervision for specific skills, treatments, and procedures by level of EMS licensure. ( )

b. The Commission will consider the United States Department of Transportation's National EMS Scope of Practice Model when preparing or revising the standards manual described in Subsection 100.02.a. of this rule; ( )

c. The scope of practice established by the EMS Physician Commission determines the objectives of applicable curricula and specialized education of licensed EMS personnel; ( )

d. The scope of practice does not define a standard of care, nor does it define what should be done in a given situation; ( )

e. Licensed EMS personnel must not provide out-of-hospital patient care that exceeds the scope of practice established by the Commission; ( )

f. Licensed EMS personnel must be credentialed by the EMS medical director, hospital supervising physician, or medical clinic supervising physician to be authorized for their scope of practice; ( )

g. The credentialing of licensed EMS personnel affiliated with an EMS agency, in accordance with IDAPA 16.01.03, "Emergency Medical Services (EMS) -- Agency Licensing Requirements," must not exceed the licensure level of that EMS agency; and ( )

h. The patient care provided by licensed EMS personnel must conform to the Medical Supervision Plan as authorized by the EMS medical director, hospital supervising physician, or medical clinic supervising physician. ( )

101. -- 199. (RESERVED)

200. EMS MEDICAL DIRECTOR, HOSPITAL SUPERVISING PHYSICIAN, AND MEDICAL CLINIC SUPERVISING PHYSICIAN QUALIFICATIONS.
The EMS Medical Director, Hospital Supervising Physician, and Medical Clinic Supervising Physician must:
( )

01. Accept Responsibility. Accept responsibility for the medical direction and medical supervision of the activities provided by licensed EMS personnel. ( )

02. Maintain Knowledge of EMS Systems. Obtain and maintain knowledge of the contemporary design and operation of EMS systems. ( )

03. Maintain Knowledge of Idaho EMS. Obtain and maintain knowledge of Idaho EMS laws, regulations, and standards manuals. ( )

201. -- 299. (RESERVED)

300. EMS MEDICAL DIRECTOR, HOSPITAL SUPERVISING PHYSICIAN, AND MEDICAL CLINIC SUPERVISING PHYSICIAN RESPONSIBILITIES AND AUTHORITY.

01. Documentation of Written Agreement. The EMS medical director must document a written agreement with the EMS agency to supervise licensed EMS personnel and provide such documentation to the EMS Bureau annually and upon request. ( )

02. Approval for EMS Personnel to Function. ( )

a. The explicit approval of the EMS medical director, hospital supervising physician, or medical clinic supervising physician is required for licensed EMS personnel under their supervision to provide medical care. ( )

b. The EMS medical director, hospital supervising physician, or medical clinic supervising physician may credential licensed EMS personnel under their supervision with a limited scope of practice relative to that allowed by the EMS Physician Commission, or with a limited scope of practice corresponding to a lower level of EMS licensure. ( )

03. Restriction or Withdrawal of Approval for EMS Personnel to Function. ( )

a. The EMS medical director, hospital supervising physician, or medical clinic supervising physician can restrict the scope of practice of licensed EMS personnel under their supervision when such personnel fail to meet or maintain proficiencies established by the EMS medical director, hospital supervising physician, or medical clinic supervising physician, or the Idaho EMS Bureau. ( )

b. The EMS medical director, hospital supervising physician, or medical clinic supervising physician can withdraw approval of licensed EMS personnel to provide services, under their supervision, when such personnel fail to meet or maintain proficiencies established by the EMS medical director, hospital supervising physician, or medical clinic supervising physician, or the EMS Bureau. ( )

c. The EMS medical director, hospital supervising physician, or medical clinic supervising physician must report in writing such restriction or withdrawal of approval within fifteen (15) days of the action to the EMS Bureau in accordance with Section 39-1393, Idaho Code. ( )

04. Review Qualifications of EMS Personnel. The EMS medical director, hospital supervising physician, or medical clinic supervising physician must document the review of the qualification, proficiencies, and all other EMS agency, hospital, and medical clinic affiliations of EMS personnel prior to credentialing the individual. ( )

05. Document EMS Personnel Proficiencies. The EMS medical director, hospital supervising physician, or medical clinic supervising physician must document that the capabilities of licensed EMS personnel are maintained on an ongoing basis through education, skill proficiencies, and competency assessment. ( )

06. Develop and Implement a Performance Assessment and Improvement Program. The EMS medical director must develop and implement a program for continuous assessment and improvement of services provided by licensed EMS personnel under their supervision. ( )

07. Review and Update Procedures. The EMS medical director must review and update protocols, policies, and procedures at least every two (2) years. ( )

08. Develop and Implement Plan for Medical Supervision. The EMS medical director, hospital supervising physician, or medical clinic supervising physician must develop, implement and oversee a plan for supervision of licensed EMS personnel as described in Subsection 400.06 of these rules. ( )

09. Access to Records. The EMS medical director must have access to all relevant agency, hospital, or medical clinic records as permitted or required by statute to ensure responsible medical supervision of licensed EMS personnel. ( )

301. -- 399. (RESERVED)

400. PHYSICIAN SUPERVISION IN THE OUT-OF-HOSPITAL SETTING.

01. Medical Supervision Required. In accordance with Section 56-1011, Idaho Code, licensed EMS personnel must provide emergency medical services under the supervision of a designated EMS medical director. ( )

02. Designation of EMS Medical Director. The EMS agency must designate a physician for the medical supervision of licensed EMS personnel affiliated with the EMS agency. ( )

03. Delegated Medical Supervision of EMS Personnel. The EMS medical director can designate other physicians to supervise the licensed EMS personnel in the temporary absence of the EMS medical director. ( )

04. Direct Medical Supervision by Physician Assistants and Nurse Practitioners. The EMS medical director can designate Physician Assistants (PA) and Nurse Practitioners for purposes of direct medical supervision of licensed EMS personnel under the following conditions: ( )

a. A designated physician is not present in the anticipated receiving health care facility; and ( )

b. The Nurse Practitioner, when designated, must have a preexisting written agreement with the EMS medical director describing the role and responsibilities of the Nurse Practitioner; or ( )

c. The physician supervising the PA, as defined in IDAPA 24.33.02, "Rules for the Licensure of Physician Assistants," authorizes the PA to provide direct (on-line) supervision; and ( )

d. The PA, when designated, must have a preexisting written agreement with the EMS medical director describing the role and responsibilities of the PA related to supervision of EMS personnel. ( )

e. Such designated clinician must possess and be familiar with the medical supervision plan, protocols, standing orders, and standard operating procedures authorized by the EMS medical director. ( )

05. Indirect Medical Supervision by Non-Physicians. Non-physicians can assist the EMS medical director with indirect medical supervision of licensed EMS personnel. ( )

06. Medical Supervision Plan. The medical supervision of licensed EMS personnel must be provided in accordance with a documented medical supervision plan that includes direct, indirect, on-scene, educational, and proficiency standards components. The requirements for the medical supervision plan are found in the Idaho EMS Physician Commission Standards Manual that is incorporated by reference under Section 004 of these rules. ( )

07. Out-of-Hospital Medical Supervision Plan Filed with EMS Bureau. The agency EMS medical director must submit the medical supervision plan within thirty (30) days of request to the EMS Bureau in a form described in the standards manual. ( )

a. The agency EMS medical director must identify the designated clinicians to the EMS Bureau annually in a form described in the standards manual. ( )

b. The agency EMS medical director must inform the EMS Bureau of any changes in designated clinicians or of a change in the agency medical director within thirty (30) days of the change(s). ( )

c. The EMS Bureau must provide the Commission with the medical supervision plans within thirty (30) days of request. ( )

d. The EMS Bureau must provide the Commission with the identification of EMS Medical directors and designated clinicians annually and upon request. ( )

401. -- 499. (RESERVED)

500. PHYSICIAN SUPERVISION IN HOSPITALS AND MEDICAL CLINICS.

01. Medical Supervision Required. In accordance with Section 56-1011, Idaho Code, licensed EMS personnel must provide emergency medical services under the supervision of a designated hospital supervising physician or medical clinic supervising physician. ( )

02. Level of Licensure Identification. The licensed EMS personnel employed or utilized for delivery of services within a hospital or medical clinic, when on duty, must at all times visibly display identification specifying their level of EMS licensure. ( )

03. Credentialing of Licensed EMS Personnel in a Hospital or Medical Clinic. The hospital or medical clinic must maintain a current written description of acts and duties authorized by the hospital supervising physician or medical clinic supervising physician for credentialed EMS personnel and must submit the descriptions upon request of the Commission or the EMS Bureau. ( )

04. Notification of Employment or Utilization. The licensed EMS personnel employed or utilized for delivery of services within a hospital or medical clinic must report such employment or utilization to the EMS Bureau within thirty (30) days of engaging such activity. ( )

05. Designation of Supervising Physician. The hospital or medical clinic administration must designate a physician for the medical supervision of licensed EMS personnel employed or utilized in the hospital or medical clinic. ( )

06. Delegated Medical Supervision of EMS Personnel. The hospital supervising physician or medical clinic supervising physician can designate other physicians to supervise the licensed EMS personnel during the periodic absence of the hospital supervising physician or medical clinic supervising physician. ( )

07. Direct Medical Supervision by Physician Assistants and Nurse Practitioners. The hospital supervising physician, or medical clinic supervising physician can designate Physician Assistants (PA) and Nurse Practitioners for purposes of direct medical supervision of licensed EMS personnel under the following conditions: ( )

a. The Nurse Practitioner, when designated, must have a preexisting written agreement with the hospital supervising physician or medical clinic supervising physician describing the role and responsibilities of the Nurse Practitioner; or ( )

b. The physician supervising the PA, as defined in IDAPA 24.33.02, "Rules for the Licensure of Physician Assistants," authorizes the PA to provide supervision; and ( )

c. The PA, when designated, must have a preexisting written agreement with the hospital supervising physician or medical clinic supervising physician describing the role and responsibilities of the PA related to supervision of EMS personnel. ( )

d. Such designated clinician must possess and be familiar with the medical supervision plan, protocols, standing orders, and standard operating procedures authorized by the hospital supervising physician or medical clinic supervising physician. ( )

08. On-Site Contemporaneous Supervision. Licensed EMS personnel will only provide patient care with on-site contemporaneous supervision by the hospital supervising physician, medical clinic supervising

physician, or designated clinicians. ( )

09. Medical Supervision Plan. The medical supervision of licensed EMS personnel must be provided in accordance with a documented medical supervision plan. The hospital supervising physician or medical clinic supervising physician is responsible for developing, implementing, and overseeing the medical supervision plan, and must submit the plan(s) within thirty (30) days of request by the Commission or the EMS Bureau. ( )

501. -- 999. (RESERVED)

16.02.06 – QUALITY ASSURANCE FOR IDAHO CLINICAL LABORATORIES

000. LEGAL AUTHORITY.
Under Section 56-1003, Idaho Code, the Idaho Legislature has delegated to the Board of Health and Welfare the authority to set standards for laboratories in the state of Idaho. ( )

001. TITLE AND SCOPE.

01. Title. These rules are titled IDAPA 16.02.06, "Quality Assurance for Idaho Clinical Laboratories." ( )

02. Scope. These rules protect the public and individual health by requiring that all Idaho clinical laboratories develop satisfactory quality assurance programs that meet minimal standards approved by the Board. ( )

002. -- 009. (RESERVED)

010. DEFINITIONS.
For the purposes of these rules, the following terms apply: ( )

01. Board. The Idaho Board of Health and Welfare. ( )

02. Department. The Idaho Department of Health and Welfare. ( )

03. Director. The Director of the Idaho Department of Health and Welfare, or their designee. ( )

04. Laboratory or Clinical Laboratory. A facility for the biological, microbiological, serological, chemical, immunohematological, hematological, biophysical, cytological, pathological, or other examinations of material derived from the human body for the purpose of providing information for the diagnosis, prevention, or treatment of any disease, or the impairment or assessment of human health. ( )

05. Laboratory Director. The person under whose supervision the laboratory is operating. ( )

06. Pathologist. A physician who is: ( )

a. Licensed by the Idaho State Board of Medicine in accordance with IDAPA 24.33.01, "Rules of the Board of Medicine for the Licensure to Practice Medicine and Surgery and Osteopathic Medicine and Surgery in Idaho"; and ( )

b. Board certified by the American Board of Anatomic and Clinical Pathology. ( )

07. Proficiency Testing. Evaluation of a laboratory's ability to perform laboratory procedures within acceptable limits of accuracy through analysis of unknown specimens distributed at periodic intervals. ( )

08. Quality Control. A day-to-day analysis of reference materials to ensure reproducibility and accuracy of laboratory results, and also includes an acceptable system to assure proper functioning of instruments, equipment and reagents. ( )

09. Reviewer. An employee or other designated representative of the Department's Idaho Bureau of Laboratories, who is knowledgeable and experienced in clinical laboratory methods and procedures. ( )

011. -- 099. (RESERVED)

100. REGISTRATION REQUIREMENTS FOR CLINICAL LABORATORIES.

01. Registration Timeframes. ( )

a. Every person responsible for the operation of a laboratory that performs tests on material derived from the human body must register such facility with the Department within thirty (30) days after first accepting specimens for testing. ( )

b. Existing laboratories must submit a completed laboratory registration form every two (2) years and

indicate any changes in laboratory operations. ( )

02. Registration Form. Each laboratory must submit its registration information on the Department-approved form. These forms are available upon request from the Department. Each completed registration form must include the following information: ( )

a. Name and location of the laboratory; ( )

b. Name of the laboratory director; ( )

c. Types of laboratory tests performed in the laboratory; and ( )

d. Other information requested by the Department that it deems necessary to evaluate the performance of the laboratory. ( )

101. -- 109. (RESERVED)

110. EXCLUSIONS.

01. Other Certifying Agencies. Laboratories will be excluded from compliance with these rules (except Sections 100 and 200) upon submission of evidence of certification from one (1) of the following agencies: ( )

a. Centers for Medicare and Medicaid Services (CMS), Clinical Laboratory Improvement Amendment (CLIA) certification program http://www.cms.gov/CLIA/01_Overview.asp; ( )

b. College of American Pathologists; ( )

c. Agencies approved by CMS as accreditation organizations. To review the current list of CMS-approved accreditation organizations go to, https://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/Downloads/AOList.pdf; ( )

d. Laboratories located in hospitals approved by the Joint Commission http://www.jointcommission.org/; and ( )

e. Other certification programs approved by the Department. ( )

02. Facilities and Laboratories. The following laboratories and facilities are also excluded from compliance with this chapter: ( )

a. Laboratories operated for teaching or research purposes only, provided tests results are not used for diagnosis or treatment; ( )

b. Prosthetic dental laboratories; and ( )

c. Facilities performing skin testing solely for detection of allergies and sensitivities. ( )

111. -- 119. (RESERVED)

120. DEPARTMENT INSPECTIONS OF CLINICAL LABORATORIES.
A qualified representative of the Department is authorized to inspect the premises and operations of all approved laboratories for the purpose of determining the adequacy of the quality control program and supervision of each laboratory. ( )

121. -- 129. (RESERVED)

130. GENERAL REQUIREMENTS FOR CLINICAL LABORATORIES.

01. Laboratory Facilities. Each laboratory must have adequate space, equipment, and supplies to perform the services offered, with accuracy, precision, and safety. ( )

02. Records. ( )

a. Laboratory records must identify the person responsible for performing the procedure. ( )

b. Each laboratory must maintain a suitable record of each test result for a period of at least two (2) years. Reports of tests must be filed in a manner that permits ready identification and accessibility. ( )

c. Laboratory records and reports must identify specimens referred to other laboratories and must identify the reference laboratory testing such referred specimens. ( )

131. -- 149. (RESERVED)

150. PERSONNEL REQUIREMENTS FOR CLINICAL LABORATORIES.
The laboratory director must ensure that the staff of the laboratory: ( )

01. Appropriate Education, Experience, and Training. Have appropriate education, experience, and training to perform and report laboratory tests promptly and proficiently; ( )

02. Sufficient in Number for the Scope and Complexity. Are sufficient in number for the scope and complexity of the services provided; ( )

03. In-service Training. Receive in-service training appropriate to the type and complexity of the laboratory services offered; and ( )

04. Procedures and Tests that are Outside the Scope of Training. Do not perform procedures and tests that are outside the scope of training of the laboratory personnel. ( )

151. -- 199. (RESERVED)

200. PROFICIENCY TESTING OF CLINICAL LABORATORIES.

01. Scope. All laboratories must subscribe to, and satisfactorily participate in, a proficiency testing program that has been approved by the Department. ( )

02. Results to the Bureau of Laboratories. The laboratory director must furnish the Laboratory Improvement Section with copies of all proficiency testing results within thirty (30) days of receipt or make provisions for a duplicate of the results to be sent by the testing service directly to the Department. ( )

201. -- 209. (RESERVED)

210. QUALITY CONTROL PROGRAM REQUIREMENTS FOR CLINICAL LABORATORIES.

01. Establishment of Quality Control Program. To ensure reliability of day-to-day results, each laboratory must establish a quality control program compatible with regional and statewide practices. ( )

02. Program Scope. An acceptable quality control program must include the following: ( )

a. An effective preventive maintenance program that ensures proper functioning of all instruments and equipment; ( )

b. Routine testing of quality control materials along with patient specimens; ( )

c. Quality control checks on reagents and media utilized in the performance of tests; ( )

d. Maintenance of quality control records that will enable determination of reliability of all procedures performed. ( )

211. -- 219. (RESERVED)

220. DEPARTMENT APPROVAL OF CLINICAL LABORATORIES.
The Department will approve clinical laboratories for performance of tests on material from the human body if the laboratory meets the minimum standards specified in these regulations. ( )

221. -- 229. (RESERVED)

230. DEPARTMENT REVOCATION OF APPROVAL.
The Department may revoke approval, either in total or in part, for the following reasons: ( )

01. Failure to Participate in Proficiency Testing. The approved laboratory fails to participate in a proficiency testing program as outlined in Section 200 of these rules. ( )

02. Failure to Participate in Quality Control. The approved laboratory fails to implement a quality control program as outlined in Section 210 of these rules. ( )

03. Failure to Obtain Satisfactory Results. The Department, through the quality review process, determines that the approved laboratory has failed to obtain satisfactory results on two (2) consecutive or on two (2) out of three (3) consecutive sets of proficiency test program specimens in one (1) or more testing categories. ( )

04. Failure to Submit Documentation. Failure to submit documentation of corrective action as indicated in Subsection 240.02 of these rules. ( )

231. -- 239. (RESERVED)

240. REVOCATION PROCEDURE.

01. Unacceptable Results. Laboratories that fail to obtain passing results on two (2) consecutive proficiency testing events, or two (2) out of three (3) events, will be required to submit documentation of corrective action within fifteen (15) working days after receipt of the notification of the failures. Evaluation of proficiency testing results may overlap from one year to the next. ( )

02. Corrective Action. Upon receipt of documentation of corrective action, a reviewer will determine the adequacy of the action taken. If, in the opinion of the reviewer, the corrective action is not adequate, the laboratory will be required to submit to an on-site inspection that may include on-site testing of unknown samples. ( )

03. On-Site Inspection. If the results of the on-site inspection indicate that the laboratory's performance is unacceptable in one (1) or more testing categories, the approval to perform the test(s) in question will be revoked. ( )

04. Satisfactory Performance. The laboratory will continue to be approved for performance of all test procedures for which it has demonstrated satisfactory performance. ( )

05. Other Deficiencies. Failure to comply with other provisions of these rules may invoke revocation procedures. ( )

241. -- 249. (RESERVED)

250. RENEWAL OF APPROVAL OF DISAPPROVED TEST OR TESTS.

01. Renewal Granted. ( )

a. A laboratory that has lost approval to perform certain tests for reasons outlined in Section 240 of these rules may gain reapproval by documenting corrective action taken, and by requesting the Department review the unacceptable performance and the corrective action taken. ( )

b. Within ten (10) days after completion of this review, the reviewer will submit their report to the Chief of the Bureau of Laboratories. ( )

c. Upon determination that corrections leading to satisfactory and acceptable performance have been made, the Chief of the Bureau of Laboratories may reinstate approval. ( )

02. Renewal Denied. If the Chief of the Bureau of Laboratories does not grant reapproval of the laboratory, they will provide the laboratory supervisor with written notice of actions to be taken to correct deficiencies. The laboratory supervisor may request a new review at any time after thirty (30) days from the date of last review. The laboratory supervisor may also file a written appeal in accordance with IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings," Section 400. ( )

251. -- 269. (RESERVED)

270. LIST OF APPROVED LABORATORIES.
The Department will maintain a list of laboratories approved in accordance with this chapter. This list must include the name and address of each approved laboratory, and the name of the person directing the laboratory. ( )

271. -- 299. (RESERVED)

300. PENALTY FOR FAILURE TO REGISTER OR OPERATION OF A NON-APPROVED CLINICAL LABORATORY.
Failure to register a clinical laboratory, operation of a non-approved clinical laboratory, or performance of unapproved testing constitutes a violation of these rules. Any violation of these rules constitutes a misdemeanor under Section 56-1008, Idaho Code. ( )

301. -- 999. (RESERVED)

000. LEGAL AUTHORITY.
Sections 39-605, 39-1003, 39-1603, and 56-1005, Idaho Code, grant authority to the Board of Health and Welfare to adopt rules protecting the health of the people of Idaho. Section 39-906, Idaho Code, provides for the Director to administer rules adopted by the Board of Health and Welfare. Section 39-4505(2), Idaho Code, gives the Director authority to promulgate rules regarding the identification of blood- or body fluid-transmitted viruses or diseases. Section 56-1003, Idaho Code, gives the Director the authority to adopt rules protecting the health of the people of Idaho and to recommend rules to the Board of Health and Welfare. Section 54-1119, Idaho Code, authorizes the Director to promulgate rules regarding the handling of dead human bodies as needed to preserve and protect the public health. ( )

001. TITLE AND SCOPE.

01. Title. These rules are titled IDAPA 16.02.10, "Idaho Reportable Diseases." ( )

02. Scope. These rules contain the official requirements governing the reporting, control, and prevention of reportable diseases and conditions and requirements to prevent transmission of health hazards from dead human bodies. The purpose of these rules is to identify, control, and prevent the transmission of reportable diseases and conditions within Idaho. ( )

002. DOCUMENTS INCORPORATED BY REFERENCE.
The documents referenced in Subsections 004.01 through 004.07 of this rule are used as a means of further clarifying these rules. These documents are incorporated by reference and are available at the Idaho State Law Library or at the Department's main office. ( )

01. Guideline for Isolation Precautions in Hospitals. Siegel, J.D., et al., "Guideline for Isolation Precautions in Hospitals." Health Care Infection Control Practices Advisory Committee, Atlanta, GA: Centers for Disease Control and Prevention, 2007. ( )

02. National Notifiable Diseases Surveillance System - Case Definitions. http://wwwn.cdc.gov/nndss/script/casedefDefault.aspx. ( )

03. Human Rabies Prevention -- United States, 2008. Morbidity and Mortality Weekly Report, May 23, 2008, Vol. 57.RR-3. Centers for Disease Control and Prevention. ( )

04. Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to Human Immunodeficiency Virus and Recommendations for Postexposure Prophylaxis. Infection Control and Hospital Epidemiology, September 2013, Vol. 34, 9. The Society for Healthcare Epidemiology of America. These guidelines are found online at http://www.jstor.org/stable/10.1086/672271. ( )

05. Compendium of Animal Rabies Prevention and Control, 2016. National Association of State Public Health Veterinarians, Inc., Journal of American Veterinary Medical Association Vol. 248(5), March 1, 2016. This document is found online at http://nasphv.org/documentsCompendia.html. ( )

06. Standards for Cancer Registries, Volume II, Data Standards and Data Dictionary. North American Association of Central Cancer Registries, Eighteenth Edition, Record Layout Version 14, September 2013. ( )

07. Use of Reduced (4-Dose) Vaccine Schedule for Postexposure Prophylaxis to Prevent Human Rabies: Recommendations of the Advisory Committee on Immunization Practices, 2010. Morbidity and Mortality Weekly Report, Recommendations and Reports, March 19, 2010/59(RR02);1-9. This document is found online at https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5902a1.htm. ( )

003. DISCLOSURE OF INFORMATION.
No employee of the Department or Health District may disclose the identity of persons named in disease reports except to the extent necessary for the purpose of administering the public health laws of this state. ( )

004. -- 009. (RESERVED)

010. DEFINITIONS A THROUGH K.
For the purposes of this chapter, the following definitions apply. ( )

01. Airborne Precautions. Methods used to prevent airborne transmission of infectious agents, as

described in "Guideline for Isolation Precautions in Hospitals," incorporated in Section 004 of these rules. ( )

02. Approved Fecal Specimens. Specimens of feces obtained from the designated person who has not taken any antibiotic orally or parenterally for two (2) days prior to the collection of the fecal specimen. The specimen must be collected and transported to the laboratory in a manner appropriate for the test to be performed. ( )

03. Bite or Other Exposure to Rabies. Bite or bitten means that the skin of the person or animal has been nipped or gripped, or has been wounded or pierced, including scratches, and includes probable contact of saliva with a break or abrasion of the skin. The term "exposure" also includes contact of saliva with any mucous membrane. In the case of bats, even in the absence of an apparent bite, scratch, or mucous membrane contact, exposure may have occurred, as described in "Human Rabies Prevention -- United States," incorporated in Section 004 of these rules. ( )

04. Board. The Idaho State Board of Health and Welfare as described in Section 56-1005, Idaho Code. ( )

05. Cancer Data Registry of Idaho (CDRI). The agency performing cancer registry services under a contractual agreement with the Department as described in Section 57-1703, Idaho Code. ( )

06. Cancers. Cancers that are designated reportable include the following as described in Section 57-1703, Idaho Code: ( )

a. In-situ or malignant neoplasms, but excluding basal cell and squamous cell carcinoma of the skin unless occurring on a mucous membrane and excluding in-situ neoplasms of the cervix. ( )

b. Benign tumors of the brain, meninges, pineal gland, or pituitary gland. ( )

07. Carrier. A carrier is a person who can transmit a communicable disease to another person, but may not have symptoms of the disease. ( )

08. Case. ( )

a. A person, who has been diagnosed as having a specific disease or condition by a physician or other health care provider, is considered a case. The diagnosis may be based on clinical judgment, on laboratory evidence, or on both criteria. Individual case definitions are described in "National Notifiable Diseases Surveillance System Case Definitions," incorporated in Section 004 of these rules. ( )

b. A laboratory detection of a disease or condition as listed in Section 050 of these rules and as further outlined in Sections 100 through 949 of these rules. ( )

09. Cohort System. A communicable disease control mechanism in which cases having the same disease are temporarily segregated to continue to allow supervision and structured attendance in a daycare or health care facility. ( )

10. Communicable Disease. A disease that may be transmitted from one (1) person or an animal to another person either by direct contact or through an intermediate host, vector, inanimate object, or other means that may result in infection, illness, disability, or death. ( )

11. Contact. A contact is a person who has been exposed to a case or a carrier of a communicable disease while the disease was communicable, or a person by whom a case or carrier of a communicable disease could have been exposed to the disease. ( )

12. Contact Precautions. Methods used to prevent contact transmission of infectious agents, as described in the "Guideline for Isolation Precautions in Hospitals," incorporated in Section 004 of these rules. ( )

13. Daycare. Care and supervision provided for compensation during part of a twenty-four (24) hour day, for a child or children not related by blood or marriage to the person or persons providing the care, in a place

other than the child's or children's own home or homes as described by Section 39-1102, Idaho Code. ( )

14. Department. The Idaho Department of Health and Welfare or its designee. ( )

15. Director. The Director of the Idaho Department of Health and Welfare or their designee as described under Sections 56-1003 and 39-414(2), Idaho Code, and Section 950 of these rules. ( )

16. Division of Public Health Administrator. A person appointed by the Director to oversee the administration of the Division of Public Health, Idaho Department of Health and Welfare, or their designee. ( )

17. Droplet Precautions. Methods used to prevent droplet transmission of infectious agents, as described in the "Guideline for Isolation Precautions in Hospitals," incorporated in Section 004 of these rules. ( )

18. Exclusion. An exclusion for a food service facility means a person is prevented from working as a food employee or entering a food establishment except for those areas open to the general public as outlined in the IDAPA 16.02.19, "Idaho Food Code." ( )

19. Extraordinary Occurrence of Illness Including Clusters. Rare diseases and unusual outbreaks of illness that may be a risk to the public are considered an extraordinary occurrence of illness. Illnesses related to drugs, foods, contaminated medical devices, contaminated medical products, illnesses related to environmental contamination by infectious or toxic agents, unusual syndromes, or illnesses associated with occupational exposure to physical or chemical agents may be included in this definition. ( )

20. Fecal Incontinence. A condition in which temporarily, as with severe diarrhea, or long-term, as with a child or adult requiring diapers, there is an inability to hold feces in the rectum, resulting in involuntary voiding of stool. ( )

21. Foodborne Disease Outbreak. An outbreak is when two (2) or more persons experience a similar illness after ingesting a common food. ( )

22. Food Employee. An individual working with unpackaged food, food equipment or utensils, or food-contact surfaces as defined in IDAPA 16.02.19, "Idaho Food Code." ( )

23. Health Care Facility. An establishment organized and operated to provide health care to three (3) or more individuals who are not members of the immediate family. This definition includes hospitals, intermediate care facilities, residential care and assisted living facilities. ( )

24. Health Care Provider. A person who has direct or supervisory responsibility for the delivery of health care or medical services. This includes: licensed physicians, nurse practitioners, physician assistants, nurses, dentists, chiropractors, and administrators, superintendents, and managers of clinics, hospitals, and licensed laboratories. ( )

25. Health District. Any one (1) of the seven (7) public health districts as established by Section 39-409, Idaho Code, and described in Section 030 of these rules. ( )

26. Health District Director. Any one (1) of the public health districts' directors appointed by the Health District's Board as described in Section 39-413, Idaho Code, or their designee. ( )

27. Idaho Food Code. Idaho Administrative Code that governs food safety, IDAPA 16.02.19, "Idaho Food Code." These rules may be found online at http://adminrules.idaho.gov/rules/current/16/160219.pdf. ( )

28. Isolation. The separation of a person known or suspected to be infected with an infectious agent, or contaminated from chemical or biological agents, from other persons to such places, under such conditions, and for such time as will prevent transmission of the infectious agent or further contamination. The place of isolation will be designated by the Director under Section 56-1003(7), Idaho Code, and Section 065 of these rules. ( )

011. DEFINITIONS L THROUGH Z.

For the purposes of this chapter, the following definitions apply. ( )

01. Laboratory Director. A person who is directly responsible for the operation of a licensed laboratory or their designee. ( )

02. Laboratory. A medical diagnostic laboratory that is inspected, licensed, or approved by the Department or licensed according to the provisions of the Clinical Laboratory Improvement Act by the United States Health Care and Financing Administration. Laboratory may also refer to the Idaho State Public Health Laboratory, and to the United States Centers for Disease Control and Prevention. ( )

03. Livestock. Livestock as defined by the Idaho Department of Agriculture in IDAPA 02.04.03, "Rules Governing Animal Industry." ( )

04. Medical Record. Hospital or medical records are all those records compiled for the purpose of recording a medical history, diagnostic studies, laboratory tests, treatments, or rehabilitation. Access will be limited to those parts of the record that will provide a diagnosis, or will assist in identifying contacts to a reportable disease or condition. Records specifically exempted by statute are not reviewable. ( )

05. Outbreak. An outbreak is an unusual rise in the incidence of a disease. An outbreak may consist of a single case. ( )

06. Personal Care. The service provided by one (1) person to another for the purpose of feeding, bathing, dressing, assisting with personal hygiene, changing diapers, changing bedding, and other services involving direct physical contact. ( )

07. Physician. A person legally authorized to practice medicine and surgery, osteopathic medicine and surgery, or osteopathic medicine in Idaho as defined in Section 54-1803, Idaho Code. ( )

08. Quarantine. The restriction placed on the entrance to and exit from the place or premises where an infectious agent or hazardous material exists. The place of quarantine will be designated by the Director or Health District Board. ( )

09. Rabies Post-Exposure Prophylaxis (rPEP). The administration of a rabies vaccine series with or without the antirabies immune globulin, depending on pre-exposure vaccination status, following a documented or suspected rabies exposure, as described in "Use of Reduced (4-Dose) Vaccine Schedule for Postexposure Prophylaxis to Prevent Human Rabies: Recommendations of the Advisory Committee on Immunization Practices," incorporated in Section 004 of these rules. ( )

10. Rabies-Susceptible Animal. Any animal capable of being infected with the rabies virus. ( )

11. Residential Care Facility. A commercial or non-profit establishment organized and operated to provide a place of residence for three (3) or more individuals who are not members of the same family, but live within the same household. Any restriction for this type of facility is included under restrictions for a health care facility. ( )

12. Restriction. ( )

a. To limit the activities of a person to reduce the risk of transmitting a communicable disease. Activities of individuals are restricted or limited to reduce the risk of disease transmission until such time that they are no longer considered a health risk to others. ( )

b. A food employee who is restricted must not work with exposed food, clean equipment, utensils, linens, and unwrapped single-service or single-use articles. A restricted employee may still work at a food establishment as outlined in the IDAPA 16.02.19, "Idaho Food Code." ( )

13. Restrictable Disease. A restrictable disease is a communicable disease, which if left unrestricted, may have serious consequences to the public's health. The determination of whether a disease is restrictable is based upon the specific environmental setting and the likelihood of transmission to susceptible persons. ( )

14. Severe Reaction to Any Immunization. Any serious or life-threatening condition that results directly from the administration of any immunization against a communicable disease. ( )

15. Significant Exposure to Blood or Body Fluids. Significant exposure is defined as a percutaneous injury, contact of mucous membrane or non-intact skin, or contact with intact skin when the duration of contact is prolonged or involves an extensive area, with blood, tissue, or other body fluids as defined in "Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to HIV and Recommendations for Postexposure Prophylaxis," incorporated in Section 004 of these rules. ( )

16. Standard Precautions. Methods used to prevent transmission of all infectious agents, as described in the "Guideline for Isolation Precautions in Hospitals," incorporated in Section 004 of these rules. ( )

17. State Epidemiologist. A person employed by the Department to serve as a statewide epidemiologist or their designee. ( )

18. Suspected Case. A person diagnosed with or thought to have a particular disease or condition by a licensed physician or other health care provider. The suspected diagnosis may be based on signs and symptoms, or on laboratory evidence, or both criteria. Suspected cases of some diseases are reportable as described in Section 050 of these rules. ( )

19. Vaccination of an Animal Against Rabies. Vaccination of an animal by a licensed veterinarian with a rabies vaccine licensed or approved for the animal species and administered according to the specifications on the product label or package insert as described in the "Compendium of Animal Rabies Prevention and Control," incorporated in Section 004 of these rules. ( )

20. Veterinarian. Any licensed veterinarian as defined in Section 54-2103, Idaho Code. ( )

21. Waterborne Outbreak. An outbreak is when two (2) or more persons experience a similar illness after exposure to water from a common source and an epidemiological analysis implicates the water as the source of the illness. ( )

22. Working Day. A working day is from 8 a.m. to 5 p.m., Monday through Friday, excluding state holidays. ( )

012. -- 019. (RESERVED)

020. PERSONS REQUIRED TO REPORT REPORTABLE DISEASES, CONDITIONS, AND SCHOOL CLOSURES.

01. Physician. A licensed physician who diagnoses, treats, or cares for a person with a reportable disease or condition must make a report of such disease or condition to the Department or Health District as described in these rules. The physician is also responsible for reporting diseases and conditions diagnosed or treated by physician assistants, nurse practitioners, or others under the physician's supervision. ( )

02. Hospital or Health Care Facility Administrator. The hospital or health care facility administrator must report all persons who are diagnosed, treated, or receive care for a reportable disease or condition in their facility unless the attending physician has reported the disease or condition. ( )

03. Laboratory Director. The laboratory director must report to the Department or Health District the identification of, or laboratory findings suggestive of, the presence of the organisms, diseases, or conditions listed in Section 050 of these rules. ( )

04. School Administrator. A school administrator must report diseases and conditions to the

Department or Health District as indicated in Section 050 of these rules. A school administrator must report the closure of any public, parochial, charter, or private school within one (1) working day when, in their opinion, such closing is related to a communicable disease. ( )

05. Persons in Charge of Food Establishments. A person in charge of an eating or drinking establishment must report diseases and conditions to the Department or Health District as indicated in Section 050 of these rules and obtain guidance on proper actions needed to protect the public. ( )

06. Others Required to Report Reportable Diseases. In addition to licensed physicians, reports must also be made by physician assistants, certified nurse practitioners, licensed registered nurses, school health nurses, infection surveillance staff, public health officials, and coroners. ( )

021. ACCESS TO MEDICAL RECORDS.
No physician, hospital administrative person, or patient may deny the Department, Health Districts, or the Board access to medical records in discharge of their duties in implementing the reportable disease rules. ( )

022. PENALTY PROVISIONS.
These rules may be enforced under the civil and criminal penalties described in Sections 39-108, 39-109, 39-607, 39-1006, 39-1606, and 56-1008, Idaho Code, and other applicable statutes and rules. Penalties may include fines and imprisonment as specified in Idaho Code. ( )

023. DELEGATION OF POWERS AND DUTIES.
The Director has the authority to delegate to the Health Districts any of the powers and duties created by these rules under Section 39-414(2), Idaho Code. Any delegation authority will be in writing and signed by the both the Director and the Health District Board. ( )

024. -- 029. (RESERVED)

030. WHERE TO REPORT REPORTABLE DISEASES AND CONDITIONS.
Subsections 030.01 through 030.09 of this rule provide where information for reporting of suspected, identified, and diagnosed diseases and conditions are to be reported. The diseases and conditions in Sections 100 through 949 of these rules are reportable to the agencies listed in Subsections 030.01 through 030.09 of this rule. ( )

01. Department of Health and Welfare, Bureau of Communicable Disease Prevention Epidemiology Program. ( )

a. Main Office Address: 450 West State Street, 4th Floor, Boise, ID 83720. ( )

b. Phone: (208) 334-5939 and FAX: (208) 332-7307. ( )

02. Health District I - Panhandle Health District. The Panhandle Health District covers the counties of Benewah, Bonner, Boundary, Kootenai, and Shoshone. ( )

a. Main Office Address: 8500 N. Atlas Road, Hayden, ID 83835. ( )

b. Phone: (208) 772-3920 and FAX: 1-866-716-2599 Toll Free. ( )

03. Health District II - Public Health Idaho North Central District. The North Central District covers the counties of Clearwater, Idaho, Latah, Lewis, and Nez Perce. ( )

a. Main Office Address: 215 10th Street, Lewiston, ID 83501. ( )

b. Phone: (208) 799-3100 and FAX: (208) 799-0349. ( )

04. Health District III - Southwest District Health. Southwest District Health covers the counties of Adams, Canyon, Gem, Owyhee, Payette, and Washington. ( )

a. Main Office Address: 13307 Miami Lane, Caldwell, ID 83607. ( )

b. Phone: (208) 455-5442 and FAX: (208) 455-5350. ( )

05. Health District IV - Central District Health Department. The Central District Health Department covers the counties of Ada, Boise, Elmore and Valley. ( )

a. Main Office Address: 707 N. Armstrong Place, Boise, ID 83704. ( )

b. Phone: (208) 327-8625 and FAX: (208) 327-7100. ( )

06. Health District V - South Central Public Health District. The South Central Public Health District covers the counties of Blaine, Camas, Cassia, Gooding, Jerome, Lincoln, Minidoka, and Twin Falls. ( )

a. Main Office Address: 1020 Washington Street N., Twin Falls, ID 83301. ( )

b. Phone: (208) 737-5929 and FAX: (208) 736-3009. ( )

07. Health District VI - Southeastern Idaho Public Health. The Southeastern Idaho Public Health District covers the counties of Bannock, Bear Lake, Bingham, Butte, Caribou, Franklin, Oneida, and Power. ( )

a. Main Office Address: 1901 Alvin Ricken Drive, Pocatello, ID 83201. ( )

b. Phone: (208) 233-9080 and FAX: (208) 233-1916. ( )

08. Health District VII - Eastern Idaho Public Health District. The Eastern Idaho Public Health District covers the counties of Bonneville, Clark, Custer, Fremont, Jefferson, Lemhi, Madison and Teton. ( )

a. Main Office Address: 1250 Hollipark Drive, Idaho Falls, ID 83401. ( )

b. Phone: (208) 533-3152 and FAX: (208) 523-4365. ( )

09. Cancer Data Registry of Idaho (CDRI). ( )

a. Main Office Address: 615 N. 7th Street, P.O. Box 1278, Boise, ID 83701. ( )

b. Phone: (208) 338-5100. ( )

10. Inter-Agency Notification. The Health District must notify the Department of reportable diseases and conditions as listed in Section 050 of these rules. ( )

a. The Department and the Health District will exchange reported information within one (1) working day on any reported case or suspected case of a reportable disease or condition when required in Sections 100 through 949 of these rules. ( )

b. The Department and the Health District will exchange reported information no later than weekly of all other cases of reportable diseases and conditions. ( )

c. The Department will notify the Idaho Department of Agriculture of any identified or suspected source of an animal related disease when required in Sections 100 through 949 of these rules. ( )

031. -- 039. (RESERVED)

040. REPORT CONTENTS AND METHOD OF REPORTING.

01. Report Contents. Each report of a reportable disease or condition must include: ( )

a. The identity and address of the attending licensed physician or the person reporting; ( )

b. The diagnosed or suspected disease or condition; ( )

c. The name, current address, telephone number, birth date, age, race, ethnicity, and sex of the individual with the disease or other identifier from whom the specimen was obtained; ( )

d. The date of onset of the disease or the date the test results were received; and ( )

e. In addition, laboratory directors must report the identity of the organism or other significant test result. ( )

02. How To Report. A report of a case or suspected case may be made to the Department or Health District by telephone, mail, fax, or through electronic-disease reporting systems as listed in Section 030 of these rules. ( )

03. After Hours Notification. An after hours report of a disease or condition may be made through the Idaho State EMS Communications Center (State Comm) at (800) 632-8000. A public health official will be contacted regarding the report. ( )

041. -- 049. (RESERVED)

050. REPORTABLE OR RESTRICTABLE DISEASES, CONDITIONS AND REPORTING REQUIREMENTS.
Reportable diseases and conditions must be reported to the Department or Health District by those required under Section 020 of these rules. The table below identifies the reportable and restrictable diseases and conditions, the timeframe for reporting, and the person or facility required to report.

REQUIREMENTS FOR REPORTABLE AND RESTRICTABLE DISEASES AND CONDITIONS
TABLE 050

Reportable or Restrictable Diseases and Conditions	Section in Rule	Reporting Timeframe	Restrictable for DC = Daycare FS = Food Service HC = Health Care Facility S = School	Which Facilities Must Report in Addition to Health Care Providers, Laboratory Directors, & Hospital Administrators (Section 020)
Acquired Immune Deficiency Syndrome (AIDS), (including CD-4 lymphocyte counts <200 cells/mm3 blood or < 14%)	100	Within 3 working days	None	
Amebiasis and Free-living Amebae	110	Within 3 working days	DC, FS, HC	Food Service Facility
Anthrax (*Bacillus anthracis*)	120	Immediately	None	
Arboviral Diseases	125	Within 3 working days	None	
Biotinidase Deficiency	130	Within 1 working day (in newborn screening)	None	
Botulism	140	Immediately	None	
Brucellosis (*Brucella* species)	150	Within 1 working day	None	

REQUIREMENTS FOR REPORTABLE AND RESTRICTABLE DISEASES AND CONDITIONS
TABLE 050

Reportable or Restrictable Diseases and Conditions	Section in Rule	Reporting Timeframe	Restrictable for DC = Daycare FS = Food Service HC = Health Care Facility S = School	Which Facilities Must Report in Addition to Health Care Providers, Laboratory Directors, & Hospital Administrators (Section 020)
Campylobacteriosis (*Campylobacter* species)	160	Within 3 working days	DC, FS, HC	Food Service Facility
Cancer	170	Report to Cancer Data Registry of Idaho within 180 days of diagnosis or recurrence (including suspected cases)	None	
Chancroid	180	Within 3 working days	None	
Chlamydia trachomatis Infections	190	Within 3 working days	HC - ophthalmia neo-natorum only	
Cholera (*Vibrio cholerae*)	200	Within 1 working day	FS, HC, DC	Food Service Facility
Congenital Hypothyroidism	210	Within 1 working day (in newborn screening)	None	
Conjunctivitis	080, 090	No reporting required	DC, S	
Cryptosporidiosis (*Cryptosporidium* species)	220	Within 3 working days	FS, HC, DC	
Cutaneous Fungal Infections	080, 090	No reporting required	DC, S	
Diarrhea (until common communicable diseases have been ruled out)	085	No reporting required	FS	
Diphtheria (*Corynebacterium diphtheriae*)	230	Immediately	DC, FS, HC, S	School
Echinococcosis	235	Within 3 working days	None	
Encephalitis, Viral or Aseptic	240	Within 3 working days	None	
Escherichia coli O157:H7 and other Shiga-Toxin Producing *E. coli* (STEC)	250	Within 1 working day	DC, FS, HC	Food Service Facility School
Extraordinary Occurrence of Illness, including Clusters	260	Within 1 working day	None	
Fever	085	No reporting required	FS	
Food Poisoning, Foodborne Ill-ness, and Waterborne Illnesses	270	Within 1 working day	None	
Galactosemia	280	Within 1 working day (in newborn screening)	None	
Giardiasis (*Giardia lamblia*)	290	Within 3 working days	DC, FS, HC	Food Service Facility

REQUIREMENTS FOR REPORTABLE AND RESTRICTABLE DISEASES AND CONDITIONS TABLE 050				
Reportable or Restrictable Diseases and Conditions	**Section in Rule**	**Reporting Timeframe**	**Restrictable for DC = Daycare FS = Food Service HC = Health Care Facility S = School**	**Which Facilities Must Report in Addition to Health Care Providers, Laboratory Directors, & Hospital Administrators (Section 020)**
Haemophilus influenzae Invasive Disease	300	Within 1 working day	DC, S	School
Hantavirus Pulmonary Syndrome	310	Within 1 working day	None	
Hemolytic-Uremic Syndrome (HUS) or Thrombotic thrombo-cytopenic purpura-HUS (TTP-HUS)	320	Within 1 working day	None	
Hepatitis A	330	Within 1 working day	DC, FS, HC	Food Service Facility
Hepatitis B	340	Within 1 working day	None	
Hepatitis C	350	Within 3 working days	None	
Human Immunodeficiency Virus (HIV)	360	Within 3 working days	None	
Human T-Lymphotropic Virus	370	Within 3 working days	None	
Jaundice	085	No reporting required	FS	
Lead Poisoning	380	Within 3 working days	None	
Legionellosis	390	Within 3 working days	None	
Leprosy (Hansen's Disease)	400	Within 3 working days	None	
Leptospirosis	410	Within 3 working days	None	
Listeriosis (*Listeria* species)	420	Within 3 working days	None	
Lyme Disease	430	Within 3 working days	None	
Malaria (*Plasmodium* species)	440	Within 3 working days	None	
Maple Syrup Urine Disease	450	Within 1 working day (in newborn screening)	None	
Measles (Rubeola)	460	Within 1 working day	DC, HC, S	School
Meningitis, Viral or Aseptic	470	Within 3 working days	None	
Methicillin-resistant *Staphylococcus aureus* (MRSA) Invasive Disease	475	Within 3 working days	None	**Note:** Only Laboratory Directors need to report.
Methicillin-resistant *Staphylococcus aureus* (MRSA) Non-Invasive Disease	475, 080, 090	No reporting required	DC, FS, HC, S	
Mumps	480	Within 3 working days	DC, S, HC	School
Myocarditis, Viral	490	Within 3 working days	None	

REQUIREMENTS FOR REPORTABLE AND RESTRICTABLE DISEASES AND CONDITIONS TABLE 050				
Reportable or Restrictable Diseases and Conditions	**Section in Rule**	**Reporting Timeframe**	**Restrictable for DC = Daycare FS = Food Service HC = Health Care Facility S = School**	**Which Facilities Must Report in Addition to Health Care Providers, Laboratory Directors, & Hospital Administrators (Section 020)**
Neisseria gonorrhoeae Infections	500	Within 3 working days	HC-ophthalmia neonatorum only	
Neisseria meningitidis Invasive Disease	510	Within 1 working day	DC, HC, S	School
Norovirus	520	Within 1 working day	DC, FS, HC, S	
Novel Influenza A Virus	522	Within 1 working day	DC, FS, HC, S	
Pediculosis	080, 090	No reporting required	DC, S	
Pertussis (*Bordetella pertussis*)	530	Within 1 working day	DC, HC, S	School
Phenylketonuria (PKU)	540	Within 1 working day (in newborn screening)	None	
Plague (*Yersinia pestis*)	550	Immediately	HC, S	School
Pneumococcal Invasive Disease in Children less than Eighteen (18) Years of Age *(Streptococcus pneumoniae)*	560	Within 3 working days	DC, S	School
Pneumocystis Pneumonia (PCP)	570	Within 3 working days	None	
Poliomyelitis	580	Within 1 working day	DC	School
Psittacosis	590	Within 3 working days	None	
Q Fever	600	Within 1 working day	None	
Rabies - Human, Animal, and Post-Exposure Prophylaxis (rPEP)	610	Immediately (human), Within 1 working day (animal or rPEP)	None	
Relapsing Fever, Tick-borne and Louse-borne	620	Within 3 working days	None	
Respiratory Syncytial Virus (RSV)	630	Within 1 working day	None	**Note:** Only Laboratory Directors need to report.
Reye Syndrome	640	Within 3 working days	None	
Rocky Mountain Spotted Fever	650	Within 3 working days	None	
Rubella (including Congenital Rubella Syndrome)	660	Within 1 working day	DC, HC, S	School
Salmonellosis (including Typhoid Fever) (*Salmonella* species)	670	Within 1 working day	DC, FS, HC	Food Service Facility
Scabies	080, 090	No reporting required	DC, S	

REQUIREMENTS FOR REPORTABLE AND RESTRICTABLE DISEASES AND CONDITIONS
TABLE 050

Reportable or Restrictable Diseases and Conditions	Section in Rule	Reporting Timeframe	Restrictable for DC = Daycare FS = Food Service HC = Health Care Facility S = School	Which Facilities Must Report in Addition to Health Care Providers, Laboratory Directors, & Hospital Administrators (Section 020)
Severe Acute Respiratory Syndrome (SARS)	680	Within 1 working day	DC, S	School
Severe Reaction to Any Immunization	690	Within 1 working day	None	
Shigellosis (*Shigella* species)	700	Within 1 working day	DC, FS, HC, S	Food Service Facility School
Smallpox	710	Immediately	DC, HC, S	School
Sore Throat with Fever	085	No reporting required	FS	
Staphylococcal Infections other than MRSA	080, 085, 090	No reporting required	DC, FS, S	
Streptococcal Pharyngeal Infections	080, 090	No reporting required	DC, S	
Streptococcus pyogenes (group A strep), Invasive or Resulting in Rheumatic Fever	720	Within 3 working days	DC, HC, S	School
Syphilis	730	Within 3 working days	None	
Taeniasis	085	No reporting required	FS	
Tetanus	740	Within 3 working days	None	
Toxic Shock Syndrome	750	Within 3 working days	None	
Transmissible Spongiform Encephalopathies (TSE), including Creutzfeldt-Jakob Disease (CJD) and Variant CJD (vCJD)	760	Within 3 working days	None	
Trichinosis	770	Within 3 working days	None	
Tuberculosis (*Mycobacterium tuberculosis*)	780	Within 3 working days	DC, FS, HC, S	School Food Service Facility
Tularemia (*Francisella tularensis*)	790	Immediately; Identification of *Francisella tularensis* - within 1 working day	None	
Uncovered and Open or Draining Skin Lesions with Pus, such as a Boil or Open Wound	085	No reporting required	FS	
Varicella (chickenpox)	080, 090	No reporting required	DC, S	
Vomiting (until noninfectious cause is identified)	085	No reporting required	FS	

REQUIREMENTS FOR REPORTABLE AND RESTRICTABLE DISEASES AND CONDITIONS TABLE 050				
Reportable or Restrictable Diseases and Conditions	**Section in Rule**	**Reporting Timeframe**	**Restrictable for DC = Daycare FS = Food Service HC = Health Care Facility S = School**	**Which Facilities Must Report in Addition to Health Care Providers, Laboratory Directors, & Hospital Administrators (Section 020)**
Yersiniosis (*Yersinia enterocolitica* and *Yersinia pseudotuberculosis*)	810	Within 3 working days; Identification of *Yersinia pestis* - immediately	FS	

( )

051. -- 059. (RESERVED)

060. TESTING FOR CERTAIN REPORTABLE DISEASES WHEN INFORMED CONSENT IS NOT POSSIBLE.
Under Section 39-4504, Idaho Code, a licensed physician may order blood or body fluid tests for hepatitis viruses, malaria, syphilis, or the human immunodeficiency virus (HIV) when an informed consent is not possible and there has been, or is likely to be, significant exposure to a person's blood or body fluids by a person providing emergency or medical services. ( )

061. -- 064. (RESERVED)

065. INVESTIGATION AND CONTROL OF REPORTABLE DISEASES.

01. Responsibility and Authority. The Department will use all reasonable means to confirm in a timely manner any case or suspected case of a reportable disease or condition, and will determine, when possible, all sources of infection and the extent of exposure. Investigations may be made when the Division of Public Health Administrator, Health District Director, or state epidemiologist determines a disease to be of public health significance. ( )

a. Every licensed physician or other health care provider attending a person with a reportable disease or condition must report the case or suspected case, as described in Section 050 of these rules. They must instruct the person on applicable control measures as outlined in Sections 100 through 949 of these rules and cooperate with the Department in the investigation and control of the disease or condition. ( )

b. Any person providing emergency or medical services who believes they have experienced a significant exposure to blood or bodily fluids as defined in Subsection 011.15 of these rules may report said exposure as soon as possible or within fourteen (14) days of the occurrence to the Department on a significant exposure report form. When, in the state epidemiologist's judgment, a significant exposure has occurred, the Department will inform the exposed individual that they may have been exposed to the HIV or HBV virus, or that there is no information available based on the Department's current HIV or HBV registry and will recommend appropriate counseling and testing for the exposed individual. ( )

02. Inspection - Right of Entry. The Department may enter private or public property for the purpose of administering or enforcing the provisions of these rules under the authority and constraints granted by Section 56-1009, Idaho Code. ( )

03. Inviolability of Placards. If it is necessary to use placards, it is unlawful for any person to interfere with, conceal, mutilate or tear down any notices or placards on any house, building or premises placed by the Department. Such placards can only be removed by the health official. ( )

04. Verification of Diagnosis. Cases of diseases or conditions reported to the Department will be treated as such upon the statement of the attending licensed physician or other health care provider, unless there is reason to doubt the diagnosis. Final decision as to the diagnosis for administrative purposes will rest with the Division of Public Health Administrator or Health District Director. ( )

05. Closure of Schools and Places of Public Assembly. The Director may order the closing of any public, parochial, or private school, or other place of public assembly when, in their opinion, such closing is necessary to protect public health. The school or other place of public assembly must not reopen until permitted by the health official. ( )

06. Transportation of Patients With Communicable Disease. No person with a reportable disease in a communicable form, who is under orders of isolation, nor any contact who is restricted under an order of quarantine, may travel or be transported from one place to another without the permission of the Division of Public Health Administrator or Health District Director. An exception may be made in instances where the patient is to be admitted directly to a hospital or treatment facility, provided adequate precautions are taken to prevent dissemination of the disease by the patient enroute to the hospital or treatment facility. ( )

07. Order to Report for Examination. The Division of Public Health Administrator or Health District Director may issue an order to report for examination. An order to report for examination must be served by delivering one (1) copy to the person to be examined, one (1) copy to the prosecuting attorney of the county or city in which the person resides, and filing one (1) copy bearing the notation of time and place of service and the signature of the person serving the notice with the issuing health authority. ( )

08. Order for Isolation. The Division of Public Health Administrator or Health District Director may issue and withdraw an order for isolation if they determine that it is necessary to protect the public from a significant risk of the spread of infectious or communicable diseases or from contamination from chemical or biological agents. Orders for isolation must be executed as described in Subsections 065.08.a. and 065.08.b. of this rule. ( )

a. The order for isolation must be executed as follows: ( )

i. One (1) copy to the individual being isolated; ( )

ii. One (1) copy to the attending licensed physician; ( )

iii. One (1) copy to the prosecuting attorney of the county or city in which the person resides; and ( )

iv. One (1) copy to be filed in the office of the issuing officer along with an affidavit of service signed by the person who served the order. ( )

b. The issuing officer will make an assessment and identify the least restrictive means of isolation that effectively protects unexposed and susceptible individuals from the public health threat. Orders of isolation require the individual to isolate himself at a certain place or places, and may require specific precautions to be taken when outside a designated place of isolation as the issuing officer deems appropriate and necessary. If the place of isolation is other than the individual's place of residence, a copy of the order must be provided to the person in charge of that place. ( )

c. The Division of Public Health Administrator or Health District Director will withdraw an order for isolation once it is determined there is no longer a significant threat to the public's health posed by the individual under order for isolation. ( )

09. Order for Quarantine. The Division of Public Health Administrator or Health District Director is empowered whenever a case of any communicable disease occurs in any household or other place within their jurisdiction and in their opinion it is necessary that persons residing within must be kept from contact with the public, to declare the house, building, apartment, or room a place of quarantine and to require that no persons will leave or enter during the period of quarantine except with specific permission of the issuing officer. Orders for quarantine must be executed as described in Subsections 065.09.a. and 065.09.b. of this rule. ( )

a. The order for quarantine must be executed as follows: ( )

i. One (1) copy to any individual being quarantined; ( )

ii. One (1) copy to the attending licensed physician; ( )

iii. One (1) copy to the prosecuting attorney of the county or city in which the quarantine occurs; ( )

iv. One (1) copy to be filed in the office of the issuing officer along with an affidavit of service signed by the person who served the order; and ( )

v. One (1) copy to the person in charge or owner of the place of quarantine. ( )

b. The issuing officer will make an assessment and identify the least restrictive timeframe of quarantine that effectively protects unexposed and susceptible individuals to the infection of public health threat. ( )

c. The Division of Public Health Administrator or Health District Director will withdraw an order for quarantine when they determine there is no longer a significant threat to the public's health posed by the individual or premises under the order for quarantine. ( )

10. Sexually Transmitted Infection Contacts. Any person infected with a sexually transmitted infection (venereal disease) as defined in Section 39-601, Idaho Code, is required to provide the name, address, and telephone number(s) of all persons from whom the disease may have been acquired and to whom the disease may have been transmitted, when such information is requested by the Department or Health District. ( )

066. -- 067. (RESERVED)

068. PREVENTING SPREAD OF HEALTH HAZARDS FROM DEAD HUMAN BODIES.

01. Embalming. ( )

a. The Division of Public Health Administrator or Health District Director may order a dead human body to be embalmed or prohibit embalming to prevent the spread of infectious or communicable diseases or exposure to hazardous substances. ( )

b. The dead human body of a person suspected of or confirmed as having a viral hemorrhagic fever at the time of death must not be embalmed, but wrapped in sealed leak-proof material and cremated or buried. ( )

02. Burial. The Division of Public Health Administrator or Health District Director may order a dead human body to be buried or cremated, or prohibit burial or cremation, and may specify a time frame for final disposition to prevent the spread of infectious or communicable diseases or exposure to hazardous substances. As required in Section 39-268, Idaho Code, all orders of cremation will be approved by the coroner and the coroner will be notified of prohibitions of cremation ordered by the Administrator or Director. ( )

03. Notification of Health Hazard. Any person authorized to release a dead human body of a person suspected of or confirmed as having a prior disease, a viral hemorrhagic fever, other infectious health hazard, or contaminated with a hazardous substance, must notify the person taking possession of the body and indicate necessary precautions on a written notice to accompany the body. ( )

069. (RESERVED)

070. SPECIAL DISEASE INVESTIGATIONS.
The Department may conduct special investigations of diseases or conditions to identify causes and means of

prevention. All records of interviews, reports, studies, and statements obtained by or furnished to the Department or other authorized agency are confidential for the identity of all persons involved. Release of information to the Department as required or permitted by these rules does not subject any party furnishing such information to an action for damages as provided under IDAPA 16.05.01, "Use and Disclosure of Department Records." ( )

071. -- 079. (RESERVED)

080. DAYCARE FACILITY - REPORTING AND CONTROL MEASURES.

01. Readily Transmissible Diseases. Daycare reportable and restrictable diseases are those diseases that are readily transmissible among children and staff in daycare facilities as listed under Section 050 of these rules. ( )

02. Restrictable Disease - Work. A person who is diagnosed to have a daycare restrictable disease must not work in any occupation in which there is direct contact with children in a daycare facility, as long as the disease is in a communicable form. ( )

03. Restrictable Disease - Attendance. A child who is diagnosed to have a daycare restrictable disease must not attend a daycare facility as long as the disease is in a communicable form. This restriction may be removed by the written certification of a licensed physician, public health nurse or school nurse that the person's disease is no longer communicable. ( )

04. Prevention of the Transmission of Disease. When satisfactory measures have been taken to prevent the transmission of disease, the affected child or employee may continue to attend or to work in a daycare facility if approval is obtained from the Department or Health District. ( )

081. -- 084. (RESERVED)

085. FOOD SERVICE FACILITY - REPORTING AND CONTROL MEASURES.

01. Food or Beverage Transmitted Disease in a Communicable Form. Under Section 050 of these rules, a person who is determined to have one (1) or more of the diseases or conditions listed as restrictable for food establishments must not work as a food employee as long as the disease is in a communicable form. ( )

02. Food Employee Health Examination. The Division of Public Health Administrator may require a food employee to submit to an examination to determine the presence of a disease that can be transmitted by means of food when there is reasonable cause to believe the food employee is afflicted with a disease listed in Section 050 of these rules as restrictable for food establishments and that disease is in a communicable form. ( )

03. Notification of Disease in a Communicable Form. If the person in charge of an eating or drinking establishment has reason to suspect that any employee has a disease listed in Section 050 of these rules as restrictable for food establishments, and that disease is in a communicable form, the person in charge must immediately notify the Department or Health District and obtain guidance on proper actions needed to protect the public. ( )

086. -- 089. (RESERVED)

090. SCHOOL - REPORTING AND CONTROL MEASURES.

01. Restrictable Diseases. School reportable and restrictable diseases are those diseases that are readily transmissible among students and staff in schools as listed under Section 050 of these rules. ( )

02. Restrictions - Work. Any person who is diagnosed to have a school restrictable disease must not work in any occupation that involves direct contact with students in a private, parochial, charter, or public school as long as the disease is in a communicable form. ( )

03. Restrictions - Attendance. Any person who is diagnosed with or reasonably suspected to have a school restrictable disease must not attend a private, parochial, charter, or public school as long as the disease is in a

communicable form. ( )

04. Determination Disease Is No Longer Communicable. A licensed physician, public health nurse, school nurse or other person designated by the Department or Health District may determine when a person with a school restrictable disease is no longer communicable. ( )

05. School Closure. A school administrator must report the closure of any public, parochial, charter, or private school within one (1) working day when, in their opinion, such closing is related to a communicable disease. ( )

091. -- 099. (RESERVED)

REPORTABLE DISEASES AND CONTROL MEASURES
(Sections 100-949)

100. ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS).

01. Reporting Requirements. Each case of acquired immune deficiency syndrome (AIDS) that meets the current case definition established by the Centers for Disease Control and Prevention must be reported to the Department or Health District within three (3) working days of identification. Positive laboratory tests for HIV Antibody, HIV Antigen (protein or nucleic acid), HIV culture or other tests that indicate prior or existing HIV infection or CD-4 lymphocyte counts of less than two hundred (200) per cubic millimeter (mm3) of blood or less than or equal to fourteen percent (14%) must be reported. ( )

02. Investigation. Each reported case of AIDS must be investigated to obtain specific clinical information, to identify possible sources, risk factors, and contacts. Other manifestations of HIV infection as defined by the Centers for Disease Control and Prevention may be investigated. ( )

101. -- 109. (RESERVED)

110. AMEBIASIS AND FREE-LIVING AMEBAE.

01. Reporting Requirements. Each case of amebiasis or infection with free-living amebae (*Ancanthamoeba* spp., *Balamuthia mandrillaris*, or *Naegleria fowleri*) must be reported to the Department or Health District within three (3) working days of identification. ( )

02. Investigation. Each reported case of infection with free-living amebae must be investigated to determine the source of infection. Each reported case of amebiasis must be investigated to determine whether the person with amebiasis is employed as a food employee, provides personal care at a health care or daycare facility, or is a child attending a daycare facility. ( )

03. Restrictions - Daycare Facility. A person excreting *Entamoeba histolytica* must not attend a daycare facility while fecally incontinent and must not work in any occupation in which they provide personal care to children in a daycare facility, unless an exemption is made by the Department or Health District. ( )

a. This restriction may be withdrawn if an effective therapeutic regimen is completed; or ( )

b. At least two (2) successive approved fecal specimens collected at least twenty-four (24) hours apart fail to show *Entamoeba histolytica* upon testing by a licensed laboratory. ( )

04. Restrictions - Food Service Facility. A symptomatic person excreting *Entamoeba histolytica* is restricted from working as a food employee. ( )

a. This restriction may be withdrawn if an effective therapeutic regimen is completed; or ( )

b. At least two (2) successive approved fecal specimens collected at least twenty-four (24) hours apart fail to show *Entamoeba histolytica* upon testing by a licensed laboratory. ( )

05. Restrictions - Health Care Facility. A person excreting *Entamoeba histolytica* must not work in any occupation in which they provide personal care to persons confined to a health care facility, unless an exemption is made by the Department or Health District. ( )

a. This restriction may be withdrawn if an effective therapeutic regimen is completed; or ( )

b. At least two (2) successive approved fecal specimens collected at least twenty-four (24) hours apart fail to show *Entamoeba histolytica* upon testing by a licensed laboratory. ( )

06. Restrictions - Household Contacts. A member of the household in which there is a case of amebiasis may not work in any occupations in Subsections 110.03 through 110.05 of this rule, unless approved by the Department or Health District. The household member must be asymptomatic and have at least one (1) approved fecal specimen found to be negative for ova and parasites on examination by a licensed laboratory prior to being approved for work. ( )

111. -- 119. (RESERVED)

120. ANTHRAX.

01. Reporting Requirements. Each case or suspected case of anthrax in humans must be reported to the Department or Health District immediately, at the time of identification, day or night. ( )

02. Investigation. Each reported case of anthrax must be investigated to confirm the diagnosis, identify clusters or outbreaks of the infection, and identify the source of infection. ( )

03. Handling of Report. The Department and Health District will exchange reported information within one (1) working day of any reported case of anthrax. The Department will notify the Idaho Department of Agriculture of any identified source or suspected source of anthrax. ( )

121. -- 124. (RESERVED)

125. ARBOVIRAL DISEASES.

01. Reporting Requirements. Each case of suspected or confirmed arboviral disease must be reported to the Department or Health District within three (3) working days of identification. Arboviral diseases include, but are not limited to, those caused by the following viruses: California encephalitis, chikungunya, Colorado tick fever, Crimean-Congo hemorrhagic fever, dengue (all subtypes), eastern equine encephalitis, Heartland, Jamestown Canyon, Japanese encephalitis, Keystone, La Crosse, Mayaro, O'nyong-nyong, Powassan, Rift Valley fever, Ross River, St. Louis encephalitis, snowshoe hare, tick-borne encephalitis, Toscana, trivittatus, Venezuelan equine encephalitis, West Nile, western equine encephalitis, yellow fever, and Zika. ( )

02. Investigation. Each reported case of arboviral disease must be investigated to confirm the diagnosis, identify the source of infection, and determine if actions need to be taken to prevent additional cases. ( )

126. -- 129. (RESERVED)

130. BIOTINIDASE DEFICIENCY.
Each case or suspected case of biotinidase deficiency must be reported to the Department or Health District within one (1) working day of identification. ( )

131. -- 139. (RESERVED)

140. BOTULISM.

01. Reporting Requirements. Each case or suspected case of botulism must be reported to the

Department or Health District immediately, at the time of identification, day or night. ( )

02. Investigation. Each reported case of botulism must be investigated to confirm the diagnosis, determine if other persons have been exposed to *botulinum* toxins, and identify the source of the disease. ( )

03. Handling of Report. The Department and the Health District will exchange reported information within one (1) working day on any reported case of botulism. ( )

141. -- 149. (RESERVED)

150. BRUCELLOSIS.

01. Reporting Requirements. Each case of brucellosis must be reported to the Department or Health District within one (1) working day of identification. ( )

02. Investigation. Each reported case of brucellosis must be investigated to confirm the diagnosis and identify the source of the disease. ( )

03. Handling of Report. The Department and the Health District will exchange reported information within one (1) working day of any reported case of brucellosis. The Department will notify the Idaho Department of Agriculture of any identified source or suspected source of the disease. ( )

151. -- 159. (RESERVED)

160. CAMPYLOBACTERIOSIS.

01. Reporting Requirements. Each case of campylobacteriosis must be reported to Department or Health District within three (3) working days of identification. ( )

02. Investigation. Each reported case of campylobacteriosis must be investigated to confirm the diagnosis, identify clusters or outbreaks of the infection and identify the source of the disease. ( )

03. Restrictions - Daycare Facility. A person excreting *Campylobacter* must not provide personal care in a daycare and an fecally incontinent person excreting *Campylobacter* must not attend a daycare facility unless an exemption is obtained from the Department or Health District. Before returning to work or daycare, the person must provide at least two (2) successive approved fecal specimens, collected at least twenty-four (24) hours apart, that fail to show *Campylobacter* upon testing by a licensed laboratory. ( )

04. Restrictions - Food Service Facility. A symptomatic person excreting *Campylobacter* is restricted from working as a food employee. ( )

05. Restrictions - Health Care Facility. A person excreting *Campylobacter* must not provide personal care to persons in a health care facility unless an exemption is obtained from the Department or Health District. Before returning to work, the person must provide at least two (2) successive approved fecal specimens, collected at least twenty-four (24) hours apart, that fail to show *Campylobacter* upon testing by a licensed laboratory. ( )

161. -- 169. (RESERVED)

170. CANCER.

01. Reporting Requirements. Cancer is to be reported within one hundred and eighty (180) days of its diagnosis or recurrence to the Cancer Data Registry of Idaho (CDRI). ( )

02. Handling of Report. All data reported to the CDRI is available for use in aggregate form for epidemiologic analysis of the incidence, prevalence, survival, and risk factors associated with Idaho's cancer experience. Disclosure of confidential information for research projects must comply with the CDRI's confidentiality policies as well as IDAPA 16.05.01, "Use and Disclosure of Department Records." ( )

03. Cancers Designated as Reportable. Cancers that are designated reportable to the CDRI include the following as described in Section 57-1703, Idaho Code. ( )

a. Each in-situ or malignant neoplasm diagnosed by histology, radiology, laboratory testing, clinical observation, autopsy, or suggested by cytology is reportable, excluding basal cell and squamous cell carcinoma of the skin unless occurring on a mucous membrane and excluding in-situ neoplasms of the cervix. ( )

b. Benign neoplasms are reportable if occurring in the central nervous system including the brain, meninges, pineal gland, or pituitary gland. ( )

c. The use of the words "apparently," "appears to," "comparable with," "compatible with," "consistent with," "favor," "malignant appearing," "most likely," "presumed," "probable," "suspected," "suspicious," or "typical" is sufficient to make a case reportable. ( )

d. The use of the words "questionable," "possible," "suggests," "equivocal," "approaching," "rule out," "potentially malignant," or "worrisome," is not sufficient to make a case reportable. ( )

04 Report Content. Each reported case must include the patient's name, demographic information, date of diagnosis, primary site, metastatic sites, histology, stage of disease, initial treatments, subsequent treatment, and survival time. Reporting of cases must adhere to cancer reporting standards as provided in "Standards for Cancer Registries, Vol. II." as incorporated by reference in Section 004 of these rules. ( )

05. Reported By Whom. Every private, federal, or military hospital, out-patient surgery center, radiation treatment center, pathology laboratory, or physician providing a diagnosis or treatment related to a reportable cancer is responsible for reporting or furnishing cancer-related data, including annual follow-up, to CDRI. ( )

171. -- 179. (RESERVED)

180. CHANCROID.

01. Reporting Requirements. Each case of chancroid must be reported to the Department or Health District within three (3) working days of identification. ( )

02. Investigation and Notification of Contacts. Each reported case of chancroid must be investigated to determine the source and extent of contact follow-up that is required. Each person diagnosed with chancroid is required to inform all sexual contacts that they have been exposed to a sexually transmitted infection, or to provide specific information to health officials in order to locate these contacts. The contacts must be notified of the disease in order to be examined and treated according to Section 39-605, Idaho Code. ( )

181. -- 189. (RESERVED)

190. CHLAMYDIA TRACHOMATIS.

01. Reporting Requirements. Each case of *Chlamydia trachomatis* infection must be reported to the Department or Health District within three (3) working days of identification. ( )

02. Investigation. Each reported case of *Chlamydia trachomatis* pelvic inflammatory disease may be investigated to determine the extent of contact follow-up that is required. ( )

03. Prophylaxis of Newborns. Prophylaxis against *Chlamydia trachomatis* ophthalmia neonatorum is required in IDAPA 16.02.12, "Newborn Screening." ( )

04. Restrictions - Health Care Facility. A person with *Chlamydia trachomatis* ophthalmia neonatorum in a health care facility must be managed under the "Guideline for Isolation Precautions in Hospitals" as incorporated by reference in Section 004 of these rules. ( )

191. -- 199. (RESERVED)

200. CHOLERA.

01. Reporting Requirements. Each case or suspected case of cholera must be reported to the Department or Health District within one (1) working day. ( )

02. Investigation. Each reported case of cholera must be investigated to confirm the diagnosis, identify clusters or outbreaks of the infection, and identify contacts, carriers, and the source of the infection. ( )

03. Handling of Report. The Department and the Health District will exchange reported information within one (1) working day on any reported case of cholera. ( )

04. Restrictions - Daycare Facility. A person excreting *Vibrio cholerae* must not attend a daycare facility while fecally incontinent and must not work in any occupation that provides personal care to children in a daycare facility while the disease is in a communicable form, unless an exemption is obtained from the Department or Health District. ( )

05. Restrictions - Food Service Facility. A symptomatic person excreting *Vibrio cholerae* must be managed under IDAPA 16.02.19, "Idaho Food Code." ( )

06. Restrictions - Health Care Facility. A person excreting *Vibrio cholerae* must not work in any occupation that provides personal care to persons confined in a health care or residential facility while in a communicable form, unless an exemption is obtained from the Department or Health District. A person in a health care facility who has cholera must be managed under the "Guideline for Isolation Precautions in Hospitals," as incorporated in Section 004 of these rules. ( )

07. Restrictions - Household Contacts. A member of the household in which there is a case of cholera may not work in any occupations listed in Subsections 200.04 through 200.06 of this rule, unless approved by the Department or Health District. The household member must be asymptomatic and provide at least one (1) approved fecal specimen found to be negative on a culture by a licensed laboratory prior to being approved for work. ( )

201. -- 209. (RESERVED)

210. CONGENITAL HYPOTHYROIDISM.
Each case or suspected case of congenital hypothyroidism must be reported to the Department or Health District within one (1) working day of identification. ( )

211. -- 219. (RESERVED)

220. CRYPTOSPORIDIOSIS.

01. Reporting Requirements. Each case of cryptosporidiosis must be reported to the Department or Health District within three (3) working days of identification. ( )

02. Investigation. Each reported case must be investigated to identify clusters or outbreaks of the infection, and identify the source of the infection. ( )

03. Restrictions - Daycare Facility. A fecally incontinent person excreting *Cryptosporidium* must not attend a daycare facility. A person excreting *Cryptosporidium* must not provide personal care in a daycare facility, unless an exemption is obtained from the Department or Health District. This restriction will be withdrawn when: ( )

a. At least two (2) successive fecal specimens collected at least twenty-four (24) hours apart fail to show *Cryptosporidium* upon testing by a licensed laboratory; or ( )

b. Diarrhea has ceased for twenty-four (24) hours. ( )

04. Restrictions - Food Service Facility. A symptomatic person excreting *Cryptosporidium* is restricted from working as a food employee. ( )

05. Restrictions - Health Care Facility. A person excreting *Cryptosporidium* must not provide personal care in a custodial institution, or health care facility while fecally incontinent, unless an exemption is obtained from the Department or Health District. This restriction will be withdrawn when: ( )

a. At least two (2) successive fecal specimens collected at least twenty-four (24) hours apart fail to show *Cryptosporidium* upon testing by a licensed laboratory; or ( )

b. Diarrhea has ceased for twenty-four (24) hours. ( )

221. -- 229. (RESERVED)

230. DIPHTHERIA.

01. Reporting Requirements. Each case or suspected case of diphtheria must be reported to the Department or Health District immediately, at the time of identification, day or night. ( )

02. Investigation and Response. Each reported case of diphtheria must be investigated to determine if the illness is caused by a toxigenic strain of *Corynebacterium diphtheriae*, identify clusters or outbreaks of the infection, and identify contacts, carriers, and the source of the infection. Contacts of a person with toxigenic diphtheria will be offered immunization against diphtheria. ( )

03. Handling of Report. The Department and the Health District will exchange reported information within one (1) working day on any reported case or suspected case of diphtheria. ( )

04. Restrictions - Daycare Facility. A person diagnosed with diphtheria must be managed under Section 080 of these rules. ( )

05. Restrictions - Health Care Facility. ( )

a. A person with oropharyngeal toxigenic diphtheria in a health care facility must be managed under the "Guideline for Isolation Precautions in Hospitals," as incorporated in Section 004 of these rules. The Department or Health District may withdraw this isolation requirement after two (2) cultures of the nose and two (2) cultures from the throat, taken at least twenty-four (24) hours apart and at least twenty-four (24) hours after the completion of antibiotic therapy, fail to show toxigenic *Corynebacterium diphtheriae* upon testing by a licensed laboratory. ( )

b. A person with cutaneous toxigenic diphtheria must be placed under contact precautions. The Department or Health District may withdraw these precautions after two (2) cultures from the wound fail to show toxigenic *Corynebacterium diphtheriae* upon testing by a licensed laboratory. ( )

06. Restrictions - Contacts. Contacts of a person with toxigenic diphtheria are restricted from working as food employees, working in health care facilities, or from attending or working in daycare facilities or schools until they are determined not to be carriers by means of a nasopharyngeal culture or culture of other site suspected to be infected. These restrictions may be withdrawn by the Department or Health District. ( )

231. -- 234. (RESERVED)

235. ECHINOCOCCOSIS.

01. Reporting Requirements. Each case of echinococcosis must be reported to the Department or Health District within three (3) working days of identification. ( )

02. Investigation. Each reported case of echinococcosis must be investigated to confirm the diagnosis and to identify possible sources of the infection. ( )

236. -- 239. (RESERVED)

240. ENCEPHALITIS, VIRAL OR ASEPTIC.

01. Reporting Requirements. Each case of viral or aseptic encephalitis, including meningoencephalitis, must be reported to the Department or Health District within three (3) working days of identification. ( )

02. Investigation. Each reported case of viral or aseptic encephalitis meningoencephalitis must be investigated to confirm the diagnosis, identify clusters or outbreaks of the infection, and identify the agent or source of the infection. ( )

241. -- 249. (RESERVED)

250. ESCHERICHIA COLI O157:H7 AND OTHER SHIGA-TOXIN PRODUCING E. COLI (STEC).

01. Reporting Requirements. Each case or suspected case of *Escherichia coli* O157:H7 or other Shiga-toxin producing *E. coli* (STEC) must be reported to the Department or Health District within one (1) working day of identification. ( )

02. Investigation. Each reported case must be investigated to determine if the person is employed as a food employee, provides personal care at a health care or daycare facility, or is a child attending a daycare facility. The investigation identifies clusters or outbreaks of the infection, and the most likely source of the infection. ( )

03. Handling of Report. The Department and the Health District will exchange reported information within one (1) working day on any reported case of *E. coli* O157:H7 or other Shiga-toxin producing *E. coli* (STEC). ( )

04. Restrictions - Daycare Facility. A person who is excreting *E. coli* O157:H7 or other STEC must not attend daycare facilities while fecally incontinent or provide personal care to children in a daycare facility while the disease is present in a communicable form without the approval of the Department or Health District. Before returning to work or attendance at a daycare, the person must provide two (2) successive approved fecal specimens collected at least twenty-four (24) hours apart, that fail to show *E. coli* O157:H7 or other STEC. ( )

05. Restrictions - Food Service Facility. A person diagnosed with *E. coli* O157:H7 or other STEC must be managed under IDAPA 16.02.19, "Idaho Food Code." ( )

06. Restrictions - Health Care Facility. A person who is excreting *E. coli* O157:H7 or other STEC must not provide personal care to persons in a health care facility while the disease is present in a communicable form without the approval of the Department or Health District. Before returning to work, the person must provide two (2) successive approved fecal specimens collected at least twenty-four (24) hours apart, that fail to show *E. coli* O157:H7 or other STEC. ( )

251. -- 259. (RESERVED)

260. EXTRAORDINARY OCCURRENCE OF ILLNESS, INCLUDING CLUSTERS.

01. Reporting Requirements. Cases, suspected cases, and clusters of extraordinary or unusual illness must be reported to the Department or Health District within one (1) working day by the diagnosing person. ( )

a. Unusual outbreaks include illnesses that may be a significant risk to the public, may involve a large number of persons, or are a newly described entity. ( )

b. Even in the absence of a defined etiologic agent or toxic substance, clusters of unexplained acute illness and early-stage disease symptoms must be reported to the Department or Health District within one (1) working day and investigated. ( )

02. Investigation. Each reported case of extraordinary occurrence of illness, including clusters, must be investigated to confirm the diagnosis, determine the extent of the cluster or outbreak, identify the source of infection or exposure, and determine whether there is a risk to the public warranting intervention by a public health agency. Evaluation and control measures will be undertaken in consultation with the Department and other appropriate agencies. The Department may elect to investigate by conducting special studies as outlined in Section 070 of these rules. ( )

03. Handling of Report. The Department and the Health District will exchange reported information within one (1) working day on any reported case or suspected case. ( )

261. -- 269. (RESERVED)

270. FOOD POISONING, FOODBORNE ILLNESS, AND WATERBORNE ILLNESS.

01. Reporting Requirements. Each case, suspected case, or outbreak of food poisoning, foodborne illness, or waterborne illness must be reported to the Department or Health District within one (1) working day of identification. ( )

02. Investigation. Each reported case or outbreak of food poisoning, foodborne illness, or waterborne illness must be investigated to confirm the diagnosis, determine the extent of transmission, identify the source, and determine if actions need to be taken to prevent additional cases. ( )

03. Handling of Report. The Department and the Health District will exchange reported information within one (1) working day of any reported case or suspected case. ( )

271. -- 279. (RESERVED)

280. GALACTOSEMIA.
Each case or suspected case of galactosemia must be reported to the Department or Health District within one (1) working day after diagnosis. ( )

281. -- 289. (RESERVED)

290. GIARDIASIS.

01. Reporting Requirements. Each case of giardiasis must be reported to the Department or Health District within three (3) working days of identification. ( )

02. Investigation. Each reported case of giardiasis must be investigated to determine if the person is employed as a food employee, provides personal care at a health care or daycare facility, or is a child attending a daycare facility. The investigation identifies clusters or outbreaks of the infection, and the most likely source of the infection. ( )

03. Restrictions - Daycare Facility. A person with diarrhea who is excreting *Giardia lamblia* must not attend daycare while fecally incontinent or provide personal care to children in a daycare facility while the disease is present in a communicable form or until therapy is completed. An asymptomatic person may provide these services or attend daycare with specific approval of the Department or Health District. ( )

04. Restrictions - Food Service Facility. A symptomatic person who is excreting *Giardia lamblia* must be managed under IDAPA 16.02.19, "Idaho Food Code." ( )

05. Restrictions - Health Care Facility. A person with diarrhea who is excreting *Giardia lamblia*

must not provide personal care to persons in a health care facility while the disease is present in a communicable form or until therapy is completed. An asymptomatic person may provide these services with specific approval of the Department or Health District. ( )

291. -- 299. (RESERVED)

300. HAEMOPHILUS INFLUENZAE INVASIVE DISEASE.

01. Reporting Requirements. Each case or suspected case of *Haemophilus influenzae* invasive disease, including, but not limited to, meningitis, septicemia, bacteremia, epiglottitis, pneumonia, osteomyelitis and cellulitis, must be reported to the Department or Health District within one (1) working day of identification. ( )

02. Investigation. Each reported case of *Haemophilus influenzae* invasive disease must be investigated to confirm the diagnosis, identify clusters or outbreaks of the infection, identify contacts, and determine the need for antimicrobial prophylaxis of close contacts. ( )

03. Handling of Report. The Department and the Health District will exchange reported information within one (1) working day on any reported case of *Haemophilus influenzae* invasive disease. ( )

04. Restrictions - Daycare Facility. A person who is diagnosed with invasive disease caused by *Haemophilus influenzae* must not work in an occupation providing personal care to children, or attend a daycare facility as long as the disease is in a communicable form. ( )

05. Restrictions - School. A person who is diagnosed with invasive disease caused by *Haemophilus influenzae* must not work in any occupation where there is direct contact with students or attend a private, parochial, charter, or public school as long as the disease is in a communicable form. ( )

301. -- 309. (RESERVED)

310. HANTAVIRUS PULMONARY SYNDROME.

01. Reporting Requirements. Each case or suspected case of hantavirus pulmonary syndrome must be reported to the Department or Health District within one (1) working day of identification. ( )

02. Investigation. Each reported case of hantavirus pulmonary syndrome must be investigated to confirm the diagnosis, determine environmental risk factors leading to the infection, and determine any other at-risk individuals. ( )

03. Handling of Report. The Department and the Health District will exchange reported information within one (1) working day by telephone on any reported case or suspected case of hantavirus pulmonary syndrome. ( )

311. -- 319. (RESERVED)

320. HEMOLYTIC-UREMIC SYNDROME (HUS).

01. Reporting Requirements. Each case of hemolytic-uremic syndrome (HUS) or thrombotic thrombocytopenic purpura-HUS (TTP-HUS) must be reported to the Department or Health District within one (1) working day. ( )

02. Investigation. Each case of HUS or TTP-HUS must be investigated to confirm the diagnosis, determine the etiologic agent including *E. coli* O157:H7, non-O157 Shiga-toxin producing *E. coli*, or other enteric pathogens, and determine the source of infection. ( )

321. -- 329. (RESERVED)

330. HEPATITIS A.

01. Reporting Requirements. Each case or suspected case of hepatitis A must be reported to the Department or Health District within one (1) working day of identification. ( )

02. Investigation. Each reported case of hepatitis A must be investigated to confirm the diagnosis, identify contacts, determine the need for immune serum globulin (gamma globulin) or vaccine, and identify possible sources of the infection. ( )

03. Testing Without an Informed Consent. A physician may order blood tests for hepatitis A when an informed consent is not possible and there has been or is likely to be significant exposure to a person's blood or body fluids by a person providing emergency or medical services. ( )

04. Restrictions - Daycare Facility. A child who has hepatitis A must not attend a daycare facility until the disease is no longer communicable as determined by a licensed physician, or unless an exemption is made by the Department or Health District. ( )

a. A person with hepatitis A must not work in any occupation in which personal care is provided to children in a daycare facility while the disease is in a communicable form. ( )

b. The Department or Health District may withdraw this restriction when the illness is considered to no longer be in a communicable form. ( )

05. Exclusion - Food Service Facility. ( )

a. A food employee with hepatitis A must be managed under IDAPA 16.02.19, "Idaho Food Code." ( )

b. A specific test for recent hepatitis A infection (IgM antiHAV) must be performed by a licensed laboratory on all food employees suspected of having hepatitis A. ( )

06. Restrictions - Health Care Facility. A person with hepatitis A in a health care facility must be managed under the "Guideline for Isolation Precautions in Hospitals," as incorporated in Section 004 of these rules. ( )

a. A person with hepatitis A must not work in any occupation in which personal care is provided to persons who are in a health care facility or living in a residential care facility while the disease is in a communicable form. ( )

b. The Department or Health District may withdraw this restriction when the illness is considered to no longer be in a communicable form. ( )

07. Restrictions - Household Contacts. Any unvaccinated household member where there is a case of hepatitis A must not work in any of the occupations listed in Subsections 330.04 through 330.06 of this rule, unless an exemption is obtained from the Department or Health District. ( )

331. -- 339. (RESERVED)

340. HEPATITIS B.

01. Reporting Requirements. Each case or suspected case of hepatitis B must be reported to the Department or Health District within one (1) working day of identification. ( )

02. Investigation. Each reported case of hepatitis B must be investigated to confirm the diagnosis, identify contacts and carriers, determine the need for prophylaxis with immune globulins, determine the need for hepatitis B vaccine, determine the exposure of any pregnant women, and identify possible sources of the infection. ( )

03. Testing Without an Informed Consent. A physician may order blood tests for hepatitis B when an informed consent is not possible and there has been or is likely to be significant exposure to a person's blood or body fluids by a person providing emergency or medical services. ( )

04. Carrier Status. The carrier status of a person diagnosed with hepatitis B will be determined six (6) months after the initial diagnosis is established. ( )

a. The carrier status will be determined by the presence of hepatitis B surface antigen (HBsAG) in blood obtained at least six (6) months after the initial diagnosis of hepatitis B. ( )

b. The test for hepatitis B surface antigen (HBsAg) must be performed by a licensed laboratory. ( )

c. A person who is a carrier of hepatitis B must be reported to the Department or Health District by the physician at the time of determination for inclusion in the hepatitis B carrier registry. ( )

341. -- 349. (RESERVED)

350. HEPATITIS C.

01. Reporting Requirements. Each case of hepatitis C must be reported to the Department or Health District within three (3) working days of identification. ( )

02. Investigation. Each reported case of hepatitis C must be investigated to confirm the diagnosis and identify possible sources of the infection. Hepatitis C may be confirmed by presence of hepatitis C antibody or antigen. ( )

03. Testing Without an Informed Consent. A physician may order blood tests for hepatitis C when an informed consent is not possible and there has been or is likely to be significant exposure to a person's blood or body fluids by a person providing emergency or medical services. ( )

351. -- 359. (RESERVED)

360. HUMAN IMMUNODEFICIENCY VIRUS (HIV).

01. Reporting Requirements. Each case of HIV infection, including positive HIV laboratory tests for HIV antibody, HIV antigen (protein or nucleic acid), human immunodeficiency virus isolations, or other tests of infectiousness that indicate HIV infection, must be reported to the Department or Health District within three (3) working days of identification. ( )

02. Investigation. Each reported case of HIV infection must be investigated to obtain specific clinical information, identify possible sources, risk factors, and contacts. Other manifestations of HIV infection as defined by the Centers for Disease Control and Prevention may be investigated. ( )

03. Testing Without an Informed Consent. A physician may order blood tests for HIV when an informed consent is not possible and there has been, or is likely to be, significant exposure to a person's blood or body fluids by a person providing emergency or medical services. ( )

361. -- 369. (RESERVED)

370. HUMAN T-LYMPHOTROPIC VIRUS.

01. Reporting Requirements. Each case of HTLV infection must be reported to the Department or Health District within three (3) working days of identification. ( )

02. Investigation. Each reported case of HTLV infection must be investigated to determine the source

of infection and evaluate risk factors. ( )

371. -- 379. (RESERVED)

380. LEAD POISONING.

01. Reporting Requirements. Each case of lead poisoning must be reported to the Department or Health District within three (3) working days of the identification of the case when determined by symptoms or a blood level of: ( )

a. Ten (10) micrograms or more per deciliter (10 ug/dL) of blood in adults eighteen (18) years and older; or ( )

b. Five (5) micrograms or more per deciliter (5 ug/dL) of blood in children under eighteen (18) years of age. ( )

02. Investigation. Each reported case of lead poisoning or excess lead exposure may be investigated to confirm blood lead levels, determine the source, and whether actions need to be taken to prevent additional cases. ( )

381. -- 389. (RESERVED)

390. LEGIONELLOSIS.

01. Reporting Requirements. Each case of legionellosis must be reported to the Department or Health District within three (3) working days of identification. ( )

02. Investigation. Each reported case of legionellosis must be investigated to confirm the diagnosis and identify possible sources of the infection. When two (2) or more cases occur within thirty (30) days of each other, an investigation must be conducted to identify a common environmental source and identify ways to prevent further infections. ( )

391. -- 399. (RESERVED)

400. LEPROSY (HANSEN'S DISEASE).

01. Reporting Requirements. Each case of leprosy must be reported to the Department or Health District within three (3) working days of identification. ( )

02. Investigation. Each reported case of leprosy must be investigated to confirm the diagnosis and to identify household or other close contacts. ( )

03. Restrictions - Examination of Contacts. All household members or close contacts of a new case must be examined by a licensed physician for signs of leprosy. Household members and close contacts and persons in remission must be registered with the Department and undergo periodic medical examinations every six (6) to twelve (12) months for five (5) years. ( )

401. -- 409. (RESERVED)

410. LEPTOSPIROSIS.

01. Reporting Requirements. Each case of leptospirosis must be reported to the Department or Health District within three (3) working days of identification. ( )

02. Investigation. Each reported case of leptospirosis must be investigated to confirm the diagnosis and to identify possible sources of the infection. ( )

03. Handling of Report. Any identified or suspected source of infection reported to the Department is reported to the Idaho Department of Agriculture if animals are involved. ( )

411. -- 419. (RESERVED)

420. LISTERIOSIS.

01. Reporting Requirements. Each case of listeriosis must be reported to the Department or Health District within three (3) working days of identification. ( )

02. Investigation. Each reported case of listeriosis must be investigated to confirm the diagnosis and to identify possible sources of the infection and extent of the outbreak. ( )

421. -- 429. (RESERVED)

430. LYME DISEASE.

01. Reporting Requirements. Each case of Lyme disease must be reported to the Department or Health District within three (3) working days of identification. ( )

02. Investigation. Each reported case of Lyme disease must be investigated to confirm the diagnosis and to identify possible sources of the infection. ( )

03. Handling of Report. Any identified or suspected source of infection reported to the Department is reported to the Idaho Department of Agriculture if animals are involved. ( )

431. -- 439. (RESERVED)

440. MALARIA.

01. Reporting Requirements. Each case of malaria must be reported to the Department or Health District within three (3) working days of identification. ( )

02. Investigation. Each reported case of malaria must be investigated to determine the type and the source of the infection. If transmission may have occurred in Idaho, an entomologic investigation will be performed by the Department or Health District to determine the extent of mosquito activity, and to institute control measures if endemic transmission is determined. ( )

03. Testing Without an Informed Consent. A physician may order blood tests for malaria when an informed consent is not possible and there has been, or is likely to be, significant exposure to a person's blood or body fluids by a person providing emergency or medical services. ( )

441. -- 449. (RESERVED)

450. MAPLE SYRUP URINE DISEASE.
Each case or suspected case of maple syrup urine disease must be reported to the Department or Health District within one (1) working day of identification. ( )

451. -- 459. (RESERVED)

460. MEASLES (RUBEOLA).

01. Reporting Requirements. Each case or suspected case of measles must be reported to the Department or Health District within one (1) working day of identification. ( )

02. Investigation. Each reported case of measles must be investigated to confirm the diagnosis, identify clusters or outbreaks of the infection, identify the source of the infection, and to identify susceptible contacts.

( )

03. Handling of Report. The Department and the Health District will exchange reported information within one (1) working day on any reported case of measles. ( )

04. Restrictions - Daycare Facility and School. ( )

a. A child diagnosed with measles must not attend a daycare facility or school as long as the disease is in a communicable form. ( )

b. In the event of a case of measles in a daycare or school, susceptible children must be excluded until adequate immunization is obtained, or the threat of further spread of the disease is contained, as provided in Sections 33-512(7) and 39-1118, Idaho Code. ( )

c. A person who is diagnosed as having measles must not work in any occupation in which there is direct contact with children, as long as the disease is in a communicable form. ( )

05. Restrictions - Health Care Facility. A person diagnosed with measles in a health care facility must be managed under the "Guideline for Isolation Precautions in Hospitals," as incorporated by reference in Section 004 of these rules. ( )

461. -- 469. (RESERVED)

470. MENINGITIS, VIRAL OR ASEPTIC.

01. Reporting Requirements. Each case of viral or aseptic meningitis must be reported to the Department or Health District within three (3) working days of identification. ( )

02. Investigation. Each reported case of viral or aseptic meningitis must be investigated to confirm the diagnosis, identify clusters or outbreaks of the infection, and identify the agent or source of the infection. ( )

471. -- 474. (RESERVED)

475. METHICILLIN-RESISTANT STAPHYLOCOCCUS AUREUS (MRSA).

01. Reporting Requirements. Each case or suspected case of invasive methicillin-resistant *Staphylococcus aureus* (MRSA), defined as MRSA isolated from a normally sterile site, must be reported to the Department or Health District within three (3) working days of identification by the laboratory director. ( )

02. Investigation. Any case of MRSA may be investigated to determine source and recommend measures to prevent spread. ( )

03. Restrictions - Daycare Facility. A person who is diagnosed with MRSA infection must not work in an occupation providing personal care to children, or attend a daycare facility, if the infection manifests as a lesion containing pus such as a boil or infected wound that is open or draining; and ( )

a. The lesion is on the hands, wrists, or exposed portions of the arms, and is not protected by an impermeable cover; or ( )

b. The lesion is on another part of the body, and is not covered by a dry, durable, tight-fitting bandage. ( )

04. Restrictions - Food Service Facility. A food employee diagnosed with MRSA infection must be managed under IDAPA 16.02.19, "Idaho Food Code." ( )

05. Restrictions - Health Care Facility. A person who is diagnosed with MRSA infection must not provide personal care to persons in a health care facility if the infection manifests as a lesion containing pus such as a

boil or infected wound that is open or draining; and ( )

a. The lesion is on the hands, wrists, or exposed portions of the arms, and is not protected by an impermeable cover; or ( )

b. The lesion is on another part of the body, and is not covered by a dry, durable, tight-fitting bandage. ( )

06. Restrictions - School. A person who is diagnosed with MRSA infection must not work in an occupation where there is direct contact with students or attend a private, parochial, charter, or public school, if the infection manifests as a lesion containing pus such as a boil or infected wound that is open or draining; and ( )

a. The lesion is on the hands, wrists, or exposed portions of the arms, and is not protected by an impermeable cover; or ( )

b. The lesion is on another part of the body, and is not covered by a dry, durable, tight-fitting bandage. ( )

476. -- 479. (RESERVED)

480. MUMPS.

01. Reporting Requirements. Each case of mumps must be reported to the Department or Health District within three (3) working days of identification. ( )

02. Investigation. Each reported case of mumps must be investigated to confirm the diagnosis, identify clusters or outbreaks of the infection, identify the source of the infection, and to identify susceptible contacts. ( )

03. Restrictions. A person with mumps must be restricted from daycare, school, or work for five (5) days after the onset of parotid swelling. ( )

481. -- 489. (RESERVED)

490. MYOCARDITIS, VIRAL.

01. Reporting Requirements. Each case of viral myocarditis must be reported to the Department or Health District within three (3) working days of identification. ( )

02. Investigation. Each reported case of viral myocarditis must be investigated to confirm the diagnosis, identify clusters or outbreaks of the infection, and identify the agent or source of the infection. ( )

491. -- 499. (RESERVED)

500. NEISSERIA GONORRHOEAE.

01. Reporting Requirements. Each case of *Neisseria gonorrhoeae* infection must be reported to the Department or Health District within three (3) working days of identification. ( )

02. Investigation. A person diagnosed with urethral, cervical, oropharyngeal, or rectal gonorrhea is required to inform all sexual contacts or provide sufficient information to health officials in order to locate these contacts. The contacts must be advised of their exposure to a sexually transmitted infection and informed they should seek examination and treatment. ( )

03. Prophylaxis of Newborns. Prophylaxis against gonococcal ophthalmia neonatorum is described in IDAPA 16.02.12, "Newborn Screening." ( )

04. Isolation - Health Care Facility. A person with gonococcal ophthalmia neonatorum in a health care facility must be managed under the "Guideline for Isolation Precautions in Hospitals," as incorporated in Section 004 of these rules. ( )

501. -- 509. (RESERVED)

510. NEISSERIA MENINGITIDIS INVASIVE DISEASE.

01. Reporting Requirements. Each case or suspected case of *Neisseria meningitidis* invasive disease, including meningitis and septicemia, must be reported to the Department or Health District within one (1) working day of identification. ( )

02. Investigation. Each reported case of *Neisseria meningitidis* invasive disease must be investigated to confirm the diagnosis, identify clusters or outbreaks of the infection, identify contacts, and determine the need for antimicrobial prophylaxis or immunization of close contacts. ( )

03. Handling of Report. The Department and the Health District will exchange reported information within one (1) working day on any reported case of *Neisseria meningitidis* invasive disease. ( )

04. Restrictions - Daycare Facility. A person who is diagnosed with a disease caused by *Neisseria meningitidis* must not provide personal care to children, or attend a daycare facility, as long as the disease is present in a communicable form. ( )

05. Restrictions - Health Care Facility. A person with *Neisseria meningitidis* in a health care facility or residential care facility must be placed under respiratory isolation until twenty-four (24) hours after initiation of effective therapy. ( )

06. Restrictions - School. A person who is diagnosed with a disease caused by *Neisseria meningitidis* must not work in any occupation that involves direct contact with students, or attend a private, parochial, charter, or public school as long as the disease is present in a communicable form. ( )

511. -- 519. (RESERVED)

520. NOROVIRUS.

01. Reporting Requirements. Each case or suspected case of norovirus must be reported to the Department or Health District within one (1) working day of identification. ( )

02. Investigation. Each reported case of norovirus must be investigated to confirm the diagnosis, identify clusters or outbreaks of the infection, and identify the source of the infection. ( )

03. Restrictions - Daycare Facility. A person excreting norovirus must not attend or provide personal care in a daycare while symptomatic, unless an exemption is obtained from the Department or Health District. This restriction will be withdrawn once asymptomatic for at least twenty-four (24) hours. ( )

04. Exclusions - Food Service Facility. A person suspected of infection with, or diagnosed with, norovirus is excluded from working as a food employee while symptomatic, unless an exemption is made by the Department or Health District. This exclusion will be withdrawn once the person is asymptomatic for at least twenty-four (24) hours. ( )

05. Restrictions - Health Care Facility. A person excreting norovirus must not provide personal care in a health care facility, unless an exemption is obtained from the Department or Health District. This restriction will be withdrawn once asymptomatic for at least twenty-four (24) hours. ( )

06. Restrictions - School. A person excreting norovirus must not attend or work in a private, parochial, charter, or public school while symptomatic, unless an exemption is obtained from the Department or Health District. This restriction will be withdrawn once asymptomatic for at least twenty-four (24) hours. ( )

521. (RESERVED)

522. NOVEL INFLUENZA A VIRUS.

01. Reporting Requirements. ( )

a. Each detection of a novel influenza A virus must be reported to the Department or Health District within one (1) working day of identification by the laboratory director. ( )

b. Each probable or confirmed case of a novel influenza A infection resulting in hospitalization must be reported to the Department or Health District within one (1) working day of the event. ( )

02. Investigation. Any case of a novel influenza A infection may be investigated to determine severity and recommend measures to prevent spread. ( )

03. Restrictions. A person diagnosed with novel influenza A virus infection must be restricted from daycare, school, or work for twenty-four (24) hours after the fever is resolved. Fever must be absent without the aid of fever-reducing medicine. ( )

523. -- 529. (RESERVED)

530. PERTUSSIS.

01. Reporting Requirements. Each case or suspected case of pertussis must be reported to the Department or Health District within one (1) working day of identification. ( )

02. Investigation. Each reported case of pertussis must be investigated to confirm the diagnosis, identify clusters or outbreaks of the infection, identify susceptible contacts, and identify the source of the infection. ( )

03. Restrictions - Daycare Facility. A person who is diagnosed with pertussis must not work in any occupation in which there is direct contact with children, or attend a daycare facility, as long as the disease is in a communicable form. ( )

04. Restrictions - Health Care Facility. A person who is diagnosed with pertussis must not work in any occupation in which there is direct contact with other persons in a health care facility as long as the disease is in a communicable form. ( )

05. Restrictions - School. A person diagnosed with pertussis must not attend or work in a private, parochial, charter, or public school as long as the disease is in a communicable form. ( )

531. -- 539. (RESERVED)

540. PHENYLKETONURIA.
Each case or suspected case of phenylketonuria must be reported to the Department or Health District within one (1) working day of identification. ( )

541. -- 549. (RESERVED)

550. PLAGUE.

01. Reporting Requirements. Each case or suspected case of plague must be reported to the Department or Health District immediately, at the time of identification, day or night. ( )

02. Investigation. Each reported case of plague must be investigated to confirm the diagnosis, determine the source, identify clusters or outbreaks of the infection, and whether there has been person-to-person

transmission. ( )

03. Handling of Report. Each case of plague reported to the Department is reported to the Idaho Department of Agriculture if animals are involved. ( )

04. Restrictions - Daycare Facility. A person who is diagnosed with pneumonic plague must not work in any occupation in which there is direct contact with children, or attend a daycare facility, as long as the disease is in a communicable form. ( )

05. Restrictions - Health Care Facility. ( )

a. A person with or suspected of having pneumonic plague in a health care facility must be managed under the "Guideline for Isolation Precautions in Hospitals," as incorporated in Section 004 of these rules. ( )

b. A person with or suspected of having bubonic plague in health care facility must be managed under the "Guideline for Isolation Precautions in Hospitals," as incorporated in Section 004 of these rules. ( )

06. Restrictions - School. A person diagnosed with pneumonic plague must not attend or work in any occupation in which there is direct contact with children, in a private, parochial, charter, or public school as long as the disease is in a communicable form. ( )

07. Prophylaxis of Contacts. Household members and face-to-face contacts of a person with pneumonic plague must be placed on chemoprophylaxis and placed under surveillance for seven (7) days. A person who refuses chemoprophylaxis must be maintained under droplet precautions with careful surveillance for seven (7) days. ( )

551. -- 559. (RESERVED)

560. PNEUMOCOCCAL INVASIVE DISEASE IN CHILDREN LESS THAN EIGHTEEN YEARS OF AGE.

01. Reporting Requirements. Each case of pneumococcal invasive disease in children under eighteen (18) years of age including, but not limited to, meningitis, septicemia, and bacteremia, must be reported to the Department or Health District within three (3) working days of identification. ( )

02. Investigation. Each reported case of pneumococcal invasive disease in children must be investigated to confirm the diagnosis and determine relevant vaccine history. ( )

03. Restrictions - Daycare Facility. A person who is diagnosed with pneumococcal invasive disease must not attend daycare or work in any occupation in which there is direct contact with children in a daycare facility as long as the disease is in a communicable form. ( )

04. Restrictions - School. A person diagnosed with pneumococcal invasive disease must not attend or work in any occupation in which there is direct contact with children in a private, parochial, charter, or public school as long as the disease is in a communicable form. ( )

561. -- 569. (RESERVED)

570. PNEUMOCYSTIS PNEUMONIA (PCP).

01. Reporting Requirements. Each case of *Pneumocystis* pneumonia (PCP) must be reported to the Department or Health District within three (3) working days of identification. ( )

02. Investigation. Each reported case of *Pneumocystis* pneumonia (PCP) must be investigated to confirm the diagnosis, and to determine the underlying cause of any immune deficiency that may have contributed to the disease. When the underlying cause is an HIV infection, it must be reported as described in Section 360 of these rules. ( )

571. -- 579. (RESERVED)

580. POLIOMYELITIS.

01. Reporting Requirements. Each case or suspected case of poliomyelitis infection must be reported to the Department or Health District within one (1) working day of identification. ( )

02. Investigation. Each reported case of poliomyelitis infection must be investigated to confirm the diagnosis, to determine whether the case is polio vaccine associated or wild virus associated, identify clusters or outbreaks of the infection, whether there has been person-to-person transmission, and to identify susceptible contacts, carriers, and source of the infection. ( )

03. Immunization of Personal Contacts. The immunization status of personal contacts is determined and susceptible contacts are offered immunization. ( )

04. Restrictions - Daycare Facility. A person who is diagnosed with poliomyelitis infection must not work in any occupation in which there is direct contact with children, or attend a daycare facility, as long as the disease is in a communicable form. ( )

05. Restrictions - School. A person diagnosed with poliomyelitis infection must not attend or work in any occupation in which there is direct contact with children, in a private, parochial, charter, or public school as long as the disease is in a communicable form. ( )

581. -- 589. (RESERVED)

590. PSITTACOSIS.

01. Reporting Requirements. Each case of psittacosis must be reported to the Department or Health District within three (3) working days of identification. ( )

02. Investigation. Each reported case must be investigated to confirm the diagnosis, identify clusters or outbreaks of the infection, and identify possible sources of the infection. ( )

03. Handling of Report. Any identified sources or suspected sources of infection must be reported to the Department which will notify the Idaho Department of Agriculture if birds or other animals are involved. ( )

591. -- 599. (RESERVED)

600. Q FEVER.

01. Reporting Requirements. Each case or suspected case of Q fever must be reported to the Department or Health District within one (1) working day of identification. ( )

02. Investigation. Each reported case of Q fever must be investigated to confirm the diagnosis, identify clusters or outbreaks of the infection, and identify the source of the infection. ( )

03. Handling of Report. Any identified or suspected sources of infection must be reported to the Department which will notify the Idaho Department of Agriculture if animals are involved. ( )

601. -- 609. (RESERVED)

610. RABIES - HUMAN, ANIMAL, AND POST-EXPOSURE PROPHYLAXIS (RPEP).

01. Reporting Requirements. ( )

a. Each case or suspected case of rabies in humans must be reported to the Department or Health District immediately, at the time of identification, day or night. ( )

b. Each case of rabies in animals must be reported to the Department or Health District within one (1) working day of identification. ( )

c. Each instance of rabies post-exposure prophylaxis (rPEP) series initiation must be reported to the Department or Health District within one (1) working day. ( )

02. Investigation. ( )

a. Each reported case or suspected case of rabies in humans must be investigated to confirm the diagnosis, identify the source and other persons or animals that may have been exposed to the source, and identify persons who may need to undergo rPEP. ( )

b. Each suspected or confirmed case of rabies in animals will be investigated to determine if potential human or animal exposure has occurred and identify persons who may need to undergo rPEP. ( )

c. Each reported rPEP series initiation must be investigated to determine if additional individuals require rPEP and identify the source of possible rabies exposure. ( )

03. Handling of Report. The Health District must notify the Department within one (1) working day of each reported case of this disease. ( )

04. Management of Exposure to Rabies. All human exposures to a suspected or confirmed rabid animal must be managed as described under the guidelines presented in the "Human Rabies Prevention -- United States" incorporated by reference in Subsection 004.03 of these rules and "Use of Reduced (4-Dose) Vaccine Schedule for Postexposure Prophylaxis to Prevent Human Rabies: Recommendations of the Advisory Committee on Immunization Practices" incorporated by reference in Subsection 004.07 in these rules. Animals involved with bites, or themselves bitten by a suspected or confirmed rabid animal, must be managed under the guidelines in the "Compendium of Animal Rabies Prevention and Control," incorporated by reference in Subsection 004.05 of these rules, and as described in Subsections 610.04.a., 610.04.b., and 610.04.c. of this rule. In the event that a human or animal case of rabies occurs, any designated representative of the Department, Health District, or Idaho State Department of Agriculture, will establish such isolation and quarantine of animals involved as deemed necessary to protect the public health. ( )

a. The management of a rabies-susceptible animal that has bitten or otherwise potentially exposed a person to rabies must be as follows: ( )

i. Any livestock that has bitten or otherwise potentially exposed a person to rabies will be referred to the Idaho State Department of Agriculture for management. ( )

ii. Any healthy domestic dog, cat, or ferret, regardless of rabies vaccination status, that has bitten or otherwise potentially exposed a person to rabies must be confined and observed for illness daily for ten (10) days following the exposure under the supervision of a licensed veterinarian or other person designated by the Idaho State Department of Agriculture, Health District, or the Department. If signs suggestive of rabies develop, immediately consult the Health District or Department to discuss euthanasia and rabies testing. ( )

iii. Any domestic dog, cat, or ferret that cannot be managed as described in Subsection 610.04.a.ii. of this rule must be destroyed by a means other than shooting in the head. The head must be submitted to an approved laboratory for rabies analysis. ( )

iv. It is the animal owner's responsibility to follow instructions provided for the management of the animal. ( )

v. Rabies susceptible animals other than domestic dogs, cats, or ferrets must be destroyed and the head submitted to an approved laboratory for rabies analysis, unless an exemption is given by the Department or

Health District. ( )

vi. No person will destroy, or allow to be destroyed, the head of a rabies-susceptible animal that has bitten or otherwise potentially exposed a person to rabies without authorization from the Department or Health District. ( )

b. The management of a rabies-susceptible animal that has not bitten a person, but has been bitten, mouthed, mauled by, or closely confined in the same premises with a confirmed or suspected rabid animal must be as follows: ( )

i. Any exposed livestock will be referred to the Idaho State Department of Agriculture for management. ( )

ii. Any domestic dog, cat, or ferret that has never been vaccinated against rabies as recommended by the American Veterinary Medical Association, must be appropriately vaccinated in accordance with guidance in the "Compendium of Animal Rabies Prevention and Control" incorporated by reference in Subsection 004.05 of these rules as soon as possible and placed in strict quarantine for a period of four (4) months (six (6) months for ferrets) under the observation of a licensed veterinarian or a person designated by the Idaho State Department of Agriculture, Health District, or the Department. The strict quarantine of such an animal must be within an enclosure deemed adequate by a person designated by the Idaho State Department of Agriculture, Health District, or the Department to prevent contact with any person or rabies-susceptible animal. If signs suggestive of rabies develop, immediately consult the Health District or Department to discuss euthanasia or rabies testing. Destruction of such an animal is permitted as an alternative to strict quarantine. ( )

iii. An animal considered currently vaccinated against rabies, or overdue for rabies vaccination but with documentation of at least one (1) prior rabies vaccination, should be revaccinated against rabies as soon as possible with an appropriate vaccine, kept under the owner's control, and observed for illness for forty-five (45) days. If signs suggestive of rabies develop, immediately consult the Health District or Department to discuss euthanasia and rabies testing. These provisions apply only to animals for which an approved rabies vaccine is available. Animals should be managed in accordance with guidance in the "Compendium of Animal Rabies Prevention and Control" incorporated by reference in Subsection 004.05 of these rules to conduct serological monitoring when a previous vaccination may have been received, but the documentation is unavailable. If evidence of previous vaccination cannot be demonstrated, the animal must be managed as described in Subsection 610.04.b.ii. of this rule. ( )

iv. The owner of the animal is financially responsible for the cost of managing and testing of the animal as described in Subsection 610.04.b. of this rule. ( )

c. Any rabies-susceptible animal other than domestic dogs, cats, ferrets, or livestock that are suspected of having rabies, or have been in close contact with an animal known to be rabid, must be destroyed. The animal must be tested by an approved laboratory for rabies if a person has been bitten or has had direct contact with the animal that might result in the person becoming infected unless an exemption is granted by the Department or Health District. ( )

05. City or County Authority. Nothing in these rules is intended or will be construed to limit the power of any city or county in its authority to enact more stringent requirements to prevent the transmission of rabies. ( )

611. -- 619. (RESERVED)

620. RELAPSING FEVER, TICK-BORNE AND LOUSE-BORNE.

01. Reporting Requirements. Each case of tick-borne or louse-borne relapsing fever must be reported to the Department or Health District within three (3) working days of identification. ( )

02. Investigation. Each reported case of tick-borne or louse-borne relapsing fever must be investigated to confirm the diagnosis, identify clusters or outbreaks of the infection, and whether transmission was from lice or ticks. ( )

621. -- 629. (RESERVED)

630. RESPIRATORY SYNCYTIAL VIRUS (RSV).
A laboratory director must report each detection of respiratory syncytial virus (RSV) infection to the Department or Health District within one (1) working day of identification. ( )

631. -- 639. (RESERVED)

640. REYE SYNDROME.

01. Reporting Requirements. Each case of Reye syndrome must be reported to the Department or Health District within three (3) working days of identification. ( )

02. Investigation. Each reported case of Reye syndrome must be investigated to obtain specific clinical information and to learn more about the etiology, risk factors, and means of preventing the syndrome. ( )

641. -- 649. (RESERVED)

650. ROCKY MOUNTAIN SPOTTED FEVER.

01. Reporting Requirements. Each case of Rocky Mountain spotted fever must be reported to the Department or Health District within three (3) working days of identification. ( )

02. Investigation. Each reported case of Rocky Mountain spotted fever must be investigated to confirm the diagnosis, identify the source of infection, and determine if control measures should be initiated. ( )

651. -- 659. (RESERVED)

660. RUBELLA - INCLUDING CONGENITAL RUBELLA SYNDROME.

01. Reporting Requirements. Each case or suspected case of rubella or congenital rubella syndrome must be reported to the Department or Health District within one (1) working day of identification. ( )

02. Investigation. Each reported case of rubella or congenital rubella syndrome must be investigated to confirm the diagnosis, identify clusters or outbreaks of the infection, identify any contacts who are susceptible and pregnant, and document the presence of the congenital rubella syndrome. ( )

03. Restrictions - Daycare Facility. A person who is diagnosed with rubella must not attend daycare or work in any occupation in which there is close contact with children in a daycare facility as long as the disease is in a communicable form. ( )

04. Restrictions - Health Care Facility. A person who is diagnosed with rubella must not work in any occupation in which there is close contact with other persons in a health care facility as long as the disease is in a communicable form. ( )

05. Restrictions - Schools. A person who is diagnosed with rubella must not attend, be present, or work in any occupation in which there is close contact with children or other persons in a private, parochial, charter, or public school as long as the disease is in a communicable form. ( )

06. Restrictions - Personal Contact. A person who is diagnosed with rubella must not work in occupations in which there is close contact with women likely to be pregnant as long as the disease is in a communicable form. ( )

661. -- 669. (RESERVED)

670. SALMONELLOSIS - INCLUDING TYPHOID FEVER.

01. Reporting Requirements. Each case or suspected case of salmonellosis or typhoid fever must be reported to the Department or Health District within one (1) working day of identification. ( )

02. Investigation. Each reported case of salmonellosis or typhoid fever must be investigated to confirm the diagnosis, identify clusters or outbreaks of the infection, and to identify contacts, carriers, and the source of infection. ( )

03. Handling of Report. The Department and the Health District will exchange reported information within one (1) working day on any suspected or reported case. ( )

04. Restrictions - Chronic Carrier. Chronic carriers, which are those who excrete *Salmonella* for more than one (1) year after onset, are restricted from working as food employees. Chronic carriers must not work in any occupation in which they provide personal care to children in daycare facilities, or to persons who are confined to health care facilities or residential care facilities, until *Salmonella* is not identified by a licensed laboratory in any of three (3) successive approved fecal specimens collected at least seventy-two (72) hours apart. ( )

05. Restrictions - Non-Typhi Salmonella. ( )

a. A fecally incontinent person excreting non-Typhi *Salmonella* must not attend a daycare facility. ( )

b. A person excreting non-Typhi *Salmonella* must not work in any occupation in which they provide personal care to children in a daycare facility or provide personal care to persons confined to a health care facility, unless an exemption is obtained from the Department or Health District. ( )

c. A symptomatic food employee excreting non-Typhi *Salmonella* must be managed under the IDAPA 16.02.19, "Idaho Food Code." ( )

d. Before a person can attend or work in a daycare facility or a health care facility, or work as a food employee, the person must provide two (2) successive approved fecal specimens collected at least twenty-four (24) hours apart, that fail to show *Salmonella*. ( )

e. The Department may withdraw this restriction on a case of non-Typhi *Salmonella* provided that the person is asymptomatic. ( )

f. Any member of a household in which there is a case of non-Typhi salmonellosis must not work as a food employee until the member provides at least one (1) approved fecal specimen that fails to show *Salmonella* upon testing by a licensed laboratory. ( )

06. Restrictions - Salmonella Typhi. ( )

a. Any person with typhoid fever will remain subject to the supervision of the Department until *Salmonella Typhi* is not isolated by a licensed laboratory from three (3) successive approved fecal specimens collected at least twenty-four (24) hours apart and not earlier than one (1) month after onset. ( )

b. A food employee excreting *Salmonella Typhi* must be managed under IDAPA 16.02.19, "Idaho Food Code." ( )

c. Any member of a household in which there is a case of *Salmonella Typhi* must not work in the occupations described in Subsection 670.05.d. of this rule until the member provides at least two (2) successive approved fecal specimens collected twenty-four (24) hours apart that fail to show *Salmonella* upon testing by a licensed laboratory. ( )

d. All chronic carriers of *Salmonella Typhi* must abide by a written agreement called a typhoid fever

carrier agreement. This agreement is between the chronic carrier and the Department or Health District. Failure of the carrier to abide by the carrier agreement may cause the carrier to be isolated under Section 065 of these rules. The carrier agreement requires: ( )

i. The carrier cannot work as a food employee; ( )

ii. Specimens must be furnished for examination in a manner described by the Department or Health District; and ( )

iii. The Department or Health District must be notified immediately of any change of address, occupation, and cases of illness suggestive of typhoid fever in their family or among immediate associates. ( )

e. Chronic carriers of typhoid fever may be released from carrier status when *Salmonella Typhi* is not identified by a licensed laboratory in any of six (6) consecutive approved fecal and urine specimens collected at least one (1) month apart. ( )

671. -- 679. (RESERVED)

680. SEVERE ACUTE RESPIRATORY SYNDROME (SARS).

01. Reporting Requirements. Each case or suspected case of severe acute respiratory syndrome (SARS) must be reported to the Department or Health District within one (1) working day of identification. ( )

02. Investigation. Each reported case of SARS must be investigated to confirm the diagnosis, review the travel and other exposure history, identify other persons potentially at risk, and identify the most likely source of the infection. ( )

03. Isolation. Recommendations for appropriate isolation of the suspected or confirmed case will be made by the Department or Health District. ( )

681. -- 689. (RESERVED)

690. SEVERE REACTION TO ANY IMMUNIZATION.

01. Reporting Requirements. Each case or suspected case of a severe reaction to any immunization must be reported to the Department or Health District within one (1) working day of identification. ( )

02. Investigation. Each reported case of severe reaction to any immunization must be investigated to confirm and document the circumstances relating to the reported reaction to the immunization. ( )

03. Handling of Report. The Department and the Health District will exchange reported information within one (1) working day on any reported case. ( )

691. -- 699. (RESERVED)

700. SHIGELLOSIS.

01. Reporting Requirements. Each case or suspected case of shigellosis must be reported to the Department or Health District within one (1) working day of identification. ( )

02. Investigation. Each reported case of shigellosis must be investigated to confirm the diagnosis and identify clusters or outbreaks of the infection. An attempt must be made to identify contacts, carriers, and the source of the infection. ( )

03. Handling of Report. The Department and the Health District will exchange reported information

within one (1) working day on any suspected or reported case. ( )

04. Restrictions - Daycare Facility. ( )

a. A person excreting *Shigella* must not attend a daycare facility while fecally incontinent. ( )

b. A person excreting *Shigella* must not work in any occupation in which they provide personal care to children in a daycare facility while the disease is present in a communicable form, unless an exemption is obtained from the Department or Health District. During an outbreak in a daycare facility, a cohort system may be approved. ( )

c. The Department or Health District may withdraw the daycare restriction when the person has provided two (2) successive approved fecal specimens collected at least twenty-four (24) hours apart that fail to show *Shigella* upon testing by a licensed laboratory. ( )

05. Exclusions - Food Service Facility. ( )

a. A food employee excreting *Shigella* must be managed under IDAPA 16.02.19, "Idaho Food Code." ( )

b. The Department or Health District may withdraw the food service restriction when the employee has provided two (2) successive approved fecal specimens collected at least twenty-four (24) hours apart that fail to show *Shigella* upon testing by a licensed laboratory. ( )

06. Restrictions - Health Care Facility. ( )

a. A person excreting *Shigella* must not work in any occupation in which they provide personal care to persons who are confined to a health care facility while the disease is present in a communicable form, unless an exemption is obtained from the Department or Health District. During an outbreak in a facility, a cohort system may be approved. ( )

b. The Department or Health District may withdraw the health care facility restriction when the employee has provided two (2) successive approved fecal specimens collected at least twenty-four (24) hours apart that fail to show *Shigella* upon testing by a licensed laboratory. ( )

c. During an outbreak in a facility, a cohort system may be approved. ( )

07. Restrictions - Household Contacts. No member of a household, in which there is a case of shigellosis, may work in any occupations in Subsections 700.04 through 700.06 of this rule, unless the Department or Health District approves and at least one (1) approved fecal specimen is negative for *Shigella* upon testing by a licensed laboratory. ( )

701. -- 709. (RESERVED)

710. SMALLPOX.

01. Reporting Requirements. Each case or suspected case of smallpox must be reported to the Department or Health District immediately, at the time of identification, day or night. ( )

02. Investigation. Each reported case of smallpox must be investigated promptly to confirm the diagnosis, identify clusters or outbreaks of the infection, and identify the source of the infection and susceptible contacts. ( )

03. Restrictions - Daycare Facility. ( )

a. A person diagnosed with smallpox must not attend a daycare facility as long as the disease is in a communicable form. ( )

b. In the event of an outbreak, the Department or Health District may exclude susceptible children and employees from daycare facilities where a case has been identified until adequate immunization is obtained or the threat of further spread is contained. ( )

04. Restrictions - Health Care Facility. A person diagnosed or suspected of having smallpox in a health care facility must be managed under the "Guideline for Isolation Precautions in Hospitals," as incorporated in Section 004 of these rules. ( )

05. Restrictions - Public Gatherings. A person diagnosed with smallpox must not attend public gatherings as long as the disease is in a communicable form. ( )

06. Restrictions - School. ( )

a. A person diagnosed with smallpox, regardless of age, must not attend a private, parochial, charter, or public school as long as the disease is in a communicable form. ( )

b. In the event of an outbreak, the Department or Health District may exclude susceptible children and employees from schools where a case has been identified until adequate immunization is obtained or the threat of further spread is contained under Section 33-512(7), Idaho Code. ( )

07. Restrictions - Working. A person diagnosed with smallpox must not work in any occupation as long as the disease is in a communicable form. ( )

711. -- 719. (RESERVED)

720. STREPTOCOCCUS PYOGENES (GROUP A STREP) INFECTIONS.

01. Reporting Requirements. Each case of *Streptococcus pyogenes* (group A strep) infection that is invasive or results in rheumatic fever or necrotizing fasciitis must be reported to the Department or Health District within three (3) working days of identification. ( )

02. Investigation. Each reported case of *Streptococcus pyogenes* (group A strep) infection that is invasive or results in rheumatic fever or necrotizing fasciitis must be investigated to confirm the diagnosis, to determine if the infection is part of an outbreak, and to identify the source of the infection. ( )

03. Restrictions - Daycare Facility. An infected person must not attend or work in a daycare until twenty-four (24) hours has elapsed after treatment is initiated or until they are no longer infectious as determined by a physician, the Department, or Health District. ( )

04. Restrictions - Health Care Facility. An infected person must not work in a health care facility until twenty-four (24) hours has elapsed after treatment is initiated or until they are no longer infectious as determined by a physician, the Department, or Health District. ( )

05. Restrictions - School. An infected person must not attend or work in a private, parochial, charter, or public school until twenty-four (24) hours has elapsed after treatment is initiated or until the patient is no longer infectious as determined by a physician, the Department, or Health District. ( )

721. -- 729. (RESERVED)

730. SYPHILIS.

01. Reporting Requirements. Each case or suspected case of syphilis must be reported to the Department or Health District within three (3) working days of identification. ( )

02. Investigation. Each reported case of primary, secondary, or early latent syphilis must be investigated by the Department or Health District. Each person diagnosed with primary, secondary, or early latent

infectious syphilis is required to inform all sexual contacts that they may have been exposed to a sexually transmitted infection, or provide sufficient information to public health officials so they may locate contacts and ensure that each is offered prompt diagnosis and treatment under Section 39-605, Idaho Code. ( )

03. Testing Without an Informed Consent. A physician may order blood tests for syphilis when an informed consent is not possible and there has been, or is likely to be, significant exposure to a person's blood or body fluids by a person providing emergency or medical services. ( )

731. -- 739. (RESERVED)

740. TETANUS.

01. Reporting Requirements. Each case of tetanus must be reported to the Department or Health District within three (3) working days of identification. ( )

02. Investigation. Each reported case of tetanus must be investigated to confirm the diagnosis and to determine the immunization status of the case. ( )

741. -- 749. (RESERVED)

750. TOXIC SHOCK SYNDROME.

01. Reporting Requirements. Each case of toxic shock syndrome must be reported to the Department or Health District within three (3) working days of identification. ( )

02. Investigation. Each reported case of toxic shock syndrome must be investigated to obtain specific clinical information on the syndrome and to determine the etiology, risk factors, and means of preventing the syndrome. ( )

751. -- 759. (RESERVED)

760. TRANSMISSIBLE SPONGIFORM ENCEPHALOPATHIES (TSE), INCLUDING CREUTZFELDT-JAKOB DISEASE (CJD) AND VARIANT CJD (VCJD).

01. Reporting Requirements. Each case or suspected case of transmissible spongiform encephalopathy (TSE), including Creutzfeldt-Jakob disease (CJD) and variant CJD (vCJD) must be reported to the Department or Health District within three (3) working days of identification. ( )

02. Investigation. Each reported case of transmissible spongiform encephalopathy (TSE) must be investigated to determine the cause and confirm the diagnosis. ( )

03. Autopsy. The state epidemiologist may order an autopsy for suspected CJD or vCJD deaths as per Section 39-277, Idaho Code. ( )

761. -- 769. (RESERVED)

770. TRICHINOSIS.

01. Reporting Requirements. Each case of trichinosis must be reported to the Department or Health District within three (3) working days of identification. ( )

02. Investigation. Each reported case of trichinosis must be investigated to confirm the diagnosis, identify clusters or outbreaks of the infection, and identify the source of the infection. ( )

03. Handling of Report. The Department will notify the Idaho Department of Agriculture and other regulatory agencies as applicable. ( )

771. -- 779. (RESERVED)

780. TUBERCULOSIS.

01. Reporting Requirements. Each case of tuberculosis must be reported to the Department or Health District within three (3) working days of identification. ( )

02. Investigation. Each reported case of tuberculosis must be investigated to confirm the diagnosis, identify contacts, associated cases, and the source of the infection. ( )

03. Active Pulmonary Tuberculosis - Definition. Tuberculosis disease of the lungs, determined by a physician to be potentially contagious by clinical or bacteriological evidence or by evidence of the spread of the disease to others. Tuberculosis is considered active until cured. ( )

04. Cure of Tuberculosis - Definition. The completion of a course of antituberculosis treatment. ( )

05. Restrictions - Daycare Facility. A person with active pulmonary tuberculosis must not attend or work in any occupation in which they have direct contact or provides personal care to children in a daycare facility, until they are determined to be noninfectious by a licensed physician, the Department, or Health District. ( )

06. Restrictions - Health Care Facility. ( )

a. A person suspected to have pulmonary tuberculosis in a health care facility must be managed under the "Guideline for Isolation Precautions in Hospitals," as incorporated in Section 004 of these rules, until the diagnosis of active pulmonary tuberculosis is excluded by a licensed physician. ( )

b. A person with active pulmonary tuberculosis in a health care facility must be managed under the "Guideline for Isolation Precautions in Hospitals," as incorporated in Section 004 of these rules, until they are determined to be noninfectious by a licensed physician, the infection control committee of the facility, or the Department. ( )

c. A person with active pulmonary tuberculosis must not work in any occupation in which they have direct contact or provides personal care to persons confined to a health care or residential care facility, until they are determined to be noninfectious by a licensed physician, infection control committee of the facility, or the Department. ( )

d. In the event that active pulmonary tuberculosis is diagnosed in an employee, patient, or resident, the health care facility must conduct an investigation to identify contacts. The Department or Health District may assist in the investigation. ( )

07. Restrictions - School. A person with active pulmonary tuberculosis must not attend or work in any occupation in which they have direct contact with students in a private, parochial, charter, or public school until they are determined to be noninfectious by a licensed physician, the Department, or Health District. ( )

08. Restrictions - Household Contacts. Any member of a household, in which there is a case of active pulmonary tuberculosis, must not attend or work in any occupation in which they provide direct supervision of students in a school, personal care to children in a daycare facility or persons confined to a health care facility, or works in a food service facility, until they have been determined to be noninfectious by a licensed physician, the Department, or Health District. ( )

781. -- 789. (RESERVED)

790. TULAREMIA.

01. Reporting Requirements. Each case or suspected case of tularemia must be reported to the Department or Health District immediately, at the time of identification, day or night. ( )

02. Investigation. Each reported case of tularemia must be investigated to confirm the diagnosis and to identify the source of the infection. ( )

03. Handling of Report. The Department will notify the Idaho Department of Agriculture of any identified source or suspected source of the infection. ( )

791. -- 809. (RESERVED)

810. YERSINIOSIS, OTHER THAN PLAGUE.

01. Reporting Requirements. Each case of yersiniosis, other than plague, must be reported to the Department or Health District within three (3) working days of identification. Plague must be reported immediately as described in Section 550 of these rules. ( )

02. Investigation. Each reported case of yersiniosis must be investigated to confirm the diagnosis, identify carriers, and the source of the infection. ( )

03. Restrictions - Food Service Facility. A symptomatic person must be managed under IDAPA 16.02.19, "Idaho Food Code." ( )

811. -- 949. (RESERVED)

DELEGATION OF POWERS AND DUTIES
(Sections 950-999)

950. DELEGATION OF POWERS AND DUTIES.
The Director has the authority to delegate to the Health Districts any of the powers and duties created by these rules under Section 39-414(2), Idaho Code. Any delegation authority will be in writing and signed by both the Director and the Health District Board. ( )

951. -- 999. (RESERVED)

16.02.11 – IMMUNIZATION REQUIREMENTS FOR LICENSED DAYCARE FACILITY ATTENDEES

000. LEGAL AUTHORITY.
The Idaho Legislature has granted to the Idaho Board of Health and Welfare the authority to adopt rules for the administration and enforcement of an immunization program for children attending licensed daycare facilities in Idaho, under Section 39-1118, Idaho Code. ( )

001. TITLE AND SCOPE.

01. Title. These rules are titled IDAPA 16.02.11, "Immunization Requirements for Licensed Daycare Facility Attendees." ( )

02. Scope. These rules contain the legal requirements for the administration and enforcement of an immunization program for children who attend licensed daycare facilities in Idaho. ( )

002. INCORPORATION BY REFERENCE.
The "Recommended Immunization Schedules for Persons Aged 0 Through 18 Years -- United States, 2010," are incorporated by reference for this chapter of rules. Published in the Morbidity and Mortality Weekly Report, January 8, 2010, Vol. 58 (51 and 52), by the Centers for Disease Control and Prevention as recommended by the Advisory Committee on Immunization Practices (ACIP). This document is referred to in this chapter of rules as "ACIP Recommended Schedule." These schedules may be obtained from the Department or viewed online at http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5851a6.htm ( )

003. -- 009. (RESERVED)

010. DEFINITIONS.

01. ACIP. The Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices. ( )

02. Board. The Idaho State Board of Health and Welfare. ( )

03. Board of Medicine. The Idaho State Board of Medicine. ( )

04. Child. A person less than thirteen (13) years of age, as defined in Section 39-1102, Idaho Code. ( )

05. Department. The Idaho Department of Health and Welfare. ( )

06. Director. The Director of the Idaho Department of Health and Welfare, or their designee. ( )

07. Immunization Record. An electronic medical health record, an immunization registry document, or a written immunization certificate confirmed by a licensed health care professional or a physician's representative that states the month, day, and year of each immunization a person has received. ( )

08. Initial Attendance. The first admission of a child to any licensed daycare facility in Idaho. ( )

09. Laboratory Proof. A certificate from a licensed medical laboratory stating the type of test performed, the date of each test and the results, accompanied by a physician's statement indicating the child is immune. Tests performed must meet the requirements in IDAPA 16.02.06, "Quality Assurance for Idaho Clinical Laboratories." ( )

10. Licensed Daycare Facility. Any Idaho daycare facility maintained by an individual, organization, or corporation and licensed by an authorized governmental entity to provide care to children. ( )

11. Licensed Daycare Facility Operator. Any person who owns and operates or is designated by an individual, organization, or corporation to manage the day-to-day operation of a licensed daycare facility described in Subsection 010.10 of this rule. ( )

12. Licensed Health Care Professional. A practitioner, licensed in the State of Idaho by the Board overseeing the practitioner's license, or by a similar body in another state or jurisdiction within the United States. The

practitioner's scope of practice for licensure must allow for the ordering of immunizations and writing of prescriptions, or the practitioner must be under the direction of a licensed physician. Licensed health care professionals who may provide for immunization requirements include: medical doctors, osteopaths, nurse practitioners, physicians' assistants, licensed registered nurses, and pharmacists. Other persons authorized by law to practice any of the healing arts, will not be considered licensed health care professionals for the purposes of this chapter. ( )

13. Parent, Custodian, or Guardian. The legal parent, custodian, or guardian of a child or those with limited power of attorney for the temporary care or custody of a minor child. ( )

14. Physician. A medical doctor or osteopath licensed by the Idaho State Board of Medicine, or by a similar body in another state or jurisdiction within the United States, to practice medicine and surgery, osteopathic medicine and surgery, or osteopathic medicine. ( )

15. Physician's Representative. Any person appointed by or vested with the authority to act on behalf of a physician in matters concerning health. ( )

16. Regulatory Authority. The Director of the Idaho Department of Health and Welfare, or the Director's designee. ( )

011. -- 099. (RESERVED)

100. IMMUNIZATION REQUIREMENTS.
All immunizations listed in Subsections 100.01 through 100.09 of this rule, are required of children who attend licensed daycare facilities. These immunizations must be administered age appropriately according to the "ACIP Recommended Schedule," incorporated by reference in Section 004 of these rules, unless fewer doses are medically recommended by a physician. These recommendations are available from the Department. ( )

01. Diphtheria, Tetanus and A-Cellular Pertussis (DTaP) Vaccine. ( )

02. Polio Vaccine. ( )

03. Measles, Mumps, and Rubella (MMR) Vaccine. ( )

04. Haemophilus Influenza Type B (HIB) Vaccine. ( )

05. Hepatitis B Vaccine. ( )

06. Varicella Vaccine. ( )

07. Pneumococcal Vaccine. ( )

08. Rotavirus Vaccine. ( )

09. Hepatitis A Vaccine. ( )

101. COMPLIANCE.
The parent, custodian, or guardian of a child must comply with the provisions contained in this chapter within fourteen (14) days of initial attendance to any licensed daycare facility in Idaho. ( )

102. EVIDENCE OF IMMUNIZATION STATUS.

01. Immunization Record. Within the deadlines established in Section 101 of these rules, a parent, custodian, or guardian of each child must present to the licensed daycare facility operator an immunization record. ( )

02. Schedule of Intended Immunizations Form. A child who has received at least one (1) dose of

each required vaccine and is currently on schedule for subsequent immunizations may conditionally attend daycare when a schedule of intended immunizations form is provided. The licensed daycare facility operator must have a schedule of intended immunizations form completed by a parent, custodian, or guardian for any child who is not immunized, excepted, or exempted, and who is in the process of receiving, or has been scheduled to receive, the required immunizations. A form provided by the Department, or one similar, must include the following information: ( )

a. Name and date of birth of child; ( )

b. Type, number and dates of scheduled immunizations to be administered; ( )

c. Signature of the parent, custodian, or guardian; and ( )

d. Signature of a licensed health care professional providing care to the child. ( )

103. -- 104. (RESERVED)

105. EXCEPTIONS TO IMMUNIZATION REQUIREMENT.
A child who meets one (1) or more of the following conditions, when supporting documentation is in the possession of the licensed daycare facility operator, will not be required to receive the required immunizations in order to attend the licensed daycare facility. ( )

01. Laboratory Proof. A child who has laboratory proof of immunity to any of the childhood diseases listed in Section 100 of these rules, will not be required to receive the required immunizations for which the child is immune. ( )

02. Disease Diagnosis. A child who has a statement signed by a licensed health care professional stating the child has had varicella (chickenpox) disease diagnosed by a licensed health care professional upon personal examination will not be required to receive the required immunizations for the diagnosed disease. ( )

03. Suspension of Requirement. The Regulatory Authority may temporarily suspend one (1) or more of the immunization requirements listed in Section 100 of these rules, if the Regulatory Authority determines that suspension of the requirement is necessary to address a vaccine shortage or other emergency situation in the state. The Regulatory Authority will suspend a requirement for the length of time needed to remedy the vaccine shortage or emergency situation. ( )

106. -- 109. (RESERVED)

110. EXEMPTIONS TO IMMUNIZATION REQUIREMENT.
When supporting documentation is in the possession of the licensed daycare facility operator, a child who meets one (1) or both of the conditions in Subsections 110.01 and 110.02 of this rule, will be exempt from the required immunizations. ( )

01. Life or Health Endangering Circumstances. A signed statement of a licensed physician that the child's life or health would be endangered if any or all of the required immunizations are administered. ( )

02. Religious or Other Objections. A signed statement of the parent, custodian, or legal guardian that must be either: ( )

a. On a standard Department form or similar form provided by the school; or ( )

b. A signed statement that must include: ( )

i. The name of child and the child's date of birth; and ( )

ii. A statement indicating that the child is exempt from immunization as provided in Section 110 of this rule for religious or other objections; and ( )

iii. The signature of the parent, custodian, or legal guardian. ( )

111. -- 149. (RESERVED)

150. EXCLUSION CRITERIA.

01. Noncompliance. A child meeting any one (1) of the following conditions must be excluded by the licensed daycare facility operator: ( )

a. Has received fewer than the required number of doses of immunizations described in Section 100 of these rules, and does not have the remaining required vaccine doses scheduled; ( )

b. Has failed to continue to receive immunizations as provided on the schedule of intended immunizations form described in Subsection 102.02 of these rules; ( )

c. Has received one (1) or more doses at less than the minimum interval or less than the minimum age as recommended by the ACIP under Section 004 of these rules; ( )

d. Has not received any doses of the required immunization and does not have a valid exception or exemption described in Sections 105 and 110 of these rules; or ( )

e. Has no immunization record on file at the daycare facility. ( )

02. Exempted Children. A child exempted under Section 110 of these rules, may be excluded by the regulatory authority in the event of a disease outbreak under IDAPA 16.02.10, "Idaho Reportable Diseases." ( )

151. -- 199. (RESERVED)

200. DOCUMENTATION AND RETENTION OF IMMUNIZATIONS RECORD BY LICENSED DAYCARE FACILITY OPERATORS.

01. Provision of Information. The licensed daycare facility operator will provide to the parent, custodian, or guardian, information on immunization requirements and the ACIP recommended immunization schedule. ( )

02. Immunization Record Retention. The immunization documentation described in Section 102 of these rules must be retained by the licensed daycare facility for each child as long as the child attends the licensed daycare facility, plus one (1) year after last attendance. ( )

201. -- 299. (RESERVED)

300. INSPECTIONS.

01. Compliance Inspection. The regulatory authority will verify that the immunization record described in Section 010 of these rules, is retained in the licensed daycare facility. ( )

02. Recording of Violation. Following an inspection that reveals a violation of this chapter by a licensed daycare facility, the regulatory authority will record the violations in writing and provide a copy to the licensed daycare facility operator. ( )

03. Response to Violation. The licensed daycare facility operator will submit a written report to the regulatory authority within thirty (30) days following the inspection stating that the specified violations have been corrected. ( )

04. Failure to Respond. The regulatory authority will report in writing to the licensing authority any

violations recorded in Subsection 300.02 of this rule, to which a licensed daycare facility operator has not responded as required by Subsection 300.03 of this rule. ( )

301. -- 309. (RESERVED)

310. ENFORCEMENT OF IMMUNIZATION REQUIREMENT.

01. Enforcement The regulatory authority may exclude any child who does not meet the requirements in this chapter and who has not been excluded from the licensed daycare facility as required in Section 150 of these rules. ( )

02. Length of Exclusion. Any child excluded from a licensed daycare facility in Idaho as required in Subsection 310.01 of this rule, may not be readmitted to the facility until the child is in compliance with the requirements of this chapter. ( )

311. -- 399. (RESERVED)

400. TECHNICAL ASSISTANCE.

01. Random Evaluations. A representative of the Department will randomly select and visit licensed daycare facilities in Idaho to evaluate the facility files for the following: ( )

a. Immunization record described in Section 010 of these rules; ( )

b. Exceptions documentation described in Section 105 of these rules; and ( )

c. Exemption statements described in Section 110 of these rules. ( )

02. Notice of Intent to Review. A representative of the Department will inform licensed daycare facilities selected in Subsection 400.01 of this rule, at least thirty (30) days prior to an intent to review the licensed daycare facilities' documents. ( )

03. Evaluation Results. Information will be provided to the licensed daycare facility about the results of the immunization evaluation described in Subsection 400.01 of this rule, and the recommendations for correcting deficiencies and increasing immunity levels. ( )

401. -- 999. (RESERVED)

000. LEGAL AUTHORITY.
The Idaho Legislature has given the Board of Health and Welfare and the Director of the Department authority to promulgate rules governing the testing of newborn infants for phenylketonuria and other preventable diseases and governing the instillation of an ophthalmic preparation in the eyes of the newborn to prevent Ophthalmia Neonatorum, under Sections 39-906, 39-909, and 39-910, Idaho Code. ( )

001. TITLE AND SCOPE.

01. Title. These rules are titled IDAPA 16.02.12, "Newborn Screening." ( )

02. Scope. These rules specify the tests and procedures that must be performed on newborn infants for early detection of metabolic disorders, endocrine disorders, hemoglobin disorders, cystic fibrosis, critical congenital heart disease, and prevention of infant blindness. ( )

002. INCORPORATION BY REFERENCE.
The Department has incorporated by reference the following documents: ( )

01. Blood Collection on Filter Paper for Newborn Screening Programs; Approved Standard, Fifth Edition. The Department has adopted "Blood Collection on Filter Paper for Newborn Screening Programs; Approved Standard," Fifth Edition, Clinical and Laboratory Standards Institute. 2007 (ISBN 1-56238-644-1), and hereby incorporates this standard by reference. A copy is available for review at the Department, or through the Clinical and Laboratory Standards Institute, 940 West Valley Road, Suite 1400, Wayne, PA 19087-1898, telephone 1-610-688-0100. ( )

02. Critical Congenital Heart Defects (CHDs). The Department has adopted the Critical CHD Screening Methods as recommended by the American Academy of Pediatrics, from "Strategies of Implementing Screening for Critical Congenital Heart Diseases," Kemper, et al., 2011, and hereby incorporates this material by reference. Copies may be obtained from the Department, see online at: https://www.cdc.gov/ncbddd/heartdefects/hcp.html. ( )

003. -- 009. (RESERVED)

010. DEFINITIONS.
The following definitions will apply in the interpretation and enforcement of this chapter: ( )

01. Critical Congenital Heart Disease (CCHD). CCHD, also known as critical congenital heart defects, is a term that refers to a group of serious heart defects, as defined by the Centers for Disease Control and Prevention (CDC), that are present from birth. ( )

02. Department. The Idaho Department of Health and Welfare. ( )

03. Dried Blood Specimen. A blood specimen obtained from an infant by means of skin puncture, not by means of venipuncture or any other method, that is placed on special filter paper and allowed to dry. ( )

04. Hyperalimentation. The administration of an amount of nutrients beyond minimum normal requirements of the appetite, in an attempt to replace nutritional deficiencies. ( )

05. Laboratory. A medical or diagnostic laboratory certified according to the provisions of the Clinical Laboratory Improvement Amendments of 1988 by the United States Department of Health and Human Services. ( )

06. Newborn Screening. Newborn screening means a laboratory procedure performed on dried blood specimens from newborns to detect those at risk for the diseases specified in Subsection 100.01 of these rules. ( )

07. Person Responsible for Registering Birth of Child. The person responsible for preparing and filing the certificate of birth is defined in Section 39-255, Idaho Code. ( )

08. Pulse Oximetry. A non-invasive test that estimates the percentage of hemoglobin in blood that is saturated with oxygen using equipment approved by the U.S. Food and Drug Administration for use with newborn infants. ( )

09. Test Kit. The materials provided by the laboratory for the purposes of dried blood specimen collection and submission of specimens for newborn screening laboratory procedures. ( )

011. -- 049. (RESERVED)

050. USE AND STORAGE OF DRIED BLOOD SPECIMENS.

01. Use of Dried Blood Specimens. Dried blood specimens will be used for the purpose of testing the infant from whom the specimen was taken, for congenital birth defects. Limited use of specimens for routine calibration of newborn screening laboratory equipment and quality assurance is permissible. ( )

02. Prohibited Use of Dried Blood Specimens. Dried blood specimens may not be used for any purpose other than those described in Subsection 050.01 of this rule without the express written consent of the parent(s) or guardian(s) of the infant from whom the specimen was collected. ( )

03. Storage of Dried Blood Specimens. Dried blood specimens may be stored at the testing facility for a period not to exceed eighteen (18) months. Acceptable use of stored specimens will be for re-testing the specimen in the event of a symptomatic diagnosis or death of the infant during the storage period. ( )

051. -- 099. (RESERVED)

100. DUTIES OF THE ADMINISTRATOR OF THE RESPONSIBLE INSTITUTION AND THE PERSON REQUIRED TO REGISTER THE BIRTH OF A CHILD.

01. Conditions for Which Infants Will Be Tested. All infants born in Idaho must be tested for at least the following conditions: ( )

a. Biotinidase deficiency; ( )

b. Congenital hypothyroidism; ( )

c. Galactosemia; ( )

d. Maple syrup urine disease; ( )

e. Phenylketonuria; and ( )

f. Critical congenital heart disease. ( )

02. Blood Specimen Collection. ( )

a. The dried blood specimen collection procedures must follow the document listed in Subsection 004.01 of these rules. ( )

b. For infants admitted to the neonatal intensive care unit (NICU), the initial dried blood specimen for newborn screening must be obtained upon admission to the NICU. ( )

c. For non-premature infants, in-hospital, the initial dried blood specimen for newborn screening must be obtained between twenty-four (24) and forty-eight (48) hours of age. ( )

d. For newborns transferred from one hospital to another, the originating hospital must assure that the dried blood specimen is drawn. If the newborn is too premature or too sick to have a dried blood specimen drawn for screening prior to transfer and a dried blood specimen is not obtained, the originating hospital must document this, and notify the hospital to which the newborn is being transferred that a dried blood specimen for newborn screening has not been obtained. ( )

e. Prior to the discharge of an infant from the institution where initial newborn care or specialized medical care was rendered, the Administrator of the institution must assure that an adequate dried blood specimen has been collected regardless of the time the infant is discharged from the institution. ( )

f. For births occurring outside of a hospital, the birth attendant is responsible for assuring that an acceptable dried blood specimen is properly collected for newborn screening as stipulated in Section 100 of this rule. ( )

g. Newborns who require a blood transfusion, hyperalimentation, or dialysis must have a dried blood specimen collected for screening prior to these procedures. ( )

h. If a dried blood specimen cannot be obtained for newborn screening before transfusion, hyperalimentation, or dialysis, the hospital must ensure that a repeat dried blood specimen is obtained at the appropriate time when the specimen will reflect the infant's own metabolic processes and phenotype. ( )

i. All infants must be retested. A test kit must be given to the parents or responsible party at the time of discharge from the institution where initial newborn care was rendered, with instructions to have a second dried blood specimen collected. The preferred time for sample collection is between ten (10) and fifteen (15) days of age. ( )

03. Specimen Data Card. The person obtaining the newborn screening specimen must complete the demographic information card attached to the sample kit. The First Specimen Card must include the infant's mother's date of birth, address, and phone number. Both the First and Second Specimen's Card must include the items listed in 100.03.a. through 100.03.k. of this rule, optional fields may be completed as needed. ( )

a. Name of the infant; ( )

b. Whether the birth was a single or multiple-infant birth; ( )

c. Name of the infant's mother; ( )

d, Gender of the infant; ( )

e. Method of feeding the infant; ( )

f. Name of the birthing facility; ( )

g. Date and time of the birth; ( )

h. Date and time the specimen was obtained; ( )

i. Name of the attending physician or other attendant; ( )

j. Date specimen was collected; and ( )

k. Name of person collecting the specimen. ( )

04. Specimen Mailing. Within twenty-four (24) hours after collection, the dried blood specimen must be mailed to the laboratory by first class mail or its equivalent, except when mailing service is not available. When mailing service is not available on weekends and holidays, dried blood specimens must be mailed to the laboratory on the first available mail pick-up day. The preferred method of mailing, following a weekend or holiday, is by expedited mail service. ( )

05. Record Keeping. Maintain a record of all dried blood specimens collected for newborn screening. This record must indicate: ( )

a. Name of the infant; ( )

b. Name of the attending physician or other attendant; ( )

c. Date specimen was collected; and ( )

d. Name of person collecting specimen. ( )

06. Collection Protocol. Ensure that a protocol for collection and submission for newborn screening of adequate dried blood specimens has been developed, documented, and implemented. Individual responsibilities must be clearly defined and documented. The attending physician must request that the test be done. The hospital may make an appropriate charge for this service. ( )

07. Responsibility for Recording Specimen Collection. ( )

a. The administrator of the responsible institution, or their designee, must record on the birth certificate whether the dried blood specimen for newborn screening has been collected. ( )

b. When a birth occurs outside a hospital, the person responsible for registering the birth of the child must record on the birth certificate whether the dried blood specimen for newborn screening has been collected and submitted within twenty-four (24) hours following collection. ( )

08. Fees. The Department will provide access to newborn screening laboratory services. If the administration of the responsible institution or the person required to register the birth of a child chooses to utilize this service, the Department will collect a fee equal to the cost of the test kit, analytical, and diagnostic services provided by the laboratory. The fees must be remitted to the Department before the laboratory provides the test kit to those responsible for ensuring the infant is tested according to these rules. ( )

101. -- 199. (RESERVED)

200. LABORATORY DUTIES.

01. Participation in Centers for Disease Control and Prevention (CDC) Newborn Screening Quality Assurance Program. All laboratories receiving dried blood specimens for newborn screening on infants born in Idaho must participate in the Newborn Screening Quality Assurance Program operated by the CDC. ( )

02. Specimen Processing. Dried blood specimens for newborn screening must be processed within twenty-four (24) hours of receipt by the laboratory or before the close of the next business day. ( )

03. Result Notification. Normal test results may be reported by mail to the submitter. Other results must be reported in accordance with Section 300 of these rules. ( )

201. -- 299. (RESERVED)

300. FOLLOW-UP FOR UNSATISFACTORY SPECIMENS, PRESUMPTIVE POSITIVE RESULTS AND POSITIVE CASES.

01. Follow-Up for Unsatisfactory Specimens. ( )

a. The laboratory will immediately report any unsatisfactory dried blood specimens to the submitting institution that originated the dried blood specimen or to the healthcare provider responsible for the newborn's care, with an explanation of the results. The laboratory will request a repeat dried blood specimen for newborn screening from the institution or individual submitting the original sample, or from the responsible provider. ( )

b. Upon notification from the laboratory, the health care provider responsible for the newborn's care at the time of the report will cause another dried blood specimen to be appropriately forwarded to the laboratory for screening. ( )

02. Follow-Up of Presumptive Positive Results. The laboratory will report positive or suspicious results on an infant's dried blood specimen to the attending physician or midwife, or, if there is none or the physician or midwife is unknown, to the person who registered the infant's birth, and make recommendations on the necessity of follow-up testing. ( )

03. Positive Case Notification. Confirmed positive cases of biotinidase deficiency, congenital hypothyroidism, galactosemia, maple syrup urine disease, and phenylketonuria must be reported as described in IDAPA 16.02.10, "Idaho Reportable Diseases." ( )

301. NEWBORN CRITICAL CONGENITAL HEART DISEASE (CCHD) SCREENING.

01. Pulse Oximetry for the Screening of CCHD. ( )

a. For births occurring in a hospital, the administrator of the institution or their designee must assure that all infants who meet the CDC criteria for CCHD screening are screened following the algorithm on the CDC website at: https://www.cdc.gov/ncbddd/heartdefects/hcp.html. ( )

b. For births occurring outside of a hospital, the birth attendant must assure that screening for congenital heart disease is conducted through the use of pulse oximetry no sooner than twenty-four (24) hours after birth and no later than forty-eight (48) hours after birth following the algorithm on the CDC website at: https://www.cdc.gov/ncbddd/heartdefects/hcp.html. ( )

02. Responsibility of Recording CCHD Screening Results. ( )

a. For births occurring in a hospital, the administrator of the responsible institution or their designee must record the pulse oximetry results on the birth certificate and whether the CCHD screening was determined as "passed" or "failed" following the algorithm on the CDC website at: https://www.cdc.gov/ncbddd/heartdefects/hcp.html, or "not screened." ( )

b. For births occurring outside of a hospital, the birth attendant or their designee must record the pulse oximetry results on the birth certificate and whether the CCHD screening was determined as "passed" or "failed" following the algorithm on the CDC website at: https://www.cdc.gov/ncbddd/heartdefects/hcp.html, or "not screened." ( )

03. Follow Up for Abnormal CCHD Screening Results. ( )

a. For births occurring in a hospital, the administrator of the responsible institution or their designee must make a referral for further evaluation of the newborn whose CCHD results are abnormal and inform the parent or legal guardian of the need for appropriate intervention. ( )

b. For births occurring outside of a hospital, the person performing the screening is responsible for making an immediate referral for further evaluation of the newborn whose CCHD results are abnormal and informing the parent or legal guardian of the need for appropriate intervention. ( )

302. -- 399. (RESERVED)

400. SUBSTANCES THAT FULFILL REQUIREMENTS FOR OPHTHALMIC PREPARATION.

Only those germicides proven to be effective in preventing ophthalmia neonatorum and recommended for use in its prevention by the U.S. Department of Health and Human Services (including the U.S. Public Health Service, the Center for Disease Control and Prevention, and the U.S. Food and Drug Administration) will satisfy the requirements established herein, under Section 39-903, Idaho Code. ( )

401. -- 999. (RESERVED)

000. LEGAL AUTHORITY.
The Idaho Legislature has granted to the Board of Health and Welfare, in cooperation with the State Board of Education and the Idaho School Boards Association, the authority to adopt rules for the administration and enforcement of an immunization program for Idaho school children, under Section 39-4801, Idaho Code. ( )

001. TITLE AND SCOPE.

01. Title. These rules are titled IDAPA 16.02.15, "Immunization Requirements for Idaho School Children." ( )

02. Scope. These rules contain the legal requirements for the administration of an immunization program for children enrolled in grades preschool, kindergarten through twelve (12) of any Idaho public, private, or parochial school. ( )

002. INCORPORATION BY REFERENCE.
The "Recommended Immunization Schedules for Persons Aged 0 Through 18 Years -- United States, 2010," are incorporated by reference for this chapter of rules. Published in the Morbidity and Mortality Weekly Report, January 8, 2010, Vol. 58 (51 and 52), by the Centers for Disease Control and Prevention as recommended by the Advisory Committee on Immunization Practices (ACIP). This document is referred to in this chapter of rules as "ACIP Recommended Schedule." These schedules may be obtained from the Department or viewed online at http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5851a6.htm. ( )

003. -- 009. (RESERVED)

010. DEFINITIONS.

01. ACIP. The Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices. ( )

02. Admission. Admission to a public, private or parochial school is: ( )

a. Registration of a child before attendance; or ( )

b. Re-entry of a child after withdrawing from previous enrollment. ( )

c. Transfer of a child from one (1) Idaho school to another or from schools outside Idaho. ( )

03. Child. A minor who is enrolled in preschool, kindergarten through grade twelve (12) in any Idaho public, private, or parochial school. ( )

04. Department. Idaho Department of Health and Welfare. ( )

05 Immunization Record. An electronic medical health record, an immunization registry document, or a written immunization certificate confirmed by a licensed health care professional or a physician's representative which states the month, day, and year of each immunization a person has received. ( )

06. Laboratory Proof. A certificate from a licensed medical laboratory stating the type of test performed, the date of each test, and the results, accompanied by a physician's statement indicating the child is immune. Tests performed must meet the requirements of IDAPA 16.02.06, "Quality Assurance for Idaho Clinical Laboratories." ( )

07. Licensed Health Care Professional. A practitioner, licensed in the State of Idaho by the Board overseeing the practitioner's license, or by a similar body in another state or jurisdiction within the United States. The practitioner's scope of practice for licensure must allow for the ordering of immunizations and writing of prescriptions, or the practitioner must be under the direction of a licensed physician. Licensed health care professionals who may provide for immunization requirements include: medical doctors, osteopaths, nurse practitioners, physicians' assistants, licensed registered nurses, and pharmacists. Other persons authorized by law to practice any of the healing arts, will not be considered licensed health care professionals for the purposes of this chapter. ( )

08. Parent, Custodian, or Guardian. The legal parent, custodian, or guardian of a child or those with

limited power of attorney for the temporary care or custody of a minor child. ( )

09. Physician. A medical doctor or osteopath licensed by the Idaho State Board of Medicine, or by a similar body in another state or jurisdiction within the United States, to practice medicine and surgery, osteopathic medicine and surgery, or osteopathic medicine. ( )

10. Physician's Representative. Any person appointed by, or vested with the authority to act on behalf of a physician in matters concerning health. ( )

11. Preschool. The provision of education for children before the commencement of statutory and obligatory education, differing from traditional daycare in that the emphasis is learning and development rather than enabling parents to work or pursue other activities. Preschools may include, but are not limited to, federally-funded Head Start centers, state-funded preschools, government-funded special education programs, public school preschool programs, and for-profit and not-for profit preschool programs. ( )

12. Private or Parochial School. Any Idaho school maintained by an individual, organization or corporation, not at public expense, and open only to children selected and admitted by the individual, organization or corporation, or to children of a certain class or possessing certain qualifications, which may or may not charge tuition fees. ( )

13. Public School. Any Idaho school maintained at the public expense and open to all children within a given district, including those responsible for the education and training of exceptional children or those schools specially chartered. ( )

14. Regulatory Authority. The Director of the Idaho Department of Health and Welfare or the Director's designee. ( )

15. School Authority. An authorized representative designated by the Board of Trustees of a public school or a person or body designated to act on behalf of the governing body of a private or parochial school. ( )

011. -- 099. (RESERVED)

100. IMMUNIZATION REQUIREMENTS.
All immunizations listed in Subsections 100.01 through 100.05 of this rule, are required of students upon admission to kindergarten through grade twelve (12) of any Idaho public, private, or parochial school. Upon admission to preschool, students must be age appropriately immunized with all immunizations listed in Subsections 100.01 through 100.03 of this rule. Immunizations must be administered according to the "ACIP Recommended Schedule," incorporated by reference in Section 004 of these rules, unless fewer doses are medically recommended by a physician. These recommendations are available from the Department. Exemptions from these immunization requirements are provided in Section 110 of these rules. ( )

01. Student Born on or Before September 1, 1999. A student born on or before September 1, 1999, must meet the following minimum immunization requirements prior to admission for these vaccines: one (1) dose of Measles, Mumps, and Rubella (MMR), four (4) doses of Diphtheria, Tetanus, Pertussis (DTaP), three (3) doses of Polio, and three (3) doses of Hepatitis B. ( )

02. Student After September 1, 1999 Through September 1, 2005. A student born after September 1, 1999, through September 1, 2005, must meet the following minimum immunization requirements prior to admission for these vaccines: two (2) doses of Measles, Mumps, and Rubella (MMR), five (5) doses of Diphtheria, Tetanus, and Pertussis (DTaP), three (3) doses of Polio, and three (3) doses of Hepatitis B. ( )

03. Student After September 1, 2005. A student born after September 1, 2005, must meet the following minimum immunization requirements prior to admission for the following vaccines: two (2) doses of Measles, Mumps, and Rubella (MMR), five (5) doses of Diphtheria, Tetanus, and Pertussis (DTaP), four (4) doses of Polio, three (3) doses of Hepatitis B, two (2) doses of Hepatitis A, and two (2) doses of Varicella. ( )

04. Seventh Grade Immunization Requirements. Effective with the 2011-2012 school year, and each year thereafter, in addition to the required immunizations listed in Section 100.01 through 100.03 of this rule, a student must meet the following minimum immunization requirements prior to admission into the seventh (7th) grade for these vaccines: one (1) dose of Tetanus, Diphtheria, Pertussis Booster (Tdap), and one (1) dose of Meningococcal. This requirement will be extended to: 7th - 8th grade students in 2012, 7th - 9th grade students in 2013, 7th - 10th grade students in 2014, 7th - 11th grade students in 2015, and 7th - 12th grade students in 2016. ( )

05. Twelfth Grade Immunization Requirements. Effective at the start of the 2020-2021 school year, and each year thereafter, in addition to the required immunizations listed in Section 100.01 through 100.04 of this rule, students must meet the following minimum immunization requirements prior to admission into the twelfth (12th) grade: ( )

a. Students who received their first dose of Meningococcal (MenACWY) vaccine before the age of sixteen (16) must have two (2) doses of Meningococcal (MenACWY) vaccine. ( )

b. Students who received their first dose of Meningococcal (MenACWY) vaccine at sixteen (16) years of age and older, or those who have never received a dose, must have one (1) dose of Meningococcal (MenACWY) vaccine. ( )

06. Summary of Immunization Requirements. ( )

a. Immunization requirements.

TABLE 100.06.a. SUMMARY OF IMMUNIZATION REQUIREMENTS

Immunization Requirement*	Student born on or before September 1, 1999	Student born after September 1, 1999, through September 1, 2005	Student born after September 1, 2005
Measles, Mumps, and Rubella (MMR)	1 dose	2 doses	2 doses
Diphtheria, Tetanus, Pertussis	4 doses	5 doses	5 doses
Polio	3 doses	3 doses	4 doses
Hepatitis B	3 doses	3 doses	3 doses
Hepatitis A	0 doses	0 doses	2 doses
Varicella	0 doses	0 doses	2 doses
* Exemptions for immunization requirements are found in Section 110 of these rules.			

( )

b. Seventh grade immunization requirements.

TABLE 100.06.b SUMMARY OF SEVENTH GRADE IMMUNIZATION REQUIREMENTS

Immunization Requirement*	Student admitted to 7th grade prior to 2011-2012 school year	Student admitted to 7th grade during 2011-2012 school year and each year thereafter
Tetanus, Diphtheria, Pertussis (Tdap)	0 doses	1 dose
Meningococcal (MenACWY)	0 doses	1 dose
* Exemptions for immunization requirements are found in Section 110 of these rules.		

( )

c. Twelfth grade immunization requirements.

TABLE 100.06.c. SUMMARY OF TWELFTH GRADE IMMUNIZATION REQUIREMENTS

Immunization Requirement*	Student admitted to 12th grade prior to the 2020-2021 school year	Student admitted to 12th grade during 2020-2021 school year and each year thereafter, if student received their first dose of Meningococcal (MenACWY) vaccine at 16 years of age or older, or if student has never received a dose	Student admitted to 12th grade during 2020-2021 school year and each year thereafter, if student received their first dose of Meningococcal (MenACWY) vaccine before the age of 16
Meningococcal (MenACWY)	1 dose	1 dose	2 doses
* Exemptions for immunization requirements are found in Section 110 of these rules.			

( )

101. COMPLIANCE.
The parent, custodian, or guardian of any student who is to attend any public, private, or parochial school in Idaho must comply with the provisions contained in this chapter at the time of admission and before attendance. ( )

102. EVIDENCE OF IMMUNIZATION STATUS.

01. Immunization Record. Within the deadlines established in Section 101 of these rules, a parent, custodian, or guardian of each student must present to school authorities an immunization record. ( )

02. Schedule of Intended Immunizations Form. A student who has received at least one (1) dose of each required vaccine and is currently on schedule for subsequent immunizations may be conditionally admitted. School authorities, at the time of admission and before attendance, must have a schedule of intended immunizations form completed by a parent, custodian, or guardian for any student who is not immunized, excepted, or exempted, and who is in the process of receiving, or has been scheduled to receive, the required immunizations. A form provided by the Department, or one similar, must include the following information: ( )

a. Name and date of birth of student; ( )

b. School and grade student is enrolled in and attending; ( )

c. Types, numbers, and dates of scheduled immunizations to be administered; ( )

d. Signature of the parent, custodian, or guardian; and ( )

e. Signature of a licensed health care professional providing care to the student. ( )

03. Students Admitted to School and Failing to Continue the Schedule of Intended Immunizations. A student, who does not receive the required immunizations as scheduled in Subsection 102.02 of this rule, will be excluded by school authorities until documentation of the administration of the required immunizations is provided to school authorities by the student's parent, custodian, or guardian. ( )

103. -- 104. (RESERVED)

105. EXCEPTIONS TO IMMUNIZATION REQUIREMENT.
When supporting documentation is in the possession of school authorities at the time of admission and before attendance, a student who meets one (1) or both of the following conditions, will not be required to receive the

required immunizations in order to attend school. ( )

01. Laboratory Proof. Laboratory proof of immunity to any of the childhood diseases listed in Section 100 of these rules, will not be required to receive the immunization for that disease for which the student is immune. ( )

02. Disease Diagnosis. A student who has a statement signed by a licensed health care professional stating that the student has had varicella (chickenpox) disease diagnosed by a licensed health care professional upon personal examination, will not be required to receive the immunization for the diagnosed disease. ( )

03. Suspension of Requirement. The Regulatory Authority may temporarily suspend one (1) or more of the immunization requirements listed in Section 100 of these rules, if the Regulatory Authority determines that suspension of the requirement is necessary to address a vaccine shortage or other emergency situation in the state. The Regulatory Authority will suspend a requirement for the length of time needed to remedy the vaccine shortage or emergency situation. ( )

106. -- 109. (RESERVED)

110. EXEMPTIONS TO IMMUNIZATION REQUIREMENT.
When supporting documentation is in the possession of school authorities, at the time of admission and before attendance, a student who meets one (1) or both of the following conditions in Subsections 110.01 and 110.02 of this rule, will not be required to receive the required immunizations. ( )

01. Life or Health Endangering Circumstances. A signed statement of a licensed physician that the student's life or health would be endangered if any or all of the required immunizations are administered. ( )

02. Religious or Other Objections. A signed statement of the parent, custodian, or legal guardian that must be either: ( )

a. On a standard Department form or similar form provided by the school; or ( )

b. A signed statement that must include: ( )

i. The name of student, and the student's date of birth; and ( )

ii. A statement indicating that the student is exempt from immunization as provided in Section 110 of this rule for religious or other objections; and ( )

iii. The signature of the parent, custodian, or legal guardian. ( )

111. -- 149. (RESERVED)

150. ENFORCEMENT OF IMMUNIZATION REQUIREMENT.

01. Noncompliance. Any student not in compliance with this chapter upon admission to any Idaho public, private, or parochial school, will be denied attendance by school authorities, unless the student is excepted or exempted from these immunization requirements as provided in Sections 105 and 110 of these rules. The regulatory authority may exclude any student who does not meet the requirements in this chapter and who has not been excluded from school. ( )

02. Length of Exclusion. Any student denied attendance in accordance with Subsection 150.01 of this rule, will not be allowed to attend any Idaho public, private or parochial school until the student is in compliance with the requirements of this chapter. ( )

03. Exempted Students. A student exempted under Section 110 of these rules, may be excluded by the regulatory authority in the event of a disease outbreak under IDAPA 16.02.10, "Idaho Reportable Diseases." ( )

151. -- 199. (RESERVED)

200. REPORTS BY SCHOOL AUTHORITIES.

01. Responsibility and Timeliness. School authorities must submit a report of each school's immunization status, by grade, to the Department on or before the first day of November each year. ( )

02. Form and Content of Report. Each school report must include the following information and be submitted on a Department form or electronically: ( )

a. Inclusive dates of reporting period; ( )

b. Name and address of school, school district and county; ( )

c. Grade being reported and total number of students enrolled in the grade; ( )

d. The name and title of the person completing the report form. ( )

e. Number of students who meet all of the required immunizations listed in Section 100 of these rules; ( )

f. Number of students who do not meet all of the required number of immunizations listed by specific immunization type; ( )

g. Number of students who do not meet the immunization requirement, but are in the process of receiving the required immunizations; and ( )

h. Number of students who claimed exemption to the required immunizations as allowed in Section 110 of these rules. ( )

201. -- 999. (RESERVED)

000. LEGAL AUTHORITY.
The State of Idaho Board of Health and Welfare is authorized under Sections 37-121 and 39-1603, Idaho Code, to adopt rules for the regulation of food establishments to protect public health.. ( )

001. TITLE, SCOPE AND APPLICABILITY.

01. Title. These rules are titled IDAPA 16.02.19, "Idaho Food Code." ( )

02. Scope. The purpose of these rules is to establish standards for the provision of safe, unadulterated and honestly presented food for consumption by the public. These rules provide requirements for licensing, inspections, review of plans, employee restriction, and license suspensions for food establishments and food processing plants. Also included are definitions and set standards for management, personnel, food operations, equipment and facilities. ( )

03. These Rules Apply to Food Establishments. Food establishments as defined in Section 39-1602, Idaho Code must follow these rules. Those facilities include but are not limited to the following: ( )

a. Restaurants, catering facilities, taverns, kiosks, vending facilities, commissaries, cafeterias, mobile food facilities, temporary food facilities; and ( )

b. Schools, senior centers, hospitals, residential care and treatment facilities, nursing homes, correctional facilities, camps, food banks, and church facilities; and ( )

c. Retail markets, meat, fish, delicatessen, bakery and supermarkets, convenience stores, health food stores, and neighborhood markets; and ( )

d. Food, water and beverage processing and bottling facilities that manufacture, process and distribute food, water and beverages within the state of Idaho, and are not inspected for food safety by a federal agency. ( )

04. These Rules Do Not Apply to These Establishments. These rules do not apply to the following establishments as exempted in Idaho Code. ( )

a. Agricultural markets as exempted in Section 39-1602, Idaho Code. ( )

b. Bed-and-breakfast operations that prepare and offer food for breakfast only to guests. The number of guest beds must not exceed ten (10) beds as defined in Section 39-1602, Idaho Code.' ( )

c. Day care facilities regulated by Sections 39-1101 through 39-1119, Idaho Code. ( )

d. Licensed outfitters and guides regulated by Sections 36-2101 through 36-2119, Idaho Code. ( )

e. Low-risk food establishments, as exempted in Section 39-1602, Idaho Code, which offer only non-time/temperature control for safety (non-TCS) foods. ( )

f. Farmers market vendors and roadside stands that only offer or sell non-time/temperature control for safety (non-TCS) foods or cottage foods. ( )

g. Non-profit charitable, fraternal, or benevolent organizations that do not prepare or serve food on a regular basis as exempted in Section 39-1602, Idaho Code. Food is not considered to be served on a regular basis if it is not served for more than five (5) consecutive days on no more than three (3) occasions per year for foods which are non-time/temperature control for safety (non-TCS). For all other food, it must not be served more than one (1) meal per week. ( )

h. Private homes where food is prepared or served for family consumption or receives catered or home-delivered food as exempted by Section 39-1602, Idaho Code. ( )

i. Cottage food operations, when the consumer is informed and must be provided contact information for the cottage food operations as follows: ( )

i. By a clearly legible label on the product packaging; or a clearly visible placard at the sales or service location that also states: ( )

ii. The food was prepared in a home kitchen that is not subject to regulation and inspection by the regulatory authority; and ( )

iii. The food may contain allergens. ( )

05. How to Use This Chapter of Rules. The rules in this chapter are modifications, additions or deletions made to the federal publication incorporated by reference in Section 004 of these rules. In order to follow these rules the publication is required. Changes to those standards are listed in this chapter of rules by listing which section of the publication is being modified at the beginning of each section of rule. ( )

002. INCORPORATION BY REFERENCE.
The Department is adopting by reference the "Food Code, 2013 Recommendations of the United States Public Health Service Food and Drug Administration," Publication PB2013-110462. A certified copy of this publication may be reviewed at the main office of the Department of Health and Welfare. It is also available online at http://www.fda.gov/Food/GuidanceRegulation/RetailFoodProtection/FoodCode/ucm374275.htm. This publication is being adopted with modifications and additions as follows: ( )

01. Chapter 1, Purpose and Definitions. Additions and modifications have been made to this chapter. See Sections 100 - 199 of these rules. ( )

02. Chapter 2, Management and Personnel. Modifications have been made to this chapter. See Sections 200 - 299 of these rules. ( )

03. Chapter 3, Food. Modifications have been made to this chapter. See Sections 300-399 of these rules. ( )

04. Chapter 4, Equipment, Utensils, and Linens. This chapter has been adopted with no modifications. ( )

05. Chapter 5, Water, Plumbing and Waste. This chapter has been adopted with no modifications. ( )

06. Chapter 6, Physical Facilities. Modifications have been made to this chapter. See Sections 600-699 of these rules. ( )

07. Chapter 7, Poisonous or Toxic Materials. Modifications have been made in this chapter. See Sections 700 - 799 of these rules. ( )

08. Chapter 8, Compliance and Enforcement. Modifications have been made in this chapter. See Sections 800-899 of these rules. ( )

09. Annexes 1 Through 7 Are Excluded. These sections have not been adopted. ( )

003. -- 005. (RESERVED)

006. CONFIDENTIALITY OF RECORDS AND PUBLIC RECORDS REQUESTS.
Any disclosure of information obtained by the Department is subject to the restrictions in Title 74, Chapter 1, Idaho Code. Restrictions contained in Section 39-610, Idaho Code, and the Idaho Department of Health and Welfare Rules, IDAPA 16.05.01, "Use and Disclosure of Department Records," must also be followed. ( )

01. Contested Hearing and Appeal Records. All contested case hearings are open to the public, unless ordered closed at the discretion of the hearing officer based on compelling circumstances. A party to a hearing must maintain confidentiality of discussions that warrant closing the hearing to the public. ( )

02. Inspection Report. A completed inspection report is a public document and is available for public disclosure to any person who requests the report as provided in Idaho's Public Records Law, Title 74, Chapter 1, Idaho Code. ( )

03. Medical Records. Medical information given to the Department or regulatory authority will be confidential and must follow IDAPA 16.05.01, "Use And Disclosure of Department Records." ( )

04. Plans and Specifications. Plans and specifications submitted to the regulatory authority as required in Chapter 8 of the 2013 Food Code referenced in Section 004 of these rules, must be treated as confidential or trade secret information under Section 74-107, Idaho Code. ( )

007. -- 049. (RESERVED)

050. TRAINING AND INFORMATIONAL MATERIALS.
The Department is authorized under Section 56-1007, Idaho Code, to establish a reasonable charge for training and informational materials that are provided to the public. ( )

051. -- 099. (RESERVED)

100. PURPOSES AND DEFINITIONS.
Sections 100 through 199 of these rules will be used for modifications and additions to Chapter 1 of the 2013 Food Code as incorporated in Section 004 of these rules. ( )

101. -- 109. (RESERVED)

110. DEFINITIONS AND ABBREVIATIONS -- A THROUGH K.
The definitions defined in this section are modifications or additions to the definitions and terms provided in the 2013 Food Code. ( )

01. Agricultural Market. Any venue where a fixed or mobile retail food establishment can engage in the sale of raw or fresh fruits, vegetables, and nuts in the shell. It may also include the sale of factory sealed non-time/temperature control for safety foods (non-TCS). Agricultural market means the same as "farmers market" or "roadside stand." ( )

02. Board. The State of Idaho Board of Health and Welfare as established in Section 56-1005, Idaho Code. ( )

03. Commissary. A commissary is a place where food containers or supplies are stored, prepared, or packaged for transit, sale, or service at other locations. ( )

04. Consent Order. A consent order is an enforceable agreement between the regulatory authority and the license holder to correct violations that caused the actions taken by the regulatory authority. ( )

05. Core Item. Modifications to Section 1-201.10(B) by amending the term "core item" to mean the same as "non-critical item." ( )

06. Cottage Food Operation. A cottage food operation is when a person or business prepares or produces cottage food products in the home kitchen of that person's primary residence or other designated kitchen or location. ( )

07. Cottage Food Product. Cottage food products are non-time/temperature control for safety (non-TCS) foods that are sold directly to a consumer. Examples of cottage foods may include but are not limited to: baked goods, fruit jams and jellies, fruit pies, breads, cakes, pastries and cookies, candies and confections, dried fruits, dry herbs, seasonings and mixtures, cereals, trail mixes and granola, nuts, vinegar, popcorn and popcorn balls, and cotton candy. ( )

08. Critical Item. A provision of this code that if in noncompliance, is more likely than other

violations to contribute to food contamination, illness, or environmental health hazard. A critical item includes items with a quantifiable measure to show control of hazards such as but not limited to, cooking, reheating, cooling, and hand washing. Critical item means the same as "priority item." Critical item is an item that is denoted with a superscript (P), ( )

09. Department. The Idaho Department of Health and Welfare as established in Section 56-1002, Idaho Code. ( )

10. Director. The Director of the Idaho Department of Health and Welfare as established in Section 56-1003, Idaho Code. ( )

11. Embargo. An action taken by the regulatory authority that places a food product or equipment used in food production on hold until a determination is made on the product's safety. ( )

12. Enforcement Inspection. An inspection conducted by the regulatory authority when compliance with these rules by a food establishment is lacking and violations remain uncorrected after the first follow-up inspection to a routine inspection. ( )

13. Farmers Market. Any fixed or mobile retail food establishment at which farmer producers sell agricultural products directly to the general public. Farmers market means the same as "agricultural market" and "roadside stand." ( )

14. Food Establishment. Modifications to Section 1-201.10 amends the definition of "food establishment" as follows: ( )

a. Delete Subparagraph 3(c) of the term "food establishment" in the 2013 Food Code; ( )

b. Add Subparagraph 3(h) to the term "food establishment" to clarify that a cottage food operation is not a food establishment. ( )

15. Food Processing Plant. Modification to Section 1-201.10 amends the definition of "food processing plant" by deleting Subparagraph 2 of the term "food processing plant" in the 2013 Food Code. ( )

16. Good Retail Practice. Good retail practice means the preventive measures that include practices and procedures that effectively control the introduction of pathogens, chemicals, and physical objects into food. ( )

17. High-Risk Food Establishment. A high-risk food establishment does the following operations: ( )

a. Extensive handling of raw ingredients; ( )

b. Preparation processes that include the cooking, cooling and reheating of time/temperature control for safety (TCS) foods; or ( )

c. A variety of processes requiring hot and cold holding of time/temperature control for safety (TCS) foods. ( )

18. Intermittent Food Establishment. An intermittent food establishment is a food vendor that operates for a period of time, not to exceed three (3) days per week, at a single, specified location in conjunction with a recurring event and that offers time/temperature control for safety (TCS) foods to the general public. Examples of a recurring event may be a farmers' or community market, or a holiday market. An intermittent food establishment does not include the vendor of farm fresh ungraded eggs at a recurring event ( )

111. DEFINITIONS AND ABBREVIATIONS -- L THROUGH Z.

The definitions defined in this section are modifications or additions to the definitions and terms provided in the 2013 Food Code. ( )

01. License. The term "license" is used in these rules the same as the term "permit" is used in the 2013 Food Code. ( )

02. License Holder. The term "license holder" is used in these rules the same as the term "permit holder" is used in the 2013 Food Code. ( )

03. Low-Risk Food Establishment. A low-risk food establishment provides factory-sealed pre-packaged non-time/temperature control for safety (non-TCS) foods. The establishment may have limited preparation of non-time/temperature control for safety (non-TCS) foods only. ( )

04. Medium-Risk Food Establishment. A medium-risk food establishment includes the following: ( )

a. A limited menu of one (1) or two (2) items; or ( )

b. Pre-packaged raw ingredients cooked or prepared to order; or ( )

c. Raw ingredients requiring minimal assembly; or ( )

d. Most products are cooked or prepared and served immediately; or ( )

e. Hot and cold holding of time/temperature control for safety (TCS) foods is restricted to single meal service. ( )

05. Mobile Food Establishment. A mobile food establishment is a food establishment selling or serving food for human consumption from any vehicle or other temporary or itinerant station and includes any movable food service establishment, truck, van, trailer, pushcart, bicycle, watercraft, or other movable food service with or without wheels, including hand-carried, portable containers in or on which food or beverage is transported, stored, or prepared for retail sale or given away at temporary locations. ( )

06. Non-Critical Item. A non-critical item is a provision of this Code that is not designated as a critical item or potentially-critical item. A non-critical item includes items that usually relate to general sanitation, operation controls, sanitation standard operating procedures (SSOPs), facilities or structures, equipment design, or general maintenance. Non-critical item means the same as CORE ITEM. ( )

07. Potentially-Critical Item. A potentially-critical item is a provision in this Code whose application supports, facilitates, or enables one (1) or more critical items. Potentially critical item includes an item that requires the purposeful incorporation of specific actions, equipment, or procedures by industry management to attain control of risk factors that contribute to foodborne illness or injury such as personnel training, infrastructure or necessary equipment, HACCP plans, documentation or record keeping, and labeling. Potentially-critical item means the same as priority foundation item. A potentially-critical item is an item that is denoted in this code with a superscript (Pf). ( )

08. Priority Item. Modification to Section 1-201.10(B) by amending the term "priority item" to read priority item means the same as critical item. ( )

09. Priority Foundation Item. Modification to Section 1-201.10(B) by amending the term "priority foundation item" to read priority foundation item means the same as potentially-critical item. ( )

10. Regulatory Authority. The Department or its designee is the regulatory authority authorized to enforce compliance of these rules. ( )

a. The Department is responsible for preparing the rules, rule amendments, standards, policy statements, operational procedures, program assessments and guidelines. ( )

b. The seven (7) Public Health Districts and the Division of Licensing and Certification have been

designated by the Director as the regulatory authority for the purpose of issuing licenses, collecting fees, conducting inspections, reviewing plans, determining compliance with the rules, investigating complaints and illnesses, examining food, embargoing food and enforcing these rules. ( )

11. Risk Control Plan. Is a document describing the specific actions to be taken by the license holder to address and correct a continuing hazard or risk within the food establishment. ( )

12. Risk Factor Violation. Risk factor violation means improper practices or procedures that are most frequently identified by epidemiologic investigation as a cause of foodborne illness or injury. ( )

13. Roadside Stand. Any fixed or mobile retail food establishment at which an individual farmer producer sells own agricultural products directly to consumers. Roadside stand means the same as "agricultural market" and "farmers market." ( )

112. -- 199. (RESERVED)

200. MANAGEMENT AND PERSONNEL.
Sections 200 through 299 of these rules will be used for modifications and additions to Chapter 2 of the 2013 Food Code as incorporated in Section 004 of these rules. ( )

201. ASSIGNMENT OF PERSON IN CHARGE.
Modification to Section 2-101.11. The license holder will be the person in charge or will designate a person in charge and will ensure that a person in charge is present at the food establishment during all hours of food preparation and service. ( )

202. -- 209. (RESERVED)

210. DEMONSTRATION OF KNOWLEDGE.
Modification to Section 2-102.11. The person in charge of a food establishment may demonstrate knowledge on the risks of foodborne illness or health hazards by one (1) of the following. ( )

01. No Critical Violations. Complying with the 2013 Food Code by not having any critical violations at the time of inspection; or ( )

02. Approved Courses. Completion of the Idaho Food Safety and Sanitation Course, or an equivalent course designed to meet the same training as the Idaho Food Safety and Sanitation Course. ( )

03. Certified Food Protection Manager. Modification to Section 2-102.12(A). Beginning July 1, 2018, at least one employee that has supervisory and management responsibility and the authority to direct and control food preparation and service must be a certified food protection manager who has shown proficiency of required information through passing a test that is part of an accredited program. ( )

211. -- 299. (RESERVED)

300. FOOD.
Sections 300 through 399 of these rules will be used for modifications and additions to Chapter 3 of the 2013 Food Code as incorporated in Section 004 of these rules. ( )

301. -- 319. (RESERVED)

320. MEAT AND POULTRY.

01. Custom Meat. Meat that is processed for individual owner(s) by a custom butcher, under the custom exemption in 9 CFR 303.1 "Mandatory Meat Inspection Exemptions," must be marked "Not For Sale" and may not be sold, served or given away to any member of the public. This meat must be for the use in the household of such owner(s), their families, non-paying guest and employees only. ( )

02. Poultry Exemption. Poultry that is exempt in 9 CFR 381.10, Subpart C "Mandatory Poultry Products Inspection Exemptions" may be sold, served or given away in Idaho, if it is processed in a licensed food processing facility and is labeled "Exempt from USDA Inspection per PL 492." ( )

321. -- 324. (RESERVED)

325. GAME ANIMALS.
Modification to Section 3-201.17(A)(4), is made by deleting Section 3-201.17(A)(4) and replacing it with Subsections 325.01 through 325.04 of these rules. ( )

01. Field Dressed Game Animals. Un-inspected wild game animals and wild poultry may be custom processed or prepared and served upon request by an individual having ownership of the animal. Except as allowed in Subsection 325.04 of this rule, un-inspected wild game animals and wild poultry must be processed for or served to that owner and for the family or guests of that individual animal owner only. ( )

02. Processing Game Animals. Game animals and birds are to be completely separated from other food during storage, processing, preparation and service with the use of separate equipment or areas or by scheduling and cleaning, providing there is compliance with the following: ( )

a. Slaughtering and cleaning of game animals or birds can not be done in the food establishment, except for meat processing establishments with kill floors; and ( )

b. Game animals and other animal carcasses are free of any visible dirt, filth, fecal matter or hair before such carcasses enter the food establishment, except for meat processing establishments with kill floors; and ( )

c. An identifying tag with the owner's name must be on each carcass or divided parts and packaged or wrapped parts; and ( )

d. Each carcass or divided parts and packaged or wrapped parts are marked or tagged with a "Not for sale" label. Except as allowed in Subsection 325.04 of this rule, these may not be sold, given away, or served to any members of the public. ( )

03. Un-Inspected Game Animals. Any un-inspected game animals prepared and served in a food establishment may only be prepared and served at the request of the owner of the animals for the owner and invited family or friends at a private dinner. Except as allowed in Subsection 325.04 of this rule, these animals may not be served, sold, or given away to any members of the public. ( )

04. Donated Game Meat. Legally harvested game meat may be donated to a food bank or food pantry when the following conditions are met: ( )

a. The end recipient of the donated game meat signs an acknowledgment statement indicating that he is aware that the meat has been donated and that the meat itself is un-inspected, wild-harvested game meat. ( )

b. The game meat must have been processed by: ( )

i. A facility that is subject to inspection by the regulatory authority with jurisdiction over meat products; ( )

ii. The facility packages the game meat into portions that require no further processing or cutting by the food bank or food pantry; and ( )

c. The meat is labeled by the processor with the following: ( )

i. Species identification; ( )

ii. The name and address of the meat processing facility; and ( )

iii. The words "Processed for Donation or Private Use" and "Cook to 165° F." ( )

326. -- 354. (RESERVED)

355. FOOD PROCESSING PLANTS.
Food processing plants, establishments, canning factories or operations must meet the requirements in Chapters 1 through 8 of the 2013 Food Code, and Subsections 355.01 through 355.07 of this rule. ( )

01. Thermal Processing of Low-Acid Foods. Low-acid food products processed using thermal methods for canning must meet the requirements of 21 CFR 113. ( )

02. Processing of Acidified Foods. Acidified food products must meet the requirements of 21 CFR 114. ( )

03. Bottled Water Processing. Bottled drinking water processed in Idaho must be from a licensed processing facility that meets the requirements of 21 CFR 129. Bottled drinking water must also meet the quality and monitoring requirements in 21 CFR 165. ( )

04. Approval of Process Methods. A variance by the regulatory authority must be approved and granted for specialized processing methods for products listed in Section 3-502.11. ( )

05. Labels. Proposed labels must be submitted to the regulatory authority for review and approval before printing. ( )

06. Testing. The license holder is responsible for chemical, microbiological or extraneous material testing procedures to identify failures or food contamination of food products being processed or manufactured by the license holder. ( )

07. Quality Assurance Program. The license holder or his designated person must develop and submit to the regulatory authority for review and approval a quality assurance program or HACCP plan which covers the food processing operation. The program must include the following: ( )

a. An organization chart identifying the person responsible for quality control operations; ( )

b. A process flow diagram outlining the processing steps from the receipt of the raw materials to the production and packaging of the finished product(s) or group of related products; ( )

c. A list of specific points in the process which are critical control points that have scheduled monitoring; ( )

d. Product codes that establish and identify the production date and batch; ( )

e. A manual covering sanitary maintenance of the facility and hygienic practices to be followed by the employees; and ( )

f. A records system allowing for review and evaluation of all operations including the quality assurance program results. These records must be kept for a period of time that exceeds the shelf life of the product by six (6) months or for two (2) years, whichever is less. ( )

356. -- 359. (RESERVED)

360. ADVISING CONSUMERS OF HEALTH RISK OF RAW OR UNDERCOOKED FOODS.
Modification to Section 3-603.11. ( )

01. Consumption of Animal Foods That Are Raw, Undercooked, or Not Otherwise Processed to Eliminate Pathogens. Except as specified in Section 3-401.11(C) and Subparagraph 3-401.11(D)(3) and under

Section 3-801.11(D), if an animal food such as beef, eggs, fish, lamb, milk, pork, poultry, or shellfish that is raw, undercooked or not otherwise processed to eliminate pathogens is offered in a ready-to-eat form as a deli, menu, vended, or other item; or as a raw ingredient in another ready-to-eat food, the license holder must inform the consumers of health risks. ( )

02. How to Inform Consumers of Health Risk. The license holder must use any effective means to inform consumers of potential health risks. Some effective ways that may be used to inform consumers are: brochures, deli case placards, signs or verbal warnings, that state, "Consuming raw or undercooked meats, poultry, seafood, shellfish, or eggs may increase your risk of foodborne illness, especially if you have certain medical conditions." ( )

361. -- 369. (RESERVED)

370. ADULTERATED OR MISBRANDED FOOD.
The regulatory authority may order the license holder or other person who has custody of misbranded food to destroy, denature or recondition adulterated or misbranded food according to Section 37-118, Idaho Code. See Section 851 of these rules for embargo, tagging, storage and release of adulterated or misbranded food. ( )

371. -- 599. (RESERVED)

600. PHYSICAL FACILITIES.
Sections 600 through 699 of these rules will be used for modifications and additions to Chapter 6 of the 2013 Food Code as incorporated in Section 004 of these rules. ( )

601. -- 619. (RESERVED)

620. PRIVATE HOMES AND LIVING OR SLEEPING QUARTERS, USE PROHIBITION.
Modifications to Section 6-202.111. Except for cottage food operations, a private home, a room used as living or sleeping quarters, or an area directly opening into a room used as living or sleeping quarters may not be used for conducting food establishment operations. Residential care or assisted living facilities designed to be a homelike environment, are exempted from Section 6-202.111. ( )

621. -- 699. (RESERVED)

700. POISONOUS OR TOXIC MATERIALS.
Sections 700 through 799 of these rules will be used for modifications and additions to Chapter 7 of the 2013 Food Code as incorporated in Section 004 of these rules. ( )

701. -- 719. (RESERVED)

720. RESTRICTION AND STORAGE OF MEDICINES.
Modifications to Section 7-207.11. ( )

01. Medicines Allowed in a Food Establishment. Only those medicines that are necessary for the health of employees, patients or residents in a care facility are allowed in a food establishment. Subsection 720.01 does not apply to medicines that are stored or displayed for retail sale. ( )

02. Labeling of Medicines. Medicines that are in a food establishment for the employees, patients or residents use must be labeled as specified under Section 7-101.11 and located to prevent the contamination of food, equipment, utensils, linens, and single-service and single-use articles. ( )

721. REFRIGERATED STORAGE OF MEDICINES.
Modification to Section 7-207.12. Medicines belonging to employees, patients or residents in a care facility that require refrigeration may be stored in a food refrigerator using the following criteria: ( )

01. Medicines Stored in a Leak Proof Container. Medicines must be stored in a package or container and kept inside a covered, leak proof container that is identified as a container for the storage of medicines. ( )

02. Accessibility of Stored Medicines. Medicines will be stored to permit access to self-medicating patients or residents to their individual medication. Authorized staff in a care facility also have access to these medications. ( )

722. -- 799. (RESERVED)

800. COMPLIANCE AND ENFORCEMENT.
Sections 800 through 899 of these rules will be used for modifications and additions to Chapter 8 of the 2013 Food Code as incorporated in Section 004 of these rules. ( )

801. -- 829. (RESERVED)

830. APPLICATION FOR A LICENSE.

01. To Apply for a Food Establishment License. To apply for an Idaho food establishment license, the application and fee is submitted to the "regulatory authority" as defined in Section 111 of these rules. ( )

02. Food License Expiration. The license for an Idaho food establishment expires on December 31st of each year. ( )

03. Renewal of License. A renewal application and a license fee must be submitted to the regulatory authority by December 1st of each year for the next calendar year starting January 1st. ( )

04. Summary Suspension of License. A license may be immediately suspended under Section 831 of these rules. Reinstatement of a license after a summary suspension does not require a new application or fee unless the license is revoked. ( )

05. Revocation of License. When corrections have been made to a food establishment whose license has been revoked under Section 860 of these rules, a new application and fee must be submitted to the regulatory authority. ( )

06. License is Non-Transferable. A license may not be transferred when ownership changes according to Section 8-304.20, of the 2013 Food Code. The new owner must apply for his own license. ( )

831. SUMMARY SUSPENSION OF LICENSE.
The regulatory authority may summarily suspend a license to operate a food establishment when it determines an imminent health hazard exists. ( )

01. Reasons a Summary Suspension May Be Issued. When a food establishment does not follow the principles of food safety, or a foodborne illness is found, or an environmental health hazard exists and public safety cannot be assured by the continued operation of the food establishment, a summary suspension may be issued. The following are some reasons the regulatory authority may determine a summary suspension is necessary: ( )

a. Inspection of the food establishment shows uncorrected critical violations; ( )

b. Examination of food shows the food is unsafe; ( )

c. Review of records shows that proper steps for food safety have not been met; ( )

d. An employee working with food is suspected of having a disease that is communicable through food; or ( )

e. An imminent health hazard exists. ( )

02. Prior Notification Is not Required for a Summary Suspension. Upon providing a written notice of summary suspension to the license holder or person in charge, the regulatory authority may suspend a food

establishment's license without prior warning, notice of hearing, or hearing. ( )

03. Written Notice of Summary Suspension. The regulatory authority must give the license holder or person in charge a written notice when suspending a license. The notice must include the following: ( )

a. The specific reasons or violations the summary suspension is issued for with reference to the specific section of the 2013 Food Code which is in violation; ( )

b. A statement notifying the food establishment its license is suspended and all food operations are to cease immediately; ( )

c. The name and address of the regulatory authority representative to whom a written request for re-inspection can be made and who can certify the reasons for the suspension have been eliminated; ( )

d. A statement notifying the food establishment of its right to an informal hearing with the regulatory authority upon submission of a written request within fifteen (15) days of receiving the summary suspension notice; and ( )

e. A statement informing the food establishment that proceedings for revocation of its license will be initiated by the regulatory authority, if violations are not corrected. ( )

f. The right to appeal to the Department as provided in Section 861 of these rules. ( )

04. Length of Summary Suspension. The suspension will remain in effect until the conditions cited in the notice of suspension no longer exist and their elimination has been confirmed by the regulatory authority during a re-inspection. ( )

05. Re-Inspection of Food Establishment. The regulatory authority will conduct a re-inspection of the food establishment within two (2) working days of receiving a written request stating the condition for the suspension no longer exists. ( )

06. Reinstatement of License. The regulatory authority will immediately reinstate the suspended license if the re-inspection determines the public health hazard no longer exists. The regulatory authority will provide a written notice of reinstatement to the license holder or person in charge. ( )

832. -- 839. (RESERVED)

840. INSPECTIONS AND CORRECTION OF VIOLATIONS.
Modification to Section 8-401.10. ( )

01. Inspection Interval Section 8-401.10(A). Except as specified in Section 8-401.10(C), the regulatory authority must inspect a food establishment at least once a year. ( )

02. Section 8-401.10(B). This section has not been adopted. ( )

03. Section 8-401.10(C). This section is adopted as published. ( )

04. Section 8-405.11. This section is adopted with the following modifications: ( )

a. Delete Section 8-405.11(B)(1); and ( )

b. Amend Section 8-405-11(B)(2) to ten (10) calendar days after the inspection for the permit holder to correct critical or potentially-critical items or HACCP plan deviations. ( )

841. INSPECTION SCORES.
The regulatory authority must provide the license holder an inspection report with a total score indicating the number of risk factor violations and the number of repeat risk factor violations added together. Repeat violations are those observed during the last inspection. The inspection report will also score the total number of good retail practice

violations and the number of repeat good retail practice violations. These scores will be used to determine if a follow-up inspection or a written report of correction is needed to verify corrections have been made. ( )

01. Medium-Risk Food Establishment. If the risk factor violations exceed three (3), or good retail practice violations exceed eight (8), an on-site follow-up inspection is required for verification of correction by the regulatory authority. ( )

02. High-Risk Food Establishment. If the risk factor violations exceed five (5), or good retail practice violations exceed eight (8), an on-site follow-up inspection is required for verification of correction by the regulatory authority. ( )

03. Written Violation Correction Report. A written violation correction report by the license holder may be provided to the regulatory authority if the total inspection score of the food establishment does not exceed those listed in Section 845 of these rules. The report must be mailed within five (5) days of the correction date identified on the inspection report. ( )

842. -- 844. (RESERVED)

845. VERIFICATION AND DOCUMENTATION OF CORRECTION.
In addition to Section 8-405.20 of the 2013 Food Code, the on-site follow-up inspection may not be required for verification of correction if the regulatory authority chooses to accept a written report of correction from the license holder. ( )

01. Written Report of Correction. The regulatory authority may choose to accept a written report of correction from the license holder stating that specific violations have been corrected. The license holder must submit this report to the regulatory authority within five (5) days after the correction date identified on the inspection report. ( )

a. Medium-risk food establishment. If the risk factor violations do not exceed three (3), or the good retail practice violations do not exceed six (6), a follow-up inspection is not required for verification of correction. ( )

b. High-risk food establishment. If the risk factor violations do not exceed five (5), or the good retail practice violations do not exceed eight (8), a follow-up inspection is not required for verification of correction. ( )

02. Risk Control Plan. The regulatory authority may require the development of a risk control plan as verification of correction. The risk control plan must provide documentation on how the license holder will obtain long term correction of critical violations that are repeated violations, including how control will be monitored and who will be responsible. ( )

846. -- 849. (RESERVED)

850. ENFORCEMENT INSPECTIONS.

01. Follow-Up Inspection. If a follow-up inspection reveals that critical, potentially-critical, or non-critical violations identified on a previous inspection have not been corrected or still exist, an enforcement inspection may be made. ( )

02. Written Notice. The license holder will receive written notice on the inspection form of the specific date for an enforcement inspection. This date must be within fifteen (15) days of the current or follow-up inspection. ( )

03. Enforcement Inspections on Consent Order. When a compliance conference results in a consent order and includes a compliance schedule to correct violations without further regulatory action, all inspections by the regulatory authority to satisfy the compliance schedule will be considered enforcement inspections until the next annual inspection. ( )

04. Regulatory Action. If the violations have not been corrected by the date of the enforcement inspection, regulatory action will be initiated to revoke the license issued to the food establishment. ( )

851. ENFORCEMENT PROCEDURES FOR ADULTERATED OR MISBRANDED FOOD.
The regulatory authority may order the license holder or other person who has custody of adulterated or misbranded food to destroy, denature or recondition adulterated or misbranded food according to Section 37-118, Idaho Code. The following procedures apply: ( )

01. Serving an Embargo Order. An embargo order must be served by one (1) of the following ways: ( )

a. Delivered personally to the license holder or person in charge of the food establishment; or ( )

b. Posted at a public entrance to the food establishment, provided a copy of the notice is sent by first-class mail to the license holder or the person in charge of the embargoed food. ( )

02. The Embargo Order Is Effective When Served. The embargo order is effective at the time the notice is delivered to the license holder or person in charge, or when the notice is posted. ( )

03. Tagging Embargoed Food. The regulatory authority must securely place an official tag or label on food or containers identified as food subject to the hold order. ( )

04. Storage of Embargoed Food. The regulatory authority allows storage of food under conditions specified in the embargo order, unless storage is not possible without risk to the public health. The regulatory authority may order immediate destruction of the adulterated or misbranded food for public safety. ( )

05. Removal of Embargo Tag or Label. The removal of the embargo tag, label or other identification from food under embargo must be done by the regulatory authority. ( )

06. Embargo Release. The issue of release and removal of the embargo tag, label or other identification from the suspected food when it is not adulterated or misbranded must be done by the regulatory authority. ( )

852. -- 859. (RESERVED)

860. REVOCATION OF LICENSE.
The regulatory authority may revoke the license issued to a food establishment when the license holder fails to comply with these rules or the operation of the food establishment is a hazard to public health. ( )

01. Reasons a License May Be Revoked. ( )

a. The license holder violates any term or condition in Section 8-304.11 of the 2013 Food Code. ( )

b. Access to the facility is denied or obstructed by an employee, agent, contractor or other representative during the performance of the regulatory authority's duties. It is not necessary for the regulatory authority to seek an inspection order to gain access as permitted in Section 8-402.40 of the 2013 Food Code, before proceeding with revocation. ( )

c. A public health hazard or critical violation remains uncorrected after being identified by the regulatory authority and an enforcement inspection confirms the violation or hazard still exists. See Section 850 of these rules on enforcement inspections. ( )

d. A non-critical violation remains uncorrected after being identified by the regulatory authority and an enforcement inspection confirms the violation still exists. See Section 845 of these rules on verification and

documentation of correction. ( )

e. Failure to comply with any consent order issued after a compliance conference. See Section 861 of these rules on compliance conference. ( )

f. Failure to comply with a regulatory authority's summary suspension order. See Section 831 of these rules on summary suspension of a license. ( )

g. Failure to comply with an embargo order. See Section 851 of these rules on adulterated or misbranded food. ( )

h. Failure to comply with a regulatory authority order issued when an employee is suspected of having a communicable disease. See Chapter 2 of the 2013 Food Code on employee health. ( )

02. Notice to Revoke a License. The regulatory authority must notify the license holder of the food establishment in writing of the intended revocation of the license. See Section 861 of these rules for appeal process. The notice must include Subsections 860.02.a. through 860.02.c. of this rule: ( )

a. The specific reasons and sections of the Idaho Food Code which are in violation and the cause for the revocation; and ( )

b. The right of the license holder to request in writing a compliance conference with the regulatory authority within fifteen (15) days of the notice; and ( )

c. The right of the license holder to appeal in writing to the Department of Health and Welfare. See Subsection 861.02 of these rules. ( )

d. The following is sufficient notification of the license holder's appeal rights: "You have the right to request in writing a compliance conference with (name and address of designated health district official) within fifteen (15) days of the receipt of this notice. You may also appeal the revocation of your license to the Director of the Department of Health and Welfare by filing a written appeal with the Department as provided in IDAPA 16.05.03, "Contested Case Proceeding and Declaratory Rulings," within fifteen (15) days of the receipt of this notice, or if a timely request is made for a compliance conference and the matter is not resolved by a consent order, within five (5) working days following the conclusion of the compliance conference." ( )

03. Effective Date of Revocation. The revocation will be effective fifteen (15) days following the date of service of notice to the license holder, unless an appeal is filed or a timely request for a compliance conference is made. If a compliance conference is requested and the matter is not resolved by a consent order, the revocation will be effective five (5) working days following the end of the conference, unless an appeal is filed with the Director of the Department of Health and Welfare within that time. See Section 861 of these rules for compliance conference, consent order and appeal process. ( )

861. APPEAL PROCESS.

A license holder may appeal a summary suspension, notice of revocation, other action, or failure to act by the regulatory authority which adversely affects the license holder. A summary suspension or other emergency order is not stayed during the appeal process. ( )

01. Compliance Conference. The license holder may request in writing a compliance conference with the regulatory authority within fifteen (15) days of receipt of the notice or action by the regulatory authority. If a timely request for a compliance conference is made, a compliance conference will be scheduled within twenty (20) days and conducted in an informal manner by the regulatory authority. At the compliance conference the license holder may explain the circumstances of the alleged violations and propose a resolution for the matter. ( )

a. If the compliance conference results in an agreement between the license holder and the regulatory authority to remedy circumstances giving rise to the action and to assure future compliance, the agreement must be put in written form and signed by both parties. This written agreement constitutes an enforceable consent order. ( )

b. Unless otherwise specifically stated in the consent order, the agreement will be for the duration of the existing license only. ( )

02. Appeal to the Director. The license holder may appeal in writing to the Director of the Department of Health and Welfare within fifteen (15) days of receipt of the notice of action by the regulatory authority, or if a timely request for a compliance conference was made, within five (5) working days following the completion of the compliance conference. ( )

a. The appeal must be in writing following the procedures in IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings." ( )

b. Procedures on appeal to the Director are governed by IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings." ( )

862. -- 869. (RESERVED)

870. SERVICE OF NOTICE.

01. Service of Notice. A notice is considered properly served by any individual, or organization authorized to serve a civil process notice in any of the following ways: ( )

a. The notice is personally delivered to the license holder, manager or person in charge of the food establishment. ( )

b. The notice is clearly posted at a public entrance to the food establishment and a copy of the notice is also sent by first-class mail to the license holder. ( )

c. The notice is sent to the license holder's last known address by registered or certified mail, or by other public means in which a written acknowledgment of receipt is acquired. ( )

02. Proof of Service. Proof of service is determined when the person delivering the notice signs a certificate stating the notice has been served or posted, or by admission of the signed receipt by the license holder or person in charge of the food establishment. ( )

871. -- 889. (RESERVED)

890. CRIMINAL AND CIVIL PROCEEDINGS.
The regulatory authority may choose to enforce the provisions of these rules and its administrative orders through the courts. ( )

01. Criminal Proceedings. Misdemeanor proceedings to enforce these rules, federal regulations, and the enabling statutes may be instituted as provided in Sections 37-117, 37-119, 37-2103, and 56-1008, Idaho Code. These statutes provide for fines or terms of imprisonment that may be sought through the court of competent jurisdiction. ( )

02. Civil Proceedings. Civil enforcement actions may be commenced and prosecuted in the district court in the county where the alleged violation occurred according to Sections 56-1009 and 56-1010, Idaho Code. The person who is alleged to have violated any statute, rule, federal regulation, license or order may be charged in the court proceeding. This action may be brought to compel compliance with these rules, regulations, license or order for relief or remedies authorized in these rules. ( )

03. Injunctive Relief. In addition to other remedies provided by law, Section 56-1009, Idaho Code, allows for a search warrant to gain access and injunctions to be issued in the name of the state against any person or entity to enjoin them from violating these rules, regulations, statutes or administrative orders. ( )

891. -- 999. (RESERVED)

16.02.23 – INDOOR SMOKING

000. LEGAL AUTHORITY.
Section 39-5508, Idaho Code, authorizes the Director of the Department of Health and Welfare to adopt rules to implement the Idaho Clean Indoor Air Act, Title 39, Chapter 55, Idaho Code. ( )

001. SCOPE.
These rules protect the public health, comfort, environment, the health of employees who work at public places, and the rights of nonsmokers to breathe clean air by prohibiting smoking in public places and at public meetings. ( )

002. -- 009. (RESERVED)

010. DEFINITIONS.
For the purpose of this chapter, the following terms apply. ( )

01. Bar Within a Restaurant. A bar is considered to be "within a restaurant," and cannot allow smoking if it does not meet all of the following requirements and must: ( )

a. Be physically isolated from all parts of the restaurant by solid floor to ceiling walls; ( )

b. Have a separate outside public entrance that is not shared with the restaurant; ( )

c. Not have any windows that can be opened, or doorways connecting it to the restaurant, either directly or through any indoor public place including lobbies, hallways, or passageways that the public uses. The bar may be connected to the restaurant through kitchens, private offices, hallways, or storerooms that are not available for public use; and ( )

d. Not be necessary for restaurant patrons to pass through the bar or any indoor public place connected to the bar to access restrooms or other facilities or accommodations of the restaurant. ( )

02. Bowling Alley or Center. A place of business with at least two (2) bowling lanes on its premises and is operated for public entertainment. ( )

03. Educational Facility. Any room, hall or building used for instruction, or supportive of instruction including: classrooms, libraries, auditoriums, gymnasiums, lounges, study areas, restrooms, halls, registration areas, and bookstores of any private or public preschool, kindergarten, elementary school, junior high or intermediate school, high school, vocational school, college or university. ( )

04. Enclosed. The space between a floor and ceiling designed to be surrounded on all sides at any time by solid walls, windows, or similar structures, not including doors, that extend from the floor to the ceiling. ( )

05. Grocery Store. Any establishment that sells food, at retail, for off-site consumption and is required to be licensed under IDAPA 16.02.19, "Idaho Food Code." ( )

06. Incidental Service of Food. Incidental service of food is only serving food that is low-risk and non-potentially hazardous food as defined in IDAPA 16.02.19, "Idaho Food Code." ( )

07. Proprietor or Person in Charge. Any person, or agent of such person, who ultimately controls, governs, or directs the activities within the public place. The term does not mean the owner of the property unless they ultimately govern, control, or direct the activities within the public place. ( )

08. Public Means of Mass Transportation. Any air, land, or water vehicle used for the transportation of persons for compensation including airplanes, trains, buses, boats, and taxis. The term does not include private, noncommercial vehicles. ( )

09. Tobacco Products. Any substance that contains tobacco including, cigarettes, cigars, pipes, snuff, smoking tobacco, tobacco paper, or smokeless tobacco. It will be presumed that a lighted cigarette, cigar, or pipe contains tobacco as defined in Title 39, Chapter 57, Idaho Code. ( )

011. -- 199. (RESERVED)

200. POSTING OF SIGNS.
Signs must be appropriately sized, conspicuous, legible with letters at least one (1) inch in height, unobscured, and

placed at a height and location easily seen and read by persons entering or within the posted area. Signs may contain information such as the international smoking and no smoking symbols and references to the Idaho Clean Indoor Air Act, Title 39, Chapter 55, Idaho Code. ( )

201. -- 999. (RESERVED)

000. LEGAL AUTHORITY.
The Department is authorized to adopt rules under the "Clandestine Drug Laboratory Cleanup Act," Section 6-2604, Idaho Code. ( )

001. TITLE AND SCOPE.

01. Title. The title of these rules is IDAPA 16.02.24, "Clandestine Drug Laboratory Cleanup." ( )

02. Scope. ( )

a. These rules establish the acceptable processes and technology-based standards for the cleanup of clandestine drug laboratories in Idaho. ( )

b. The rules also establish a program to add and remove residential properties that housed a clandestine drug laboratory from a list maintained by the Department. ( )

002. RIGHT TO APPEAL PROPERTY LISTING.
Appeal of Property Listing. The certification by the reporting law enforcement agency that it is more likely than not that the property has been contaminated through use as a clandestine drug laboratory is prima facie evidence for listing the property on the Clandestine Drug Laboratory Site Property List. ( )

01. Property Owner's Right to Appeal. The property owner listed on the Clandestine Drug Laboratory Site Property List may appeal the listing by filing a written request for hearing with the Administrative Procedures Section, 10th Floor, 450 West State Street, P.O. Box 83720, Boise, ID 83720-0036, within twenty-eight (28) days of the mailing of the notification by the law enforcement agency. ( )

02. Burden of Proof. The burden is on the property owner to show, by a preponderance of evidence, that the property has not been contaminated through use as a clandestine drug laboratory. ( )

003. – 009. (RESERVED)

010. DEFINITIONS.
For the purposes of these rules, the following terms are used as defined below: ( )

01. Certificate of Delisting. A document issued by the Department certifying that a property has met the cleanup standard. ( )

02. Certify. To guarantee as meeting a standard. ( )

03. Chain of Custody. A procedure used to document each person that has had custody or control of an environmental sample from its source to the analytical laboratory, and the date and length of time of possession by each person. ( )

04. Clandestine Drug Laboratory. The area(s) where controlled substances or their immediate precursors, as those terms are defined in Section 37-2701, Idaho Code, have been, or were attempted to be, manufactured, processed, cooked, disposed of, or stored, and all proximate areas that are likely to be contaminated as a result of such manufacturing, processing, cooking, disposing or storing. ( )

05. Clandestine Drug Laboratory Site Property List. The list, maintained by the Department, of properties that have been identified as clandestine drug laboratories. ( )

06. Cleanup Contractor. One (1) or more individuals or commercial entities hired to conduct cleanup in accordance with the requirements of this rule. ( )

07. Cleanup Standard. The technology-based numerical value, established in Section 500 of these rules. ( )

08. Clearance Sampling. Testing conducted by a qualified industrial hygienist to verify that cleanup standards have been met. ( )

09. Contamination or Contaminated. The presence of chemical residues that exceed the cleanup

standard established in Section 500 of these rules. ( )

10. **Delisted**. Removal of a property from the Clandestine Drug Laboratory Site Property List. ( )

11. **Demolish**. To completely tear down and dispose of a structure in compliance with local, state, and federal laws and regulations. ( )

12. **Department**. The Idaho Department of Health and Welfare. ( )

13. **Discrete Sample**. A single sample taken. ( )

14. **Documentation**. Preserving a record of an observation through writings, drawings, photographs, or other appropriate means. ( )

15. **Listed**. Addition of a property to the Clandestine Drug Laboratory Site Property List. ( )

16. **Methamphetamine**. Dextro-methamphetamine, levo-methamphetamine, and any racemic mixture of dextro/levo methamphetamine. ( )

17. **Non-Porous**. Resistant to penetration or saturation of chemical substances. ( )

18. **Porous**. Subject to penetration or saturation by chemical substances. ( )

19. **Qualified Industrial Hygienist**. Must be one (1) of the following: ( )

a. Certified Industrial Hygienist. An individual who is certified in comprehensive practice by the American Board of Industrial Hygiene. ( )

b. Registered Professional Industrial Hygienist™. An individual who is a registered member of the Association of Professional Industrial Hygienists and possesses a baccalaureate degree, issued by an accredited college or university, in industrial hygiene, engineering, chemistry, physics, biology, medicine, or related physical and biological sciences who has a minimum of three (3) years full-time industrial hygiene experience. A completed master's degree in a related physical or biological science, or in a related engineering discipline, may be substituted for one (1) year of the experience requirement; and a similar doctoral degree may be substituted for an additional year of the experience requirement. ( )

20. **Sampling**. A surface sample collected by wiping a sample media on the surface being sampled. ( )

21. **Technology-Based Standard**. A cleanup level based on what is believed to be conservative and protective, while at the same time achievable by currently available technologies. ( )

22. **Vacant**. Being without an occupant for the purposes of habitation or occupancy. ( )

011. -- 099. (RESERVED)

100. POSTING THE CLANDESTINE DRUG LABORATORY SITE.
In accordance with Section 6-2605, Idaho Code, the law enforcement agency having jurisdiction is responsible for posting a property with a sign stating that it has been identified as a clandestine drug laboratory. ( )

101. -- 109. (RESERVED)

110. NOTIFICATION PROCESS.
Once a property has been identified as a clandestine drug laboratory, the law enforcement agency having jurisdiction is responsible for initiating notification to the property owner and the Department within seventy-two (72) hours using the Department-approved form available to law enforcement. ( )

111. -- 119. (RESERVED)

120. RECORD-KEEPING, LISTING, AND DELISTING A PROPERTY.

01. Listing a Property. Upon notification by a law enforcement agency, using the Department approved form, the Department will place the property on a Clandestine Drug Laboratory Site Property List. No property may be listed unless the reporting law enforcement agency certifies, on the approved form, that it is more likely than not that the property has been contaminated through use as a clandestine drug laboratory. The list will be publicly available online at: https://publicdocuments.dhw.idaho.gov/WebLink/DocView.aspx?id=1432&dbid=0&repo=PUBLIC-DOCUMENTS&cr=1. ( )

02. Delisting a Property. When a property is determined by a qualified industrial hygienist to meet the cleanup standard set forth by the Department in these rules, or the property owner submits documentation establishing that the property has been fully and lawfully demolished, the Department will issue the property owner a certificate of delisting. The certificate will include the date the property was listed as a clandestine drug laboratory site and the date the property was delisted. ( )

03. Voluntary Compliance. When a property owner voluntarily reports their property as a clandestine drug laboratory, the property will be placed on the Clandestine Drug Laboratory Site Property List and will be delisted when the requirements of these rules are met. This action will afford the property owner immunity from civil actions as provided in Section 6-2608, Idaho Code. ( )

121. -- 199. (RESERVED)

200. RESPONSIBILITIES OF THE PROPERTY OWNER.
The owner of a listed property must: ( )

01. Ensure the Vacancy of the Listed Property. Ensure the property remains vacant until the property is delisted in accordance with Section 120 of these rules; and ( )

02. Ensure That Cleanup Standards Are Met. ( )

a. Ensure that the property is cleaned up to meet the cleanup standards in Section 500 of these rules and have the analytical results certified by a qualified industrial hygienist; or ( )

b. Ensure that the property is demolished, in lieu of clean up, as provided for in Section 6-2606, Idaho Code. Demolition and removal of materials must be conducted in compliance with applicable local, state, and federal laws and regulations; and ( )

03. Provide the Department With a Written Report. Provide the Department with a written report in accordance with Section 600 of these rules. ( )

201. RESPONSIBILITIES OF THE QUALIFIED INDUSTRIAL HYGIENIST.

01. Conduct Sampling by Qualified Industrial Hygienist. A qualified industrial hygienist must conduct sampling in accordance with Section 400 of these rules and meet the reporting requirements under Section 600 of these rules. ( )

02. Independent Qualified Industrial Hygienist. To prevent any real or potential conflicts of interest, qualified industrial hygienists conducting the sampling must be independent of the company or entity conducting the cleanup or analysis or both. ( )

202. DEPARTMENT LIST OF QUALIFIED INDUSTRIAL HYGIENISTS.
The Department will maintain a list of qualified industrial hygienists on their website is https://healthandwelfare.idaho.gov/health-wellness/environmental-health/clandestine-labs. ( )

203. -- 299. (RESERVED)

300. CLEANUP PROCESS.

01. Cleanup Options for the Property Owner. The property owner may choose to hire a cleanup contractor or conduct the cleanup himself in accordance with all applicable local, state, and federal laws and regulations. Cleanup must be conducted to reduce the concentration of methamphetamine to the standard specified in Section 500 of these rules. ( )

02. Removal of Porous Materials from Property. Porous materials must be removed from the property unless a qualified industrial hygienist certifies that the porous materials may remain on the property. An adequate coating or sealant can be applied to a porous surface as an acceptable cleanup method, if it meets the requirements under Subsection 500.02 of these rules. ( )

301. DISPOSAL OF CLEANUP WASTE.
Waste disposal must be conducted in compliance with applicable local, state, and federal laws and regulations. ( )

302. -- 399. (RESERVED)

400. CLEARANCE SAMPLING REQUIREMENTS.

01. Qualified Industrial Hygienist Required. Sampling must be conducted by a qualified industrial hygienist to verify that cleanup standards have been met. ( )

02. General Sampling Procedures. Sample collection must be conducted according to the following minimum requirements: ( )

a. All sample locations must be photographed, and the photographs included in the final report required under Section 600 of these rules. ( )

b. All sample locations must be shown on a floor plan of the property, and the floor plan included in the final report required under Section 600 of these rules. ( )

c. All samples must be obtained, preserved, and handled in accordance with professional standards for the types of samples and analytical testing to be conducted under the chain of custody protocol. ( )

d. Samples must be analyzed by a laboratory certified by the U.S. Environmental Protection Agency or accredited by the American Industrial Hygiene Association laboratory accreditation program for the analyte being analyzed. ( )

e. All sampling locations must be numerically identified and the numbered sampling locations delineated on the floor plan, visible in photographs, and linked to samples. ( )

f. Standard three inch by three (3x3) inch gauze must be used for all sampling. The gauze must be wetted with analytical grade methanol or isopropanol. Each surface being sampled must be wiped at least five (5) times in two (2) perpendicular directions and the gauze turned onto itself throughout the wiping process. ( )

g. After sampling, the sample must be placed in a new, clean sample container and sealed with a Teflon-lined lid. The sample container must be properly labeled with at least the site or project identification number, date, time, and actual sample location. The sample container must be handled according to professional standards and conducted under the chain of custody protocol. ( )

h. Discrete sampling must be used in areas expected to have the highest levels of contamination, as identified on the Department approved form. A ten (10) centimeter by ten (10) centimeter area (one hundred square centimeters (100 cm^2), or approximately sixteen (16) square inches) must be sampled from non-porous surfaces such as floors, walls, appliances, sinks, or countertops in each room. The sample area must be composed of no fewer than three (3) discrete samples. ( )

i. All other rooms of the property with lowest levels of contamination must be sampled using one (1) discrete sample per room. ( )

j. A ten (10) centimeter by ten (10) centimeter area (one hundred square centimeters (100 cm^2), or approximately sixteen (16) square inches) must be sampled from the ventilation system in a location to be determined by the qualified industrial hygienist. ( )

401. -- 499. (RESERVED)

500. CLEANUP STANDARDS.

01. Cleanup Standard for Methamphetamine. A level of methamphetamine that does not exceed a concentration of point one (0.1) micrograms per one hundred (100) square centimeters (0.1 µg/100 cm^2) as demonstrated by clearance sampling conducted by a qualified industrial hygienist. ( )

02. Cleanup Standard for a Porous Surface. If a porous surface has a level of methamphetamine that does not exceed a concentration of point five (0.5) micrograms per one hundred (100) square centimeters (0.5 µg/100 cm^2) as demonstrated by clearance sampling conducted by a qualified industrial hygienist, an adequate coating or sealant appropriate to the material can be used as a method to meet the cleanup standard under Subsection 500.01 of this rule. ( )

03. Other Cleanup Standards. Standards may be established for the cleanup of other controlled substances found in clandestine drug laboratories on a case by case basis, based on an inventory of chemicals found, and after consultation with the Department, the property owner, law enforcement, and a qualified industrial hygienist. ( )

501. -- 599. (RESERVED)

600. REPORTING REQUIREMENTS.
In order for the property to be delisted, the property owner must provide the Department with an original or certified copy of the final report from the qualified industrial hygienist. The final report must include at least the following information: ( )

01. Property Description. The property description including physical street address (apartment or motel number, if applicable), city, zip code, legal description, ownership, and number and type of structures present. ( )

02. Documentation of Clearance Sampling Procedures. Documentation of sampling procedures in accordance with the requirements under Section 400 of these rules. ( )

03. Laboratory Results. Analytical results from a laboratory as specified in Section 400 of these rules. ( )

04. Qualifications of the Qualified Industrial Hygienist. Qualified industrial hygienist statement of qualifications, including professional certification or documentation. ( )

05. Signed Certification Statement. A signed certification statement as stating: "I certify that the cleanup standard established by the Idaho Department of Health and Welfare has been met as evidenced by testing I conducted." ( )

06. Demolition Documentation. If the property owner chooses to demolish the property, documentation must be provided to the Department showing that the structure was completely and lawfully demolished and disposed of in compliance with local, state, and federal laws and regulations. ( )

601. -- 999. (RESERVED)

000. LEGAL AUTHORITY.
In accordance with Sections 56-202, 56-203, 56-209, 56-239, 56-250, 56-253, 56-255, 56-256 and 56-257, Idaho Code, the Idaho Legislature has authorized the Department of Health and Welfare to adopt and enforce rules for the administration of Title XIX of the Social Security Act (Medicaid), and Title XXI of the Social Security Act. ( )

001. TITLE AND SCOPE.

01. Title. These rules are titled IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children." ( )

02. Scope. These rules provide standards for issuing coverage for Title XIX and Title XXI of the Social Security Act. ( )

002. WRITTEN INTERPRETATIONS.
This agency has written statements that pertain to the interpretation of the rules of this chapter, or to the documentation of compliance with the rules of this chapter. The document is available for public inspection and copying at cost at the Department of Health and Welfare or at any of the Department's Regional Offices. ( )

003. -- 009. (RESERVED)

010. DEFINITIONS (A THROUGH L).
For the purposes of this chapter, the following terms apply. ( )

01. Advanced Payment of Premium Tax Credit. Payment of federal tax credits specified in 26 U.S.C. Part 36B (as added by section 1401 of the Affordable Care Act) which are provided on an advance basis to an eligible individual enrolled in a Qualified Health Plan (QHP) through an exchange in accordance with sections 1402 and 1412 of the Affordable Care Act. ( )

02. Adult. Any individual who has passed the month of his nineteenth birthday. ( )

03. Affordable Care Act. The Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152). ( )

04. Applicant. A person applying for public assistance from the Department, including individuals referred to the Department from a Health Insurance Exchange or Marketplace. ( )

05. Application. An application for benefits including an Application for Assistance (AFA) or other application recognized by the Department, including referrals from a Health Insurance Exchange or Marketplace. ( )

06. Application Date. The date the Application for Assistance (AFA) is received by the Department or by the Health Insurance Exchange or Marketplace electronically, telephonically, in person, or the date the application is postmarked, if mailed. ( )

07. Caretaker Relative. A caretaker relative is a relative of a child by full- or half-blood, adoption, or marriage with whom the child is living and who assumes primary responsibility for the child's care. A caretaker relative includes a child's natural, adoptive, or step parents, grandparents, siblings, aunt, uncle, niece, nephew, or cousin. ( )

08. Child. Any individual from birth through the end of the month of his nineteenth birthday. ( )

09. Citizen. A person having status as a "national of the United States" defined in 8 U.S.C. 1101(a)(22) that includes both citizens of the United States and non-citizen nationals of the United States. ( )

10. Cost-Sharing. A participant payment for a portion of Medicaid service costs such as deductibles, co-insurance, or co-payment amounts. ( )

11. Creditable Health Insurance. Creditable health insurance is coverage that provides benefits for inpatient and outpatient hospital services and physicians' medical and surgical services. Creditable coverage excludes

liability, limited scope dental, vision, specified disease, or other supplemental-type benefits. ( )

12. **Department**. The Idaho Department of Health and Welfare. ( )

13. **Federal Poverty Guidelines (FPG)**. The federal poverty guidelines issued annually by the Department of Health and Human Services (HHS).The Federal Poverty Guidelines (FPG) are available on the U.S. Health and Human Services website at http://aspe.hhs.gov/poverty. ( )

14. **Health Assessment**. Health Assessment is an examination performed by a primary care provider in order to determine the appropriate health plan for a Medicaid-eligible individual. ( )

15. **Health Care Assistance (HCA)**. Health coverage includes Medicaid coverage under Title XIX or Title XXI as well as private health insurance plans purchased with a Premium Tax Credit described in Subsection 010.01 of this rule granted by the Department for persons or families within the State of Idaho. ( )

16. **Health Insurance Premium Program (HIPP)**. The Premium Assistance program in which Title XIX and Title XXI participants may participate. ( )

17. **Health Plan**. A set of health services paid for by Idaho Medicaid, or health insurance coverage obtained through the Health Insurance Exchange or Marketplace. ( )

18. **Health Questionnaire**. A tool used to assist Health and Welfare staff in determining the correct Health Plan for the Medicaid applicant. ( )

19. **Internal Revenue Code**. The federal tax law used to determine eligibility under Title 26 U.S.C. for individual income and self-employment income. ( )

20. **Internal Revenue Service (IRS)**. The U.S. government agency in charge of tax laws. These laws are used to determine income eligibility. The IRS website is at http://www.irs.gov. ( )

21. **Insurance Affordability Programs**. Insurance affordability programs include Title XIX title XXI and all insurance programs available in the Health Insurance Exchange or Marketplace. ( )

22. **Lawfully Present**. An individual who is a qualified non-citizen as described in Section 221 of these rules. ( )

011. DEFINITIONS (M THROUGH Z).
For the purposes of this chapter, the following terms apply. ( )

01. **MAGI-Based Income**. Income calculated using the same financial methodologies used by the IRS to determine modified adjusted gross income for federal tax filers, with the exception that: ( )

a. Educational income is excluded in Section 382 of these rules; ( )

b. Indian monies excluded by federal law are not included in MAGI-based income; ( )

c. Lump sum income is counted only in the month received in Section 384 of these rules; and ( )

d. For Medicaid applicants, MAGI-based income is calculated based on income received in the month of application. ( )

02. **Medicaid**. Idaho's Medical Assistance Program administered by the Department and funded with federal and state funds according to Title XIX of the Social Security Act that provides medical care for eligible individuals. ( )

03. **Modified Adjusted Gross Income (MAGI)**. Modified Adjusted Gross Income (MAGI), is

Adjusted Gross Income as defined by the IRS, plus certain tax-exempt income. ( )

04. **Newborn Deemed Eligible**. A child born to a woman who is eligible for and receiving medical assistance on the date of the child's birth, including during a month of retroactive eligibility for the mother. A child so born is eligible for Medicaid for the first year of his life. ( )

05. **Non-Citizen**. Same as "alien" defined in Section 101(a)(3) of the Immigration and Nationality Act (INA) (8 U.S.C. 1101 (a)(3)), and includes any individual who is not a citizen or national of the United States. ( )

06. **Parent**. For a household with a MAGI-based eligibility determination a parent can be: ( )

a. Natural; ( )

b. Biological; ( )

c. Adoptive; or ( )

d. Step-parent. ( )

07. **Participant**. An individual who is eligible for, and enrolled in, a Health Care Assistance program. ( )

08. **Qualified Hospital**. A qualified hospital has a Memorandum of Understanding (MOU) with the Department, participates as a provider under the Medicaid state plan, may assist individuals in completing and submitting applications for Health coverage, and has not been disqualified from doing presumptive eligibility determinations. ( )

09. **Qualified Non-Citizen**. Same as "qualified alien" defined at 8 U.S. C.164(b) and (c). ( )

10. **Reasonable Opportunity Period**. A period of time allowed for an individual to provide requested proof of citizenship or identity. A reasonable opportunity period extends for ninety (90) days beginning on the 5th day after the notice requesting the proof has been mailed to the applicant. This period may be extended if the Department determines that the individual is making a "good faith" effort to obtain necessary documentation. ( )

11. **Sibling**. For household with MAGI-based eligibility determination: Is a natural or biological, adopted, half- or step-sibling. ( )

12. **Tax Dependent**. A person, who is a related child, or other qualifying relative or person, according to federal IRS standards for whom another individual can claim a deduction for a personal exemption when filing a federal income tax for a taxable year. ( )

13. **Third Party**. Includes a person, institution, corporation, public or private agency that is liable to pay all or part of the medical cost of injury, disease, or disability of a medical assistance participant. ( )

14. **Title XIX**. Title XIX of the Social Security Act, known as Medicaid, is a medical benefits program jointly financed by the federal and state governments and administered by the States. This program pays for medical assistance for certain individuals and families with low income, and for some program types, limited resources. ( )

15. **Title XXI**. Title XXI of the Social Security Act, known as the Children's Health Insurance Program (CHIP), is a federal and state partnership similar to Medicaid, that expands health insurance to targeted, low-income children. ( )

012. -- 099. **(RESERVED)**

APPLICATION REQUIREMENTS
(Sections 100-199)

100. PARTICIPANT RIGHTS.
The participant has rights protected by federal and state laws and Department rules. The Department must inform participants of the following rights during the application process and eligibility reviews. ( )

01. Right to Apply. Any person has the right to apply for any Health Care Assistance program. Applications may be submitted by paper, electronically, fax, or telephonically. Application information must be in a form or format provided by the Department. ( )

02. Right to Hearing. Any participant can request a hearing to contest a Department or Health Insurance Exchange or Marketplace decision under the provisions in IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Ruling." ( )

03. Right to Request Reinstatement of Benefits. Any participant has the right to request reinstatement of benefits until a hearing decision is made if the request for the reinstatement is made before the effective date of the action taken on the notice of decision. Reinstatement pending a hearing decision is not provided in the case of an application denied because an individual did not provide citizenship or identity documentation during a reasonable opportunity period allowed by the Department. ( )

101. -- 110. (RESERVED)

111. SIGNATURES.
An individual who is applying for benefits, receiving benefits, or providing additional information as required by this chapter, may do so with the depiction of the individual's name either handwritten, electronic, or recorded telephonically. Such signature serves as intention to execute or adopt the sound, symbol, or process for the purpose of signing the related record. ( )

112. -- 129. (RESERVED)

130. APPLICATION TIME LIMITS.
Each application must be processed as close to real time as practicable, but not longer than forty-five (45) days, from the date of application, unless prevented by events beyond the Department's control. ( )

131. -- 139. (RESERVED)

140. ELIGIBILITY EFFECTIVE DATES.
Title XIX and Title XXI coverage begins the first day of the application month. Coverage for a newborn is effective the date of birth. ( )

141. -- 149. (RESERVED)

150. RETROACTIVE MEDICAL ASSISTANCE ELIGIBILITY.
Title XIX and Title XXI can begin up to three (3) calendar months before the application month if the participant is eligible during the prior period. Coverage is provided if services that can be paid by Medicaid were received in the prior period. ( )

151. -- 199. (RESERVED)

NON-FINANCIAL REQUIREMENTS
(Sections 200-299)

200. NON-FINANCIAL CRITERIA FOR DETERMINING ELIGIBILITY.
Non-financial criteria are conditions of eligibility, other than income, that must be met before Health Care Assistance can be authorized. ( )

201. -- 209. (RESERVED)

210. RESIDENCY.
The participant must live in Idaho and have no immediate intention of leaving, including an individual who has entered the state to look for work, or who has no permanent, fixed address. ( )

211. -- 219. (RESERVED)

220. U.S. CITIZENSHIP VERIFICATION.

01. Citizenship Verified. Citizenship must be verified through electronic means when available. If an electronic verification is not immediately obtainable, the Department may request documentation from the applicant. The Department will not deny the application for Health Coverage until the applicant has had a reasonable opportunity period to obtain and provide the necessary proof of U. S. citizenship. ( )

02. Benefits During Reasonable Opportunity Period. Benefits are provided during the reasonable opportunity period that is provided to allow the applicant time to obtain and provide documentation to verify U.S. citizenship. No overpayment exists for the reasonable opportunity period if the applicant does not provide necessary documentation during the reasonable opportunity period so that the application results in denial. ( )

221. U.S. CITIZENSHIP AND QUALIFIED NON-CITIZEN REQUIREMENTS.
To be eligible, an individual must be a lawfully present member of one (1) of the following groups: ( )

01. U.S. Citizen. A U.S. Citizen or a "national of the United States." ( )

02. Child Born Outside the U.S. A child born outside the U.S., as defined in Public Law 106-395, is considered a citizen if all of the following conditions are met: ( )

a. At least one (1) parent is a U.S. Citizen. The parent can be a citizen by birth or naturalization. This includes an adoptive parent; ( )

b. The child is residing permanently in the U.S. in the legal and physical custody of a parent who is a U.S. Citizen, and the child does not have IR-4 status; ( )

c. The child is under eighteen (18) years of age; ( )

d. The child is a lawful permanent resident; and ( )

e. If the child is an adoptive child, the child was residing in the U.S. at the time the parent was naturalized and was in the legal and physical custody of the adoptive parent. ( )

03. Full-Time Active Duty U.S. Armed Forces Member. A qualified non-citizen as defined in 8 U.S.C. 1641(b) or (c) who is currently on full-time active duty with the U.S. Army, U.S. Air Force, U.S. Marine Corps, U.S. Navy or U.S. Coast Guard, or a spouse or unmarried dependent child of the U.S. Armed Forces member. ( )

04. Veteran of the U.S. Armed Forces. A qualified non-citizen as defined in 8 U.S.C. 1641(b) or (c) who was honorably discharged from the U.S. Army, U.S. Air Force, U.S. Marine Corps, U.S. Navy, or U.S. Coast Guard for a reason other than their citizenship status, or a spouse, including a surviving spouse who has not remarried, or an unmarried dependent child of the veteran. ( )

05. Non-Citizen Entering the U.S. Before August 22, 1996. A non-citizen who entered the U.S. before August 22, 1996, who is currently a qualified non-citizen as defined in 8 U.S.C. 1641(b) or (c), who remained continuously present in the U.S. until he became a qualified non-citizen. ( )

06. Non-Citizen Entering on or After August 22, 1996. A non-citizen who entered the U.S. on or

after August 22, 1996, and who is: ( )

a. A refugee admitted into the U.S. under 8 U.S.C. 1157, and can be eligible for seven (7) years from the date of entry; ( )

b. An asylee granted asylum into the U.S. under 8 U.S.C. 1158, and can be eligible for seven (7) years from the date asylee status is assigned; ( )

c. An individual whose deportation or removal from the U.S. has been withheld under 8 U.S.C. 1253 or 1231(b)(3) as amended by Section 305(a) of Division C of Public Law 104-208, and can be eligible for seven (7) years from the date deportation or removal was withheld; ( )

d. An Amerasian immigrant admitted into the U.S. under 8 U.S.C. 1612(b)(2)(A)(i)(V), and can be eligible for seven (7) years from the date of entry; or ( )

e. A Cuban or Haitian entrant to the U.S. under Section 501(e) of the Refugee Assistance Act under Section 501(e) of P.L. 96-422 (1980), and can be eligible for seven (7) years from the date of entry. ( )

07. Qualified Non-Citizen Entering on or After August 22, 1996. A qualified non-citizen under 8 U.S.C. 1641(b) or (c), who entered the U.S. on or after August 22, 1996, and who has held a qualified non-citizen status for at least five (5) years. ( )

08. American Indian Born in Canada. An American Indian born in Canada, under 8 U.S.C. 1359. ( )

09. American Indian Born Outside the U.S. An American Indian born outside of the U.S., who is a member of a U.S. federally recognized tribe under 25 U.S.C. 450 b(e). ( )

10. Qualified Non-Citizen Child Receiving Federal Foster Care. A qualified non-citizen child as defined in 8 U.S.C. 1641(b) or (c), and receiving federal foster care assistance. ( )

11. Victim of Severe Form of Trafficking. A victim of a severe form of trafficking in persons, as defined in 22 U.S.C. 7102(13); who meets one (1) of the following: ( )

a. Is under the age of eighteen (18) years; or ( )

b. Is certified by the U.S. Department of Health and Human Services as willing to assist in the investigation and prosecution of a severe form of trafficking in persons; and ( )

i. Has made a bona fide application for a temporary visa under 8 U.S.C. 1104(a)(15)(T), which has not been denied; or ( )

ii. Is remaining in the U.S. to assist the U.S. Attorney General in the prosecution of traffickers in persons. ( )

12. Afghan Special Immigrant. An Afghan special immigrant, as defined in Public Law 110-161, who has special immigration status after December 26, 2007. ( )

13. Iraqi Special Immigrant. An Iraqi special immigrant, as defined in Public Law 110-181, who has special immigration status after January 28, 2008. ( )

14. Individuals not Meeting the Citizenship or Qualified Non-Citizen Requirements. An individual who does not meet the citizenship or qualified non-citizen requirements in Subsections 221.01 through 221.13 of this rule, may be eligible for emergency medical services if he meets all other conditions of eligibility. ( )

222. U.S. CITIZENSHIP AND IDENTITY VERIFICATION REQUIREMENTS.

Any individual who participates in a Title XIX Medicaid or Title XXI CHIP funded program must provide proof of U.S. citizenship and identity unless he has otherwise met the requirements under Section 226 of these rules. ( )

223. DOCUMENTATION OF U.S. CITIZENSHIP.

01. Documents Accepted as Stand-Alone Proof of U.S. Citizenship and Identity. The following documents are accepted as proof of both U.S. citizenship and identity: ( )

a. A U.S. passport or a U.S. passport card, without regard to expiration date as long as the passport or passport card was issued without limitation; ( )

b. A Certificate of Naturalization; ( )

c. A Certificate of U.S. Citizenship. ( )

d. Documented evidence, issued by a federally recognized Indian tribe, including tribes with an international border that identifies: ( )

i. The federally recognized Indian Tribe issuing the document; ( )

ii. The individual by name; ( )

iii. Confirms the individual's membership; and ( )

iv. Enrollment or affiliation with the Tribe. ( )

e. Verification of U.S. citizenship by a federal agency or another state on or after July 1, 2006, no further documentation of U.S. citizenship or identity is required. ( )

02. Documents Accepted as Evidence of U.S. Citizenship. The following documents are accepted as proof of U.S. citizenship if documented proof in Subsection 223.01 of this rule is not available. These documents are not proof of identity and must be used in combination with a least one (1) document listed in Subsection 223.03 or Section 224 of these rules to establish both citizenship and identity. ( )

a. A U.S. birth certificate that shows the individual was born in one (1) of the following: ( )

i. United States' fifty (50) states; ( )

ii. District of Columbia; ( )

iii. Puerto Rico, on or after January 13, 1941; ( )

iv. Guam; ( )

v. U.S. Virgin Islands, on or after January 17, 1917; ( )

vi. America Samoa; ( )

vii. Swain's Island; ( )

viii. Northern Mariana Islands, after November 4, 1986; or ( )

b. A cross match with a state's vital statistics agency that documents birth records. ( )

c. A certification of report of birth issued by the Department of State, Forms DS-1350 or FS-545; ( )

d. A report of birth abroad of a U.S. Citizen, Form FS 240; ( )

e. A U.S. Citizen I.D. card, DHS Form I-197; ( )

f. A Northern Mariana Identification Card; ( )

g. A final adoption decree showing the child's name and U.S. place of birth, or if the adoption is not final, a statement from the state-approved adoption agency that shows the child's name and U.S. place of birth; ( )

h. Evidence of U.S. Civil Service employment before June 1, 1976; ( )

i. An official U.S. Military record showing a U.S. place of birth; ( )

j. Certification of birth abroad, Form FS-545; ( )

k. Verification with the Department of Homeland Security's Systematic Alien Verification for Entitlements (SAVE) database; ( )

l. Evidence of meeting the automatic criteria for U.S. citizenship outlined in the Child Citizenship Act of 2000; ( )

m. Medical records from a hospital, clinic, or doctor, admission papers from nursing facility, skilled care facility, or other institution that indicates a U.S. place of birth: ( )

n. Life, health, or other insurance record that indicates a U.S. place of birth. ( )

o. Officially recorded religious record that indicates a U.S. place of birth; ( )

p. School records, including pre-school, Head Start, and daycare that shows the child’s name and indicates a U.S. place of birth; ( )

q. Federal or state census record that shows U.S. Citizenship or indicates a U.S. place of birth; or ( )

r. When an applicant has none of the documents listed in Subsections 223.02.a. through q. of this rule, an affidavit signed by another individual under the penalty of perjury who can reasonably attest to the applicant’s citizenship, and that contains the applicant’s name, and indicates the date and U.S. place of birth, may be submitted. The affidavit does not need to be notarized. ( )

03. Documents Accepted for Evidence of Identity. The following documents are accepted as proof of identity provided the document has a photograph or other identifying information that includes name, age, sex, race, height, weight, eye color, or address. ( )

a. A driver's license issued by a state or territory. A driver’s license issued by a Canadian government authority is not a valid indicator of identity in the U.S. and cannot be used as evidence of identity. ( )

b. An identity card issued by federal, state, or local government; ( )

c. School identification card; ( )

d. U.S. Military card or draft record; ( )

e. Military dependent's identification card; ( )

f. U. S. Coast Guard Merchant Mariner card; or ( )

g. A finding of identity from a federal or state governmental agency, when the agency has verified and certified the identity of the individual, including public assistance, law enforcement, internal revenue or tax bureau, or corrections agency; ( )

h. A finding of identity from another state benefits agency or program provided that it obtained verification of identity as a criterion of participation; ( )

i. Two (2) documents containing consistent information that corroborates the applicant's identity including: employer identification cards, high school or high school equivalency diplomas, college diplomas, marriage certificates, divorce decrees, property deeds or titles; ( )

j. Identity affidavits are acceptable evidence of identity for individuals living in a residential care facility. ( )

k. When an applicant has none of the specified findings or documents listed in Subsections 223.03.a. through j. of this rule, the applicant may submit an affidavit signed by another individual under the penalty of perjury who can reasonably attest to the applicant's identity. The affidavit must contains the applicant's name, and identifying information to establish identity. The affidavit does not need to be notarized. ( )

224. IDENTITY RULES FOR CHILDREN.
The following additional sources of documentation of identity for children under nineteen (19) years of age may be used: ( )

01. School Records. School records may be used to establish identity, including nursery or day care records. ( )

02. Medical Records. Clinic, hospital, or doctor records may be used to establish identity. ( )

225. ELIGIBILITY FOR APPLICANTS WHO DO NOT PROVIDE U.S. CITIZENSHIP AND IDENTITY DOCUMENTATION.

01. U.S. Citizenship and Identity not Verified. When the Department is unable to obtain verification of U.S. citizenship and identity through electronic means, or the applicant is unable to provide documentation at the time of application, the applicant will have a reasonable opportunity period of ninety (90) days to provide proof of U.S. citizenship and identity. ( )

02. Notice Mailed. The reasonable opportunity period of ninety (90) days to provide needed documentation for proof of U.S. citizenship and identity begins five (5) days after the date the notice requesting the proof of documentation is mailed. ( )

03. Medicaid Benefits. If the applicant meets all other eligibility requirements, Medicaid benefits will be approved pending verification of U.S. citizenship and identity. Medicaid benefits will be denied if the applicant refuses to obtain documentation. ( )

226. INDIVIDUALS CONSIDERED AS MEETING THE U.S. CITIZENSHIP AND IDENTITY DOCUMENTATION REQUIREMENTS.
The individuals listed in Subsections 226.01 through 226.06 of this rule are considered to have met the U.S. citizenship and identity requirements and are not required to provide further documentation. ( )

01. Supplemental Security Income (SSI) Recipients. ( )

02. Social Security Disability Income (SSDI) Recipients. ( )

03. Individuals Entitled or Enrolled in Medicare by SSA. Individuals determined by the SSA to be entitled or enrolled in any part of Medicare. ( )

04. Adoptive or Foster Care Children Receiving Assistance. Adoptive or foster care children receiving under Title IV-B or Title IV-E of the Social Security Act. ( )

05. Individuals Deemed Eligible for Medicaid. A waived newborn under Section 530 of these rules. ( )

06. Individuals Whose Records Match Records of the SSA. Confirmed records of SSA that match and include: ( )

a. Name; ( )

b. Social Security Number; and ( )

c. Declaration of U.S. Citizenship. ( )

227. ASSISTANCE IN OBTAINING DOCUMENTATION.
The Department will provide assistance to individuals who need assistance in securing satisfactory documentary evidence of U.S. citizenship. ( )

228. VERIFICATION OF CITIZENSHIP AND IDENTITY ONE TIME.
Once an individual's U.S. citizenship and identity have been verified, whether through an electronic data match or by provided documentation, changes in eligibility will not require an individual to provide the verification again. If later verification, documentation, or information provides the Department with good cause to question the validity of the individual's U.S. citizenship or identity, the individual may be requested to provide further verification. ( )

229. -- 249. (RESERVED)

250. EMERGENCY MEDICAL CONDITION.
An individual who meets eligibility criteria for a category of assistance but does not meet U.S. citizenship requirements or eligible non-citizen requirements may receive medical assistance under a Title XIX or Title XXI coverage group as follows: ( )

01. Emergency Medical Conditions. An individual not meeting the U.S. citizenship requirement may receive medical services necessary to treat an emergency medical condition, including labor and delivery. Emergency medical conditions have acute symptoms of severity, including severe pain. ( )

02. Determination of Emergency Medical Conditions. The Department determines if a condition meets criteria of an emergency medical condition. ( )

03. Limitation on Medical Assistance. Medical assistance is limited to the period of time established for the emergency medical condition. ( )

04. Documentation Waived. For undocumented individuals with emergency medical conditions, the Social Security Number (SSN) requirement is waived because an SSN cannot be issued. Individuals must be otherwise eligible for Title XIX or XXI. ( )

251. SPONSOR DEEMING.
Income of a legal non-citizen's sponsor and the sponsor's spouse are counted in determining eligibility. ( )

252. SPONSOR RESPONSIBILITY.
Section 213 of the Immigration and Naturalization Act requires that a sponsor signing Form I-864, Affidavit of Support, reimburse the Department for Health Care Assistance benefits paid for a sponsored, qualified non-citizen. ( )

253. -- 269. (RESERVED)

270. SOCIAL SECURITY NUMBER (SSN) REQUIREMENT.

01. SSN Required. An applicant must provide his social security number (SSN), or proof he has applied for an SSN, to the Department before approval of eligibility. If the applicant has more than one (1) SSN, all numbers must be provided. ( )

a. The SSN must be verified by the Social Security Administration (SSA) electronically. When an SSN is unverified, the applicant is not eligible for Health Care Assistance. ( )

b. The Department must notify the applicant in writing if eligibility is being denied or lost for failure to meet the SSN requirement. ( )

02. Application for SSN. The applicant must apply for an SSN, or a duplicate SSN when he cannot provide his SSN to the Department. If the SSN has been applied for, but not issued by the SSA, the Department can not deny, delay, or stop benefits. The Department will help an applicant with required documentation when the applicant applies for an SSN. ( )

03. Failure to Apply for SSN. The applicant may be granted good cause for failure to apply for an SSN if they have a well-established religious objection to applying for an SSN. A well-established religious objection means the applicant: ( )

a. Is a member of a recognized religious sect or division of the sect; and ( )

b. Adheres to the tenets or teachings of the sect, or division of the sect, and for that reason is conscientiously opposed to applying for or using a national identification number. ( )

04. SSN Requirement Waived. An applicant may have the SSN requirement waived when he is: ( )

a. Only eligible for emergency medical services as described in Section 250 of these rules; or ( )

b. A newborn deemed eligible child as described in Section 530 of these rules. ( )

271. -- 279. (RESERVED)

280. GROUP HEALTH PLAN ENROLLMENT.
Title XIX and Title XXI participants must apply for and enroll in a cost-effective group health plan if one is available. A cost-effective health plan is one which has premiums and co-payments at a lower cost than Medicaid would pay for full medical services. Medicaid will pay premiums and other co-payments for plans the Department finds cost-effective. ( )

281. MEDICAL EXCEPTION FOR INMATES.
An inmate can receive Medicaid while they are an inpatient in a medical facility. The inmate must meet all Medicaid eligibility requirements. ( )

282. -- 289. (RESERVED)

290. ASSIGNMENT OF RIGHTS TO MEDICAL SUPPORT AND THIRD PARTY LIABILITY.
By operation of Sections 56-203B and 56-209b(3), Idaho Code, medical support rights are assigned to the Department by signature on the application for assistance. The participant must cooperate to secure medical support from any liable third party. The cooperation requirement may be waived if the participant has good cause for not cooperating. ( )

291. MEDICAL SUPPORT COOPERATION.
A Medicaid participant responsible for assigning their rights to medical support must cooperate to identify and locate the noncustodial parent, establish paternity, and establish, modify, and enforce a medical support order. ( )

01. Cooperation Defined. Cooperation includes providing all information to identify and locate the non-custodial parent, and identifying other liable third party payers. The participant must provide the first and last name of the non-custodial parent. The participant must also provide at least two (2) of the following pieces of information about the non-custodial parent: ( )

a. Birth date; ( )

b. Social Security Number; ( )

c. Current address; ( )

d. Current phone number; ( )

e. Current employer; ( )

f. Make, model, and license number of any motor vehicle owned by the non-custodial parent; or ( )

g. Names, phone numbers, and addresses of the parents of the non-custodial parent. ( )

02. Good Cause Defined. The participant may claim good cause for failure to cooperate in securing medical support for a minor child. Good cause is limited to the following reasons: ( )

a. There is proof the child was conceived as a result of incest or rape; ( )

b. There is proof the child's non-custodial parent may inflict physical or emotional harm to the participant, the child, the custodial parent, or the caretaker relative; ( )

c. A credible explanation is provided showing the participant cannot provide the minimum information regarding the non-custodial parent; or ( )

d. A participant who has good cause for not cooperating as described in Subsection 291.03.b of this rule. ( )

03. Conditions for Non-Denial of Medicaid. Medicaid cannot be denied for individuals who meet one (1) of the following conditions: ( )

a. A child or unmarried minor child who cannot legally assign his rights to medical support; or ( )

b. A pregnant woman whose income is at or below the federal poverty guideline, and who does not cooperate in establishing paternity and obtaining medical support from, or derived from, the father of the unborn child. ( )

292. -- 295. (RESERVED)

296. COOPERATION WITH THE QUALITY CONTROL PROCESS.
When the Department or federal government selects a case for review in the quality control process, the participant must cooperate in the review of the case. ( )

297. -- 299. (RESERVED)

FINANCIAL REQUIREMENTS
(Sections 300-344)

300. HOUSEHOLD COMPOSITION AND FINANCIAL RESPONSIBILITY.
Household composition and financial responsibility are divided into two categories: tax-filing and non-tax filing

households. ( )

301. TAX FILING HOUSEHOLD.

01. Taxpayers. For an individual filing a federal tax return for the taxable year in which an initial determination or redetermination of eligibility is made, and who is not claimed as a tax dependent by another taxpayer, the tax filing household consists of the taxpayer, the taxpayer's spouse, and the taxpayer's tax dependents. ( )

02. Individuals Claimed as a Tax-Dependent. For an individual who is claimed as a tax dependent by another taxpayer, the tax filing household is the household of the taxpayer claiming such individual as a tax dependent, with the exception that tax dependents meeting any of the following criteria will be treated as non-filers described in Section 302 of these rules: ( )

a. Individuals claimed as a tax dependent by an individual other than a spouse or custodial parent; ( )

b. Individuals under age nineteen (19) living with both parents, if the parents are not married, or married filing separately; and ( )

c. Individuals under age nineteen (19) claimed as a tax dependent by a parent residing outside of the applicant household. ( )

03. Married Couples. For married couples living together, each spouse is included in the household of the other spouse, regardless of whether a joint federal tax return is filed, if one (1) spouse is claimed as a tax dependent by the other spouse, or if each filed separately. ( )

302. NON-TAX FILING HOUSEHOLD.

01. Individuals Not Filing a Tax Return and Not Claimed as a Tax Dependent. For an individual who does not expect to file a federal tax return and is not claimed as a tax dependent by a tax filer, or meets one (1) of the exceptions in Subsections 301.02.a. through 301.02.c. of these rules, the household consists of the individual and, if living with the individual the following: ( )

a. The individual's spouse; ( )

b. The individual's natural, adopted, and stepchildren under age nineteen (19); or ( )

c. In the case of individuals under age nineteen (19), the individual's natural, adopted, and step parents and natural, adoptive and step siblings under age nineteen (19). ( )

02. Married Couples. Married couples living together will be included in the household of the other spouse. ( )

303. -- 344. (RESERVED)

INCOME
(Sections 345-394)

345. HOUSEHOLD INCOME.
The sum of calculated Modified Adjusted Gross Income (MAGI-based income) of every individual whose income must be included in the household budget minus a standard disregard in the amount of five percent (5%) of Federal Poverty Guidelines (FPG) by family size, if the disregard is used to establish eligibility. ( )

346. DETERMINING INCOME ELIGIBILITY.
Financial eligibility for Medicaid applicants must be based on calculated monthly household income and household size. Eligibility for Health Care Assistance is determined by comparing the individual's calculated income against the

income limit. ( )

347. EARNED INCOME.
Earned income is derived from labor or active participation in a business. Earned income includes taxable wages, tips, salary, commissions, bonuses, self-employment and any other type of income defined as earnings by the Internal Revenue Service (IRS). Earned income is counted as income when it is received, or would have been received except for the decision of the participant to postpone receipt. Earnings over a period of time and paid at one (1) time, such as the sale of farm crops, livestock, or poultry are annualized and IRS allowable self-employment expenses deducted. ( )

348. DEPENDENT CHILD'S EARNED INCOME.
A dependent child's earned income is excluded, unless the child is required to file a tax return based on his own income. ( )

349. (RESERVED)

350. IN-KIND INCOME.
An individual who receives a service, benefit, or durable goods instead of wages is earning in-kind income. In-kind income is excluded. ( )

351. SELF-EMPLOYMENT EARNED INCOME.
Income from self-employment is treated as earned income. Calculated self-employment income is the taxable self-employment income after gross receipts and the IRS allowable costs of producing the self-employment income, when the self-employment is expected to continue as provided in Title 26, U.S.C. ( )

352. -- 369. (RESERVED)

370. UNEARNED INCOME.
Unearned income is any income the individual receives that is not gained through employment. Unearned income is not excluded income if it is taxable. ( )

371. – 383. (RESERVED)

384. LUMP SUM INCOME.
A non-recurring lump sum payment is income in the month the lump sum is received. Lump sum income is a retroactive monthly benefit or a windfall payment. The lump sum may be earned or unearned income that is paid in a single sum. Lump sum income includes retirement, survivors, and disability insurance (RSDI), severance pay, disability insurance, and lottery winnings. ( )

385. -- 387. (RESERVED)

388. DEPENDENT CHILD'S UNEARNED INCOME.
A child's unearned income is countable towards his household's eligibility, only when the child must file a tax return based on his own income. ( )

389. -- 394. (RESERVED)

DISREGARDS
(Section 395-399)

395. INCOME DISREGARDS.
A standard disregard in the amount of five percent (5%) of Federal Poverty Guidelines (FPG) by family size is applied to the calculated income of an individual in those situations where the application of the disregard is necessary in order for the individual to be eligible for the highest income limit Health Care coverage for which they may be eligible. ( )

396. -- 399. (RESERVED)

HEALTH COVERAGE FOR ADULTS
(Sections 400-499)

400. MEDICAID FOR ADULTS.
Medicaid is available for the following adults: ( )

01. Parent, Caretaker Relative, or a Pregnant Woman. ( )

a. The individual who is a parent, caretaker relative, or a pregnant woman in the household budget unit. ( )

b. The individual who is responsible for an eligible dependent child, which includes the unborn child of a pregnant woman. ( )

c. The individual who lives in the same household with the eligible dependent child. ( )

02. Adults Under Age 65. The individual must: ( )

a. Be age nineteen (19) or older and under age sixty-five (65); ( )

b. Not entitled to or enrolled in Medicare Part A or Part B; and. ( )

c. Not otherwise eligible for any other coverage under the State Plan. ( )

03. MAGI Income Eligibility. For any of the eligibility groups described in Subsections 400.01 and 02, the individual must meet all income requirements of the Medicaid program for eligibility determined according to MAGI methodologies identified in Sections 300 through 303, and 411 of these rules. Eligibility is based on: ( )

a. The number of members included in the household budget unit; ( )

b. All countable income for the household budget unit; and ( )

c. Eligible individuals will have income calculated using their modified adjusted gross income (MAGI). Individuals with MAGI not greater than one hundred thirty-three per cent (133%) after applying a five per cent (5%) disregard to income are eligible to receive Medicaid in this section. ( )

04. Member of More Than One Budget Unit. No person may receive benefits in more than one (1) budget unit during the same month. ( )

05. More Than One Medicaid Budget Unit in Home. If there is more than one (1) Medicaid budget unit in a home, each budget unit is considered a separate unit. ( )

401. -- 410. (RESERVED)

411. INCOME LIMITS FOR PARENTS AND CARETAKER RELATIVES.
The income limits are based on the number of household budget unit members. Parents and caretaker relatives, whose MAGI-based income does not exceed the guidelines listed in the table below for their household size, meet the income limit for parent and caretaker relative Medicaid.

TABLE 411 INCOME LIMITS	
Number of Household Members	**Income Limit**
1	$233
2	$289
3	$365
4	$439
5	$515
6	$590
7	$666
8	$741
9	$816
10	$982
Over 10 Persons	Add $75 Each

( )

412. -- 418. (RESERVED)

419. TRANSITIONAL MEDICAID FOR ADULTS.
Participants who no longer qualify for Medicaid due to an increase in earned income or working hours are eligible for an additional twelve (12) months of Medicaid. Participants must have been eligible for Medicaid during at least three (3) of the six (6) months immediately preceding the month in which the participant became ineligible. ( )

420. EXTENDED MEDICAID FOR SPOUSAL SUPPORT INCREASE.
Participants are eligible for four (4) calendar months of Extended Medicaid if an increase in the participant's spousal support causes them to exceed the income limit for their household budget unit size. The participant must have received Medicaid in Idaho in at least three (3) of the six (6) months before the month the participant became income ineligible. ( )

421. PREGNANT WOMAN INELIGIBLE BECAUSE OF EXCESS INCOME.
A pregnant woman who receives health care assistance and becomes ineligible because of an increase in income will continue to receive coverage through the end of the month in which the sixtieth day of her postpartum period falls. ( )

422. -- 519. (RESERVED)

HEALTH COVERAGE FOR CHILDREN
(Sections 520-529)

520. FINANCIAL ELIGIBILITY.
Children are eligible for Health Care Assistance when the household's total MAGI-Based income minus a standard disregard in the amount of five percent (5%) of Federal Poverty Guidelines (FPG) by family size is less than or equal to the applicable income limit for the age of the child. ( )

01. Title XIX Income Limit. For children age zero (0) to six (6), Title XIX income limit is one hundred forty-two percent (142%) of the FPG for the household size. For children age six (6) through age eighteen (18) the income limit is one hundred thirty three percent (133%) of the FPG for the household size. ( )

02. Title XXI Income Limit. For children age zero to six (0-6), Title XXI income limit is between one hundred forty-two percent (142%) and one hundred eighty-five percent (185%) of the FPG for the household size. For children ages six (6) through eighteen (18) the income limit is between one hundred thirty-three percent (133%) and one hundred eighty five percent (185%) of the FPG for the household size. ( )

03. Disregard Applied. A standard disregard in the amount of five percent (5%) of Federal Poverty Guidelines (FPG) by family size is applied to the calculated income used to establish the child's eligibility when applying the disregard is necessary for the child to be financially eligible. ( )

521. HOUSEHOLD SIZE AND FINANCIAL RESPONSIBILITY.
Household size and financial responsibility for health coverage for children is determined using the methodology described in Section 300 of these rules. ( )

522. (RESERVED)

523. ACCESS TO OR COVERAGE UNDER OTHER HEALTH PLANS.
A child is ineligible for coverage under the CHIP plan if they have access to or are enrolled in other health coverage plans as described below: ( )

01. Covered by Creditable Health Insurance. The child is covered by creditable health insurance at the time of application. ( )

02. Eligible for Title XIX. The child is eligible under Idaho's Title XIX State Plan. ( )

03. Idaho State Employee Benefit Plan. The child is eligible to receive health insurance benefits under Idaho's State employee benefit plan. ( )

524. CONTINUOUS HEALTH CARE ASSISTANCE ELIGIBILITY FOR CHILDREN UNDER AGE NINETEEN.
Children under age nineteen (19), who are found eligible for health coverage in an initial determination or at renewal, remain eligible for a period of twelve (12) months. The twelve (12) month continuous eligibility period does not apply if, for any reason, eligibility was determined incorrectly. ( )

01. Reasons Continuous Eligibility Ends. Continuous eligibility for children ends for one (1) of the following reasons: ( )

a. The child is no longer an Idaho resident; ( )

b. The child dies; ( )

c. The participant requests closure; or ( )

d. The child turns nineteen (19) years of age as defined in Subsection 010.05 of these rules. ( )

02. Children Not Eligible for Continuous Eligibility. Children are not eligible for continuous eligibility for one (1) of the following reasons: ( )

a. A child is approved for emergency medical services; or ( )

b. A child is approved for pregnancy-related services. ( )

525. FORMER FOSTER CHILD.
An individual who is between the age of eighteen (18) and twenty-six (26), who was in foster care in Idaho and became ineligible for Medicaid as a foster child due to age, may receive Medicaid coverage until his twenty-sixth birthday. There are no financial eligibility criteria. The only non-financial criteria are the receipt of foster care services and age. ( )

526. -- 529. (RESERVED)

SPECIAL CIRCUMSTANCES FOR CHILDREN (Sections 530-549)

530. NEWBORN CHILD DEEMED ELIGIBLE FOR MEDICAID.
A child is deemed eligible for Medicaid for his first year of life when the following exists. ( )

01. Mother Filing an Application. The child is born to a mother who files an application for medical assistance. ( )

02. Mother Is Eligible for Medicaid. The mother is eligible for Medicaid in the newborn's birth month, including a month of retroactive coverage. This includes a mother who qualifies for coverage only for the delivery because of her alien status. ( )

531. MINOR PARENT LIVING WITH PARENTS.
A minor parent is a child under the age of eighteen (18) who is pregnant or has a child. Minor parents who live with their parents may be eligible for Health Care Assistance for themselves and their children. The minor parent's eligibility is determined according to the Section 300 of these rules related to tax filing households. ( )

532. RESIDENT OF AN ELIGIBLE INSTITUTION.
A resident of an eligible institution must meet all nonfinancial and financial criteria of Title XIX, Title XXI, or any other applicable program. ( )

533. CHILDREN WITH SPECIAL CIRCUMSTANCES AND MEDICAID.
Children who receive foster care or are in adoptive placements are eligible for Medicaid. The children must meet nonfinancial criteria and must meet the financial requirements described for the children's coverage group. ( )

534. (RESERVED)

535. TITLE IV-E FOSTER CARE CHILD.
A child may be eligible for Medicaid under the Title IV-E foster care program if they meet the eligibility requirements in IDAPA 16.06.01, "Child and Family Services," Section 425. ( )

536. -- 539. (RESERVED)

540. YOUTH EMPOWERMENT SERVICES (YES) PROGRAM CHILDREN.

01. Payments for Children Under Eighteen (18) Years of Age with SED. In accordance with Section 56-254(2), Idaho Code, the Department will make payments for medical assistance for a child under eighteen (18) years of age with serious emotional disturbance (SED), as defined in Section 16-2403, Idaho Code, and verified by an independent assessment: ( )

a. Whose family income does not exceed three hundred percent (300%) of the federal poverty guideline (FPG) as determined using MAGI-based eligibility standards; or ( )

b. Who meets other Title XIX Medicaid eligibility standards in accordance with the rules of the Department. ( )

02. Youth Empowerment Services (YES) Benefits. Applicants whose family income is equal to or less three hundred percent (300%) of the Federal Poverty Guidelines (FPG) for children zero (0) to eighteen (18) years of age and who meet the non-financial eligibility criteria in Sections 200 through 299 of these rules may receive the following benefits: ( )

a. Youth Empowerment Services (YES) State Plan option services and supports described in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Sections 635 through 638; and ( )

b. Additional covered services set forth in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Sections 075 through 799. ( )

03. Additional Eligibility Criteria and Program Requirements for YES. Additional eligibility criteria and program requirements applicable to the Youth Empowerment Services (YES) State Plan option are described in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Sections 635 through 638. ( )

541. -- 544. (RESERVED)

545. PRESUMPTIVE ELIGIBILITY FOR CHILDREN AND ADULTS.
Presumptive eligibility determination for qualifying medical coverage groups can only be provided by a qualified hospital defined in Section 011 or these rules. ( )

01. Presumptive Eligibility Decisions. Decisions of presumptive eligibility can be made for individuals, who meet program requirements for MAGI-based Medicaid coverage. ( )

02. Presumptive Eligibility Determination. Presumptive eligibility determinations are made by a qualified hospital when an individual receiving medical services is not covered by health care insurance and the financial assessment by hospital staff indicates the individual is eligible for Medicaid Coverage in Idaho. This determination is made by hospital staff through an online presumptive application process: ( )

a. Prior to completion of a full Medicaid application; and ( )

b. Prior to a determination being made by the Department on the full application. ( )

03. Presumptive Eligibility Period. The presumptive eligibility period begins on the date the presumptive application is filed online and ends with the earlier of the following: ( )

a. The date the full eligibility determination is completed by the Department; or ( )

b. The end of the month after the month the qualified hospital completed the presumptive eligibility determination. ( )

546. QUALIFIED HOSPITAL PRESUMPTIVE ELIGIBILITY PROCESSES.
A qualified hospital must have a Memorandum of Understanding (MOU) with the Department and follow all standards and processes agreed to in the MOU. ( )

01. Acceptance of Application. The qualified hospital accepts the request for services in the same manner as all applications for assistance are accepted. ( )

02. Standards and Processes. The presumptive eligibility determination must be based on standards and processes provided by the Department. ( )

03. Assistance to Applicant. The qualified hospital must assist the applicant in completing the Department's application process. ( )

04. Qualified Hospital Staff. Only qualified hospital staff who are trained in presumptive eligibility standards can make a presumptive eligibility determination. ( )

05. Notice to Applicant. The qualified hospital or the Department will provide notice to the applicant within two business days on the presumptive eligibility determination. ( )

06. Notice and Hearing Rights. Presumptive eligibility decisions are not appealable and do not have hearing rights under the Title XIX Medicaid program. ( )

07. Number of Presumptive Eligibility Periods Allowed. Only one (1) presumptive eligibility period

is allowed per applicant in any twelve (12) month period. ( )

547. -- 599. (RESERVED)

CASE MAINTENANCE REQUIREMENTS
(Sections 600-701)

600. ANNUAL ELIGIBILITY RENEWAL.
Participants must have an annual eligibility review of all eligibility factors. Exceptions to the annual eligibility renewal are listed in Section 601 of these rules. ( )

01. Continuing Eligibility. Continuing eligibility is determined using available electronic verification sources without participant contact, unless: ( )

a. Information is not available; ( )

b. Information sources provide conflicting information; or ( )

c. Information is inconsistent with information provided by the participant. ( )

02. Inconsistency Impacts Eligibility. When inconsistency exists from electronic verification sources that impact participant eligibility, information must be verified by the participant. The Department provides the participant a document that displays household information currently being used to establish eligibility and asks the participant to verify correctness, and if not correct to provide updated information. ( )

601. EXCEPTIONS TO ANNUAL RENEWAL.
A participant who receives Title XIX or Title XXI through time-limited coverage does not require an annual renewal when the following exists. ( )

01. Extended Medicaid. A participant who receives extended Medicaid is eligible as provided in Section 420 of these rules. ( )

02. Pregnant Woman. A participant who receives Medicaid as a Low Income Pregnant Woman is eligible as provided in Section 500 of these rules. ( )

03. Newborn Child of Medicaid-Eligible Mother. A participant receiving Medicaid as the newborn child of a Medicaid-eligible mother is eligible as provided in Section 530 of these rules. ( )

602. -- 609. (RESERVED)

610. REPORTING REQUIREMENTS.
Changes in family circumstances must be reported to the Department by the tenth of the month following the month in which the change occurred. Report of changes may be made verbally, in writing, through personal contact, telephone, fax, electronic mail, or mail. ( )

611. TYPES OF CHANGES THAT MUST BE REPORTED.
Changes in circumstances the participant must report are the following: ( )

01. Name or Address. A name change for any participant must be reported. A change of address or location must be reported. ( )

02. Household Composition. Changes in family composition must be reported if a parent or relative caretaker receives Medicaid. ( )

03. Marital Status. Marriages or divorces of any family member must be reported if a parent or relative caretaker receives Medicaid. ( )

04. New Social Security Number. A Social Security Number (SSN) that is newly assigned to a Medicaid Health Care Assistance program participant must be reported. ( )

05. Health Insurance Coverage. Enrollment or disenrollment of a participant in a health insurance plan must be reported. ( )

06. End of Pregnancy. Pregnant participants must report when pregnancy ends. ( )

07. Earned Income. Changes in the amount or source of earned income must be reported if a parent or relative caretaker receives Title XIX benefits. ( )

08. Unearned Income. Changes in the amount or source of unearned income must be reported if a parent or relative caretaker receives Title XIX benefits. ( )

09. Support Income. Changes in the amount of spousal support received by an adult household member. ( )

10. Disability. A family member who becomes disabled or is no longer disabled must be reported if a parent or relative caretaker receives Title XIX benefits. ( )

612. -- 619. (RESERVED)

620. NOTICE OF CHANGES IN ELIGIBILITY.
The Department will notify the participant of changes in his Health Care Assistance. The notice must give the effective date, the reason for the action, the rule that supports the action, and appeal rights. ( )

621. NOTICE OF CHANGE OF PLAN.
The Department is allowed to switch a participant from the Medicaid Basic Plan to the Medicaid Enhanced plan within the same month. Advance notice must be given to the participant when there is a decrease in their benefits and he will be switched from the enhanced plan to the basic plan. ( )

622. ADVANCE NOTICE RESPONSIBILITY.
The Department must notify the participant at least ten (10) calendar days before the effective date of when a reported change results in Health Care Assistance closure. The effective date must allow for a five (5) day mailing period for any notice. ( )

623. ADVANCE NOTICE NOT REQUIRED.
Advance notice is not required when a condition listed in Subsections 623.01 through 623.08 of this rule exists. The participant must be notified no later than the date of the action. ( )

01. Death of Participant. The Department has proof of the participant's death. ( )

02. Participant Request. The participant requests closure in writing. ( )

03. Participant in Institution. The participant is admitted or committed to an institution. Further payments to the participant do not qualify for federal financial participation under the state plan. ( )

04. Nursing Care. The participant is placed in a nursing facility or Intermediate Care Facility for Persons with Intellectual Disabilities (ICF/IID). ( )

05. Participant Address Unknown. The participant's whereabouts are unknown. ( )

06. Medical Assistance in Another State. A participant is approved for medical assistance in another state. ( )

07. Eligible One Month. The participant is eligible for aid only during the calendar month of his application for aid. ( )

08. Retroactive Medicaid. The participant's Title XIX or Title XXI eligibility is for a prior period. ( )

624. -- 699. (RESERVED)

700. OVERPAYMENTS.
Health Care Assistance overpayments occur when a participant receives benefits during a month he was not eligible. ( )

701. RECOVERY OF OVERPAYMENTS.
All Health Care Assistance overpayments are subject to recovery. Overpayments are recovered by direct payment from the participant. ( )

01. Notice of Overpayment. The participant must be informed of the Health Care Assistance overpayment and appeal rights. ( )

02. Notice of Recovery. The participant must be informed when his Health Care Assistance overpayment is fully recovered. ( )

702. -- 999. (RESERVED)

000. LEGAL AUTHORITY.
The Idaho Legislature has delegated to the Board of Health and Welfare the responsibility to establish and enforce rules to promote safe and adequate treatment of individuals within a Skilled Nursing Facility under Sections 39-1306, 39-1307, 39-1307A, and 39-1307B, Idaho Code. ( )

001. TITLE AND SCOPE.

01. Title. These rules are titled, IDAPA 16, Title 03, Chapter 02, "Skilled Nursing Facilities." ( )

02. Scope. These rules establish regulations and standards for the provision of adequate care and licensure of Skilled Nursing Facilities in the state of Idaho. These rules are expressly intended for the benefit of all skilled nursing residents. To this end, the Idaho State Board of Health and Welfare may issue variances to these rules under standards and procedures established by the Board. ( )

002. WRITTEN INTERPRETATIONS.
This agency may have written statements that pertain to the interpretations of the rules of this chapter. ( )

003. – 008. (RESERVED)

009. CRIMINAL HISTORY AND BACKGROUND CHECK REQUIREMENTS.

01. Criminal History and Background Check. A skilled nursing facility must complete a criminal history and background check on employees and contractors hired or contracted with after October 1, 2007, who have direct patient access to residents in the skilled nursing facility. A Department check conducted under IDAPA 16.05.06, "Criminal History and Background Checks," satisfies this requirement. Other criminal history and background checks may be accepted provided they meet the criteria in Subsection 009.02 of this rule and the entity conducting the check issues written findings. The entity must provide a copy of these written findings to both the facility and the employee. ( )

02. Scope of a Criminal History and Background Check. The criminal history and background check must, at a minimum, be a fingerprint-based criminal history and background check that includes a search of the following record sources: ( )

a. Federal Bureau of Investigation (FBI); ( )

b. Idaho State Police Bureau of Criminal Identification; ( )

c. Sexual Offender Registry; ( )

d. Office of Inspector General List of Excluded Individuals and Entities; and ( )

e. Nurse Aide Registry. ( )

03. Availability to Work. Any direct resident access individual hired or contracted with on or after October 1, 2007, must self-disclose all arrests and convictions before having access to residents. The individual is allowed to only work under supervision until the criminal history and background check is completed. If a disqualifying crime as described in IDAPA 16.05.06, "Criminal History and Background Checks," is disclosed, the individual cannot have access to any resident. ( )

04. Submission of Fingerprints. The individual's fingerprints must be submitted to the entity conducting the criminal history and background check within twenty-one (21) days of their date of hire. ( )

05. New Criminal History and Background Check. An individual must have a criminal history and background check when: ( )

a. Accepting employment with a new employer; and ( )

b. Their last criminal history and background check was completed more than three (3) years prior to their date of hire. ( )

06. Use of Criminal History Check Within Three Years of Completion. Any employer may use a previous criminal history and background check obtained under these rules if: ( )

a. The individual has received a criminal history and background check within three (3) years of their date of hire; ( )

b. The employer has documentation of the criminal history and background check findings; ( )

c. The employer completes a state-only background check of the individual through the Idaho State Police Bureau of Criminal Identification; and ( )

d. No disqualifying crimes are found. ( )

07. Employer Discretion. The new employer, at its discretion, may require an individual to complete a criminal history and background check at any time, even if the individual has received a criminal history and background check within the three (3) years of their date of hire. ( )

010. DEFINITIONS.
For the purposes of these rules the following terms are used, as defined herein: ( )

01. Administrator. The person delegated the responsibility for management of a facility by the legal owner, employed as a full-time administrator in each facility, and licensed by the state of Idaho. The administrator and legal owner may be the same individual. ( )

02. Advanced Practice Registered Nurse. A licensed registered nurse having specialized skills, knowledge and experience who is authorized under the Idaho Board of Nursing rules to provide certain health services in addition to those performed by licensed registered nurses (R.N.). ( )

03. Board. The Idaho State Board of Health and Welfare. ( )

04. Change of Ownership. The sale, purchase, exchange, or lease of an existing facility by the present owner or operator to a new owner or operator. ( )

05. Charge Nurse. One (1) or more licensed nurse(s) who has direct responsibility for nursing services in an operating unit or physical subdivision of a facility during one (1) eight (8) hour shift, to be provided by herself and by any other licensed nurse or auxiliary personnel under her immediate charge. ( )

06. Department. The Idaho Department of Health and Welfare. ( )

07. Director. The Director of the Department of Health and Welfare or designee. ( )

08. Director of Nursing Services (DNS). A licensed registered nurse currently licensed by the state of Idaho and qualified by training and experience. ( )

09. Existing Facility. A nursing home currently licensed. ( )

10. Governmental Unit. The state of Idaho, any county, municipality, or other political subdivision, or any department, division, board or other agency thereof. ( )

11. Hospital Licensing Act. The act set out in Sections 39-1301 through 39-1314, Idaho Code. ( )

12. Licensee. The person or organization to whom a license is issued. ( )

13. Licensing Agency. The Department of Health and Welfare. ( )

14. Licensed Nursing Personnel. A licensed registered nurse (R.N.) or licensed practical nurse

(L.P.N.) currently licensed by the Idaho State Board of Nursing. ( )

15. New Construction. ( )

a. New buildings to be used as a facility. ( )

b. Additions to existing buildings and/or added bed capacity. ( )

c. Conversion of existing buildings or portions thereof for use as a facility. ( )

16. Person. Any individual, firm, partnership, corporation, company, association, joint stock association, governmental unit, or legal successor thereof. ( )

17. Pharmacist. Any person licensed by the Idaho Board of Pharmacy as a licensed pharmacist. ( )

18. Physician. Any person who holds a license issued by the State Board of Medicine to practice medicine and surgery, osteopathic medicine and surgery, or osteopathic medicine, provided further, that others authorized by law to practice any of the healing arts will not be considered physicians (Section 54-1803(3), Idaho Code). ( )

19. Resident. An individual requiring and receiving skilled nursing care and residing in a facility licensed to provide the level of care required. ( )

20. Skilled Nursing Facility (SNF). A facility designed to provide area, space, and equipment to meet the health needs of two (2) or more individuals who, at a minimum, require inpatient care and services for twenty-four (24) or more consecutive hours for unstable chronic health problems requiring daily professional nursing supervision and licensed nursing care on a twenty-four (24) hour basis, restorative, rehabilitative care and assistance in meeting daily living needs. Medical supervision is necessary on a regular, but not daily, basis (Section 39-1301, Idaho Code). ( )

21. Substantial Compliance. A facility is in substantial compliance with these rules, regulations and minimum standards when there are no deficiencies that would endanger the health, safety, or welfare of the residents. ( )

22. Supervising Nurse. The one (1) licensed nurse designated by the DNS to be responsible for the overall direction and control of all nursing services throughout the entire facility during one (1) eight (8) hour shift. ( )

23. Waiver or Variance. A waiver or variance to these rules and minimum standards in whole or in part that may be granted under the following conditions: ( )

a. Good cause is shown for such waiver and the health, welfare or safety of residents will not be endangered by granting such a waiver; ( )

b. Precedent will not be set by granting of such waiver. The waiver may be renewed annually if sufficient written justification is presented to the Licensing Agency. ( )

011. – 049. (RESERVED)

050. LICENSURE.

01. General Requirements. Before any person either directly or indirectly operates a facility, they must make an application for and receive a valid license for operation of the facility, and no resident must be admitted or cared for in a facility that is required under Idaho law to be licensed, until a license is obtained. ( )

a. The facility and all related buildings associated with the operation of the facility, as well as all

records required under these rules, must be accessible at any reasonable time to authorized representatives of the Department for the purpose of inspection, with or without prior notice. ( )

b. Before any building is constructed or altered for use as a facility, written approval of construction or alteration of plans must be obtained from the Department. ( )

c. Information received by the licensing agency through filed reports, inspection, or as otherwise authorized under this law, must not be disclosed publicly in such a manner as to identify individual residents except in a proceeding involving the question of licensure. Public disclosure of information obtained by the licensing agency for the purposes of this law must be governed by rules, regulations, and minimum standards adopted by the Board. ( )

02. Application for an Initial License. In addition to obtaining prior approval of plans for construction or alterations, all persons planning the operation of a facility must provide a Department-approved application for an initial facility license at least three (3) months prior to the planned opening date with the following: ( )

a. Evidence of a request for a determination of applicability for Section 1122 (Social Security Act) regulatory review. ( )

b. A copy of the nursing home administrator's license with the application. ( )

c. A certificate of occupancy from the local building and fire authority. ( )

03. Issuance of License. Every facility must be designated by a distinctive name in applying for a license, and the name must not be changed without first notifying the Department in writing at least thirty (30) days prior to the date the proposed change in name is to be effective. ( )

a. Each license will be issued only for the premises and persons or governmental units named in the application and will not be transferable. ( )

b. Each license will specify the maximum allowable number of beds in each facility, which may not be exceeded, except on a time-limited emergency basis, and authorized by the Department. ( )

c. The facility license must be framed and posted so as to be visible to the general public. ( )

04. Expiration and Renewal of License. Each license to operate a facility must, unless sooner suspended or revoked, expire on the date designated on the license. Each application for renewal of a license must be submitted on a form prescribed by the Department and prior to the renewal of the license. ( )

05. Denial or Revocation of License. The Director may deny the issuance of a license or revoke any license when persuaded by a preponderance of the evidence that such conditions exist as to endanger the health or safety of any resident, or that the facility is not in substantial compliance with these rules and minimum standards. ( )

a. Additional causes for denial of a license may include the following: ( )

i. The applicant has willfully misrepresented or omitted information on the application or other documents pertinent to obtaining a license. ( )

ii. The applicant of the person proposed as the administrator has been guilty of fraud, gross negligence, abuse, assault, battery, or exploitation in relationship to the operation of a health facility. ( )

iii. The applicant or the person proposed as the administrator of the facility: ( )

(1) Has been denied or has had revoked any health facility license; or ( )

(2) Has been convicted of operating any health facility without a license; or ( )

(3) Has been enjoined from operating a health facility; or ( )

b. Additional causes for revocation of license. ( )

i. Any act adversely affecting the welfare of residents is being permitted, aided, performed, or abetted by the person or persons in charge of the facility. Such acts may include, but are not limited to, neglect, physical abuse, mental abuse, emotional abuse, violation of civil rights, or exploitation. ( )

ii. Any condition exists in the facility that endangers the health or safety of any resident. ( )

iii. The licensee has willfully misrepresented or omitted information on the application or other documents pertinent to obtaining a license. ( )

iv. The applicant or administrator has demonstrated lack of sound judgment in the operation or management of the skilled nursing facility. ( )

v. The facility lacks adequate staff to properly care for the number and type of residents residing at the facility. ( )

vi. The applicant or administrator of the facility: ( )

(1) Has been denied or has had revoked any health facility license; or ( )

(2) Has been convicted of operating any health facility without a license; or ( )

(3) Has been enjoined from operating a health facility or shelter home; or ( )

(4) Is directly under the control or influence of any person who has been subject to the proceedings in Subsection 050.05. ( )

06. Change of Ownership, Operator, or Lessee. When a change of a licensed facility's ownership, operator, or lessee is contemplated, the owner/operator must notify the Department at least thirty (30) days prior to the proposed date of change and new application submitted when there is a change of operator, ownership, or lessee. ( )

07. Penalty for Operating a Facility or Agency Without a License. Any person establishing, conducting, managing, or operating any facility or agency as defined, without a license, under Sections 39-1301 through 39-1314, Idaho Code, is guilty of a misdemeanor punishable by imprisonment in a county jail for a period of time not exceeding six (6) months, or by a fine not exceeding three hundred dollars ($300), or by both such fine and imprisonment, and each day of continuing violation constitutes a separate offense. In the event that the prosecuting attorney in the county where the alleged violation occurred fails or refuses to act within sixty (60) days of notification of the violation, the attorney general is authorized to prosecute any violations (Section 39-1312, Idaho Code). ( )

051. -- 099. (RESERVED)

100. ADMINISTRATION.

01. Governing Body. Each facility must be organized and administered under one (1) authority which may be a proprietorship, partnership, association, corporation, or governmental unit. The following requirements must be met: ( )

a. That the true name and current address for each person or business entity having a five percent (5%) or more direct, or indirect, ownership interest in the facility is supplied to the Department at the time of licensure application or preceding any change in ownership. ( )

b. That the names, addresses, and titles of offices held by all members of the facility's governing authority are submitted to the Department. ( )

c. That a copy of the lease (if a building or buildings are leased to a person or persons to operate as a facility) showing clearly in the context which party to the agreement is to be held responsible for the maintenance and upkeep of the property to meet minimum standards is available for review by the Department. Terms of the financial arrangement may be omitted from the copy of the lease available to the Department. ( )

02. Administrator. The governing body, owner, or partnership must appoint a licensed nursing home administrator for each facility who is responsible and accountable for carrying out the policies determined by the governing body. In combined hospital and nursing home facilities, the administrator may serve both the hospital and nursing home provided they are currently licensed as a nursing home administrator. The following requirements must be met: ( )

a. In the absence of the administrator, an individual who is responsible and accountable and at least twenty-one (21) years of age is to be authorized, in writing, to act in their behalf to assure administrative direction of the facility. ( )

b. The administrator is responsible for establishing and assuring the implementation of written policies and procedures for each service offered by the facility, or through arrangements with an outside service. ( )

c. The administrator, their relatives, or employees, are not to act as, the legal guardian of, or have power of attorney for any residents unless specifically adjudicated as such by appropriate legal order. ( )

d. The administrator is to provide to the public and the resident an accurate description of the facility services and care. Representation of the facility's services to the public is not to be misleading. ( )

e. The administrator is responsible for providing sufficient and qualified staff to carry out all of the basic services offered by the facility. ( )

f. The administrator, owner, and employees of a facility are governed by the provisions of Section 15-2-616, Idaho Code, concerning the devise or bequest of a resident's property by a last will and testament. ( )

03. Admission Policies. The administrator must establish written admission policies for all resident admissions and be available to residents, their relatives, and to the general public. The following requirements must be met: ( )

a. A history and physical examination is recorded within forty-eight (48) hours after admission to the facility, unless the resident is accompanied by a record of a physical examination completed by a physician not more than five (5) days prior to admission. ( )

b. Information upon admission includes the results of a tuberculosis skin test, chest x-ray, medical and/or psycho-social diagnosis, physician's plan of care, the resident's activity limitation, and the rehabilitation potential, and are to be dated and signed by the physician. ( )

c. No children other than residents are to regularly occupy any portion of the resident living area. ( )

d. Reasonable precautions are taken in all admissions for the safety of other residents. ( )

e. Nothing in these rules and minimum standards should be construed as to require any facility to compel any person to undergo any medical screening, examination, diagnosis, or treatment or to accept any other health care or services provided under such plan for any purpose (other than for the purpose of discovering and preventing the spread of infection or other contagious disease or for the purpose of protecting environmental health), if such person objects (or, in case such person is a child, their parent or guardian objects), thereto on religious

grounds. ( )

04. Use of Restraints. The following types of restraints must not be used under any conditions: canvas jackets, canvas sheets, canvas cuffs, leather belts, leather cuffs, leather hand mitts or restraints requiring a lock and key. ( )

05. Record of Resident's Personal Valuables. An inventory and proper accounting must be kept for all valuables entrusted to the facility for safekeeping and the status of the inventory is to be available to the resident, their conservator, guardian, or representative for review upon request. ( )

06. Accident or Injury. The administrator must show evidence of written safety procedures for handling of residents, equipment lifting, and the use of equipment. The following requirements must be met: ( )

a. That an incident-accident record be kept of all incidents or accidents sustained by employees, residents, or visitors in the facility and include the following information: ( )

i. Name and address of employee, resident, or visitor; ( )

ii. A factual description of the incident or accident; ( )

iii. Description of the condition of the resident, employee, or visitor including any injuries resulting from the accident; and ( )

iv. Time of notification of physician, if necessary. ( )

b. That the physician is immediately notified regarding any resident injury or accident when there are significant changes requiring intervention or assessment. ( )

c. That immediate investigation of the cause of the incident or accident be instituted by the facility administrator and any corrective measures indicated adopted. ( )

101. -- 104. (RESERVED)

105. PERSONNEL.

01. Daily Work Schedules. Daily work schedules must be maintained that reflect: ( )

a. Personnel on duty at any given time for the previous three (3) months; ( )

b. The first and last names of each employee, including professional designation (R.N., L.P.N., etc.) and position; and ( )

c. Any adjustments made to the schedule. ( )

02. Job Description. Job descriptions must be current, on file, and: ( )

a. Include the authority, responsibilities, and duties of each classification of personnel; and ( )

b. Be given to each employee consistent with their classification. ( )

03. Age Limitations. Employees, other than licensed personnel, who are less than eighteen (18) years of age may not provide direct resident care except when employees are students or graduates of a recognized vocational health care training program. ( )

04. Resident Employment. Whenever work of economic benefit to the facility is performed by a resident, such work will be subject to the provisions prescribed by law for any employee. ( )

05. Employee Health. Personnel policies relating to employee health must include: ( )

a. That the facility establishes, upon hiring a new employee, the current status of a tuberculin skin test. The determination may be based upon a report of the skin test taken prior to employment or within thirty (30) days after employment. If the skin test is positive, either by history or current test, a chest X-ray is taken, or a report of the results of a chest X-ray taken within three (3) months preceding employment and accepted. The TB Skin Test status is recorded and a chest X-ray alone is not a substitute. No subsequent chest X-ray or skin test is required for routine surveillance. ( )

b. That a repeat skin test is required if a resident or other staff develop tuberculosis. ( )

c. That the facility requires all employees report immediately to their supervisor any signs or symptoms of personal illness. ( )

d. That personnel who have a communicable disease, infectious wound, or other transmittable condition and who provide care or services to residents are required to implement protective infection control techniques approved by administration; are not to work until the infectious stage is corrected; are reassigned to a work area where contact with others is not expected and likelihood of transmission of infection is absent; or seeks other remedy to avoid spreading the employee's infection. ( )

06. Personnel Files. Personnel files must be kept for each employee containing: ( )

a. Name, current address, and telephone number of the employee; ( )

b. Social security number; ( )

c. Qualifications for the position for which the employee is hired, including education and experience; ( )

d. If Idaho license is required, verification of current license; ( )

e. Position in facility; ( )

f. Date of employment; ( )

g. Date of termination and reason; and ( )

h. Verification of TB skin test upon employment and any subsequent test results. ( )

106. FIRE AND LIFE SAFETY.

Facilities must meet general requirements for the fire and life safety standards for a health care facility as follows: ( )

01. General Requirements. General requirements for the fire and life safety standards for a health care facility are as follows: ( )

a. The facility must be structurally sound, maintained, and equipped to assure the safety of residents, employees, and the public. ( )

b. Where natural or man-made hazards are present on the premises, that the facility must provide suitable fences, guards, and/or railings to isolate the hazard from the resident's environment. ( )

02. Life Safety Code Requirements. The facility must meet provisions of the Life Safety Code of the National Fire Protection Association, 2012 Edition as are applicable to a health care facility except existing facilities licensed prior to the effective date of these rules and in compliance with a previous edition of the Life Safety Code may continue to comply with the edition in force at that time. ( )

03. Smoking. Because smoking has been acknowledged to be a potential fire hazard, a continuous effort must be made to reduce such a hazard in the facility to include adopting written rules available to all facility personnel, residents, and the public with the following: ( )

a. That smoking is prohibited in any area where flammable liquids, gases, or oxygen are in use or stored and posted with "No Smoking" signs. ( )

b. That residents are not permitted to smoke in bed. ( )

c. That unsupervised smoking by residents not mentally or physically responsible is prohibited. This includes residents affected by medication. ( )

d. That designated areas are assigned for employee, resident, and public smoking. ( )

e. Nothing in Section 106 requires that smoking be permitted in facilities whose admission policies prohibit smoking. ( )

04. Report of Fire. A separate report of each fire incident occurring within the facility must be submitted to the licensing agency within thirty (30) days of the occurrence. The reporting form "Facility Fire Incident Report" will be issued by the licensing agency to secure specific data concerning date, origin, extent of damage, method of extinguishment, and injuries (if any). ( )

05. Storage, Heating Appliances, Hazardous Substances. The following requirements must be met: ( )

a. That attics and crawl spaces are not used for storage of any materials. ( )

b. That rooms housing heating appliances are not used for storage of combustible materials. ( )

c. That all fuel-fired heating devices have an easily accessible, plainly marked, functional remote fuel shut-off valve. ( )

d. That all ranges are provided with hoods, mechanical ventilation, and removable filters. ( )

107. DIETARY SERVICE.
The following requirements must be met: ( )

01. Approved Diet Manual. A current diet manual approved by the Department and available in the kitchen (the Idaho Diet Manual is approved by the Department). ( )

02. Preparation and Correction of Menus. That menus are prepared at least a week in advance and corrected to conform with food actually served (items not served deleted and food actually served written in.) The corrected copy of the menu and diet plan is to be dated and kept on file for thirty (30) days. ( )

03. Variety and Adequacy of Food. That menus provide a sufficient variety of foods in adequate amounts at each meal. Menus are to be different for the same days each week and adjusted for seasonal changes. ( )

108. ENVIRONMENTAL SANITATION.
The following requirements must be met: ( )

01. Water Supply. An approved public or municipal water supply is used wherever available. ( )

a. In areas where an approved public or municipal water supply is not available, a private water

supply is provided, and meets the standards approved by the Department. ( )

b. If water is from a private supply, water samples are submitted to the Department through the district public health laboratory for bacteriological examination at least once every three (3) months. Monthly bacteriological examinations are recommended. Copies of the laboratory reports are kept on file in the facility by the administrator. ( )

c. There is sufficient amount of water under adequate pressure to meet the sanitary requirements of the facility at all times. ( )

02. Linen-Laundry Facilities. Personal Laundry. Residents' and employees' laundry must be collected, transported, sorted, washed, and dried in a sanitary manner and not be washed with bed linens. Residents' clothing is to be labeled to ensure proper return to the owner. ( )

109. -- 119. (RESERVED)

120. EXISTING BUILDINGS.
These standards must be applied to all currently licensed health care facilities. Any minor alterations, repairs, and maintenance must meet these standards. In the event of a change in ownership of a facility, the entire facility must meet these standards prior to issuance of a new license. ( )

01. Codes and Standards. Construction features of all existing facilities must be in accordance with applicable local, state, national codes, standards, and regulations in effect at the time of adoption of these rules. ( )

a. In the event of a conflict of requirement between the codes, the most restrictive apply. ( )

b. In addition, existing facilities are to comply with applicable fire and life safety codes and standards as set forth in Section 106. ( )

02. Site Requirements. The location of an existing facility must meet the following criteria: ( )

a. It must be served by an all-weather road, kept open to motor vehicles at all times of the year. ( )

b. It must be accessible to physician and medical services. ( )

c. It must be remote from railroads, factories, airports and similar noise, odor, smoke, dust and other nuisances. ( )

d. It must be accessible to public utilities. ( )

e. It must be in a lawfully constituted fire district. ( )

f. It must provide off-street motor vehicle parking at the rate of one (1) space for every three (3) licensed beds. ( )

03. General Building Requirements. An existing facility must be of such character to be suitable for use as a facility. The facility is subject to approval by the Department. Other requirements are as follows: ( )

a. That the building and all equipment are in good repair. ( )

b. That handrails of sturdy construction are provided on both sides of all corridors used by residents. ( )

c. That no facility is maintained in an apartment house or other multiple dwelling. ( )

d. That roomers or boarders are not accepted for lodging in any facility. ( )

04. Resident/Staff Communication. Requirements governing communication must be as follows: ( )

a. That each building has a telephone for resident use so located as to provide wheelchair access for personal, private telephone communications. A telephone with amplifying equipment is available for the hearing impaired. ( )

b. That a staff calling system is installed at each resident bed and in each resident toilet, bath, and shower room. The staff call in the toilet, bath, or shower room must be an emergency call. All calls are to register at the staff station and actuate a visible signal in the corridor at the resident's door. The activating mechanism within the resident's sleeping room is to be located as readily accessible to the resident at all times. ( )

05. Resident Accommodations. Accommodations for the residents of the facility must include the following: ( )

a. That each resident room is an outside room. ( )

b. That not more than four (4) residents can be housed in any multi-bed sleeping room. ( )

c. That every resident sleeping room is provided with a window as follows: ( )

i. Equal to at least one-eighth (1/8) of the floor area. ( )

ii. Openable to obtain fresh air. ( )

iii. Provided with curtains, drapes, or shades. ( )

iv. Located to permit the resident a view from a sitting position. ( )

v. Has screens. ( )

d. No resident room can be located: ( )

i. In such a way that its outside walls are below grade. ( )

ii. In an attic, trailer house or in any room other than an approved room. ( )

iii. So it can be reached only by passing through another individual's room, a utility room, or any other room. ( )

iv. So it opens into any room in which food is prepared or stored. ( )

e. That resident rooms are a sufficient size to allow no less than eighty (80) square feet of usable floor space per resident in multiple-bed rooms. Private rooms will have no less than one hundred (100) square feet of usable floor space. ( )

f. That resident beds are not placed in hallways or in any location commonly used for other than bedroom purposes. ( )

g. That rooms have dimensions that allow no less than three (3) feet between beds and two (2) feet of space between the bed and side wall. ( )

h. That ceiling heights in resident rooms are a minimum of seven (7) feet, six (6) inches. ( )

i. That closet space in each sleeping room is twenty (20) inches by twenty-two (22) inches per

resident. Common closets utilized by two (2) or more residents are provided with substantial dividers for separation of each resident's clothing for prevention of cross contamination. All closets are equipped with doors. Freestanding closets will be deducted from the square footage in the sleeping room. ( )

j. That every health care facility provides a living room or recreation room for the sole use of the residents. Under no circumstances may these rooms be used as bedrooms by residents or personnel. A hall or entry is not acceptable as a living room or recreation room. ( )

k. That all resident rooms are numbered and all other rooms numbered or identified as to purpose. ( )

l. That a drinking fountain is connected to cold running water, is accessible to both wheelchair and non-wheelchair residents, and located in each nursing or staff unit. ( )

m. That residents of the opposite sex are not housed in the same bedroom or ward, except in cases of husband and wife. ( )

n. That gardens, yards, or portions of yards are secure for outdoor use by all residents and bounded by a substantial enclosure if intended for unsupervised use by residents who may wander away from the facility. ( )

o. That toilet rooms, tub/shower rooms, and handwashing facilities are constructed as follows: ( )

i. Toilet rooms and bathrooms for residents and personnel are not to open directly into any room in which food, drink, or utensils are handled or stored. ( )

ii. Toilet and bathroom are separated from all other rooms by solid walls or partitions. ( )

iii. On floors where wheelchair residents are housed, there is at least one (1) toilet and one (1) bathing facility large enough to accommodate wheelchairs. ( )

iv. All inside bathrooms and toilet rooms have forced ventilation to the outside. ( )

v. Toilet rooms for resident use are arranged that it is not necessary for an individual to pass through or into another resident's room to reach the toilet facilities. ( )

vi. Handrails and/or grab bars are provided in resident toilet rooms and bathrooms and are located so as to be functionally adequate. ( )

vii. Each resident floor or nursing unit has at least one (1) tub or shower for every twelve (12) licensed beds; one (1) toilet for every eight (8) licensed beds; and one (1) lavatory with mirror for every eight (8) licensed beds. Tubs, showers, and lavatories are connected to hot and cold running water. ( )

06. Dining/Recreation Facilities. Facilities must provide one (1) or more attractively furnished, multipurpose areas for dining/recreation purposes that meets the following requirements: ( )

a. A minimum of twenty-five (25) square feet per licensed bed is to be provided. Any facility not in compliance on the effective date of this rule will not be required to comply until the number of licensed beds is increased or until there is a change of ownership of the facility. Provided, however, that a facility not in compliance may not reduce the number of licensed beds and reduce its present dining/recreation space until at least twenty-five (25) square feet per licensed bed is provided. ( )

b. It is for the sole use of the residents, and a hall or entry is not acceptable. ( )

07. Isolation Units (Temporary). Each health care facility must have available a room with private toilet, lavatory, and other accessory facilities for temporary isolation of a resident with a communicable or infectious

disease. ( )

08. Utility Areas. A utility room with a separate entrance and physically partitioned from any toilet and/or bathing facility must be provided for the preparation, cleansing, sterilization, and storing of nursing supplies and equipment. A utility room must be provided on each floor in each nursing or staff unit of the facility. Provisions must be made for the separation of clean and soiled activities. Food and/or ice must not be stored or handled in a utility room. Soiled utility rooms must be provided with forced mechanical ventilation to the outside. ( )

09. Storage Space. The facility must provide general storage areas and medical storage areas as follows: ( )

a. General storage at the rate of ten (10) square feet per licensed bed, in addition to suitable storage provided in the resident's sleeping room. ( )

b. The facility provides safe and adequate storage space for medical supplies and equipment and a space appropriate for the preparation of medications. ( )

10. Electrical and Lighting. All electrical and lighting installation must be in accordance with the National Electrical Code and as follows: ( )

a. All electrical equipment intended to be grounded is grounded. ( )

b. Frayed cords, broken plugs, and the like are repaired or replaced. ( )

c. Plug adaptors and multiple outlets are prohibited. ( )

d. Extension cords are U.L. approved, adequate in size (wire gauge), and limited to temporary usage. ( )

e. All resident personal electrical appliances are inspected and approved by the facility engineer and/or administrator. ( )

f. All resident rooms have a minimum of thirty (30) foot candles of light delivered to reading surfaces and ten (10) foot candles of light in the rest of the room. ( )

g. All hallways, storerooms, stairways, inclines, ramps, exits, and entrances have a minimum of five (5) foot candles of light measured in the darkest corner. ( )

11. Ventilation. The facility must be ventilated and precautions taken to eliminate offensive odors in the facility. ( )

12. Heating. A heating system must be provided for the facility that is capable of maintaining a temperature of seventy-five degrees (75F) to eighty degrees (80F) Fahrenheit in all weather conditions. ( )

a. Oil space heaters, recessed gas wall heaters, and floor furnaces cannot be used as heating systems for health care facilities. ( )

b. Portable comfort heating devices are not used. ( )

13. Plumbing. Plumbing at the facility must be as follows: ( )

a. All plumbing complies with applicable local and state codes. ( )

b. Vacuum breakers are installed where necessary to prevent backsiphonage. ( )

c. The temperature of hot water at plumbing fixtures used by residents is between one hundred five degrees (105F) and one hundred twenty degrees (120F) Fahrenheit. ( )

121. NEW CONSTRUCTION STANDARDS.
The following requirements must be met: ( )

01. Plans, Specifications, and Inspections. New facility construction or any addition, conversion, or renovation of an existing facility is governed by the following rules: ( )

a. Prior to commencing work pertaining to construction of new buildings, any additions, structural changes to existing facilities, or conversion of buildings to be used as a facility, plans and specifications must be submitted to, and approved by, the Department to assure compliance with the applicable construction standards, codes, rules, and regulations. ( )

b. The plans and specifications must be prepared by, or executed under, the immediate supervision of a licensed architect registered in the state of Idaho. The employment of an architect may be waived by the Department in certain minor alterations. ( )

c. Preliminary plans must be submitted and include at least the following: ( )

i. The assignment of all spaces, size of areas and rooms, and indicated in outline the fixed and movable equipment and furniture. ( )

ii. The plans are drawn at a scale sufficiently large to clearly present the proposed design, but not less than a scale of one-eighth inch (1/8") equals one foot (1'). ( )

iii. The drawings include a plan for each floor, including the basement or ground floor with approach or site plan, showing roads, parking areas, sidewalks, etc. ( )

iv. The total floor area and number of beds are computed and noted on the drawings. ( )

v. Outline specifications provide a general description of the construction, including interior finishes, acoustical material, its extent and type and heating, electrical, and ventilation systems. ( )

d. Before commencing construction, the working drawings must be developed in close cooperation with, and approved by, the Department and other appropriate agencies with the following. ( )

i. Working drawings and specifications are prepared so that clear, distinct prints may be obtained, accurately dimensioned, and include all necessary explanatory notes, schedules, legends, and stamped with the licensed architect's seal. ( )

ii. Working drawings are complete and adequate for contract purposes. Separate drawings are prepared for each of the following branches of work: architectural, mechanical and electrical. ( )

e. Prior to occupancy, the facility must be inspected and approved by the licensing agency. The agency will be notified at least two (2) weeks prior to completion in order to schedule a final inspection. ( )

02. Codes and Standards. New construction features must be in accordance with applicable local, state, national standards, codes, and regulations in effect at the time of the construction, addition, remodeling, or renovation. ( )

a. In the event of a conflict of requirements between codes, the most restrictive applies. ( )

b. Compliance with the applicable provisions of the following codes and standards must be required by, and reviewed for, by this agency: ( )

i. American National Standard Specifications for Making Buildings and Facilities Accessible to and Usable by Physically Handicapped People (ANSI A117.1). ( )

ii. Idaho Department of Health and Welfare Rules, IDAPA 16.02.19, "Idaho Food Code." ( )

03. Site Requirements. The location of all new facilities or conversion of existing buildings is controlled by the following criteria: ( )

a. That it is adjacent to an all-weather road(s). ( )

b. That it is accessible to physician's services and medical facilities. ( )

c. That it is accessible to public utilities. ( )

d. That it is in a lawfully constituted fire district. ( )

e. That each facility has parking spaces to satisfy the minimum needs of residents, employees, staff, and visitors. In the absence of a local requirement, each facility provides not less than one (1) space for each day shift staff member and employee, plus one (1) space for each five (5) resident beds. This ratio may be reduced in areas convenient to a public transportation system or to public parking facilities provided that approval of any reduction is obtained from the appropriate state agency. Space must be provided for emergency and delivery vehicles. ( )

04. Resident Care Unit. Each resident care unit must be in compliance with the following: ( )

a. That the number of beds in a unit does not exceed sixty (60); ( )

b. That at least eighty percent (80%) of the beds are located in rooms designed for one (1) or two (2) residents; ( )

c. That at least one (1) room in each facility is available for single occupancy for isolation of disease, for privacy in personality conflict, or disruptive resident situations. Each isolation room meets the following requirements: ( )

i. All features of regular resident rooms, as described in Subsection 121.05.d.; ( )

ii. Supply an entry area that is adequate for gowning; ( )

iii. Supply a handwashing lavatory in or directly adjacent to the resident room entry; ( )

iv. Provide a private toilet; ( )

v. Have finishes easily cleanable; and ( )

vi. Not be carpeted; ( )

d. That each resident room meets the following requirements: ( )

i. Minimum room area, exclusive of toilet rooms, closets, lockers, wardrobes, alcoves, or vestibules is one hundred (100) square feet in single-bed rooms and eighty (80) square feet in multiple bed rooms per resident; ( )

ii. Beds in all rooms are placed so that they are three (3) feet apart, two (2) feet away from the side wall parallel with beds, and three (3) feet, six (6) inches from the end of the bed to the opposite wall, or other obstructions; ( )

iii. A lavatory is provided in each resident room. The lavatory may be omitted from a single-bed or two (2) bed room when a lavatory is located in an adjoining toilet room that serves that room only; ( )

iv. Each resident has access to a toilet room without entering the general corridor area. One (1) toilet room serves no more than four (4) beds, and no more than two (2) resident rooms. The toilet room contains a water

closet and a lavatory. The lavatory may be omitted from a toilet room if each resident room served by that toilet room contains a lavatory; ( )

v. Each resident is provided, within the room, a wardrobe, locker, or closet with a minimum of four (4) square feet. Common closets are not permitted. An adjustable clothes rod and adjustable shelf is provided; ( )

vi. Each resident room cannot be located more than one hundred twenty (120) feet from the soiled workroom or the soiled holding room; ( )

vii. Each room has a window that can be opened without the use of tools. The window sill must not be higher than three (3) feet above the floor and needs to be above grade. The window is at least one-eighth (1/8) of the floor area and provided with shades or drapes; ( )

viii. Cubicle curtains of fire retardant material, capable of enclosing the bed is provided in multiple-bed rooms to insure privacy for the residents. Alternatives to this arrangement may be allowed if the alternative provides the same assurance of privacy; ( )

ix. Mirror(s) are arranged for convenient use by residents in wheelchairs, as well as by residents in standing position; ( )

x. A staff calling system is installed at each resident bed and in each resident toilet, bath, and shower room. The staff call in the toilet, bath, and shower room is an emergency call. All calls register at the staff station and activate a visible signal in the corridor at the resident's door. The emergency call system is designed so that a signal light activated at the resident's station will remain lit until turned off at the resident's calling station; ( )

xi. All resident rooms are visible to a staffed nurse's station; ( )

xii. Each resident room is an outside room; ( )

xiii. Residents cannot be cared for or housed in any attic story, trailer house, or in any room other than an approved resident room; ( )

xiv. Resident beds are not be placed in hallways or any location commonly used for other than bedroom purposes; ( )

xv. Ceiling heights in resident rooms are a minimum of eight (8) feet; ( )

xvi. No room can be used for a resident room that can only be reached by passing through another resident room, utility room or any other room. All resident rooms have direct access to an exit corridor; ( )

xvii. Resident rooms do not open into any room in which food is prepared, served, or stored; and ( )

xviii. All resident rooms are numbered. All other rooms are numbered or identified as to purpose. ( )

e. Service Areas. That the following service areas are located in, or readily available to, each resident care unit. The size and disposition of each service will depend upon the number and types of beds to be served. Although identifiable spaces are required to be provided for each of the indicated functions, consideration will be given to design solutions that would accommodate some functions without specific designation of areas or rooms. Details of such proposals are submitted for prior approval. Each service area may be arranged and located to serve more than one (1) resident care unit, but at least (1) such service area is provided on each resident floor and as follows: ( )

i. Staff station with space for charting and storage for administrative supplies convenient to handwashing facilities; ( )

ii. Lounge and toilet room(s) for staff (toilet room may be unisex); ( )

iii. Individual closets or compartments for the safekeeping of coats and personal effects of personnel located close to the duty station of personnel or in a central location; ( )

iv. Clean workroom or clean holding room. If the room is used for work, that it contains a counter and handwashing facilities. When the room is used only for storage as part of a system for distributing clean and sterile supplies, the work counter and handwashing facilities may be omitted; ( )

v. A soiled workroom contains a clinical sink or equivalent flushing rim fixture sink for handwashing, work counter, waste receptacle, and soiled linen receptacle. When the room is used only for temporary holding of soiled materials, the work counter may be omitted; ( )

vi. Drug distribution station. Provisions are made for secure, convenient, and prompt twenty-four (24) hour availability of medicine to residents. A secure medicine preparation area is available and under the nursing staff's visual control and contains a work counter, refrigerator, and locked storage for controlled drugs, and has a minimum area of fifty (50) square feet. A medicine dispensing unit may be located at the nurse's station, in the clean workroom, or in an alcove or other space convenient to staff for staff control; ( )

vii. Clean linen storage. A separate closet or a designated area within the clean workroom is provided. If a closed cart system is used, storage may be in an alcove; ( )

viii. Nourishment station. The station contains a sink equipped for handwashing, equipment for serving nourishment between scheduled meals, refrigerator, and storage cabinets. Ice for residents' service and treatment is provided only by icemaker-dispenser units; ( )

ix. Equipment storage room(s). Room(s) is available for storage of equipment such as I.V. stands, inhalators, air mattresses, and walkers; ( )

x. Resident bathing facilities. A minimum of one (1) bathtub or shower is provided for each ten (10) beds not otherwise served by bathing facilities at resident rooms. Residents have access to at least one (1) bathtub in each nursing unit. Each tub or shower is in an individual room or enclosure that provides space for private use of the bathing fixture, for drying and dressing, and for a wheelchair and attendant. At least one (1) shower in each central bathing facility has a minimum of four (4) feet square without curbs and designed for use by a wheelchair. ( )

f. Resident Toilet Facilities. That each resident toilet room meets the following criteria: ( )

i. The minimum dimensions of a room containing only a water closet is three (3) feet by six (6) feet. Additional space is provided if a lavatory is located within the same room. Water closets are accessible for use by wheelchair residents. ( )

ii. At least one (1) room on each floor is appropriate for toilet training. It is accessible from the corridor. A clearance of three (3) feet is provided at the front and at each side of the water closet and the room contains a lavatory. ( )

iii. A toilet room is accessible to each central bathing area without having to go through the general corridor. This may be arranged to serve as the required toilet training facility. ( )

g. Sterilizing Facilities. That a system for the sterilization of equipment and supplies is provided. ( )

05. Resident Dining and Recreation Areas. The following minimum requirements apply to dining/recreation areas. ( )

a. Area Requirement. The total area set aside for these purposes is at least thirty (30) square feet per bed with a minimum, total area of at least two hundred twenty-five (225) square feet. For facilities with more than

one hundred (100) beds, the minimum area may be reduced to twenty-five (25) square feet per bed. If day care programs are offered, additional space is provided as needed to accommodate for day care residents needing naps or for dining and activities. ( )

b. Storage. Storage space is provided for recreational equipment and supplies. ( )

06. Rehabilitation Therapy Facilities. Each facility must include provisions for physical and occupational therapy for rehabilitation of long term care residents. Areas and equipment is necessary to meet the intent of the program. As a minimum, the following must be located on-site, convenient for use to the nursing unit: ( )

a. Space for files, records and administrative activities. ( )

b. Storage for supplies and equipment. ( )

c. Storage for clean and soiled linen. ( )

d. Handwashing facilities within the therapy unit. ( )

e. Space and equipment for carrying out each of the types of therapy that may be prescribed. ( )

f. Provisions for resident privacy. ( )

g. Janitor closets, in or near unit. ( )

h. If the program includes outpatient treatment, additional provisions include: ( )

i. Convenient access from exterior for use by the handicapped. ( )

ii. Lockers for secure storage of residents' clothing and personal effects. ( )

iii. Outpatient facilities for dressing and changing. ( )

iv. Showers for resident use. ( )

i. Waiting area with provision for wheelchair outpatients. ( )

07. Personal Care Unit. A separate room must be provided with equipment for hair care and grooming needs of the residents. ( )

08. Dietary Facilities. The following must be provided: ( )

a. Handwashing facilities in the food preparation area. ( )

b. Resident meal service space including facilities for tray assembly and distribution. ( )

c. Warewashing in a room or an alcove separate from food preparation and serving areas. This includes commercial type dishwashing equipment. Space is also provided for receiving, scraping, sorting, and stacking soiled tableware and for transferring clean tableware to the using area. Handwashing facilities are conveniently available. ( )

d. Potwashing facilities. ( )

e. Waste storage facilities that are easily accessible for direct pickup or disposal. ( )

f. Office or suitable work space for the dietitian or food service supervisor. ( )

g. Toilets for dietary staff with handwashing facility immediately available. ( )

h. Janitor's closet located within the dietary department. The closet contains a floor receptor or service sink and storage space for housekeeping equipment and supplies. ( )

09. Administration and Public Areas. The following must be provided: ( )

a. Entrance at grade level, sheltered from the weather and able to accommodate wheelchairs. ( )

b. Lobby space, including: ( )

i. Storage space for wheelchairs. ( )

ii. Reception and information counter or desk. ( )

iii. Waiting space(s). ( )

iv. Public toilet facilities. ( )

v. Public telephone(s). ( )

vi. Drinking fountain(s). ( )

c. General or individual office(s) assuring privacy for interviews, business transactions, medical and financial records, and administrative and professional staff. ( )

d. Multipurpose room for conferences, meetings, and health education purposes. ( )

e. Storage for office equipment and supplies. ( )

10. Linen Services. The following requirements apply: Laundry processing room with commercial type equipment with which a seven (7) days' need can be processed. ( )

11. Central Stores. General storage rooms must have a total area of not less than ten (10) square feet per bed and concentrated in one (1) area. ( )

12. Janitors' Closets. In addition to the janitors' closets called for in certain departments, sufficient janitor's closets must be provided throughout the facility to maintain a clean and sanitary environment. These contain a floor receptor or service sink and storage space for housekeeping equipment and supplies. ( )

13. Engineering Services and Equipment Areas. The following must be provided: ( )

a. Equipment room(s) or separate building(s) for boilers, mechanical equipment and electrical equipment. ( )

b. Office or suitable desk space for the engineer. ( )

c. Maintenance shop(s). ( )

d. Storage room(s) for building maintenance supplies. ( )

e. Yard equipment storage consisting of a separate room or building for yard maintenance equipment and supplies if ground maintenance is provided by the facility. ( )

14. Details and Finishes. A high degree of safety for the residents must be provided to minimize the

incidence of accidents with special consideration for residents who will be ambulatory to assist them in self-care. Hazards such as sharp corners must be avoided. All details and finishes for modernization projects as well as for new construction must comply with the following requirements: ( )

a. Details: ( )

i. All rooms containing bathtubs, sitz baths, showers, and water closets subject to occupancy by residents are equipped with doors and hardware that will permit access from the outside of the rooms in an emergency. When such rooms have only one (1) opening or are small, the doors must open outwards or be designed to be opened without the need to push against a resident who may have collapsed within the room. ( )

ii. Windows and outer doors that may be frequently left in an open position are provided with insect screens. ( )

iii. Doors, sidelights, borrowed lights, and windows in which the glazing extends down to within eighteen (18) inches of the floor (thereby creating a possibility for accidental breakage by pedestrian traffic) is glazed with safety glass, wire glass, or plastic glazing material that will resist breaking and will not create dangerous cutting edges when broken. Similar materials are used in wall openings of recreation rooms and exercise rooms unless required otherwise for safety. Safety glass or plastic glazing materials as noted above are used for shower doors and bath enclosures. ( )

iv. Dumbwaiters, conveyors, and material handling systems do not open directly into a corridor or exitway. ( )

vi. Thresholds and expansion joint covers are made flush with the floor surface to facilitate use of wheelchair and carts. ( )

vi. Grab bars are provided at all resident toilets, showers, tubs, and sitz baths. The bars have one and one-half (1-1/2) inches clearance to walls and sufficient strength and anchorage to sustain a concentrated load of two hundred fifty (250) pounds. ( )

vii. Recessed soap dishes are provided in showers and bathrooms. ( )

viii. Handrails are provided on both sides of corridors used by residents. A clear distance of one and one-half (1-1/2) inches is provided between the handrail and the wall. Ends are returned to the wall. ( )

ix. The arrangement of handwashing facilities provides sufficient clearance for blade-type operating handles and are installed to permit use by wheelchair residents. ( )

x. Lavatories and handwashing facilities are securely anchored to withstand an applied vertical load of not less than two hundred fifty (250) pounds on the front of the fixture. ( )

xi. Mirrors are arranged for convenient use by residents in wheelchairs as well as by residents in a standing position. ( )

xii. Paper towel dispensers and waste receptacles are provided at all handwashing fixtures. ( )

xiii. Ceiling heights are as follows: ( )

(1) Boiler rooms have ceiling clearances not less than two (2) feet, six (6) inches above the main boiler header and connecting piping. ( )

(2) Rooms containing ceiling-mounted equipment have height required to accommodate the equipment. ( )

(3) All other rooms have not less than eight (8) foot ceilings except that corridors, storage rooms, toilet rooms, and other minor rooms may not have less than seven (7) feet, eight (8) inches. Suspended tracks, rails, and

pipes located in the path of normal traffic are not less than six (6) feet, eight (8) inches above the floor. ( )

xiv. Recreation rooms, exercise rooms, and similar spaces where impact noises may be generated are not located directly over resident bed areas unless special provisions are made to minimize the noise. ( )

b. Finishes: ( )

i. Floor materials are easily cleaned and have wear resistance appropriate for the location involved. Floors in areas used for food preparation or food assembly are water resistant and grease proof. Joints in tile and similar materials in such areas are resistant to food acids. In all areas frequently subject to wet cleaning methods or spillage, floor materials are not physically affected by germicidal and cleaning solutions. Floors that are subject to traffic while wet (such as shower and bath areas, kitchens, and similar work areas) have an impervious nonslip surface. Vinyl asbestos tile is not acceptable for such areas. ( )

ii. Wall bases in kitchens, soiled workrooms, and other areas that are frequently subject to wet cleaning methods are made integral and coved with the floor, tightly sealed within the wall, and constructed without voids that can harbor insects. ( )

iii. Wall finishes are washable and in the immediate area of plumbing fixtures smooth and moisture resistant. Finish, trim, and wall and floor construction in dietary and food preparation areas are free from spaces that can harbor rodents and insects. ( )

iv. Floor and wall penetrations by pipes, ducts and conduits are tightly sealed to minimize entry of rodents and insects. Joints of structural elements are similarly sealed. ( )

v. Ceilings throughout the facility are easily cleanable. Ceilings in the dietary and food preparation areas have a finished ceiling covering all overhead piping and duct work. Finished ceilings may be omitted in mechanical and equipment spaces, shops, general storage areas and similar spaces, unless required for fire resistance purposes. ( )

15. Construction Features. The facility must be designed and constructed to sustain dead and live loads in accordance with local building codes. All construction must comply with applicable provisions of the codes and standards as listed in Section 121 and as follows: ( )

a. All buildings having resident use areas on more than one (1) floor have at least one (1) electrical or electrohydraulic elevator. ( )

b. All mechanical installations comply with applicable codes and the following: ( )

i. Prior to completion, all mechanical systems are tested, balanced, and operated to demonstrate to the owner or representative that the installation and operation conform to the plans and specifications. ( )

ii. Heating and cooling ventilating systems. ( )

(1) Normal comfort the design temperature for all occupied areas provides a minimum of sixty-eight degrees (68) and a maximum of eighty degrees (80) Fahrenheit. ( )

(2) All air supply and air exhaust systems are mechanically operated. All fans serving exhaust systems are located at the discharge end of the system. ( )

c. Outdoor air intakes are located as far as practical but not less than twenty-five (25) feet from exhaust outlets of ventilating systems, combustion equipment stacks, medical-surgical vacuum systems, plumbing vent stacks, or from areas that may collect vehicular exhaust and other noxious fumes. The bottom of outdoor air intakes serving central systems are located as high as practical but not less than six (6) feet above ground level or, if installed above the roof, three (3) feet above roof level. ( )

d. The bottom of ventilation opening is not be less than three (3) inches above the floor of any room.

( )

e. All central ventilation or air-conditioning systems are equipped with filters having efficiencies no less than: ( )

i. Eighty percent (80%) for resident care, treatment, diagnostic, and related areas that may be reduced to thirty-five (35%) for all outdoor air systems. ( )

ii. Eighty percent (80%) for food preparation areas and laundries. ( )

iii. Twenty-five percent (25%) for all administrative, bulk storage, and sorted holding areas. ( )

f. Plumbing standards. All plumbing systems are designed to meet the following: ( )

i. Shower bases and tubs are provided with nonslip surfaces. ( )

ii. The water supply system are designed to supply water at sufficient pressure to operate all fixtures and equipment during maximum demand periods. ( )

iii. Vacuum breakers are installed on hose bibs, janitors' sinks, bedpan flushing attachments, and on all other fixtures to which hoses or tubing can be attached. ( )

iv. Water distribution systems are arranged to provide hot water at each hot water outlet at all times. Hot water at shower, bathing, and handwashing facilities do not exceed one hundred twenty degrees (120) Fahrenheit. ( )

v. Hot water heating equipment has sufficient capacity to supply water at the temperature and amounts as follows: ( )

(1) Clinical. Six and one-half (6 1/2) gallons per hour per bed at one hundred twenty degrees (120) Fahrenheit. ( )

(2) Dietary. Four (4) gallons per hour per bed at one hundred eighty degrees (180) Fahrenheit. ( )

(3) Laundry. Four and one-half (4 1/2) gallons per hour per bed at one hundred sixty-five degrees (165) Fahrenheit. ( )

g. Electrical standards. All electrical installations comply with applicable codes and the following: ( )

i. General. Prior to completion, all electrical installations and systems are tested to show that the equipment is installed and operating as planned or specified. ( )

ii. Switchboards and power panels are located in a separate enclosure accessible only to authorized personnel. ( )

iii. Panel boards serving lighting and appliance circuits are located on the same floor as the circuits they serve. ( )

iv. Lighting: ( )

(1) All spaces occupied by people, machinery and equipment within buildings, approaches to buildings and parking lots have lighting. ( )

(2) Residents have general lighting and night lighting. A reading light is provided for each resident. At least one (1) light fixture for night lighting is switched at the entrance to each resident room. All switches for control

of lighting in resident areas are of the quiet operating type. ( )

v. Receptacles (convenience outlets): ( )

(1) Resident rooms. Each resident room has duplex ground type receptacles as follows: One (1) on each side of the head of each bed; one (1) for television if used; and one (1) on another wall. ( )

(2) Corridors. Duplex receptacles for general use are installed approximately fifty (50) feet apart in all corridors and within twenty-five (25) feet of ends in corridors. ( )

vi. Equipment installation in special areas. The electrical circuits to fixed or portable equipment in hydrotherapy units are provided with five (5) milliampere ground fault interrupters. ( )

vii. Nurse/staff calling system. A nurse/staff calling system is provided as specified in Subsection 121.05.d.x. ( )

122. FURNISHINGS AND EQUIPMENT.

01. Furnishings – Resident Living Rooms and Bedrooms. Living rooms for residents' use must be provided with a sufficient number of reading lamps, tables, chairs, or sofas of satisfactory design for age and condition of the residents. The following requirements must be met: ( )

a. Each resident is provided with their own bed that is at least thirty-six (36) inches wide, have a head and a footboard, be substantially constructed, and in good repair. Roll-away type beds, cots, folding beds, double beds, or Hollywood-type beds are not to be used. ( )

b. Each bed is provided with satisfactory type springs in good repair and a clean, comfortable mattress at least five (5) inches thick, (four (4) inches if of foam rubber construction and four and one-half (4-1/2) inches if of innerspring type) and standard in size for the bed. ( )

c. Each resident is provided with an individual rack with towel and washcloth. ( )

d. In addition to basic resident care equipment, each resident is provided an individual reading light, bedside cabinet with drawer, comfortable chair, and storage space for clothing and other possessions. ( )

e. Each resident is provided with a cup and a covered pitcher of fresh water (or the equivalent) at the bedside if the resident needs assistance to ambulate but is able to drink without assistance. ( )

02. General Requirements. Equipment and supplies must be provided to satisfactorily meet the individualized needs of the residents of the facility. Equipment and supplies will vary according to the size of the facility and the type of residents. An authorized representative of the Department will make the final determination as to the adequacy and suitability of equipment and supplies. The following must be met: ( )

a. Cubicle curtains of fire-retardant material that are designed to enclose the bed are provided in multiple-bed rooms to ensure privacy for the residents. Alternatives may be provided if equivalent privacy is allowed. ( )

b. All furniture and equipment are maintained in a sanitary manner, kept in good repair, and be located for convenient use. ( )

c. An adequate supply of clean linen is available and in good repair to keep the resident clean, odor-free, and insures the comfort of the resident. ( )

d. Equipment and supplies are stored in a designated area specific for equipment and supplies. Utensils not in use are sterilized prior to being stored. Those that cannot be sterilized are thoroughly cleansed in accordance with procedures approved by the Department. ( )

e. All utensils are kept in good condition. Chipped and otherwise damaged utensils are not to be used. ( )

f. Any single-use or disposable equipment and supplies are not to be reused. ( )

123. -- 150. (RESERVED)

151. ACTIVITIES PROGRAM.
The facility must provide adequate funding for the activity program. Residents must not be required to support the funding. ( )

152. SOCIAL SERVICES.
The facility must provide for the identification of the social and emotional needs of the residents either directly or through arrangements with an outside resource and provide means to meet the needs identified. Sufficient staff must be provided to implement the program as follows: ( )

01. Licensed Social Worker. That a social worker is licensed by the state of Idaho as a social worker or who receives regular consultation from such a qualified social worker. ( )

02. Outside Resources. That if the facility does not provide the services directly but arranges with an outside resource to provide the services, a facility staff member is designated in writing as a liaison person. ( )

03. Identify and Implement Programs. That the facility ensures that identification of needs and implementation of programs meets the needs and appropriate record keeping is accomplished. ( )

153. (RESERVED)

154. PHYSICIAN SERVICES.
The following standards must be met: ( )

01. Physician Supervision. That each resident is under the direct and continuing supervision of a physician of their own choice licensed by the Idaho Board of Medicine. ( )

02. Necessary Medical Information. That the physician provides the facility with medical information necessary to care for the resident that includes at least a current history and physical or medical findings completed made no longer than five (5) days prior to admission or within forty-eight (48) hours after admission. The information includes diagnosis, medical findings, activity limitations, and rehabilitation potential. ( )

03. Physician's Plan of Care. That a physician's plan of care is provided to the facility upon admission of the resident that reflects medication orders, treatments, diet orders, activity level approved, and any other directives to the facility for the care of the resident. ( )

04. Plan of Care Review. That the physician's plan of care for the resident is reviewed by the physician as follows: ( )

a. Every thirty (30) to sixty (60) days for skilled care residents depending upon the visit schedule authorized. ( )

b. The plan of care is reordered with any changes included by the physician and signed and dated by the physician at the time of the review. ( )

155. -- 199. (RESERVED)

200. NURSING SERVICES.
The following requirements must be met: ( )

01. Director of Nursing Services (DNS). A licensed registered nurse currently licensed by the state of

Idaho and qualified by training and experience is designated DNS in each SNF and is responsible and accountable for the following: ( )

a. Participating in the development and implementation of resident care policies; ( )

b. Developing and/or maintaining goals and objectives of nursing service, standards of nursing practice, and nursing policy and procedures manuals; ( )

c. Assisting in the screening and selection of prospective residents in terms of their needs, and the services available in the facility; ( )

d. Observing and evaluating the condition of each resident and developing a written, individualized patient care plan that is based upon an assessment of the needs of each resident, and that is kept current through review and revision; ( )

e. Recommending to the administrator the numbers and categories of nursing and auxiliary personnel to be employed and participating in their recruitment, selection, training, supervision, evaluation, counseling, discipline, and termination when necessary. Developing written job descriptions for all nursing and auxiliary personnel; ( )

f. Planning and coordinating orientation programs for new nursing and auxiliary personnel, as well as a formal, coordinated in-service education program for all nursing personnel; ( )

g. Preparing daily work schedule for nursing and auxiliary personnel that includes names of employees, professional designation, hours worked, and daily patient census; and ( )

h. Coordinating the nursing service with related resident care services; ( )

02. Minimum Staffing Requirements. That minimum staffing requirements include the following: ( )

a. A Director of Nursing Services (DNS) works full time on the day shift but the shift may be varied for management purposes. If the DNS is temporarily responsible for administration of the facility, there is a licensed registered nurse (RN) assistant to direct patient care. The DNS is required for all facilities five (5) days per week. ( )

i. The DNS in facilities with an average occupancy rate of sixty (60) residents or more has strictly nursing administrative duties. ( )

ii. The DNS. in facilities with an average occupancy rate of fifty-nine (59) residents or less may, in addition to administrative responsibilities, serve as the supervising nurse. ( )

b. A supervising nurse, licensed registered nurse, or a licensed practical nurse, and who meets the requirements designated by the Idaho Board of Nursing to assume responsibilities as a charge nurse and meets the definition in Subsection 002.35. ( )

c. A charge nurse, a licensed registered, or a licensed practical nurse, and who meets the requirements designated by the Idaho Board of Nursing to assume responsibilities as a charge nurse in accordance with the definition in Subsection 002.07. A charge nurse is on duty as follows: ( )

i. In SNFs with an average occupancy rate of fifty-nine (59) residents or less a licensed registered nurse is on duty eight (8) hours of each day and no less than a licensed practical nurse is on duty for each of the other two (2) shifts. ( )

ii. In SNFs with an average occupancy rate of sixty (60) to eighty-nine (89) residents a licensed registered nurse is on duty for each a.m. shift (approximately 7:00 a.m. - 3:00 p.m.) and p.m. shift (approximately 3:00 p.m. to 11:00 p.m.) and no less than a licensed practical nurse on the night shift. ( )

iii. In SNFs with an average occupancy rate of ninety (90) or more residents a licensed registered nurse is on duty at all times. ( )

iv. In those facilities authorized to utilize a licensed practical nurse as charge nurse, the facility must make documented arrangements for a licensed registered nurse to be on call for these shifts to provide professional nursing support. ( )

d. Nursing hours per resident per day are provided to meet the total needs of the residents. The minimum staffing is as follows: ( )

i. Skilled Nursing Facilities with a census of fifty-nine (59) or less residents provide two and four-tenths (2.4) hours per resident per day. Hours do not include the DNS but the supervising nurse on each shift may be counted in the calculations of the two and four-tenths (2.4) hours per resident per day. ( )

ii. Skilled Nursing Facilities with a census of sixty (60) or more residents provide two and four-tenths (2.4) hours per resident per day. Hours do not include the DNS or supervising nurse. ( )

iii. Nursing hours per resident per day are required seven (7) days a week with provision for relief personnel. ( )

iv. Skilled Nursing Facilities are considered in compliance with the minimum staffing ratios if, on Monday of each week, the total hours worked by nursing personnel for the previous seven (7) days equal or exceed the minimum, staffing ratio for the same period when averaged on a daily basis and the facility has received prior approval from the Licensing Agency to calculate nursing hours in this manner. ( )

e. Combined Hospital and Skilled Nursing Facility. In a combined facility the DNS may serve both the hospital and long term care unit with supervising and charge nurses as required under Subsection 200.02.b. and 200.02.c. In a combined facility of less than forty-one (41) beds, the supervising or charge nurse may be an LPN. Combined beds (forty-one (41) or less) represent the total number of acute care (hospital) and long term care (nursing home) beds. ( )

f. Waiver of Licensed Registered Nurse as Supervising or Charge Nurse. In the event that a facility is unable to hire licensed registered nursing personnel to meet these regulation requirements, a licensed practical nurse will satisfy the requirements so long as: ( )

i. The facility continues to seek a licensed registered nurse at a compensation level at least equal to that prevailing in the community; ( )

ii. A documented record of efforts to secure employment of licensed registered nursing personnel is maintained in the facility; ( )

iii. The facility maintains at least forty (40) hours a week R.N. coverage. ( )

g. There is at least two (2) nursing personnel on duty on each shift to ensure resident safety in the event of accidents, fires, or other disasters. ( )

h. Nursing care is given only by licensed staff, nursing personnel, and auxiliary nursing personnel. ( )

03. Resident Care. That nursing staff must document on the resident medical record, any assessments of the resident, any interventions taken, effect of interventions, significant changes and observations, and the administration of medications, treatments, and any other services provided, and entries made at the time the action occurs with signature, date and time. At a minimum, a monthly summary of the resident's condition and reactions to care must be written by a licensed nursing staff person. ( )

04. Medication Administration. Medications must be provided to residents by licensed nursing staff

in accordance with established written procedures that includes at least the following: ( )

a. Administered in accordance with physician's, dentist's, or nurse practitioner's written orders; ( )

b. The resident is identified prior to administering the medication; ( )

c. Medications are administered as soon as possible after preparation; ( )

d. Medications are administered only if properly identified; ( )

e. Medications are administered by the person preparing the medication for delivery to the resident (exception: Unit dose); ( )

f. Residents are observed for reactions to medications and if a reaction occurs, it is immediately reported to the charge nurse and attending physician; ( )

g. Each resident's medication is properly recorded on their individual medication record by the person administering the medication. The record includes: ( )

i. Method of administration; ( )

ii. Name and dosage of the medication; ( )

iii. Date and time of administration; ( )

iv. Site of injections; ( )

v. Name or initial (that has elsewhere been identified) of person administering the medication; ( )

vi. Medications omitted; ( )

vii. Medication errors (that are reported to the charge nurse and attending physician. ( )

05. Tuberculosis Control. That in order to assure the control of tuberculosis in the facility, there is a planned, organized program of prevention through written and implemented procedures that are consistent with current accepted practices and includes: ( )

a. The results of a T.B. skin test is established for each resident upon admission. If the status is not known upon admission, a T.B. skin test is done as soon as possible, but no longer than thirty (30) days after admission. ( )

b. If the T.B. skin test is negative, the test does not have to be repeated. ( )

c. If the T.B. skin test is positive, if determined upon admission or following the test conducted after admission, the resident receives a chest x-ray. A chest x-ray conducted thirty (30) days prior to admission is acceptable. ( )

d. When a chest x-ray is indicated and the resident's condition presents a transportation problem to the x-ray machine, a Sputum culture for m.tuberculosis is acceptable instead of a chest x-ray until the resident's next visit for any purpose to a place where x-ray is available. ( )

e. Annual T.B. skin testing and/or chest x-rays are not required. ( )

f. If a case of T.B. is found in the facility, all residents and employees are retested. ( )

201. PHARMACY SERVICES.
The following requirements must be met: ( )

01. Pharmacy Service. That each SNF has a written agreement with a pharmacist licensed by the state of Idaho to direct, supervise, and be responsible for pharmacy service in the facility and for coordinating services when more than one (1) supplier of medications is utilized by the facility. ( )

02. Care of General Medications. That the care and handling of medications is conducted in the following manner: ( )

a. Medications are administered to residents of the SNF only on the order of a person authorized by law in Idaho to prescribe medications. This order is recorded on the resident's medical record, dated and signed by the ordering physician, dentist or nurse practitioner. ( )

b. All telephone and verbal orders are taken by licensed nurses, pharmacists and physicians only, and recorded on the resident's clinical record, dated and signed by the person taking the order. Telephone and verbal orders are countersigned by the ordering physician, dentist or nurse practitioner within seven (7) days. ( )

c. No person other than licensed nursing personnel and physicians administer medications. This does not include execution of duties of inhalation therapists as ordered by the attending physician. ( )

d. Nursing service personnel do not package or repackage, bottle or label any medication, in whole or in part. ( )

e. Prescription medication is administered only to the resident whose name appears on the prescription legend. ( )

f. All medications are labeled with the original prescription legend including the name and address of the pharmacy, resident's name, physician's name, prescription number, original date and refill date, dosage unit, number of dosage units, and instructions for use and drug name. (Exception: See Unit Dose System.) ( )

g. No alteration or replacement of original prescription legend is allowed. ( )

h. Prescription renewal or refill is made only under physician's, dentist's, or nurse practitioner's authorization. ( )

i. Drugs dispensed meet the standards established by the United States Pharmacopeia, the National Formulary, New Drugs, the Idaho Board of Pharmacy, and the U.S. Food and Drug Administration. ( )

j. All medications in the facility are maintained in a locked cabinet with the key for the lock carried only by licensed nursing personnel and/or the pharmacist. ( )

k. Poisons and toxic chemicals are stored in separate locked areas apart from medications. ( )

03. Record of Medications. ( )

a. An accurate and complete record of all medication given, both prescription and nonprescription, is recorded in the resident's chart. The record includes the time given, the medication given, date, dosage, method of administration, and the name and professional designation (R.N., L.P.N.) of the person preparing and administering the medication. The first and last name initials may be used if identified fully elsewhere in the medical record. ( )

b. Entries are made on the resident's medication record whenever medications are started or discontinued. ( )

c. Reasons for administration of a PRN medication and the resident's response to the medication are documented in the nurse's notes. ( )

04. Unit Dose Pharmacy. That a unit dose pharmacy system may be provided in a SNF as the drug distribution system under the following rules and regulations. ( )

a. All residents of the facility are served by the unit dose system. ( )

b. All medications distributed to the residents are under the unit dose system, if they are prepared and available in unit dose. ( )

c. The unit dose system is on a signed, written agreement basis between the facility and the pharmacist. If the facility employs a pharmacist to operate its own in-house pharmacy, a signed, written agreement is not necessary. ( )

d. All medications are packaged by individual unit dose, and labeled with drug (proprietary and/or generic) name, unit of dose, and lot identification number or date packaged, and such other rules that may be promulgated by the Board of Pharmacy. The pharmacist maintains a log identifying the drug lot number by date packaged. ( )

e. The pharmacist (or the facility) provides suitable drug-distribution cabinets that can be locked, or in lieu of a locked cabinet, medications are stored in a room that can be locked. Safe, orderly transport of the drug distribution cabinets are assured by the pharmacist. ( )

f. A direct copy of all medication orders from the resident's chart are supplied to the pharmacist in a timely manner so that they can maintain each individual resident's medication profile in the pharmacy from which they fill each resident's twenty-four (24) hour medication orders. ( )

g. The pharmacist is responsible to see that each individual resident's medication drawer is filled from the drug distribution cabinet each twenty-four (24) hours from the resident's medication profile; records individual doses not administered from returned sets of drawers; indicates the reason the medication was not administered; and records medications supplied for the next twenty-four (24) hour period. ( )

h. Designated nursing staff check each resident's medication drawer contents against their medication profile prior to distribution to the resident. ( )

i. The unit dose system is an alternate to packaging and labeling requirements and does not preclude the facility from meeting all other requirements of Section 201. ( )

05. Customized Medication Packaging. That the packaging of medications commonly referred to as "blister paks," "punch cards" and "bingo cards" may be utilized by the facility provided that measures of accountability, safety and sanitation are employed. Customized packaging is not to be interpreted to mean a unit dose system. All other requirements of Section 201 applies except for alternate packaging systems. ( )

202. PET THERAPY.
The following requirements must be met: ( )

01. Policies and Procedures. That policies and procedures are developed by the facility concerning the admission of pets through a visitation program or on a permanent basis. ( )

02. Type of Pet Allowed. That the types of pets allowed are as follows: ( )

a. Only domesticated household pets (dogs, cats, birds, fish, hamsters, etc.) are permitted. Exotic pets and wild animals, even though trained, are not be permitted due to the high potential for spread of disease and injury to residents or staff. These include, but are not limited to, iguanas, snakes and other reptiles, monkeys, raccoons and skunks. Turtles are not permitted in the facility. ( )

b. If animals that are prohibited as designated in Subsection 202.02.a. of these rules are brought in for visitation, they are kept on a leash and under the control of the trainer at all times. ( )

03. Examination of Pets. That pets receive an examination by a veterinarian prior to admission to the facility. Appropriate vaccinations are given. Birds subject to transmission of psittacosis are included. ( )

04. Enclosures. That small animals such as hamsters and birds are kept in enclosures. ( )

05. Permitted Areas. That pets are not to be allowed in food preparation or storage areas or any other area if their presence would pose a significant risk to residents, staff or visitors. ( )

06. Interference. That the presence of pets do not interfere with the health and rights of other individuals, i.e., noise, odor, allergies, and interference with the free movement of individuals about the facility. ( )

203. RESIDENT RECORDS.
The facility maintains medical records for all residents in accordance with accepted professional standards and practices. The following requirements must be met: ( )

01. Responsible Staff. That the administrator designates a staff member the responsibility for the accurate maintenance of medical records. If this person is not a Registered Health Information Administrator (RHIA) or a Registered Health Information Technician (RHIT), consultation from such a qualified individual is provided periodically to the designated staff person. ( )

02. Individual Medical Record. That an individual medical record is maintained for each admission with all entries kept current, dated, and signed. ( )

03. Confidentiality. That the facility safeguards medical record information against loss, destruction, and unauthorized use. ( )

204. DAY CARE SERVICES.
Day care services may be provided for up to twelve (12) hours per day as determined by facility policy. If provided, it cannot interfere with the regular services to facility residents. The following requirements must be met: ( )

01. Staffing. That the facility provides additional staff depending upon the number of day care participants with the following: ( )

a. Assure that in-house facility residents are provided the nursing hours per resident per day as described in Subsection 200.02.c. ( )

b. Assure that the day care participants receive the services necessary to meet their needs. ( )

02. Records. That a day care participant record is maintained. ( )

03. Space and Supplies. That facilities accepting day care participants provide such space and supplies as necessary to comfortably and efficiently meet the needs of both in-house residents and day care participants. ( )

205. CHILD CARE CENTERS.
The following requirements must be met: ( )

01. Policies and Procedures. That any facility that permits a child care center adjacent to or attached to the skilled nursing facility establishes well-defined written and implemented policies and procedures pertaining to the relationship between the child care center and the SNF. These include, but are not limited to infection control and prevention of disease transmission. ( )

02. Day Care Licensure. That any day care home or day care center for children, as defined under Basic Day Care License Act, Sections 39-1101 through 39-1117, Idaho Code, either attached as a distinct part or as a separate facility on the premises of the SNF facility is licensed separately by the appropriate state or local licensing

agency. ( )

03. Day Care Compliance. That every child day care home or center complies with the Idaho Department of Health and Welfare Rules, IDAPA 16.02.10, "Idaho Reportable Diseases." ( )

04. Day Care Staff. That each child day care home or center is staffed appropriately to meet the needs of the children cared for as a completely separate staff from those employees of the SNF facility. ( )

206. -- 300. (RESERVED)

301. RESPITE CARE SERVICES.
If the SNF offers respite care to relieve families or other individuals, there must be policies and procedures written and implemented regarding the program. The following requirements must be met: ( )

01. Admissions. That respite care residents are admitted to the facility in the same manner as any other admission that includes, but is not limited to: ( )

a. Authorization by a physician. ( )

b. Current medical and other information sufficient to allow the facility to safely care for the resident. ( )

c. Medication and treatment orders signed and dated by the resident's attending physician. ( )

02. Limitations. That no resident is considered as respite care when the stay at the facility is not for purposes of relief for other care givers or families and that exceeds a four (4) week period of time. Variances may be granted by the Department on a case-by-case basis. ( )

03. Records. That records are maintained for all respite care residents that include at least the following: ( )

a. Medical information sufficient to care for the resident submitted by the attending physician. ( )

b. Signed and dated physician's orders for care, including diet, medications, treatments, and any physical activity limitations. ( )

c. Nursing and other notes by staff caring for the resident. ( )

d. Medication administration record. ( )

e. Pertinent resident data information such as name, address, next of kin, who to call in an emergency, name of physician, etc. ( )

04. Exceptions. That due to the short length of stay, certain documents and actions provided to and required for other in-house nonrespite care residents are not required for respite care residents. Allowances to be considered are as follows: ( )

a. A complete history and physical examination by the physician is not required so long as he provides the facility with sufficient information to care for the resident. ( )

b. Physician visits are required only if the resident needs such a visit due to illness or injury or if the resident exceeds the definition of respite care and remains in the facility beyond a four (4) week period of time. ( )

c. The resident care plan may be limited to include care and services to be provided during their stay and short and long term goals are not necessary. ( )

d. Activity assessments and plans are not necessary so long as any activity limitations are known and recorded on the resident's plan of care. ( )

302. (RESERVED)

303. OTHER SERVICES.
If a SNF offers home health, hospice, or other services from the facility, the needs and requirements for the delivery of those services must in no way interfere with the ongoing operation of the SNF. ( )

304. -- 999. (RESERVED)

000. LEGAL AUTHORITY.
The Idaho Legislature has granted the Department of Health and Welfare authority to enter into contracts and agreements with the Federal government to carry out the purposes of any Federal acts pertaining to public assistance or welfare services. The Department of Health and Welfare has authority to make rules governing the administration and management of the Department's business, pursuant to Sections 56-203, Idaho Code. ( )

001. TITLE, SCOPE, AND PURPOSE.

01. Title. These rules are titled IDAPA 16.03.04 "Idaho Food Stamp Program." ( )

02. Scope. These rules contain the requirements for application and the eligibility criteria to receive benefits in the Food Stamp Program. These rules are administered by the Department of Health and Welfare for the United States Department of Agriculture. ( )

03. Purpose. The purpose of these rules is to raise the nutritional level among low-income households whose limited food purchasing power contributes to hunger and malnutrition among members of such households. These rules also provide the regulatory basis for that procedure. ( )

002. -- 007. (RESERVED)

008. AUDIT, INVESTIGATION AND ENFORCEMENT.
In addition to any actions specified in these rules, the Department may audit, investigate and take enforcement action under the provisions of IDAPA 16.05.07, "Investigation and Enforcement of Fraud, Abuse or Misconduct." ( )

009. (RESERVED)

010. DEFINITIONS A THROUGH D.
For the Food Stamp Program, the following definitions apply: ( )

01. Adequate Notice. Notice a household must receive on or before the first day of the month an action by the Department is effective. ( )

02. Administrative Error Claim. A claim resulting from an overissuance caused by the Department's action or failure to act. ( )

03. Aid to the Aged, Blind and Disabled (AABD). Cash, excluding in-kind assistance, financed by federal, state or local government and provided to cover living expenses or other basic needs. ( )

04. Applicant. A person applying for Food Stamps. ( )

05. Application for Participation. The application form filed by the head of the household or authorized representative. ( )

06. Application for Recertification. When a household applies for recertification within thirty (30) days of the end of the certification period, it is considered an application for recertification even if a partial month of benefits is received. ( )

07. Authorized Representative. A person designated by the household to act on behalf of the household to apply for or receive and use Food Stamps. Authorized representatives include private nonprofit organizations or institutions conducting a drug addiction or alcoholic treatment and rehabilitation center acting for center residents. Authorized representatives include group living arrangement centers acting for center residents. Authorized representatives include battered women's and children's shelters acting for the shelters' residents. Homeless meal providers may not be authorized representatives for homeless Food Stamp recipients. ( )

08. Battered Women and Children's Shelter. A shelter for battered women and children which is a public or private nonprofit residential facility. If the facility serves others, a portion of the facility must be set aside on a long-term basis to serve only battered women and children. ( )

09. Boarder. Any person or group to whom a household, other than a commercial boarding house, furnishes meals and lodging in exchange for an amount equal to or greater than the thrifty food plan. Children,

parents and spouses in a household must not be treated as boarders. ( )

10. Boarding House. A licensed commercial enterprise offering meals and lodging for payment to make a profit. ( )

11. Broad Based Categorical Eligibility. If a participant meets the eligibility requirements found in 7 CFR Section 273.2(j)(2) as well as all other Food Stamp eligibility criteria, then the participant is eligible for Food Stamps. Participants who are eligible under this definition are also subject to resource, gross, and net income eligibility standards. ( )

12. Categorical Eligibility. If all household members receive or are authorized to receive monthly cash payment through TAFI, AABD or SSI, the household is categorically eligible. Categorically eligible households are exempt from resource, gross and net income eligibility standards. ( )

13. Certification Period. The period of time a household is certified to receive Food Stamp benefits. The month of application counts as the first month of certification. ( )

14. Contact (Six-Month). A six-month contact is a recertification that waives the interview requirement, allowing for written contact and verification of the participant's circumstances in lieu of the interview. ( )

15. Claim Determination. The action taken by the Department establishing the household's liability for repayment when an overissuance of Food Stamps occurs. ( )

16. Client. A person entitled to or receiving Food Stamps. ( )

17. Department. The Idaho Department of Health and Welfare. ( )

18. Disqualified Household Members. Individuals required to be excluded from participation in the Food Stamp Program are Disqualified Household Members. These include: ( )

a. Ineligible legal non-citizen who do not meet the citizenship or eligible legal non-citizen requirements. ( )

b. Individuals awaiting proof of citizenship when citizenship is questionable. ( )

c. Individuals disqualified for failure or refusal to provide a Social Security Number (SSN). ( )

d. Individuals disqualified for Intentional Program Violation (IPV). ( )

e. Individuals disqualified for receiving three (3) months of Food Stamps in a three (3) year period in which they did not meet the work requirement for able-bodied adults without dependent children. ( )

f. Individuals disqualified as a fugitive felon or probation or parole violator. ( )

g. Individuals disqualified for a voluntary quit or reduction of hours of work to less than thirty (30) hours per week. ( )

h. Individuals disqualified for failure to cooperate in establishing paternity and obtaining support for a child under eighteen (18). ( )

i. Individuals convicted under federal or state law of any offense classified as a felony involving the possession, use, or distribution of a controlled substance when they do not comply with the terms of a withheld judgment, probation, or parole. The felony must have occurred after August 22, 1996. ( )

19. Documentation. The method used to record information establishing eligibility. The information

must sufficiently explain the action taken and the proof and how it was used. ( )

20. Drug Addiction or Alcoholic Treatment Program. Any drug addiction or alcoholic treatment rehabilitation program conducted by a private nonprofit organization or institution or a publicly operated community mental health center under Part B of Title XIX of the Public Health Service Act (42 USC 300x, et seq.). Indian reservation based centers may qualify if FNS requirements are met and the program is funded by the National Institute on Alcohol Abuse under Public Law 91-616 or was transferred to Indian Health Service funding. ( )

011. DEFINITIONS E THROUGH L.
For the Food Stamp Program, the following definitions apply: ( )

01. Electronic Benefit Transfer. A method of issuing Food Stamps to an eligible household. ( )

02. Eligible Foods. Any food or food product for human consumption excluding alcohol, tobacco, and hot foods and hot food products ready for immediate consumption. Eligible foods include: ( )

a. Garden seeds and plants to grow food for human consumption. ( )

b. Meals prepared for the elderly at a communal dining facility. ( )

c. Meals prepared and delivered by an authorized meal delivery service. ( )

d. Meals served to a narcotics addict or alcoholic who participate and reside in a rehabilitation center program. ( )

e. Meals prepared and served by an authorized group living center to blind or disabled residents who receive benefits under Titles I, II or X, XIV, XVI of the Social Security Act. ( )

f. Meals prepared and served at a shelter for battered women and children to eligible residents. ( )

g. Meals prepared and served by an authorized public or private nonprofit establishment to homeless Food Stamp participants. ( )

03. Eligible Household. A household living in Idaho and meeting the eligibility criteria in these rules. ( )

04. Emancipated Minor. A person, age fourteen (14) but under age eighteen (18), who has been married or whose circumstances show the parent and child relationship has been renounced such as a child in the military service. ( )

05. Enumeration. The requirement that each household member provide the Department either their Social Security Number (SSN) or proof that they have applied. ( )

06. Exempt. A household member who is not required to register for or participate in the JSAP program is exempt. A household member who is not required to register for work is exempt. ( )

07. Extended Certification Household (EC). A household in which all members are elderly or disabled, and no one has earned income. ( )

08. Fair Hearing. A fair hearing in an appeal of a Department decision. See Section 003 of these rules for appeals. ( )

09. Federal Fiscal Year. The federal fiscal year (FFY) is from October 1 to September 30. ( )

10. Field Office. A Department of Health and Welfare service delivery site. ( )

11. Food and Nutrition Service (FNS). The Food and Nutrition Service of the U.S. Department of Agriculture. This is the federal entity that administers the Food Stamp program. ( )

12. Group Living Arrangement. A public or private nonprofit residential setting serving no more than sixteen (16) residents. The residents are blind or disabled and receiving benefits under Title II or XVI of the Social Security Act, certified by the Department under regulations issued under Section 1616(e) of the Social Security Act, or under standards determined by the Secretary of USDA to be comparable to Section 1616(e) of the Social Security Act. ( )

13. Homeless Person. A person: ( )

a. Who has no fixed or regular nighttime residence. ( )

b. Whose primary nighttime residence is a temporary accommodation for not more than ninety (90) days in the home of another individual or household. ( )

c. Whose primary nighttime residence is a temporary residence in a supervised public or private shelter providing temporary residence for homeless persons. ( )

d. Whose primary nighttime residence is a temporary residence in an institution which provides temporary residence for people who are being transferred to another institution. ( )

e. Whose primary nighttime residence is a temporary residence in a public or private place which is not designed or customarily used as sleeping quarters for people. ( )

14. Homeless Meal Provider. A public or private nonprofit establishment or a profit-making restaurant which provides meals to homeless people. The establishment or restaurant must be approved by the Department and authorized as a retail food store by FNS. ( )

15. Identification Card. The card identifying the bearer as eligible to receive and use Food Stamps. ( )

16. Inadvertent Household Error Claim (IHE). A claim resulting from an overissuance, caused by the household's misunderstanding or unintended error. A household error claim pending an intentional program violation decision. ( )

17. Income and Eligibility Verification System (IEVS). A system of information acquisition and exchange for income and eligibility verification which meets Section 1137 of the Social Security Act requirements. ( )

18. Institution of Higher Education. Any institution which normally requires a high school diploma or equivalency certificate for enrollment. These institutions include colleges, universities, and business, vocational, technical, or trade schools at the post-high school level. ( )

19. Institution of Post-Secondary Education. Educational institutions normally requiring a high school diploma or equivalency certificate for enrollment, or admits persons beyond the age of compulsory school attendance. The institution must be legally authorized by the state and provide a program of training to prepare students for gainful employment. ( )

20. Legal Noncitizen. A qualified alien under 8 USC Section 1641(b). ( )

21. Limited Utility Allowance (LUA). Utility deduction given to a food stamp household that has a cost for more than one (1) utility. This includes electricity and fuel for purposes other than heating or cooling, water, sewage, well and septic tank installation and maintenance, telephone, and garbage or trash collection. ( )

012. DEFINITIONS M THROUGH Z.

For the Food Stamp Program, the following definitions apply: ( )

01. Migrant Farmworker Household. A migrant farmworker household has a member who travels from community to community to do agricultural work. ( )

02. Minimum Utility Allowance (MUA). Utility deduction given to a food stamp household that has a cost for one (1) utility that is not heating, cooling, or telephone. ( )

03. Nonexempt. A household member who must register for and participate in the JSAP program. A household member who must register for work. ( )

04. Nonprofit Meal Delivery Service. A political subdivision or a private nonprofit organization, which prepares and delivers meals, authorized to accept Food Stamps. ( )

05. Overissuance. The amount Food Stamps issued exceeds the Food Stamps a household was eligible to receive. ( )

06. Parental Control. Parental control means that an adult household member has a minor in the household who is dependent financially or otherwise on the adult. Minors, emancipated through marriage, are not under parental control. Minors living with children of their own are not under parental control. ( )

07. Participant. A person who receives Food Stamp benefits. ( )

08. Program. The Food Stamp Program created under the Food Stamp Act and administered in Idaho by the Department. ( )

09. Public Assistance. Public assistance means Temporary Assistance for Families in Idaho (TAFI), and Aid to the Aged, Blind, and Disabled (AABD). ( )

10. Recertification. A recertification is a process for determining ongoing eligibility for Food Stamps. ( )

11. Retail Food Store. A retail food store, for Food Stamp purposes means: ( )

a. An establishment, or recognized department of an establishment, or a house-to-house food trade route, whose food sales volume is more than fifty percent (50%) staple food items for home preparation and consumption. ( )

b. Public or private communal dining facilities and meal delivery services. ( )

c. Private nonprofit drug addict or alcohol treatment and rehabilitation programs. ( )

d. Public or private nonprofit group living arrangements. ( )

e. Public or private nonprofit shelters for battered women and children. ( )

f. Private nonprofit cooperative food purchasing ventures, including those whose members pay for food prior to the receipt of the food. ( )

g. A farmers' market. ( )

h. An approved public or private nonprofit establishment which feeds homeless persons. The establishment must be approved by FNS. ( )

12. Sanction. A penalty period when an individual is ineligible for Food Stamps. ( )

13. Seasonal Farmworker Household. A seasonal farmworker household has a member who does

agricultural work of a seasonal or other temporary nature. ( )

14. Self-Employment. Self-employment is the process of actively earning income directly from one's own business, trade, or profession. To be considered self-employed, a person is responsible for obtaining or providing a service or product that generates or is expected to generate income. Self-employment applies only to a business owned by one (1) person. A business owned by more than one (1) person is considered employment, not self-employment. ( )

15. Spouse. Persons who are legally married under Idaho law. ( )

16. Standard Utility Allowance (SUA). Utility deduction given to a food stamp household that has a cost for heating or cooling. ( )

17. State. Any of the fifty (50) States, the District of Columbia, Puerto Rico, Guam, the Northern Mariana Islands and the Virgin Islands of the United States. ( )

18. State Agency. The Idaho Department of Health and Welfare. ( )

19. Student. An individual between the ages of eighteen (18) and fifty (50), physically and intellectually fit, and enrolled at least half-time in an institution of higher education. ( )

20. Supplemental Security Income (SSI). Monthly cash payments under Title XVI of the Social Security Act. Payments include state or federally administered supplements. ( )

21. Systematic Alien Verification for Entitlements (SAVE). The federal automated system that provides immigration status needed to determine an applicant's eligibility for many public benefits, including Food Stamps. ( )

22. Telephone Utility Allowance (TUA). Utility deduction given to a Food Stamp household that has a cost for telephone services and no other utilities. ( )

23. Timely Notice. Notice that is mailed via the U. S. Postal Service, or electronically, at least ten (10) days before the effective date of an action taken by the Department. ( )

24. Twelve Month Contact. For households that have a twenty-four (24) month certification period, Department staff contact the household during the twelfth month of the certification period for the purpose of determining continued eligibility. ( )

25. Tribal General Assistance. Cash, excluding in-kind assistance, financed by federal, state or local government and provided to cover living expenses or other basic needs. This cash is intended to promote the health and well-being of recipients. ( )

26. Verification. The proof obtained to establish the accuracy of information and the household's eligibility. ( )

27. Verified Upon Receipt. Food stamp benefits are adjusted on open food stamp cases when information is received from "verified upon receipt" sources. Information "verified upon receipt" is received from a manual query or automated system match with the Social Security Administration or Homeland Security query for citizenship status. ( )

28. Written Notice. Correspondence that is generated by any method including handwritten, typed, or electronic, delivered to the customer by hand, U.S. Mail, professional delivery service, or by any electronic means. The terms "notice" and "written notice" are used interchangeably. ( )

013. ABBREVIATIONS A THROUGH G.

For the purposes of the Food Stamp Program, the following abbreviations are used. ( )

01. **AABD**. Aid to the Aged, Blind and Disabled. ( )

02. **ABAWD**. Able bodied adults without dependents. ( )

03. **AE**. Administrative Error. ( )

04. **AFA**. Application for Assistance. ( )

05. **BIA**. Bureau of Indian Affairs. ( )

06. **BIA GA**. Bureau of Indian Affairs-general assistance. ( )

07. **COLA**. Cost of Living Allowance. COLA data comes from SSA. ( )

08. **CSS**. Bureau of Child Support Services. ( )

09. **DHW**. The Department of Health and Welfare in Idaho. ( )

10. **DMV**. Department of Motor Vehicles in Idaho. ( )

11. **EBT**. Electronic Benefit Transfer. ( )

12. **EWS**. Enhanced Work Services. ( )

13. **FNS**. The Food and Nutrition Service of the U.S. Department of Agriculture. ( )

14. **FFY**. Federal fiscal year. ( )

15. **FMV**. Fair market value. ( )

16. **FPG**. Federal Poverty Guideline(s). ( )

17. **FQC**. Federal Quality Control. ( )

18. **HUD**. The U.S. Department of Housing and Urban Development. ( )

014. ABBREVIATIONS I THROUGH Z.

For the purposes of the Food Stamp Program, the following abbreviations are used. ( )

01. **ICCP**. Idaho Child Care Program. ( )

02. **IHE**. Inadvertent household error. ( )

03. **INS**. Immigration and Naturalization Service, in 2003, became the United States Citizenship and Immigration Service (USCIS), a Division of Homeland Security. ( )

04. **INA**. Immigration and Nationality Act. ( )

05. **IPV**. Intentional program violation. ( )

06. **IRS**. Internal Revenue Service. ( )

07. **JSAP**. Job Search Assistance Program. ( )

08. **LUA**. Limited utility allowance. ( )

09. **MUA**. Minimum utility allowance. ( )

10. **PA**. Public Assistance. ( )

11. **RSDI**. Retirement, Survivors, Disability Insurance received from SSA. ( )

12. **SAVE**. Systematic Alien Verification for Entitlements. ( )

13. **SDX**. State Data Exchange. ( )

14. **SQC**. State Quality Control. ( )

15. **SRS**. Self Reliance Specialist. ( )

16. **SUA**. Standard utility allowance. ( )

17. **SSA**. Social Security Administration. ( )

18. **SSI**. The Federal Supplemental Security Income Program for the aged, blind or disabled. ( )

19. **SSN**. Social Security number. ( )

20. **TAFI**. Temporary Assistance for Families in Idaho. ( )

21. **TOP**. Treasury Offset Program. ( )

22. **TUA**. Telephone Utility Allowance. ( )

23. **UI**. Unemployment Insurance. ( )

24. **USDA**. United States Department of Agriculture. ( )

25. **VA**. The Veterans Administration. ( )

26. **WIOA**. The Workforce Innovation and Opportunity Act. ( )

27. **WIC**. The special supplemental Food Program for Women, Infants, and Children. ( )

015. -- 098. **(RESERVED)**

099. SIGNATURES.
An individual who is applying for benefits, receiving benefits, or providing additional information as required by this chapter, may do so with the depiction of the individual's name either handwritten, electronic, or recorded telephonically. Such signature serves as intention to execute or adopt the sound, symbol, or process for the purpose of signing the related record. ( )

100. APPLICATION.
To apply for Food Stamps, the household or an authorized representative must complete and file the application form, interview with the Department and verify information. There is no age requirement for applicants. Applicants may bring anyone to the interview. The Department will act on all applications. The Department will grant Food Stamps to eligible households back to the date of application. ( )

101. APPLICATION FORMS.
Households can file an application the first day they contact the Department. The Department will have Application for Assistance (AFA) (HW 0901) forms readily available to households. ( )

01. **Expectation**. The household must turn in page one (1) of the AFA to file for Food Stamps. The Department will provide an AFA to any person making a request. Requests for the application can be made by

telephone, in person or by another person. The Department will mail or give the AFA to the person on the day requested. ( )

02. Explanation of Application Process. The Department will provide a written statement telling what the household must do to complete the application process. The statement will identify sources of the proof needed to complete the application process. ( )

102. (RESERVED)

103. FILING AN APPLICATION.
The AFA must contain the applicant's name, address, signature and application date. A household can file for Food Stamps by turning in page one of the AFA to the Food Stamp office. This protects the application date. If the household is eligible, Food Stamps for the first month will be prorated from the application date. The AFA can be submitted at the Field Office by the household or authorized representative. The AFA can be submitted by mail.
( )

104. -- 105. (RESERVED)

106. DETERMINATION OF WHEN A NEW APPLICATION FOR ASSISTANCE (AFA) IS REQUIRED.
The Department must follow the procedure outlined in 7 CFR 273.2(g) and (h) in determining when a food stamp household is required to fill out a new application for assistance (AFA). ( )

107. -- 112. (RESERVED)

113. HOUSEHOLD COOPERATION.
The household must cooperate with the Department. The application must be denied if the household refuses to cooperate. Refusal to cooperate includes failing to act without a sound and timely excuse. Giving false information on purpose is failure to cooperate. The Department must show false information was given on purpose before denying the application. The household is ineligible if it refuses to cooperate in a six-month or twelve-month contact, recertification, program review or evaluation. If an application is denied or Food Stamps are stopped for refusal to cooperate, the household can reapply. The household is not eligible until it cooperates with the Department.
( )

114. APPLICATION WITHDRAWAL.
Households can withdraw their application any time before the eligibility decision. The Department will document the withdrawal reason in the case record and whether the household was contacted to confirm the withdrawal. The Department will tell the household of the right to reapply. ( )

115. AUTHORIZED REPRESENTATIVE.
The household can choose a nonhousehold member to act as an authorized representative. The household can designate in writing another responsible household member or a responsible adult outside the household as an authorized representative. An adult employee, of an authorized drug addiction or alcoholic treatment and rehabilitation center or an authorized group living arrangement center, may act as an authorized representative for the household. Conditions for an authorized representative are: ( )

01. Designating Authorized Representative. When household members cannot apply for, receive or use Food Stamps, the household can choose an authorized representative. The household must appoint the authorized representative in writing. The authorized representative should be aware of household circumstances. The household should prepare or review the AFA when the authorized representative will be interviewed. ( )

02. Persons Who Cannot Be an Authorized Representative. Persons with a conflict of interest may not act as an authorized representative without the Department's written approval. The Field Office supervisor must determine if no one else is available and give written approval. Persons with a conflict of interest are listed below:
( )

a. Retailers allowed to accept Food Stamps. ( )

b. Department employees involved in the certification or issuance process. ( )

c. A person disqualified for IPV during the penalty period, unless he is the only adult household member and no one else is available. ( )

d. Homeless meal providers. ( )

03. Department Responsibilities. The Department will: ( )

a. Make sure authorized representatives are properly selected. ( )

b. Record the representative's name in the case record. ( )

c. Not place limits on the number of households a representative may represent. ( )

d. Inform the household it will be liable for any overissuance resulting from wrong information given by the representative. ( )

e. Make sure the household freely requested the representative. ( )

f. Make sure the household is getting the correct amount of benefits. ( )

g. Make sure the representative is properly using the Food Stamps. ( )

04. Authorized Representative Removed. The Department may remove an authorized representative for up to one (1) year if the person knowingly distorts a household's circumstances, gives false information, or improperly uses the Food Stamps. This provision does not apply to drug and alcohol centers and group homes. Written notice must be sent to the household and the authorized representative thirty (30) days before the penalty begins. The notice must list: ( )

a. The proposed action. ( )

b. The reason for the action. ( )

c. The right to a fair hearing. ( )

d. The name and telephone number to contact for more information. ( )

05. Contingency Designation. A household member able to apply for and get Food Stamps can name an authorized representative, in writing, in case the household becomes unable to use Food Stamps. ( )

06. Emergency Designation. The household may choose an emergency authorized representative if unforeseen circumstances arise. The household must complete a statement appointing the person as the authorized representative. The authorized representative must sign the statement. The household cannot be required to go to the Field Office to complete this statement. ( )

116. -- 119. (RESERVED)

120. HOUSEHOLD INTERVIEWS.
The Department must conduct an interview with the applicant, a member of the household, or the authorized representative. Interviews must be conducted either face-to-face or via telephone, based on hardship criteria evident in the case record. The applicant may bring any other person to the interview. The Department does not require households to report for an in-office interview during their certification period. The frequency of the interview must be as follows: ( )

01. Twenty-Four Months. The interview must be at least once every twenty-four (24) months for households certified for twenty-four (24) months. ( )

02. Twelve Months. The interview must be every twelve (12) months for all other households. ( )

121. -- 132. (RESERVED)

133. VERIFICATION.
The Department must have verification to support the benefit determination. Verification is third party data or documents used to prove the accuracy of AFA information. The Department must give the applicant household a clear written statement of the proof to bring to the interview. The statement will indicate the Department will help the household get proof if needed. The Department must give the household ten (10) calendar days from the request date to provide proof. Proof can be provided in person, by mail or by an authorized representative. If the proof supplied is faulty, not complete or not consistent, the Department can require further proof. The Department must notify the household of any other steps necessary to complete the application process. ( )

134. (RESERVED)

135. SOURCES OF VERIFICATION.
The following sources of verification must be considered: ( )

01. Written Confirmation. A primary source of proof is written confirmation of circumstances. Written proof includes driver's licenses, work or school identification, birth certificates, wage stubs, award letters, court orders, divorce decrees, separation agreements, insurance policies, rent receipts and utility bills. Acceptable proof is not limited to a single document. Proof can be obtained from the household or other sources. Secondary sources of proof must be used to verify a household's circumstances if the primary source cannot be obtained or does not prove eligibility or benefit level. ( )

02. Collateral Contacts. A collateral contact is an oral confirmation of a household's circumstances by a person outside of the household. The collateral contact may be made either in person or over the telephone. ( )

03. Automated System Data. Information that is obtained through interfacing with other government agency computer systems. ( )

136. (RESERVED)

137. PROOF FOR QUESTIONABLE INFORMATION.
Prior to the certification, a six-month or twelve-month contact, or recertification of the household, the Department must verify all questionable information regarding eligibility and benefit level. Proof is required when details are not consistent with information received by the Department. Proof may be obtained either verbally or in writing. ( )

138. PROVIDING PROOF TO SUPPORT APPLICATION STATEMENTS.
The household has primary responsibility to provide proof supporting its statements on the application. The household has primary responsibility to resolve any questionable information. The Department must assist the household in obtaining proof. Households may supply proof in person, through the mail, by facsimile or other electronic device, or through an authorized representative. The Department will not require the household to present proof in person. ( )

139. -- 141. (RESERVED)

142. PROCESSING STANDARDS.
The Department will determine Food Stamp eligibility within thirty (30) days of the application date. The application date is the day the AFA is received and date stamped by the Field Office. The application date for a person released from a public institution is the release date, if the person applied for Food Stamps before his release. The AFA must contain at least the applicant's name and address. The AFA must be signed by a responsible household member or representative. ( )

143. -- 145. (RESERVED)

146. DENIAL OF FOOD STAMP APPLICATION.
The Department will deny the Food Stamp application under conditions listed below. The Department will send the household notice of denial. ( )

01. Household Ineligible. The Department will deny the application for ineligible households as soon as possible, but not later than thirty (30) calendar days following the application date. ( )

02. Household Fails to Appear for Interview. If the household fails to appear for an interview, and fails to contact the Department, the application will be denied thirty (30) calendar days after the application date. ( )

03. Household Does Not Provide Proof After Interview. If the household did not provide requested proof after an interview or later request, the Department will deny the application ten (10) calendar days after the request for proof. ( )

147. CASE ACTION AFTER DELAY CAUSED BY HOUSEHOLD.
The Department must follow the procedure outlined in 7 CFR 273.2(g) and (h) in determining the appropriate action to take on food stamp benefits when the household has delayed completing the application process. ( )

148. DELAYS IN PROCESSING CAUSED BY THE DEPARTMENT.
A processing delay exists when the Department does not determine Food Stamp eligibility within thirty (30) days of application. The Department will determine the cause of the delay. Delays caused by the Department are: ( )

01. No Application Help. The Department did not offer or try to offer help to complete the application. ( )

02. Work Registration. ( )

a. The Department did not register household members for work. ( )

b. The Department did not inform the household of the need to register for work. ( )

c. The Department did not give the household ten (10) days from the notice date to register for work. ( )

03. Application Forms Mailed Late. Application forms were requested in writing or by telephone. The Department did not mail the application forms the same day the household made the request. ( )

04. Proof. The Department did not allow the household ten (10) days from the notice date to provide the missing proof. ( )

149. (RESERVED)

150. DELAYS OVER SIXTY DAYS.
If the Department caused the delay, the Department will process the original application until an eligibility decision is made. The original application must be used even if the second thirty (30) day period has passed. If the household is found eligible and the delay was the Department's fault during the first thirty (30) days, provide Food Stamps back to the application date. If the household is found eligible and the delay was the household's fault during the first thirty (30) days and the Department's fault during the second thirty (30) days, issue Food Stamps for the month after the application month. If the household is at fault for the first and second thirty (30) day delay, deny the application. A new application is required. ( )

151. -- 154. (RESERVED)

155. EXPEDITED SERVICE ELIGIBILITY.
Applicants must be screened to determine if the household is entitled to expedited service. The household must meet one (1) of the expedited service criteria below. The household must have provided proof postponed by the last expedited service or have been certified under the normal standards since the last expedited service. ( )

01. Low Income and Resources. To receive expedited services the household's monthly countable gross income must be less than one hundred fifty dollars ($150) and the household's liquid resources must not exceed one hundred dollars ($100). ( )

02. Destitute. To receive destitute expedited services the household must be a destitute migrant or seasonal farmworker household. The household's liquid resources must not exceed one hundred dollars ($100). ( )

03. Income Less Than Rent and Utilities. The household's combined monthly gross income and liquid resources are less than their monthly rent, or mortgage, and utilities cost. ( )

156. TIME LIMITS FOR EXPEDITED FOOD STAMPS.
Time limits for acting on expedited Food Stamp applications are listed below: ( )

01. Seven Day Limit for Food Stamps. For households entitled to expedited service, the Department will provide Food Stamps to the household within seven (7) days of the application date. ( )

02. Seven Days After Discovery. If not discovered at initial screening, the Department will provide expedited services to an expedite eligible household within seven (7) days. Seven (7) days begins the day after the Department finds the household is entitled to expedited service. ( )

03. Seven Days for Waived Interview. The Department will provide expedited services within seven (7) days for households entitled to an office interview waiver. Seven (7) days is counted from the application date. If a telephone interview is conducted, the AFA must be mailed to the household for signature. The mailing time must not be included in the seven (7) days. Mailing time includes the days the AFA is in the mail to and from the household. Mailing time includes the days the AFA is at the household pending signature and mailing. ( )

04. Treatment Centers. For residents of drug addiction or alcoholic treatment centers, Food Stamps must be provided within seven (7) days of the application date. ( )

05. Shelter Residents. For residents of shelters for battered women and children, Food Stamps must be provided within seven (7) days of the application date. ( )

157. EXPEDITED FOOD STAMP WORK REGISTRATION.
The applicant must complete work registration unless he is exempt or has a representative register him. Other non-exempt household members must register if the registration can be done in seven (7) days. ( )

158. EXPEDITED VERIFICATION.
The Department will verify the applicant's identity through readily available proof or a collateral contact. Proof may include identification such as a driver's license, birth certificate or voter registration card. The Department will try to get proof so that benefits can be issued within seven (7) days of the application date. Expedited Food Stamps must not be delayed beyond seven (7) days for proof other than identity. Other proof can be postponed to issue expedited Food Stamps. ( )

159. (RESERVED)

160. EXPEDITED CERTIFICATION.
If all required proof is provided for expedited certification, a normal certification period is assigned. Certification based on application date, household type and proof is listed below: ( )

01. Nonmigrant Household Applying from the First Through the Fifteenth of the Month. For a non-migrant household applying from the first through the fifteenth of the month, if proof of eligibility factors is

postponed, assign a normal certification period. Issue the first month's benefits. Do not issue the second month's benefits until the postponed proof is received. When proof is postponed the household has thirty (30) days from the application date to provide the proof. The household must be given timely and adequate notice no further benefits will be issued until proof is completed. If the proof results in changes in the household's Food Stamps, the Department will act on the changes without advance notice. If postponed proof is provided before the second month, process an issuance for the first working day of the second month. If proof is provided in the second month, issue benefits within seven (7) calendar days from the date the proof is received. If postponed proof is not provided within thirty (30) days from the application date, close the case. ( )

02. Nonmigrant Household Applying from the Sixteenth Through the End of the Month. For a non-migrant household applying from the sixteenth to the end of the month, if proof of eligibility factors is postponed, assign a normal certification period. Issue the first and second month's benefits within the expedited time frame. When proof is postponed the household has thirty (30) days from the application date to complete the proof. The household must be given timely and adequate notice no further benefits will be issued until proof is completed. If the proof results in changes in the household's Food Stamps, the Department will act on the changes without advance notice. If postponed proof is provided within thirty (30) days, process an issuance for the first working day of the third month. If postponed proof is not provided within thirty (30) days from the application date, close the case. ( )

03. Migrant Household Applying from the First Through the Fifteenth of the Month. For a migrant household applying from the first (1st) through the fifteenth (15th) of the month, if proof of eligibility factors is postponed, assign a normal certification period. Issue the first month's benefits. When proof is postponed the household has thirty (30) days from the application date to complete in-state proof. The household has sixty (60) days from the application date to complete out-of-state proof. The household must be given adequate and timely notice no further benefits will be issued until the postponed proof is completed. Before the second month's benefits are issued, the household must provide all in-state postponed proofs. Before the third month's benefits are issued, the household must provide all out-of-state postponed proof. If the proofs result in changes in the household's Food Stamps the Department will act on these changes, without providing advance notice. Migrants are entitled to postponed out-of-state proof only once each season. If postponed in-state proof is provided before the second month, process an issuance for the first working day of the second month. If postponed out-of-state proof is provided before the third month, process a regular issuance for the third month. If postponed out-of-state proof is provided in the third month, issue benefits within seven (7) calendar days from the date proof is received. If postponed in-state proof is not provided within thirty (30) days from the application date, close the case. If postponed out-of-state proof is not provided within sixty (60) days from the application date, close the case. ( )

04. Migrant Household Applying from the Sixteenth Through the End of the Month. For a migrant household applying from the Sixteenth to the end of the month, if proof of eligibility factors is postponed, assign a normal certification period. Issue the first and second months' benefits within the expedited time frame. When proof is postponed the household has thirty (30) days from the application date to provide in-state proof. The household has sixty (60) days from the application date to provide out-of-state proof. The household must be given adequate and timely notice no further benefits will be issued until the postponed proof is completed. Before the third month's benefits are issued, the household must provide all in-state and out-of-state postponed proofs. If the proofs result in changes in the household's Food Stamps the Department will act on these changes without providing advance notice. Migrants are entitled to postponed out-of-state proof only once each season. If postponed proof is provided before the third month, process a regular issuance for the third month. If postponed out-of-state proof is provided in the third month, issue benefits within seven (7) calendar days from the date proof is received. If postponed in-state proof is not provided within thirty (30) days from the application date, close the case. If postponed out-of-state proof is not provided within sixty (60) days from the application date, close the case. ( )

05. Reapplying Household. When a household granted postponed proof at the last expedited certification reapplies, it must provide the postponed proof. The Department does not require postponed proof if the household was certified under normal standards since the last expedited certification. ( )

161. NO LIMIT TO EXPEDITED CERTIFICATIONS.

There is no limit to the number of times a household can receive expedited certification. The household must provide proof postponed at the last expedited certification. The Department does not require postponed proof if the household was certified under normal standards since the last expedited certification. ( )

162. EXPEDITED SERVICES FOR DESTITUTE HOUSEHOLDS.
Migrant or seasonal farmworker households meeting destitute conditions below can get expedited services. The rules for destitute households apply at initial application, the six-month or twelve-month contact, and recertification, but only for the first month of each contact or certification period. ( )

01. Terminated Source of Income. The household's only income for the application month was received before the application date and was from a terminated source. The household is considered destitute. Terminated income is income received monthly or more often, no longer received from the same source the rest of the application month or the next month or income received less often than monthly, not expected in the month the next regular payment is normally due. ( )

02. New Income in Application Month. When only new income is expected in the application month, the household is considered destitute. Only twenty-five dollars ($25), or less, of new income can be received in the ten (10) days after the application date. Income is new if twenty-five dollars ($25), or less, is received during the thirty (30) days before the application date. New income received less often than monthly was not received in the last normal payment interval or was twenty-five dollars ($25) or less. ( )

03. Terminated Income and New Income in Application Month. Destitute households can get terminated income before the application date and new income before and after the application date. New income must not be received for ten (10) days after application and must not exceed twenty-five dollars ($25). The household must get no other income in the application month. ( )

04. Application Month. For the application month, count only income received between the first day of the month and the application date. Do not count income from a new source expected after the application date. ( )

163. SPECIAL CONSIDERATION OF INCOME FOR DESTITUTE HOUSEHOLDS.
Special consideration of income for destitute households is listed below. The rules for destitute households apply at initial application, a six-month or twelve-month contact, and recertification, but only for the first month of each contact or certification period. ( )

01. Travel Advances. For destitute eligibility and benefit level, travel advances apply as follows: Travel advances from employers for travel costs to a new employment location are excluded. Travel advances against future wages are counted as income, but not a new source of income. ( )

02. Household Member Changes Job. A person changing jobs with the same employer is still getting income from the same source. A migrant's income source is the grower, not the crew chief. When a migrant moves with a crew chief from one (1) grower to another, the income from the first grower is ended. The income from the next grower is new income. ( )

03. Recertification or Six-Month or Twelve-Month Contact. Disregard income from the new source for the first month of the new certification period if more than twenty-five dollars ($25) will not be received by the tenth calendar day after the normal issuance. ( )

164. DENIAL OF EXPEDITED SERVICE.
The Department will deny expedited service if the household does not meet expedite criteria. The Department will deny expedited service if the household fails to cooperate in the application process. Failure to cooperate includes missing a scheduled expedited service appointment. The Department will still process the application under standard methods. ( )

165. CONTESTING DENIED EXPEDITED SERVICE.
The Department will offer an agency conference to a household contesting denial of expedited services. The Department will tell households they can request an agency conference. The Department will tell a household an agency conference will not delay or replace a fair hearing. Migrant farmworker households and households planning to move are entitled to expedited fair hearings. ( )

166. -- 176. (RESERVED)

177. FOOD STAMPS FOR TAFI OR AABD HOUSEHOLDS.
The Department will tell TAFI or AABD applicants they can apply for Food Stamps when they apply for TAFI or AABD. Households, applying for TAFI or AABD and Food Stamps at the same time, must complete an application for TAFI or AABD and Food Stamps. Households may be eligible for an out-of-office interview. The Food Stamps must be issued by Food Stamp rules. The Department will tell Food Stamp households, applying for TAFI, that TAFI time limits and requirements do not apply to the Food Stamp program. Households no longer receiving TAFI may still be eligible for Food Stamps. ( )

178. CATEGORICALLY ELIGIBLE HOUSEHOLDS.
Households with all members meeting one (1) of the criteria below are categorically eligible for Food Stamps. The Department will not compute resource eligibility. The Department will not compute gross or net income eligibility. Categorically eligible households must meet all other Food Stamp eligibility criteria. Categorically eligible households have the same rights as other households. ( )

01. Cash Benefits. All household members are approved for, or already receive, TAFI or AABD or SSI cash benefits. The household is categorically eligible. ( )

02. Benefits Recouped. All household members have AABD or SSI benefits being recouped. The household is categorically eligible. ( )

03. Grant Less Than Ten Dollars. All household members not receiving TAFI or AABD or SSI because their grant is less than ten dollars ($10). The household is categorically eligible. ( )

179. HOUSEHOLDS NOT CATEGORICALLY ELIGIBLE.
The households listed below are not categorically eligible for Food Stamps. ( )

01. Medicaid Only. Households are not categorically eligible if any household member receives Medicaid benefits only. ( )

02. IPV. Households are not categorically eligible, if any household member is disqualified for a Food Stamp Intentional Program Violation (IPV). ( )

03. Work Requirements. Households are not categorically eligible, if any household member fails to comply with the Food Stamp work requirements. ( )

04. Ineligible Legal Non-Citizen or Student. Households are not categorically eligible if any member is an ineligible legal non-citizen or ineligible student. ( )

05. Nonexempt Institution. Households are not categorically eligible if any member is a person living in a nonexempt institution. ( )

180. CATEGORICAL ELIGIBILITY ENDS.
Categorical eligibility ends when the household member is no longer eligible for TAFI, AABD or SSI. If the household is still eligible under Food Stamp rules, the household will continue to receive Food Stamps. If categorical eligibility ends and household income or resources exceed the Food Stamp limits, the household is no longer eligible for Food Stamps. Food Stamps will stop after timely advance notice. ( )

181. BROAD BASED CATEGORICALLY ELIGIBLE HOUSEHOLD EXCEPTIONS.
If a household contains any of the following members, the household is not eligible under Broad Based Categorical Eligibility. ( )

01. IPV. Any household member is disqualified for an Intentional Program Violation (IPV). ( )

02. Drug-Related Felony. Any household member is ineligible because of a drug-related felony. ( )

03. Strike. Any household member is on strike. ( )

04. Transferred Resources. Any household member transferred resources in order to qualify for benefits. ( )

05. Refusal to Cooperate. Any household member refused to cooperate in providing information that is needed to determine initial or ongoing eligibility. ( )

182. VERIFICATION FOR TAFI OR AABD HOUSEHOLDS.
To determine eligibility for Food Stamps in TAFI or AABD households, the Department will use TAFI or AABD proof. ( )

183. TIME LIMITS FOR CATEGORICALLY ELIGIBLE HOUSEHOLDS.
Food Stamp eligibility can be determined before a public assistance eligibility determination is made. The Food Stamp application must not be delayed or denied because of a delayed public assistance decision. If a Food Stamp household might be categorically eligible, the application cannot be denied until thirty (30) days after the application date. ( )

184. -- 194. (RESERVED)

195. DISASTER CERTIFICATION.
When allowed by FNS, under the authority of Section 302(a) of the Disaster Relief Act of 1974, the Department can certify households affected by a natural disaster. If the Secretary of USDA declares a disaster area, the Department will follow disaster instructions issued by the USDA. ( )

196. -- 199. (RESERVED)

200. NONFINANCIAL CRITERIA.
Nonfinancial criteria are identification, residency, Social Security Number, citizenship, and work requirements. Households must meet these nonfinancial criteria to be eligible for Food Stamps. ( )

201. IDENTIFICATION.
The person making application for Food Stamps must prove identity. The authorized representative, applying on behalf of a household, must prove identity. If an authorized representative is used, the identity of the head of the household must also be proved. Proof includes a driver's license, school identification, wage stubs, and birth certificates. The Department will accept other reasonable proof of identity. ( )

202. RESIDENCY.
A household must live in Idaho when it applies for Food Stamps. A person can get Food Stamps as a member of only one (1) household a month. ( )

01. Place of Residency. Households must live in the project area in which they make application. An eligible Food Stamp household is not required to live in a permanent dwelling or have a fixed mailing address. There is no residence duration requirement. ( )

02. Vacationing Persons Not Residents. Persons in Idaho for vacation only are not residents for Food Stamp eligibility. Vacation is the period a household spends away from their usual activity, work, or home. Vacation is taken for travel, rest, or recreation. ( )

03. Physical and Mailing Address Different. The physical address and the mailing address of a Food Stamp household can be different. If the mailing address is not the household's physical address, the household must provide proof of the physical address. ( )

203. SOCIAL SECURITY NUMBER (SSN) REQUIREMENT.

01. Expectations. Before certification, households must provide the Department the SSN, or proof of

application for SSN, for each household member. If a household member has more than one (1) SSN, he must provide all of his SSNs. Each SSN must be verified by the Social Security Administration (SSA). A household member with an unverified SSN is not eligible for Food Stamp benefits. The ineligible person's income and resources must be counted in the Food Stamp budget. If benefits are reduced or ended, because one (1) or more persons fail to meet the SSN requirement, the household must be notified in writing. ( )

02. Good Cause for Not Applying for SSN. If a household member can show good cause why an SSN application was not completed in a timely manner, an extension must be granted to allow him to receive Food Stamp benefits for one (1) month in addition to the month of application. Good cause for failure to apply must be shown monthly in order for such a household member to continue to participate. Good cause is described below: ( )

204. CITIZENSHIP AND QUALIFIED NON-CITIZEN REQUIREMENTS.
To be eligible for Food Stamps, an individual must meet the requirements specified in 7 CFR 273.4, "Citizenship and alien status." In addition, special immigrants from Iraq and Afghanistan have refugee status under Public Law 111-118, Subsection 8120. ( )

205. WRITTEN DECLARATION OF CITIZENSHIP OR IMMIGRATION STATUS.
To get Food Stamps, one (1) adult household member must certify by signing a statement, under penalty of perjury, regarding the citizenship and immigration status of household members applying for benefits. ( )

206. PROOF OF PROPER IMMIGRATION STATUS.

01. Expectations. Households are required to submit documents to verify the immigration status of the legal non-citizen applicants. An alien number, by itself, is not considered proof of immigration status. ( )

02. Failure to Provide Legal Non-Citizen Documents. If a household says it is unable or unwilling to provide legal non-citizen status documents for a legal non-citizen household member, the legal non-citizen member must be classified as an ineligible legal non-citizen. ( )

207. NON-CITIZEN ELIGIBILITY PENDING VERIFICATION.
When the applicant or the Department has submitted a request to a federal agency for proof of eligible alien status, the Department must certify the person applying as eligible for Food Stamps pending the results of the investigation. The certification can last up to six (6) months from the date of the original request for proof. ( )

208. -- 211. (RESERVED)

212. FOOD STAMP HOUSEHOLDS.
A Food Stamp household is composed of a person, or group of persons, applying for or getting Food Stamps. The composition of Food Stamp households is listed below: ( )

01. Living Alone. A person living alone. ( )

02. Living with Others. Preparing Separate Meals. A person or persons living with others but customarily purchasing food and preparing meals separately from the others. ( )

03. Living with Others, But Paying for Meals. A person or persons living with others and furnished both meals and lodging. The person or persons pay less than the thrifty food plan. ( )

04. Living Together and Preparing Common Meals. A group of persons who live, purchase food, and customarily prepare meals together for home consumption. ( )

05. Women Living in Shelter. Women, or women with their children, temporarily residing in a shelter for battered women and children. ( )

06. Living in Drug or Alcohol Treatment Center. Person living in a publicly operated community health center or in a private nonprofit center for drug addiction or alcoholic treatment and rehabilitation. ( )

07. Resident of Group Living Center. Person residing in a group living arrangement center certified by the Department. ( )

213. SEPARATE FOOD STAMP HOUSEHOLD COMPOSITION FOR RELATED MEMBERS.
One (1) of the conditions below must be met for related persons living together to be separate Food Stamp households. ( )

01. Children Age Twenty-Two and Older Living With Parents. Children age twenty-two (22) and older, living with their parents, can be separate Food Stamp households. The households must purchase and prepare their food separately. ( )

02. Households Must Prepare Food Together Because of Age and Disability. Households that must purchase and prepare food together because one (1) household contains a person sixty (60) years of age or older unable to purchase and prepare meals because of a disability, can be separate Food Stamp households. The spouse of the disabled person must be considered a member of that person's household. These households must meet the following conditions: The disability must be permanent under the Social Security Act or a nondisease related, severe permanent disability. The income of the household, which does not contain the person unable to purchase and prepare meals separately, must not exceed one hundred sixty-five percent (165%) of the net monthly income limit for the household size. To count income for the one hundred sixty-five percent (165%) net monthly income standard: Exclude the income of the disabled person and his spouse. Count all available income to the household not containing the disabled person. Compare the net monthly income eligibility standard for that size household. ( )

214. CHILD CUSTODY.
For a child who is under the age of eighteen (18), the parent who has primary physical custody is eligible to receive Food Stamp benefits for that child. If both parents request food stamp benefits for the child, primary custody is determined by where the child is expected to spend fifty-one percent (51%) or more of the nights during a certification period. When only one (1) parent applies for food stamp benefits, the child may be included in that parent's household even though they do not have primary physical custody of the child. ( )

215. PERSONS NOT ELIGIBLE FOR SEPARATE FOOD STAMP HOUSEHOLD STATUS.
Persons listed below cannot be separate Food Stamp households. For Food Stamps, they are part of the household where they live. ( )

01. Spouse. Spouses are not separate Food Stamp households. ( )

02. Boarder. Boarders are not separate Food Stamp households. ( )

03. Parents and Children Together. Children under age twenty-two (22), living together with their parents, are not separate Food Stamp households. Parents and children living together include natural, adopted, or stepchildren. Parents and children living together include natural, adopted, or stepparents. ( )

04. Child Under Age Eighteen Under Parental Control. A child under age eighteen (18) and under parental control of an adult household member is not a separate household, unless the child is a foster child. ( )

216. ELDERLY OR DISABLED FOOD STAMP HOUSEHOLD MEMBERS.
To be counted as an elderly or disabled Food Stamp household member, the person must meet one (1) of the criteria listed below: ( )

01. Age. Age sixty (60) or older. ( )

02. SSI. Entitled to Supplemental Security Income (SSI) benefits. This includes SSI presumptive disability payments, SSI emergency advance payments, or special SSI status. ( )

03. RSDI. Entitled to Social Security payments based on disability or blindness. ( )

04. State Supplement. Entitled to State or Federally funded State supplement payments to the SSI program such as AABD. ( )

05. Medicaid. Entitled to Medicaid based on SSI related disability or blindness. ( )

06. Disability Retirement. Entitled to Federal or State funded disability retirement benefits because of a disability considered permanent by the Social Security Administration. ( )

07. Disabled Veteran. A veteran with a service or nonservice connected disability rated or paid as total. ( )

08. Veteran Needing Aid and Attendance. A veteran considered in need of regular aid and attendance or permanently housebound under Title 38 of the U.S. Code. ( )

09. Veteran's Surviving Spouse. A veteran's surviving spouse in need of aid and attendance or permanently housebound. ( )

10. Veteran's Surviving Child. A veteran's surviving child permanently incapable of self-support under Title 38 of the U.S. Code. ( )

11. Veteran's Survivor Entitled. A veteran's surviving spouse or child entitled to receive payment for a service-connected death under Title 38 of the U.S. Code. The veteran's surviving spouse or child must be permanently disabled under Section 221(i) of the Social Security Act. A veteran's surviving spouse or child entitled to pension benefits for a nonservice death under Title 38 of the U.S. Code. The veteran's surviving spouse or child must be permanently disabled under Section 221(i) of the Social Security Act. "Entitled" refers to veterans, surviving spouses and children receiving pay or benefits or who have been approved for payments, but are not yet receiving them. ( )

12. Railroad Retirement and Medicare. Entitled to an annuity payment under Section 2(a)(1)(iv) of the Railroad Retirement Act of 1974 and determined eligible for Medicare by the Railroad Retirement Board. ( )

13. Railroad Retirement and Disability. Entitled to an annuity payment under Section 2(a)(1)(v) and is determined disabled by the Board according to SSI criteria. ( )

217. NONHOUSEHOLD MEMBERS.
Nonhousehold members are persons not counted in determining Food Stamp household size. Their income and resources do not count toward the Food Stamp household. Nonhousehold members may be eligible as a separate household. Nonhousehold members are listed below: ( )

01. Roomers. A person who pays for lodging, but not meals. ( )

02. Live-In Attendants. A person living with a household to provide medical, housekeeping, child care, or other similar services. ( )

03. Ineligible Students. A person between the ages of eighteen (18) and fifty (50), physically and intellectually fit, enrolled at least half-time in an institution of higher education, and not meeting Food Stamp eligibility requirements for students. ( )

04. Residents of Institutions. A resident of an institution is not a member of the Food Stamp household. A resident of an institution is an ineligible household member because the institution provides the resident over fifty percent (50%) of three (3) meals daily, as part of the normal services. The institution is not allowed to accept Food Stamps. ( )

218. PERSONS DISQUALIFIED AS FOOD STAMP HOUSEHOLD MEMBERS.
Persons disqualified as Food Stamp household members must not participate in the Food Stamp program. Disqualified household members are not counted in the household size. Disqualified household members' income

and resources are counted. Disqualified household members are listed below: ( )

01. Ineligible Legal Non-Citizen. Ineligible legal non-citizens not meeting citizenship or eligible legal non-citizen requirements. ( )

02. Persons with Citizenship Questionable. Persons refusing to sign a declaration attesting to citizenship or legal non-citizen status. ( )

03. Person Refusing SSN. Persons disqualified for failure or refusal to provide a Social Security Number. ( )

04. JSAP or Work Registration Noncompliance. Persons disqualified for failure to comply with JSAP or work registration requirements. ( )

05. Persons With IPV. Persons disqualified for an Intentional Program Violation (IPV). ( )

06. Voluntary Quit or Reduction of Hours of Work. Persons disqualified for a voluntary quit or reduction in hours of work. ( )

07. ABAWD Not Meeting Work Requirement. Persons who have received three (3) months of Food Stamp benefits in a three (3) year period without meeting the ABAWD work requirement. ( )

08. Fugitive Felon. Individuals who are fleeing to avoid prosecution or custody for a crime, or an attempt to commit a crime, that would be classified as a felony (or in the State of New Jersey, a high misdemeanor) or who are violating a condition of probation or parole under a federal or state law. ( )

09. Drug Convicted Felon. Individuals convicted under federal or state law of any offense classified as a felony involving the possession, use or distribution of a controlled substance when they do not comply with the terms of a withheld judgment, probation or parole. The felony must have occurred after August 22, 1996. ( )

10. Failure to Cooperate in Paternity Establishment or Obtaining Support. Persons disqualified for failure to cooperate in establishing paternity and obtaining support for a child under eighteen (18). ( )

219. CIRCUMSTANCES UNDER WHICH FOOD STAMP PARTICIPATION IS PROHIBITED.

01. Prohibition from Receiving Food Stamp Benefits. An individual is prohibited from receiving Food Stamp benefits at the time of application if he: ( )

a. Receives tribal commodities; ( )

b. Is incarcerated; ( )

c. Is in an institution; ( )

d. Is in foster care and the foster parents are receiving a cash benefit for providing care and maintenance for the child; ( )

e. Receives Food Stamp benefits in another household; ( )

f. Is deceased; or ( )

g. Receives cash benefits in a TAFI Caretaker Relative household. ( )

02. Prohibited Participation During the Certification Period. If the Department learns of prohibited participation during the certification period, it will act to end benefits for that individual. ( )

220. -- 225. (RESERVED)

226. JOB SEARCH ASSISTANCE PROGRAM (JSAP).
The JSAP program is designed to help Food Stamp recipients become self-sufficient. ( )

01. JSAP Status. All household members, unless exempt, must participate in JSAP. Household members who are on strike must participate in JSAP. Members who are not migrants in the job stream must participate in JSAP. Determine the JSAP status of a participant at certification, a six-month or twelve-month contact, recertification, and when household changes occur. ( )

02. JSAP Information. The Department will explain the JSAP requirement, rights, responsibilities, and the result of failure to comply. ( )

227. EXEMPTIONS FROM JSAP.
Exemptions from JSAP are listed in Subsections 227.01 through 227.13 of these rules. ( )

01. Parents or Caretakers of a Child Under Six Years of Age. A parent or caretaker responsible for the care of a dependent child under age six (6) is exempt from JSAP. If the child becomes six (6) during the certification period, the parent or caretaker must register for JSAP at the next scheduled six-month or twelve-month contact or recertification, unless exempt for another reason. ( )

02. Parents and Caretakers of an Incapacitated Person. A parent or caretaker responsible for the care of a person incapacitated due to illness or disability is exempt from JSAP. ( )

03. Persons Who Are Incapacitated. A person who is physically or intellectually unfit for employment is exempt from JSAP. If a disability is claimed which is not evident, proof to support the disability can be required. Acceptable proof includes receipt of permanent or temporary disability benefits, or a statement from a physician or licensed or certified psychologist. ( )

04. Students Enrolled Half Time. A student who is eighteen (18) years or older is exempt from JSAP if: ( )

a. He is enrolled at least half-time in any institution of higher learning and if he meets the definition of an eligible student in Section 282 of these rules; or ( )

b. He is enrolled at least half-time in any other recognized school or training program. ( )

c. He remains enrolled during normal periods of class attendance, vacation, and recess. If he graduates, enrolls less than half-time, is suspended or expelled, drops out, or does not intend to register for the next normal school term (excluding summer), he must register for work at the next scheduled six-month or twelve-month contact or recertification. ( )

05. SSI Applicants. A person who is applying for SSI is exempt from JSAP until SSI eligibility is determined. ( )

06. Persons Who Are Employed. A person who is employed is exempt from JSAP if: ( )

a. He is working at least thirty (30) hours per week; or ( )

b. He is receiving earnings equal to the Federal minimum wage multiplied by thirty (30) hours; or ( )

c. He is a migrant or seasonal farm worker under contract or agreement to begin employment within thirty (30) days. ( )

07. Persons Who Are Self-Employed. A person who is self-employed is exempt from JSAP when the person is working a minimum of thirty (30) hours per week and is receiving earnings equal to or greater than the Federal minimum wage multiplied by thirty (30) hours. ( )

08. Persons in Treatment for a Substance Use Disorder. A regular participant in a drug or alcohol treatment and rehabilitation program is exempt from JSAP. ( )

09. Unemployment Insurance (UI) Applicant/Recipient. A person receiving UI is exempt from JSAP. A person applying for, but not receiving UI, is exempt from JSAP if he is required to register for work with the Department of Commerce and Labor as part of the UI application process. ( )

10. Children Under Age Sixteen. A child under age sixteen (16) is exempt from JSAP. A child who turns sixteen (16) within a certification period must register for JSAP at the six-month or twelve-month contact or recertification, unless exempt for another reason. ( )

11. Persons Age Sixteen or Seventeen. A household member age sixteen (16) or seventeen (17) is exempt from JSAP if he is attending school at least half-time, or is enrolled in an employment and training program, including GED, at least half-time. ( )

12. Participants Age Sixty or Older. A participant age sixty (60) or older is exempt from JSAP. ( )

13. Pregnant Women. A pregnant woman in her third trimester is exempt from JSAP. ( )

228. DEFERRALS FROM JSAP FOR HOUSEHOLD MEMBERS PARTICIPATING IN TAFI.
Deferrals from JSAP for household members participating in the TAFI program are listed in Subsections 228.01 through 228.03. ( )

01. Reasonable Distance. Appropriate child care is not available within a reasonable distance from the participant's home or work site. ( )

02. Relative Child Care. Informal child care by relatives or others is not available or is unsuitable. ( )

03. Child Care Not Available. Appropriate and affordable child care is not available. ( )

229. PARTICIPANTS LOSING JSAP EXEMPT STATUS.
If an exempt household member becomes mandatory, the Department must notify the participant of JSAP requirements. Mandatory JSAP participants must sign a JSAP agreement. ( )

230. -- 235. (RESERVED)

236. GOOD CAUSE.
A mandatory participant may get a deferral from JSAP requirements, if the Department determines a valid reason exists. ( )

237. SANCTIONS FOR FAILURE TO COMPLY WITH JSAP WORK PROGRAM REQUIREMENTS.
When a JSAP participant fails or refuses to comply with work program requirements without good cause, sanctions listed in Subsections 237.01 and 237.02 of these rules must be applied. In determining which sanction to impose, sanctions previously imposed for voluntary quit or reduction in work hours as described in Section 271 of these rules must be considered. ( )

01. Noncomplying Household Member. The participant who commits the work program violation is excluded as a household member when determining the Food Stamp allotment. The person cannot receive Food Stamps, but his income and resources are counted in the Food Stamp computation for the household. The person must serve a minimum sanction period plus take corrective action to become eligible for Food Stamps again. If the sanctioned household member becomes exempt from JSAP requirements, end the sanction. ( )

a. First work program violation. A minimum sanction period of one (1) month is imposed. ( )

b. Second work program violation. A minimum sanction period of three (3) months is imposed.

( )

c. Third and subsequent work program violations. A minimum sanction period of six (6) months is imposed. ( )

02. Joins Another Household. If a sanctioned household member leaves the original household and joins another Food Stamp household, treat the sanctioned member as an excluded household member. The person cannot receive Food Stamps, but his income and resources are counted in the Food Stamp computation for the household. The person is excluded for the rest of the sanction period and until corrective actions are taken. ( )

03. Closure Reason. The household must be informed of the reason for the closure. ( )

04. Sanction Notice. The household must be informed of the proposed sanction period. ( )

05. Sanction Start. The household must be informed the sanction will begin the first month after timely notice. ( )

06. Actions to End Sanction. The household must be informed of the actions the household can take to end the sanction. ( )

07. Fair Hearing. The household must be informed of the right to a fair hearing. ( )

238. NOTICE OF SANCTIONS FOR FAILURE TO COMPLY WITH JSAP.
Send the household a Notice of Decision when a participant fails to comply with JSAP requirements. The Notice of Decision must contain data listed in Subsections 238.01 through 238.04. If Notice of Decision is sent, and the Department proves the member complied by the effective date of the action, the action to end Food Stamps does not take effect. ( )

01. Sanction Period. The Notice of Decision must include the proposed sanction period. ( )

02. Reason for Sanction. The Notice of Decision must include the reason for sanction. ( )

03. Actions to End Sanction. The Notice of Decision must include the actions the sanctioned person must take to end the sanction. ( )

04. Right to Appeal. The Notice of Decision must tell the household of it's right to a fair hearing. ( )

239. RIGHT TO APPEAL SANCTION.
The participant has the right to appeal the decision to sanction. The participant may contest a decision of mandatory status or a denial, reduction, or termination of benefits, due to failure to comply with JSAP. Appeals are conducted under Idaho Department of Health and Welfare Rules, IDAPA 16.05.03, Section 350, "Contested Case Proceedings and Declaratory Rulings." The Department will notify JSAP of the fair hearing. ( )

240. JSAP SANCTION BEGINS.
The sanction period begins the first month after the Notice of Decision, unless a fair hearing is requested. ( )

241. ENDING SANCTIONS FOR FAILURE TO COMPLY WITH JSAP.
Household members sanctioned for not complying with JSAP are ineligible until a condition listed below is met. ( )

01. Fair Hearing Reversal. Sanction ends if a fair hearing reverses the sanction. ( )

02. Sanctioned Member Becomes Exempt. Sanction ends if the sanctioned member becomes exempt from JSAP. ( )

03. Member Complies With JSAP. Sanction ends if the member, who refused to comply with a JSAP

requirement, complies. The member must complete corrective action and serve the minimum sanction period. ( )

242. CORRECTIVE ACTION FOR WORK PROGRAMS.
A mandatory participant can requalify for Food Stamps after a sanction. The participant must contact the Department and request an opportunity to comply. The participant must show that failure to comply has ended. Before certifying failure to comply has ended, the Department may require the participant to attend an assigned activity for up to two (2) weeks, to show willingness to comply with work program requirements. ( )

243. -- 250. (RESERVED)

251. ABLE BODIED ADULTS WITHOUT DEPENDENTS (ABAWD) WORK REQUIREMENT.
To participate in the Food Stamp program, a person must meet one (1) of the conditions in Subsections 251.01 through 251.05 of this rule. A person who does not meet one (1) of these conditions may not participate in the Food Stamp program as a member of any household for more than three (3) full months (consecutive or otherwise) in a fixed thirty-six (36) month period. ( )

01. Work at Least Eighty Hours per Month. The person must work at least eighty (80) hours per month. The definition of work under Section 251 of this rule is any combination of: ( )

a. Work in exchange for money. ( )

b. Work in exchange for goods or services, known as "in-kind" work. ( )

c. Unpaid work, with a public or private non-profit agency. ( )

02. Participate in JSAP or Another Work Program. The person must participate in and comply with the requirements of the JSAP program (other than job search or job readiness activities), the WIOA program, a program under Section 236 of the Trade Act of 1974, or another work program recognized by the Department. The person must participate for at least eighty (80) hours per month. ( )

03. Combination of Work and Work Programs. The person must work and participate in a work program. Participation in work and work programs must total at least eighty (80) hours per month. ( )

04. Participate in Work Opportunities. The person must participate in and comply with the requirements of a Work Opportunities program. ( )

05. Residents of High Unemployment Areas. ABAWDs residing in a county identified as having high unemployment or lack of jobs are not subject to the three (3) month limitation of benefits. ABAWDs residing in these counties are subject to JSAP work requirement but will not lose Food Stamp eligibility after three (3) months if they participate fewer than eighty (80) hours per month. An ABAWD residing in a high unemployment area must participate according to his plan. ( )

252. PROOF REQUIRED FOR ABAWDS.
The Department requires proof of compliance with the ABAWD requirements. ( )

01. Proof of Hours Worked. Each month the ABAWD must supply proof of work hours, participation in work programs, or participation in work opportunities. ( )

02. Food Stamp Months in Another State. If there is evidence the ABAWD got Food Stamps in another state, get proof of the number of countable months from that state, before certification. A written or verbal statement from the other state agency of countable months is acceptable proof. ( )

253. ABAWD GOOD CAUSE.
The work requirement is met if an ABAWD would have worked at least eighty (80) hours per month, but missed work for good cause. The absence from work must be temporary. The ABAWD must keep the job. Circumstances beyond control of the ABAWD are the basis of good cause. These include illness, illness of a household member

requiring the presence of the ABAWD, household emergency, and lack of transportation. ( )

254. REPORTING ABAWD CHANGES.
ABAWDs must report within ten (10) days of the date of change, if total work or work program hours drop below eighty (80) hours per month. ( )

255. REGAINING ELIGIBILITY.
ABAWDs whose three (3) month eligibility expires may regain eligibility for Food Stamps. During any thirty (30) consecutive days, the person must meet one (1) of the work requirements in Subsections 255.01 and 255.02. Prorate Food Stamp benefits from the date the person regains eligibility. ABAWDs must continue to meet the work requirement to get Food Stamps, or meet conditions for the three (3) additional months. There is no limit on the number of times an ABAWD may regain and maintain eligibility by meeting the work requirement. ( )

01. Work Eighty Hours. The person must work eighty (80) or more hours per month. ( )

02. Participate in JSAP. The person must participate in and comply with the requirements of the JSAP program (other than job search or job search training), the WIOA program, or a program under section 236 of the Trade Act of 1974 for eighty (80) or more hours per month. ( )

256. THREE ADDITIONAL MONTHS OF FOOD STAMPS AFTER REGAINING ELIGIBILITY.
A person who regained eligibility under Section 255 of these rules, but is no longer fulfilling the ABAWD work requirements in Section 251 of these rules through no fault of his own, may get Food Stamps for an additional three (3) consecutive months. For an applicant, the three (3) consecutive months begin the first full month of benefits. For a participant, the three (3) consecutive months begin the month following the month the participant no longer meets the work requirements. A person is eligible for the additional three (3) consecutive months only once in a thirty-six (36) month period. ( )

257. PERSONS NOT CONSIDERED ABAWD.
Persons meeting a condition in Subsections 257.01 through 257.04 of this rule are not considered ABAWD. ( )

01. Age. Persons under eighteen (18) and fifty (50) years of age or older. ( )

02. Disability. Persons medically certified as physically or intellectually unfit for employment. Proof of the disability is required. A person is medically certified as physically or intellectually unfit for employment if: ( )

a. Receiving temporary or permanent disability benefits issued by a government or private source. ( )

b. Obviously intellectually or physically unfit for employment, as determined by the Department. ( )

c. The person has a statement from a physician, physician's assistant, nurse, nurse practitioner, designated representative of the physician's office, licensed or certified psychologist, a social worker, or any other medical personnel the Department determines appropriate, verifying physical or intellectual unfitness for employment. ( )

03. Residing in a Household Where a Member Is Under Age Eighteen. All persons residing in a household where a household member is under eighteen (18) years old. ( )

04. Pregnancy. Pregnant persons. ( )

258. FOOD STAMPS ISSUED TO INELIGIBLE ABAWD.
If an ineligible ABAWD gets a Food Stamp issuance, the issuance is an overissuance until the ABAWD pays it back in full. The overpaid months count against the ABAWD time limit until repaid. ( )

259. STRIKES.
Households must be denied Food Stamps if a member is unemployed because of a strike, unless the household was eligible for or getting Food Stamps the day before the strike. ( )

260. GOVERNMENT EMPLOYEES DISMISSED FOR STRIKE.
State, Federal, and local government employees, dismissed because of joining in a strike against the governmental entity, have voluntarily quit a job without good cause. ( )

261. VOLUNTARY JOB QUIT.
An employed household member who voluntarily quits a job without good cause is not eligible for Food Stamps. The Department is required to make a voluntary job quit determination when it learns that any employed household member has quit his job and any of the circumstances apply that are listed in Subsections 261.01 through 261.02 of this rule. ( )

01. Voluntary Job Quit Timeframes. The Department must make a voluntary job quit determination: ( )

a. For any applicant who quits his job within sixty (60) days of the application date. ( )

b. For any new household member who quit his job within the sixty (60) days prior to entering the household. ( )

c. For any recipient who quits his job at any time during the certification period. ( )

02. Job Definition for Voluntary Job Quit. The Department must make a voluntary job quit determination for any household member who is not exempt from work registration for any reason other than employment, if: ( )

a. He quit a job of at least thirty (30) hours a week; or ( )

b. His weekly earnings from the job he quit are equivalent to the Federal minimum wage multiplied by thirty (30) hours. ( )

262. VOLUNTARY REDUCTION IN WORK HOURS.
An employed household member who voluntarily reduces hours of work without good cause is not eligible for Food Stamps. The Department is required to make a reduction in work hours determination when it learns that any employed household member has voluntarily reduced his work hours and any of the circumstances apply that are listed in Subsections 262.01 through 262.02 of this rule. ( )

01. Voluntary Work Reduction Timeframe. The Department must make a reduction in work hours determination if the hours of work were voluntarily reduced: ( )

a. By an applicant, within sixty (60) days of the application date. ( )

b. By a new household member, within the sixty (60) days prior to entering the household. ( )

c. By a recipient, at any time during the certification period. ( )

02. What Counts as a Significant Voluntary Work Reduction. In order for any household member's eligibility for Food Stamps to be affected, the Department must determine that: ( )

a. Prior to the voluntary reduction in hours, the job was at least thirty (30) hours a week; and ( )

b. The hours of work have been voluntarily reduced to less than thirty (30) hours per week without good cause. ( )

263. -- 264. (RESERVED)

265. SITUATIONS NOT CONSIDERED VOLUNTARY JOB QUIT OR REDUCTION OF WORK.
Situations not counted as a voluntary job quit or reduction of work hours are listed below: ( )

01. Ending Self-Employment. The person ends self-employment enterprise. ( )

02. Employer Demands Resignation. A person resigns from a job at the demand of the employer. ( )

03. Laid Off From New Job. A person quits a job, secures new employment at comparable salary or hours and then is laid off. A person quits a job, secures new employment at comparable salary or hours and through no fault of his own loses the new job. ( )

266. HOUSEHOLD MEMBER LEAVES DURING A PENALTY PERIOD.
When the household member who committed a voluntary quit or reduction in hours penalty leaves the household, the penalty follows the household member who caused it. If the household member who committed the penalty joins another household, he is ineligible for the balance of the penalty period unless he meets the conditions stated in Subsection 275.01 of these rules. ( )

267. GOOD CAUSE FOR VOLUNTARILY QUITTING A JOB OR REDUCING WORK HOURS.
If a household member voluntarily quits a job, determine if the quit was for good cause. All facts and circumstances submitted by the household and the employer must be considered. Good cause includes the reasons listed below: ( )

01. Personal Difficulties. Personal difficulties include: ( )

a. Health problems; ( )

b. Structured drug and alcohol treatment; ( )

c. Jailed or necessary court appearances; and ( )

d. Conflicts with verified and practiced religious and ethical beliefs. ( )

02. Family Emergencies. Family emergencies include: ( )

a. Crisis in family health; and ( )

b. Child legal or behavioral problems. ( )

03. Environmental Barriers. Environmental barriers include: ( )

a. Weather conditions preventing the person from reaching the work site; ( )

b. Unexpected loss of transportation; and ( )

c. Housing or utility problems requiring immediate attention. ( )

04. Work Site Problems. Work site problems include: ( )

a. Temporary layoff from a regular, full-time job. The person must be able to return to the job within ninety (90) days; ( )

b. Work site conditions not meeting legal or local standards of health and safety, hours, pay, or benefits; and ( )

c. Alleged discrimination on the job site. ( )

05. Employment or School. The household member accepts employment, or enrolls at least half (1/2) time in any recognized school, training program, or an institution of higher education. ( )

06. Employment or School in Another Area. Another household member accepts employment in another area, requiring the household to move. Another household member enrolls at least half (1/2) time in a recognized school, a training program, or an institution of higher education in another area, requiring the household to move. ( )

07. Retirement. Persons under age sixty (60) resign, if the resignation is recognized as retirement. ( )

08. Full Time Job Does Not Develop. A person accepts a bona fide offer of a full time job. The job does not develop. The job results in employment of less than thirty (30) hours a week, or weekly earnings of less than the Federal minimum wage multiplied by thirty (30) hours. ( )

09. Temporary Pattern of Employment. Person leaves a job where workers move from one (1) employer to another, such as migrant farm labor or construction work. Households may apply for benefits between jobs, when work is not yet available at the new site. Even though the new employment has not actually begun, the previous quit is with good cause if it is the pattern of that type of employment. ( )

268. PROOF OF JOB QUIT OR REDUCTION OF WORK HOURS.
Request proof if the household's job quit or reduction of work hours is questionable. The household is responsible for providing proof. If the household cannot get timely proof, offer assistance. Proof includes, but is not limited to, contacts with the previous employer or union organizations. If the employer cannot be contacted or the employer will not provide the information try to get the proof from a third party. In some cases, the household and the Department cannot prove the circumstances of the quit. This may occur because the employer cannot be located or refused to cooperate. This may include quits due to employer discrimination or unreasonable employer demands. In cases where proof of the voluntary quit cannot be obtained, the household must not be denied Food Stamps on the basis of a voluntary quit or reduction of work hours. If a household member refuses, without good cause, to provide enough information to determine voluntary quit or work reduction, a penalty must be imposed. Impose the appropriate quit or reduction penalty. ( )

269. (RESERVED)

270. PENALTY FOR APPLICANT QUITTING A JOB OR REDUCING WORK HOURS.
If the Department determines a voluntary quit or reduction of work hours was not for good cause, the member who quit is not eligible for a ninety (90) day penalty period. The penalty period begins the date the household member quit. The applicant household must be told the job quit and work reduction penalty information listed below: ( )

01. Denial Reason. The household must be informed of the reason for the Food Stamp denial for the member. ( )

02. Sanction Period. The household must be informed of the proposed voluntary quit or work reduction sanction period. ( )

03. Fair Hearing. The household must be informed of the right to a fair hearing. ( )

04. Right to Reapply. The household must be informed of the right to reapply after the ninety (90) day penalty period. ( )

271. PENALTY FOR RECIPIENT QUITTING A JOB OR REDUCING WORK HOURS.
If the Department determines a member of the household voluntarily quit a job or reduced work hours, the penalty listed in Subsection 271.01 of this rule must be imposed. Food Stamps must be reduced, beginning the first month after timely notice. The household must be told the information listed in Subsections 271.02 through 271.06 within

ten (10) calendar days of the voluntary quit or reduction in work ruling. When determining the sanction to impose, previous sanctions for noncompliance with JSAP and work registration requirements as described in Section 237 of these rules must be considered. Previous sanctions for recipient voluntary quit or work reduction must also be considered. If the sanctioned household member becomes exempt from JSAP requirements, end the sanction. The voluntary quit sanction does not end if the sanctioned household member becomes exempt due to application or receipt of Unemployment Insurance. ( )

01. Non-Complying Household Member. The participant who commits the work program violation is excluded as a household member when determining the Food Stamp allotment. The person cannot receive Food Stamps, but his income and resources are counted in the Food Stamp computation for the household. The person must serve a minimum sanction period plus take corrective action to become eligible for Food Stamps again. Corrective action includes: returning to work, increasing work hours to meet the work exemption, or completing required activities with EWS. ( )

a. First work program violation. A minimum sanction period of one (1) month is imposed. ( )

b. Second work program violation. A minimum sanction period of three (3) months is imposed. ( )

c. Third and subsequent work program violation. A minimum sanction period of six (6) months is imposed, ( )

02. Joins Another Household. If a sanctioned household member leaves the original household and joins another Food Stamp household, treat the sanctioned member as an excluded household member. The person cannot receive Food Stamps, but his income and resources are counted in the Food Stamp computation for the household. The person is excluded for the rest of the sanction and until corrective actions are taken. ( )

03. Closure Reason. The household must be informed of the reason for the closure. ( )

04. Sanction Notice. The household must be informed of the proposed sanction period. ( )

05. Sanction Start. The household must be informed the sanction will begin the first month after timely notice. ( )

06. Actions to End Sanction. The household must be informed of the actions the household can take to end the sanction. ( )

07. Fair Hearing. The household must be informed of the right to a fair hearing. ( )

272. VOLUNTARY QUIT OR REDUCTION OF WORK HOURS DURING THE LAST MONTH OF THE CERTIFICATION PERIOD.

If the Department determines a member of the household voluntarily quit a job or reduced work hours, without good cause, in the last month of the six-month or twelve-month contact or certification period the voluntary quit or work reduction penalty is imposed. ( )

01. No Reapplication. If the household does not apply for recertification in the last month of the six-month or twelve-month contact or certification, the appropriate penalty is imposed. Begin the penalty the first month after the last month of the certification. The penalty is in effect should the household apply during the penalty period. ( )

02. Reapplication. If the household does apply for recertification in the last month of the six-month or twelve-month contact or certification period, the person quitting work or reducing hours is ineligible. The penalty is imposed, beginning the first month after the last month of the six-month or twelve-month contact or certification period. ( )

273. VOLUNTARY QUIT OR REDUCTION OF WORK HOURS NOT FOUND UNTIL THE LAST MONTH OF THE CERTIFICATION PERIOD.

The Department may find a household member voluntarily quit a job or reduced work hours, without good cause, before the last month of the certification period. If the voluntary quit or reduction is not found until the last month of the certification, the voluntary quit or reduction penalty must be determined. ( )

274. (RESERVED)

275. ENDING VOLUNTARY QUIT WORK PROGRAM PENALTIES.
Eligibility may be reestablished before the end of the penalty period for an otherwise eligible household member when he meets the conditions in Subsection 275.01 of this rule. Eligibility may be reestablished after a voluntary quit or work reduction penalty period has elapsed for an otherwise eligible household member when he meets a condition in Subsection 275.02 of this rule. ( )

01. Ending Voluntary Quit or Reduction Penalty Before the End of the Penalty Period. If the sanctioned household member becomes exempt from JSAP requirements, his eligibility for Food Stamps may be reestablished. The voluntary quit penalty does not end if the sanctioned household member becomes exempt due to application or receipt of Unemployment Insurance. ( )

02. Ending Voluntary Quit or Reduction Penalty After Penalty Period. ( )

a. If the sanctioned household member gets a new job comparable in salary or hours to the job he quit, his eligibility for Food Stamps may be reestablished. A comparable job may entail fewer hours or a lower net salary than the job which was quit. To be comparable, the hours for the new job cannot be less than thirty (30) hours per week and the salary or earnings for the new job cannot be less than Federal minimum wage multiplied by thirty (30) hours per week. ( )

b. If the sanctioned household member's hours of work are restored to more than thirty (30) hours per week before reduction, his eligibility for Food Stamps may be reestablished. ( )

c. A sanctioned household member can requalify for Food Stamps after serving the minimum sanction period and completing corrective action. The participant must contact the Department and request an opportunity to correct the sanction. The Department may require the participant to attend an assigned EWS activity for up to two (2) weeks to show his willingness to comply with work program requirements. ( )

276. FAILURE TO COMPLY WITH A REQUIREMENT OF ANOTHER MEANS - TESTED PROGRAM.
Food Stamps must not increase when a failure to comply causes other means-tested benefits to decrease. Benefits from means-tested programs like TAFI may decrease due to failure to comply with a program requirement. Food Stamp benefits must not increase because of this income loss. If a reduction in benefits from another means- tested program occurs, verify the reason for the reduction. If the reason for the reduction cannot be verified, document the case record to reflect the good faith effort to verify the information. ( )

277. PENALTY FOR FAILURE TO COMPLY WITH A REQUIREMENT OF ANOTHER MEANS - TESTED PROGRAM.
To prevent an increase in Food Stamp benefits, penalties will be applied to a Food Stamp case for failure to comply with a requirement of another means-tested program such as TAFI. When a Food Stamp recipient fails to comply with a requirement of the TAFI program, count that portion of the benefit decrease attributed to the TAFI penalty. Conditions for ending the penalty are listed in Subsections 277.01 through 277.03 of this rule. ( )

01. Time-Limited TAFI Penalty. If the TAFI penalty is time-limited, end the FS penalty when the TAFI penalty is ended. ( )

02. Lifetime TAFI Penalty. If the TAFI penalty is a lifetime penalty, apply the FS penalty for a length of time to match the remaining months of TAFI eligibility for the household. End the FS penalty if the household subsequently reapplies for TAFI and is denied for a reason other than the noncompliance that caused the TAFI penalty. ( )

03. Member Who Caused the TAFI Penalty Leaves the Household. End the FS penalty when the

member who caused the TAFI penalty leaves the household. ( )

278. COOPERATION IN ESTABLISHMENT OF PATERNITY AND OBTAINING SUPPORT.
A natural or adoptive parent or other individual living with and exercising parental control over a minor child who has an absent parent must cooperate in establishing paternity for the child and obtaining support for the child and themselves. ( )

279. FAILURE TO COOPERATE.
When a parent or individual fails to cooperate in establishing paternity and obtaining support, they are not eligible to participate in the Food Stamp Program. ( )

280. EXEMPTIONS FROM THE COOPERATION REQUIREMENT.
The parent or individual will not be required to provide information about the absent or alleged parent or otherwise cooperate in establishing paternity or obtaining support if good cause for not cooperating exists. Good cause for failure to cooperate in obtaining support is listed below: ( )

01. Rape or Incest. Proof the child was conceived as a result of incest or forcible rape. ( )

02. Physical or Emotional Harm. Proof the absent parent may inflict physical or emotional harm to the children, the participant or individual exercising parental control. This must be supported by medical evidence, police reports, or as a last resort, an affidavit from a knowledgeable source. ( )

03. Minimum Information Cannot be Provided. Substantial and credible proof is provided indicating the participant cannot provide the minimum information regarding the non-custodial parent. ( )

281. (RESERVED)

282. STUDENT DEFINED.
A student must be between the ages of eighteen (18) and fifty (50). A student must be physically and intellectually fit. A student must be enrolled, at least half-time, in an institution of higher education. An institution of higher education usually requires a high school or general equivalency diploma for enrollment. This includes colleges, universities, and vocational or technical schools at the post-high school level. ( )

283. STUDENT ENROLLMENT.
A student is considered enrolled in an institution of higher education if participating in a regular curriculum there. Enrollment status of a student begins the first day of the institution of higher education school term. The enrollment continues through normal periods of class attendance, vacation and recess. Enrollment stops if the student graduates, is suspended or expelled, drops out, or does not intend to register for the next normal school term. Summer school terms are not normal school terms. ( )

284. DETERMINING STUDENT ELIGIBILITY.
To be eligible for Food Stamps, a student must meet at least one (1) of the criteria listed below: ( )

01. Employment. ( )

a. The student is employed a minimum of eighty (80) hours per month and is paid for such employment; or ( )

b. The student is self-employed a minimum of eighty (80) hours per month; and ( )

c. The student must earn at least the Federal minimum wage times eighty (80) hours. ( )

02. Work Study Program. The student is in a State or Federally financed work study program during the regular school year. The student exemption begins the month the school term begins, or the month the work study is approved, whichever is later. The exemption continues until the end of the month the school term ends, or it becomes known the student has refused an assignment. The student work study exemption stops when there are breaks of a full calendar month or longer between terms, without approved work study. The exemption only applies to

months the student is approved for work study. ( )

03. Caring for Dependent Child. The student is responsible for the care of a dependent household member under age six (6). There must not be another adult in the household available to care for the child. Availability of adequate child care is not a factor. The student is responsible for the care of a dependent household member at least age six (6) but under age twelve (12). The Department must determine adequate child care is not available to enable the student to attend class and satisfy the twenty (20) hour work requirement. The student must be a single parent responsible for the care of a dependent child under the age of twelve (12). The student is enrolled full-time in an institution of higher education. Full-time enrollment is determined by the institution. Availability of adequate child care is not a factor. ( )

04. TAFI Participant. The student gets cash benefits from the TAFI program. ( )

05. Training. The student is assigned to or placed in an institution of higher education through or complying with the WIOA program, the JOBS program, the JSAP program, a program under Section 236 of the Trade Act of 1974, or a program for employment and training operated by a State or local government. ( )

285. INELIGIBILITY OF FUGITIVE FELONS AND PROBATION AND PAROLE VIOLATORS.
A person is ineligible to receive Food Stamps for any month during which he meets a condition listed below. ( )

01. Fleeing to Avoid Prosecution. The person is fleeing to avoid prosecution for a crime which is a felony (or in New Jersey, a high misdemeanor) under the laws of the state he is fleeing. ( )

02. Fleeing to Avoid Custody or Confinement After Conviction. The person is fleeing to avoid custody or confinement after conviction for a crime which is a felony (or in New Jersey, a high misdemeanor) under the laws of the state he is fleeing. ( )

03. Violating a Condition of Probation or Parole. The person is violating a condition or probation or parole imposed under Federal or State law. ( )

286. EFFECTIVE DATE OF INELIGIBILITY.
Ineligibility of fugitive felons and probation and parole violators begins the earlier of the month a warrant, court order or decision, or decision by a parole board is issued finding the person is fleeing (or fled) to avoid prosecution, or custody or confinement after conviction or is violating (or violated) parole; or the first month the person fled to avoid prosecution, custody or conviction or violated a condition of probation or parole. ( )

287. INELIGIBILITY FOR A FELONY CONVICTION FOR POSSESSION, USE, OR DISTRIBUTION OF A CONTROLLED SUBSTANCE.
Individuals convicted under federal or state law of any offense classified as a felony involving the possession, use, or distribution of a controlled substance can receive Food Stamps when they comply with the terms of a withheld judgment, probation, or parole. The felony must have occurred after August 22, 1996. Controlled substance felons not complying with the terms of a withheld judgment, probation, or parole are not eligible for Food Stamps. Count the income and resources of the disqualified individual in full. ( )

288. -- 299. (RESERVED)

300. RESOURCES DEFINED.
Resources include but are not limited to cash, bank accounts, stocks, bonds, personal property, and real property. A household must have the right, authority, or power to change the resource to cash for the resource to be counted. The household must have the legal right to use the resource for support and maintenance for the resource to be counted. ( )

301. DETERMINING RESOURCES.
The resources of all household members are counted unless the resource is excluded. ( )

302. -- 304. (RESERVED)

305. RESOURCE LIMIT.
The Food Stamp resource limit is five thousand dollars ($5,000) for Broad Based Categorically Eligible households. Households that do not meet the requirements for Broad Based Categorical Eligibility are subject to resource limits published by the USDA Food and Nutrition Service. ( )

306. -- 307. (RESERVED)

308. EQUITY VALUE OF RESOURCES.
Equity value is the current market value of a resource, minus any encumbrance. The current market value is the price the resource is expected to sell for, on the open market, in the geographic area involved. An encumbrance is a legally binding debt against property. The encumbrance on the property does not prevent the property owner from selling to a third party. ( )

309. LIQUID RESOURCES.
All liquid resources are counted, unless excluded. Liquid resources are listed below. Liquid resources can be easily converted to cash. ( )

01. Cash. Cash on hand. ( )

02. Bank Accounts. Checking, savings and credit union accounts. ( )

03. Lump Sum Payments. Lump sum payments such as insurance, SSI, retirement, income tax refund. ( )

04. Trusts. Unrestricted trust accounts and any available amounts from restricted trust accounts. ( )

05. Stocks. Stocks, less fees for transfer and penalty for early sale. ( )

06. Bonds. Savings bonds, treasury bonds, commercial bonds at current market value. ( )

07. Savings Certificates. Saving certificates or certificates of deposit issued by banks, credit unions, or other financial concerns, less the penalty for early withdrawal. ( )

310. NONLIQUID RESOURCES.
Countable nonliquid resources are listed below. Nonliquid resources are resources not easily converted to cash. ( )

01. Real Property. Equity value of real property (land and buildings, including mobile homes) unless specifically excluded. Property may be excluded if: ( )

a. The property is used as a home. ( )

b. The property is income-producing, and the income is consistent with the property's fair market value. ( )

c. The property is essential to employment or self- employment. ( )

d. The property is used in connection with an excluded vehicle. ( )

02. Vehicles. Licensed and unlicensed automobiles, trucks, vans, motorcycles, self-propelled motor homes, snowmobiles, boats, aircraft, all-terrain vehicles, and mopeds. ( )

03. Personal Property. Personal property not otherwise excluded. Personal property includes trailers pulled by another means or campers placed on the bed of a truck or pickup. ( )

311. FACTORS MAKING PROPERTY A RESOURCE.
Property of any kind, including cash, can be a resource. The property must meet all criteria listed below: ( )

01. Ownership Interest. A client must have ownership interest in property for it to be counted as a resource. Property is not a resource if the client does not own all or part of the property. ( )

02. Legal Right to Spend or Convert Property. A client must have a legal right to spend or convert property to cash. Property is not a resource if the owner lacks the legal right to spend or convert property into cash. Physical possession of property is not needed if the owner has the legal ability to spend or convert the property to cash. ( )

03. Legal Ability to Use for Support and Maintenance. Property is not a resource if it can not legally be used for the owner's support and maintenance. ( )

312. -- 313. (RESERVED)

314. JOINTLY-OWNED RESOURCES.
A resource owned jointly by members of two (2) or more households is counted in its entirety for each household, unless the household proves the resource is not available. If the household shows it has access to only a portion of a resource, that portion of the resource is counted. ( )

315. JOINTLY-OWNED RESOURCES EXCLUDED.
A jointly-owned resource is excluded, if the household shows it cannot sell or divide the resource without consent of the other owner, and the other owner will not sell or divide the resource. A jointly-owned resource is excluded, if owned by a resident in a shelter for battered women and children and access to the resource requires agreement of a joint owner living in the former household. A vehicle, jointly owned by a household member and a person not living in the household, may be excluded. The household member must not have possession of the vehicle. The household member must not be able to sell the vehicle. ( )

316. -- 320. (RESERVED)

321. RESOURCES OF DISQUALIFIED HOUSEHOLD MEMBERS.
The household must report the resources of members disqualified for Food Stamps. The household must verify any questionable information. The resources of the disqualified person are included in determining the resource limit. Disqualified household members with resources counted toward the household limit are listed below: ( )

01. Member Disqualified for IPV. Resources of a household member disqualified for an intentional program violation are counted. ( )

02. Member Disqualified for Failure to Comply with Work Requirements. Resources of a household member disqualified for failing to comply with a work requirement are counted. ( )

03. Member Ineligible Due to SSN. Resources of a household member ineligible for refusing to get an SSN are counted. ( )

04. Ineligible Legal Non-Citizen. Resources of an ineligible legal non-citizen household member are counted. ( )

05. Member Disqualified for Failure to Meet the ABAWD Work Requirement. Resources of a household member disqualified for failure to meet the ABAWD work requirement are counted. ( )

06. Member Disqualified for a Voluntary Quit or Reduction in Hours of Work. Resources of a member disqualified for a voluntary quit or reduction of work are counted. ( )

07. Member Disqualified as a Fugitive Felon or Probation or Parole Violator. Resources of a member disqualified as a fugitive felon or probation or parole violator are counted. ( )

08. Member Disqualified for Failure to Cooperate in Establishing Paternity and Obtaining Support. Resources of a member disqualified for failure to cooperate in establishing paternity and obtaining support are counted. ( )

09. Member Disqualified for Conviction of a Controlled Substance Felony. Resources of individuals convicted under federal or state law of any offense classified as a felony involving the possession, distribution, or use of a controlled substance when they do not comply with the terms of a withheld judgment, probation, or parole are counted. The felony must have occurred after August 22, 1996. ( )

322. RESOURCES OF NONHOUSEHOLD MEMBERS.
Resources of nonhousehold members are not included when determining household resources. Resources of nonhousehold members are listed below: ( )

01. Ineligible Student. Resources of an ineligible student are not counted. ( )

02. Boarder or Roomer. Resources of a boarder or roomer are not counted. ( )

03. Foster Child. Resources of a foster child are not counted, if the child is not a member of the Food Stamp household. ( )

04. Foster Adult. Resources of a foster adult are not counted, if the adult is not a member of the Food Stamp household. ( )

323. LUMP SUM RESOURCES.
Nonrecurring lump sum payments are considered a resource in the month received, unless excluded under these rules. A household is not required to report changes in resources during a certification period. Some lump sum payments are listed below: ( )

01. Retroactive Payments. Retroactive payments from: ( )

a. Social Security. ( )

b. SSI. ( )

c. Public Assistance. ( )

d. Railroad Retirement Benefits. ( )

e. Unemployment Compensation Benefits. ( )

f. Child Support. ( )

02. Insurance. Insurance settlements. ( )

03. Refunds. Income tax refunds, rebates, or credits. ( )

04. Property Payments. Lump sum payment from sale of property. Contract payments from the sale of property are counted as income. ( )

05. Security Deposits. Refunds of security deposits on rental property or utilities. ( )

06. Disability Pension. Annual adjustment payments in VA disability pensions. ( )

07. Vacation Pay. Vacation pay, withdrawn in one lump sum by a terminated employee. ( )

08. Military Bonus. Military re-enlistment bonuses. ( )

09. Readjustment Pay. Job Corps readjustment pay. ( )

10. Severance Pay. Severance pay, paid in one (1) lump sum to a former employee. ( )

11. TAFI One-Time Cash Payment. The one-time TAFI cash diversion payment. ( )

324. -- 333. (RESERVED)

334. VEHICLES.
Treat any vehicle that is used primarily for transportation and not for recreational use, as described in Subsections 334.01 and 334.02 of this rule. The value of any vehicle that is primarily for recreational use counts toward the household's resource limit. ( )

01. Exclude One Vehicle Per Adult. The value of one (1) vehicle per adult in the Food Stamp household is excluded beginning with the highest valued vehicle. ( )

02. All Other Vehicles Are Subject To Federal Regulations. All other vehicles in the household will have their values counted as provided in 7 CFR 273. ( )

335. -- 350. (RESERVED)

351. EXCLUDED RESOURCES.
Some resources do not count against the limit because they are excluded. Resources excluded by federal law are also excluded for Food Stamps. Exclusions from resources are listed in Sections 352 through 382. ( )

352. HOUSEHOLD GOODS EXCLUDED.
Household goods are items of personal property normally found in the home. The items must be used for maintenance, use, and occupancy of the home. Household goods include, but are not limited to, furniture, appliances, television sets, carpets, and utensils for cooking and eating. Household goods are excluded as resources. ( )

353. PERSONAL EFFECTS EXCLUDED.
Personal effects are items worn or carried by a client, or items having an intimate relation to the client. They include, but are not limited to, clothing, jewelry, personal care items, and prosthetic devices. Personal effects include items for education or recreation, such as books, musical instruments, or hobby materials. Personal effects are excluded as resources. ( )

354. HOME AND LOT EXCLUDED.
The home and surrounding land and buildings not separated by property owned by others, are excluded as a resource. A public road or right of way that separates any plot from the home will not affect the exclusion. Home may be a house, a trailer, or a vehicle. ( )

01. Unoccupied Home Exclusion. A temporarily unoccupied home is excluded if the household members intend to return. The household members must be absent because of employment, training for future employment, or illness, or the home must be temporarily uninhabitable from casualty or natural disaster. ( )

02. Building Lot Exclusion. A lot where a household is building a permanent home is excluded as a resource. A lot where a household intends to build a permanent home is excluded as a resource. The lot and partly completed home are excluded. The household can only have one home and lot excluded. The household can not own a home and lot and have a building lot exclusion for another property. ( )

355. LIFE INSURANCE EXCLUDED AS A RESOURCE.
The cash surrender value of life insurance policies is excluded as a resource. ( )

356. BURIAL SPACE OR PLOT AND FUNERAL AGREEMENT EXCLUSIONS.
Burial spaces or plots and funeral agreements are excluded from resources as listed in Subsections 356.01 through 356.02. ( )

01. Burial Space or Plot Exclusion. Exclude one (1) burial space or plot, for each household member, from resources. The value of the burial space or plot does not affect this exclusion. ( )

02. Funeral Agreement Exclusion. Exclude up to one thousand, five hundred dollars ($1,500) of the equity value of one (1) bona fide funeral agreement, for each household member, from resources. The equity value over one thousand, five hundred dollars ($1,500) is counted as a resource. ( )

357. PENSION PLANS OR FUNDS EXCLUDED AS A RESOURCE.
The cash value of any funds in a plan, contract, or account, described in Sections 401(a), 403(a), 403(b), 408, 408A, 457(b), and 501(c) of the Internal Revenue Code of 1986 and the value of funds in a Federal thrift Savings Plan account as provided for in 5 U.S.C. 8439 are excluded as a resource. This exclusion includes any current or future tax preferred retirement accounts which are approved under federal or state law. ( )

358. INCOME-PRODUCING PROPERTY EXCLUDED.
Property which annually produces income consistent with its fair market value is excluded as a resource. Real property, not used as a home, is excluded as a resource if it produces income consistent with it's fair market value. This exclusion includes land and buildings. Annual income is consistent with the property's fair market value when consistent with area market trends. ( )

359. LIVESTOCK EXCLUDED.
Livestock includes cows, pigs, sheep, llamas, and horses. Farm animals kept for food are excluded. ( )

360. PROPERTY USED FOR SELF-SUPPORT EXCLUDED.
Property essential to the employment or self-employment of a household member, such as tools of a trade or the farm land and machinery of a farmer, is excluded as a resource. Essential work-related equipment of an ineligible legal non-citizen or disqualified person is excluded as a resource. Self-support property is excluded during employment and temporary periods of unemployment. For a household member engaged in farming, property essential to self-employment continues to be excluded for one (1) year from the date the household member ends self-employment from farming. ( )

361. PROPERTY USED WITH EXCLUDED VEHICLE.
Portions of real or personal property are excluded as a resource if used in connection with an excluded vehicle. The vehicle must be used to produce income or be necessary for transporting a physically disabled household member. ( )

362. SALABLE ITEM WITHOUT SIGNIFICANT RETURN EXCLUDED.
Resources that cannot be sold for a significant return are excluded. A significant return is one-half (1/2) the household resource limit. One-half (1/2) the household resource limit is one thousand dollars ($1,000) or one thousand five hundred dollars ($1,500), depending on household composition. The Department requires the household to give proof of the value of a resource only if it questions the resource data provided. Vehicles are not included under this rule. A single resource cannot be divided to get an exclusion under this rule. A resource meeting the conditions described in Subsections 362.01 through 362.03 is not counted. ( )

01. No Profit from Sale. The sale, or other disposal, of the resource is not likely to produce one-half (1/2) the resource limit for the household. ( )

02. No Interest in Resource. The household's interest in a resource is slight. The sale of the resource is not likely to bring one-half (1/2) the household resource limit. ( )

03. Cost of Sale Too Great. The cost of selling the household's interest in a resource is excessive. The household is not likely to sell the resource for one-half (1/2) the resource limit. ( )

363. HUD FAMILY SELF-SUFFICIENCY (FSS) ESCROW ACCOUNT.
Escrow accounts and the interest earned on an escrow account established by HUD for families participating in the Family Self-Sufficiency (FSS) Program established by Section 544 of the National Affordable Housing Act, are excluded as a resource when determining eligibility for food stamps. The federal exclusion for the funds in this program and other similar type escrow funds are only excluded while the funds are still in the escrow account or

being used for a HUD approved purpose. Participants in the FSS program may withdraw funds from the escrow account before completing the program, with permission from the public housing authority, but only for purposes related to the goal of the Family Self-Sufficiency contract, such as completion of higher education, job training, or to meet start-up expenses involved in creation of a small business. ( )

364. EDUCATIONAL ACCOUNTS EXCLUDED AS A RESOURCE.
The cash value of any funds in a qualified tuition program described in Section 529 of the Internal Revenue Code of 1986 or in a Coverdell education savings account under Section 530 of the Internal Revenue Code are excluded as a resource. ( )

365. INDIVIDUAL DEVELOPMENT ACCOUNT EXCLUDED AS A RESOURCE.
The cash value of an Individual Development Account (IDA) established in compliance with Section 56-1101(5), Idaho Code, is excluded as a resource. ( )

366. -- 372. (RESERVED)

373. GOVERNMENT PAYMENTS EXCLUDED.
Government payments for the restoration of a home damaged in a disaster are excluded as a resource. The household must be subject to legal sanction if the funds are not used as intended. ( )

374. EXCLUDED INACCESSIBLE RESOURCES.
The cash value of resources not legally available to the household is excluded as a resource. The household must provide proof resources are not available. ( )

375. FROZEN OR SECURED ACCOUNTS EXCLUDED.
Frozen bank accounts used as security for a loan or due to bankruptcy proceedings are excluded as resources. ( )

376. REAL PROPERTY EXCLUDED IF ATTEMPT TO SELL.
Real property is excluded as a resource if the household is making a good faith effort to sell it at a reasonable price. Verify the property is for sale and the household has not refused a reasonable offer. Document in the case record the reason for excluding the property and the household's efforts to sell. ( )

377. TRUST FUNDS EXCLUDED.
Trust funds are excluded if all conditions listed below are met: ( )

01. Trust Irrevocable or Not Changeable by Household. The household must be unable to revoke the trust agreement or change the name of the beneficiary during the certification period. ( )

02. Trust Unlikely to End During Certification. The trust arrangement must be unlikely to end during the certification period. ( )

03. Trustee Independent from Household Control. The trustee of the fund is either a court, institution, corporation, or organization not under the direction or ownership of a household member, or a court appointed person who has court-imposed limits placed on the use of funds. ( )

04. Trust Not Under Control of Household-Directed Business. The trust investments do not directly involve or help any business or corporation under the control, direction, or influence of a household member. ( )

05. Origin and Use of Trust. The funds held in an irrevocable trust are: ( )

a. Set up from the household's own funds. The trustee uses the funds only to make investments for the trust, or to pay education or medical expenses of the beneficiary; or ( )

b. Set up from nonhousehold funds by a non-household member. ( )

378. INSTALLMENT CONTRACTS EXCLUDED.
An installment contract for the sale of land and buildings is excluded as a resource. The purchase price must be consistent with the property's fair market value. The contract or agreement must produce income consistent with the property's fair market value. Income is consistent with the property's fair market value when consistent with area market trends. The actual property sold under an excluded installment contract is excluded as a resource. Property held as security for the fulfillment of an excluded installment contract is excluded as a resource. ( )

379. TREATMENT OF EXCLUDED RESOURCES.
An excluded resource kept in a separate account is excluded for an unlimited period. If an excluded resource is combined with countable resources, the resource is not counted for six (6) months from the date the funds are combined. After six (6) months, the total combined resources are counted. ( )

380. (RESERVED)

381. NONLIQUID RESOURCES WITH LIENS EXCLUDED.
A nonliquid resource, with a lien placed against it, is excluded. The lien must result from a business loan. The lien agreement must forbid the household to sell the resource. ( )

382. (RESERVED)

383. EXCLUDED RESOURCE CHANGES TO COUNTED RESOURCE.
Resource value increases when a client replaces an excluded resource with a counted resource. ( )

384. -- 385. (RESERVED)

386. TRANSFER OF RESOURCES.
If a household transfers a resource within three (3) calendar months before the date of application for Food Stamps, determine if the transfer was made with the intent to qualify for the Food Stamp Program. Disqualify a household if the transfer was made with the intent to qualify for the Food Stamp Program. After a household is certified for Food Stamps, the transfer of a resource to remain eligible for Food Stamps will result in disqualification. ( )

387. TRANSFER OF RESOURCE NOT COUNTED FOR DISQUALIFICATION.
A transferred resource is not counted for disqualification, if conditions below: ( )

01. Three Months Before Application. The transfer of a resource more than three (3) months before the date of Food Stamp application is not counted. ( )

02. Resources Less Than Limit. The transfer of a resource is not counted if the resource, when added to the other countable resources, does not exceed the resource limit. ( )

03. Transfer at Fair Market Value. The sale or trade of a resource, made at or near the fair market value, is not counted. ( )

04. Transfer Between Household Members. A resource transferred between members of the same household, including ineligible legal non-citizens or disqualified persons whose resources are considered available to the household, is not counted. ( )

05. Transfer for Reasons Other Than Food Stamps. A resource transferred for reasons other than trying to qualify for Food Stamps is not counted. ( )

388. DISQUALIFICATION FOR TRANSFERRING RESOURCES.
Disqualify a household from Food Stamps for up to one (1) year from the discovery date of the transfer. Base the disqualification period on the amount the transferred resource exceeds the resource limit, when added to other countable resources. Disqualification periods are listed in Table 388. The disqualification period begins in the month of application unless the household is already certified when the transfer is discovered. If the household is already certified, the disqualification period starts with the first allotment after timely notice to end benefits. ( )

389. -- 399. (RESERVED)

400. INCOME.
All household income is counted in the Food Stamp budget unless excluded under these rules. Income can be earned or unearned. Income must be verified and documented. ( )

401. EARNED INCOME.
Earned income includes, but is not limited to, income listed in Section 401. ( )

01. Wages or Salary. Wages and salaries of an employee, advances, tips, commissions, meals, and military pay are earned income. Garnishments from wages are earned income. ( )

02. Self-Employment Income. Income from self-employment, including capital gains, is earned income. Rental property is a self-employment enterprise. The income is earned if a household member manages the property an average of twenty (20) or more hours per week. Payment from a roomer or boarder is self-employment income. ( )

03. Training Allowances. Training allowances from programs such as Vocational Rehabilitation are earned income. ( )

04. Payments Under Title I. Payments under Title I, such as VISTA and University Year for Action under P.L. 93-113 are earned income. ( )

05. On-the-Job Training Programs. WIA income includes monies paid by WIA or the employer. Income from WIA on-the-job training programs is earned income, unless paid to a household member under age nineteen (19). The household member under age nineteen (19) must be under the control of another household member. ( )

06. Basic Allowance for Housing (BAH). BAH is an Armed Services housing allowance. BAH is counted as earned income. ( )

402. UNEARNED INCOME.
Unearned income includes, but is not limited to income listed below: ( )

01. Public Assistance (PA). Payments from SSI, TAFI, AABD, GA, or other Public Assistance programs are unearned income. ( )

02. Retirement Income. Payments from annuities, pensions, and retirement are unearned income. Old age, survivors, or Social Security benefits are unearned income. ( )

03. Strike Benefits. Strike benefits are unearned income. ( )

04. Veteran's Benefits. Veteran’s benefits are unearned income. ( )

05. Disability Income. Disability benefits are unearned income. ( )

06. Workers' Compensation. Workers’ Compensation is unearned income. ( )

07. Unemployment Insurance. Unemployment Insurance is unearned income. ( )

08. Contributions. Contributions are unearned income. ( )

09. Rental Property Income. Rental property income, minus the cost of doing business, is unearned income if a household member is not managing the property at least twenty (20) hours per week. ( )

10. Support Payments. Support payments, including child support payments, are unearned income. ( )

11. Alimony. Alimony payments are unearned income. ( )

12. Education Benefits. Educational scholarships, grants, fellowships, deferred payment loans, and veteran's educational benefits are excluded unearned income. ( )

13. Government Sponsored Program Payments. Payments from government sponsored programs are unearned income. ( )

14. Dividends, Interest, and Royalties. Dividends, interest, and royalties are unearned income. Interest income is excluded unearned income. ( )

15. Contract Income. Contract income from the sale of property is counted as unearned income. ( )

16. Funds From Trusts. Monies withdrawn from trusts exempt as a resource are unearned income. Dividends paid or dividends that could be paid from trusts exempt as a resource are unearned income. ( )

17. Recurring Lump Sum Payments. Recurring lump sum payments are unearned income. ( )

18. Prizes. Cash prizes, gifts and lottery winnings are unearned income. ( )

19. Diverted Support or Alimony. Child support or alimony payments, diverted by the provider to a third party, to pay a household expense are unearned income. ( )

20. Agent Orange Payments. Payments made under the Agent Orange Act of 1991 and disbursed by the U.S. Treasury are unearned income. ( )

21. Garnishments. Garnishments from unearned income are unearned income. ( )

22. Tribal Gaming Income. Tribal gaming income is unearned income. The participant can choose to count the income in the month received, or prorate the income over a twelve (12) month period. ( )

23. Other Monetary Benefits. Any monetary benefit, not otherwise counted or excluded, is unearned income. ( )

403. -- 404. (RESERVED)

405. EXCLUDED INCOME.
Income excluded when computing Food Stamp eligibility is listed below: ( )

01. Money Withheld. Money withheld voluntarily or involuntarily, from an assistance payment, earned income, or other income source, to repay an overpayment from that income source, is excluded. If an intentional noncompliance penalty results in a decrease of benefits under a means tested program such as SSI or GA, count that portion of the benefit decrease attributed to the repayment as income. ( )

02. Child Support Payments. Child support payments received by TAFI recipients which must be given to CSS are excluded as income. ( )

03. Earnings of Child Under Age Eighteen Attending School. Earned income of a household member under age eighteen (18) is excluded. The member must be under parental control of another household member and attending elementary or secondary school. For the purposes of this provision, an elementary or secondary student is someone who attends elementary or secondary school or who attends GED or home-school classes that are recognized, operated, or supervised by the school district. This exclusion applies during semester and summer vacations if enrollment will resume after the break. If the earnings of the child and other household members cannot be differentiated, prorate equally among the working members and exclude the child's share. ( )

04. Retirement Benefits Paid to Former Spouse or Third Party. Social Security retirement benefits based on the household member's former employment, but paid directly to an ex-spouse, are excluded as the household member's income. Military retirement pay diverted by court order to a household member's former spouse is excluded as the household member's income. Any retirement paid directly to a third party from a household member's income by a court order is excluded as the household member's income. ( )

05. Infrequent or Irregular Income. Income received occasionally is excluded as income if it does not exceed thirty dollars ($30) total in a three (3) month period. ( )

06. Cash Donations. Cash donations based on need and received from one (1) or more private nonprofit charitable organizations are excluded as income. The donations must not exceed three hundred dollars ($300) in a calendar quarter of a federal fiscal year (FFY). ( )

07. Income in Kind. Any gain or benefit, such as meals, garden produce, clothing, or shelter, not paid in money, is excluded as income. ( )

08. Vendor Payments. A vendor payment is a money payment made on behalf of a household by a person or organization outside of the household directly to either the household's creditors or to a person or organization providing a service to the household. ( )

09. Third Party Payments. If a person or organization makes a payment to a third party on behalf of a household using funds that are not owed to the household, the payment will be excluded from income. ( )

10. Loans. Loans are money received which is to be repaid. Loans are excluded as income. ( )

11. Money for Third Party Care. Money received and used for the care and maintenance of a third party who is not in the household. If a single payment is for both household members and nonhousehold members the identifiable portion of the payment for nonhousehold members is excluded. If a single payment is for both household members and nonhousehold members, exclude the lesser of: ( )

a. The prorated share of the nonhousehold members if the portion cannot be identified. ( )

b. The amount actually used for the care and maintenance of the nonhousehold members. ( )

12. Reimbursements. Reimbursements for past or future expenses not exceeding actual costs. Payments must not represent a gain or benefit. Payments must be used for the purpose intended and for other than normal living expenses. Excluded reimbursements are not limited to: ( )

a. Travel, per diem, and uniforms for job or training. ( )

b. Out-of-pocket expenses of volunteer workers. ( )

c. Medical and dependent care expenses. ( )

d. Pay for services provided by Title XX of the Social Security Act. ( )

e. Repayment of loans made by the household from their personal property limit. The repayment must not exceed the amount of the loan. ( )

f. Work-related and dependent care expenses paid by the JSAP program. ( )

g. Transitional child care payments. ( )

h. Child care payments under the Child Care and Dependent Block Grant Act of 1990. ( )

13. Federal Earned Income Tax Credit (EITC). Federal EITC payments are excluded as income. ( )

14. Work Study. Work Study income received while attending post-secondary school is excluded as income. ( )

15. HUD Family Self-Sufficiency (FSS) Escrow Account. The federal exclusion for these funds are only excluded while the funds are in the escrow account or being used for a HUD approved purpose. See Section 363 of these rules for further clarification. ( )

16. Temporary Census Earnings. Wages earned for temporary employment related to U. S. Census activities are excluded as income during the regularly scheduled ten (10) year U. S. Census. ( )

17. Income Excluded by Federal Law. If income is excluded by federal law, it is excluded for Food Stamps. ( )

406. (RESERVED)

407. INCOME AND ELIGIBILITY VERIFICATION SYSTEM (IEVS).
Income must be verified with the IEVS system for all households applying for or getting Food Stamps. Income must be verified for disqualified members with income counted toward the household Food Stamp benefits. ( )

408. (RESERVED)

409. USE OF IEVS INFORMATION FOR APPLICANT HOUSEHOLDS.
IEVS data must be used to compute eligibility and benefits if IEVS data is received before the application is processed. IEVS data on applicant households must be used as soon as possible, even if the applicant household was approved before the IEVS data was received. Action on applications must not be delayed pending receipt of IEVS data. If IEVS data requiring further proof is received, before application approval, the proof must be obtained and resolved before approving the application. If an applicant household cannot provide an SSN at application, IEVS data must be used as soon as possible after the SSN is known. IEVS data must be used for all household members, eligible, excluded or disqualified. ( )

410. (RESERVED)

411. VERIFIED IEVS DATA.
The IEVS data listed below is considered verified upon receipt, unless it is questionable: ( )

01. Benefit Data Exchange (BENDEX). BENDEX Social Security retirement and disability income data. ( )

02. State Data Exchange (SDX). Benefit and eligibility data from SSA under Titles II and XVI of the Social Security Act accessed through the State Data Exchange (SDX). ( )

03. TAFI. Temporary Assistance for Families in Idaho. ( )

04. AABD. Aid to the Aged, Blind, or Disabled. ( )

05. Medicaid. The Federally-aided program for medical care (Title XIX, Social Security Act). ( )

412. UNVERIFIED IEVS DATA.
The IEVS data listed below is considered unverified: ( )

01. IRS Reported Unearned Income. Unearned income data from IRS, including any unreported assets producing income. ( )

02. Wages. Wage file data. Wage data from Department of Commerce and Labor or its counterpart in another state. Wage data from BEER. ( )

03. Self-Employment Earnings. Self-employment earnings data from BEER. ( )

04. Questionable Information. Income information the Department feels is doubtful. ( )

413. -- 414. (RESERVED)

415. EDUCATIONAL INCOME.
Educational income includes deferred repayment educational loans, grants, scholarships, fellowships, and veterans' educational benefits. The school attended must be a recognized institution of post secondary education, a school for the handicapped, a vocational education program, or a program providing completion of a secondary school diploma, or equivalent. Educational income is excluded. ( )

416. -- 426. (RESERVED)

427. AVERAGING SELF-EMPLOYMENT INCOME.

01. Annual Self-Employment Income. When self-employment income is considered annual support by the household, the Department averages the self-employment income over a twelve-month (12) period, even if: ( )

a. The income is received over a shorter period of time than twelve (12) months; and ( )

b. The household receives income from other sources in addition to self-employment. ( )

02. Seasonal Self-Employment Income. A seasonally self-employed individual receives income from self-employment during part of the year. When self-employment income is considered seasonal, the Department averages self-employment income for only the part of the year the income is intended to cover. ( )

428. CALCULATION OF SELF-EMPLOYMENT INCOME.
The Department calculates self-employment income by adding monthly income to capital gains and subtracting a deduction for expenses as determined in Subsection 428.03 of this rule. ( )

01. How Monthly Income Is Determined. If no income fluctuations are expected, the average monthly income amount is projected for the certification period. If past income does not reflect expected future income, a proportionate adjustment is made to the expected monthly income. ( )

02. Capital Gains Income. Capital gains include profit from the sale or transfer of capital assets used in self-employment. The Department calculates capital gains using the federal income tax method. If the household expects to receive any capital gains income from self-employment assets during the certification period, this amount is added to the monthly income, as determined in Subsection 428.01 of this rule, to determine the gross monthly income. ( )

03. Self-Employment Expense Deduction. The Department uses the standard self-employment deduction in Subsection 428.03.a. of this rule, unless the applicant claims that his actual allowable expenses exceed the standard deduction and provides proof of the expenses as described in Subsection 428.03.b. of this rule. ( )

a. The self-employment standard deduction is determined by subtracting fifty percent (50%) of the gross monthly self-employment income as determined in Subsections 428.01 and 428.02 of this rule; or ( )

b. The self-employment actual expense deduction is determined by subtracting the actual allowable expenses from the gross monthly self-employment income. The following items are not allowable expenses and may not be subtracted from gross monthly self-employment income. ( )

i. Net losses from previous tax years; ( )

ii. Federal, state, and local income taxes; ( )

iii. Money set aside for retirement; ( )

iv. Work-related personal expenses such as transportation to and from work; and ( )

v. Depreciation. ( )

429. SELF-EMPLOYED FARMER.
To be considered a self-employed farmer, a person must receive, or expect to receive, an annual gross income of one thousand dollars ($1,000) or more earned from farming activities. If a farmer's cost of producing self-employment income results in a loss, the Department subtracts the loss from other countable income in the household in accordance with 7 CFR 273.11(a)(2)(ii)(A) and (B). ( )

430. -- 500. (RESERVED)

501. INITIAL CHANGES IN FOOD STAMP CASE.
Act on changes in household circumstances found during the application or the initial interview. ( )

01. Food Stamp Issuance Changes. The Department will make changes to the household's Food Stamp issuance when it is required to act on a change. ( )

02. Change Before Certification. If a household reports a change in household circumstances before certification, include the reported information in determining Food Stamp eligibility and amount. ( )

03. Change After Certification. If a household reports a change after the initial Food Stamp benefit has been paid, the Department must act on the change as required by policy for acting on changes within a certification period. Notice of the change must be given to the Food Stamp household. ( )

502. EARNED INCOME WHEN A HOUSEHOLD MEMBER TURNS AGE EIGHTEEN.
When a child attending elementary or secondary school turns age eighteen (18), do not count earned income received or expected by that person until the next six-month or twelve-month contact, or recertification. ( )

503. -- 507. (RESERVED)

508. PROJECTING MONTHLY INCOME.
Income is projected for each month. Past income may be used to project future income. Changes expected during the certification period must be considered. Criteria for projecting monthly income is listed below: ( )

01. Income Already Received. Count income already received by the household during the month. If the actual amount of income from any pay period is known, use the actual pay period amounts to determine the total month's income. Convert the actual income to a monthly amount if a full month's income has been received or is expected to be received. If no changes are expected, use the known actual pay period amounts for the past thirty (30) days to project future income. ( )

02. Anticipated Income. Count income the household and the Department believe the household will get during the remainder of the certification period. If the exact income amount is uncertain or unknown, that portion must not be counted. If the date of receipt of income cannot be anticipated for the month of the eligibility determination, that portion must not be counted. If the income has not changed and no changes are anticipated, use the income received in the past thirty (30) days as one indicator of anticipated income. If changes in income have occurred or are anticipated, past income cannot be used as an indicator of anticipated income. If income changes and income received in the past thirty (30) days does not reflect anticipated income, the Department can use the household income received over a longer period to anticipate income. If income changes seasonally, the Department can use the household income from the last season, comparable to the certification period, to anticipate income.
( )

509. TYPES OF INCOME TO BE AVERAGED.

Types of income to be averaged are listed below. Income for a destitute migrant or seasonal farm worker household is not averaged. ( )

01. Self-Employment Income. Average self-employment income. ( )

02. Contract Income. Average contract income over the period of the contract, if not received on an hourly or piecework basis. Households with averaged contract income include school employees, share croppers and farmers. These households do not include migrants or seasonal farm workers. ( )

03. Income Received Less Often Than Monthly. When receipt of income is less often than monthly, the anticipated income can be averaged over the period intended to cover to determine the average monthly income. ( )

04. Child Support. Child support income can be averaged to make a valid projection for ongoing income. ( )

510. -- 511. (RESERVED)

512. SPECIAL CASES FOR COUNTING INCOME.
Special cases for counting income are listed below: ( )

01. Wages Held at the Request of Employee. Wages held at the request of the employee are income in the month the wages would have been paid by the employer. ( )

02. Garnishments Held by Employer. Garnishments withheld by an employer are income in the month the wages would have been paid. ( )

03. Wages Held by Employer, Other Than Garnishment and Employee Request. Wages held by the employer, even if in violation of law, are not counted as income. ( )

04. Advances on Wages. Advances on wages will count as income if the household reasonably expects the advance to be paid. ( )

05. Varying Payment Cycles. Households getting unearned or earned income on a recurring monthly or semi-monthly basis do not have varying income merely because mailing or payment cycles cause additional payments to be received in a month. The income is counted for the month it is intended. ( )

06. Nonrecurring Lump Sum Payments and Capital Gains. Nonrecurring lump sum payments must not be counted as income. Nonrecurring lump sum payments are counted as a resource starting in the month received. Nonrecurring lump sum payments include capital gains from the sale or transfer of securities, real estate, or other real property held as an investment for a set period of time. The capital gains are income only if the assets were used in self-employment. ( )

07. PA Entitlement. If a household intentionally fails to comply with a means-tested program, a penalty may be imposed and benefits reduced to collect the means-tested program overpayment. Means-tested programs include PA. Count the full amount of means-tested benefits the household is entitled to, not the reduced amount caused by the failure to comply. ( )

513. -- 531. (RESERVED)

532. GROSS INCOME LIMIT.
Households exceeding the gross income limit for the household size are not eligible, unless they are categorically eligible or have an elderly or disabled member. A household with an elderly or disabled household member is exempt from the gross income limit. If all household members receive or are authorized to receive monthly payments through TAFI, AABD, or SSI, the household is categorically eligible. The gross income limit is raised each federal fiscal year by FNS, based on the federal cost of living (COLA) adjustment. ( )

533. HOUSEHOLD ELIGIBILITY AND BENEFIT LEVEL.
A household's eligibility and benefit level is calculated in accordance with 7 CFR 273.10, except as indicated below in Subsections 533.01 through 533.07. of this rule. The deductions in Subsections 533.01 through 533.07 of this rule are subtracted from non-excluded income. ( )

01. Standard Deductions. The standard deductions are controlled by Federal law. The monthly amounts are specified in Title 7 United States Code Section 2014. ( )

02. Earned Income Deduction. The earned income deduction is twenty percent (20%) of gross earned income. ( )

03. Homeless Shelter Deduction. The homeless shelter deduction is established by FNS. ( )

04. Excess Medical Deduction. Excess medical expense is nonreimbursed medical expense of more than thirty-five dollars ($35) per household per month. The household member must be either age sixty (60) or older or disabled to get this expense deduction. Special diets are not deductible. For allowable medical expenses, see Section 535 of these rules. ( )

05. Dependent Care Deduction. The dependent care expense deduction is for monthly dependent care expenses. The dependent care may be needed for children or adults. ( )

06. Child Support Deduction. The child support expense deduction is the legally obligated child support and arrearage the household pays, or expects to pay, to or for a non-household member. ( )

07. Excess Shelter Deduction. Excess shelter expense is the monthly shelter cost over fifty percent (50%) of the household's income after all other deductions. The excess shelter expense is not deducted if the household has received the homeless shelter deduction. For allowable shelter expenses, see Section 542 of these rules. ( )

534. AVERAGING INFREQUENT, FLUCTUATING, OR ONE-TIME ONLY EXPENSES.
Infrequent, fluctuating, or one-time only expenses for medical, child support, shelter or child care are averaged. ( )

535. MEDICAL EXPENSES.
Elderly or disabled household members that incur medical expenses over thirty-five dollars ($35) per month are allowed a Standard Medical Expense (SME) deduction. Eligible households must verify monthly medical expenses of more than thirty-five dollars ($35) at initial application. Households with medical expenses that exceed the monthly Standard Medical Expense may either verify the minimum amount to receive the SME or request and verify excess costs to receive an actual expense deduction at application and recertification. The household must provide proof of the incurred or anticipated cost before a deduction is allowed. ( )

536. DEPENDENT CARE EXPENSES.
The care of a dependent must be necessary to maintain employment, conduct job search, or attend school or training. The dependent care expenses must be deducted from income. ( )

537. DEPENDENT CARE RESTRICTIONS.
Dependent care restrictions are listed below: ( )

01. Care by Household Member. Dependent care cannot be deducted if the care is provided by another household member. ( )

02. In-Kind Payment. Dependent care cannot be deducted if the payment is in-kind, such as food or exchanges for shelter. ( )

03. Vendor Payment. Dependent care cannot be deducted if paid by vendor payment. ( )

04. Spouse Can Give Care. Dependent care cannot be deducted if the spouse in the home is physically

capable of the dependent care and is not working, seeking work, or registered for work. ( )

05. Paid or Reimbursed Dependent Care. Dependent care cannot be deducted if paid or reimbursed under a federal child care program. ( )

538. CHILD SUPPORT EXPENSES.
Child support expense may be deducted for a household paying or expecting to pay legally obligated child support to or for a person living outside the household. The child support expense deducted must reflect the child support the household pays or expects to pay during the certification period, rather than the obligated amount. ( )

539. -- 541. (RESERVED)

542. COSTS ALLOWED FOR SHELTER DEDUCTION.
Shelter costs are current charges for the shelter occupied by the household. Shelter costs include costs for the home temporarily not occupied because of employment or training away from home or illness. ( )

543. UTILITY ALLOWANCES.
The shelter deduction is computed using one (1) of four (4) utility allowances: Standard Utility Allowance (SUA). Limited Utility Allowance (LUA), the Minimum Utility Allowance (MUA), or the Telephone Utility Allowance (TUA). Utility allowances are not prorated. ( )

01. Standard Utility Allowance (SUA). ( )

a. The household must have a primary heating or cooling cost to qualify for the SUA. The heating or cooling costs must be separate from rent or mortgage payments. ( )

b. Occupied and unoccupied homes are households with both an occupied home and an unoccupied home, that are limited to one (1) SUA. ( )

02. Limited Utility Allowance (LUA). The household must be billed for more than one (1) utility that is not for heating or cooling. ( )

03. Minimum Utility Allowance (MUA). The household must be billed for one (1) utility that is not for heating, cooling, or telephone service. ( )

04. Telephone Utility Allowance (TUA). The household must be billed for telephone service and have no other verified utility expenses. ( )

544. -- 546. (RESERVED)

547. COSTS NOT ALLOWED FOR THE SHELTER DEDUCTION.
The costs listed below are not allowed in computing the shelter deduction. ( )

01. Utility Deposit. Fees for a one (1) time utility deposit. ( )

02. Rental Deposit. Damage or advance deposits on rentals. ( )

03. Past Due Rent. Payments made to pay past due rent. ( )

04. Wood Cutting. The cost to cut the household's own wood for heating. ( )

05. Furniture Rental. Rental furniture fees. ( )

06. Personal Insurance. Insurance on furniture or personal belongings. ( )

07. Vehicle Not Used as Residence. Payments or gasoline costs on vehicles used only for recreation. ( )

08. Repairs Not Paid by Household. Costs for repairing or replacing shelter paid by private or public agencies, insurance companies, or any other source. ( )

09. Shelter Not Paid by Household. Shelter paid by a vendor or employer. ( )

10. Utility Cost Paid by Utility Payment. Utility costs paid entirely by HUD or FmHA negative utility payment. ( )

548. COMPUTING THE SHELTER DEDUCTION.
The shelter deduction is computed as listed below: ( )

01. Household with Elderly or Disabled Member. If the household has an elderly or disabled member, deduct the monthly shelter cost exceeding fifty percent (50%) of the household's income after all other deductions. ( )

02. Household with No Elderly or Disabled Member. If the household does not have an elderly or disabled member, deduct the excess of fifty percent (50%) of the household's income, after all other deductions, up to the maximum limit as specified in Title 7 USC Section 2014. ( )

549. NET INCOME LIMIT TEST.
Categorically eligible households do not have to meet the net income limit. All other households, including those with an elderly or disabled household member, must not exceed the net income limit to be eligible for Food Stamps. ( )

550. DETERMINATION OF FOOD STAMP BENEFIT.
The Food Stamp benefit is computed in accordance with 7 CFR 273.9 and 273.10. ( )

551. ROUNDING FOOD STAMP PAYMENT.
Income and deductions are not rounded in determining gross or net income. Only the final Food Stamp amount is rounded. ( )

552. -- 561. (RESERVED)

562. PRORATING INITIAL MONTH'S BENEFITS.
Prorating is based on a thirty (30) day calendar month. Benefits are prorated from the application date to the end of the month. ( )

563. FOOD STAMP PRORATING FORMULA.
The prorated Food Stamp amount is determined per 7 CFR 273.10(a)(1)(iii)(B). If the amount for the initial month is less than ten dollars ($10), benefits must not be issued. ( )

564. BENEFITS AFTER THE INITIAL MONTH.
After the initial month, benefits must be issued as described below. ( )

01. One and Two Person Households. All eligible one (1) and two (2) person households must receive a minimum allotment equal to eight percent (8%) of the maximum one (1) person allotment. ( )

02. Three or More Person Household. ( )

a. All eligible households with three (3) or more members entitled to one dollar ($1), must receive two dollars ($2). ( )

b. All eligible households with three (3) or more members entitled to three dollars ($3), must receive four dollars ($4). ( )

c. All eligible households with three (3) or more members entitled to five dollars ($5), must receive

six dollars ($6). ( )

03. Not Categorically Eligible. All households, except categorically eligible households, must be denied if the household's net income exceeds the level at which benefits are issued. ( )

565. FOOD STAMP BENEFITS FOR CATEGORICALLY ELIGIBLE HOUSEHOLD.
Categorically eligible households with one (1) or two (2) household members are eligible to get an allotment amount of Food Stamps that is equal to at least eight percent (8%) of the maximum monthly one (1) person allotment, regardless of net income. Categorically eligible households with three (3) or more household members are eligible for Food Stamps, but do not get Food Stamps if the net income is too high. ( )

566. -- 572. (RESERVED)

573. ACTING ON HOUSEHOLD COMPOSITION CHANGES.
Changes in household composition are not required to be reported. If a household does report a change in household composition, the Department will act on the change as required by options allowed under 7 CFR 273.12(c).
( )

574. ADDING PREVIOUSLY DISQUALIFIED HOUSEHOLD MEMBERS.
The resources, income, and deductions of a previously disqualified household member must be determined. Change the previously disqualified household member's participation the month following the last month in the sanction or if the person becomes exempt. The disqualification must have been due to an intentional program violation (IPV), work registration or Job Search Assistance Program (JSAP) sanction, voluntary quit or reduction of work hours, failure to comply with the SSN requirement, or ineligible legal non-citizen status. The person's resources, income, and deductions that were previously prorated are counted in full the month after the disqualification ends. Prorate benefits from the date the ABAWD becomes Food Stamp eligible by reaching eighty (80) hours by working, participating in a work program, or combining work and work programs. ( )

575. HOUSEHOLD COMPOSITION CHANGES FOR STUDENT.
Ineligible students are defined as non-household members. When a student's status changes, the change is treated as a new person entering or leaving the Food Stamp household. ( )

576. -- 587. (RESERVED)

588. NOTICE OF DECISION TO HOUSEHOLDS.
The Department must send the household a written notice as soon as Food Stamps are approved or denied. The household must get the notice no later than thirty (30) days after the application date. ( )

589. -- 600. (RESERVED)

601. REPORTING REQUIREMENTS AND RESPONSIBILITIES.
Changes may be reported by phone, mail, or e-mail, or directly to the Department. Households must report as follows: ( )

01. Income Exceeds One Hundred Thirty Percent (130%) of FPG. When the household's total gross income exceeds one hundred thirty percent (130%) of the Federal Poverty Guideline (FPG) for the household size. ( )

02. Decrease in ABAWD Hours to Less Than Eighty (80) Hours Per Month. When there is a decrease in the household's ABAWD hours to less than eighty (80) hours per month. ( )

602. (RESERVED)

603. PERSON OUTSIDE HOUSEHOLD FAILS TO PROVIDE PROOF -- CHANGES.
Food Stamps cannot be closed solely because a person outside the household fails to provide requested proof. The Department will attempt to get another source of proof if a person outside the household does not provide requested proof. Disqualified household members are not persons outside the household. ( )

604. -- 610. (RESERVED)

611. TIME FRAMES FOR REPORTING CHANGES IN HOUSEHOLD CIRCUMSTANCES.
Households must report changes in circumstances as required in Section 601 of these rules. Households reporting required changes to the Department must do so by the tenth day of the month following the month in which the change occurred. ( )

01. Reporting Methods. Changes can be reported by telephone, personal contact, mail, or e-mail. Changes can be reported by a household member or authorized representative. ( )

02. Failure to Report. If Food Stamps are over-issued because a household fails to report required changes, a Claim Determination must be prepared. A person can be disqualified for failure to report a change if he commits an Intentional Program Violation. ( )

612. (RESERVED)

613. CHANGES ON WHICH THE DEPARTMENT MUST ACT.
The Department must follow the procedures for acting on reported changes as described in 7 CFR 273.12. ( )

614 -- 616. (RESERVED)

617. INCREASES IN FOOD STAMP BENEFITS.

01. Household Reports a Change. If a household reports a change that results in an increase in Food Stamps and the proof cannot be obtained through interfaces or data brokers, the Department must allow the household ten (10) days to provide proof. ( )

02. Failure to Provide Proof of Change. If the household fails to provide proof of a change that would increase the benefit level, the Food Stamp benefit remains at the amount already established. ( )

03. Proof Provided Within Ten Days. If the household provides proof within ten (10) days of reporting the change, the Department will increase the Food Stamp benefits beginning the month immediately following the month in which the change was reported. For changes reported after the 20th of the month, a supplement is issued for the next month no later than the 10th of the next month. If the change is reported and verified after the final date to adjust Food Stamp benefits for the following month in the Department's automated eligibility system, the change to the Food Stamp benefits must be made by the following month, even if a supplement must be issued. ( )

04. Proof Not Provided Within Ten Days. If the household fails to provide proof within ten (10) days of reporting the change, but provides proof later, benefits are increased the month after the proof of the change is provided. ( )

618. DECREASES IN FOOD STAMP BENEFITS.
If the Department acts on a change that results in a decrease in Food Stamp benefits, the Department must give timely notice, if required. The notice must explain the reason for the action. ( )

619 -- 620. (RESERVED)

621. TAFI OR AABD HOUSEHOLD REPORTING CHANGES.
If a change in the AABD or TAFI grant results in a change in the household's Food Stamp benefits, the Department must count the new grant amount, regardless of whether the Food Stamps increase or decrease. If a change requires a reduction or ending of TAFI or AABD and Food Stamp benefits, the Department will issue a Notice of Decision for both programs. If the household makes a timely request for a fair hearing and continued benefits, Food Stamp benefits continue pending the hearing. The household must reapply if certification expires before the hearing is complete. ( )

622. CHANGE ENDS TAFI OR AABD INCOME.
A change ending a household's income from a TAFI or AABD grant during the certification period may affect Food Stamp eligibility. A household's Food Stamp benefits must not be closed just because of a TAFI or AABD closure. Food Stamp benefits will be closed only if the change requires the Department to take action under Section 613 of these rules and the action would close Food Stamps. If the household appeals and TAFI or AABD is continued, continue Food Stamps at the same level. If a TAFI or AABD notice is not required or the household does not appeal, the Department must send a notice explaining that the household's benefits will end. A notice must be sent to the household when Food Stamp benefits change because of a TAFI or AABD change. If TAFI or AABD ends and the household remains Food Stamp eligible, the Department must advise the household of the work registration requirements. ( )

623. FAILURE TO TAKE REQUIRED ACTION.
If the Department is unable to make a change in Food Stamp eligibility or issuance and an overissuance results, collect the overpayment. If the Department fails to act on a change that increases household benefits, restore lost benefits. ( )

624. -- 628. (RESERVED)

629. NOTICE OF LOWERING OR ENDING BENEFITS.
Households must be sent a Notice of Decision when Food Stamps are ended or reduced, unless notice is not required under these rules. ( )

630. ADEQUATE NOTICE.
Adequate notice is a written statement telling the household the action the Department is taking. The notice must tell the reasons for the action. The notice must advise the household of the right to a hearing. All notices must be adequate. If Food Stamps are reduced, the household must receive the notice on or before the first day of the month the action is effective. ( )

631. NOTICE.
Notices must be sent within the time limits listed in these rules. Timely notice must be mailed at least ten (10) days before the effective date of the action. ( )

632. TIMELY NOTICE NOT REQUIRED.
Timely notice is not required when the conditions listed below are met. Adequate notice must be given. ( )

01. Statement of Household. The Department gets a clear, written, signed statement from the household. Food Stamps can be ended or reduced from the facts given in the household statement. ( )

02. Food Stamps Reduced After Closure Notice. The household is sent a notice of closure because it did not provide requested proof. The household provides the proof before the first day of the month of closure. If the proof results in reduced Food Stamps, the reduced benefits are issued. Timely notice of the reduction is not required. ( )

03. Food Stamps Closed or Reduced Because of Intentional Program Violation (IPV) Penalty. The Department must impose the IPV penalty the first of the month after the month it gives written notice to the client. Timely notice is not required. ( )

633. NOTICE OF CHANGES NOT REQUIRED.
Notice to individual Food Stamp households is not required when the conditions listed in Subsection 633.01 below are met. Mass notice must be given in some situations, as listed in Subsection 633.02 below: ( )

01. Waiver by the Household. A household member or authorized representative provides a written statement requesting closure. The person gives information causing reduction or an end to benefits and states, in writing, they know adverse action will be taken. The person acknowledges in writing continuation of benefits is waived, if a fair hearing is requested. ( )

02. Mass Change. Mass changes include: ( )

a. Changes in the income limit tables. ( )

b. Changes in the issuance tables. ( )

c. Changes in Social Security benefits. ( )

d. Changes in SSI payments. ( )

e. Changes in TAFI or AABD grants. ( )

f. Changes caused by a reduction, suspension, or cancellation of Food Stamps ordered by the Secretary of USDA. ( )

g. When it performs mass changes, the Department notifies Food Stamp households of the mass change by one of the following methods: ( )

i. Media notices. ( )

ii. Posters in the Food Stamp offices and issuance locations. ( )

iii. A general notice mailed to households. ( )

03. Mass Changes in TAFI or AABD. When a mass change to TAFI or AABD causes a Food Stamp change, use the following criteria: ( )

a. If the Department has thirty (30) days advance notice of the TAFI or AABD mass change, Food Stamps must be adjusted the same month as the change. ( )

b. If the Department does not have advance notice, Food Stamp benefits must be changed no later than the month after the TAFI or AABD mass change. ( )

c. Ten (10) day advance notice to Food Stamp households is not required. Adequate notice must be sent to Food Stamp households. ( )

d. If a household requests a fair hearing because of an issue other than mass change, continue Food Stamps. ( )

04. Notice of Death. Notice is not required when the Department learns of the death of all household members. ( )

05. Completion of Restored Benefits. Notice is not required when an increased allotment, due to restored benefits, ends. The household must have been notified in writing when the increase would end. ( )

06. Joint Public Assistance and Food Stamp Applications. Notice is not required if the household jointly applies for TAFI or AABD and Food Stamps and gets Food Stamps pending TAFI or AABD approval. The household must be notified at certification that Food Stamps will be reduced upon TAFI or AABD approval. ( )

07. Converting From Repayment to Benefit Reduction. Notice is not required if a household with an IHE or IPV claim fails to repay under the repayment schedule. An allotment reduction is enforced. ( )

08. Households Receiving Expedited Service. Notice is not required if all the following conditions are met: ( )

a. The applicant received expedited services. ( )

b. Proof was postponed. ( )

c. A regular certification period was assigned. ( )

d. Written notice, stating future Food Stamps depend on postponed proof, was given at approval. ( )

09. Residents of a Drug or Alcoholic Treatment Center or a Group Living Arrangement Center. Notice is not required when the Department ends Food Stamps to residents of a drug or alcoholic treatment center or group living arrangement center if: ( )

a. The Department revokes the center's certification. ( )

b. FNS disqualifies the center as a retailer. ( )

634. VERBAL REQUEST FOR END OF FOOD STAMPS.
If a household makes a verbal request for closure, end the benefits and notify the household with a ten (10) day advance Notice of Decision. ( )

635. -- 638. (RESERVED)

639. CONTINUATION OF BENEFITS PENDING A HEARING.
The household retains the right to continued benefits when the household requests a fair hearing within the ten (10) day notice period. The household must request this continuation of Food Stamps. If certification has not expired, Food Stamps can continue at the former level. Benefits must be continued within five (5) working days of the household's request for a fair hearing. ( )

640. (RESERVED)

641. REDUCING OR ENDING BENEFITS BEFORE HEARING DECISION.
Benefits may be ended or reduced before the hearing decision, if a condition listed below is met: ( )

01. Appeal of Federal Law. The hearing official states, in writing, the sole issue being appealed is one of Federal law, regulation, or policy. ( )

02. Food Stamp Issuance Changes. Food Stamp eligibility or benefit level changes occur before the hearing decision and a new hearing is not requested. ( )

03 Food Stamps Expire. The Food Stamp certification period expires. ( )

04. Mass Change. A mass change occurs before the hearing decision. ( )

642. -- 643. (RESERVED)

644. EXPIRATION OF CERTIFICATION PERIOD.
Household eligibility ends when the certification period expires. ( )

645. RECERTIFICATION PROCESS.
The Department must follow the recertification procedures described in 7 CFR 273.14. ( )

646. NOTICE OF DECISION FOR TIMELY RECERTIFICATION.
A Notice of Decision must be sent to households that reapply for Food Stamps. To receive Food Stamps with no break in issuance, households must complete a six-month or twelve-month contact or recertification before the fifteenth day of the last month of certification or six-month or twelve-month contact period. If the household applies before the fifteenth day of the month, the Department will notify the household of eligibility or denial by the end of the current certification period. ( )

647. -- 649. (RESERVED)

650. RESTORATION OF LOST BENEFITS.
Lost benefits must be restored. The Department may find Food Stamps have been incorrectly denied, ended, or underissued to an eligible household. The Department may learn of lost benefits from case reviews, Quality Control reviews, or other sources. Benefits are restored when caused by a Department error, when a fair hearing is reversed, or an IPV disqualification is reversed. Restore benefits to eligible and previously eligible households. Restore benefits to households who have moved out of state. Restore benefits for SSA joint processing errors. ( )

651. TIME FRAMES FOR RESTORATION OF BENEFITS.
Benefits must not be restored if lost more than twelve (12) months before notification or discovery. ( )

01. Lost Benefits Reported by Household. Lost benefits are restored when the Department learns of lost benefits reported by the household, a person outside the household or by another agency. Twelve (12) months are counted from the month the Department is notified of the lost benefits. ( )

02. Lost Benefits Discovered by Department. Lost benefits are restored when the Department discovers lost benefits during the course of business. Twelve (12) months are counted from the month the Department discovers the benefits were lost. ( )

03. Lost Benefits From Fair Hearing. Lost benefits are restored to a household that requests a fair hearing and the decision is in the household's favor. Twelve (12) months are counted from the effective date of the adverse action causing the fair hearing. ( )

652. -- 655. (RESERVED)

656. REPLACING FOOD DESTROYED BY A DISASTER.
Conditions and procedures for replacing food destroyed by a disaster are listed below. The food must have been purchased with Food Stamps. ( )

01. Food Destroyed in a Disaster. The actual value of loss, not to exceed one (1) month's allotment, can be replaced. The food bought with Food Stamps must have been destroyed in a disaster. The disaster may involve only the household, such as a house fire, or a larger scope, such as a flood. There is no limit on the number of times food destroyed in a disaster may be replaced. ( )

02. Replacement Time Limit for Disaster Loss. The Department must provide either disaster Food Stamps or replacement Food Stamps, but not both, within ten (10) days of the reported loss, if: ( )

a. The household reports the disaster within ten (10) days of the incident. ( )

b. The disaster is verified by collateral contact, an organization such as the Fire Department or Red Cross, or by home visit. ( )

657. -- 674. (RESERVED)

675. IPV, IHE AND AE FOOD STAMP CLAIMS.
An overissuance exists when the amount of Food Stamps issued exceeds the Food Stamps a household is eligible to receive. The Department must establish a claim against the household, to recover the value of Food Stamps overissued or misused. The types of Food Stamp claims are listed in Subsections 675.01 through 675.03 of this rule. ( )

01. Intentional Program Violation (IPV) Claim. An IPV claim is an overissuance caused by an intentional, knowing, and willful program violation. ( )

02. Inadvertent Household Error (IHE) Claims. An IHE is a household error, without intent to cause an overissuance, which results in a Food Stamp over-issuance. Causes of IHE claims are: ( )

a. Failure to give information. A household, without intent to cause an over-issuance, fails to give correct or complete information. ( )

b. Failure to report change that was required to be reported. A household, without intent to cause an over-issuance, fails to report changes or to report at all. ( )

c. Failure to comply. A household, without intent to cause an over-issuance, fails to comply due to language barrier, educational level, or not understanding written or verbal instructions. ( )

d. Pending IPV. An IHE claim occurs between the time of an IPV referral, and the IPV decision. ( )

03. Agency Error Claim (AE). An agency error claim results from an overissuance caused by a Department action, or a failure to act. ( )

676. PERSONS LIABLE FOR FOOD STAMP CLAIMS.
The persons listed in Subsections 676.01 through 676.03 are responsible for paying a claim. ( )

01. Adult Household Members. Adult members of the household at the time of the overissuance or trafficking, are liable. They are individually and jointly liable, whether residing in the household where the claim arose, or in any other household. ( )

02. Sponsor of an Alien. The sponsor of an alien household member, if the sponsor is at fault for the claim. ( )

03. Person Connected to the Household. A person connected to the household, such as an authorized representative, who actually trafficks, or causes an overissuance or trafficking. ( )

677. COMPUTING FOOD STAMP CLAIMS.
The Department computes Food Stamp claims as described in Subsections 677.01 and 677.02 of this rule. ( )

01. Claims Not Related to Trafficking. The Department computes claims, not related to trafficking, back to a minimum of twelve (12) months before it became aware of the overissuance. The Department does not compute claims, not related to trafficking, back more than six (6) years. For an IPV claim, the Department computes back to the month the first act of IPV occurred. The Department continues to compute back a minimum of twelve (12) months before the first act of IPV. The Department does not compute IPV claims back more than six (6) years before the first act of IPV. ( )

02. Trafficking-Related Claims. Claims arising from trafficking-related offenses are the value of the trafficked Food Stamps as determined by: ( )

a. The individual's admission. ( )

b. Adjudication. ( )

c. The documentation forming the basis for the trafficking determination. ( )

678. -- 691. (RESERVED)

692. DETERMINING DELINQUENT CLAIMS.
The Department determines if a claim is delinquent by using Subsections 692.01 through 692.05 of this rule. ( )

01. Claim Not Paid by Due Date. The claim is delinquent if not paid by the due date, and there is not a satisfactory payment arrangement. The claim remains delinquent until paid in full, a satisfactory repayment agreement is negotiated, or allotment reduction is invoked. ( )

02. Payment Arrangement Not Followed. The claim is delinquent if a payment arrangement is established, but scheduled payment is not made by the due date. The claim remains delinquent until paid in full, allotment reduction is invoked, or the Department agrees to resume or re-negotiate the repayment schedule. ( )

03. Previous Claim. A claim is not delinquent if another claim for the same household is being paid through an installment agreement or allotment reduction. The Department begins collection on the new claim after the first claim is settled. ( )

04. Collection Coordinated Through Court. A claim is not delinquent if the Department is unable to determine delinquency status because collection is coordinated through the court system. ( )

05. Claim Awaiting Hearing Decision. A claim awaiting a hearing decision is not delinquent. If later the hearing officer affirms a claim does exist against the household, the Department notifies the household. ( )

693. (RESERVED)

694. COLLECTING CLAIMS.
The Department collects payment for claims using the methods listed in Subsections 695.01 through 695.05 of these rules. ( )

01. Allotment Reduction. The Department reduces the Food Stamp allotment to collect the claim. ( )

a. For an IPV claim, the allotment reduction limit is the greater of twenty dollars ($20) per month or twenty percent (20%) of the household's monthly allotment. ( )

b. For an IHE or AE claim, the allotment reduction limit is the greater of ten dollars ($10) per month or ten percent (10%) of the household's monthly allotment. The household can agree to a higher amount. ( )

c. The Department does not reduce the initial month's Food Stamps, unless the household agrees to this reduction. ( )

02. Repayment from EBT Account. The household pays the claim from its Electronic Benefit Transfer (EBT) account. ( )

03. Cash, Check, or Money Order. Payment by cash, check, or money order. ( )

04. Household Performing Public Service. Payment by public service as ordered by a court, specifically as payment of a claim. ( )

05. Collection by Treasury Offset Program (TOP). The Department submits claims delinquent for one hundred and eighty (180) days, or more, for collection through TOP. ( )

695. TOP NOTICES.
The Department will provide the household with a notice of intent to collect via Treasury offset. The notice must inform the household of the right to request a Department review of the intended collection action. The Department must receive the request for review within sixty (60) days of the notice of intent to collect. The notice of review determination must inform the household of the right to request that FNS review the Department's decision. The notice must include instructions for requesting a review by FNS and the address of the FNS regional office. ( )

696. EFFECTS OF TOP ON THE FOOD STAMP HOUSEHOLD.
When a claim is referred to TOP, any eligible Federal payment owed to the household may be intercepted, and applied to the claim to reduce the debt. The household may be required to pay collection or processing fees charged by the Federal government to intercept the payment. ( )

697. REMOVING A CLAIM FROM TOP.
The Department removes a claim from TOP under the conditions listed in Subsections 697.01 through 697.05 of this rule. ( )

01. Instructed by FNS or Treasury. FNS or Treasury instructs the Department to remove the debt from TOP. ( )

02. Household Undergoing Allotment Reduction. The person is a member of a Food Stamp household undergoing allotment reduction. ( )

03. Claim Is Paid in Full. The claim is paid in full. ( )

04. Claim Is Satisfied. The claim is satisfied through a hearing, termination, compromise, or other means. ( )

05. Payments Resumed. The household makes arrangements to resume payments. ( )

698. INTENTIONAL PROGRAM VIOLATION (IPV).
An IPV includes the actions listed in Subsections 698.01 through 698.06 of this rule. The client must intentionally, knowingly, and willfully commit a program violation. ( )

01. False Statement. A person makes a false statement to the Department, either orally or in writing, to get Food Stamps. ( )

02. Misleading Statement. A person makes a misleading statement to the Department, either orally or in writing, to get Food Stamps. ( )

03. Misrepresenting. A person misrepresents facts to the Department, either orally or in writing, to get Food Stamps. ( )

04. Concealing. A person conceals or withholds facts to get Food Stamps. ( )

05. Violation of Regulations. A person commits any act violating the Food Stamp Act, Federal regulations, or State Food Stamp regulations. The violation may relate to use, presentation, transfer, acquisition, receipt, or possession of Food Stamps. ( )

06. Trafficking in Food Stamps. Trafficking in Food Stamps means any of the following: ( )

a. The buying, selling, stealing, or otherwise effecting an exchange of food stamp benefits issued and accessed via Electronic Benefit Transfer (EBT) cards, card numbers and personal identification numbers (PINs), or by manual voucher and signature, for cash or consideration other than eligible food, either directly, indirectly, in complicity or collusion with others, or acting alone; ( )

b. Attempting to buy, sell, steal, or otherwise affect an exchange of food stamp benefits issued and accessed via Electronic Benefit Transfer (EBT) cards, card numbers and personal identification numbers (PINs), or by manual voucher and signatures, for cash or consideration other than eligible food, either directly, indirectly, in complicity or collusion with others, or acting alone; ( )

c. The exchange of firearms, ammunition, explosives, or controlled substances, as defined in Section 802 of Title 21, U.S.C., for food stamp benefits; ( )

d. Purchasing a product with food stamp benefits that has a container requiring a return deposit with the intent of obtaining cash by discarding the product and returning the container for the deposit amount, intentionally discarding the product, and intentionally returning the container for the deposit amount; ( )

e. Purchasing a product with food stamp benefits with the intent of obtaining cash or consideration other than eligible food by reselling the product, and subsequently intentionally reselling the product purchased with

food stamp benefits in exchange for cash or consideration other than eligible food; or ( )

f. Intentionally purchasing products originally purchased with food stamp benefits in exchange for cash or consideration other than eligible food. ( )

699. ESTABLISHING AN INTENTIONAL PROGRAM VIOLATION (IPV).
The Department establishes an IPV by the actions listed in Subsections 699.01 through 699.03 of this rule. ( )

01. Waiver. The client signs a waiver to a disqualification hearing. ( )

02. Hearing. An administrative disqualification hearing determines an IPV. ( )

03. Judgement. A court judgement determines an IPV. ( )

700. ADMINISTRATIVE RESPONSIBILITY FOR ESTABLISHING IPV.
The Department must investigate and refer cases for an IPV determination. If there is enough recorded evidence to establish an IPV, the Department must take the actions listed below: ( )

01. Act to Collect. The Department must act to collect overissuances. The Department must set up IHE overissuance claims, when a suspected IPV claim is not pursued under administrative or prosecution procedures. ( )

02. Obtain Administrative Disqualification. The Department pursues administrative disqualification when: ( )

a. The case facts do not warrant civil or criminal prosecution. ( )

b. The case referred for prosecution was declined. ( )

c. The case was referred for prosecution and no action was taken in a reasonable time. ( )

d. The case was referred for prosecution, but the case was withdrawn by the Department. ( )

03. Do Not Obtain Administrative Disqualification. The Department must not pursue an administrative disqualification in cases: ( )

a. Being referred for prosecution. ( )

b. After any prosecutor action against the accused if the case issues are the same or related circumstances. ( )

701. PENALTIES FOR AN IPV.
IPV persons are ineligible for Food Stamps for twelve (12) months for the first violation. IPV persons are ineligible for Food Stamps for twenty-four (24) months for the second violation. IPV persons are ineligible for Food Stamps permanently for the third violation. The Department will disqualify only the person or persons who committed the IPV. The Department will notify the person in writing of the disqualification penalty. The penalty continues without interruption until completed, regardless of the eligibility of the disqualified person. An IPV penalty can be imposed, even if no overissuance claim exists. ( )

01. Administrative Disqualification Hearings. The disqualification begins no later than the first day of the second month following the date the person gets written notice of the disqualification. ( )

02. Waivers. The disqualification begins the first day of the month, following the date the person gets the written notice of disqualification. ( )

03. Court Decisions. The disqualification begins on the date imposed by the court (to start the

beginning of the following month) or, if no date is specified, within forty-five (45) days of the date the disqualification was ordered, beginning the first day of the month. ( )

702. PENALTIES FOR IPV TRAFFICKING.
IPV persons are ineligible for Food Stamps for two (2) years for the first finding by a court the recipient purchased illegal drugs with Food Stamps. IPV persons are permanently ineligible for Food Stamps for a second finding by the court the recipient purchased illegal drugs with Food Stamps. IPV persons are permanently ineligible for Food Stamps for a first finding by a court the recipient purchased firearms, ammunition or explosives with Food Stamps. A person convicted of trafficking in Food Stamp benefits of five hundred dollars ($500) or more is permanently disqualified from the Food Stamp program. ( )

703. PENALTIES FOR IPV RECEIPT OF MULTIPLE BENEFITS.
A person found making a fraudulent statement or representation about identity or residence to get multiple benefits is ineligible for Food Stamps for ten (10) years for the first and second offenses and permanently for the third offense. ( )

704. -- 714. (RESERVED)

715. WAIVED HEARINGS.
Persons accused of an IPV may waive their right to an administrative disqualification hearing by completing and signing a Waiver of Disqualification Hearing. The steps needed to waive the hearing are listed below: ( )

01. Review of Evidence. The Department must be sure the evidence warrants scheduling a disqualification hearing before giving household members, suspected of an IPV, the waiver option. Household circumstances must be reviewed by the Examiner assigned the case and a program supervisor or designee. ( )

02. Advance Notice. If the reviewers determine a waiver is proper, each household member suspected of IPV must be mailed or given a Waiver of Disqualification Hearing. ( )

716. DISQUALIFICATION AFTER WAIVED HEARING.
Persons waiving their right to an IPV administrative disqualification hearing must have penalties imposed. ( )

717. COURT REFERRALS.
Procedures for court referrals are listed below: ( )

01. Referred Cases. The Department may refer persons suspected of getting or receiving Food Stamps by committing an IPV. The Department may refer persons suspected of committing an IPV. ( )

02. Impose Court Penalties. The Department must disqualify a person found guilty of IPV by a court for the length of time specified by the court. The disqualified member's household will remain responsible for the overissuance, resulting from the disqualified member's IPV, regardless of the household's eligibility. If the court fails to specify a period, use the IPV penalty periods specified in Section 701 unless they are contrary to the court order. ( )

718. DEFERRED ADJUDICATION.
Deferred Adjudication is an out-of-court settlement between the accused IPV member and the prosecutor. Terms of the settlement are listed below: ( )

01. Deferred Judgement Conditions. Guilt is not decided by the court because the accused person has met the terms of a court order or an agreement with the prosecutor. ( )

02. Agreement with Prosecutor. If the Department has an agreement with the prosecutor, the prosecutor may defer adjudication. The prosecutor must agree to give advance written notice to the member stating the consequences of consenting to disqualification. ( )

03. Notice to Food Stamp Member. If the prosecutor decides deferred adjudication is fitting, the household member suspected of IPV must be mailed or presented with a Deferred Adjudication Disqualification

Consent Agreement. ( )

04. Disqualification Period. The period of disqualification must begin within forty-five (45) days of the date the member signed the Deferred Adjudication Disqualification Consent Agreement (HW 0546). The period of disqualification must begin as agreed upon with the Prosecutor. Once a disqualification penalty is imposed against a member, the period continues uninterrupted regardless of the household's eligibility. The disqualified member's household continues to be responsible for overissuance repayment resulting from the disqualified member's IPV regardless of the household's eligibility. ( )

05. Notice of Disqualification. The Department must provide a completed Notice of Disqualification (HW 0541) before the disqualification to the disqualified member and remaining household members. The Department must provide a Demand Letter for Overissuance and Repayment Agreement (HW 0544). ( )

719. (RESERVED)

720. CLAIMS DISCHARGED BY BANKRUPTCY.
The Department will act for FNS in bankruptcy proceedings against households owing claims. The Department may file proofs of claims, objections to discharge, exceptions, petitions and any other documents, motions, or objectives FNS might have filed. ( )

721. (RESERVED)

722. INTERSTATE CLAIMS COLLECTION.
If a household owes a claim and moves from one State to another, the first State should start or continue collection action. The first State has the initial opportunity to collect. The receiving State should take collection action if the first State fails to act. The receiving State should contact the first State to be sure the first State does not intend to pursue collection. The State share of claims collected is kept by the State making the collection. ( )

723. -- 727. (RESERVED)

728. FOOD STAMP REDUCTION, SUSPENSION, OR CANCELLATION.
Food Stamps for all Food Stamp households must be reduced suspended, or cancelled, if ordered by the USDA Secretary to comply with Section 18 of the Food Stamp Act of 1977. Reduced Food Stamps are computed using the thrifty food plan amounts and are reduced by a percentage defined by FNS. Food Stamp reduction, suspension, and cancellation rules are described below: ( )

01. Reducing Food Stamps. FNS will notify the Department of the effective date of reduction and of the thrifty food plan reduction percentage. The Department must: ( )

a. Act immediately to carry out the reduction. ( )

b. Guarantee one (1) and two (2) person households a minimum benefit of equal to eight percent (8%) of the maximum one (1) person allotment unless the reduction is ninety percent (90%) or more of total projected monthly benefits. ( )

02. Restoring Lost Benefits. Households whose Food Stamps are reduced or cancelled under this section are not entitled to restoration of benefits. Reductions or cancellations of Food Stamps may be ordered restored by the USDA Secretary. ( )

03. Suspension or Cancellation. If a suspension or cancellation is in effect, no Food Stamps are to be issued to the applicant. ( )

04. Hearings. Any household whose allotment was reduced, suspended, or cancelled under this section can request a fair hearing. ( )

729. -- 750. (RESERVED)

751. BOARDERS.
Rules for Food Stamp boarders are listed below: ( )

01. Boarder Included with Food Stamp Household. Boarders may be included in the Food Stamp household providing board. The Food Stamp household must request the boarder be included. The household must be otherwise eligible. ( )

02. Foster Children. Foster children are boarders. Foster care payments and guardianship payments are not income for Food Stamps if the foster child does not get Food Stamps as part of the household. If the household requests the foster child be included in the Food Stamp household, foster care payments and guardianship payments are counted. ( )

03. Foster Adults. Foster adults are boarders. Foster care payments are not income for Food Stamps if the foster adult does not get Food Stamps as part of the household. If the household requests the foster adult be included in the Food Stamp household, the foster care payments are counted. ( )

04. Meal Compensation. Boarder status must be given to persons paying a reasonable monthly amount for meals. ( )

a. Payments for more than two (2) meals a day must equal or exceed the thrifty food plan for the boarder household size. ( )

b. Payments for two (2) meals or less per day must equal or exceed two-thirds (2/3) of the thrifty food plan for the boarder household size. ( )

05. Nonboarder Status. A person paying less than a reasonable amount for meals is a member of the household providing board. ( )

06. Income from Boarders. If the boarder is not a Food Stamp household member: ( )

a. The meals and lodging payment is self-employment income for the Food Stamp household. ( )

b. The boarder's income and resources are not counted for the Food Stamp household. ( )

752. STRIKERS.
Households with strikers are not eligible to get Food Stamps, unless the household was eligible the day before the strike. ( )

753. SPONSORED LEGAL NON-CITIZENS.
Sponsored legal non-citizens are lawfully admitted for permanent United States residence, as defined in Sections 101(a)(15) and 101(a)(20) of the Immigration and Nationality Act. A sponsor executes an I-864 affidavit of support on behalf of legal non-citizen, as a condition of the legal non-citizen's entry or admission into the United States as a permanent resident. The income and resources of the sponsor will be deemed until the legal non-citizen becomes a naturalized citizen or until he has worked forty (40) qualifying quarters of coverage under Title II of the Social Security Act, or the sponsor dies. A qualifying quarter includes a quarter worked by the legal non-citizen's parent while the legal non-citizen was under eighteen (18) and a quarter worked by the legal noncitizen's spouse during marriage if the legal non-citizen remains married to the spouse or the spouse is deceased. Any quarter after January 1, 1997 in which a legal non-citizen received any federal means-tested benefit is not counted as a qualifying quarter. ( )

754. DEEMING INCOME AND RESOURCES TO SPONSORED LEGAL NON-CITIZEN.
Income and resources of the sponsor are deemed available to the legal non-citizen. If the sponsor lives with his spouse, the spouse's income and resources are also deemed available to the legal non-citizen. The income and resources are deemed, even if the sponsor and spouse were married after the sponsor signed the sponsorship agreement. The Department counts income and resources deemed to the legal non-citizen toward Food Stamp eligibility and issuance level of the legal non-citizen's household. ( )

01. Battered Legal Non-Citizen Whose Sponsor Signed an Affidavit of Support. For sponsor deeming, a battered legal non-citizen includes the non-citizen and the child of the non-citizen. The non-citizen or child must be battered in the U.S. by a spouse, parent, or member of the family in the same household. The non-citizen must not participate in, or acquiesce to, the battering of the child. ( )

a. A battered legal non-citizen whose sponsor signed an affidavit of support is exempt from the sponsor deeming requirement for one (1) year, if the need for Food Stamps is connected to the battery and the legal non-citizen no longer lives with the batterer. ( )

b. The exemption from the sponsor deeming requirement can exceed more than one (1) year if the legal non-citizen demonstrates the battery has been recognized in an order of a judge or by the INS and the need for Food Stamps is connected to the battery. ( )

02. Indigent Legal Non-Citizen Whose Sponsor Signed an Affidavit of Support. A non-citizen is indigent if the household income does not exceed one-hundred thirty percent (130%) of the poverty income guideline (gross income limit) for the household size. ( )

a. For an indigent non-citizen, the Department counts the noncitizen's own income and the cash or in-kind income and resources actually provided by the sponsor and spouse who signed an affidavit of support. ( )

b. A legal non-citizen that satisfies the indigent exemption criteria is exempt from deeming for twelve (12) months. The exemption can be renewed for additional twelve-month periods. ( )

c. If a legal non-citizen is granted an indigence exemption, the department must provide written notification to the Statistics Branch of the INS on an annual basis. Required information includes, written notice of the determination, the sponsored legal non-citizen's name, and the sponsor's name. ( )

d. A legal non-citizen can elect to decline the indigent exemption to avoid sponsor liability, and notification to the INS. ( )

e. If the legal non-citizen declines the indigent exemption, the household is subject to sponsored deeming. ( )

755. – 756. (RESERVED)

757. SPONSORED LEGAL NON-CITIZEN'S RESPONSIBILITY.
The legal non-citizen and legal non-citizen's spouse are responsible for getting the sponsor to cooperate with the Department in determining Food Stamp eligibility. The legal non-citizen and legal non-citizen's spouse are responsible for providing the information and proof to determine the income and resources of the sponsor and sponsor's spouse. The legal non-citizen and legal non-citizen's spouse are responsible for providing information and proof to determine if the sponsor sponsors other legal non-citizens and how many. ( )

758. – 760. (RESERVED)

761. COLLECTING CLAIMS AGAINST SPONSORS WHO SIGNED AN I-864 AFFIDAVIT OF SUPPORT ON OR AFTER DECEMBER 19, 1997.
The Department must send a demand letter to the sponsor. The demand letter must include the amount owed, the reason for the claim, and the repayment options. The demand letter must tell the sponsor he will not have to repay, if he can show he did not give false statements or withhold information about his circumstances. Collection action may be stopped if documentation is obtained showing the sponsor cannot be located. Collection action may be stopped if the cost of collection exceeds the amount to be recovered. If the sponsor responds to the demand letter, a lump sum cash payment may be collected if the sponsor can pay the claim at one (1) time. If the sponsor cannot pay by lump sum, a monthly repayment schedule may be negotiated. Sponsor repayments must be recorded in the case file and identified as either an IHE or IPV claim. ( )

762. COLLECTING CLAIMS AGAINST SPONSORED LEGAL NON-CITIZENS.
Claims may be collected against sponsored legal non-citizens with a sponsor who signed an I-864 affidavit of support on or after December 19, 1997. Action may be taken to collect by submitting an IHE or IPV. ( )

763. REIMBURSEMENT FOR BENEFITS RECEIVED.
A sponsor who signed an affidavit on or after December 19, 1997 must reimburse the Department for the amount of Food Stamps received by the sponsored legal non-citizen. At the time of application for a sponsored legal non-citizen, the legal non-citizen's sponsor must be notified that he will be required to reimburse the Department for the entire amount of Food Stamps received by the sponsored legal non-citizen. ( )

764. -- 774. (RESERVED)

775. FOOD STAMPS FOR HOUSEHOLDS WITH IPV MEMBERS, INELIGIBLE FUGITIVE FELON, PROBATION/PAROLE VIOLATOR, WORK REQUIREMENT SANCTIONS, OR A MEMBER CONVICTED OF A CONTROLLED SUBSTANCE-RELATED FELONY.
The Department calculates Food Stamp eligibility and benefit level for households containing members disqualified for an IPV, ineligible fugitive felon, probation/parole violator, members ineligible because of work requirement sanctions including JSAP, and Voluntary Quit, or a member ineligible because of a controlled substance-related felony. The household's Food Stamps must not increase because a household member is disqualified for IPV.
( )

776. -- 790. (RESERVED)

791. RESIDENT OF AN INSTITUTION.
A resident of an institution is not eligible for Food Stamps unless the resident meets one (1) of the requirements listed below. A person is a resident of an institution if the institution provides over fifty percent (50%) of the person's meals as a part of normal services. Residents must be otherwise Food Stamp eligible. ( )

01. Resident Under Housing Act. The resident is in Federally subsidized housing for the elderly, under Section 202 of the Housing Act or 236 of the National Housing Act. ( )

02. Narcotic Addict or Alcoholic. The resident is a narcotic addict or an alcoholic living and taking part in a treatment and rehabilitation program. ( )

03. Blind or Disabled. The person is a disabled or blind resident of a group living arrangement.
( )

04. Battered Women and Children. The resident is a woman or a woman and her children, temporarily living in a shelter for battered women and children. ( )

a. The woman is a separate household from other shelter residents for Food Stamps. ( )

b. The woman and her children are a separate household from other shelter residents for Food Stamps.
( )

05. Homeless Persons. The resident is a person living in a public or private nonprofit shelter for homeless persons. ( )

792. PRERELEASE APPLICANTS FROM PUBLIC INSTITUTIONS.
Residents of public institutions who apply for prerelease program SSI may apply for Food Stamps before their release from public institutions. The application date is the date the person is released from the institution. Eligibility is based on the best estimate of a household's circumstances for the release month and the month after. Eligibility and Food Stamp amount are based on income and resources. Food Stamps for the initial month are prorated from the date the person is released from the institution to the end of the calendar month. ( )

793. NARCOTIC ADDICT AND ALCOHOLIC TREATMENT CENTERS.

01. Center Provides Certification List. Each month, each center must give the Field Office a list of current client residents. The list's accuracy must be certified in writing by the center manager or designee. The Department must conduct random on-site visits to assure list accuracy. If the list is not accurate, or the Department fails to act on the change, the Department may transfer the Food Stamp amount from the center's account to the household's Food Stamp account, for the months the household was not living in the center. ( )

02. Center Misusing Food Stamps. The Department must promptly notify FNS if it believes a center is misusing Food Stamps. The Department must not take action before FNS takes action against the center. ( )

794. TREATMENT CENTER RESPONSIBILITIES.
Each treatment center must follow SNAP application standards, with the exception of: ( )

01. Return Food Stamps. ( )

a. The center must return all issue documents and Food Stamps, not given to a departing resident, to the Department. ( )

b. Food Stamps must be returned to the Department if the client left before the sixteenth of the month and the center was unable to give him the Food Stamps. ( )

c. Food Stamps must be returned to the Department if they were left over for a resident who left on or after the sixteenth of the month. ( )

02. Give Food Stamps to Departing Client. ( )

a. The center must give the departing client the ID card and any unredeemed Food Stamps. ( )

b. The center must give the client a full month's Food Stamps if they have been issued, but none have been spent on behalf of the client. ( )

c. The center must give the departing client one-half (1/2) of the monthly Food Stamps if the client leaves before the sixteenth of the month and a portion of the Food Stamps have been spent on behalf of the client. ( )

d. If the client leaves the center on or after the sixteenth, and Food Stamps were issued and used, the center is not required to give Food Stamps to the client. ( )

03. Food Stamp Misuse. The center must be disqualified if it is administratively or judicially found the center misappropriated or used Food Stamps for purchases not contributing to a certified client's meals. ( )

04. FNS Disqualifies Center. If FNS disqualifies a center as a retailer, the Department must close residents' cases. Individual notice of adverse action is not required. ( )

795. RESIDENTS OF GROUP LIVING ARRANGEMENTS.
Disabled or blind residents of public or private non-profit group living arrangements, serving no more than sixteen (16) residents may get Food Stamps. Residents get Food Stamps under the same standards as other households. Group living arrangements rules are listed below: ( )

01. FNS Authorized Retailer or Department Certified. The center must be an FNS authorized retailer or be certified by the Department as a non-profit group living center. Center status must comply with Section 1616(e) of the Social Security Act or comparable standards of the Secretary of USDA. ( )

02. Application Option. Residents may apply on their own. Residents may apply as a group. Residents may apply through an authorized representative employed and designated by the center. Residents may apply through an authorized representative of the resident's choice. ( )

03. Residents Apply on Their Own Behalf. A person or a group of residents making up a household can apply on their own behalf. The center must determine the resident is physically and intellectually capable of handling his own affairs. If the resident is eligible the center does not act as the authorized representative. The resident or group is responsible for reporting any changes affecting eligibility or benefit level. The resident is responsible for overissuances. ( )

04. Certification. Residents of a center applying through the center's authorized representative must be certified as a one (1) person household. Residents of a center applying on their own behalf must be certified according to household size. ( )

05. Exempt From Work Registration. Residents are exempt from work registration. ( )

06. Notices. Residents are entitled to notices of adverse action. If a group living arrangement center loses its authorization or certification notice is not required. ( )

07. Using Food Stamps. The Food Stamps may be used by the resident, a group of residents, or by the center to purchase food for the resident. The center may accept Food Stamps as payment for meals. If residents purchase or prepare food for home consumption, the center must insure each resident's Food Stamps are used for meals intended for that resident. ( )

796. SHELTERS FOR BATTERED WOMEN AND CHILDREN.
The Department must determine if the shelter for battered women and children is a public or private non-profit residential facility. The Department must determine if the shelter serves only battered women and their children. If the facility serves other persons, the Department must determine if a portion of the facility is set aside to serve only battered women and children. Shelters having FNS authorization to redeem Food Stamps on a wholesale basis meet the shelter definition. Battered women and children shelter rules are listed below: ( )

01. Food Stamp Eligibility. Women and children who recently left a household containing a person who abused them may get Food Stamps, even if the household they left was getting Food Stamps. Shelter residents may apply for and get separate Food Stamps only once in a month. The original Food Stamp certification must have included the person who subjected them to abuse. The resident household must meet eligibility criteria for income, resources, and expenses. ( )

02. Income, Resources, and Expenses. Income, resources, and expenses of the household are counted. Income, resources, and expenses of their former household, containing the person who subjected them to abuse, are not counted. Jointly held resources are inaccessible if the resources are jointly owned by the shelter resident and members of the abusive household. Jointly held resources are inaccessible if the shelter residents' access to the resource is dependent on the agreement of the joint owner still living in the former household. Room payments to the shelter are shelter expenses. ( )

03. Food Stamps for Former Household. The Department must take prompt action to correct the former household's eligibility and allotment. The Department must issue a ten (10) day advance notice of adverse action. ( )

797. -- 815. (RESERVED)

816. PURCHASE OF PREPARED MEALS.
Persons listed below may purchase prepared meals with their Food Stamps at sites authorized to accept Food Stamps. ( )

01. Older Persons Eating at Communal Dining Facility. Persons sixty (60) or older and their spouses, or persons who receive SSI and their spouses, can use Food Stamps to buy meals made for them at communal dining facilities authorized to accept Food Stamps. ( )

02. Persons Unable to Prepare Meals Getting Meal Delivery Service. A person sixty (60) years of age or over, and a spouse, can elect to use Food Stamps to purchase meals from a nonprofit meal delivery service. A

housebound, physically handicapped or otherwise disabled person, unable to adequately prepare all meals, and a spouse, can elect to use Food Stamps to purchase meals from a nonprofit meal delivery service. ( )

03. Resident Center. A resident of a drug addiction or alcoholic center can use Food Stamps at the center. The person must be enrolled in a treatment and rehabilitation program operated by a nonprofit organization or institution. ( )

04. Battered Women and Children. A resident of a shelter for battered women and children can use Food Stamps to purchase meals prepared by the shelter. ( )

05. Homeless. A homeless Food Stamp client can use Food Stamps to buy meals prepared by a homeless meal provider. ( )

817. -- 849. (RESERVED)

850. FOOD STAMP HOUSEHOLD RIGHTS.
The Food Stamp household has rights protected by Federal and State laws and Department rules. The Department must inform clients of their rights during the application process and eligibility reviews. Food Stamp rights are listed below: ( )

01. Application. The right to get an application on the date requested. ( )

02. Application Registered. The right to have the signed application accepted right away. ( )

03. Representative. The right to have an authorized representative if the applicant cannot get to the Food Stamp office. The authorized representative must have knowledge of the applicant's situation. ( )

04. Thirty Day Processing. The right to have the application processed and Food Stamps issued within thirty (30) days. ( )

05. Notification. The right to be told in writing of: ( )

a. The reasons for the Department's action if the application is rejected. ( )

b. The reasons for the Department's action if Food Stamps are reduced or stopped. ( )

06. Fair Hearing. The right to request a fair hearing about the Department's decision. The right to request a fair hearing if the household feels discrimination has taken place in any way. Food Stamp fair hearings must be requested within ninety (90) days from the day notice is mailed. In certain situations, Food Stamps may continue if a fair hearing is requested. ( )

851. (RESERVED)

852. FOOD STAMP HOUSEHOLD RESPONSIBILITIES.
The Food Stamp household must provide correct and complete information so the Department can make accurate eligibility and benefit decisions. The responsibilities of the Food Stamp household are listed below: ( )

01. Provide Information. The Food Stamp household must provide information to determine Food stamp eligibility. This includes, but is not limited to, all information about household income, work and housing cost. ( )

02. Quality Control. The Food Stamp household must cooperate with Quality Control if the case is selected for review. ( )

853. DEPARTMENT INFORMING RESPONSIBILITIES.
The Department must inform the Food Stamp household of what is expected of the household in the eligibility determination process. The Department must advise the household of the information listed below: ( )

01. Households Rights and Responsibilities. The Department must inform the household of the household's rights and responsibilities. ( )

02. Eligibility Factors. The Department must inform the household of the eligibility factors that must be met. ( )

03. Eligibility Factor Proof. The Department must inform the household all eligibility factors must be proven. ( )

04. Consequences of Failure to Cooperate. The Department must inform the household of the consequences for failure to provide proof of eligibility factors. ( )

05. Methods for Getting Proof. The Department must inform the household of the alternate methods to prove eligibility when the household is unable to provide proof. ( )

06. Department Methods for Getting Proof. The Department must inform the household of the methods it uses to prove eligibility when the household is unable to provide proof. ( )

07. Social Security Number Use. The Department must inform the household Social Security Numbers will be used to get wage, income and employment information. Information is obtained from the Department of Employment (DOE), the Social Security Administration (SSA) and the Internal Revenue Service (IRS). ( )

854. DEPARTMENT WILL DOCUMENT ELIGIBILITY DECISIONS.
The Department will document eligibility, ineligibility and Food Stamp issuance in the case record. The Department must record enough detail to support the Food Stamp determination. ( )

855. -- 860. (RESERVED)

861. NO DISCRIMINATION IN FOOD STAMP PROGRAM.
The Department must not allow human rights discrimination in the Food Stamp Program. The Department will administer the Food Stamp program so no applicant or recipient in Idaho is discriminated for or against due to race, color, gender or age. The Department will administer the Food Stamp program so no applicant or recipient in Idaho is discriminated for or against, due to political or religious belief or affiliation, national origin, handicap or disability. ( )

862. PUBLIC NOTICE FOR NO DISCRIMINATION.
The Department must inform the public the Food Stamp Program is conducted without discrimination. The Department must display the U.S.D.A. poster "... And Justice for All" in all Field Offices. The application form must inform the public the Food Stamp Program is conducted without discrimination. Department Food Stamp publications must inform the public the Food Stamp Program is conducted without discrimination. ( )

863. DISCRIMINATION COMPLAINT INFORMATION.
Field Offices must maintain copies of notices informing the public the Food Stamp Program is conducted without discrimination. These files must be available for inspection during reviews and audits. ( )

864. DISCRIMINATION COMPLAINT PROCEDURE.
Any person can file a discrimination complaint. The person may use the Department's complaint procedure. The person may file a complaint directly to FNS, to the Department or both. The Field Office must explain both procedures orally or in writing. The Field Office must explain the one hundred eighty (180) day filing time limit, extensions and where to submit complaints. The Department must submit a written report describing the discrimination complaint and the action taken. This report is submitted to the Department's Civil Rights Coordinator. The Department must keep all complaints and complaint records for three (3) years. ( )

865. DISCLOSURE OF INFORMATION.
Department programs include the Food Stamp Act, Federal regulations, Federal or Federally-aided means-tested

assistance programs and general assistance programs with a means test and formal application procedures. The Department will make available to any Federal, State, or local law enforcement officer the address, SSN, and (if available) photograph of a Food Stamp recipient. The officer must furnish the recipient's name and notify the Department the person is fleeing to avoid prosecution, custody or confinement for a felony; violating a condition of parole or probation; or has information necessary for the officer to conduct an official duty related to a felony/parole violation. ( )

866. AVAILABILITY OF PUBLIC INFORMATION.
Rules, plans of operation, procedures, manuals and instructions used to certify households must be available to the public. These materials must be available for public examination during regular office hours and workdays. Copies of audits or investigations, conducted by USDA, are for official use only and are not for public examination. ( )

867. FOOD STAMP INFORMATION REQUIREMENTS.
Federal regulations and procedures in FNS notices and policy memos must be available for examination by the public. State plans of operation must be available for examination by the public. Examination may take place during office hours at Department headquarters. Handbooks must be available for examination upon request at each Field Office. The Department must provide information about Food Stamps through mass media, posters, fliers, pamphlets and face-to-face contacts. Minimum requirements are listed below: ( )

01. Rights and Responsibilities. Households must be informed of Food Stamp program rights and responsibilities. ( )

02. Bilingual Information. All program information must be available in Spanish. Spanish information must say the program is available without regard to race, color, sex, age, handicap, religious creed, national origin or political belief. ( )

868. -- 871. (RESERVED)

872. PROGRAM TRANSFER DURING CERTIFICATION PERIOD.
Households changing from one (1) program to the other program within a certification period can do so only by ending participation. The household must tell the proper agency of its intent to switch programs. Households certified in either program on the first day of the month can only get that program's benefits during that month. A household, wanting to switch from one (1) program to the other program, must have its eligibility stopped for the currently certified program. Eligibility must end as of the last day of the month it chooses to change programs. The household must file an application for the program in which it wishes to take part. ( )

873. -- 875. (RESERVED)

876. PERSONNEL REQUIREMENTS.
The Department must provide the qualified employees needed to assure prompt action on applications and issuance of benefits. Department employees certifying households for Food Stamps must be hired under Idaho Personnel Commission standards. Only qualified Department employees can interview households and determine eligibility and benefit amount. Only authorized employees or contractors of the Department may have access to Food Stamp cards or other issuance documents. ( )

877. VOLUNTEERS.
Volunteers, or other persons not employed by the Department, can engage in certification-related activities. Volunteers, or other persons not employed by the Department, must not conduct interviews or certify households. Volunteers and other persons can teach nutrition education and provide transportation to the Field Offices. Volunteers and other persons can help households complete the application forms. Volunteers and other persons can help get proof for information reported on the application. ( )

878. PERSONNEL AND FACILITIES OF PARTIES TO A STRIKE.
Persons or organizations, who are parties to a strike or lockout, cannot be used in any activity related to certification. These persons must not certify applicant households, interview households or help get proof for the households. These persons can give proof of information provided by households, if they are in the best position to confirm a household's circumstances. Facilities of persons or organizations who are parties to a strike or lockout cannot be used

in the certification process or as an interview site. ( )

879. REVIEW OF CASE FILE.
The client or his representative is allowed to review his case file under Department Rules, IDAPA 16.05.01, "Use and Disclosure of Department Records." ( )

880. -- 882. (RESERVED)

883. QUALITY CONTROL AND FOOD STAMP ELIGIBILITY.
State Quality Control (SQC) is the Department's case review system. SQC determines rates of correct Food Stamp issuances and Department and recipient caused errors. Quality control reviews open Food Stamp cases, denials and closures. The quality control review period extends from October 1st to September 30th of the next year. Households selected for quality control review by State Quality Control (SQC) and Federal Quality Control (FQC) must cooperate with both reviews. ( )

01. Refusal to Cooperate with SQC or FQC. If a household refuses to cooperate in a SQC or FQC review, it is not eligible. ( )

a. The Department must send the household advance notice to end Food Stamps. The notice must list the reason for the proposed action, the right to a hearing, the right to schedule a conference or to continue the SQC or FQC review. ( )

b. The Department will close the Food Stamp case. ( )

02. Food Stamp Eligibility During Quality Control Review Period, After Refusal to Cooperate. The household is not eligible for Food Stamps during the Quality Control review period until it cooperates with the SQC or FQC review. ( )

884. -- 999. (RESERVED)

000. LEGAL AUTHORITY.
The Idaho Department of Health and Welfare, according to Section 56-202, Idaho Code, adopts these rules for the administration of public assistance programs. ( )

001. TITLE AND SCOPE.

01. Title. These rules are titled IDAPA 16.03.05, "Eligibility for Aid to the Aged, Blind, and Disabled (AABD)." ( )

02. Scope. These rules provide standards for issuing AABD cash benefits and related Medicaid benefits. ( )

002. INCORPORATION BY REFERENCE.
The Department is adopting by reference the "Medicare Modernization Act - Prescription Drug Program Guidance to States for the Low Income Subsidy (LIS)," dated May 25, 2005. The guidelines may be viewed at the main office of the Department of Health and Welfare. It is also available online at https://www.cms.gov/Medicare/Eligibility-and-Enrollment/LowIncSubMedicarePresCov/Downloads/StateLISGuidance021009.pdf. ( )

003. -- 009. (RESERVED)

010. DEFINITIONS.
For purposes of this chapter, the following terms apply. ( )

01. AABD Cash. An EBT payment to a participant, a participant's guardian, or a holder of a limited power of attorney for EBT payments. AABD Cash is a payment of a supplemental cash amount to an individual who meets the program requirements. This payment may be made through direct deposit or an electronic benefits card. ( )

02. Applicant. A person applying for public assistance from the Department, including individuals referred to the Department from a health insurance exchange or marketplace. ( )

03. Annuity. A right to receive periodic payments, either for life, a term of years, or other interval of time, whether or not the initial payment or investment has been annuitized. It includes contracts for single payments where the single payment represents an initial payment or investment together with increases or deductions for interest or fees rather than an actuarially-based payment from an insurance pool. ( )

04. Asset. Includes all income and resources of the individual and the individual's spouse, including any income or resources which the individual or such individual's spouse is entitled to, but does not receive because of action by: ( )

a. The individual or such individual's spouse; ( )

b. A person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or such individual's spouse; or ( )

c. A person, including any court or administrative body, acting at the direction or upon the request of the individual or such individual's spouse. ( )

05. Asset Transfer for Sole Benefit. An asset transfer is considered to be for the sole benefit of a spouse, blind or disabled child, or disabled individual if the transfer is arranged in such a way that no individual or entity except the spouse, blind or disabled child, or disabled individual can benefit from the assets transferred in any way, whether at the time of transfer or at any time in the future. ( )

06. Child. Any individual from birth through the end of the month of his nineteenth birthday. ( )

07. Citizen. A person having status as a "national of the United States" defined in 8 U.S.C. 1101(a)(22) that includes both citizens of the United States and non-citizen nationals of the United States. ( )

08. Department. The Department of Health and Welfare. ( )

09. Direct Deposit. The electronic deposit of a participant's AABD cash to the participant's personal account with a financial institution. ( )

10. Electronic Benefits Transfer (EBT). A method of issuing AABD cash to a participant, a participant's guardian or a holder of a limited power of attorney for EBT payments for a participant. ( )

11. Essential Person. A person of the participant's choice whose presence in the household is essential to the participant's well-being. The essential person provides the services a participant needs to live at home. ( )

12. Fair Market Value. The fair market value of an asset is the price for which the asset can be reasonably expected to sell on the open market, in the geographic area involved. ( )

13. Long-Term Care. Long-term care services are services provided to an institutionalized individual as defined in 42 U.S.C. 1396p(c)(1)(C). ( )

14. Medicaid. Idaho's Medical Assistance Program administered by the Department and funded with federal and state funds according to Title XIX, Social Security Act that provides medical care for eligible individuals. ( )

15. Medical Assistance Rules. Idaho Department of Health and Welfare Rules, IDAPA 16.03.09, "Medicaid Basic Plan Benefits," IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," and IDAPA 16.03.17, "Medicare/Medicaid Coordinated Plan Benefits." ( )

16. Medicaid for Families With Children Rules. Idaho Department of Health and Welfare Rules, IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children." ( )

17. Needy. A person is considered needy for AABD cash payments if the person meets the nonfinancial requirements of Title XVI of the Social Security Act and the criteria in Section 514 of these rules. ( )

18. Non-Citizen. Same as "alien" defined in Section 101(a)(3) of the Immigration and Nationality Act (INA) (8 U.S.C. 1101 (a)(3)), and includes any individual who is not a citizen or national of the United States. ( )

19. Participant. An individual who is eligible for, and enrolled in, a Health Care Assistance Program or Medicaid. ( )

20. Partnership Policy. A partnership policy is a qualified long-term care insurance policy as defined in Section 7702B(b) of the Internal Revenue Code of 1986, which meets the requirements of the long-term care insurance model regulation and long-term care insurance model act promulgated by the National Association of Insurance Commissioners (NAIC), as incorporated in 42 USC 1396p(b)(5)(A). ( )

21. Premium. A regular, periodic charge or payment for health coverage. ( )

22. Reasonable Opportunity Period. A period of time allowed for an individual to provide requested proof of citizenship or identity. A reasonable opportunity period extends for ninety (90) days beginning on the 5th day after the notice requesting the proof has been mailed to the applicant. This period may be extended if the Department determines that the individual is making a "good faith" effort to obtain necessary documentation. ( )

23. Pension Funds. Pension funds are retirement funds held in individual retirement accounts (IRAs), as described by the Internal Revenue Code, or in work-related pension plans, including plans for self-employed individuals sometimes referred to as Keogh plans. ( )

24. Sole Beneficiary. The only beneficiary of a trust, including a beneficiary during the grantor's life, a beneficiary with a future interest, and a beneficiary by the grantor's will. ( )

25. **TAFI Rules**. Idaho Department of Health and Welfare Rules, IDAPA 16.03.08, "Temporary Assistance for Families in Idaho." ( )

26. **Title XVI**. Title XVI of the Social Security Act, known as "Grants to States for Aid to the Aged, Blind, or Disabled," is a program for financial assistance to needy individuals who are sixty-five (65) years of age or over, are blind, or are eighteen (18) years of age or over and permanently and totally disabled. ( )

27. **Title XIX**. Title XIX of the Social Security Act, known as Medicaid, is a medical benefits program jointly financed by the federal and state governments and administered by the states. ( )

28. **Title XXI**. Title XXI of the Social Security Act, known as the Children's Health Insurance Program (CHIP), is a federal and state partnership that provides health insurance to targeted, low-income children. ( )

29. **Treasury Rate**. The five (5) year security note rate listed in the "Daily Treasury Yield Curve Rate" by the U.S. Treasury on January 1 of each year. The January 1 rate is used for the entire calendar year. ( )

30. **Working Day**. A calendar day when regular office hours are observed by the state of Idaho. Weekends and state holidays are not considered working days. ( )

011. -- 019. (RESERVED)

020. ABBREVIATIONS.

01. **AABD**. Aid to the Aged, Blind and Disabled. ( )

02. **AB**. Aid to the Blind. ( )

03. **AFA**. Application for Assistance. ( )

04. **APTD**. Aid to the Permanently and Totally Disabled. ( )

05. **ASVI**. Alien Status Verification Index. ( )

06. **COLA**. Cost of Living Adjustment. ( )

07. **CSA**. Community Spouse Allowance. ( )

08. **CSNS**. Community Spouse Need Standard. ( )

09. **CSRA**. Community Spouse Resource Allowance. ( )

10. **DHW**. Department of Health and Welfare. ( )

11. **EBT**. Electronic Benefits Transfer. ( )

12. **EITC**. Earned Income Tax Credit. ( )

13. **FMA**. Family Member Allowance. ( )

14. **FSI**. Federal Spousal Impoverishment. ( )

15. **HCBS**. Home and Community Based Services. ( )

16. **HUD**. The U.S. Department of Housing and Urban Development. ( )

17. **IEVS**. Income and Eligibility Verification System. ( )

18. **INA**. Immigration and Nationality Act. ( )

19. **IRS**. The U.S. Internal Revenue Service. ( )

20. **MA**. Medical Assistance. ( )

21. **OAA**. Old Age Assistance. ( )

22. **PASS**. Plan for Achieving Self-Support. ( )

23. **RSDI**. Retirement, Survivors, and Disability Insurance. ( )

24. **SAVE**. Systematic Alien Verification for Entitlements. ( )

25. **SSA**. Social Security Administration. ( )

26. **SSI**. Supplemental Security Income. ( )

27. **SSN**. Social Security Number. ( )

28. **TAFI**. Temporary Assistance for Families in Idaho. ( )

29. **UIB**. Unemployment Insurance Benefits. ( )

30. **VA**. Veterans Administration. ( )

021. -- 048. (RESERVED)

049. SIGNATURES.
An individual who is applying for benefits, receiving benefits, or providing additional information as required by this chapter, may do so with the depiction of the individual's name either handwritten, electronic, or recorded telephonically. Such signature serves as intention to execute or adopt the sound, symbol, or process for the purpose of signing the related record. ( )

050. APPLICATION FOR ASSISTANCE.

01. **Application Submitted by Participant**. The participant must submit an application form to the Department. An adult participant, a legal guardian or a representative, must sign the application form. ( )

02. **Application Submitted Through Social Security Administration (SSA) Low-Income Subsidy Data Transmission**. For low-income subsidy applicants identified on the SSA data transmission, the protected Medicare Savings Program application date is the day they applied for the low-income subsidy (LIS). ( )

051. EFFECTIVE DATE.
The effective date for aid is the first day of the month of application. Medicaid eligibility begins as described in Subsections 051.01 through 051.04. ( )

01. **AABD Cash**. AABD cash aid is effective on the application date. ( )

02. **Normal Medicaid Eligibility**. Medicaid coverage begins on the first day of the application month. ( )

03. **Retroactive (Backdated) Medicaid Eligibility**. Medicaid benefits must be backdated to the first day of the calendar month, for each of the three (3) months before the month of application, if the participant was Medicaid eligible during that month. If the participant is not eligible for Medicaid when he applies, retroactive eligibility is evaluated. ( )

04. Ineligible Non-Citizen Medicaid. Ineligible legal or illegal non-citizen coverage is restricted to emergency services. Coverage begins when the emergency treatment is required. Coverage ends with the last day emergency treatment is required. ( )

052. PERSONAL INTERVIEW.
Each applicant for AABD must participate in a telephone interview unless good cause exists. Upon request, the Department may require a face-to-face interview. ( )

053. -- 069. (RESERVED)

070. TIME LIMITS.
The application must be processed within forty-five (45) days for an applicant sixty-five (65) years of age or older. The application must be processed within ninety (90) days for a disabled applicant. The time limit can be extended by events beyond the Department's control. ( )

071. DEATH OF APPLICANT.
An application may be filed for a deceased person. The application must be filed within the backdated eligibility period. Medicaid can be approved, through the date of death, if an AABD applicant dies before eligibility is determined. ( )

072. REQUIRED VERIFICATION.
Applicants must prove their eligibility for aid. The participant is allowed ten (10) calendar days to provide requested proof. The application is denied if the applicant does not provide proof in ten (10) calendar days of the written request and does not have good cause for not providing proof. The Department may also use electronic verification sources when they are available. ( )

073. -- 089. (RESERVED)

090. APPLICATIONS FOR MEDICAID.
The Department must examine the potential eligibility of the participant for all Medicaid coverage groups when a participant applies for Medicaid. ( )

091. OUT OF STATE APPLICANTS.
A participant receiving AABD cash from another state must not receive AABD cash in Idaho until he is living in Idaho and the cash benefit has ended in the other state. A participant may receive Medicaid in Idaho before AABD cash or Medicaid stops in another state. AABD cash from another state is unearned income for Medicaid. Out-of-state medical coverage is a Medicaid third party resource. Idaho residents temporarily out of the state, and not receiving aid, may apply for aid in Idaho. ( )

092. CONCURRENT BENEFIT PROHIBITION.
If a person is potentially eligible for AABD cash, TAFI, or foster care, only one (1) program may be chosen.
( )

093. -- 099. (RESERVED)

100. RESIDENCY.
The participant must be living in Idaho and have no immediate intention of leaving. For Medicaid, other persons are Idaho residents if they meet a criteria in Subsections 100.01 through 100.05 of this rule. ( )

01. Foster Child. A participant living in Idaho and receiving child foster care payments from another state. ( )

02. Incapable Participant. A participant, who is incapable of indicating his state of residency after age twenty-one (21), is considered a resident of Idaho when: ( )

a. His parent or guardian lives in Idaho; or ( )

b. He resides in an Idaho institution. ( )

03. Placed in Another State by Idaho. A participant placed by the state of Idaho in an institution in another state. ( )

04. Homeless. A participant not maintaining a permanent home or having a fixed address who intends to remain in Idaho. ( )

05. Migrant. A migrant working and living in Idaho. ( )

101. TEMPORARY ABSENCE.
A participant may be temporarily absent from his home and still receive AABD cash and Medicaid. A participant is temporarily absent if he intends to return home within one (1) month. Temporary absence may exceed one (1) month for a child attending school or vocational training or a participant in a medical institution, hospital, or nursing home. ( )

102. U.S. CITIZENSHIP VERIFICATION REQUIREMENTS.
Any individual who participates in AABD cash, Health Care Assistance, or Medicaid benefits must provide proof of U.S. citizenship unless he has otherwise met the requirements under Subsection 104.06 of these rules. ( )

01. Citizenship Verified. Citizenship must be verified by electronic means when available. If an electronic verification is not immediately obtainable, the Department may request documentation from the applicant The Department will not deny the application until the applicant has had a reasonable opportunity period to obtain and provide the necessary proof of U.S. citizenship. ( )

02. Benefits During Reasonable Opportunity Period. Benefits are provided during the reasonable opportunity period that is provided to allow the applicant time to obtain and provide documentation to verify U.S. citizenship. No overpayment will exist for the reasonable opportunity period if the applicant does not provide necessary documentation during the reasonable opportunity period so that the application results in denial. ( )

03. Electronic Verification. Electronic interfaces initiated by the Department with agencies that maintain citizenship and identity information are the primary sources of verification of U.S. Citizenship and Identity. ( )

04. Documents. When verification is not available through an electronic interface, the individual must provide the Department with the most reliable document that is available. Documents can be: ( )

a. Originals; ( )

b. Photocopies; ( )

c. Facsimiles; ( )

d. Scanned; or ( )

e. Other type of copy of a document. ( )

05. Accepted Documentation. Other forms of documentation are accepted to the same extent as an original document, unless information on the submitted document is: ( )

a. Inconsistent with other information available to the Department; or ( )

b. The Department has good cause to question the validity of the document or the information on it. ( )

06. Submission of Documents. The Department accepts documents that are submitted: ( )

a. In person; ( )

b. By mail or parcel service; ( )

c. Through an electronic submission; or ( )

d. Through a guardian or authorized representative. ( )

103. SOCIAL SECURITY NUMBER (SSN) REQUIREMENT.

01. SSN Required. The applicant must provide his social security number (SSN), or proof he has applied for an SSN, to the Department before approval of eligibility. If the applicant has more than one (1) SSN, all numbers must be provided. ( )

a. The SSN must be verified by the Social Security Administration (SSA) electronically. An applicant with an unverified SSN is not eligible for AABD cash, Health Care Assistance, or Medicaid benefits. ( )

b. The Department must notify the applicant in writing if eligibility is denied or lost for failure to meet the SSN requirement. ( )

02. Application for SSN. To be eligible, the applicant must apply for an SSN, or a duplicate SSN when he cannot provide his SSN to the Department. If the SSN has been applied for but not issued by the SSA, the Department cannot deny, delay, or stop benefits. The Department will help an applicant with required documentation when the applicant applies for an SSN. ( )

03. Failure to Apply for SSN. The applicant may be granted a good cause exception for failure to apply for an SSN if they have a well-established religious objection to applying for an SSN. A well-established religious objection means the applicant: ( )

a. Is a member of a recognized religious sect or division of the sect; and ( )

b. Adheres to the tenets or teachings of the sect or division of the sect and for that reason is conscientiously opposed to applying for or using a national identification number. ( )

04. SSN Requirement Waived. An applicant may have the SSN requirement waived when he is: ( )

a. Only eligible for emergency medical services as described in Section 801 of these rules; or ( )

b. A newborn child deemed eligible as described in Section 800 of these rules. ( )

104. U.S. CITIZENSHIP AND IDENTITY DOCUMENTATION REQUIREMENTS.
To be eligible for AABD cash and Medicaid, an individual must provide proof of U.S. citizenship and identity unless he has otherwise met the requirements under Subsection 104.06 of this rule. The individual must provide the Department with the most reliable document that is available. The Department will accept documents as described in Section 102 of these rules. ( )

01. Documents Accepted as Proof of Both U.S. Citizenship and Identity. The following documents are accepted as proof of both U.S. citizenship and identity: ( )

a. A U.S. passport, including a U.S. Passport card, without regard to expiration date as long as the passport or passport card was issued without limitation; ( )

b. A Certificate of Naturalization; or ( )

c. A Certificate of U.S. Citizenship. ( )

d. Documentary evidence issued by a federally recognized Indian tribe. Such documents include: ( )

i. A tribal enrollment card; ( )

ii. A certificate of Degree of Indian Blood; ( )

iii. A tribal census document; or ( )

iv. Documents on tribal letterhead, issued under the signature of the appropriate tribal official. ( )

02. Documents Accepted as Evidence of U.S. Citizenship. The following documents are accepted as proof of U.S. citizenship if the proof in Subsection 104.01 of this rule is not available. These documents are not proof of identity and must be used in combination with a least one (1) document listed in Subsections 104.03 and 104.04 of this rule to establish both citizenship and identity. If the applicant does not have one (1) of the documents listed below, he may submit an affidavit signed by another individual under penalty of perjury who can reasonably attest to the applicant's citizenship, and that contains the applicant's name, date of birth, and place of U.S. birth. The affidavit does not have to be notarized. ( )

a. A U.S. birth certificate that shows the individual was born in one (1) of the following: ( )

i. United States fifty (50) states; ( )

ii. District of Columbia; ( )

iii. Puerto Rico, on or after January 13, 1941; ( )

iv. Guam; ( )

v. U.S. Virgin Islands, on or after January 17, 1917; ( )

vi. America Samoa; ( )

vii. Swain's Island; or ( )

viii. Northern Mariana Islands, after November 4, 1986; ( )

b. A certification of report of birth issued by the Department of State, Forms DS-1350 or FS-545; ( )

c. A report of birth abroad of a U.S. Citizen, Form FS-240; ( )

d. A U.S. Citizen I.D. card, DHS Form I-197; ( )

e. A Northern Mariana Identification Card; ( )

f. A final adoption decree showing the child's name and U.S. place of birth, or if the adoption is not final, a statement from the state-approved adoption agency that shows the child's name and U.S. place of birth; ( )

g. Evidence of U.S. Civil Service employment before June 1, 1976; ( )

h. An official U.S. Military record showing a U.S. place of birth; ( )

i. A certification of birth abroad, FS-545; ( )

j. Verification with the Department of Homeland Security's Systematic Alien Verification for Entitlements (SAVE) database; ( )

k. Evidence of meeting the automatic criteria for U.S. citizenship outlined in the Child Citizenship Act of 2000; ( )

l. Medical records, including, hospital, clinic, or doctor records, or admission papers from a nursing facility, skilled care facility, or other institution that indicate a U.S. place of birth; ( )

m. Life, health, or other insurance record that indicates a U.S. place of birth; ( )

n. Official religious record recorded in the U.S. showing that the birth occurred in the U.S; ( )

o. School records, including pre-school, Head Start, and daycare, showing the child's name and U.S. place of birth; or ( )

p. Federal or state census record showing U.S. citizenship or a U.S. place of birth. ( )

03. Evidence of Identity. The following documents are accepted as proof of identity, provided the document has a photograph or other identifying information including: name, age, sex, race, height, weight, eye color, or address. ( )

a. A state- or territory-issued driver's license. A driver's license issued by a Canadian government authority is not a valid indicator of identity in the U. S.; ( )

b. A federal, state, or local government-issued identity card; ( )

c. School identification card; ( )

d. U.S. Military card or draft record; ( )

e. Military dependent's identification card; ( )

f. U. S. Coast guard Merchant Mariner card; ( )

g. A cross-match with a federal or state governmental, public assistance, law enforcement, or corrections agency's data system; ( )

h. A finding of identity from a federal or state governmental agency, when the agency has verified and certified the identity of the individual, including public assistance, law enforcement, internal revenue or tax bureau, or corrections agency; ( )

i. A finding of identity from another state benefits agency or program provided that it obtained verification of identity as a criterion of participation; ( )

j. Verification of citizenship by a federal agency or another state. If the Department finds that a federal agency or an agency in another state verified citizenship on or after July 1, 2006, no further documentation of citizenship or identity is required; ( )

k. Two (2) documents containing consistent information that corroborates the applicant's identity including: employer identification cards, high school or high school equivalency diplomas, college diplomas, marriage certificates, divorce decrees, property deeds or titles; or ( )

l. When the applicant does not have any documentation as specified in Subsections 104.03.a. through k. of this rule, the applicant may submit an affidavit signed by another individual under penalty of perjury, who can

reasonably attest to the applicant's identity. The affidavit must contain the applicant's name and other identifying information to establish identity stated in Subsection 104.03 of this rule. The affidavit does not have to be notarized. ( )

04. Identity Rules for Children. For children under age nineteen (19), clinic, doctor, or hospital records, including pre-school or daycare records, may be used as additional sources of documentation of identity. ( )

05. Eligibility for Medicaid Applicants Who Do Not Provide U.S. Citizenship and Identity Documentation. If verification of U.S. citizenship and identity is not obtained through electronic means, or if the applicant is unable to provide documentation at the time of application, the applicant has ninety (90) days to provide proof of U.S. citizenship and identity. The ninety (90) days begins five (5) days after the date the notice is mailed requesting the documentation of citizenship and identity. Medicaid benefits will be approved pending verification if the applicant meets all other eligibility requirements. Medicaid will be denied if the applicant refuses to obtain documentation. ( )

06. Individuals Considered as Meeting the U.S. Citizenship and Identity Documentation Requirements. The following individuals are considered to have met the U.S. citizenship and identity documentation requirements, regardless of whether documentation required in Subsections 104.01 through 104.05 of this rule is provided: ( )

a. Supplemental Security Income (SSI) recipients; ( )

b. Individuals determined by the SSA to be entitled to or enrolled in any part of Medicare; ( )

c. Social Security Disability Income (SSDI) recipients; ( )

d. Adoptive or foster care children receiving assistance under Title IV-B or Title IV-E of the Social Security Act; ( )

e. Individuals deemed eligible for Medicaid as a newborn under Section 800 of these rules; and ( )

f. Individuals whose name and social security number are validated by the Social Security Administration data match as meeting U.S. citizenship status. ( )

07. Assistance in Obtaining Documentation. The Department will provide assistance to individuals who need assistance in securing satisfactory documentary evidence of citizenship. ( )

08. Provide Verification of U.S. Citizenship and Identity One Time. When an individual's U.S. citizenship and identity have been verified, whether through electronic data matches or provision of documentation, changes in eligibility will not require an individual to provide the verification again. If later verification provides the Department with good cause to question the validity of the individual's citizenship or identity, the individual may be requested to provide further verification. ( )

105. CITIZENSHIP AND QUALIFIED NON-CITIZEN REQUIREMENTS.
To be eligible for AABD cash and Medicaid, an individual must be a member of one (1) of the groups listed in Subsections 105.01 through 105.16 of this rule. An individual must also provide proof of identity as provided in Section 104 of these rules. ( )

01. U.S. Citizen. A U.S. Citizen or a "national of the United States." ( )

02. Child Born Outside the U.S. A child born outside the U.S., as defined in Public Law 106-395, is considered a citizen if all of the following conditions are met: ( )

a. At least one (1) parent is a U.S. Citizen. The parent can be a citizen by birth or naturalization. This includes an adoptive parent; ( )

b. The child is residing permanently in the U.S. in the legal and physical custody of a parent who is a U.S. Citizen; ( )

c. The child is under eighteen (18) years of age; ( )

d. The child is a lawful permanent resident; and ( )

e. If the child is an adoptive child, the child was residing in the U.S. at the time the parent was naturalized and was in the legal and physical custody of the adoptive parent. ( )

03. Full-Time Active Duty U.S. Armed Forces Member. A qualified non-citizen as defined in 8 U.S.C. 1641(b) or (c) currently on full-time active duty with the U.S. Army, U.S. Air Force, U.S. Marine Corps, U.S. Navy or U.S. Coast Guard, or a spouse or unmarried dependent child of the U.S. Armed Forces member. ( )

04. Veteran of the U.S. Armed Forces. A qualified non-citizen as defined in 8 U.S.C. 1641(b) or (c) honorably discharged from the U.S. Army, U.S. Air Force, U.S. Marine Corps, U.S. Navy or U.S. Coast Guard for a reason other than their citizenship status or a spouse, including a surviving spouse who has not remarried, or an unmarried dependent child of the veteran. ( )

05. Non-Citizen Entering the U.S. Before August 22, 1996. A non-citizen who entered the U.S. before August 22, 1996, and is currently a qualified non-citizen as defined in 8 U.S.C. 1641(b) or (c) and remained continuously present in the U.S. until they became a qualified alien. ( )

06. Non-Citizen Entering on or After August 22, 1996. A non-citizen who entered on or after August 22, 1996, and; ( )

a. Is a refugee admitted into the U.S. under 8 U.S.C. 1157, and can be eligible for seven (7) years from their date of entry; ( )

b. Is an asylee granted asylum into the U.S. under 8 U.S.C. 1158, and can be eligible for seven (7) years from the date their asylee status is assigned; ( )

c. Is an individual whose deportation or removal from the U.S. has been withheld under 8 U.S.C. 1253 or 1231(b)(3) as amended by Section 305(a) of Division C of Public Law 104-208, and can be eligible for seven (7) years from the date their deportation or removal was withheld; ( )

d. Is an Amerasian immigrant admitted into the U.S. under 8 U.S.C. 1612(b)(2)(A)(i)(V), and can be eligible for seven (7) years from the date of entry; ( )

e. Is a Cuban or Haitian entrant to the U.S. under Section 501(e) of the Refugee Assistance Act, and can be eligible for seven (7) years from their date of entry; ( )

f. Is an Afghan special immigrant, as defined in Public Law 110-161, who has special immigration status after December 26, 2007; or ( )

g. Is an Iraqi special immigrant, as defined in Public Law 110-181, who has special immigration status after January 28, 2008. ( )

07. Qualified Non-Citizen Entering on or After August 22, 1996. A qualified non-citizen under 8 U.S.C. 1641(b) or (c), entering the U.S. on or after August 22, 1996, and who has held a qualified non-citizen status for at least five (5) years. ( )

08. American Indian Born in Canada. An American Indian born in Canada under 8 U.S.C. 1359. ( )

09. American Indian Born Outside the U.S. An American Indian born outside of the U.S., and is a

member of a U.S. federally recognized tribe under 25 U.S.C. 450 b(e). ( )

10. Qualified Non-Citizen Child Receiving Federal Foster Care. A qualified non-citizen child as defined in 8 U.S.C. 1641(b) or (c), and receiving federal foster care assistance. ( )

11. Victim of Severe Form of Trafficking. A victim of a severe form of trafficking in persons, as defined in 22 U.S.C. 7102(13); who meets one (1) of the following: ( )

a. Is under the age of eighteen (18) years; or ( )

b. Is certified by the U.S. Department of Health and Human Services as willing to assist in the investigation and prosecution of a severe form of trafficking in persons; and ( )

i. Has made a bona fide application for a temporary visa under 8 U.S.C. 1104(a)(15)(T), which has not been denied; or ( )

ii. Is remaining in the U.S. to assist the U.S. Attorney General in the prosecution of traffickers in persons. ( )

12. Qualified Non-Citizen Receiving Supplement Security Income (SSI). A qualified non-citizen under 8 U.S.C. 1641(b) or (c), and is receiving SSI; or ( )

13. Permanent Resident Receiving AABD Cash On August 22, 1996. A permanent resident receiving AABD cash on August 22, 1996. ( )

14. Individuals Not Meeting the Citizenship or Qualified Non-Citizen Requirements. An individual who does not meet the citizenship or qualified non-citizen requirements in Subsections 105.01 through 105.13 of this rule, may be eligible for emergency medical services if he meets all other conditions of eligibility. ( )

106. (RESERVED)

107. INSTITUTIONAL STATUS.
An institution provides treatment, services, food, and shelter to four (4) or more people, not related to the owner. A participant living in an ineligible institution an entire calendar month is not eligible for AABD cash, unless he qualifies for the institution payment exception. ( )

01. Eligible Institutions. Eligible institutions for AABD and Medicaid are defined in Subsections 107.01.a. through 107.01.c. ( )

a. Medical institution. A public or private medical institution, including a hospital, nursing care facility, or an intermediate care facility for persons with intellectual disabilities is an eligible institution. A participant is not eligible for AABD cash if he is a resident of a medical institution the full month. ( )

b. Child care institution. A non-profit private child care institution is an eligible institution. A public child care institution with no more than twenty-five (25) beds is an eligible institution. A child care institution must be licensed or approved by the Department. A detention facility for delinquent children is not a child care institution. A child care institution for mental diseases (IMD) is an eligible institution if it has sixteen (16) beds or less. A participant is not eligible for AABD cash if he is a resident of a child care institution the full month. ( )

c. Community residence. A community residence is a facility providing food, shelter, and services to residents. A privately operated community residence is an eligible institution. A publicly operated community residence serving no more than sixteen (16) residents is an eligible institution. The Community Restorium in Bonners Ferry, Idaho, is an eligible institution even though more than sixteen (16) residents are served. ( )

02. Ineligible Institutions. Ineligible institutions for AABD and Medicaid are defined in Subsections 107.02.a. through 107.02.d. ( )

a. Public institution. Public institutions are ineligible institutions unless listed in Subsection 108.01. ( )

b. Institution for mental diseases. An institution for mental diseases for adults is an ineligible institution. A facility is an institution for mental diseases if it is maintained primarily for the care and treatment of persons with mental diseases. ( )

c. Institution for tuberculosis. An institution for tuberculosis is an ineligible institution. A facility is an institution for tuberculosis if it is maintained primarily for the care and treatment of persons with tuberculosis. ( )

d. Correctional institution. A correctional institution is an ineligible institution. A correctional institution is a facility for prisoners, persons detained pending disposition of charges, or held under court order as material witnesses or juveniles. ( )

03. Medicaid Exception for Inmates. An inmate can receive Medicaid while they are an inpatient in a medical facility. The inmate must meet all Medicaid eligibility requirements. ( )

108. AABD ELIGIBILITY IN INELIGIBLE INSTITUTIONS.
A participant may get AABD cash in an ineligible institution or a medical institution if he meets one (1) of the conditions listed in Subsections 108.01 and 108.02. ( )

01. First Month in Institution. An AABD participant can get AABD cash for the month he entered the institution. Eligibility for the entry month applies to these residents: ( )

a. Resident of a public institution. The person is a resident if he or anyone pays for his food, shelter, and other services in the institution. ( )

b. Patient in a medical institution. A patient is a person receiving room, board, and professional services in a medical institution, including an institution for tuberculosis or mental diseases. ( )

02. Temporary Institution Stay. An AABD participant can get up to three (3) months' AABD payment during a temporary stay in an institution. A participant entering a public medical or psychiatric institution, a hospital, a nursing facility, or an ICF/IID may continue to get AABD payments. The Department must receive the temporary stay data no later than the ninetieth full day of confinement, or the release date, whichever is first. The payments may continue up to three (3) months if these conditions are met: ( )

a. The Department is informed of the institutional stay. ( )

b. A physician certifies the participant's stay is not likely to exceed three (3) full months. ( )

c. A signed statement from the participant or a responsible party showing the participant's need to continue to maintain and pay for the place he intends to return to live. ( )

109. CONDITIONS FOR TEMPORARY AABD IN INSTITUTIONS.
Special conditions for AABD when a participant is in an institution are listed in Subsections 109.01 through 109.05. ( )

01. Living Arrangement. AABD cash is paid based on the participant's living arrangement the month before the first month in the institution. Changes in living arrangement costs are used to determine AABD cash eligibility and benefit amount. ( )

02. Participant Becomes Ineligible. If the participant becomes ineligible for AABD during his temporary institutional stay, his AABD payment must be ended after proper notice. ( )

03. AABD Status. A participant must get AABD for the month he enters the institution to receive

continued AABD payments. ( )

04. Counting Three Full Months. A full month is a month the participant is in the institution every day of the month. If the participant enters after the first day of a month, the month of entry is not included in the three (3) full months. If the participant is discharged before the last day of the month, the month of discharge is not included in the three (3) full months. ( )

05. SSI Benefits. If SSA decides a participant's SSI benefit will continue while the participant is in the institution, AABD payments can also continue. ( )

110. -- 128. (RESERVED)

129. PARTICIPANT'S GUARDIAN FOR AABD CASH.
A court appointed guardian can manage AABD cash for a participant who is not competent to do so. The Department may petition the District Court to appoint a guardian if one is needed. ( )

130. ESTATE NOT IN PROBATE.
An administrator for public aid for a deceased participant's AABD cash can be court appointed. The administrator must spend AABD cash, accessible through EBT before the participant's death, for the estate. The AABD cash can only be spent to meet the needs of the participant, or his dependents, for the month it was paid. If a participant had no debts for himself, or his dependents, the administrator must return the AABD cash to the Department. AABD benefits paid by direct deposit or posted to the participant's EBT account, after the participant's death, are the property of the state of Idaho. ( )

131. ESTATE IN PROBATE.
AABD cash received by a participant before his death is disbursed as part of the participant's estate, if it is probated. The probate administrator spends the AABD cash under his oath of administration. ( )

132. -- 154. (RESERVED)

155. AABD FOR THE AGED.
To qualify for AABD for the aged, a person must be age sixty-five (65) or older. ( )

156. AABD FOR THE DISABLED.
To qualify for AABD for the blind or disabled, a person must meet the definition of blindness or disability used by the SSA for RSDI and SSI benefits. ( )

01. SSA Decision for Disabled. SSA's disability decision is binding on the Department unless: ( )

a. The participant states his disabling condition is different from, or in addition to, his condition considered by SSA, and the participant has not reapplied for SSI; or ( )

b. More than twelve (12) months have passed since the SSA made a final determination the participant was not disabled, and the participant states his condition has changed or become worse since that final determination, and the participant has not reapplied for SSI. ( )

02. Medicaid Pending SSA Appeal. When SSA decides a participant is no longer disabled, he meets the AABD disability requirement and can continue receiving Medicaid if he appeals SSA's decision. Medicaid ends if the SSA decision is upheld. ( )

03. Grandfathered Participant for Aid to the Permanently and Totally Disabled (APTD) or Aid to the Blind (AB). A participant is disabled if he was eligible as disabled in December 1973, and continues to meet the disability requirement in effect in December 1 1973. He must also meet the other current eligibility requirements. ( )

157. -- 165. (RESERVED)

166. FUGITIVE FELON OR PROBATION OR PAROLE VIOLATOR.
A participant is ineligible to receive AABD for any month during which he is fleeing to avoid prosecution for a felony, fleeing to avoid custody or confinement after a felony conviction, or violating a federal or state condition of probation or parole. ( )

167. FRAUDULENT MISREPRESENTATION OF RESIDENCY.
A participant is ineligible for AABD for ten (10) years if he was convicted in a federal or state court of having fraudulently misrepresented residence to get AABD, SSI, TAFI, Food Stamps or Medicaid from two (2) or more states at the same time. ( )

168. -- 199. (RESERVED)

200. RESOURCES DEFINED.
Resources are cash, personal property, real property, and notes receivable. A participant, or spouse, must have the right, authority, or power to convert the resource to cash. The participant must have the legal right to use the resource for support and maintenance. ( )

201. RESOURCE LIMIT.
The value of countable resources must be two thousand dollars ($2,000) or less, for a single person to be AABD eligible. A married person must have countable resources of three thousand dollars ($3,000) or less to be eligible for AABD cash. Resources are counted the first moment of each calendar month and apply to the entire month. ( )

202. CHANGE IN VALUE OF RESOURCES.
A change in the value of resources is counted the first moment of the next month. ( )

203. RESOURCES AND CHANGE IN MARITAL STATUS.
A change in marital status changes the resource limit. The resource limit change is effective the month after individual participants are married, divorced, separated, or one (1) spouse dies. ( )

204. FACTORS MAKING PROPERTY A RESOURCE.
Property of any kind is a resource if the participant has an ownership interest in the property and the legal right to spend or convert the property to cash. ( )

205. COUNTING RESOURCES AND INCOME.
An asset cannot be counted as income and resources in the same month. Assets received in cash or in-kind during a month are income. Income held past the month received is a resource. ( )

206. TYPES OF RESOURCES.
Liquid resources are resources in cash or resources convertible to cash within twenty (20) working days. Nonliquid resources are any resources, not in the form of cash, which cannot be converted to cash within twenty (20) workdays. ( )

207. EQUITY VALUE OF RESOURCES.
Equity value is the fair market value of a resource, minus any debts on it. ( )

208. SHARED OWNERSHIP RULE.
Except for checking and savings accounts and time deposits, each owner of shared property owns only his fractional interest in the property. The total value of the property is divided among the owners, in direct proportion to each owner's share. ( )

209. CONVERSION OR SALE OF A RESOURCE NOT INCOME.
Payment from the sale, exchange, or replacement of a resource is not income. The payment is a resource. ( )

210. RESOURCES EXCLUDED BY FEDERAL LAW.
A resource excluded by federal law is not counted in determining the resource amount available to the participant.

( )

211. -- 214. (RESERVED)

215. DEEMING RESOURCES.
Resources are deemed from a spouse to a participant, from a parent or spouse of a parent to a child participant, from an essential person to a participant, or from a sponsor to a legal non-citizen participant. Resource deeming is determined by the participant's circumstances the first moment of the month. Deeming starts the first full calendar month the participant is in a deeming situation. Deeming ends the first full calendar month the participant is not in a deeming situation. Deeming to a child ends the month after the child's eighteenth birthday. ( )

01. Spouse of Adult Participant. When a participant lives with a spouse, his resources include those of the spouse. The resource limit is for a couple, when the spouse was a member of the household as of the first moment of the benefit month. The AABD resource exclusions are subtracted. Pension funds the ineligible spouse has on deposit are excluded. ( )

02. Resources of Parent(s) of Child Under Age Eighteen. When a child participant, under age eighteen (18), is living with his parent or the spouse of his parent, their resources are deemed to the child. When there is more than one (1) child participant in the household, deemed parental resources are divided equally among the child AABD cash participants. When the child lives with one (1) parent, resources over the single person resource limit are deemed to the child. When the child lives with both parents, resources over the couple limit are deemed to the child. A stepparent's resources are not deemed to the child for Medicaid eligibility. A stepparent's resources are deemed to the child for AABD cash. Resources and exclusions of the child participant, and the parents, are computed separately. Pension funds owned by an ineligible parent or parent's spouse are excluded from resources for deeming. ( )

03. Resources of Essential Person of Participant. When a participant lives with an essential person, the resources of the essential person are deemed to the participant. The essential person's countable resources are combined with the participant's countable resources. When the essential person is not the participant's spouse, the single person resource limit is used. When the essential person is the participant's ineligible spouse, the couple resource limit is used. ( )

04. Resources of Legal Non-Citizen's Sponsor -- No INS Form I-864 Signed. A legal non-citizen's resources include those of his sponsor and of the sponsor's spouse. When the sponsor has not signed an I-864 affidavit of support, the resources deeming period is three (3) years after the legal non-citizen's admission to the U.S. A sponsor's resources are not deemed to the legal non-citizen for Medicaid eligibility. ( )

a. If the sponsor does not have a spouse living with him, the sponsor's countable resources over the single person resource limit are deemed to the legal non-citizen participant. ( )

b. If the sponsor's spouse lives with him, the sponsor couple's resources over the couple resource limit are deemed to the legal non-citizen participant. ( )

c. If a person sponsors two (2) or more legal non-citizen participants, the sponsor's deemed resources are divided and deemed equally to the legal non-citizen participants. ( )

05. Resources of Legal Non-Citizen's Sponsor -- INS Form I-864 Signed. For a legal non-citizen admitted to the U.S. on or after August 22, 1996, whose sponsor has signed an INS Form I-864 affidavit of support, all resources of the sponsor and sponsor's spouse are deemed to the legal non-citizen for AABD cash and Medicaid eligibility. Exceptions are listed in Subsections 215.05.a. and 215.05.b. of these rules. ( )

a. The legal non-citizen, or the legal non-citizen child's parent, was battered or subjected to extreme cruelty in the U.S. There is a substantial connection between the battery and the participant's need for assistance. The person subjected to the battery or cruelty no longer lives with the person responsible for the battery or cruelty. ( )

b. Alien sponsor deeming is suspended for twelve (12) months, if the legal non-citizen is not able to

get food and shelter without AABD cash. ( )

216. HOUSEHOLD FOR RESOURCE COMPUTATIONS.
A participant living in an institution is not a household for resource computations. ( )

217. UNKNOWN RESOURCES.
An asset is not a resource if the participant is unaware of his ownership. The asset is a resource the month after discovery. ( )

218. -- 221. (RESERVED)

222. VEHICLES.
Vehicles are excluded as resources as described in Subsection 222.01 of these rules. If more than one (1) vehicle is owned, the exclusion applies in the best way for the participant. ( )

01. One Vehicle Excluded. One (1) vehicle is excluded, regardless of value. ( )

02. Other Vehicles Not Excluded. The equity value of a vehicle not excluded under Subsection 222.01 of these rules is a resource. ( )

223. BURIAL FUNDS EXCLUDED FROM RESOURCE LIMIT.
Burial funds up to one thousand five hundred dollars ($1,500) per person, set aside for the burial expenses of the participant or spouse, are excluded from resources. To be excluded, burial funds must be kept separate from assets not burial related. A burial contract that can be revoked or sold, without significant hardship, is a resource. Any portion of the contract for the purchase of burial spaces is excluded from resources. A burial contract that cannot be revoked, and cannot be sold without significant hardship, is not a resource. The burial fund portion of the contract counts against the one thousand five hundred dollar ($1,500) burial funds exclusion. The burial space portion of the contract does not count against the burial funds exclusion. Interest earned on excluded burial funds is also excluded. ( )

01. Life Insurance Policy as Burial Funds. The participant can designate a countable life insurance policy as a burial fund. The face value of excluded life insurance policies on the participant counts against the burial funds exclusion. ( )

02. Face Value of Burial Insurance Policies Not Counted. The face value of burial insurance policies does not count toward the one thousand five hundred dollar ($1,500) life insurance limit, when computing the total face value of life insurance policies owned by a participant. Interest on excluded burial funds does not count toward the one thousand five hundred dollar ($1,500) burial funds exclusion. ( )

03. Effective Date of Burial Funds Exclusion. The exclusion is effective the month after the month the funds were set aside. Burial funds can be designated retroactively, back to the first day of the month the participant intended the funds to be set aside. The participant must confirm the designation in writing. ( )

04. Penalty for Misusing Burial Funds. If the participant does not get SSI, burial funds used for another purpose lose the exclusion. An overpayment must be recovered. If the participant gets SSI, and is penalized by SSA because he used excluded burial funds for another purpose, his AABD payment must not be increased to compensate the SSA penalty. ( )

224. BURIAL SPACE OR PLOT EXCLUSION.
A burial space is a burial plot, grave site, crypt, mausoleum, casket, urn, niche, or other repository normally used for the deceased's remains. A burial space, or burial space purchase agreement, held for the burial of the participant, spouse, or other member of his immediate family is an excluded resource. ( )

01. Burial Space Contract. The burial space contract must list all burial spaces and include a value for each space or the total value of all the spaces. The contract must not require further payment after the contract is signed. ( )

02. Space Held by Ineligibles Excluded. A space held by an ineligible spouse or parent, for the burial of a participant, spouse, and any member of the participant's immediate family, is excluded. A space held by a legal non-citizen sponsor, or essential person, for his own burial is excluded only if the sponsor is a member of the participant's immediate family. ( )

225. -- 234. (RESERVED)

235. EXCLUDED HOUSEHOLD GOODS AND PERSONAL EFFECTS.
Household goods and personal effects are excluded from resources, regardless of their dollar value. ( )

236. (RESERVED)

237. REAL PROPERTY DEFINITION.
Real property is land, including buildings or immovable objects attached permanently to the land. Real property is a resource unless excluded. ( )

238. HOME AS RESOURCE.
An individual's home is property he owns, and serves as his principal place of residence. His principal place of residence is the place he considers his principal home. If the individual is absent from his home, it is still his principal place of residence if he intends to return. ( )

01. AABD Cash, and Medicaid With the Exception of Long-Term Care. For AABD Cash and Medicaid with the exception of long-term care, the value of an individual's home is an excluded resource. ( )

02. Long-Term Care Services. For long-term care services, when the value of a participant's equity in the home is seven hundred fifty thousand dollars ($750,000) or less, the home is excluded as a resource. When the equity value exceeds seven hundred fifty thousand dollars ($750,000), the individual is ineligible for long-term care services. The equity value, regardless of the amount, is an excluded resource when one (1) of the following applies: ( )

a. The spouse of the individual lives in the home; or ( )

b. The individual's child, who is under age twenty-one (21), or is blind, or meets the disability requirements for AABD cash, lives in the home. ( )

239. SALE OF EXCLUDED HOME AND REPLACEMENT.
If the participant plans to buy another excluded home, proceeds from the sale of a participant's excluded home are excluded resources. Proceeds from the sale of an excluded home must be used to replace the home within three (3) calendar months. Proceeds retained beyond three (3) calendar months are a countable resource. ( )

240. REPLACEMENT OF EXCLUDED RESOURCES.
Cash and in-kind payments for replacement or repair of lost, damaged, or stolen excluded resources, are excluded resources for nine (9) months from the date received. This exclusion can be extended for cash payments, up to an additional nine (9) months. The extension can be made if, for the first nine (9) months, circumstances beyond the participant's control prevent repair or replacement of the lost, damaged or stolen property and keep the participant from contracting for repair or replacement. This exclusion can be extended for twelve (12) more months for a catastrophe the President declares a major disaster. Interest earned by funds excluded under this provision is excluded from resources. ( )

241. UNDUE HARDSHIP EXCLUSION FROM SALE OF JOINTLY-OWNED REAL PROPERTY.
A participant's ownership interest, in jointly-owned real property, is an excluded resource, as long as sale of the property will cause undue hardship to a co-owner. Undue hardship results if a co-owner uses the property as his principal place of residence, would have to move if the property were sold, and has no other readily available housing. ( )

242. INDIAN PROPERTY EXCLUDED.
For the purposes of determining eligibility for an individual who is an Indian, the following property is excluded:

( )

01. Property. Real property and improvements located on a reservation, including any federally recognized Indian Tribe's reservation, pueblo, or colony, and Indian allotments on or near a reservation as designated and approved by the Bureau of Indian Affairs. ( )

02. Natural Resources. Ownership interest in rents, leases, royalties, or usage rights related to natural resources resulting from the exercise of federally protected rights. ( )

03. Other Ownership Interests or Usage Rights. Ownership interests in or usage rights to property not covered by Subsections 242.01 or 242.02 of this rule that have a unique religious, spiritual, traditional, or cultural significance or rights that support subsistence or traditional lifestyle according to applicable tribal law or custom. ( )

243. RESOURCES ASSOCIATED WITH PROPERTY.
Resources associated with real property are mineral rights, timber rights, easements, leaseholds, water rights, remainder interests, and sale of natural resources. These resources are counted as real property. ( )

244. RESOURCES ESSENTIAL FOR SELF-SUPPORT EXCLUDED.
Resources are excluded as essential to self-support, if they fall into one (1) of the categories described in Subsections 244.01 through 244.03. ( )

01. Essential Property in Current Use. Property in current use in the type of activity that qualifies it as essential to self-support is excluded, regardless of value or rate of return. Trade or business property, government permits, and personal property used by an employee for work are excluded regardless of value or rate of return. If the property is not in current use, for reasons beyond the participant's control, there must be a reasonable expectation the required use will resume. If the participant does not intend to resume the self-support activity, the property is a countable resource for the month after the month of last use. ( )

02. Nonbusiness Property Producing Goods or Services. Up to six thousand dollars ($6,000) of the equity value of nonbusiness property, used to produce goods or services essential to daily activities, is excluded regardless of rate of return. Equity value over six thousand dollars ($6,000) is not excluded. This exclusion is not used for income producing property. ( )

03. Nonbusiness Income Producing Property. Up to six thousand dollars ($6,000) equity in nonbusiness income producing property is excluded if it produces at least a six percent (6%) rate of return. The property must produce a net annual return equal to at least six percent (6%) of the excluded equity. If a participant owns more than one (1) piece of income producing property, the six percent (6%) return requirement applies to each. The six thousand dollars ($6,000) equity value limit applies to the total equity value of all the properties meeting the six percent (6%) return requirement. If the earnings decline is for reasons beyond the participant's control, up to twenty-four (24) months can be allowed for the property to resume producing a six percent (6%) return. If the property still is not producing a six percent (6%) return at the end of the twenty-four (24) month extension, the resource exclusion must end the month after the month the twenty-four (24) month period ends. ( )

245. RESOURCES SET ASIDE AS PART OF A PLAN FOR ACHIEVING SELF-SUPPORT (PASS) EXCLUDED.
PASS allows blind and disabled participants to set aside income and resources necessary for the achievement of its goals. Resources set aside as part of an approved PASS are excluded. The PASS disregard must not be applied to resources unless the participant would be ineligible due to excess resources. To disregard resources, the PASS must show how resources the participant has or will receive under the plan, will be used to obtain the PASS goal. The PASS must show how the disregarded resources will be identified separately from the participant's other resources. The PASS must list items or activities requiring savings or purchases and the amounts the participant anticipates saving or spending. The PASS must show a specific target date to achieve the objective. ( )

246. LIMITED AWARD TO CHILD WITH LIFE-THREATENING CONDITION.
Any gift from a tax exempt nonprofit organization to a child under age eighteen (18), who has a life threatening condition, is excluded from resources under the conditions in Subsections 246.01 through 246.02. ( )

01. In-Kind. An in-kind gift is excluded if the gift is not converted to cash. ( )

02. Cash. Cash gifts are excluded up to two thousand dollars ($2,000) for the calendar year the cash gifts are made. ( )

247. LIFE ESTATE INTEREST IN ANOTHER'S HOME.
The purchase of a life estate interest in another individual's home is a resource unless the purchaser resides in the home for a period of at least twelve (12) consecutive months after the date of purchase. ( )

248. -- 254. (RESERVED)

255. RETROACTIVE SSI AND RSDI BENEFITS.
Retroactive SSI and RSDI benefits are issued after the calendar month for which they are paid. Retroactive SSI and RSDI benefits are excluded from resources for nine (9) calendar months after the month they are received. Interest earned by excluded funds is counted as income. ( )

256. (RESERVED)

257. DISASTER ASSISTANCE.
Assistance received because of a major disaster, declared by the President, is excluded from resources. Interest earned on excluded funds is excluded from income and resources. ( )

258. CASH TO PURCHASE MEDICAL OR SOCIAL SERVICES.
Cash paid by a recognized medical or social services program, for the participant to purchase medical or social services, is not a resource for one (1) calendar month after receipt. The cash must not be repayment for a bill already paid. ( )

259. (RESERVED)

260. ALASKA NATIVE CLAIMS SETTLEMENT ACT.
Payments to Alaska Natives and their descendants from the Alaska Native Claims Settlement Act, under public Law 100-241, are excluded from resources. ( )

261. STOCK IN ALASKA REGIONAL OR VILLAGE CORPORATIONS.
Stock held by Alaska natives in regional or village corporations is inalienable for a twenty (20) year period under Sections 7(h) and 8(c) of the Alaska Native Claims Settlement Act. ( )

262. VICTIMS' COMPENSATION PAYMENTS.
Payments, from a fund set up by a State to aid victims of crime, are excluded from resources for nine (9) months. Interest earned on unspent victims' compensation payments is counted for income and resources. ( )

263. -- 264. (RESERVED)

265. TAX ADVANCES AND REFUNDS RELATED TO EARNED INCOME TAX CREDITS.
A Federal tax refund or payment made by an employer, related to Earned Income Tax Credits (EITC), is excluded from resources, for the month after the month the refund or payment is received. Interest earned on unspent tax refunds related to EITC is counted for income and resources. ( )

266. IDENTIFYING EXCLUDED FUNDS COMMINGLED WITH FUNDS NOT EXCLUDED.
Excluded funds must be separately identifiable to remain excluded. ( )

267. DEDICATED ACCOUNT FOR SSI PARTICIPANT.
A dedicated account for past-due SSI benefits, set up in a financial institution for an SSI participant under age eighteen (18) is an excluded resource. The account must be set up by the child's SSI representative payee, and excluded by SSA. ( )

268. SUPPORT AND MAINTENANCE ASSISTANCE (HOME ENERGY ASSISTANCE).
Support and Maintenance Assistance (SMA) is in-kind support and maintenance, or cash paid for food or shelter needs. It includes Home Energy Assistance. SMA Home Energy Assistance is aid to meet the costs of heating or cooling a home. SMA and Home Energy Assistance are excluded resources. ( )

269. -- 270. (RESERVED)

271. VA MONETARY ALLOWANCES TO A CHILD BORN WITH SPINA BIFIDA.
VA monetary allowances to a child born with spina bifida, who is the child of a Vietnam veteran, are excluded resources. ( )

272. WALKER V. BAYER PAYMENTS.
Class action settlement payments in Susan Walker v. Bayer Corporation, et al are excluded from resources for Medicaid by Public Law 105-33. These payments are not excluded for AABD cash. ( )

273. -- 275. (RESERVED)

276. EXCLUDED REAL ESTATE CONTRACT.
The principal balance of a real estate contract is excluded from resources of a participant in long-term care when the Department determines it is in the Department's best interest to exclude the contract. The determination by the Department of its best interest is final. ( )

277. FEES PAID TO A CONTINUING CARE RETIREMENT COMMUNITY (CCRC) OR LIFE CARE COMMUNITY.
An entrance fee to a CCRC or a life care community is a resource if the participant or applicant for long-term care has discretion to spend the fee or if the fee may be used to pay for care in a contingency. A CCRC or life care community is a type of long-term care facility that offers varying levels of care and in which a resident contracts with the facility to obtain care that is intended to endure for the remainder of the resident's life in exchange for valuable consideration. ( )

278. TRUSTS.
A trust is a resource to a participant with the legal right to revoke the trust, and use the principal for his own support and maintenance. See Sections 838 through 873 in these rules for treatment of trusts for Medicaid. ( )

279. RETIREMENT FUNDS.
Retirement funds are work-related plans for providing income or pensions when employment ends. A retirement fund, owned by a participant, is a resource if he has the option of withdrawing a lump sum, even though he is not yet eligible for periodic retirement payments. If the participant is eligible for periodic retirement payments, the fund is not a countable resource. The value of a retirement fund is the amount of money a participant can currently withdraw from the fund. ( )

280. INHERITANCE.
An inheritance is cash, a right, including probate allowances, trust payments and annuities, or noncash items received as the result of someone's death. Cash or noncash items in an inheritance are income the month received and a resource the next month. Participants are required to make claims and take all reasonable action necessary to obtain any inheritance to which they may be entitled. Failure to make such claims or take reasonable steps to obtain an inheritance is an asset transfer. A contested inheritance is not counted as a resource until the contest is settled and money is distributed. ( )

281. LIFE INSURANCE.
A life insurance policy is an excluded resource if its face value, plus the face value of all other life insurance policies the participant owns on the same insured person, totals one thousand five hundred dollars ($1,500) or less. If the face values exceed one thousand five hundred dollars ($1,500) the policies are a resource in the amount of the cash surrender value. ( )

282. CONSERVATORSHIP.
Funds required to be made available for the care and maintenance of a participant, under a court order, are the

participant's resource. This is true even if the participant or his agent is required to petition the court to withdraw funds for the participant's care. ( )

283. CONDITIONAL BENEFITS.
A participant ineligible due solely to excess nonliquid resources, can receive AABD cash and related Medicaid. The participant must meet two (2) conditions. First, his countable liquid resources must not exceed three (3) times the participant's AABD cash budgeted needs. Second, the participant agrees, in writing, to sell excess nonliquid resources at their fair market value, within three (3) months. The value of excess real property is not counted as a resource, as long as the participant makes reasonable efforts to sell the property at its fair market value, and his reasonable efforts to sell are not successful. This exclusion is also used to compute deemed resources. ( )

01. Conditional Benefits Payments Disposal/Exclusion Period. The disposal period and exclusion period for excess nonliquid resources begins on the date the participant signs the Agreement to Sell Property. The disposal and exclusion periods can begin earlier for a participant who met all requirements to receive conditional benefits before his first opportunity to sign the Agreement to Sell Property. The participant must sign the Agreement to Sell Property before his application is approved. ( )

02. Time Period for Disposal of Excess Resources. The disposal period for excess nonliquid personal property is three (3) months. One (1) three (3) month extension, for sale of personal property, is allowed when good cause exists. ( )

03. Good Cause for Not Making Efforts to Sell Excess Property. The participant has good cause exists for not making efforts to sell property, when circumstances beyond his control prevent his taking the required actions. Without good cause, the participant's countable resources include the value of the excess property, retroactive to the beginning of the conditional benefits period. ( )

284. RESOURCE TRANSFER FOR LESS THAN FAIR MARKET VALUE.
Starting November 1, 2000, AABD cash participants are subject to a period of ineligibility if they transfer resources for less than fair market value. The participant is not subject to a period of ineligibility if his total countable resources in the transfer month were under two thousand dollars ($2,000), even if he had kept the transferred resources. Excluded resources, except for the excluded home and associated property, are not subject to the resource transfer period of ineligibility. The exceptions to the period of ineligibility for transfer of resources are listed in Section 292. ( )

01. Transfer of Resources. Transfer of resources includes reducing or eliminating the participant's ownership or control of the resource. Transfer of resources includes giving away cash resources without receiving fair market value. ( )

02. Transfer of Resources by a Spouse. A transfer by the participant's spouse of either spouse's resources subjects the participant to the resource transfer period of ineligibility. ( )

03. Transfer of Resources by a Co-Owner. Transfer of the participant's resources by a co-owner subjects the participant to a period of ineligibility based on his share of the co-owed resources. ( )

04. Transfer of Resources by a Legal Representative. Transfer of the participant's resources by a legal representative such as a legal guardian or parent of a minor child subjects the participant to a period of ineligibility. ( )

285. AABD PERIOD OF INELIGIBILITY FOR RESOURCE TRANSFERS.
The resource transfer period of ineligibility is a period of AABD ineligibility for up to sixty (60) months. The period of ineligibility begins the first day of the month after the transfer month. The participant must be notified, in writing, at least ten (10) days before a resource transfer period of ineligibility is imposed. ( )

286. RESOURCE TRANSFER LOOK-BACK PERIOD.
The resource transfer penalty applies to any transfer for less than fair market value made during a period preceding a request for cash assistance. The look-back period is determined as follows: ( )

01. Transfers Prior to February 8, 2006. For any resource transferred prior to February 8, 2006, the look-back period is thirty-six (36) months. The look-back period is counted from the month prior to the month the application was submitted. ( )

02. Transfers On or After February 8, 2006. Any resource transferred on or after February 8, 2006, regardless of type, is subject to a look-back period of sixty (60) months. The look-back period is counted from the date of the application for cash, or the date of the transfer, whichever is later in time. ( )

287. CALCULATING THE PERIOD OF INELIGIBILITY FOR RESOURCE TRANSFERS.
The period of ineligibility is the number of months computed by dividing the difference between the fair market value of the resource and the amount the participant received for the resource by the full AABD allowances for the participant's living arrangement. For an applicant, use the full AABD allowance for the application month. For a participant, use the full AABD allowances for the transfer month. For an AABD couple, the period of ineligibility is computed by dividing the difference between the fair market value of the resource and the amount the participant received for the resource by the full AABD allowances for the couple's living arrangement. The number of months of ineligibility is computed to two (2) decimal places and rounded down to the nearest whole number. If the amount transferred is less than the participant's AABD allowances for one (1) month, the participant is not subject to a period of ineligibility. ( )

288. LENGTH OF PERIOD OF INELIGIBILITY.
The period of ineligibility begins with the month after the month the transfer took place. The period of ineligibility continues whether or not the participant receives AABD. Ineligibility continues until all the resources are returned to the participant or spouse, adequate consideration for all the resources is received, sixty (60) months passes, or the penalty period ends. ( )

289. SPOUSE APPLIES AFTER PERIOD OF INELIGIBILITY IS COMPUTED.
If the spouse applies after the period of ineligibility is computed, compute the spouse's period of ineligibility by multiplying the number of months in the period of ineligibility already expired by the full AABD allowances for the couple's living arrangement. Subtract the total from the original difference between the fair market value of the resource and the amount the participant received for the resource. Divide the remaining difference between the fair market value of the resource and the amount the participant received for the resource by the full AABD allowances for the couple's living arrangement for the first month of ineligibility. ( )

290. MULTIPLE RESOURCE TRANSFERS.
If the participant makes more than one (1) resource transfer, the difference between the fair market value of all the transferred resource's and the amount the participant received for all the transferred resources is used to determine the length of the period of ineligibility. The period of ineligibility begins with the month after the month of the first transfer. ( )

291. TRANSFERS TO TRUSTS.
A trust established from the participant's resources is a resource transfer for less than fair market value, unless it meets an exception in Section 292 of these rules. If the trust includes resources of another person, the resource transfer period of ineligibility applies to the participant's share of the trust. ( )

01. Payment from Trust Not for Participant. If a payment is made to another individual from a trust counted as a resource, and the payment is not for the benefit of the participant, the payment is a resource transfer for less than fair market value. ( )

02. Payment from Trust Restricted. If the participant takes action so no payment from a trust counted as a resource can be made for any reason, the trust is a resource transfer for less than fair market value. By taking the action, the participant causes the trust to be no longer counted as a resource and the participant is subject to the period of ineligibility. The date of the action restricting payment is the date of the transfer. ( )

292. PERIOD OF INELIGIBILITY EXCEPTIONS.
A participant or spouse is not subject to the resource transfer period of ineligibility if one (1) of the following conditions is satisfied. ( )

01. Home to Spouse. Title to the home is transferred solely to the spouse. ( )

02. Home to Minor Child or Disabled Adult Child. Title to the home is transferred to the child of the participant or spouse. The child must be under age twenty-one (21), blind or totally disabled under Social Security and SSI rules in 20 CFR Part 416. ( )

03. Home to Brother or Sister. Title to the home is transferred to a brother or sister of the participant or spouse who must have had an equity interest or life estate in the transferred home and was residing in that home for at least one (1) year immediately before the month the home was transferred. ( )

04. Home to Adult Child. Title to the home was transferred to a son or daughter of the participant or spouse, other than a child under the age of twenty-one (21). The son or daughter must have resided in that home for at least two (2) years immediately before the month the participant entered a medical facility or long-term care. The son or daughter must have provided care to the participant, which permitted him to live at home rather than enter a medical facility or long-term care. ( )

05. Benefit of Spouse. Resources, other than the home, were transferred to the participant's spouse or to another person for the sole benefit of the spouse. ( )

06. Transfer from Spouse. The resources were transferred from the participant's spouse to another person for the sole benefit of the participant's spouse. ( )

07. Transfer to Child. The resources were transferred to the participant's child or to a trust established solely for the benefit of the participant's child. The child must be blind or totally disabled under Social Security and SSI rules in 20 CFR Part 416. The child may be any age. ( )

08. Transfer to Trust for Person Under Sixty-Five. The resources were transferred to a trust for the sole benefit of a person under age sixty-five (65), blind or totally disabled under Social Security and SSI rules in 20 CFR Part 416. The person must be blind or totally disabled under Social Security and SSI rules in 20 CFR Part 416. ( )

09. Transfer to a Trust That Is a Countable Resource. The resources were transferred to a trust and the trust is a countable resource for AABD in the amount of the transfer. ( )

10. Intent to Receive Fair Market Value. The participant or spouse proves he intended to dispose of the resources at fair market value or for other adequate consideration, but can prove good cause for not doing so. ( )

11. Resources Returned. All resources transferred for less than fair market value have been returned to the participant. ( )

12. No AABD Purpose. The participant or spouse proves the resources were transferred exclusively for a purpose other than qualifying for AABD. Purposes other than qualifying for AABD include: ( )

a. After the resource transfer the participant has a traumatic onset of disability. ( )

b. After the resource transfer a previously unknown disabling condition is diagnosed. ( )

c. After the resource transfer the participant has an unexpected loss of income or resources resulting in eligibility for AABD. ( )

d. The resource was excludable in the transfer month. ( )

e. The transfer of resources was court-ordered, provided the participant did not petition the court to order the transfer. ( )

f. The participant took a vow of poverty and gave the resources to a religious order. ( )

13. Undue Hardship. The participant proves failure to receive AABD would deprive him of food or shelter and his total available funds, including income and liquid resources, are less than his AABD allowances for the month he claims undue hardship. Undue hardship must be proven for each month of the period of ineligibility. When determining total available funds for a child, count any income and resources deemed from his parents. ( )

14. Exception to Fair Market Value. The amount received is reasonable, even if less than fair market value if a forced sale was done under reasonable circumstances, and little or no market demand exists for the type of resource transferred, or the resource was transferred to settle a legal debt approximately equal to the fair market value of the transferred resource. ( )

15. No Benefit to Participant. The participant received no benefit from the resource because he or the spouse held title to the property only as a trustee for another person, or the transfer was done to clear title to property and the participant or spouse had no interest in the property that would benefit him. ( )

16. Fraud Victim. The resource was transferred because the participant or spouse was the victim of fraud, misrepresentation, or coercion. The participant or spouse must take all possible steps to recover the resources or property or its equivalent in damages. The participant must assign recovery rights to the state of Idaho. ( )

293. EFFECT ON MEDICAID ELIGIBILITY.
Ineligibility for AABD cash because of property transfer does not make the participant ineligible for Medicaid. ( )

294. -- 299. (RESERVED)

300. INCOME DEFINITION.
Income is anything that can be used to meet needs for food, or shelter. Income is cash, wages, pensions, in-kind payments, inheritances, gifts, awards, rent, dividends, interest, or royalties the participant receives during a month. ( )

01. Cash Income. Cash income is currency, checks, money orders, or electronic funds transfers. Cash income includes Social Security checks, unemployment checks, and payroll checks. ( )

02. In-Kind Income. In-kind income is not cash. In-kind income is food or shelter. Wages paid as in-kind earnings, such as food or shelter, are counted as unearned income. Other in-kind income is not counted. ( )

03. Inheritances. An inheritance is cash, a right, or noncash items received as the result of someone's death. Cash or noncash items in an inheritance are income the month received and a resource the next month. A contested inheritance is not counted as income until the contest is settled and money is distributed. ( )

301. APPLICATION FOR POTENTIAL BENEFITS.
The participant must apply for benefits, including RSDI, VA, pensions, Workman's Compensation, or Unemployment Insurance, when there is potential eligibility. The participant must apply when he reaches the earliest age to qualify for the benefit. ( )

01. SSI. To get AABD cash, the participant must apply for SSI benefits, if he is potentially eligible. To get AABD-Medicaid, the participant does not have to apply for SSI benefits. ( )

02. VAIP. Participants entitled to a VA pension as of December 31, 1978 are not required to file for Veterans Administration Improved Pension Plan (VAIP), to get AABD cash or AABD-related Medicaid. ( )

03. Other Benefits. EITC, TAFI, BIA General Assistance and victim's compensation benefits are exempt from the filing requirement. ( )

302. RELATIONSHIP OF INCOME TO RESOURCES.

Income is counted as income in the current month. If the participant keeps countable income after the month received, it is counted as a resource. ( )

303. WHEN INCOME IS COUNTED.
Income is counted the earliest of when received, when credited to a participant's account, or when set aside for the participant's use. Income from SSA, SSI or VA is counted for the month it is intended to cover. ( )

304. PROSPECTIVE ELIGIBILITY.
Eligibility for AABD cash and Medicaid is prospective. Expected income for the month is compared to the participant's income limit that month. ( )

305. PROJECTING MONTHLY INCOME.
Income is projected for each month to determine AABD cash amount. Past income may be used to project future income. Expected changes must be considered. Income received less often than monthly is not prorated or converted. Patient liability income is not prorated or converted. ( )

306. CRITERIA FOR PROJECTING MONTHLY INCOME.
Monthly income is projected as described in this Subsections 306.01 through 306.08. ( )

01. Converting Income to a Monthly Amount. If a full month's income is expected, but is received on other than a monthly basis, convert the income to a monthly amount using one (1) of the formulas in Subsections 306.01.a. through 306.01.d.

TABLE 306.01 MONTHLY CONVERSION OF INCOME

	Conversion	Procedure
a.	Weekly to Monthly	Multiply weekly amounts by 4.3.
b.	Biweekly to Monthly	Multiplying bi-weekly amounts by 2.15.
c.	Semimonthly to Monthly	Multiplying semi-monthly amounts by 2.
d.	Exact Amount	Use the exact monthly income if it is expected for each month.

( )

02. Income Already Received. Count income already received during the month. Convert the actual income to a monthly amount if a full month's income has been received or is expected to be received as described in Subsections 306.02.a. and 306.02.b. ( )

a. Actual income. If the actual amount of income from any pay period a month is known, use the actual pay period amounts to determine the total month's income. Convert the actual income to a monthly amount if a full month's income has been received or is expected. ( )

b. Projecting income. If no pay changes are expected, use the known actual pay period amounts for the past thirty (30) days to project future income. Convert the actual income to a monthly amount if a full month's income has been received or is expected. ( )

03. Expected Income. Count income the participant and the Department believe the participant will get. Convert expected income to a monthly amount as described in Subsections 306.03.a. through 306.03.d. ( )

a. Exact income unknown. If the exact income amount is uncertain or unknown, the uncertain or unknown portion must not be counted. The certain or known amount is counted. ( )

b. Income not changed. If the income has not changed and no changes are expected, past income can be used to project future income. ( )

c. Income changes. If income changes, and income received in the past thirty (30) days does not reflect expected income, income received over a longer period is used to project future income. ( )

d. Seasonal income changes. If income changes seasonally, income from the last comparable season is used to project future income. ( )

04. Ongoing Income. Ongoing income comes from an ongoing source. It was received in the past and is expected to be received in the future. Convert ongoing income to a monthly amount as described in Subsections 306.04.a. through 306.04.d. ( )

a. Full month's income not expected from ongoing source. If a full month's income is not expected from an ongoing source, count the amount of income expected for the month. If actual income is known, use actual income. If actual income is unknown, project expected income. Convert income to a monthly amount. Use zero (0) income for any pay period in which income was not received that month. ( )

b. Income from new source. If a full month's income from a new source is not expected, count the actual income expected for the month. Do not convert the income to a monthly amount. ( )

c. Income stops. If income stops and no additional income is expected from the terminated source, count the actual income received during the month. Do not convert the terminated source of income. ( )

d. Full month's income not expected from new or stopped source. If a full month's income is not expected from a new or terminated source, count the income expected for the month. If the actual income is known, use the known income. If the actual income is unknown, project the income. Do not convert the income to a monthly amount if a full month's income from a new or terminated source is not expected. ( )

05. Income Paid on Salary. Income paid on salary, rather than an hourly wage, is counted at the expected monthly salary rate. ( )

06. Income Paid at Hourly Rate. Compute expected income paid on an hourly basis by multiplying the hourly pay by the expected number of hours the participant will work in the pay period. Convert the pay period amount to a monthly basis. ( )

07. Monthly Income Varies. When monthly income varies each pay period and the rate of pay remains the same, average the income from the past thirty (30) days to determine the average pay period amount. Convert the average pay period amount to a monthly amount. When income changes and income from the past thirty (30) days is not a valid indicator of future income, a longer period of income history is used to project income. ( )

08. Income Received Less Often Than Monthly. Recurring income, such as quarterly payments or annual income, is counted in the month received, even if the payment is for multiple months. The income is not prorated or converted. If the amount is known, use the actual. If the amount is unknown, use the best information available to project income. ( )

307. COUNTING RESOURCES AND INCOME.
An asset cannot be counted as income and resources in the same month. Assets received in cash or in-kind during a month are income. Income held past the month received is a resource. ( )

308. -- 309. (RESERVED)

310. ADOPTION ASSISTANCE UNDER TITLE IV-B OR TITLE XX.
Adoption assistance payments, provided under Title IV-B or Title XX of the Social Security Act, are excluded. Adoption assistance payments using funds provided under Title IV-E are income. The twenty dollar ($20) standard disregard is not subtracted. ( )

311. -- 312. (RESERVED)

313. ASSISTANCE BASED ON NEED (ABON).
ABON is aid paid under a program using income as a factor of eligibility. ABON is funded wholly by a State, or a political subdivision of a State, or an Indian tribe, or a combination of these sources. Federal funds are not used. ABON is excluded. ( )

314. (RESERVED)

315. BUREAU OF INDIAN AFFAIRS (BIA) FOSTER CARE.
BIA foster care payments are social services. They are excluded for the foster child and foster family. ( )

316. BLIND OR DISABLED STUDENT EARNED INCOME.
To qualify for this exclusion, the student must be blind or disabled. The student must be under age twenty-two (22). The student must be regularly attending high school, college, university or course of vocational or technical training designed to prepare him for gainful employment. The maximum monthly and annual exclusions cannot exceed the limits set by SSI for the current year. ( )

317. "BUY-IN" REIMBURSEMENT.
The SSA reimbursement for self-paid Medicare Part B "Buy-In" premiums is excluded. ( )

318. COMMODITIES, FOOD STAMPS, AND FOOD PROGRAMS.
Food, under the Federal Food Stamp Program, Donated Commodities Program, School Lunch Program, and Child Nutrition Program, is excluded. This includes free or reduced price food for women and children under the National School Lunch Act and the Child Nutrition Act of 1966. ( )

319. CONTRIBUTIONS FOR RESIDENTIAL AND ASSISTED LIVING FACILITY RESIDENTS.
Contributions from a third party, for a participant residing in a Residential and Assisted Living Facility, are excluded. The contribution must be paid directly to the facility. The contribution must pay for items or services provided to the participant by the facility. The items or services must not be included in the participant's State Plan Personal Care Services or his Personal Care Supplement or must be charges for rent, utilities, or food exceeding the Personal Care Supplement Allowance. The participant must not be charged a higher rate than other residents of the facility. The person making the contribution must provide a signed statement identifying the item or service the payment covers, the reason the item or service is needed by the participant, and the monthly amount of the payment. ( )

320. CONVERSION OR SALE OF A RESOURCE NOT INCOME.
Payment from the sale, exchange, or replacement of a resource is excluded. The payment is a resource that changed form. ( )

321. CREDIT LIFE OR DISABILITY INSURANCE PAYMENTS.
Credit life or credit disability insurance covers payments on loans and mortgages, in case of death or disability. Insurance payments are made directly to loan or mortgage companies, and are not available to the participant. These payments are excluded. ( )

322. DEPARTMENT OF EDUCATION SCHOLARSHIPS.
Any grant, scholarship, or loan, to an undergraduate for educational purposes, made or insured under any program administered by the Commissioner of Education, is excluded. ( )

323. GIFTS OF DOMESTIC TRAVEL TICKETS.
A ticket for domestic travel received as a gift by a participant or spouse is excluded. ( )

324. GRANTS, SCHOLARSHIPS, AND FELLOWSHIPS.
Any grant, scholarship, or fellowship, not administered by the Commissioner of Education, and used for paying tuition, fees, or required educational expenses is excluded. This exclusion does not apply to any portion set aside or actually used for food or shelter. ( )

325. DISASTER ASSISTANCE.
Payments received because of a major disaster, declared by the President, are excluded. This includes payments to repair or replace the person's own home or other property, and disaster unemployment aid. ( )

326. DOMESTIC VOLUNTEER SERVICE ACT PAYMENTS.
Compensation, other than wages, provided to volunteers in the Foster Grandparents Program, RSVP, and similar National Senior Volunteer Corps programs under Sections 404(g) and 418 of the Domestic Volunteer Service Act is excluded. ( )

327. EARNED INCOME TAX CREDITS.
Earned Income Tax Credits advance payments and refunds are excluded. ( )

328. FEDERAL HOUSING ASSISTANCE.
Federal housing assistance listed in Subsections 328.01 through 328.05 is excluded. ( )

01. United States Housing Act of 1937. United States Housing Act of 1937, Section 1437 et seq. of 42 U.S. Code. ( )

02. The National Housing Act. The National Housing Act, Section 1701 et seq. of 12 U.S. Code. ( )

03. Housing and Urban Development Act of 1965. Section 101 of the Housing and Urban Development Act of 1965, Section 1701s of 12 U.S. Code, and Section 1451 of 42 U.S. Code. ( )

04. Housing Act of 1949. Title V of the Housing Act of 1949, Section 1471 et seq. of 42 U.S. Code. ( )

05. Housing Act of 1959. Section 202(h) of the Housing Act of 1959. ( )

329. FOSTER CARE PAYMENTS.
Foster care payments using funds provided under Title IV-B or Title XX of the Social Security Act are excluded. Payments for foster care of a non SSI-child placed by a public or private non-profit child placement or child care agency are excluded. Foster care payments using funds provided under Title IV-E are income. The twenty dollar ($20) standard disregard is not subtracted. ( )

330. EXPENSE OF OBTAINING INCOME.
Essential expenses of obtaining unearned income are subtracted from the income. An expense is essential if the participant would not receive the income unless he paid the expense. Expenses of receiving income, such as withheld taxes, are not subtracted. ( )

331. GARNISHMENTS.
Garnishments of unearned income are counted as unearned income. Garnishments of earned income are counted as earned income. ( )

332. GERMAN REPARATIONS.
Reparations payments from the Federal Republic of Germany received on or after November 1, 1984 are excluded. ( )

333. GOVERNMENT MEDICAL OR SOCIAL SERVICES.
Governmental payments authorized by Federal, State, or local law, for medical or social services, are excluded. Any cash provided by a nongovernmental medical or social services organization (including medical and liability insurers) for medical or social services already received is excluded. ( )

01. Medical Services. Medical services are diagnostic, preventive, therapeutic, or palliative treatment. Treatment must be performed, directed, or supervised by a State licensed health professional. Medical services include room and board provided during a medical confinement. Medical services include in-kind medical items such as prescription drugs, eye glasses, prosthetics, and their maintenance. In-kind medical items include devices intended to bring the physical abilities of a handicapped person to a par with an unaided person who is not handicapped. Electric wheelchairs, modified scooters, and service animals and their food are in-kind medical items. ( )

02. Social Service. A social service is any service, other than medical. A social service helps a handicapped or socially disadvantaged person to function in society on a level comparable to a person not handicapped or disadvantaged. Housebound and Aid and Attendance Allowances, including Unusual Medical Expense Allowances, received from the Veterans Administration are excluded. ( )

334. HOME ENERGY ASSISTANCE (HEA) AND SUPPORT AND MAINTENANCE ASSISTANCE (SMA).
SMA is in-kind support and maintenance, or cash paid for food or shelter needs. SMA includes HEA. HEA is aid to meet the costs of heating or cooling a home. SMA must be provided in-kind by a nonprofit organization. HEA must be provided in cash or in-kind by suppliers of home heating gas or oil or a municipal utility providing home energy. SMA and HEA are excluded. ( )

335. HOME PRODUCE FOR PERSONAL USE.
Home produce is excluded if it is consumed by the participant or his household. Home produce includes livestock grown for personal consumption. ( )

336. IN-HOME SUPPORTIVE SERVICES.
Payments made by Title XX or other governmental programs to pay an ineligible spouse or ineligible parent for in-home supportive services provided to a participant are excluded. In-home supportive services include attendant care, chore services and homemaker services. ( )

337. INCOME EXCLUDED BY LAW.
Any income excluded by Federal statute, is excluded. ( )

338. INFREQUENT OR IRREGULAR INCOME.
The first thirty dollars ($30) of earned income and the first sixty dollars ($60) of unearned income per calendar quarter are excluded, when they are infrequent or irregular payments. Income is infrequent if the participant receives it once in a calendar quarter from a single source. Income is irregular if the participant could not reasonably expect to receive it. ( )

339. (RESERVED)

340. LOANS.
Loans are excluded, if the participant has signed a written repayment agreement. The signed agreement must state how the loan will be repaid. The signed written agreement can be obtained after the loan is received. Items bought on credit are paid with a loan and are not income. Money repaid to a participant on the principal of a loan is not income, it is a resource. Interest received by a participant on money loaned by him is countable income. ( )

341. MANPOWER DEVELOPMENT AND TRAINING ACT PAYMENTS.
Payments made under the Manpower Development and Training Act of 1962, as amended by the Manpower Act of 1965 are excluded. ( )

342. NATIVE AMERICAN PAYMENTS.
Payments authorized by law made to people of Native American ancestry are excluded. ( )

343. (RESERVED)

344. NUTRITION PROGRAMS FOR OLDER AMERICANS.
Payments, other than a wage or salary, made under Chapter 35 of Title 42 of the U.S. Code, Programs for Older Americans, are excluded. ( )

345. PERSONAL SERVICES.
A personal service performed for a participant is excluded. Personal services include lawn mowing, house cleaning, grocery shopping, and baby sitting. ( )

346. (RESERVED)

347. REBATES, REFUNDS, AABD UNDERPAYMENTS AND REPLACEMENT CHECKS.
Rebates, refunds, AABD underpayments and returns of money already paid are excluded. A replacement check is excluded. ( )

348. RELOCATION ASSISTANCE.
Relocation payments under Title II of the Uniform Relocation Assistance and Real Property Acquisitions Policies Act of 1970, Subchapter II, Chapter 61, Title 42 of the U.S. Code are excluded. Relocation payments, paid to civilians of World War II per Public Law 100-383, are excluded. ( )

349. REPLACEMENT OF INCOME ALREADY RECEIVED.
Replacement of a participant's lost, stolen, or destroyed income is excluded. ( )

350. RETURN OF MISTAKEN PAYMENTS.
A returned mistaken payment is excluded. If the participant keeps the mistaken payment, it is income. ( )

351. TAX REFUNDS.
Refunds of Federal, State or local taxes paid on income, real property, or food bought by the participant and his family, are excluded. ( )

352. UTILITY PAYMENTS.
Payments for utility costs made to low-income housing tenants by a local housing authority are excluded when paid directly to the tenant or jointly to the tenant and the utility company. ( )

353. (RESERVED)

354. VICTIMS' COMPENSATION PAYMENTS.
Any payment made from a State-sponsored fund to aid victims of crime is excluded. ( )

355. VOCATIONAL REHABILITATION SERVICES PAYMENTS.
Payments other than wages made to an eligible handicapped individual employed in a Vocational Rehabilitation Services project under Title VI of the Rehabilitation Act of 1973 are excluded. ( )

356. VOLUNTEER SERVICES INCOME.
Payments to volunteers under Chapter 66 of Title 42 of the U.S. Code Domestic Volunteer Services (ACTION programs) are excluded. Payments are not excluded, if the Director of the ACTION agency determines the value, adjusted for hours served, is equal to or greater than the Federal or State minimum wage. ( )

357. WALKER V. BAYER PAYMENTS.
Class action settlement payments in Susan Walker v. Bayer Corporation, et al are excluded for Medicaid but not for AABD cash. ( )

358. WEATHERIZATION ASSISTANCE.
Weatherization assistance is excluded. ( )

359. TEMPORARY CENSUS INCOME.
For Medicaid only, all wages paid by the Census Bureau for temporary employment related to U.S. Census activities are excluded. ( )

360. -- 399. (RESERVED)

400. EARNED INCOME.
Earned income remaining after disregards and exclusions are subtracted is counted in computing AABD cash. Wages are counted the month they become available to the participant. ( )

401. COMPUTING SELF-EMPLOYMENT INCOME.
Countable self-employment income is the difference between the gross receipts and the allowable costs of producing the income, if the amount is expected to continue. Self-employment income is computed using one (1) of the methods

listed in Subsections 401.01 through 401.03. ( )

01. Self-Employed at Least One Year. For individuals who are self-employed for at least one (1) year, income and expenses are averaged over the past twelve (12) months. ( )

02. Self-Employed Less Than One Year. For individuals who are self-employed for less than one (1) year, income and expenses are averaged over the months the business has been in operation. ( )

03. Monthly Increase or Decrease. If a monthly average does not reflect actual monthly income, because of an increase or decrease in business, the self-employment income is counted monthly. This method is not used for businesses with seasonal or unusual income peaks at certain times of the year. ( )

04. Net Self-Employment Income Seven and Sixty-Five Hundredths Percent Deduction. If net self-employment income is over four hundred dollars ($400) per year, seven and sixty-five hundredths percent (7.65%) is deducted. This deduction compensates for Social Security taxes paid. If self-employment Social Security tax is not paid, this deduction is not allowed. ( )

402. SELF-EMPLOYMENT ALLOWABLE EXPENSES.
Allowable operating expenses subtracted from self-employment income are listed in Subsections 402.01 through 402.17 of this rule. ( )

01. Labor. Labor paid to individuals not in the family. ( )

02. Materials. Materials such as stock, seed and fertilizer. ( )

03. Rent. Rent on business property. ( )

04. Interest. Interest paid to purchase income producing property. ( )

05. Insurance. Insurance paid for business property. ( )

06. Taxes. Taxes on income producing property. ( )

07. Business Transportation. Business transportation as defined by the IRS. ( )

08. Maintenance. Landscape and grounds maintenance. ( )

09. Lodging. Lodging for business related travel. ( )

10. Meals. Meals for business related travel. ( )

11. Use of Home. Costs of partial use of home for business. ( )

12. Legal. Business related legal fees. ( )

13. Shipping. Business related shipping costs. ( )

14. Uniforms. Business related uniforms. ( )

15. Utilities. Utilities for business property. ( )

16. Advertising. Business related advertising. ( )

17. Depreciation. Depreciation for equipment, machinery, or other capital investments. ( )

403. SELF-EMPLOYMENT EXPENSES NOT ALLOWED.
Self-employment expenses not allowed are listed in Subsections 403.01 through 403.08. ( )

01. Payments on the Principal of Real Estate. Payments on the principal of real estate mortgages on income-producing property. ( )

02. Purchase of Capital Assets or Durable Goods. Purchases of capital assets, equipment, machinery, and other durable goods. Payments on the principal of loans for these items. ( )

03. Taxes. Federal, state, and local income taxes. ( )

04. Savings. Monies set aside for future use such as retirement or work related expenses. ( )

05. Labor Paid to Family Member. Labor paid to any family member. ( )

06. Loss of Farm Income. Loss of farm income subtracted from other income. ( )

07. Personal Transportation. Personal transportation. ( )

08. Net Losses. Net losses from previous periods. ( )

404. ROYALTIES.
Royalties received as part of a trade or business, or for publication of the participant's work are earned income. Other royalties are unearned income. ( )

405. HONORARIA.
An honorarium for services rendered is earned income. An honorarium for travel expenses and lodging for a guest speaker is unearned income in the amount it exceeds the expenses. The portion that equals the expenses is excluded as an expense of obtaining the income. ( )

406. SHELTERED WORKSHOP OR WORK ACTIVITIES CENTER PAYMENTS.
Payments for services performed in a sheltered workshop or work activities center are earned income. ( )

407. JOB TRAINING PARTNERSHIP ACT (JTPA).
JTPA payments are earned income. JTPA payments for child care, transportation, medical care, meals, and other reasonable expenses, provided in cash or in-kind, are not income. ( )

408. PROGRAMS FOR OLDER AMERICANS.
Wages or salary paid under Chapter 35 of Title 42 of the U.S. Code, Programs for Older Americans, is earned income. ( )

409. UNIFORMED SERVICES PAY AND ALLOWANCES.
Basic pay is earned income. All other pay and allowances are unearned income. ( )

410. RENTAL INCOME.
Net rental income is unearned income, unless from the business of renting real property. Net unearned rental income is gross rent less the expenses on the rental property listed in Subsections 410.01 through 410.06. Net rental income from the business of renting properties is self-employment earned income. ( )

01. Interest. Interest and escrow portions of a mortgage payment. ( )

02. Insurance. Real estate insurance. ( )

03. Repairs. Minor repairs to an existing rental structure. ( )

04. Taxes. Property taxes. ( )

05. Yard Care. Lawn care, including tree and shrub care and snow removal. ( )

06. Advertising. Advertising costs for tenants. ( )

411. OVERPAYMENT WITHHOLDING OF UNEARNED INCOME.
Money withheld by any benefit program to recover an overpayment is counted as income. Money withheld is not income if the overpaid benefit amount was used to compute AABD cash. ( )

412. RETIREMENT, SURVIVORS, AND DISABILITY INSURANCE (RSDI).
RSDI monthly benefits are unearned income. The income is the amount reported by SSA, regardless of penalties to recover an SSI overpayment. ( )

413. SSI PAYMENTS.
SSI monthly payments are unearned income. The income is the amount reported by SSA, regardless of penalties to recover an SSI overpayment. An advance SSI payment, to an applicant appearing SSI eligible with a financial emergency, is not income the month received. When SSA reduces ongoing SSI to recover the advance, the SSI payment before the reduction continues to be counted as income. ( )

414. BLACK LUNG BENEFITS.
Black Lung payments are unearned income. ( )

415. RAILROAD RETIREMENT PAYMENTS.
Railroad Retirement Board payments are unearned income. ( )

416. UNEMPLOYMENT INSURANCE BENEFITS.
Unemployment insurance benefits received under State and Federal unemployment laws are unearned income. ( )

417. UNIFORM GIFTS TO MINORS ACT (UGMA).
UGMA payments from the custodian to the minor are income to the minor. UGMA property, including earnings or additions, are not income to the minor until the month the minor becomes eighteen (18) years of age. ( )

418. WORKERS' COMPENSATION.
Workers' compensation, less expenses required to get the payment, is unearned income. ( )

419. MILITARY PENSIONS.
Military pensions are unearned income. ( )

420. VA PENSION PAYMENTS.
VA pension payments are unearned income. The twenty dollar ($20) standard disregard is not subtracted, except by a special act of Congress. ( )

421. VA COMPENSATION PAYMENTS.
VA compensation payments to a veteran, spouse, child, or widow(er) are unearned income. ( )

422. VA EDUCATIONAL BENEFITS.
VA educational payments funded by the government are excluded. ( )

423. ALIMONY, SPOUSAL, AND ADULT SUPPORT.
Alimony, spousal, and other adult support payments are unearned income. ( )

424. CHILD SUPPORT PAYMENTS.
Child support payments are unearned income. One-third (1/3) of a child support payment is excluded for the child receiving support. Child support collected by a State and retained for TAFI payments is not income. ( )

425. DIVIDENDS AND INTEREST.
Dividends and interest are unearned income. ( )

426. AWARDS.

Awards are unearned income. ( )

427. GIFTS.
Gifts are unearned income. ( )

428. PRIZES.
Prizes are unearned income. ( )

429. WORK-RELATED UNEARNED INCOME.
Work-related payments that are not salary or wages are unearned income. ( )

430. COMMUNITY SERVICE BLOCK GRANTS.
Community service block grant distributions are unearned income, unless excluded by the type of aid, such as medical services or Support and Maintenance Assistance. ( )

431. FEDERAL EMERGENCY MANAGEMENT AGENCY (FEMA) EMERGENCY FOOD DISTRIBUTION AND SHELTER PROGRAMS.
FEMA funds are unearned income, unless excluded by the type of aid, such as medical services or Support and Maintenance Assistance. ( )

432. BUREAU OF INDIAN AFFAIRS GENERAL ASSISTANCE (BIA GA).
BIA GA payments are unearned income. BIA GA payments are Federally-funded income based on need. They are paid in cash or in-kind. The twenty dollar ($20) standard disregard is not subtracted. ( )

433. BIA ADULT CUSTODIAL CARE (ACC) AND CHILD WELFARE ASSISTANCE (CWA) PAYMENTS.
BIA ACC and CWA payments, other than foster care, made to participants out of an institution, are unearned income. ( )

434. INDIVIDUAL INDIAN MONEY (IIM) ACCOUNTS.
Deposits to an unrestricted IIM account are income in the month deposited. ( )

435. ACCELERATED LIFE INSURANCE INCOME.
Accelerated life insurance payments are unearned income in the month received. ( )

436. REAL ESTATE CONTRACT INCOME.
Payments received on the interest of a negotiable real estate contract are unearned income for Medicaid eligibility. Payments received on the principal of a negotiable real estate contract are a resource for Medicaid eligibility. Payments received on a nonnegotiable real estate contract are unearned income. Principal and interest payments received on an excluded real estate contract of a long-term care participant are unearned income for patient liability. ( )

437. LIMITED AWARD TO CHILD WITH LIFE-THREATENING CONDITION.
Any gift from a tax exempt nonprofit organization to a child under age eighteen (18), who has a life threatening condition, is excluded from income under the conditions in Subsections 437.01 through 437.02. ( )

01. In-Kind. An in-kind gift is excluded if the gift is not converted to cash. ( )

02. Cash. Cash gifts are excluded up to two thousand dollars ($2,000) for the calendar year the cash gifts are made. ( )

438. -- 450. (RESERVED)

451. DEEMING INCOME.
Income deeming counts the income of another person as available to an AABD participant, for eligibility and the amount of AABD cash. Income is deemed to the participant from his ineligible spouse. Income is deemed to the child participant from his ineligible parent. Income deeming starts the first full calendar month the participant is in a

deeming situation. Deeming ends the first full calendar month the participant is not in a deeming situation. Deeming to a child ends the month after the child's eighteenth birthday. ( )

01. Ineligible Parent. A natural or adoptive father or mother, or a stepparent, who does not receive AABD and lives in the same household as a child. ( )

02. Ineligible Spouse. A participant's husband or wife, living with the participant, not receiving AABD is an ineligible spouse. The ineligible husband or wife, of the parent of a child participant, living with the child participant and his parent, is an ineligible spouse. ( )

03. Ineligible Child. A child under age twenty-one (21) who does not receive AABD, and lives with the AABD participant. ( )

04. Income Deeming Exclusions. Income excluded from deeming is listed in Table 451.04.

TABLE 451.04 - INCOME DEEMING EXCLUSIONS

Type of Income	Ineligible Spouse or Parent, Ineligible Child, Eligible Legal Non-citizen	Essential Person	Sponsor of Legal Non-citizen
Income excluded by Federal laws other than the Social Security Act.	Excluded	Excluded	Excluded
Public Income Maintenance Payments (PIM). Public income maintenance payments include TAFI, AABD, SSI, refugee cash assistance, BIA-GA, VA payments based on need, local, county and state payments based on need, and payments under the 1974 Disaster Relief Act.	Excluded	Not Excluded	Not Excluded
Income used by a PIM program for amount of payment to someone other than an SSI recipient.	Excluded	Not Excluded	Not Excluded
Grants, scholarships, fellowships.	Excluded	Not Excluded (unless excluded by Federal laws)	Not Excluded (unless excluded by Federal laws)
Foster care payments.	Excluded	Not Excluded	Not Excluded
Food Stamps and Dept. of Agriculture donated foods.	Excluded	Not Excluded	Not Excluded
Home grown produce.	Excluded	Not Excluded	Not Excluded
Tax refunds on real property or food.	Excluded	Not Excluded	Not Excluded
Income used in an approved plan for achieving self support (PASS).	Excluded	Not Excluded	Not Excluded
Income used to pay court ordered or Title IV-D support payments.	Excluded	Not Excluded	Not Excluded
Payments based to Alaskans based on age and residence.	Excluded (not applicable to children)	Not Excluded	Not Excluded
Disaster Assistance.	Excluded	Excluded	Excluded

TABLE 451.04 - INCOME DEEMING EXCLUSIONS			
Type of Income	**Ineligible Spouse or Parent, Ineligible Child, Eligible Legal Non-citizen**	**Essential Person**	**Sponsor of Legal Non-citizen**
Infrequent or irregular income.	Excluded	Not Excluded	Not Excluded
Blind Work Expenses (BWE).	Excluded	Not Excluded	Not Excluded
Payments to provide in-home support.	Excluded	Not Excluded	Not Excluded
Home energy assistance and support and maintenance assistance.	Excluded	Excluded	Excluded
Child's earned income, up to one thousand two hundred and ninety dollars ($1,290) per month and five thousand two hundred dollars ($5,200) per year.	Excluded (not applicable to spouses or parents)	Does Not Apply	Does Not Apply
Impairment-related work expenses (IRWE).	Excluded	Not Excluded	Not Excluded
Interest on burial funds, appreciation in the value of burial space purchase agreements excluded from resources and interest on the value of burial space purchase agreements.	Excluded	Not Excluded	Not Excluded

( )

452. DEEMING INCOME FROM INELIGIBLE SPOUSE TO PARTICIPANT.
Income is deemed from an ineligible spouse to the participant, if they live together. Income is deemed as described in Subsections 452.01 through 452.08.

TABLE 452 - INCOME DEEMED FROM INELIGIBLE SPOUSE		
Step		**Procedure**
01.	Compute Child's Living Allowance.	Compute the living allowance for each ineligible child in the household. The living allowance is the difference between the basic allowance for a person living alone and the basic allowance for a couple. Round up cents to the next dollar. A child receiving public income-maintenance payments does not get a living allowance. Subtract the child's unearned income from his living allowance. Subtract the child's earned income from any living allowance remaining.
02.	Adjust Spouse Income with Child's Living Allowance	Subtract the remaining living allowance, for each ineligible child in the household, from the ineligible spouse's gross unearned income, then from gross earned income.
03.	Add Adjusted Earned and Unearned Incomes	Add adjusted earned and unearned income. This is the deemed income of the ineligible spouse.

TABLE 452 - INCOME DEEMED FROM INELIGIBLE SPOUSE		
	Step	**Procedure**
04.	Compute Participant's Needs as a Single Person	Compute the participant's budgeted AABD needs as if he was a single person, living alone.
05.	Deemed Income Equal to or Less Than One-Half of Participant's Needs	If the deemed income is equal to, or less than, one-half of the participant's budgeted needs, computed as if he was a single person living alone, no income is deemed from the ineligible spouse.
06.	Deemed Income More Than One-Half Participant's Needs	If the deemed income is more than one-half of the participant's budgeted needs, computed as if he was a single person living alone, continue the deeming process.
07.	Compute Participant's Income	Add the remaining earned and unearned ineligible spouse deemed income (after the ineligible child deduction) to the gross earned and unearned incomes of the participant. This is the total earned and unearned income. Subtract the standard disregard of twenty dollars ($20) from the total unearned income. If the total unearned income is less than twenty dollars ($20), subtract the remainder from the total earned income. Subtract the earned income disregard of sixty-five dollars ($65) from the earned income. Subtract one-half of the remaining earned income. Combine the remaining unearned income and the remaining earned income to compute the participant’s total countable income. Determine the couple's budgeted needs as if they were an eligible couple. If the participant's countable income, including deemed income, is more than the couple's budgeted needs, the participant is ineligible. If the participant's countable income, including deemed income, is less than the couple's budgeted needs compute the participant's AABD cash.
08.	Determine AABD Cash	Subtract the participant's countable and deemed incomes from the couple’s budgeted needs, to compute the budget deficit. Compute a second budget deficit, using the participant’s income, and the single person budgeted needs. AABD cash is the smaller of the two (2) budget deficits.

( )

453. DEEMING INCOME FROM INELIGIBLE PARENT TO AABD CHILD.
Income is deemed from an ineligible parent, or his ineligible spouse, to a child participant under age eighteen (18) living in the same household. A stepparent’s income is deemed to the child for AABD cash, but not Medicaid. The income is deemed as described in Subsections 453.01 through 453.11.

TABLE 453 - INCOME DEEMED FROM INELIGIBLE PARENT		
Step		**Procedure**
01.	Compute Child's Living Allowance	Compute the living allowance for each ineligible child in the household. The living allowance is the difference between the basic allowance for a person living alone and the basic allowance for a couple. Round up cents to the next dollar. A child receiving public income-maintenance payments does not get a living allowance. Subtract the child's unearned income from his living allowance. Subtract the child's earned income from any living allowance remaining. Subtract the remaining living allowance, for each ineligible child in the household, from the ineligible parents unearned income. If any living allowance remains subtract it from the parent's earned income.
02.	Remaining Parental Income	The parent may have remaining income. Go to Subsection 453.03.
03.	Subtract Income Disregard	Subtract one (1) standard twenty dollar ($20) disregard from the unearned income of the parents. If unearned income is less than twenty dollars ($20) subtract the balance of the twenty dollars ($20) from the earned income of the parents.
04.	Subtract Earned Income Disregard	Subtract one (1) sixty-five dollar ($65) earned income disregard from the earned income of the parents. Subtract one-half (1/2) of the remaining balance of the earned income of the parents.
05.	Combine Income	Combine any remaining parental earned income with any remaining parental unearned income.
06.	Compute Living Allowance for Parent	Compute a living allowance for the ineligible parent. For one (1) parent, the living allowance is the basic allowance for a person living alone. For two (2) parents, the living allowance is the basic allowance for a couple. A parent receiving public income maintenance payments does not get a living allowance.
07.	Subtract Living Allowance	Subtract the parent living allowance from the remaining balance of the parent's income. This is the deemed parental income.
08.	Divide Deemed Income	If there is more than one (1) child participant in the household, the deemed parental income is divided equally between those children. Each child's share of parental income must only reduce the amount of his AABD cash to zero, when combined with the child's own countable income. Excess deemed parental income, remaining after a child participant's AABD cash is reduced to zero, is divided equally between the other child participants in the household. The excess deemed income is combined with their share of the parental income available for deeming.

TABLE 453 - INCOME DEEMED FROM INELIGIBLE PARENT		
Step		**Procedure**
09.	Subtract Disregard	Subtract the standard twenty dollar ($20) disregard from each child participant's unearned income, including deemed income. If a child's total unearned income is less than twenty dollars ($20), subtract the balance of the standard disregard from the child's earned income.
10.	Subtract Disregard	Subtract the sixty-five dollar ($65) earned income disregard and one-half of the balance from each child's own earned income.
11.	Combine Income	Combine each child's unearned income with his earned income. If the child's remaining countable income is less than his actual budgeted needs, the child has a budget deficit. If the child is otherwise eligible, his AABD cash is the budget deficit.

( )

454. DEEMING INCOME FROM ESSENTIAL PERSON TO PARTICIPANT.
If a participant and an essential person live in the same household, the essential person's income is deemed to the participant. If essential person deeming makes the participant ineligible, do not use essential person deeming. The income is deemed as described in Subsections 454.01 through 454.06.

TABLE 454 - DEEMING FROM ESSENTIAL PERSON TO PARTICIPANTS		
Step		**Procedure**
01.	Compute Income	Compute the total earned and unearned income of the essential person. Subtract income exclusions.
02.	Subtract Disregard	Subtract income exclusions and disregards from the participant's income.
03.	Add Unearned Income	Add the income from Subsection 454.01 to the participant's unearned income.
04.	Add Earned Income	Add the participant's remaining earned income from Subsection 454.02 to the income in Subsection 454.03. This is the participant's countable income.
05.	Compute Needs	Compute the participant's budgeted needs, as though the participant and the essential person were an AABD couple.
06.	Subtract Income	Subtract participant's income in Subsection 454.04 from his budgeted needs. The difference is the participant's AABD cash.

( )

455. DEEMING INCOME FROM INELIGIBLE SPOUSE TO PARTICIPANT AND CHILD PARTICIPANT.
If a participant, his ineligible spouse and their child participant live in the same household, income is deemed from the participant to the child participant. The income is deemed as described in Subsections 455.01 through 455.03.

TABLE 455 - DEEMING FROM INELIGIBLE SPOUSE TO PARTICIPANT AND CHILD PARTICIPANT		
Step		**Procedure**
01.	Compute AABD cash	Use the procedures in Table 452, to determine if the participant is eligible for AABD cash. If the participant is eligible, no income is deemed to the child participant.

TABLE 455 - DEEMING FROM INELIGIBLE SPOUSE TO PARTICIPANT AND CHILD PARTICIPANT		
	Step	**Procedure**
02.	Participant Not Eligible	If the participant has too much income, including deemed income, to be eligible for AABD cash, all income over the amount needed to reduce the participant's AABD cash to zero is deemed to the child participant.
03.	Divide Deemed Income	If there is more than one (1) child participant in the household, the deemed parental income is divided equally between those children. Each child's share of parental income must only reduce the amount of his AABD cash to zero, when combined with the child's own countable income. Excess deemed parental income, remaining after a child participant's AABD cash is reduced to zero, is divided equally between the other child participants in the household. The excess deemed income is combined with their share of the parental income available for deeming.

( )

456. DEEMING INCOME FROM SPONSOR TO LEGAL NON-CITIZEN PARTICIPANT -- NO I-864 AFFIDAVIT OF SUPPORT.
Deem income as described in this Section, if the legal non-citizen's sponsor signed an affidavit of support other than the I-864. The deemed income is counted, even if the participant does not live in the sponsor's household. The sponsor's income is not deemed to the participant for Medicaid. ( )

01. Three Year Limit. Effective October 1, 1996 the deeming period, regardless of admission date, is three (3) years after the date the legal non-citizen is lawfully admitted. Deeming stops the end of the month, three (3) years from the date the sponsored participant lawfully entered the U.S. for permanent residence. ( )

02. Sponsored Legal Non-Citizen Exempt from Deeming. A lawfully admitted legal non-citizen participant is exempt from sponsor deeming if one (1) or more of the conditions in Subsections 456.02.a. through 456.02.m. applies. ( )

a. Refugee. The legal non-citizen was admitted to the U.S. as a refugee, asylee, or parolee. ( )

b. Applied before October 1, 1980. The legal non-citizen first applied for AABD before October 1, 1980. ( )

c. Permanent resident. The legal non-citizen is a permanent resident under color of law. ( )

d. Sponsored with job. The legal non-citizen's entry into the U.S. was sponsored by a church, other social service organization, or an employer who has offered him a job. ( )

e. Blind or disabled. The legal non-citizen becomes blind or disabled after he is admitted to the U.S. ( )

f. Legal non-citizen lives with spouse. The legal non-citizen was sponsored by and resides in the same household with his ineligible spouse or ineligible parent. Use ineligible spouse and ineligible parent deeming, not sponsor deeming. ( )

g. Sponsor dies. The legal non-citizen's sponsor dies. ( )

h. Legalized legal non-citizen. The legal non-citizen was legalized under the Immigration Reform and Control Act of 1986. ( )

i. Resided for thirty-six (36) months. The legal non-citizen has lived in the U.S. for thirty-six (36)

months beginning with the month he was admitted for permanent residence or granted permanent residence status. ( )

j. Registry legal non-citizen. The legal non-citizen was admitted under Section 249 of the INA as a registry legal non-citizen. ( )

k. Amerasian legal non-citizen. The legal non-citizen is an applicant for permanent residence who is an Amerasian or a specified relative of an Amerasian. The Amerasian must be born in Vietnam between January 1, 1962 and January 1, 1976. A specified relative is a spouse, child, parent or stepparent of the Amerasian, or someone who has acted in the place of a parent of an Amerasian and/or his spouse or child. ( )

l. Cuban/Haitian. The legal non-citizen is an applicant for adjustment under the Cuban/Haitian provisions of Section 202 of the Immigration Reform and Control Act of 1986. ( )

03. Sponsor/Legal Non-Citizen Relationships. Sponsor/legal non-citizen relationships and deeming rules are listed in Subsections 456.03.a. through 456.03.f.

TABLE 456.03 - SPONSOR/LEGAL NON-CITIZEN RELATIONSHIPS AND DEEMING

Step		Procedure
a.	Sponsor is Spouse	If the legal non-citizen's sponsor is his ineligible spouse, and the couple does not live together, sponsor to legal non-citizen deeming is used.
b.	Legal Non-Citizen is a Child	If the legal non-citizen is a child, and does not live with his sponsor parent(s), sponsor to legal non-citizen deeming is used.
c.	Child With Ineligible Parent	If the participant is a child whose ineligible parent(s) and sponsor both have income available for deeming to him, the income of the ineligible parent(s) is deemed as in Section 376.
d.	Child Eligible After Parent Deeming	If the child remains eligible after income is deemed from his ineligible parent(s), the sponsor's income is deemed to him under the sponsor to legal non-citizen deeming procedures.
e.	Participant Couple With Sponsors	If each member of a participant couple has his own sponsor, separate deeming computations are used. The couple's countable income includes the combined deemed incomes.
f.	Member of Couple Not Eligible	If one (1) member of a couple with separate sponsors is not eligible, the ineligible spouse's income is deemed to the participant as in Section 379. This is in addition to income deemed from the sponsor.

( )

04. Sponsor to Legal Non-Citizen Deeming Procedures. Budget the legal non-citizen's actual needs, as if he is a single person living alone. Subtract the legal non-citizen's own income, less exclusions and disregards. Subtract the couple's income, less exclusions, from their needs. If there is no budget deficit, the participant is not eligible. If there is a budget deficit, follow the procedures in Subsections 456.04.a. through 456.04.d. to compute sponsor deemed income.

TABLE 456.04 - SPONSOR TO LEGAL NON-CITIZEN DEEMING PROCEDURES

Step		Procedure
a.	Compute Income	Compute the gross monthly earned and unearned income of the sponsor, and the sponsor's spouse, if living with him.

TABLE 456.04 - SPONSOR TO LEGAL NON-CITIZEN DEEMING PROCEDURES		
Step		Procedure
b.	Subtract Living Allowance	Subtract a living allowance for the sponsor the sponsor's spouse, if living with him. The sponsor's living allowance is the basic allowance for a single person living alone. The living allowance for the sponsor's spouse is one-half the basic allowance for a single person living alone. Round up cents to the next dollar.
c.	Subtract Dependent Living Allowance	Subtract a living allowance for each dependent claimed by the sponsor on his most recent Federal tax return. Do not subtract an allowance for the sponsor's spouse in this step. The living allowance is one-half the basic allowance for a single person living alone. Round up cents to the next dollar. Do not reduce the living allowance by the dependent's income.
d.	Deem Income	Income remaining is deemed to the participant from the sponsor.

( )

457. DEEMING INCOME FROM SPONSOR TO LEGAL NON-CITIZEN -- SPONSOR SIGNED INS FORM I-864 AFFIDAVIT OF SUPPORT.
If the legal non-citizen's sponsor has signed an INS form I-864 affidavit of support, all income of the sponsor and the sponsor's spouse is deemed to the legal non-citizen for AABD cash and Medicaid eligibility. Deeming continues until the legal non-citizen becomes a naturalized citizen or has forty (40) quarters of work. Exceptions are listed in Subsections 457.01 and 457.02. ( )

01. Battery Exception. The legal non-citizen, or the legal non-citizen child's parent, was battered or subjected to extreme cruelty in the U.S. There is a substantial connection between the battery and the participant's need for assistance. The person subjected to the battery or cruelty no longer lives with the person responsible for the battery or cruelty. ( )

02. Indigence. Alien sponsor deeming is suspended for twelve (12) months, if the legal non-citizen is not able to get food and shelter without AABD cash. ( )

458. -- 499. (RESERVED)

500. FINANCIAL NEED.
The participant has financial need if his allowances, as described in Sections 501 through 513 of these rules, are more than his income. ( )

501. BASIC ALLOWANCE.
Each participant receives a basic allowance unless he lives in a nursing facility. The basic allowance for each living arrangement is listed in Subsections 501.01 through 501.03 of this rule. The Semi-Independent Group Residential Facility, Room and Board, Residential and Assisted Living Facility and Certified Family Home basic allowances are those in effect January 1, 2001. They do not change with the annual cost-of-living increase in the federal SSI benefit amount. ( )

01. Single Participant. Through December 31, 2000, a participant is budgeted five hundred forty-five dollars ($545) monthly as a basic allowance when living in a situation described in Subsections 501.01.a. through 501.01.e. of these rules. Beginning January 1, 2001, the basic allowance increase for a single participant is the dollar amount of the annual cost-of-living increase in the federal SSI benefit rate for a single person. ( )

a. Living alone. ( )

b. Living with his ineligible spouse. ( )

c. Living with another participant who is not his spouse. ( )

d. Living in another's household. This includes a living arrangement where the participant purchases lodging (room) and meals (board) from his parent, child or sibling. ( )

e. Living with his TAFI child. ( )

02. Couple or Participant Living with Essential Person. Through December 31, 2000, a participant living with his participant spouse or his essential person is budgeted seven hundred sixty-eight dollars ($768) monthly as a basic allowance. Beginning January 1, 2001, the basic allowance increase for a couple is the dollar amount of the annual cost-of-living increase in the federal SSI benefit rate for a couple. The increase may be rounded up. ( )

03. SIGRIF. A participant living in a semi-independent group residential facility (SIGRIF) is budgeted three hundred forty-nine dollars ($349) monthly as a basic allowance. ( )

502. SPECIAL NEEDS ALLOWANCES.
Special needs allowances are a restaurant meals allowance and a service animal food allowance. ( )

01. Restaurant Meals. The restaurant meals allowance is fifty dollars ($50) monthly. A physician must state the participant is physically unable to prepare food in his home. A participant able to prepare his food, but living in a place where cooking is not permitted, may be budgeted the restaurant meals allowance for up to three (3) months. ( )

02. Service Animal Food. The service animal food allowance is seventeen dollars ($17) monthly. The allowance is budgeted for a blind or disabled participant, using a trained service animal. ( )

503. -- 511. (RESERVED)

512. ROOM AND BOARD HOME ALLOWANCE.
Room and board is a living arrangement where the participant purchases lodging (room) and meals (board) from a person he lives with who is not his parent, child or sibling. ( )

01. Budgeted Room and Board Allowance. Beginning January 1, 2006, a participant living in a room and board home is budgeted six hundred ninety-three dollars ($693). Beginning July 1, 2013, the Room and Board allowance will be adjusted annually by the percentage of the annual cost-of-living increase in the federal SSI benefit rate for a single person. This adjustment will be effective on January 1st of each year. The room and board allowance increase will be rounded to the next dollar. ( )

02. Basic Allowance for Participant in Room and Board Home. A participant living in a room and board home is budgeted seventy-seven dollars ($77) monthly as a basic allowance. Beginning July 1, 2013, this basic allowance will be adjusted annually by the percentage of the annual cost-of-living increase in the federal SSI benefit rate for a single person. This adjustment will be effective on January 1st of each year. The basic allowance increase will be rounded to the nearest dollar. ( )

513. RESIDENTIAL ASSISTED LIVING FACILITY AND CERTIFIED FAMILY HOME ALLOWANCES.
A participant living in a Residential Assisted Living Facility (RALF), in accordance with IDAPA 16.03.22, "Residential Assisted Living Facilities," or a Certified Family Home (CFH), in accordance with IDAPA 16.03.19, "Certified Family Homes," is budgeted a basic allowance of ninety-six dollars ($96) monthly. Beginning July 1, 2013, this basic allowance will be adjusted annually by the percentage of the annual cost-of-living increase in the federal SSI benefit rate for a single person. This adjustment will be effective on January 1st of each year. The basic allowance increase will be rounded to the nearest dollar. ( )

01. Budgeted Monthly Allowance Based On Level of Care. A participant is budgeted a monthly allowance for care based on the level of care received as described in Section 515 of these rules. If the participant

does not require State Plan Personal Care Services (PCS), his eligibility and allowances are based on the Room and Board rate in Section 512 of these rules. ( )

02. Care Levels and Monthly Allowances. Beginning January 1, 2006, care levels and monthly allowances are those listed in Table 513.02 of these rules. Beginning July 1, 2013, the RALF and CFH allowances for participants living in a RALF or CFH on State Plan PCS will be adjusted annually by the percentage of the annual cost-of-living increase in the federal SSI benefit rate for a single person. This adjustment will be effective on January 1st of each year. This increase will be rounded to the next dollar.

TABLE 513.02 - STATE PLAN PCS CARE LEVELS AND ALLOWANCES AS OF 1-1-06

	Level of Care	Monthly Allowance
a.	Level I	Eight hundred and thirty-five dollars ($835)
b.	Level II	Nine hundred and two dollars ($902)
c.	Level III	Nine hundred and sixty-nine dollars ($969)

( )

03. CFH Operated by Relative. A participant living in a Certified Family Home (CFH) operated by his parent, child or sibling is not entitled to the CFH State Plan PCS allowances. He may receive the allowance for a person living with a relative as described in Section 501 of these rules. A relative for this purpose is the participant's parent, child, sibling, aunt, uncle, cousin, niece, nephew, grandparent or grandchild by birth, marriage, or adoption. ( )

514. AABD CASH PAYMENTS.
Only a participant who receives an SSI payment for the month is eligible for an AABD cash payment in the same month. The AABD cash payment amount is based on the participant's living arrangement described in Subsections 514.01 through 514.04 of this rule. An AABD cash payment is the difference between a participant's financial need and his countable income. If the difference is not an even dollar amount, AABD cash is paid at the next higher dollar. AABD cash is paid electronically as provided in IDAPA 16.03.20, "Electronic Payments of Public Assistance, Food Stamps, and Child Support." ( )

01. Single Participant Maximum Payment. For a single participant described in Section 501.01 of these rules, the maximum monthly AABD cash payment amount is fifty-three dollars ($53). ( )

02. Couple or Participant Living with Essential Person Maximum Amount. For participants described in Subsection 501.02 of these rules, the maximum monthly AABD cash payment amounts are: ( )

a. A couple receives twenty dollars ($20); or ( )

b. A participant living with essential person receives eighteen dollars ($18). ( )

03. Semi-Independent Group Maximum Payment. For a participant described in Subsection 501.03 and Section 511 of these rules, the maximum monthly AABD cash payment amount is one hundred sixty-nine dollars ($169). ( )

04. Room and Board Maximum Payment. For a participant described in Section 512 of these rules, the maximum monthly AABD cash payment is one hundred ninety-eight dollars ($198). ( )

05. RALF and CFH. A participant residing in a RALF or CFH is not eligible for an AABD cash payment. ( )

515. RESIDENTIAL AND ASSISTED LIVING FACILITY CARE AND CERTIFIED FAMILY HOME ASSESSMENT AND LEVEL OF CARE.

The participant's need for care, level of care, plan of care, and the licensed facility's ability to provide care is assessed by the Bureau of Long-Term Care Services (BLTCS) when a participant is admitted. The BLTCS must approve the placement before Medicaid can be approved. ( )

516. CHANGE IN LEVEL OF CARE.
A change in the participant's level of care affects eligibility as described in Subsections 516.01 and 516.02 of this rule. ( )

01. Increase in Level of Care. An increase in level of care is effective the month the BLTCS reassesses the level of care. ( )

02. Decrease in Level of Care. When the BLTCS verifies the participant has a decrease in his level of care, and his income exceeds his new level of care, his Medicaid must be stopped after timely notice. When the BLTCS determines the participant no longer meets any level of care, his eligibility and allowances are based on the Room and Board rate in Section 512 of these rules. ( )

517. -- 520. (RESERVED)

521. MOVE FROM RESIDENTIAL ASSISTED LIVING FACILITY OR CERTIFIED FAMILY HOME TO LIVING SITUATION OTHER THAN A NURSING HOME OR HOSPITAL.
A participant may move from a licensed facility to a living situation, other than a nursing home or hospital. No change to his Medicaid income limit is made, based on the move, until the next month. ( )

522. -- 523. (RESERVED)

524. MOVE FROM NURSING HOME OR HOSPITAL.
If a participant moves from a nursing home or hospital to a different living situation, other than a residential and assisted living facility or certified family home, his AABD cash for the month is determined as if he lived in his new situation the entire month. His AABD cash is his AABD allowances less his countable income. ( )

525. -- 530. (RESERVED)

531. COUPLE BUDGETING.
Income of an AABD participant and his participant spouse living in the same household is combined. The twenty dollar ($20) standard income disregard and the sixty-five dollar ($65) earned income disregard are subtracted once a month, per couple. Each member of a couple living in an institution must have income budgeted as a single person. A couple living together as of the first day of a month, is counted as living together throughout that month. Budgeting as a couple continues through the month the couple stops living together. For couple budgeting, a household is a home, a rental, another's household, or room and board. ( )

532. -- 539. (RESERVED)

540. STANDARD DISREGARD.
The standard disregard is twenty dollars ($20). The standard disregard is first subtracted from unearned income. If the unearned income is less than the standard disregard, the remainder of the standard disregard is subtracted from earned income. The participant retains the standard disregard for his personal use. ( )

01. Standard Disregard and a Couple. Subtract the standard disregard only once a month from the combined income of a couple in the same household. ( )

02. Standard Disregard Exception. The standard disregard must not be subtracted from nonservice-connected VA payments, Title IV-E foster care payments, or BIA General Assistance. ( )

541. SUBTRACTION OF EARNED INCOME DISREGARDS.
Earned income disregards are subtracted from AABD earned income in the order listed in Sections 542 through 547. They are subtracted the month the income is paid. ( )

542. SIXTY-FIVE DOLLAR EARNED INCOME DISREGARD.
Sixty-five dollars ($65) of earned income in a month are not counted. Subtract the sixty-five dollar ($65) disregard only once a month from the combined income of a couple in the same household. The sixty-five dollar ($65) disregard is a work incentive. The participant retains the sixty-five dollar ($65) disregard for his personal use. ( )

543. IMPAIRMENT-RELATED WORK EXPENSE (IRWE) DISREGARD.
Impairment-related work expenses are items and services needed and used by a disabled AABD participant to work. The items must be needed because of the participant's impairment. The items may be bought or rented. The cost for impairment-related work expenses is subtracted from the participant's earned income, for eligibility and AABD cash amount. An item disregarded as a blindness work expense, or as part of a PASS, cannot be disregarded as an impairment-related work expense. ( )

544. ONE-HALF REMAINING EARNED INCOME DISREGARD.
One-half (1/2) of remaining earned income, after the IRWE is subtracted, is not counted. The one-half (1/2) of remaining earned income is a work incentive. The participant retains the one-half (1/2) of remaining earned income for his personal use. ( )

545. BLINDNESS WORK EXPENSE DISREGARD.
The cost of earning income is subtracted from the earned income of a blind person. The blind person must be under age sixty-five (65). If the blind person is age sixty-five (65) or older, he must receive SSI for blindness, or have received AABD the month before he became sixty-five (65). ( )

01. Blind Work Expense Limit. Blindness work expenses are subtracted from earned income. The amount subtracted must not exceed the participant's monthly earnings. ( )

02. No Duplication for Blind Work Expenses. Expenses, subtracted under the impairment-related work expense disregard, cannot be subtracted again under this disregard. ( )

546. PLAN TO ACHIEVE SELF-SUPPORT (PASS).
A blind or disabled participant, with an approved plan to achieve self-support (PASS), must have income and resources disregarded. Conditions for this disregard are listed in Subsections 546.01 through 546.03. ( )

01. Under Age Sixty-Five. The participant must be under sixty-five (65), or receive AABD for the blind or disabled during the month of his sixty-fifth birthday. ( )

02. Approved PASS. A participant receiving SSI must have a PASS approved by SSA. A participant not receiving SSI must have a PASS approved by the Department. ( )

03. Income Necessary for Self-Support. The income and resources disregarded under the PASS must be necessary for the participant to achieve self-support. ( )

547. PASS APPROVED BY DEPARTMENT.
A PASS approved by the Department must be in writing. The PASS must contain all the items in Subsections 547.01 through 547.06. ( )

01. Occupational Objective. The PASS must have a specific occupational objective. ( )

02. Specific Goals. The PASS must have specific goals for using the disregarded income and resources to achieve self-support. ( )

03. Time Limit. The PASS must show a specific target date to achieve the goal. An approved PASS is limited to an initial period of eighteen (18) months. Extensions may be granted if needed. ( )

a. The first extension period lasts up to eighteen (18) months. ( )

b. A second eighteen (18) month extension period can be granted. ( )

c. A final extension, up to twelve (12) months can be granted. The PASS can be extended a total of forty-eight (48) months, when the original PASS goal required extensive education or vocational training. ( )

04. No Duplication of Disregards. An item disregarded as an impairment-related work expense or under the blindness exception cannot be disregarded under the PASS. ( )

05. Resource Limitation. The PASS disregard must not be used for resources, unless the resources cause the participant to be ineligible without the PASS disregard. ( )

06. Disregard of Resources. The PASS must list the participant's resources. The PASS must list any resources the participant will receive under the plan. The PASS must show how the resources will be used toward the occupational goal. The PASS must list goal-related items or activities requiring savings or purchases and the amounts the participant plans to save or spend. The PASS must list resources disregarded under the plan. The PASS must show resources disregarded under the plan can be identified separate from the participant's other resources. ( )

548. -- 599. (RESERVED)

600. DEPARTMENT NOTICE RESPONSIBILITY.
The participant must be notified of changes in eligibility or AABD cash amount. The notice must give the effective date, the reason for the action, the rule that supports the action, and appeal rights. ( )

601. ADVANCE NOTICE RESPONSIBILITY.
When a reported change results in closure or decrease, the participant must be notified at least ten (10) calendar days before the effective date of the action. ( )

602. ADVANCE NOTICE NOT REQUIRED.
Advance notice is not required when a condition listed in Subsections 602.01 through 602.12 exists. The participant must be notified by the date of the action. ( )

01. Death of Participant. The Department has proof of the participant's death. ( )

02. Participant Request. The participant requests closure in writing. ( )

03. Participant in Institution. The participant is admitted or committed to an institution. Further payments to the participant do not qualify for federal financial participation under the state plan. ( )

04. Nursing Care. The participant is placed in a nursing facility, or Intermediate Care for Persons with Intellectual Disabilities. ( )

05. Participant Address Unknown. The participant's whereabouts are unknown. Department mail is returned with no forwarding address. ( )

06. Aid in Another State. A participant is approved for aid in another state. ( )

07. Eligible One Month. The participant is eligible for aid only during the calendar month of his application for aid. ( )

08. Non-Citizen With Emergency. The participant is an illegal or legal non-citizen whose Medicaid eligibility ends the day his emergency medical condition stops. ( )

09. Retroactive Medicaid. The participant's Medicaid eligibility is for a prior period. ( )

10. Special Allowance. A special allowance granted for a specific period is stopped. ( )

11. Patient Liability. Patient liability or client participation changes. ( )

12. Level of Care. The participant's level of care changes. ( )

603. (RESERVED)

604. PARTICIPANT DETERMINED SSI ELIGIBLE AFTER APPEAL.
If the SSA finds a participant is blind or disabled, based on an appeal of an SSA decision, the participant meets the disability requirements for AABD cash and related Medicaid on the effective date determined by SSA. AABD cash payments are effective no earlier than the month SSA issues the favorable decision for SSI payments. ( )

605. REPORTING REQUIREMENTS.
The participant must report changes in circumstances verbally or in writing, by the tenth of the month following the month in which the change occurred. The participant must show good cause for not reporting changes. If failure to report a change results in an overpayment, the overpayment must be recovered. ( )

606. REQUIRED PROOF.
The participant must prove continuing eligibility for aid when a change could affect eligibility. The participant is allowed ten (10) calendar days to provide requested proof. The case is closed if the participant does not provide proof within ten (10) days and does not have good cause for not providing proof. ( )

607. CHANGES AFFECTING ELIGIBILITY OR AABD CASH AMOUNT.
If a participant reports a change that results in an increase, AABD cash is increased effective the month of report. If a participant reports a change that results in a decrease, AABD cash is decreased or ended effective the first month after proper notice. ( )

608. AABD CASH UNDERPAYMENT.
If the Department is at fault for issuing a payment less than the participant should have received, the Department issues a supplemental payment for the difference. ( )

609. AABD CASH OVERPAYMENT.
If the participant is paid more AABD cash than he is eligible for, the Department must collect the overpayment. The Department must notify the participant of the right to a hearing, the method for repayment and the need for a repayment interview. ( )

610. OFFSET OF OVERPAYMENT AND UNDERPAYMENT.
When an underpayment is computed, any overpayment for that month is subtracted from the underpayment. When an overpayment is computed, any underpayment for the month is subtracted. ( )

611. -- 616. (RESERVED)

617. HEARING REQUEST.
A participant may request a hearing to contest a Department decision. The participant must make the request within thirty (30) days of the date the Department mailed the notice of decision. Hearings will be conducted according to IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings." ( )

618. CONTINUED BENEFITS PENDING A HEARING DECISION.
The participant may continue to receive benefits upon request, pending the hearing decision. The Department must receive the participant's request for continued benefits before the effective date of the Department's action stated in the notice of decision. An applicant cannot receive continued benefits when appealing a denial for failure to provide citizenship and identity verification after the expiration of a reasonable opportunity period. ( )

01. Amount of Assistance. The Department will continue the participant's assistance at the current month's level while the hearing decision is pending, unless another change affecting assistance occurs. ( )

02. Continued Eligibility. The participant must continue to meet all eligibility requirements not related to the hearing issue. ( )

03. Overpayment. When the hearing decision is in the Department's favor, the participant must repay

assistance received while the hearing decision was pending. ( )

619. (RESERVED)

620. MEDICAID OVERPAYMENT.
If the participant receives Medicaid services during a month he is not eligible, the Department must collect the overpayment. If too little patient liability or client participation is computed, the Department must collect the overpayment. The participant must be notified of the overpayment. ( )

621. CHANGES IN PATIENT LIABILITY.

01. Increase in Patient Liability. If the patient liability is increased for the current or a past month, the Department will collect the patient liability directly from the client. ( )

02. Decrease in Patient Liability. If the patient liability is decreased for a current or past month, the funds will be paid to the provider and the provider must reimburse the client for the portion of the costs the client paid in excess of their patient liability. ( )

622. (RESERVED)

623. ELIGIBILITY REDETERMINATION.
An eligibility redetermination is completed at least once every year and when a change affecting eligibility occurs. ( )

624. -- 649. (RESERVED)

650. COOPERATION WITH THE QUALITY CONTROL PROCESS.
When the Department or federal government selects a case for review in the quality control process, the participant must cooperate in the review of the case. Benefits must be stopped, following advance notice, when a participant is unwilling to take part in the quality control process. If the participant reapplies for benefits he must fully cooperate with the quality control process before the application can be approved. ( )

651. -- 699. (RESERVED)

700. MEDICAID ELIGIBILITY.
A participant must meet the eligibility requirements for at least one (1) Medicaid coverage group to be eligible for Medicaid benefits. Income and circumstances in the current month are used for eligibility for the current month. Resources are counted as of the first moment of the month. ( )

701. MEDICAID APPLICATION.
An adult participant, a legal guardian or a representative of the participant must sign the application. The participant must submit the application to the Department. A Medicaid application may be made for a deceased person. ( )

702. MEDICAL SUPPORT COOPERATION.
Medical support rights are assigned to the Department by signature on the application. The participant must cooperate with the Department to secure medical support and payments, to be eligible for Medicaid. The participant must cooperate on behalf of himself and any participant for whom he can legally assign rights. A participant who cannot legally assign his own rights must not be denied Medicaid if the legally responsible person does not cooperate. ( )

703. CHILD SUPPORT COOPERATION.
The participant must cooperate to identify and locate the noncustodial parent, establish paternity, and establish, modify and enforce a child medical support order, to be eligible for Medicaid. This includes support payments received directly from the noncustodial parent. The cooperation requirement is waived for poverty level pregnant women exempt from cooperating in establishing paternity and obtaining medical support from, or derived from, the father of a child born out of wedlock. A participant who cannot legally assign his own rights must not be denied

Medicaid if the legally responsible person does not cooperate. ( )

704. COOPERATION DEFINED.
Cooperation includes, but is not limited to, providing all information to identify and locate the noncustodial parent. Cooperation for Medicaid includes identifying other liable third party payers. ( )

01. Name of Noncustodial Parent. The participant must provide the first and last name of the noncustodial parent. ( )

02. Information About Noncustodial Parent. The participant must also provide at least two (2) pieces of information, about the noncustodial parent, listed in Subsections 703.02.a. through 703.02.g. ( )

a. Birth Date. ( )

b. Social Security Number. ( )

c. Current address. ( )

d. Current phone number. ( )

e. Current employer. ( )

f. Make, model, and license number of any motor vehicle owned by the noncustodial parent. ( )

g. Names, phone numbers and addresses of the parents of the noncustodial parent. ( )

705. GOOD CAUSE FOR NOT COOPERATING IN SECURING MEDICAL AND CHILD SUPPORT.
The participant may claim good cause for failure to cooperate in securing medical and child support for himself or a minor child. Good cause is limited to the reasons listed in Subsections 705.01 through 705.03. ( )

01. Rape or Incest. There is proof the child was conceived as a result of incest or rape. ( )

02. Physical or Emotional Harm. There is proof the child's non-custodial parent may inflict physical or emotional harm to the participant, the child, the custodial parent or the caretaker relative. There is proof another person may inflict physical or emotional harm to an AABD-related participant if the participant cooperates in securing medical and child support. ( )

03. Minimum Information Cannot Be Provided. Substantial and credible proof is provided indicating the participant cannot provide the minimum information regarding the non-custodial parent. ( )

706. CLOSURE AFTER REVIEW OF GOOD CAUSE REQUEST.
If the participant claims good cause for not cooperating, but the Department determines there is not good cause, the participant must be given the opportunity to withdraw the application or have his Medicaid closed. ( )

707. APPLICATION REQUIREMENTS FOR POTENTIAL MEDICAL COVERAGE.

01. Group Health Plan Enrollment Requirement. Each participant must apply for and enroll in a cost-effective employer group health plan as a condition of eligibility for Medicaid. Medicaid coverage must not be denied, delayed, or stopped pending the start of a participant's group health insurance coverage. A child entitled to enroll in a group health plan must not be denied Medicaid coverage solely because his caretaker fails to apply for the child's enrollment. ( )

02. Medicare Enrollment Requirement. Each participant who may be eligible for Medicare must apply for all parts of Medicare parts A, B, and D for which he is likely to be eligible, as a condition of eligibility for Medicaid. ( )

708. MEDICAID QUALIFYING TRUST PAYMENTS.

For Medicaid Qualifying Trusts established before August 11, 1993, the maximum payment permitted to be made to a participant from the trust must be counted for Medicaid eligibility. The maximum is counted whether or not the trustee actually distributes payments. ( )

709. MEDICAID ELIGIBILITY FOR AABD PARTICIPANT.
A participant eligible for AABD cash is eligible for Medicaid, unless he is in an ineligible institution, receives excess payment from a Medicaid Qualifying Trust, or has an irrevocable trust that is not exempt. ( )

710. -- 719. (RESERVED)

720. LONG-TERM CARE RESIDENT AND MEDICAID.
A resident of a long-term care facility must meet the AABD eligibility criteria to be eligible for Medicaid. A long-term care facility is a nursing facility or an intermediate care facility for persons with intellectual disabilities. The need for long-term care is determined using IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." ( )

01. Resources of Resident. The resident's resource limit is two thousand dollars ($2,000). Resources of a married person in long-term care are computed using Federal Spousal Impoverishment rules. Under the SSI method, spouses can use the three thousand dollar ($3,000) couple resource limit if more advantageous. The couple must have lived in the nursing home, in the same room, for six (6) months. ( )

02. Medicaid Income Limit of Long-Term Care Resident Thirty Days or More. The monthly income limit for a long-term care facility resident is three (3) times the Federal SSI benefit for a single person. To qualify for this income limit the participant must be, or be likely to remain, in long-term care at least thirty (30) consecutive days. ( )

03. Medicaid Income Limit of Long-Term Care Resident Less Than Thirty Days. The monthly income limit, for the resident of a long-term care facility for less than thirty (30) consecutive days, is the AABD income limit for the participant's living situation before long-term care. Living situations before long-term care do not include hospital stays. ( )

04. Income Not Counted. The income listed in Subsections 720.04.a. through 720.04.e. of these rules is not counted to compute Medicaid eligibility for a long-term care facility resident. This income is counted in determining participation in the cost of long-term care. ( )

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

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

c. Any VA Aid and Attendance allowance, including any increment 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. ( )

d. RSDI benefit increases, from cost-of-living adjustments (COLA) after April 1977, are not counted if they made the participant lose SSI or AABD cash. The COLA increases after SSI or AABD cash stopped are not counted. ( )

e. Income paid into an income trust exempt from counting for Medicaid eligibility under Subsection 872.02 of these rules is used for patient liability. Income paid to the trust and not used for patient liability, is subject to the asset transfer penalty. ( )

05. Medicaid Participant Residing in a Skilled Nursing Facility. When a Medicaid participant who is a resident of a skilled nursing facility and meets that level of care as evidenced by the PASARR defined in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Section 227, the resident is determined to be disabled for the duration of his residency in the skilled nursing facility. ( )

721. QUALIFIED LONG-TERM CARE PARTNERSHIP POLICY.

Participants who have received, or are entitled to receive, benefits under a Qualified Long-Term Care Partnership policy issued in Idaho after November 1, 2006, will have certain resources disregarded as described in Subsections 721.01 and 721.02 of these rules. ( )

01. Value of the Participant's Resources. The total dollar amount of the insurance benefits paid out for a policy holder of a Qualified Long-Term Care Partnership policy is disregarded in calculating the value of the participant's resources for long-term care Medicaid eligibility. The amount that is disregarded is determined on the effective date of an initial application approval for long-term care Medicaid benefits. ( )

02. Resource Disregard Excluded From Estate Recovery. The amount of the resources disregarded from a Qualified Long-Term Care Partnership policy under Subsection 721.01 of this rule, is deducted from the assets of the estate for Medicaid estate recovery. ( )

722. PATIENT LIABILITY.
Patient liability is the participant's income counted toward the cost of long-term care. Patient liability begins the month after the first full calendar month the patient is receiving benefits in a long-term care facility. ( )

723. PATIENT LIABILITY FOR PERSON WITH NO COMMUNITY SPOUSE.
For a participant with no community spouse, patient liability is computed as described in Subsections 723.01 through 723.03 of this rule. ( )

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 of this rule. ( )

02. Community Property Income of Long-Term Care Participant with Long-Term Care Spouse. Patient liability income for a participant, whose spouse is also in long-term care, choosing the community property method, is one-half (1/2) his share of the couple's community income, plus his own separate income. The deductions in Table 723.03 are subtracted from his income. ( )

03. Income of Participant in Facility. A participant residing in the long-term care facility at least one (1) full calendar month, beginning with his most recent admission, must have the deductions in Subsection 723.03 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. ( )

a. AABD Income Exclusions. Subtract income excluded in determining eligibility for AABD cash. ( )

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. ( )

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. ( )

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. ( )

e. First Ninety ($90) Dollars of VA Pension. Subtract the first ninety ($90) dollars of a VA pension for a veteran in a private long-term care facility or a State Veterans Nursing Home. ( )

f. Personal Needs. Subtract forty dollars ($40) for the participant's personal needs. For a veteran or surviving spouse in a private long-term care facility or a State Veterans Nursing Home the first ninety ($90) dollars of VA pension substitutes for the forty dollar ($40) personal needs deduction. ( )

g. Employed and Sheltered Workshop Activity Personal Needs. For an employed participant or

participant engaged in sheltered workshop or work activity center activities, 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. ( )

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. ( )

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. ( )

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. ( )

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. ( )

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 is the same person, the total deduction for guardian and trust fees must not exceed twenty-five dollars ($25) monthly. ( )

m. Trust Fees. Subtract up to twenty-five dollars ($25) monthly paid to the trustee for administering the participant's trust. ( )

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 that are purchased or rented to perform work. The items must be needed because of the participant's impairment. The actual monthly expense of the impairment-related items is subtracted. Expenses must not be averaged. ( )

o. Income Garnished for Child Support. Subtract income garnisheed for child support to the extent the expense is not already accounted for in computing the maintenance need standard. ( )

p. Incurred Medical Expenses. Subtract amounts for certain limited medical or remedial care expenses that have current balances owed and are deemed medically necessary as defined in IDAPA 16.03.09, "Medicaid Basic Plan Benefits." Current medical expenses that are not covered by the Idaho Medicaid Plan, or by a third party, may be deducted from the base participation amount. ( )

q. Pre-existing Medical Expenses. Subtract amounts for medical and remedial care expenses incurred within the three (3) months prior to the month of application. The deductions for medical and remedial care expenses are limited to those medically necessary expenses incurred by the participant for the participant's care. The deduction for medical and remedial care expenses is limited to the amount of liability owed by the participant, and if applicable, after any third-party insurance has been applied. The deduction for medical and remedial care expenses that were incurred as the result of imposition of a transfer of assets penalty period is limited to zero. ( )

724. INCOME OWNERSHIP OF PARTICIPANT WITH COMMUNITY SPOUSE.
Income ownership of a long-term care participant with a community spouse is determined before patient liability is computed. The participant's income ownership is counted as shown in Subsections 724.01 through 724.04. ( )

01. Income Paid in the Name of Spouse. Income paid solely in the name of a spouse, and not paid from a trust, is the separate income of the spouse. ( )

02. Payment in Name of Both Spouses. Income paid in the names of both the long-term care participant and the community spouse is divided evenly between each spouse. ( )

03. Payment in Name of Spouse or Spouses and Another Person. Income paid in the names of the participant and/or the community spouse and another person is counted as available to each spouse, in proportion to the spouse's ownership. If payment is made to both spouses, and no proportion of ownership is specified, one-half of the income is counted to each spouse. ( )

04. Payment of Aid and Attendance. In the case of VA Aid and Attendance Allowance paid in the veteran's name, with an increment for the veteran's spouse, the increment is counted to the veteran. ( )

725. PATIENT LIABILITY FOR PARTICIPANT WITH COMMUNITY SPOUSE.
After income ownership is decided, patient liability is determined using steps in Table 725.

TABLE 725 - INCOME DEDUCTIONS FOR PARTICIPANT IN FACILITY

Step		Procedure
01.	AABD Income Exclusions	Subtract income excluded in determining eligibility for AABD cash.
02.	Aid and Attendance and UME Allowances	Subtract a VA Aid and Attendance allowance and Unusual Medical Expense (UME) allowance for a veteran or surviving spouse, unless the veteran lives in a state operated veterans' home.
03.	SSI Payment Two (2) Months	Subtract the SSI payment for a participant entitled to receive SSI at his at-home rate for up to two (2) months, while temporarily in a long-term care facility.
04.	AABD Cash	Subtract the AABD cash payment and income used to compute AABD cash, for a participant eligible to have his AABD cash continued up to three (3) months, while he is in long-term care.
05.	VA Pension	Subtract the first ninety (90$) of the VA pension for a veteran.
06.	Personal Needs	Subtract forty dollars ($40) for the participant's personal needs. Do not allow this deduction for a veteran.
07.	Employed and Sheltered Workshop Activity Needs	For an employed participant or participant engaged in sheltered workshop or work activity center activities subtract the lower of two hundred dollars ($200) or his earned income.

TABLE 725 - INCOME DEDUCTIONS FOR PARTICIPANT IN FACILITY		
	Step	**Procedure**
08.	Community Spouse Allowance: Step a.	Compute the Community Spouse Allowance (CSA) using Step a. through Step c. Compute the Shelter Adjustment. Add the current Food Stamp Program Standard Utility Allowance to the community spouse's shelter costs. Shelter costs include rent, mortgage principal and interest, homeowner's taxes, insurance, and condominium or cooperative maintenance charges. The Standard Utility Allowance must be reduced by the value of any utilities included in maintenance charges for a condominium or cooperative. Subtract the Shelter Standard from the shelter and utilities. The Shelter Standard is thirty percent (30%) of one hundred fifty percent (150%) of one-twelfth (1/12) of the income official poverty line defined by the Federal Office of Management and Budget (OMB) for a family of two (2) persons. The Shelter Adjustment is the positive balance remaining.
09.	Community Spouse Allowance: Step b.	Compute the Community Spouse Need Standard (CSNS). Add the Shelter Adjustment to the minimum CSNS. The minimum CSNS equals one hundred fifty percent (150%) of one-twelfth (1/12) of the income official poverty line defined by the OMB for a family unit of two (2) members. The minimum CSNS is revised annually in July. The total CSNS may not exceed the maximum CSNS. The maximum CSNS is computed by multiplying one thousand five hundred dollars ($1,500) by the percentage increase in the consumer price index for all urban Consumers (all items; U.S. city average) between September 1988 and the September before the current calendar year. The maximum CSNS is revised annually in January.
10.	Community Spouse Allowance: Step c.	Compute the Community Spouse Allowance. Subtract the community spouse's gross income from the CSNS. The community spouse’s income includes income produced by his resources. Round any remaining cents to the next higher dollar. Any positive balance remaining is the CSA. The CSA is subtracted as actually paid to the community spouse, up to the computed maximum. A larger spouse support amount must be used as the CSA, if court-ordered. The CSA ordered by a court is not subject to the CSA limit.

TABLE 725 - INCOME DEDUCTIONS FOR PARTICIPANT IN FACILITY		
Step		**Procedure**
11.	Family Member Allowance (FMA)	Compute the family member's gross income. Subtract the family member's gross income from the minimum CSNS. Divide the difference by three (3). Round cents to the next higher dollar. Any remainder is the FMA for that family member. The FMA is allowed, whether or not it is actually paid by the participant. A family member is, or could be claimed, as a dependent on the Federal income tax return of either spouse. The family member must be a minor or dependent child, dependent parent or dependent sibling of either spouse. The family member must live in the community spouse's home.
12.	Medicare and Health Insurance Premiums	Subtract expenses for Medicare and other health insurance premiums, and deductibles or coinsurance charges, not subject to payment by a third party. Deduction of Medicare Part B premiums is limited to the first two (2) months of Medicaid eligibility. Do not subtract the Medicare Part B premiums if the participant got SSI or AABD cash the month prior to the month for which patient liability is being computed.
13.	Mandatory Income Taxes	Subtract taxes mandatorily withheld from unearned income for income tax purposes. To qualify for deduction of mandatory taxes, the tax must be withheld from income before the participant receives the income.
14.	Guardian Fees	Subtract court-ordered guardianship fees of the lesser of ten percent (10%) of the monthly benefit handled by the guardian, or twenty-five dollars ($25). Where the guardian and trustee are the same person, the total deduction for guardian and trust fees must not exceed twenty-five dollars ($25) monthly.
15.	Trust Fees	Subtract up to twenty-five dollars ($25) monthly paid to the trustee for administering the participant's trust.
16.	Impairment Related Work Expenses	Subtract impairment-related work expenses for an employed participant who is blind or disabled under AABD criteria. Impairment-related work expenses are purchased or rented items and services, purchased or rented to perform work. The items must be needed because of the participant's impairment. The actual monthly expense of the impairment-related items is subtracted. Expenses must not be averaged.
17.	Income Garnisheed for Child Support	Subtract income garnisheed for child support to the extent the expense is not already accounted for in computing the Family Member Allowance.
18.	Incurred Medical Expenses	Subtract amounts for certain limited medical or remedial care expenses that have current balances owed and are deemed medically necessary as defined in IDAPA 16.03.09, “Medicaid Basic Plan Benefits.” Current medical expenses that are not covered by the Idaho Medicaid Plan, or by a third party, may be deducted from the base participation amount.

TABLE 725 - INCOME DEDUCTIONS FOR PARTICIPANT IN FACILITY		
Step		**Procedure**
19.	Pre-existing Medical Expenses	Subtract amounts for medical and remedial care expenses incurred within the three (3) months prior to the month of application. The deductions for medical and remedial care expenses are limited to those medically necessary expenses incurred by the participant for the participant's care. The deduction for medical and remedial care expenses is limited to the amount of liability owed by the participant, and if applicable, after any third-party insurance has been applied. The deduction for medical and remedial care expenses that were incurred as the result of imposition of a transfer of assets penalty period is limited to zero.

( )

726. PERSONAL NEEDS SUPPLEMENT (PNS).
A nursing home participant may receive a PNS to bring his gross income up to forty dollars ($40). Gross income is income after exclusions and before disregards. Gross income includes money withheld to recover an AABD overpayment. The PNS is the difference between the participant's gross income and forty dollars ($40). If not in an even dollar amount, the PNS is rounded up to the next dollar. The participant's income including the PNS must not exceed forty dollars ($40). ( )

727. FAIR HEARING ON CSA DECISION.
Either spouse may ask for a fair hearing, to show the community spouse needs a higher CSA. The hearing officer must consider if, due to unusual conditions, using the computed CSA causes significant financial hardship for the community spouse. If the fair hearing decision finds the community spouse needs more income than the CSA, the CSA must include the additional income. ( )

728. -- 730. (RESERVED)

731. MEDICAID ELIGIBILITY OF MARRIED PERSONS.
There are three (3) methods for Medicaid eligibility of an aged, blind, or disabled married person: The SSI method, the Community Property (CP) method, and the Federal Spousal Impoverishment (FSI) method. The FSI method takes precedence. If the participant is not subject to the FSI method, the CP or SSI methods can be used. ( )

732. CHOOSING FSI, SSI, OR CP RESOURCE COUNTING METHOD.
Table 732 is used determine the resource counting method for a married person. If an HCBS participant with a spouse at home is not eligible using the FSI method, resources are computed using the SSI/CP method.

TABLE 732 - CHOOSING FSI, SSI, OR CP RESOURCE COUNTING METHOD					
	SPOUSE ONE (1) IN NURSING HOME BEFORE 9/30/89	SPOUSE ONE (1) IN NURSING HOME ON OR AFTER 9/30/89	SPOUSE ONE (1) AT HOME NO HCBS	SPOUSE ONE (1) AT HOME WITH HCBS BEFORE 9/30/89	SPOUSE ONE (1) AT HOME WITH HCBS ON OR AFTER 9/30/89
SPOUSE TWO (2) IN NURSING HOME BEFORE 9/30/89	SSI/CP	SSI/CP	SSI/CP	SSI/CP	SSI/CP

TABLE 732 - CHOOSING FSI, SSI, OR CP RESOURCE COUNTING METHOD					
SPOUSE TWO (2) IN NURSING HOME ON OR AFTER 9/30/89	SSI/CP	SSI/CP	FSI	SSI/CP	SSI/CP
SPOUSE TWO (2) AT HOME NO HCBS	SSI/CP	FSI	SSI/CP	SSI/CP	FSI
SPOUSE TWO (2) AT HOME WITH HCBS BEFORE 9/30/89	SSI/CP	SSI/CP	SSI/CP	SSI/CP	SSI/CP
SPOUSE TWO (2) AT HOME WITH HCBS ON OR AFTER 9/30/89	SSI/CP	SSI/CP	FSI	SSI/CP	SSI/CP

( )

733. CHOOSING FSI, SSI, OR CP INCOME COUNTING METHOD.
Table 733 is used determine the income counting method for a married person. If a participant subject to the FSI method is not eligible using FSI, income is computed using the SSI/CP method.

TABLE 733 - CHOOSING FSI, SSI, OR CP INCOME COUNTING METHOD					
	SPOUSE ONE (1) IN NURSING HOME BEFORE 9/30/89	SPOUSE ONE (1) IN NURSING HOME ON OR AFTER 9/30/89	SPOUSE ONE (1) AT HOME NO HCBS	SPOUSE ONE (1) AT HOME WITH HCBS BEFORE 9/30/89	SPOUSE ONE (1) AT HOME WITH HCBS ON OR AFTER 9/30/89
SPOUSE TWO (2) IN NURSING HOME BEFORE 9/30/89	SSI/CP	SSI/CP	FSI	SSI/CP	SSI/CP
SPOUSE TWO (2) IN NURSING HOME ON OR AFTER 9/30/89	SSI/CP	SSI/CP	FSI	SSI/CP	SSI/CP
SPOUSE TWO (2) AT HOME NO HCBS	FSI	FSI	SSI/CP	FSI	FSI

TABLE 733 - CHOOSING FSI, SSI, OR CP INCOME COUNTING METHOD					
SPOUSE TWO (2) AT HOME WITH HCBS BEFORE 9/30/89	SSI/CP	SSI/CP	FSI	SSI/CP	SSI/CP
SPOUSE TWO (2) AT HOME WITH HCBS ON OR AFTER 9/30/89	SSI/CP	SSI/CP	FSI	SSI/CP	SSI/CP

( )

734. CHOOSING FSI, SSI, OR CP PATIENT LIABILITY OR CLIENT PARTICIPATION METHOD.
Table 734 is used determine the patient liability or client participation method for a married participant in long term care or receiving HCBS.

TABLE 734 - PATIENT LIABILITY OR CLIENT PARTICIPATION METHOD					
	SPOUSE ONE IN NURSING HOME BEFORE 9/30/89	SPOUSE ONE IN NURSING HOME ON OR AFTER 9/30/89	SPOUSE ONE AT HOME NO HCBS	SPOUSE ONE AT HOME WITH HCBS BEFORE 9/30/89	SPOUSE ONE AT HOME WITH HCBS ON OR AFTER 9/30/89
SPOUSE TWO IN NURSING HOME BEFORE 9/30/89	SSI/CP	SSI/CP	FSI	SSI/CP	SSI/CP
SPOUSE TWO IN NURSING HOME ON OR AFTER 9/30/89	SSI/CP	SSI/CP	FSI	SSI/CP	SSI/CP
SPOUSE TWO AT HOME NO HCBS	FSI	FSI	N/A	FSI	FSI
SPOUSE TWO AT HOME WITH HCBS BEFORE 9/30/89	SSI/CP	SSI/CP	FSI	SSI/CP	SSI/CP
SPOUSE TWO AT HOME WITH HCBS ON OR AFTER 9/30/89	SSI/CP	SSI/CP	FSI	SSI/CP	SSI/CP

( )

735. FEDERAL SPOUSAL IMPOVERISHMENT (FSI) METHOD OF COUNTING INCOME AND RESOURCES OF A COUPLE.
The FSI method must be used to compute income and resources of a married participant, who requires long-term care as defined in Section 010 of these rules, and who has a community spouse. The participant must have entered long-term care on or after September 30, 1989. Terms used in the FSI method are listed in Subsections 735.01 through 735.05 of this rule. ( )

01. Long-Term Care Spouse. The long-term care spouse must be in a medical institution or nursing facility, or be an HCBS participant, for thirty (30) consecutive days, or appear likely to meet the thirty (30) days requirement. ( )

02. Community Spouse. The community spouse is the husband or wife of the long-term care participant. A community spouse is not in long-term care and is not an HCBS participant. ( )

03. Continuous Period of Long-Term Care. A continuous period of long-term care is a period of residence either in a medical institution with nursing facility services, or at home with HCBS. A continuous period of long-term care is also a combination of institution and personal care services likely to last at least thirty (30) consecutive days. Absence from the institution, or a lapse in HCBS eligibility, of thirty (30) consecutive days breaks continuity. The thirty (30) consecutive days of long-term care must not begin on a day the participant is hospitalized. If the participant is hospitalized after the first day of the thirty (30) consecutive days, the hospital stay does not interrupt the thirty (30) consecutive days. ( )

04. Start of Continuous Period. The start of a continuous period of long-term care is the first month of long-term care or HCBS. ( )

05. Nursing Facility Services. Nursing facility services are services at the nursing facility level or the intermediate care for persons with intellectual disabilities level provided in a medical institution. ( )

736. ASSESSMENT DATE AND COUNTING FSI RESOURCES.
The assessment date is the start date of the first continuous period of long-term care. The Department does a one-time assessment to determine the value of the couple's community and separate resources as of the date of the first continuous period of long-term care. The resource assessment is done at the request of either spouse, after one spouse is in long-term care or meets the level of care for HCBS, whether or not the couple has applied for Medicaid. State laws relating to community property or the division of marital property are not applied in determining the FSI total combined resources of the couple. ( )

737. TREATMENT OF RESOURCES FOR ASSESSMENT.
The resource rules used in determining eligibility for AABD cash and Medicaid are also used in determining the couple's total combined resources for the FSI resource assessment with the following exceptions: ( )

01. Resources For Sale. Excess resources offered for sale, are not excluded from the couple's total combined resources for the FSI resource assessment. ( )

02. Jointly Owned Real Property. Jointly owned real property that is not the principal residence of the participant, is not excluded, if the community spouse is the joint owner. ( )

03. Long-term Care Partnership Policy. Resources excluded because of a participant's qualified long-term care policy are not excluded for the FSI resource assessment. ( )

04. Excluded Home. As defined in 42 U.S.C. 1396r-5(c)(5), an excluded home placed in trust retains its exclusion for purposes of the resource assessment. ( )

738. ONE-HALF SPOUSAL SHARE.
The spousal share is one-half (1/2) of the couple's total combined resources on the assessment date. The spousal share does not change, even if the participant leaves long-term care and then enters long-term care again. The Department must inform the couple of the resources counted in the assessment and the value assigned. The couple must sign the assessment form under penalty of perjury. The signature requirement may be waived for the long-term care spouse if

he or his representative says he is unable to sign the resources assessment. A copy of the assessment form must be provided to each spouse when eligibility is determined or when either spouse requests a assessment prior to application. ( )

739. -- 741. (RESERVED)

742. COMMUNITY SPOUSE RESOURCE ALLOWANCE.
The CSRA protects resources for the community spouse. The CSRA is determined by subtracting the greater of the minimum resource allowance, or the spousal share from the couple's total combined resources as of the first day of the application month. The deduction must not be more than the maximum resource allowance at the time eligibility is determined. ( )

743. RESOURCE ALLOWANCE LIMITS.
The maximum resource allowance is computed by multiplying sixty thousand dollars ($60,000) by the percentage increase in the consumer price index for all urban consumers (all items; U.S. city average) between September 1988 and the September before the current calendar year. The minimum resource allowance is computed by multiplying twelve thousand dollars ($12,000) by the percentage increase in the consumer price index for all urban consumers (all items; U.S. city average) between September 1988 and the September before the current calendar year. If the result is not an even one hundred dollar ($100) amount, round up to the next one hundred dollars ($100). The couple's resources exceeding the CSRA are counted for the long-term care spouse. ( )

744. INCOME COUNTED FIRST FOR CSRA REVISION.
Income is determined prior to determining resources. If the couple's income is more than the minimum CSNS, the CSRA cannot be increased. If the community spouse has less income than the minimum CSNS, the CSRA may be increased as provided in Section 745 of these rules. Couple income is the community spouse's gross income plus the long-term care spouse's income. The long-term care spouse's income is his gross income less the AABD cash income exclusions and his patient liability income deductions, but not the CSA deduction. ( )

745. UPWARD REVISION OF CSRA.
If the community spouse's income, including income from his CSA and income-producing resources in his CSRA, is less than the minimum CSNS, the CSRA may be increased. The CSRA is increased by enough resources, transferred from the long-term care spouse, to raise the community spouse's income to the minimum CSNS Resources included in the transfer are presumed to produce income at the treasury rate, whether or not the resources produce income. If the community spouse shows he is making reasonable use of his income and resources, to generate income, the Department may waive the treasury rate requirement. Actual income produced by the resources transferred to the community spouse is used to compute the CSA. A higher CSA can be requested under Section 727 of these rules. If the transferred resources produce more than the treasury rate, the actual income produced is used to determine the additional resources that can be transferred to the community spouse in the CSRA. The long-term care spouse must transfer the resources to the community spouse, or the CSRA is not revised. ( )

746. RESOURCE TRANSFER ALLOWANCE (RTA).
The resource transfer allowance (RTA) is computed by subtracting the community spouse's resources, at the time of application, from the CSRA. The community spouse must own less than the CSRA to get an RTA. The long term care spouse may transfer the RTA to the community spouse without an asset transfer penalty. If the institutional spouse transfers more than the RTA, the amount of the couple's resources over the CSRA counts as the institutional spouse's resources. After the month a long-term care spouse is determined Medicaid eligible under FSI, resources of the community spouse are not considered available to the him while he remains in long-term care. ( )

747. PROTECTED PERIOD FOR RTA TRANSFER.
The long-term care spouse has sixty (60) days, from the date his application is approved, to transfer his ownership of the RTA resources to the community spouse. The long-term care spouse must state, in writing, his intent to transfer the RTA resources to the community spouse, within the protected period, before he can be Medicaid eligible. Resources not transferred within the sixty (60) day protected period are available to the long-term care spouse, effective the day he entered the facility. ( )

748. EXTENSION FOR RTA TRANSFER.
The protected period can be extended beyond sixty (60) days if necessary because of the participant's circumstances. ( )

749. RESOURCE ELIGIBILITY FOR COMMUNITY SPOUSE.
When the community spouse is a Medicaid participant, the spouse's resources are counted using Medicaid rules. The FSI rules apply only to the long-term care spouse. For the month the couple stopped living together, resources of the community spouse available for his Medicaid eligibility are the resources owned by the couple. ( )

750. INCOME ELIGIBILITY FOR COMMUNITY SPOUSE.
When the community spouse is a Medicaid participant, the spouse's income is counted using Medicaid rules. The FSI rules apply only to the long-term care spouse. The community spouse may choose between the SSI and CP methods for determining income for Medicaid eligibility. ( )

751. CHANGE IN CIRCUMSTANCES.
The FSI method of calculating income and resources stops the first full calendar month after a change in circumstances resulting in a couple no longer having a community spouse and a long-term care spouse. ( )

752. NOTICE AND HEARING.
The Department must tell the participant the CSA, the family member allowance, the CSRA and how it was computed, and RTA. Any hearing requested about the CSRA or the RTA must be held within thirty (30) days of the date of the request for hearing. ( )

753. -- 760. (RESERVED)

761. CHOICE OF SSI OR CP METHODS.
A married participant, not using FSI, must be furnished a written explanation of SSI and CP income and resource counting methods. The couple chooses the most useful method, based on their circumstances. The same method must be used for both spouses. ( )

762. SSI METHOD OF COUNTING INCOME AND RESOURCES OF A COUPLE.
The SSI method is the same method used to count income and resources for AABD cash. Income and resources of the participant and spouse are counted as mutually available. This method must be used for months either spouse gets SSI or AABD cash, or an SSI and/or AABD application is filed and approved. This method must be used for Medicaid eligibility, and liability for the cost of long-term care, whether one (1) or both spouses apply for Medicaid. For long-term care, the couple's income and resources are mutually available when one (1) or both spouses apply during the month they separated, because one (1) or both left their mutual home to enter a long-term care facility. ( )

763. COMMUNITY PROPERTY (CP) METHOD OF COUNTING INCOME AND RESOURCES OF A COUPLE.
A married participant in long-term care, whose spouse is not in the community, can use the CP method. A married participant using the FSI method, but not income eligible using FSI, may choose the CP method for income eligibility. The CP method must not be used for the FSI participant's resource eligibility or patient liability. ( )

764. CP METHOD.
The CP method gives each spouse has an equal one-half (1/2) share of the couple's community income and resources. Each spouse also has his or her own separate income and resources. Whether the spouses live together or, if not living together, the length of time they have lived apart, does not change the way income and resources are counted. A spouse's property includes income, personal property and real property. The income and resources of a married couple acquired during the marriage are presumed to be community property of the couple. The couple can give evidence to rebut the presumption that property acquired during the marriage is community property. ( )

765. TRANSFER OF RIGHTS TO FUTURE INCOME NOT VALID.
An agreement between spouses, transferring or assigning rights to future income from one (1) spouse to the other, is not valid for eligibility for Medicaid. ( )

766. CP METHOD NEED STANDARD.
The participant is budgeted as a single person if his spouse is not a Medicaid applicant, is not living with him, or was not living with him on the first day of the month. The participant and spouse are budgeted as a couple if they both apply, and live together, or if they were living together on the first day of the month. ( )

767. CP METHOD RESOURCE LIMIT.
The participant's resource limit is two thousand dollars ($2,000) if his spouse is not a Medicaid applicant, is not living with him, or was not living with him on the first day of the month. The participant and spouse have a resource limit of three thousand dollars ($3,000) if they both apply, and live together, or if they were living together on the first day of the month. ( )

768. CP METHOD INCOME DISREGARDS.
The participant gets the twenty dollar ($20) standard disregard if his spouse is not a Medicaid applicant, is not living with him, or was not living with him on the first day of the month. If the participant has earned income, he gets the sixty-five dollar plus one-half ($65 + 1/2) of the remainder earned income disregard. The participant and spouse get the standard disregard on their combined unearned income if they both apply, and live together, or if they were living together on the first day of the month. If either spouse has earned income, they get the earned income disregard from their combined earned income. ( )

769. -- 775. (RESERVED)

776. 1972 RSDI RECIPIENT.
A participant remains eligible if he meets any of the conditions in Subsections 776.01 through 776.03 and all other Medicaid eligibility requirements. ( )

01. Money Payment in August 1972. In August 1972, the participant was eligible for, or received, a state money payment of OAA, AB, APTD or Aid to Families with Dependent Children (AFDC). ( )

02. Eligible If Not in Institution. The participant would have been eligible for OAA, AB, APTD or Aid to Families with Dependent Children (AFDC) if he were not in a medical institution or intermediate care facility in August 1972. ( )

03. Getting RSDI in August 1972. The participant received RSDI benefits in August 1972, and became ineligible for a state money payment due to the RSDI benefit increase effective in September 1972. ( )

777. ELIGIBLE SSI RECIPIENT.
An SSI recipient, or an individual who would be SSI eligible if he applied, is eligible for Medicaid if he meets any of the conditions in Subsections 777.01 through 777.03. ( )

01. Receives SSI. Gets SSI payments, even if eligibility is based on presumptive disability or presumptive blindness. ( )

02. Conditionally Eligible. Is conditionally eligible for SSI, based on an agreement to dispose of excess resources. ( )

03. Eligible Spouse. Has his SSI payments combined with his spouse's SSI payments. ( )

778. INELIGIBLE SSI RECIPIENT.
An SSI recipient is not eligible for Medicaid if he meets any of the conditions in Subsections 778.01 through 778.04. ( )

01. Medicaid Qualifying Trust. Has excess income from a Medicaid Qualifying Trust, created and funded before August 11, 1993. ( )

02. Noncooperation. Fails to cooperate in establishing paternity or securing support. ( )

03. Institution. Is in an ineligible institution. ( )

04. Trust. Has a trust that makes him ineligible for Medicaid. ( )

779. PSYCHIATRIC FACILITY RESIDENT.
A resident of a long-term care psychiatric medical facility, is eligible for Medicaid if he is age sixty-five (65) or older. He must meet all the requirements of a long-term-care resident. ( )

780. GRANDFATHERED SSI RECIPIENT.
A grandfathered SSI recipient is eligible for Medicaid. A grandfathered SSI recipient received, or was eligible to receive, APTD, APTD-MA, AB or AB-MA or APTD-MA in long-term care on December 31, 1973, or had an application for this assistance on file December 31, 1973. ( )

01. Disability and Blindness Criteria. The grandfathered SSI recipient must have been eligible under the disability criteria for APTD or the blindness criteria for AB in effect on December 31, 1973. For each consecutive month after December 1973, the grandfathered SSI recipient must continue to meet the criteria for disability or blindness. ( )

02. Eligibility Requirements. The grandfathered SSI recipient must meet all current Medicaid rules, except the criteria for blindness or disability. A long-term care participant must also remain in long-term care, and continue to need long-term care. ( )

781. RSDI RECIPIENT ENTITLED TO COLA DISREGARD.
A participant receiving RSDI is eligible for Medicaid if he became and remains ineligible for SSI payments as of April 2011, or for AABD cash or SSI payments from May 1977 through March 2011. The participant must still be entitled to AABD cash or SSI, except for a cost-of-living adjustment (COLA) in RSDI benefits. All RSDI COLAs received by the participant, and any person whose income and resources are counted in determining the participant's eligibility, are disregarded for Medicaid. ( )

782. MEDICAID BENEFITS UNDER SECTION 1619(B) OF THE SOCIAL SECURITY ACT.
A participant may be eligible for Medicaid under Section 1619(b) of the Social Security Act either under federal or state criteria, depending on his circumstances. ( )

01. Federally Qualified Under SSA Section 1619(b). An SSI recipient with a disability, previously eligible for SSI cash, who, because of earnings from employment, no longer meets the financial eligibility requirements for SSI cash, is eligible for Medicaid. SSA determines the qualification for eligibility under Section 1619(b). ( )

02. State-Only Qualified Under SSA Section 1619(b). An AABD cash participant with a disability, who, because of earnings from employment, no longer meets the financial eligibility requirements for AABD cash, may be eligible for Medicaid. The Department determines eligibility for State-only Section 1619(b) Medicaid. State-only Section 1619(b) Medicaid is authorized under Section 1905(q) of the Social Security Act. ( )

a. Eligibility Requirements. A participant must meet all of the following requirements to be eligible for State-only 1619(b) Medicaid: ( )

i. The participant received AABD cash in the month prior to the first month of his eligibility under this Section of rule. ( )

ii. The participant is under age sixty-five (65). ( )

iii. The participant continues to have a disability. ( )

iv. The participant must depend on Medicaid coverage to continue working. An individual depends on Medicaid coverage if he: ( )

(1) Used Medicaid coverage within the past twelve (12) months; or ( )

(2) Expects to use Medicaid coverage in the next twelve (12) months; or ( )

(3) Would be unable to pay unexpected medical bills in the next twelve (12) months without Medicaid

coverage. ( )

v. The participant is not able to afford medical insurance equivalent to Medicaid, including attendant care. The participant meets this requirement if his earnings are under the limit referred to in Subsection 782.02.a.vii. of this rule. ( )

vi. The participant continues to meet all of the non-disability eligibility requirements in these rules. ( )

vii. The participant's annual gross earned income is less than the current calendar year's charted threshold for Idaho as developed by SSA for federal qualification for Section 1619(b) Medicaid. The charted threshold for Idaho is online at http://policy.ssa.gov/poms.nsf/lnx/0502302200. ( )

b. Ending State-Only 1619(b) Medicaid. State-only Section 1619(b) Medicaid ends when the participant meets one (1) of the following criteria: ( )

i. The participant is no longer eligible for AABD cash for a reason other than excess earned income; ( )

ii. The participant's gross earned income is equal to or more than the current calendar year's annual earnings threshold for Idaho developed by the Social Security Administration for Federal Section 1619(b) Medicaid; ( )

iii. The participant is age sixty-five (65) or older; or ( )

iv. The participant regains eligibility for AABD cash. ( )

783. APPEAL OF SSA DECISION - APPLICANT DETERMINED SSI ELIGIBLE AFTER APPEAL.
An applicant denied Medicaid, because he does not meet SSI eligibility or RSDI disability requirements, can appeal the SSA denial with SSA. He can get Medicaid, if found eligible for SSI or Social Security disability as a result of his appeal. The effective date for Medicaid is the first day of the month of the Medicaid application that was denied, because of the SSA denial. The participant's eligibility for backdated Medicaid coverage must be determined. ( )

784. APPEAL OF SSA DECISION AND CONTINUED MEDICAID.
A Medicaid participant, denied RSDI or SSI because he is not disabled, can continue to get Medicaid if he appeals the SSA decision. The appeal must be filed within sixty (60) days of the SSA decision. If the final administrative decision rules against the participant's appeal, Medicaid benefits must end. Medicaid benefits paid during the appeal are not an overpayment. ( )

785. CERTAIN DISABLED CHILDREN.
A disabled child, not eligible for Medicaid outside a medical institution, is eligible for Medicaid if he meets the conditions in Subsections 785.01 through 785.08 of these rules. ( )

01. Age. Is under nineteen (19) years old. ( )

02. AABD Criteria. Meets the AABD blindness or disability criteria. ( )

03. AABD Resource Limit. Meets the AABD single person resource limit. ( )

04. Income Limit. Has monthly income not exceeding three (3) times the Federal SSI benefit payable monthly to a single person. ( )

05. Eligible for Long Term Care. Meets the medical conditions for long-term care in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." ( )

06. Appropriate Care. Is appropriately cared for outside a medical institution, under a physician's

plan of care. ( )

07. Cost of Care. Can be cared for cost effectively outside a medical institution. The estimated cost of caring for the child must not exceed the cost of the child's care in a hospital, nursing facility, or ICF/IID. ( )

08. Share of Cost. The financially responsible adult of a certain disabled child, who has family income above one hundred fifty percent (150%) of the federal poverty guidelines, is required to share in the cost of the child's Medicaid benefits under the provisions in IDAPA 16.03.18, "Medicaid Cost-Sharing." ( )

786. EXTENDED (POSTPARTUM) MEDICAID FOR PREGNANT WOMEN.
A woman receiving Medicaid while pregnant continues to be eligible through the last day of the month in which the sixty (60) day post partum period ends. ( )

787. HOME AND COMMUNITY BASED SERVICES (HCBS).
An aged, blind, or disabled participant, who is not income eligible for SSI or AABD cash, in his own home or community setting, is eligible for Medicaid if he meets the conditions in Subsections 787.01 through 787.07 of these rules, and meets all requirements in one (1) of the waiver Sections 788 through 789 of these rules. ( )

01. Resource Limit. Meets the AABD single person resource limit. ( )

02. Income Limit. Income of the participant must not exceed three (3) times the Federal SSI monthly benefit for a single person. A married participant living at home with his spouse who is not an HCBS participant, may choose between the SSI, CP, and FSI methods. If his spouse is also an HCBS participant or lives in a nursing home, the couple may choose between the SSI and CP methods. ( )

03. Maintained in the Community. The applicant must be able to be maintained safely and effectively in his own home or in the community with the waiver services. ( )

04. Cost of Care. The cost of the participant's care must be determined to be cost effective as provided in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." ( )

05. Waiver Services Needed. The participant must need and receive, or be likely to need and receive, waiver services for thirty (30) consecutive days. The participant is ineligible when there is a break in need for, or receipt of, waiver services for thirty (30) consecutive days. ( )

06. Effective Date. Waiver services are effective the first day the participant is likely to need and receive waiver services. Medicaid begins the first day of the month in which the first day of approved waiver services are received. ( )

07. Annual Limit. The Department limits the number of participants approved for waiver services each year. A participant who applies for waiver services after the annual limit is reached, must be denied waiver services. ( )

788. AGED AND DISABLED (A&D) WAIVER.
In order to be eligible for the Aged and Disabled (A&D) Waiver, the participant must: ( )

01. Age Eighteen Through Sixty-Four. Be eighteen (18) through sixty-four (64) years old and meet both the disability criteria, as provided in Section 156 of these rules, and need nursing facility level of care as provided in IDAPA 16.03.10 "Medicaid Enhanced Plan Benefits"; or ( )

02. Age Sixty-Five or Older. Be age sixty-five (65) or older and need nursing facility level of care as provided in IDAPA 16.03.10 "Medicaid Enhanced Plan Benefits." ( )

789. DEVELOPMENTALLY DISABLED (DD) WAIVER.
To be eligible, the participant must be at least eighteen (18) years of age and need the level of care provided by an intermediate care facility for persons with intellectual disabilities (ICF/IID) under IDAPA 16.03.10 "Medicaid Enhanced Plan Benefits." ( )

790. -- 798. (RESERVED)

799. MEDICAID FOR WORKERS WITH DISABILITIES.
An individual is eligible to participate in the Medicaid for Workers with Disabilities coverage group if the individual meets the requirements in Subsections 799.01 through 799.07 of this rule. ( )

01. Non-Financial Requirements. An individual must: ( )

a. Be at least sixteen (16) but less than sixty-five (65) years of age; ( )

b. Meet the Medicaid residency requirement as described in Section 100 of these rules; ( )

c. Meet the citizenship requirements as described in Sections 105 and 106 of these rules; ( )

d. Meet the SSN requirements as described in Section 104 of these rules; and ( )

e. Meet the child support cooperation requirements as described in Sections 703 through 706 of these rules. ( )

02. Disability. An individual must meet the medical definition for having a disability or blindness used by the Social Security Administration for Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) benefits. ( )

03. Employment. An individual must be employed which may include self-employment. Proof of employment must be provided to the Department. Hourly wage or hours worked will not be used to determine employment. ( )

04. Resources. Countable resources cannot exceed ten thousand dollars ($10,000) for an individual or fifteen thousand dollars ($15,000) for a couple. When calculating resources the following items will be excluded: ( )

a. Any resources excluded under Section 210 and Sections 222 through 299 of these rules; ( )

b. A second vehicle as described in Sections 222 of these rules; ( )

c. Life insurance policies; ( )

d. Retirement accounts; and ( )

e. Exempt trusts as described in Section 872 of these rules. ( )

05. Countable Income. Countable income is calculated using exclusions and disregards as described in Sections 300 through 547 of these rules. ( )

a. An individual's countable income cannot exceed five hundred percent (500%) of the current federal poverty guideline for a household of one (1). ( )

b. A couple's countable income cannot exceed five hundred percent (500%) of the current federal poverty guideline for a household of two (2). ( )

06. Earned Income Test. Gross income is the total of earned and unearned income before exclusions or disregards. Each individual's gross earned income must be at least fifteen percent (15%) of his total gross income to qualify. ( )

07. Cost-Sharing. A participant in the Medicaid for Workers with Disabilities coverage group may be required to cost-share. If a participant is required to cost-share for Medicaid, the costs are determined under the

provisions in IDAPA 16.03.18, "Medicaid Cost-Sharing." ( )

800. NEWBORN CHILD OF MEDICAID MOTHER.
A child is deemed eligible for Medicaid without an application if born to a woman receiving Medicaid on the date of the child's birth, including during a period of retroactive eligibility for the mother. The child remains eligible for Medicaid for up to one (1) year without an application. An application for Medicaid must be filed on behalf of the child no later than his first birthday. He must qualify for Medicaid in his own right after the month of his first birthday. ( )

801. INELIGIBLE NON-CITIZEN WITH EMERGENCY MEDICAL CONDITION.
A non-citizen, who is otherwise ineligible only because of his status as a non-citizen, is eligible only for medical services necessary to treat an emergency medical condition. ( )

01. Emergency Medical Condition. An emergency medical condition can reasonably be expected to seriously harm the patient's health, cause serious impairment to bodily functions, or cause serious dysfunction of any bodily organ or part, without immediate medical attention. The Division of Medicaid determines if the condition is an emergency and the services necessary to treat it. ( )

02. Effective Date of Eligibility. Medicaid eligibility begins no earlier than the date the participant experienced the medical emergency and ends the date the emergency condition stops. The Division of Medicaid determines the beginning and ending dates. ( )

802. WOMAN DIAGNOSED WITH BREAST OR CERVICAL CANCER.
A woman not otherwise eligible for Medicaid and meeting the conditions in Subsections 802.01 through 802.06 of this rule is eligible for Medicaid for the duration of her cancer treatment. Medicaid income and resource limits do not apply to this coverage group. ( )

01. Diagnosis. The participant is diagnosed with breast or cervical cancer through the Centers for Disease Control and Prevention's National Breast and Cervical Cancer Early detection Program. ( )

02. Age. The participant is under age sixty-five (65). ( )

03. Creditable Health Insurance. The participant is uninsured or, if insured, the plan does not cover her type of cancer. ( )

04. Non-Financial Eligibility. The participant meets the Medicaid non-financial eligibility requirements in Sections 100 through 108 and Sections 166 and 167 of these rules. ( )

05. Medical Support Cooperation. The participant meets the medical support cooperation requirement in Sections 702 through 706 of these rules. ( )

06. Group Health Plan Enrollment. The participant meets the requirement to enroll in available cost-effective employer group health insurance. ( )

07. Presumptive Eligibility. The Department can presume the participant is eligible for Medicaid, before a formal Medicaid eligibility determination is made. A clinic authorized to screen for breast or cervical cancer by the National Breast and Cervical Cancer Early Detection Program makes the presumptive eligibility determination. The clinic tells the participant how to complete the formal Medicaid determination process. The Medicaid notice and hearing rights do not apply to presumptive eligibility. No overpayment occurs if the formal Medicaid determination finds the participant is not eligible. ( )

08. End of Treatment. The Division of Medicaid determines the end of treatment date according to IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." ( )

803. -- 805. (RESERVED)

806. DISABLED ADULT CHILD.

A participant age eighteen (18) or older is eligible for Medicaid if he received SSI or AABD cash based on blindness or a disability which began before he reached age twenty-two (22), and becomes ineligible for and remains ineligible for AABD cash or SSI because his disabled child RSDI benefit started or increased July 1, 1987, or later. ( )

01. RSDI Benefits Disregarded for Disabled Adult Child. If the participant became ineligible because he began receiving a disabled child benefit on or after July 1, 1987, the benefit amount and any later increases are disregarded. ( )

02. RSDI Increase Disregarded for Disabled Adult Child. If the participant became ineligible because his disabled child benefit increased on or after July 1, 1987, the increase and any later increases are disregarded. ( )

807. (RESERVED)

808. EARLY WIDOWS AND WIDOWERS BEGINNING JANUARY 1, 1991.
A participant who meets the conditions in Subsections 808.01 through 808.06 is considered an SSI recipient for Medicaid. ( )

01. Age. The participant, age fifty (50) to age sixty four and one-half (64-1/2), began receiving early widows or widowers Social Security benefits. ( )

02. Lost SSI or AABD. The participant lost SSI or AABD cash because he began receiving early widows or widowers Social Security benefits. ( )

03. Received SSI or AABD. The participant received SSI or AABD cash in the month, before the month, he became ineligible because he began receiving early widows or widowers Social Security benefits. ( )

04. Widows or Widowers Benefits. The participant would still be eligible for SSI or AABD cash if his Social Security early widows or widowers benefits were not counted as income. ( )

05. No "Part A" Insurance. The participant is not entitled to Medicare Part A hospital insurance. ( )

06. Applied On or After January 1, 1991. The participant's Medicaid application was filed, or pending, on or after January 1, 1991. ( )

809. CERTAIN DISABLED WIDOWS AND WIDOWERS THROUGH JUNE 30, 1988.
A participant who meets the conditions in Subsections 809.01 through 809.04 is considered an SSI recipient for Medicaid. ( )

01. Age. The participant was under age sixty (60) when his disabled widows and widowers benefits began. ( )

02. Lost SSI. The participant is ineligible for SSI because of an increase in SSA disability benefits starting January, 1984. ( )

03. Continuously Entitled. The participant is continuously entitled to Social Security benefits for disabled widows and widowers starting January, 1984 or earlier. ( )

04. Applied Before July 1, 1988. The participant applied for Medicaid before July 1, 1988. ( )

810. QUALIFIED MEDICARE BENEFICIARY (QMB).
A person meeting all requirements in Subsections 810.01 through 810.07 is eligible for QMB. QMB Medicaid pays Medicare premiums, coinsurance, and deductibles. ( )

01. Medicare Part A. The participant must be entitled to hospital insurance under Part A of Medicare

at the time of his application. ( )

02. Nonfinancial Requirements. The participant must meet the Medicaid residence, citizenship, support cooperation, and SSN requirements. ( )

03. Income. Monthly income must not exceed one hundred percent (100%) of the Federal Poverty Guidelines (FPG). The single person income limit is the poverty line for a family of one (1) person. The couple income limit is the poverty line for a family of two (2) persons. The annual Social Security cost of living increase is disregarded from income, until the month after the month the annual FPG revision is published. AABD cash is not counted as income. The income exclusions and disregards used for AABD are used for QMB. ( )

04. Dependent Income. Income of the dependent child, parent, or sibling is not counted. ( )

05. QMB Dependent Family Member Disregard. A dependent family member is a minor child, adult child meeting SSA disability criteria, parent or sibling of the participant or spouse living with the participant. The family member is or could be claimed on the Federal tax return of the participant or spouse. A participant with a dependent family member has an income disregard based on family size. The spouse is included in family size, whether or not the spouse is also participant. The disregard is based on the official poverty line income as defined by the OMB. The disregard is the difference between the poverty line for one (1) person, or two (2) persons if the participant has a spouse, and the poverty line for the family size including the participant, spouse, and dependent. ( )

06. Resource Limit. The resource limit is equal to the amount defined under 42 U.S.C. 1396d(p)(1)(C). The resource exclusions used for AABD are used for QMB. ( )

07. Effective Dates. The effective date of QMB coverage is no earlier than the first day of the month after the approval month. A QMB participant is not entitled to backdated Medicaid. ( )

811. SPECIFIED LOW INCOME MEDICARE BENEFICIARY (SLMB).
A person meeting all requirements in Subsections 811.01 through 811.06 is eligible for SLMB. Medicaid pays the Medicare Part B premiums for a SLMB. The income and resource exclusions and disregards used for AABD are used for SLMB. ( )

01. Other Medicaid. The SLMB may be eligible for other Medicaid. ( )

02. Medicare Part A. The SLMB must be entitled to hospital insurance under Part A of Medicare at the time of his application. ( )

03. Nonfinancial Requirements. The SLMB must meet the Medicaid eligibility requirements of residence, citizenship, support cooperation, and SSN. ( )

04. Income. The annual Social Security cost of living increase is disregarded from income, until the month after the month the annual FPG revision is published. The single person limit is based on a family of one (1). The couple limit is based on a family of two (2). The monthly income limit is up to one hundred twenty percent (120%) of the FPG. ( )

05. Resource Limit. The resource limit is equal to the amount defined under 42 USC 1396d(p)(1)(C). The resource exclusions used for AABD are used for SLMB. ( )

06. Effective Dates. SLMB coverage begins on the first day of the application month. SLMB coverage may be backdated up to three (3) calendar months before the application month. ( )

812. QUALIFIED INDIVIDUAL (QI).
A person meeting all requirements in Subsections 812.01 through 812.07 is eligible for QI. Medicaid pays the Medicare Part B premiums for a QI. The income and resource exclusions and disregards used for AABD are used for QI. ( )

01. Other Medicaid. The QI cannot be eligible for any other type of Medicaid. ( )

02. Medicare Part A. The QI must be entitled to hospital insurance under Part A of Medicare at the time of his application. ( )

03. Nonfinancial Requirements. The QI must meet the Medicaid eligibility requirements of residence, citizenship, support cooperation, and SSN. ( )

04. Income. The annual Social Security cost of living increase is disregarded from income, until the month after the month the annual FPG revision is published. The single person limit is based on a family of one (1). The couple limit is based on a family of two (2). The monthly income limit is up to one hundred thirty-five percent (135%) of the FPG. ( )

05. Resource Limit. The resource limit is equal to the amount defined under 42 USC 1396d(p)(1)(C). The resource exclusions used for AABD are used for SLMB. ( )

06. Coverage Limits. There is an annual limit on participants served, based on availability of federal funds. New applications are denied when the annual limit is reached. ( )

07. Effective Dates. QI coverage begins on the first day of the application month. QI coverage may be backdated up to three (3) calendar months before the application month. ( )

813. QUALIFIED DISABLED AND WORKING INDIVIDUAL (QDWI).
A person meeting all requirements in Subsections 812.01 through 812.05 of these rules is eligible for QDWI. The person must not be eligible for any other type of Medicaid. A QDWI is eligible only for Medicaid payment of his Medicare Part A premium. ( )

01. Age and Disability. The participant must be a disabled worker under age sixty-five (65). ( )

02. Nonfinancial Requirements. The participant must meet the Medicaid eligibility requirements of residence, citizenship, support cooperation and SSN. ( )

03. Section 1818A Medicare. SSA determined the participant meets the conditions of Section 1818A of the Social Security Act. ( )

04. Income. Monthly income must not exceed two hundred percent (200%) of the one (1) person official poverty line defined by the OMB. ( )

05. Resource Limit. The resource limit is equal to the amount defined under 42 USC 1396d(s). The resource exclusions used for AABD are used for QDWI. ( )

814. SPONSORED LEGAL NON-CITIZEN.
All income and resources of a legal non-citizen's sponsor are deemed for Medicaid eligibility if the sponsor has signed an I-864 affidavit of support. ( )

815. CHILD SUBJECT TO DEEMING.
Income and resources of a child's stepparent are not deemed to the child in determining his Medicaid eligibility. ( )

816. FUGITIVE FELON OR PROBATION OR PAROLE VIOLATOR.
A person denied SSI or AABD cash because of the prohibition against payment to fugitive felons and probation and parole violators is not disqualified from Medicaid. ( )

817. -- 830. (RESERVED)

831. ASSET TRANSFER RESULTING IN PENALTY.
Starting August 11, 1993, the participant is subject to a penalty if he transfers his income or resources for less than

fair market value. The asset transfer penalty applies to Medicaid services received October 1, 1993 and later. Excluded resources, other than the home and associated property, are not subject to the asset transfer penalty. Asset transfers subject to penalty under these rules may be voided and set aside by court action as provided in Section 56-218, Idaho Code. The asset transfer penalty applies to a Medicaid participant in long-term care or HCBS. A participant in long-term care is a patient in a nursing facility or a patient in a medical institution, requiring and receiving the level of care provided in a nursing facility. ( )

01. Rebuttable Presumption. Unless a transfer meets the requirements of Section 841 of these rules, it is presumed that the transfer was made for the purpose of qualifying for Medicaid. The asset transfer penalty is applied unless the participant shows that the asset transfer would not have affected his eligibility for Medicaid or the transfer was made for another purpose than qualifying for Medicaid. ( )

02. Contract for Services Provided by a Relative. A contract for personal services to be furnished to the participant by a relative is presumed to be made for the purpose of qualifying for Medicaid. The asset transfer penalty applies unless the participant shows that: ( )

a. A written contract for personal services was signed before services were delivered. The contract must require that payment be made after services are rendered. The contract must be dated and the signatures notarized. Either party must be able to terminate the contract; and ( )

b. The contract must be signed by the participant or a legally authorized representative through a power of attorney, legal guardianship or conservatorship. A representative who signs the contract must not be the provider of the personal care services under the contract; and ( )

c. Compensation for services rendered must be comparable to rates paid in the open market. ( )

03. Transfer of Income or Resources. Transfer of income or resources includes reducing or eliminating the participant's ownership or control of the asset. ( )

04. Transfer of Income or Resources by a Spouse. A transfer by the participant's spouse of either spouse's income or resources, before eligibility is established, subjects the participant to the asset transfer penalty. After the participant's eligibility is established, a transfer by the spouse of the spouse's own income or resources does not subject the participant to the asset transfer penalty. ( )

05. Transfer of Certain Notes and Loans. Funds used to purchase a promissory note, loan, or mortgage are considered a transferred asset which subjects the participant to a period of ineligibility. The amount of the asset transfer of such note, loan or mortgage is the outstanding balance due on the date of the Medicaid application, unless the note, loan or mortgage meets the following: ( )

a. Has a repayment term that is actuarially sound; ( )

b. Provides for payments to be made in equal amounts during the term of the loan with no deferral and no balloon payments; and ( )

c. Prohibits the cancellation of the balance upon the death of the lender. ( )

832. MEDICAID PENALTY FOR ASSET TRANSFERS.
The asset transfer penalty is restricted Medicaid coverage. ( )

01. Restricted Coverage. Restricted coverage means Medicaid will not participate in the cost of nursing facility services. Medicaid will not participate in a level of care in a medical institution equal to nursing facility services. The penalty for a person receiving PCS or community services under the HCBS waiver is ineligibility. ( )

02. Notice and Exemption. The participant must be notified, in writing, at least ten (10) days before an asset transfer penalty is imposed. ( )

833. ASSET TRANSFER LOOK-BACK PERIOD.
The asset transfer penalty applies to any transfer for less than fair market value made during a period preceding or following a request for long-term care services. The look-back period is determined as follows: ( )

01. Transfers Prior to February 8, 2006. For any asset transferred prior to February 8, 2006, the look-back period is thirty-six (36) months, unless the transfer is to or from a trust. If the transfer is to or from a trust, the look-back period is sixty (60) months. If the person is entitled to Medicaid or HCBS services, the look-back period is counted from the month long-term care or HCBS services began, or would have begun, were it not for a penalty. If the person is not entitled to Medicaid, the look-back period is counted from the month prior to the month the application was submitted. ( )

02. Transfers On or After February 8, 2006. Any asset transferred on or after February 8, 2006, regardless of type, is subject to a look-back period of sixty (60) months. The look-back period is counted from the date of the application for long-term care or HCBS services or the date of the transfer, whichever is later in time. ( )

834. PERIOD OF RESTRICTED COVERAGE FOR ASSET TRANSFERS.
The period of restricted coverage is the number of months computed by dividing the net uncompensated value of the transferred asset by the statewide average cost of nursing facility services to private patients. The cost is computed for the time of the participant's most recent request for Medicaid. If the spouse becomes eligible for long-term care Medicaid, the rest of the period of restricted coverage is divided between the participant and spouse. ( )

835. APPLYING THE PENALTY PERIOD OF RESTRICTED COVERAGE.
Restricted coverage continues until the participant or spouse recovers all the assets, receives fair market value at the time of the transfer for all of the assets, or the period of restricted coverage ends. The penalty continues whether or not the participant is in long-term care. The penalty period for asset transfers is applied as follows: ( )

01. Penalty Period for Transfer Prior to February 8, 2006. For assets transferred prior to February 8, 2006, there is no penalty if the amount transferred is less than the cost of one (1) month's care. The penalty period begins running the month the transfer took place. The month the transfer took place is counted as one (1) of the penalty months. A penalty period is computed for each transfer. A penalty period must expire before the next begins. Each partial month before the end of consecutive penalty periods is a penalty month. A partial month at the end of consecutive penalty periods is dropped. ( )

02. Penalty Period for Transfers On or After February 8, 2006. For assets transferred on or after February 8, 2006, the penalty period begins running the first day of the month after the month the transfer took place or was discovered to have taken place, or the date the individual would have been eligible for long-term care services or HCBS, if not for the transfer, whichever date is later in time. The value of all asset transfers made during the look-back period is accumulated for the purpose of calculating the penalty. If an additional transfer is discovered after the penalty has been served, a new penalty period begins the month following timely notice of closure of benefits. When a penalty period ends after the first day of the month, eligibility for long-term care services begins the day after the penalty period ends. ( )

836. MULTIPLE PENALTY PERIODS APPLIED CONSECUTIVELY.
A penalty period is computed for each transfer. One (1) penalty period must expire before the next begins. ( )

837. LIFE ESTATE AS ASSET TRANSFER.

01. Transfer of a Remainder Interest. When a life estate in real property is retained by an individual, and a remainder interest in the property is transferred during the look-back period for less than the fair market value of the remainder interest transferred, the value of the uncompensated remainder is subject to the asset transfer penalty as described in Sections 831 through 835 of these rules. To compute the value of the life estate remainder, multiply the fair market value of the real property at the time of transfer by the remainder factor for the participant's age at the time of transfer listed in the following table:

TABLE 837.01 - REMAINDER TABLE

Age	Remainder	Age	Remainder	Age	Remainder	Age	Remainder
0	.02812	**28**	.03938	**56**	.20994	**84**	.63002
1	.01012	**29**	.04187	**57**	.22069	**85**	.64641
2	.00983	**30**	.04457	**58**	.23178	**86**	.66236
3	.00992	**31**	.04746	**59**	.24325	**87**	.67738
4	.01019	**32**	.05058	**60**	.25509	**88**	.69141
5	.01062	**33**	.05392	**61**	.26733	**89**	.70474
6	.01116	**34**	.05750	**62**	.27998	**90**	.71779
7	.01178	**35**	.06132	**63**	.29304	**91**	.73045
8	.01252	**36**	.06540	**64**	.30648	**92**	.74229
9	.01337	**37**	.06974	**65**	.32030	**93**	.75308
10	.01435	**38**	.07433	**66**	.33449	**94**	.76272
11	.01547	**39**	.07917	**67**	.34902	**95**	.77113
12	.01671	**40**	.08429	**68**	.36390	**96**	.77819
13	.01802	**41**	.08970	**69**	.37914	**97**	.78450
14	.01934	**42**	.09543	**70**	.39478	**98**	.79000
15	.02063	**43**	.10145	**71**	.41086	**99**	.79514
16	.02185	**44**	.10779	**72**	.42739	**100**	.80025
17	.02300	**45**	.11442	**73**	.44429	**101**	.80468
18	.02410	**46**	.12137	**74**	.46138	**102**	.80946
19	.02520	**47**	.12863	**75**	.47851	**103**	.81563
20	.02635	**48**	.13626	**76**	.49559	**104**	.82144
21	.02755	**49**	.14422	**77**	.51258	**105**	.83038
22	.02880	**50**	.15257	**78**	.52951	**106**	.84512
23	.03014	**51**	.16126	**79**	.54643	**107**	.86591
24	.03159	**52**	.17031	**80**	.56341	**108**	.89932
25	.03322	**53**	.17972	**81**	.58033	**109**	.95455
26	.03505	**54**	.18946	**82**	.59705		
27	.03710	**55**	.19954	**83**	.61358		

( )

02. Transfer of a Life Estate. When a life estate in real property is transferred by an individual during the look-back period for less than fair market value, the value of the life estate is subject to the asset transfer penalty as described in Sections 831 and 835 of these rules. To compute the value of the life estate, multiply the fair market value of the real property at the time of transfer by the life estate factor for the participant's age at the time of transfer listed in the following table:

TABLE 837.02 - LIFE ESTATE TABLE

Age	Life Estate	Age	Life Estate	Age	Life Estate	Age	Life Estate
0	.97188	**28**	.96062	**56**	.79006	**84**	.36998
1	.98988	**29**	.95813	**57**	.77391	**85**	.35359
2	.99017	**30**	.95543	**58**	.76822	**86**	.33764
3	.99008	**31**	.95254	**59**	.75675	**87**	.32262
4	.98981	**32**	.94942	**60**	.74491	**88**	.30859
5	.98938	**33**	.94608	**61**	.73267	**89**	.29526
6	.98884	**34**	.94250	**62**	.72002	**90**	.28221
7	.98822	**35**	.93868	**63**	.70696	**91**	.26955
8	.98748	**36**	.93460	**64**	.69352	**92**	.25771
9	.98663	**37**	.93026	**65**	67970	**93**	.24692
10	.98565	**38**	.92567	**66**	.66551	**94**	.23728
11	.98453	**39**	.92083	**67**	.65098	**95**	.22887
12	.98359	**40**	.91571	**68**	.63610	**96**	.22181
13	.98198	**41**	.91030	**69**	.62086	**97**	.21550
14	.98066	**42**	.90457	**70**	.60522	**98**	.21000
15	.97937	**43**	.89855	**71**	.58914	**99**	.20486
16	.97815	**44**	.89221	**72**	.57261	**100**	.19975
17	.97700	**45**	.88558	**73**	.55571	**101**	.19532
18	.97590	**46**	.87863	**74**	.53862	**102**	.19054
19	.97480	**47**	.87137	**75**	.52149	**103**	.18437
20	.97365	**48**	.86374	**76**	.50441	**104**	.17856
21	.97425	**49**	.85578	**77**	.48742	**105**	.16962
22	.97120	**50**	.83743	**78**	.47049	**106**	.15488
23	.96986	**51**	.83674	**79**	.45357	**107**	.13409
24	.96841	**52**	.82969	**80**	.43659	**108**	.10068
25	.96678	**53**	.82028	**81**	.41967	**109**	.04545
26	.96495	**54**	.81054	**82**	.40295		
27	.96290	**55**	.80046	**83**	.38642		

( )

838. ANNUITY AS ASSET TRANSFER.

Except as provided in this rule, when assets are used to purchase an annuity during the look-back period, it is an asset transfer presumed to be made for the purpose of qualifying for Medicaid. To rebut this presumption, the participant must provide proof that clearly establishes the annuity was not purchased to make the participant eligible for Medicaid or avoid recovery from the estate following death. Proof is met if the participant shows the annuity meets

the requirements described in Subsections 838.02 through 838.05 of this rule. ( )

01. Revocable Annuity. A revocable annuity is an annuity that can be assigned. The surrender amount of a revocable annuity is a countable resource. ( )

02. Irrevocable Annuity. The purchase price of an irrevocable, non-assignable annuity is treated as an asset transfer, unless the requirements of Subsections 838.03 through 838.05 of this rule are met. ( )

03. Irrevocable Annuity Life Expectancy Test. The participant's life expectancy, as shown in the following table, must equal or exceed the term of the annuity. Using the Table 838.03 compare the face value of the annuity to the participant's life expectancy at the purchase time. The annuity meets the life expectancy test if the participant's life expectancy equals or exceeds the term of the annuity. If the exact age is not in the Table, use the next lower age.

TABLE 838.03 - LIFE EXPECTANCY TABLE

Age	Years of Life Remaining Male	Years of Life Remaining Female	Age	Years of Life Remaining Male	Years of Life Remaining Female
0	73.26	79.26	**74**	10.12	12.74
10	64.03	69.93	**75**	9.58	12.09
20	54.41	60.13	**76**	9.06	11.46
30	45.14	50.43	**77**	8.56	10.85
40	35.94	40.86	**78**	8.07	10.25
50	27.13	31.61	**79**	7.61	9.67
60	19.07	22.99	**80**	7.16	9.11
61	18.33	22.18	**81**	6.72	8.57
62	17.60	21.38	**82**	6.31	8.04
63	16.89	20.60	**83**	5.92	7.54
64	16.19	19.82	**84**	5.55	7.05
65	15.52	19.06	**85**	5.20	6.59
66	14.86	18.31	**86**	4.86	6.15
67	14.23	17.58	**87**	4.55	5.74
68	13.61	16.85	**88**	4.26	5.34
69	13.00	16.14	**89**	3.98	4.97
70	12.41	15.44	**90**	3.73	4.63
71	11.82	14.75	**95**	2.71	3.26
72	11.24	14.06	**100**	2.05	2.39
73	10.67	13.40	**110**	1.14	1.22

( )

04. State Named as Beneficiary. The purchase of an annuity is treated as an asset transfer unless the State of Idaho, Medicaid Estate Recovery is named as: ( )

a. The remainder beneficiary in the first position for at least the total amount of medical assistance paid on behalf of the institutionalized individual under this title; or ( )

b. The remainder beneficiary in the second position after the community spouse or minor or disabled child and is named in the first position if the community spouse or a representative of the minor or disabled child disposes of any remainder for less than fair market value. ( )

05. Equal Payment Test. The annuity must provide for payments in equal amounts during the term of the annuity with no deferral and no balloon payments made. ( )

06. Permitted Annuity. The purchase of an annuity is not treated as an asset transfer if the annuity meets any of the descriptions in Sections 408(b), or 408(q), Internal Revenue Code; or is purchased with proceeds from an account or trust described in Sections 408(a), 408(c), or 408(p), Internal Revenue Code, or is a simplified employee pension as described in Section 408(k), Internal Revenue Code, or is a Roth IRA described in Section 408A, Internal Revenue Code. ( )

839. TRUSTS AS ASSET TRANSFERS.
A trust established wholly or partly from the participant's assets is an asset transfer. Assets transferred to a trust on or after August 11, 1993 are subject to the asset transfer penalty, regardless of when the trust was established. If the trust includes assets of another person, the asset transfer penalty applies to the participant's share of the trust. ( )

840. TRANSFER OF JOINTLY-OWNED ASSET.
Transfer of an asset owned jointly by the participant and another person is considered a transfer by the participant. The participant's share of the asset is used to compute the penalty. If the participant and his spouse are joint owners of the transferred asset, the couple's combined ownership is used to compute the penalty. If the spouse becomes eligible for long-term care Medicaid, the rest of the period of restricted coverage is divided between the participant and spouse. ( )

841. PENALTY EXCEPTIONS FOR ASSET TRANSFERS.
A participant is not subject to the asset transfer penalty for taking any action described in Subsections 841.01 through 841.14 of this rule. ( )

01. Home to Spouse. The asset transferred was a home. Title to the home was transferred to the spouse. ( )

02. Home to Minor Child or Disabled Adult Child. The asset transferred was a home. Title to the home was transferred to the child of the participant or spouse. The child must be under age twenty-one (21) or blind or totally disabled under Social Security and SSI rules in 20 CFR Part 416. ( )

03. Home to Brother or Sister. The asset transferred was a home. Title to the home was transferred to a brother or sister of the participant or spouse. The brother or sister must have an equity interest in the transferred home. The brother or sister must reside in that home for at least one (1) year immediately before the month the participant starts long-term care. ( )

04. Home to Adult Child. The asset transferred was a home. Title to the home was transferred to a son or daughter of the participant or spouse, other than a child under the age of twenty-one (21). The son or daughter must reside in that home for at least two (2) years immediately before the month the participant started long-term care. The adult child must prove he provided nursing facility level medical care to the participant which permitted him to live at home rather than enter long-term care. The son or daughter must not have received payment from Medicaid for home and community based services provided to the participant. ( )

05. Benefit of Spouse. The assets were transferred to the participant's spouse or to another person for the sole benefit of the spouse. ( )

06. Transfer From Spouse. The assets were transferred from the participant's spouse to another person for the sole benefit of the participant's spouse. ( )

07. Transfer to Child. The assets were transferred to the participant's child, or to a trust established solely for the benefit of the participant's child. The child must be blind or totally disabled under Social Security and SSI rules in 20 CFR Part 416. The child may be any age. ( )

08. Intent to Get Fair Market Value. The participant or spouse proves he intended to dispose of the assets at fair market value or for other adequate consideration. ( )

09. Assets Returned. All assets transferred for less than fair market value have been returned to the participant. ( )

10. Medicaid Qualification Not the Intent. The participant or spouse proves the assets were transferred exclusively for a purpose other than to qualify for Medicaid or to avoid recovery. ( )

11. Undue Hardship. The participant, his representative, or the facility in which he resides may request the hardship waiver. The hardship waiver must be requested in writing within ten (10) days of the date of the asset transfer penalty notice. Undue hardship exists if any of the conditions in Subsections 841.11.a. through 841.11.d. of this rule apply. ( )

a. The participant proves he is not able to pay for his nursing facility services or his wavier services by any means. ( )

b. The participant proves that he has made reasonable efforts, consistent with his physical and financial ability, to recover the transferred asset. The participant must fully cooperate with the state of Idaho in efforts to recover the transferred asset and, upon request, must assign his rights to recover the asset to the State of Idaho. ( )

c. The participant proves he did not knowingly transfer the asset. ( )

d. The participant proves he would be deprived of food, clothing, shelter or other necessities of life if the asset transfer penalty is imposed and he assigns his rights to recover the asset to the State of Idaho. ( )

12. Exception to Fair Market Value. The amount received is adequate, even if not fair market value. This exception must meet one (1) of the conditions in Subsections 841.12.a. through 841.12.c. of this rule. ( )

a. A forced sale was done under reasonable circumstances. ( )

b. Little or no market demand exists for the type of asset transferred and the lack of market demand was not created by a voluntary act of the participant to qualify for assistance or to avoid recovery. ( )

c. The asset was transferred to settle a legal debt approximately equal to the fair market value of the transferred asset. ( )

13. No Benefit to Participant. The participant received no benefit from the asset. This exception must meet one (1) of the conditions in Subsections 841.13.a. and 841.13.b. of this rule. ( )

a. The participant or spouse held title to the property only as a trustee for another person. The participant or spouse had no beneficial interest in the property. ( )

b. The transfer was done to clear title to property. The participant or spouse had no beneficial interest in the property. The defect in the title was not created in an attempt to transfer assets to qualify for assistance or avoid recovery. ( )

14. Fraud Victim. The asset was transferred because the participant or spouse was the victim of fraud, misrepresentation, or coercion. The participant or spouse must take all possible steps to recover the assets or property, or its equivalent in damages and must assign recovery rights to the state of Idaho. ( )

15. Transfer to Trust of Disabled Person. The assets were transferred to a trust established solely for the benefit of an individual under sixty-five (65) years of age who is disabled. ( )

842. -- 870. (RESERVED)

871. TREATMENT OF TRUSTS.
These trust treatment rules apply to all Medicaid participants. These rules apply to trusts established with the participant's assets on August 11, 1993 or later, and to amounts placed in trusts on or after August 11, 1993. Section 871 of these rules does not apply to an irrevocable trust if the participant meets the undue hardship exemption in Subsection 841.11 of these rules. Assets transferred to a trust are subject to the asset transfer penalty. Section 871 does not apply to a trust created with assets other than those of the individual, including a trust established by a will. ( )

01. Revocable Trust. Revocable trusts are treated as listed in Subsections 871.01.a. through 871.01.d. of these rules. A revocable burial trust is not a trust for the purposes of Subsection 871.01 of these rules. ( )

a. The body (corpus) of a revocable trust is a resource. ( )

b. Payments from the trust to or for the participant are income. ( )

c. Any other payments from the trust are an asset transfer, triggering an asset transfer penalty period. ( )

d. As defined in 42 U.S.C. 1396p(e)(5), the home and adjoining property loses its exclusion for eligibility purposes when transferred to a revocable trust, unless the participant or spouse is the sole beneficiary of the trust. The home is excluded again if removed from the trust. The exclusion restarts the month following the month the home was removed from the trust. ( )

02. Irrevocable Trust. Irrevocable trusts are treated as listed in Subsections 871.02.a. through 871.02.g. of these rules. ( )

a. The part of the body of an irrevocable trust, from which corpus or income payments could be made to or for the participant, is a resource. ( )

b. Payments made to or for the participant are income. ( )

c. Payments from the trust for any other reason are asset transfers, triggering the asset transfer penalty. ( )

d. Any part of the trust from which payment cannot be made to, or for the benefit of, the participant under any circumstances, is an asset transfer. ( )

e. The effective date of the transfer is the date the trust was established, or the date payments to the participant were foreclosed. ( )

f. The value of the trust, for calculating the transfer penalty, includes any payments made from that portion of the trust after the date the trust was established or payments were foreclosed. ( )

g. An irrevocable burial trust is not subject to treatment under Subsection 871.02 of these rules, unless funds in the trust can be paid for a purpose other than the participant's funeral and related expenses. The trust can provide that funds not needed for the participant's funeral expenses are available to reimburse Medicaid, or to go to the participant's estate. ( )

872. EXEMPT TRUSTS.
A trust, created or funded on or after August 11, 1993, is exempt from trust treatment and not subject to the asset transfer penalty if it meets a condition in Subsections 872.01 through 872.03 of this rule. ( )

01. Trust for Disabled Person. To be exempt, a trust for a disabled person must meet all the conditions in Subsections 872.01.a. through 872.01.f. of this rule. ( )

a. The trust contains the assets of a person under age sixty-five (65). ( )

b. The person is blind or totally disabled under the Social Security and SSI rules in 20 CFR Part 416. ( )

c. The trust is established for the person's benefit by his parent, grandparent, legal guardian or a court. ( )

d. The trust is irrevocable. ( )

e. The trust is exempt until the person reaches age sixty-five (65). After the person reaches age sixty-five (65), additions or augmentations are not exempt from trust treatment. ( )

f. Upon the person's death, the amount not distributed by the trust must first be paid to the state of Idaho, up to the amount Medicaid has paid on the person's behalf. ( )

02. Income Trust. To be exempt, an income trust must meet all the conditions in Subsections 872.02.a. through 872.02.e. of this rule. ( )

a. The trust is established for the sole benefit of a person who would be eligible for Medicaid in long-term care, or eligible for HCBS except for excess income. ( )

b. Any income, placed directly into an income trust in the same calendar month in which received by the recipient, is not considered income to the individual for determining long-term care Medicaid eligibility. Money paid into the trust is income for patient liability or client participation. ( )

c. The trust is irrevocable. The trust document may include a clause allowing the trust to be revoked if the participant leaves the nursing facility or HCBS for a reason other than death, and is no longer eligible for Medicaid because of excess income, if Medicaid is reimbursed up to the amount Medicaid has paid on the person's behalf. ( )

d. Income transferred to the trust must be used to pay patient liability or client participation. If income is not used to pay allowable expenses, it is subject to the asset transfer penalty, unless one (1) of the following exceptions in Subsections 872.02.d.i. through 872.02.d.iii. of this rule applies. ( )

i. Benefit of the spouse in Subsection 841.05 of these rules; ( )

ii. Transfer from the spouse in Subsection 841.06 of these rules; or ( )

iii. Undue hardship in Subsection 841.11 of these rules. ( )

e. Upon the person's death, the amount not distributed by the trust must first be paid to the state of Idaho, up to the amount Medicaid has paid on the person's behalf. ( )

03. Trust Managed by Non-Profit Association for Disabled Person. To be exempt, a trust managed by non-profit association for a disabled person must meet all the conditions in Subsections 872.03.a. through 872.03.e. of this rule. ( )

a. The trust is established and managed by a nonprofit association. The nonprofit association must not be the participant, his parent or his grandparent. ( )

b. The trust contains the assets of a disabled person. The person must be blind or totally disabled under Social Security and SSI rules in 20 CFR Part 416. ( )

c. Accounts in the trust are established only for the benefit of disabled persons. An account can be established by the disabled person, his parent, grandparent, legal guardian, or a court. A separate account must be maintained for each beneficiary of the trust. For purposes of investment and management, the trust may pool the funds in the accounts. ( )

d. The trust is irrevocable. ( )

e. Upon the person's death, the amount not distributed by the trust must first be paid to the state of Idaho, up to the amount Medicaid has paid on the person's behalf. ( )

873. PAYMENTS FROM AN EXEMPT TRUST FOR DISABLED PERSON OR POOLED TRUST.
Cash payments from an exempt trust for a disabled person or a pooled trust must be treated as described in Subsections 873.01 through 873.04 of these rules. ( )

01. Payments from Exempt Trust. Cash payments from an exempt trust for a disabled person are income in the month received. ( )

02. Payments from Pooled Trust. Cash payments from a pooled trust made directly to the participant are income in the month received. ( )

03. Payments for Food or Shelter. Payments for the participant's food or shelter are income in the month paid. The payments for food or shelter are valued at one-third (1/3) of the AABD budgeted needs for the participant's living arrangement. ( )

04. Payments Not Made to Participant. Payments from the exempt trust not made to, or on behalf of, the participant are an asset transfer. ( )

874. -- 914. (RESERVED)

915. MEDICAID REDETERMINATION.
Medicaid eligibility is redetermined each year. The redetermination for AABD cash is the Medicaid redetermination for participants receiving both programs. ( )

916. -- 999. (RESERVED)

000. LEGAL AUTHORITY.
Sections 56-202 and 56-203, Idaho Code, authorize the Department to administer this program. ( )

001. SCOPE.
These rules govern the administration of the Refugee Medical Assistance Program in the state of Idaho. ( )

002. -- 009. (RESERVED)

010. DEFINITION OF TERMS AND ABBREVIATIONS.
For the purposes of these rules, the following terms and abbreviations apply: ( )

01. Department. The Idaho Department of Health and Welfare or designee. ( )

02. Federal Poverty Guidelines (FPG). The federal poverty guidelines issued annually by the Department of Health and Human Services (HHS). ( )

03. INA. Immigration and Nationality Act, 8 USC Sections 1101-1537. ( )

04. I-94. An alien identification card issued to refugees prior to their release to a sponsor. This card gives the refugee's name, United States address, and other identifying data. ( )

05. Medical Assistance Program. Services funded by Titles XIX or XXI of the federal Social Security Act, as amended. ( )

06. Children's Health Insurance Program (CHIP). CHIP is Title XXI of the Social Security Act. ( )

011. -- 099. (RESERVED)

100. IDENTIFICATION OF REFUGEES.
A person has refugee status for purposes of assistance under the Refugee Medical Assistance Program if they are one (1) of the following: ( )

01. I-94 Indication. A person from any country who has an I-94 indicating that the person has been: ( )

a. Paroled under Section 212(d)(5) of the INA as a refugee or asylee; or ( )

b. Admitted as a conditional entrant under Section 203(a)(7) of the INA; or ( )

c. Admitted as a refugee under Section 207 of INA; or ( )

d. Granted asylum under Section 208 of INA; or ( )

02. Afghan Special Immigrants. An Afghan special immigrant, as defined in Public Law 110-161, who has special immigration status after December 26, 2007. ( )

03. Iraqi Special Immigrants. An Iraqi special immigrant, as defined in Public Law 110-181, who has special immigration status after January 28, 2008. ( )

04. Other Factors in Determining Eligibility for the Refugee Medical Assistance Program. ( )

a. An applicant who has applied for, but has not been granted asylum, is not eligible. ( )

b. A person who entered the United States as a resident alien is not eligible. ( )

c. An I-94 which shows a person has been paroled into the United States under Section 212(d)(5) of the INA must clearly indicate that the person has been paroled as a "Refugee" or "Asylee" if such form was issued: ( )

i. To a person from Cuba; or ( )

ii. To a person from any other country at any time. ( )

d. A person whose status is Cuban/Haitian Entrant must have his eligibility for benefits under the Refugee Medical Assistance Program determined under 45 CFR 401. ( )

e. An Amerasian or close family member admitted as an immigrant but eligible for Refugee Medical Assistance as though they were a refugee must have either of the following documents verifying their status: ( )

i. A temporary identification document, I-94, stamped "Processed for I-551. Temporary evidence of lawful admission for permanent residence. Valid until (expiration date). Employment authorized." The back of an I-94 contains the stamped word "Admitted" and is coded AM1, AM2, or AM3; or ( )

ii. A permanent identification document, Form I-551 coded AM6, AM7, or AM8. ( )

101. -- 149. (RESERVED)

150. REFUGEE MEDICAL ASSISTANCE PROGRAM.

01. Time Limitation. Medical assistance under the Refugee Medical Assistance Program will be limited to eight (8) consecutive months beginning with the month the refugee enters the United States. ( )

02. Eligibility. Refugees whose countable income does not exceed one hundred fifty percent (150%) of the Federal Poverty Guidelines are eligible for Refugee Medical Assistance. ( )

03. Refugee Medical Assistance with "Spend Down." An applicant for Refugee Medical Assistance whose countable income exceeds one hundred fifty percent (150%) FPG for their family size may become eligible for Refugee Medical Assistance under certain conditions. A special provision, for refugees only, will allow those refugees whose income exceeds one hundred fifty percent (150%) FPG for their family size to subtract their medical costs from their income and thus "spend down" to the FPG limit for their family size. ( )

04. Counting Income for Refugee Medical Assistance. ( )

a. Income is counted or excluded in accordance with IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children." The sole exception is that Refugee Cash Assistance is excluded from income when determining eligibility for Refugee Medical Assistance. ( )

b. The income of sponsors, and the in-kind services and shelter provided to refugees by their sponsors, will not be considered in determining eligibility for Refugee Medical Assistance. ( )

151. -- 699. (RESERVED)

700. OVERPAYMENTS AND RESTORATION OF BENEFITS.
Policy governing recovery of overpayments and restoration of benefits of Refugee Medical Assistance is contained in IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children." ( )

701. -- 994. (RESERVED)

995. PROVISIONS CONTINGENT UPON FEDERAL FUNDING.
The provisions in these rules, are contingent upon availability and receipt of funds appropriated through federal legislation. When federal funds are not available to the State of Idaho, these provisions, or any part therein, will not be in force and operation of the Refugee Medical Assistance Program in Idaho will be suspended. Advance notice of termination or reduction of benefits is not needed. ( )

996. -- 999. (RESERVED)

000. LEGAL AUTHORITY.
Section 39-2401(2), Idaho Code, authorizes the Board to adopt rules for the operation of home health agencies (HHAs). ( )

001. WRITTEN INTERPRETATIONS.
This agency may have written statements that pertain to the interpretations of the rules of this chapter. ( )

002. -- 005. (RESERVED)

006. CONFIDENTIALITY OF RECORDS AND PUBLIC RECORDS REQUESTS.

01. Confidential Records. Information about an individual covered by these rules and contained in the Department's records must comply with IDAPA 16.05.01, "Use and Disclosure of Department Records." ( )

02. Public Records. The Department will comply with Title 74, Chapter 1, Idaho Code, when requests for the examination and copying of public records are made. Unless exempted, all public records in Department custody are subject to disclosure. ( )

03. Disclosure of Patient Identity. Information received by the Department through filed reports, inspections, or as authorized under the law, will not be disclosed publicly so as to identify individual patients except as necessary in a proceeding involving a question of licensure. ( )

04. Public Availability of Deficiencies. The agency survey reports are available upon written request to the Department and posted on the Licensing and Certification website. ( )

007. -- 008. (RESERVED)

009. CRIMINAL HISTORY AND BACKGROUND CHECK REQUIREMENTS.

01. Compliance with Department's Criminal History and Background Check. A home health agency (HHA) must comply with IDAPA 16.05.06, "Criminal History and Background Checks." ( )

02. Individuals Subject To Criminal History Checks. Owners, administrators, employees, and contractors hired or contracted with after October 1, 2007, who have direct access to patients must complete and receive Department criminal history and background check clearance. ( )

03. Availability to Work. Any direct patient access individual hired or contracted on or after October 1, 2007, must complete an application before having access to patients and have their fingerprints submitted to the Department within twenty-one (21) days of completion of the notarized application. If a disqualifying crime as described in IDAPA 16.05.06, "Criminal History and Background Checks," is disclosed, the individual cannot have access to any patient without a clearance by the Department. Once the notarized application is completed the individual can only work under supervision until the individual has been fingerprinted. ( )

010. DEFINITIONS.

01. Board. The Idaho Board of Health and Welfare. ( )

02. Business Entity. A public or private organization owned or operated by one (1) or more persons. ( )

03. Department. The Idaho Department of Health and Welfare. ( )

04. Health Care Services. Any of the following services that are provided at the residence of an individual: ( )

a. Skilled nursing services; ( )

b. Homemaker/home health aide services; ( )

c. Physical therapy services; ( )

d. Occupational therapy services; ( )

e. Speech therapy services; ( )

f. Nutritional Services/Registered Dietitian Services; ( )

g. Respiratory therapy services; ( )

h. Medical/social services; ( )

i. Intravenous therapy services; and ( )

j. Such other services as authorized by rule of the Board. ( )

05. Home Health Agency (HHA). Any business entity that primarily provides skilled nursing services by licensed nurses and at least one (1) other health care service as defined in Subsection 010.04 to a patient in that patient's place of residence. Any entity that has a provider agreement with the Department as a personal assistance agency under Title 39, Chapter 56, Idaho Code, requires licensure as an HHA only if it primarily provides nursing services. ( )

06. Individual. A natural person who is a recipient of provided health care services. ( )

07. Licensing Agency. The Idaho Department of Health and Welfare. ( )

08. Skilled Nursing Services. Services provided directly by a licensed nurse for the purpose of promoting, maintaining, or restoring the health of an individual or to minimize the effects of injury, illness, or disability. ( )

09. Voluntary Withdrawal. ( )

a. Failure to submit an annual application and annual report will be considered a voluntary withdrawal as an HHA. ( )

b. When the agency has not provided home health services in the last calendar year, this will be considered a voluntary withdrawal as an HHA. ( )

011. -- 012. (RESERVED)

013. LICENSURE - GENERAL REQUIREMENTS.
For licensure, HHAs must meet all the requirements in Title 42, Chapter IV, Subchapter G, of the Code of Federal Regulations (CFR), Standards and Certification, Part 484. ( )

01. Exception. Entities whose sole payor source is the Department of Labor are exempt from meeting the federal Conditions of Participation but must meet the Department of Labor requirements for the provision of services for the Energy Workers Program and the requirements of their Accreditation Organization. These entities are required to submit survey results performed by the Accreditation Organization and the agency's Plan of Correction. ( )

02. Types of Licensure. ( )

a. A license is issued to an HHA found to be in substantial compliance with these rules. ( )

b. A provisional license is issued to an agency which is not found to be in substantial compliance with these rules. ( )

03. Application for Licensure. An application for a license must be made to the Department upon forms provided by it and contain such information as it reasonably requires, which includes affirmative evidence of

ability to comply with such reasonable standards, and rules as are lawfully adopted by the Board. ( )

04. Issuance of License. Upon receipt of a Department application, the Department will issue a license if the applicant meets the requirements established under this chapter. ( )

a. A license, unless suspended, revoked, or the agency has voluntarily withdrawn from the program is renewable each year upon filing by the licensee, and approval by the Department. ( )

b. Each license is issued only for the premises, persons, or governmental units in the application and is not transferable or assignable except with the written approval of the Department. ( )

c. Every agency must be designated by a distinctive name that cannot be changed without first notifying the Department in writing at least thirty (30) days prior to the date the proposed name change is to be effective. ( )

d. Licenses must be posted in a conspicuous place on the licensed premises. ( )

05. Denial of Application. Before denial is final, the Department will provide opportunity for a hearing and the owner of an HHA may appear and show cause why the license should not be denied. Hearings for denial will be conducted by the Department pursuant to the provisions of IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings." The Department may deny any application when evidence exists that: ( )

a. Conditions endanger the health or safety of any patient; ( )

b. Conditions violate the patients' rights; ( )

c. The HHA does not meet requirements for licensure that hinders its ability to provide quality services; or ( )

d. The HHA owner has a history of repeat deficiencies. ( )

06. Expiration Date and Renewal. Each license to operate an HHA expires on the date designated on the license, unless suspended, revoked, or the agency has voluntarily withdrawn from the program. ( )

07. Revocation of License. The licensing agency may deny or revoke any license when persuaded by the evidence that the HHA: ( )

a. Has any existing conditions that endanger the health or safety or welfare of any patient. ( )

b. Has a history of repeat deficiencies. ( )

c. Has had licensure denied or revoked to operate a health or personal care facility or agency, has been convicted of operating without a license, or has been enjoined from operating such agency within two (2) years from the date of application. ( )

d. Lacks personnel sufficient in number or qualifications by training, experience, or judgment to properly service the proposed or actual number and type of patients. ( )

e. Has been guilty of fraud, deceit, or misrepresentation in the preparation of the application or other documents required by the licensing agency and dishonesty associated with the operation of a licensed HHA; ( )

f. Has been guilty of negligence, abuse, neglect, assault, or battery while associated with the provision of services in the operation of an HHA. ( )

g. Has refused to allow inspection of all records. ( )

h. Has lost federal certification. ( )

08. Suspension. If the Department finds the public health, safety, or welfare requires emergency action, a license may be suspended pending proceedings for revocation or other action, and the HHA was found: ( )

a. Guilty of fraud, deceit, or misrepresentation in the preparation of the application or other documents required by the licensing agency and dishonesty associated with the operation of the HHA; ( )

b. Guilty of negligence, abuse, or neglect, assault, or battery while associated with the provision of services in the operation of an HHA. ( )

09. Return of License. Each license is the property of the state of Idaho and must returned to the Department immediately upon license revocation or the agency has voluntarily withdrawn from the program. ( )

10. Appeal. Before denial or revocation is final, the Department will provide opportunity for a hearing at which time the owner of an agency may appear and show cause why the license should not be denied or revoked. ( )

11. Injunction to Prevent Operation Without License. Regardless of the existence or pursuit of any other remedy, the Department may maintain an action for injunction or other process against any person or governmental unit to restrain or prevent the establishment, conduct, management, or operation of an agency without a license required under this chapter. The Department will be represented by the county prosecutor of the county in which the violation occurs or by the office of the attorney general. ( )

12. Inspection of Records. The HHA and all records required under these rules must be accessible at any reasonable time to authorized representatives of the Department for the purpose of inspection with or without prior notice. Refusal to allow such access will result in revocation of the HHA's license. ( )

014. CHANGE OF ADMINISTRATOR OR LESSEE.
When a change of a licensed agency's ownership, administrator, lessee, title, or address occurs, the owner/ or administrator must notify the Department within thirty (30) days in writing. ( )

015. CHANGE OF OWNERSHIP.
A new owner must submit a new application for licensure and receive the license from the Department before operating the agency. A "change in ownership" is a change in the individual or legal organization that has final decision-making authority over the daily operation of an HHA. ( )

01. Change in Ownership. An HHA must apply for a change of ownership when: ( )

a. The form of legal organization of the facility changes, such as when a sole proprietorship becomes a partnership or corporation; ( )

b. A transfer of the HHA's title changes from the current licensee to another party; ( )

c. The licensee is a partnership and an event occurs that dissolves the partnership; ( )

d. The licensee is a corporation; and ( )

i. The corporation is dissolved; ( )

ii. The corporation merges with another corporation which is the surviving corporation; or ( )

iii. A new corporation is formed through consolidation with one (1) or more other corporations. ( )

e. A change of ownership or lessee, or establishment of a branch occurs.

02. No Change in Ownership. Ownership does not change when: ( )

a. The licensee contracts with another party to manage the facility and act as the licensee's agent, and the licensee retains final decision-making authority over daily operating decisions; or ( )

b. When the licensee is a corporation, some or all of its corporate stock is transferred, and the corporation continues to exist. ( )

03. Application for Change of Ownership. A HHA must apply to the Department for a change of ownership at least ninety (90) days prior to the proposed date of the change, using the initial licensing application form. ( )

016. -- 069. (RESERVED)

070. DISCONTINUATION OF AGENCY.
Upon determination the HHA will discontinue providing services, the agency is required to: ( )

01. Provide Written Notice. Provide written notice no less than thirty (30) days from the intended date of discontinuation of services to the: ( )

a. Patient or patient representative; and ( )

b. Department’s Division of Licensing and Certification. ( )

02. Provide Clinical Records. Provide a copy of the patient’s clinical records to: ( )

a. Patient or patient representative; and ( )

b. Any agency in which the patient or patient representative has elected to have their care transferred. ( )

03. Inform Public. Inform the public no less than thirty (30) days from the intended day of discontinuation of services by publishing a public notice in a media outlet prominent in the community of the HHA. ( )

04. Ensure Confidentiality, Safekeeping, and Storage of Records. ( )

a. The HHA will retain records for a period of not less than five (5) years and inform the Department of the location of said records; and ( )

b. Failure to store and protect said records may result in a referral to the Office of Civil Rights and other relevant agencies. ( )

05. Discontinuation of Operation. Agencies discontinuing operation must obtain approval of a plan to preserve or destroy clinical records prior to disposition. ( )

06. Return License to the Department. The HHA will return the license to the Department the day following the final day of operation. ( )

071. ENFORCEMENT ACTIONS.
Enforcement actions, as described in Sections 071 through 074 of these rules, are actions the Department can impose upon an agency. The Department will consider an agency's compliance history, change(s) of ownership, and the number, scope, and severity of the deficiencies when initiating or extending an enforcement action. ( )

072. ENFORCEMENT ACTION OF A PROVISIONAL LICENSE.

A provisional license may be issued when an agency has one (1) or more Conditions of Participation not met that limit the capacity of the HHA to furnish services of an adequate level and quality. ( )

073. ENFORCEMENT ACTION OF SUMMARY SUSPENSION.
When the Department finds that the agency's deficient practice(s) immediately place the health or safety of any residents in danger, the Department may take immediate action through summary suspension of the agency's license. ( )

074. ENFORCEMENT ACTION OF A CONSULTANT.
A consultant may be required, as a condition of a provisional license, to submit periodic reports to the Licensing Agency. ( )

075. -- 994. (RESERVED)

995. WAIVERS.
Pursuant to Section 39-2404, Idaho Code, waivers to these rules, may be granted by the Department as necessary, provided that granting the waiver does not endanger the health or safety or rights of any patient. The decision to grant a waiver is not to be considered as precedent or be given any force or effect in any other proceeding. Said waiver may be renewed annually if sufficient written justification is presented to the Department. ( )

996. -- 999. (RESERVED)

000. LEGAL AUTHORITY.
The Idaho Department of Health and Welfare is authorized to adopt rules for the administration of public assistance programs under Section 56-202, Idaho Code, and 45 CFR Parts 260 - 265. ( )

001. TITLE, SCOPE, AND PURPOSE.

01. Title. These rules are titled IDAPA 16.03.08, "Temporary Assistance for Families in Idaho (TAFI) Program." ( )

02. Scope. These rules provide standards for the administration of the TAFI program. ( )

03. Purpose. The purpose of these rules are to help participants in the Temporary Assistance for Families in Idaho (TAFI) program to obtain jobs by providing assistance and support. This focus requires more than government alone can or should provide. This program requires relationships where participants, families, local communities and employers work together to help participants obtain employment and achieve self-reliance. Department resources for applicants and participants will be provided in the following priority order, if applicable: Child Support Services (CSS); child care assistance; other Department services such as Medicaid, Food Stamps, Aid to the Aged, Blind and Disabled (AABD); and TAFI. ( )

002. – 007. (RESERVED)

008. AUDIT, INVESTIGATION AND ENFORCEMENT.
In addition to any actions specified in these rules, the Department may audit, investigate and take enforcement action under the provisions of IDAPA 16.05.07, "Investigation and Enforcement of Fraud, Abuse, or Misconduct." ( )

009. (RESERVED)

010. DEFINITIONS.

01. Agency Error. A benefit error caused by the Department's action or failure to act. ( )

02. Applicant. An individual who applies for Temporary Assistance for Families in Idaho. ( )

03. Assistance. Cash payments, vouchers, and other benefits designed to meet a household's ongoing basic needs. Assistance includes recurring benefits, such as transportation and child care, conditioned on participation in work activities. ( )

04. Caretaker Relative. An adult who is a specified relative, other than parents, who has an eligible related child residing with them and who is responsible for the child's care. Only one (1) child in the household must be related to one (1) of the following specified relatives: brother, sister, aunt/great aunt, uncle/great uncle, grandparent/great grandparent, nephew, niece, cousin, any one (1) of these relationships by half-blood, a step-sibling, or a spouse of a relative by marriage, even if the marriage has ended. ( )

05. Department. The Idaho Department of Health and Welfare. ( )

06. Dependent Child. A child under the age of eighteen (18). ( )

07. Good Cause. The conduct of a reasonably prudent person in the same or similar circumstances, unless otherwise defined in these rules. ( )

08. Household. A unit of eligible individuals that includes parents, or may include caretaker relatives who have an eligible child residing with them. ( )

09. Inadvertent Household Error (IHE). A benefit error caused unintentionally by the household. ( )

10. Noncustodial Parent. A parent legally responsible for the support of a dependent minor child, who does not live in the same household as the child. ( )

11. Parent. The mother/step-mother or father/step-father of the dependent child. In Idaho, a man is

presumed to be the child's father if he is married to the child's mother at the time of conception or at the time of the child's birth. ( )

12. **Participant**. An individual who has signed a Personal Responsibility Contract. ( )

13. **Personal Responsibility Contract (PRC)**. An agreement negotiated between a household and the Department that is intended to result in self-reliance. ( )

011. ABBREVIATIONS.

01. **AABD**. Aid to the Aged, Blind and Disabled. ( )

02. **CSS**. Child Support Services. ( )

03. **ECA**. Extended Cash Assistance. ( )

04. **EITC**. Earned Income Tax Credit. ( )

05. **HUD**. The U.S. Department of Housing and Urban Development. ( )

06. **IPV**. Intentional Program Violation. ( )

07. **PRC**. Personal Responsibility Contract. ( )

08. **SSN**. Social Security Number. ( )

09. **TAFI**. Temporary Assistance for Families in Idaho, which is the TANF program in Idaho. ( )

10. **TANF**. Temporary Assistance to Needy Families (Federal Program). ( )

11. **VA**. Veterans Administration. ( )

012. -- 099. (RESERVED)

100. TAFI ELIGIBILITY.
To be eligible for TAFI, an individual must sign an application; provide verification requested by the Department; negotiate and sign a PRC; cooperate in establishing and obtaining support; complete work activities including job search; and meet all other personal responsibility and financial criteria. ( )

101. TIME LIMIT.
Lifetime eligibility for adults is limited to twenty-four (24) months unless otherwise provided by these rules. When there is more than one (1) adult in the household, the number of months of the adult with the most months of TANF participation will be counted towards the time limit. Any month that a TANF benefit was received in another state after June 30, 1997, counts toward the twenty-four (24) month Idaho time limit, unless the other state reports it did not count the months toward the federal time limit. If during the twenty-four (24) month time limit the Department does not end benefits at the appropriate time and a payment is made in error, the month is not counted towards the twenty-four (24) month time limit. It is counted toward the federal sixty (60) month time limit. ( )

102. RESIDENCE EXCEPTION TO TIME LIMIT.
In determining the number of months of federal TANF or state TAFI participation, the Department will not count any month the adult meets the conditions in Subsections 102.01 and 102.02. ( )

01. **Lived in Indian Country or Alaskan Native Village**. The adult lived in Indian country or an Alaskan Native village during the month. ( )

02. **Fifty Percent Not Employed**. The most reliable data about the month shows at least one thousand

(1,000) individuals lived in the Indian country unit or Alaskan Native Village and fifty percent (50%) or more of the adults were not employed. ( )

103. -- 105. (RESERVED)

106. SIGNATURES.
An individual who is applying for benefits, receiving benefits, or providing additional information as required by this chapter, may do so with the depiction of the individual's name either handwritten, electronic, or recorded telephonically. Such signature serves as intention to execute or adopt the sound, symbol, or process for the purpose of signing the related record. ( )

107. (RESERVED)

108. APPLICATION FOR ASSISTANCE.
The application form must be signed by an adult participant, a legal guardian, or a representative, and received by the Department. A new TAFI application is required if the application was denied for failure to provide verification and more than thirty (30) days have elapsed since the household applied. ( )

109. (RESERVED)

110. EFFECTIVE DATE.
The effective date of the TAFI grant is the date income and resource criteria are met, and a PRC is signed, unless the Department causes a delay, or a later date that is negotiated with the Department. ( )

111. SUBSTANCE ABUSE SCREENING AND TESTING NOTICE AT APPLICATION.
The Department will provide notice of substance abuse screening and possible testing to each TAFI applicant. The notice will advise the applicant of the factors listed in Subsections 111.01 through 111.08. ( )

01. Screening Requirement. The Department conducts substance abuse screening as a condition of receiving TAFI cash assistance. ( )

02. Testing Requirement. The Department conducts substance abuse testing as a condition for receiving TAFI cash assistance, if screening indicates the applicant is engaged in, or at high risk of, substance abuse. ( )

03. Treatment Requirement. Participants must enter a substance abuse treatment program and cooperate with treatment, if screening, assessment or testing shows them in need of substance abuse treatment. ( )

112. (RESERVED)

113. CONCURRENT MULTIPLE BENEFIT PROHIBITION.

01. Multiple TAFI Benefits. If individuals in a household unit are potentially eligible for TAFI benefits, only one (1) TAFI cash benefit is allowed in the same month for the household unit. ( )

02. Multiple Program Benefits. If an individual is potentially eligible for either TAFI or AABD, only one (1) program may be chosen. If a child is potentially eligible for either TAFI or foster care, only one (1) program may be chosen. No individual may be eligible for benefits as a member of more than one (1) household in the same month. ( )

03. Program Benefits from Another State. Individuals cannot receive TAFI benefits from Idaho and TANF benefits from another state in the same month. ( )

114. -- 115. (RESERVED)

116. PERSONAL RESPONSIBILITY CONTRACT (PRC).

A personal responsibility contract must be negotiated and signed by the mandatory adult household members defined under Section 125 of these rules, with all application activities completed before eligibility can be approved. The household must continue to comply with ongoing personal responsibility contract requirements to remain eligible. ( )

117. (RESERVED)

118. SUBSTANCE ABUSE ASSESSMENT.
A Department approved substance abuse contractor will conduct screening to evaluate a participant's need for testing. The contractor will use a screening instrument approved by the Department as a valid and reliable indicator of possible substance abuse. The contractor must have adequate training in the recognition of substance abuse, use of the screening instrument, and interpretation of results. When found necessary by the contractor, the assessment process will include substance abuse testing. The contractor will interpret the results. ( )

119. REFERRAL FOR SUBSTANCE ABUSE ASSESSMENT.
The Department will refer the participant for assessment when screening results indicate a reasonable suspicion the participant is engaged in, or at high risk of, substance abuse. A Department approved substance abuse contractor will conduct the assessment. ( )

120. SUBSTANCE ABUSE TESTING.
Idaho law requires substance abuse testing of any TAFI applicant or recipient, if the Department has a reasonable suspicion they are engaged in, or at high risk of, substance abuse. Testing will be conducted if screening and assessment give a reasonable suspicion the participant is engaged in substance abuse. TAFI participants must comply with substance abuse testing as a condition of eligibility. ( )

121. CONSENT AND ACKNOWLEDGMENT REQUIRED BEFORE SUBSTANCE ABUSE TESTING.
Before taking a substance abuse test, the participant must sign a consent for testing. The participant will be asked, but not required, to advise the person administering the test of the use of any over-the-counter or prescription drugs. This information will be considered in the results of the drug test. The participant must acknowledge, in writing, they received and understands the notice elements listed this Section and Section 111 of these rules. ( )

122. ADMINISTRATION OF SUBSTANCE ABUSE TEST.
A Department approved contractor will administer the substance abuse test. The contractor must have training, through a licensed laboratory, in correct procedures for specimen collection and chain of custody. Specimen collection will be documented including labeling containers to prevent erroneous drug test results. The contractor must perform specimen collection, storage, and transportation to the laboratory site in a manner preventing specimen contamination or adulteration. A licensed laboratory will evaluate specimens. The laboratory will analyze specimens for controlled substances and alcohol. ( )

01. Specimen Collection Procedures. The contractor must collect the specimen for substance abuse testing with due regard for the privacy of the participant providing the specimen and in a manner preventing substitution or contamination of the specimen. ( )

02. Test Results. The Department will evaluate the results of the substance abuse test, before notifying the participant of them. The Department will evaluate all positive test results to verify the specimen was collected, transported, and analyzed under proper procedures. The Department will determine if other circumstances caused the positive test result. The Department will review and confirm medical information provided by the applicant. After this evaluation is complete, the Department will notify the participant of the test results. If the test result is positive, the Department will inform the participant of available substance abuse treatment programs, and of the requirement for treatment to be TAFI eligible. ( )

03. Request for New Test. Within ten (10) calendar days of notice of a positive test result, the participant can request a new test. The participant must notify the Department in writing of the intent to challenge the test results. For those participants approved for TAFI, benefits will continue during the re-test process. ( )

123. TAFI APPROVAL BEFORE SUBSTANCE ABUSE SCREENING AND TESTING RESULTS KNOWN.

Applicants may be approved for TAFI, if otherwise eligible, when they agree to substance abuse screening. They must complete the screening instrument and if required, participate in a substance abuse assessment. This includes providing a specimen for testing, if needed as part of the assessment process. The applicant should complete these steps within fifteen (15) calendar days of approval. If the process takes longer than fifteen (15) calendar days, through no fault of the applicant, TAFI may be approved if the participant is cooperative in satisfying their substance abuse screening requirements. ( )

124. SUBSTANCE ABUSE TREATMENT.
If substance abuse screening, assessment or testing shows the participant needs substance abuse treatment, the Department will require the participant to enter a substance abuse treatment program and cooperate with treatment. Treatment will be provided at no cost to TAFI participants. Treatment will be community based and gender specific. The Department will provide for the participant's transportation and child care needs if necessary. ( )

125. MANDATORY TAFI HOUSEHOLD MEMBERS.
Individuals who must be included in the household are listed in the following: ( )

01. Children. Children under the age of eighteen (18) must reside with a parent or caretaker relative who exercises care and control of them. A dependent child's brother or sister, including half (1/2) siblings, living in the same home as the dependent child will be included in the household. Children receiving Supplemental Security Income (SSI) are excluded from the household. ( )

02. Parents. Parents, as defined in Section 010 of these rules, who have an eligible child residing with them. ( )

03. Pregnant Woman. A pregnant woman with no other children who is in at least the third calendar month before the baby is due and is unable to work due to medical reasons. ( )

04. Spouses. Anyone related by marriage to another mandatory household member. ( )

126. BUDGETING FOR CARETAKER RELATIVES.
Individuals who may be eligible are listed in Subsections 126.01 and 126.03 of this rule. ( )

01. Relatives. Adult specified relatives other than parents who have an eligible related child residing with them and who are responsible for the child's care. Only one (1) child in the household must be related to one (1) of the specified caretaker relatives defined in Section 010 of these rules. ( )

02. Caretaker Relative Applying Only for Relative Child. When a caretaker relative applies only for a relative child, only the child's income is counted. ( )

03. Multiple Children. When multiple children are included in the household unit and any child receives Supplemental Security Income, that income is not counted in the determination of the grant amount. ( )

127. MARRIED CHILD UNDER AGE EIGHTEEN.
A married child under age eighteen (18) is no longer considered a dependent child. The child's subsequent separation, divorce or annulment does not change that status. ( )

128. UNMARRIED PARENT UNDER THE AGE OF EIGHTEEN.
An unmarried parent under age eighteen (18) must live with their parents, unless good cause is established. Two (2) unmarried parents under the age of eighteen (18), with a child in common, can choose to live with the parents of the unmarried father or the unmarried mother. ( )

129. GOOD CAUSE NOT TO LIVE WITH PARENTS.
Good cause reasons are required for unmarried parents under age eighteen (18) to not live with their parents. ( )

130. (RESERVED)

131. CITIZENSHIP AND QUALIFIED NON-CITIZEN CRITERIA.
To be eligible, an individual must be a member of one (1) of the groups listed in Subsections 131.01 through 131.10 of this rule. ( )

01. U.S. Citizen. A U.S. Citizen; or ( )

02. U.S. National, National of American Samoa or Swains Island. A U. S. National, National of American Samoa or Swains Island; or ( )

03. Full-Time Active Duty U.S. Armed Forces Member. A qualified non-citizen as defined in 8 U.S.C. 1641(b) or (c) currently on full-time active duty with the U.S. Army, U.S. Air Force, U.S. Marine Corps, U.S. Navy or U.S. Coast Guard, or a spouse or unmarried dependent child of the U.S. Armed Forces member; or ( )

04. Veteran of the U.S. Armed Forces. A qualified non-citizen as defined in 8 U.S.C. 1641(b) or (c) honorably discharged from the U.S. Army, U.S. Air Force, U.S. Marine Corps, U.S. Navy or U.S. Coast Guard for a reason other than their citizenship status or a spouse, including a surviving spouse who has not remarried, or an unmarried dependent child of the veteran; or ( )

05. Non-Citizen Entering the U.S. Before August 22, 1996. A non-citizen who entered the U.S. before August 22, 1996, and is currently a qualified non-citizen as defined in 8 U.S.C. 1641(b) or (c); or ( )

06. Non-Citizen Entering on or After August 22, 1996. A non-citizen who entered on or after August 22, 1996, and ( )

a. Is a refugee admitted into the U.S. under 8 U.S.C. 1157, and can be eligible for seven (7) years from their date of entry; or ( )

b. Is an asylee granted asylum into the U.S. under 8 U.S.C. 1158, and can be eligible for seven (7) years from the date their asylee status is assigned; or ( )

c. Is an individual whose deportation or removal from the U.S. has been withheld under 8 U.S.C. 1253 or 1231(b)(3) as amended by Section 305(a) of Division C of Public Law 104-208, and can be eligible for seven (7) years from the date their deportation or removal was withheld; or ( )

d. Is an Amerasian immigrant admitted into the U.S. under 8 U.S.C. 1612(b)(2)(A)(i)(V), and can be eligible for seven (7) years from the date of entry; or ( )

e. Is a Cuban or Haitian entrant to the U.S. under Section 501(e) of the Refugee Assistance Act, and can be eligible for seven (7) years from their date of entry; or ( )

07. Qualified Non-Citizen Entering on or After August 22, 1996. A qualified non-citizen under 8 U.S.C. 1641(b) or (c), entering the U.S. on or after August 22, 1996, and who has had a qualified non-citizen status for at least five (5) years; or ( )

08. Victim of Severe Form of Trafficking. A victim of a severe form of trafficking in persons, as defined in 22 U.S.C. 7102(13); who meets one (1) of the following: ( )

a. Is under the age of eighteen (18) years; or ( )

b. Is certified by the U.S. Department of Health and Human Services as willing to assist in the investigation and prosecution of a severe form of trafficking in persons; and ( )

i. Has made a bona fide application for a temporary visa under 8 U.S.C. 1104(a)(15)(T), which has not been denied; or ( )

ii. Is remaining in the U.S. to assist the U.S. Attorney General in the prosecution of traffickers in persons. ( )

09. Afghan Special Immigrants. An Afghan special immigrant, as defined in Public Law 111-118, who has special immigration status after December 26, 2007, is eligible from the date they enter into the U.S. as a special immigrant or the date they convert to the special immigrant status. ( )

10. Iraqi Special Immigrants. An Iraqi special immigrant, as defined in Public Law 111-118, who has special immigration status after January 28, 2008, is eligible from the date they enter the U.S. as a special immigrant or the date they convert to the special immigrant status. ( )

132. (RESERVED)

133. SOCIAL SECURITY NUMBER (SSN) REQUIREMENT.
An applicant must provide their Social Security Number (SSN), or proof they have applied for an SSN, to the Department before approval of eligibility, unless good cause exists. If the applicant has more than one (1) SSN, all numbers must be provided. The SSN will be verified by the Social Security Administration (SSA) electronically. When an SSN is unverified, the applicant is not eligible for TAFI benefits. The Department will notify the applicant in writing if eligibility is being denied or lost for failure to meet the SSN requirement. ( )

134. RESIDENCE IN IDAHO.
Individuals must live in the state of Idaho, have no immediate intention of leaving, and cannot be a resident of another state. ( )

135. -- 141. (RESERVED)

142. SCHOOL ATTENDANCE RESPONSIBILITY.
School age children included in the household must attend school until they reach age eighteen (18). A fifty dollar ($50) penalty per month, per child, will be subtracted from the grant if a dependent child does not attend school. This penalty does not apply if the child is participating in work activities outlined in the PRC. ( )

143. -- 146. (RESERVED)

147. ASSIGNMENT OF SUPPORT RIGHTS.
The parent, or the caretaker relative included in the grant, is required by law to assign to the State their rights to child support payments for the household to be eligible for TAFI. The State will retain all child support collections up to the amount of assistance that the household receives. This assignment only applies to the period of time the household is receiving TAFI. ( )

148. COOPERATION RESPONSIBILITY.
For the household to be eligible, a parent, or a caretaker relative included in the grant, must cooperate with the Department to identify and locate any non-custodial parent, establish paternity, and establish, modify and enforce the child support order, unless good cause exists. ( )

149. GOOD CAUSE FOR NOT COOPERATING.
Good cause for not cooperating with Child Support Services (CSS) includes: ( )

01. Rape or Incest. Proof is provided that the child was conceived as a result of incest or rape. ( )

02. Physical or Emotional Harm. Proof is provided that the non-custodial parent may inflict physical or emotional harm to the children, the custodial parent or the caretaker relative. ( )

03. Minimum Information Cannot Be Provided. Substantial and credible proof is provided indicating the participant cannot provide the minimum information regarding the non-custodial parent. ( )

150. (RESERVED)

151. PATERNITY NOT ESTABLISHED WITHIN TWELVE MONTHS.
If information is provided but paternity is not established within twelve (12) months from the effective date of the application or the birth of a child, whichever is later, the grant is reduced by fifty percent (50%), unless the delay is caused by the Department or a third party. When determining the twelve (12) months, the Department will count only months the household received TAFI. ( )

152. -- 156. (RESERVED)

157. APPLICANT JOB SEARCH.
Before the application can be approved, adult applicants will be required to engage in job search activities, unless good cause is established. ( )

158. (RESERVED)

159. APPLICANT VOLUNTARY QUIT.
The household is not eligible for ninety (90) days from the date any adult household member has voluntarily quit the most recent job of twenty (20) or more hours per week without good cause, within sixty (60) days of the application date. ( )

160. PROHIBITION ON APPLICANT STRIKING.
When any applicant adult household member is on strike, the entire household is not eligible. A strike is a concerted stoppage or slowdown of work by employees. ( )

161. -- 162. (RESERVED)

163. WORK ACTIVITIES RESPONSIBILITY.
All adult mandatory household members must participate in work activities, up to forty (40) hours per week. A child between the ages of sixteen (16) and eighteen (18), who is not attending school, must participate up to forty (40) hours per week in assigned work activities. A single custodial parent of a child less than six (6) years of age is not required to participate in a work activity if one of the reasons listed in Subsections 163.01 through 163.03 occurs. ( )

01. Reasonable Distance. Appropriate child care is not available within a reasonable distance from the participant's home or work site. ( )

02. Relative Child Care. Informal child care by relatives or others is not available or is unsuitable. ( )

03. Child Care Not Available. Appropriate and affordable child care is not available. ( )

164. WORK ACTIVITIES.
Work activities include paid work, including self-employment that produces earnings of at least the federal minimum wage; unpaid work; community service; work search activities; education leading to high school diploma or equivalency; work preparation education; vocational or job skills training; and other activities that improve the ability to obtain and maintain employment or support self-reliance. ( )

165. WORK REQUIREMENTS DURING SUBSTANCE ABUSE TREATMENT.
The Department may require participants to engage in appropriate work activities during substance abuse treatment. The treatment program will judge the work activities to be appropriate to the participant's treatment plan. Negotiation of the Personal Responsibility Contract between the participant, the Department and the Treatment program will include the work activities. ( )

166. CONSENT TO RELEASE CONFIDENTIAL INFORMATION.
Participants entering a substance abuse treatment program must sign a consent to release program information to the Department. The treatment program will only release substance abuse treatment information to report participant progress. ( )

167. FAILURE TO COMPLY WITH SUBSTANCE ABUSE SCREENING AND TESTING REQUIREMENTS.
TAFI applicants or participants refusing to cooperate with substance abuse screening, assessment, testing or treatment are ineligible. ( )

168. NOT COMPLYING WITH WORK ACTIVITIES.
Each time an adult does not comply with work activity requirements in the PRC, without good cause, it is counted as an occurrence. The household is subject to the penalties, based on the number of occurrences, as listed in Subsections 168.01 through 168.03. ( )

01. First Occurrence. The household is ineligible for one (1) month or until compliance, whichever is longer. ( )

02. Second Occurrence. The household is ineligible for three (3) months or until compliance, whichever is longer. ( )

03. Third Occurrence. The household is ineligible for lifetime. ( )

169. APPLYING PENALTIES FOR NOT COMPLYING WITH WORK ACTIVITIES.
Work activity penalties are applied as listed in Subsections 169.01 through 169.02. ( )

01. Household Penalty. Penalties apply to the entire household, but the number of individual occurrences follows the individual. The penalty period for the household is the greatest number of any individual's occurrences. If the individual leaves the household, any period of ineligibility caused by that individual ends. If an adult who does not comply returns or joins another household, any remaining period of ineligibility resumes. ( )

02. Work Activity Penalty. A fifty dollar ($50) penalty per month, per child, will be subtracted from the household grant when a child sixteen (16) years of age or older does not comply with work activities, as long as the child resides with the household. ( )

170. -- 176. (RESERVED)

177. TEMPORARY ABSENCE.
Eligible individuals may be temporarily absent from the home for a reasonable period not to exceed one hundred eighty (180) days. ( )

178. NOTIFICATION REQUIREMENT.
The Department will notify the household, in writing, of the approval or denial of the application and the right of appeal, if applicable. ( )

179. -- 199. (RESERVED)

200. RESOURCE LIMIT.
The total of the entire household's countable resources must not be greater than five thousand dollars ($5,000) in any month. Resources are money, financial instruments, vehicles, and real property. ( )

201. COUNTABLE RESOURCES.
Resources are countable when the household has a legal interest in the resource and can take action to obtain or dispose of the resource. Except for vehicles, the fair market value of the resource less all liens, mortgages, or other encumbrances, is the countable amount of the resource. ( )

202. -- 206. (RESERVED)

207. VEHICLES.
The Department counts the resource value of a vehicle as described in Subsections 207.01 and 207.02 of these rules

as long as the vehicle is used primarily for transportation and not for recreational use. The value of any vehicle that is primarily for recreational use counts toward the household's resource limit. ( )

01. Exclude One Vehicle Per Adult. The value of one (1) vehicle per adult in the TAFI household is excluded beginning with the highest valued vehicle. ( )

02. All Other Vehicles Subject to Federal Regulations. All other vehicles in the household will have their values counted as provided in the Federal Food Stamp Program under 7 CFR 273.8. ( )

208. RESOURCE EXCLUSIONS.
The resources listed in Subsections 208.01 through 208.14 of this rule, are excluded. ( )

01. Home and Lot. The household's home, surrounding land and buildings not separated by property owned by others. A public road or right of way that separates any plot from the home does not affect the exclusion. ( )

02. Household Goods. Household goods are items of personal property normally found in the home. The items will be used for maintenance, use, and occupancy of the home. Household goods include furniture, appliances, television sets, carpets, and utensils for cooking and eating. ( )

03. Personal Effects. Personal effects are items worn or carried by a participant, or items having an intimate relation to the participant. Personal effects include clothing, jewelry, personal care items, and prosthetic devices. Personal effects also include items for education or recreation, such as books, musical instruments, or hobby materials. ( )

04. Building Lot. One (1) unoccupied lot and one (1) partially built home. Only one (1) home and one (1) lot can be excluded. ( )

05. Unoccupied Home. A home temporarily unoccupied due to employment, training, medical care or treatment and natural disasters. ( )

06. Home Loss or Damage Insurance Settlements. An insurance settlement awarded to a household for home loss or damage, for twelve (12) months from the date of receipt. ( )

07. Income Producing Property. Real property that annually produces income consistent with its fair market value. ( )

08. Equipment Used in a Trade or Business. Equipment used in a trade or business or reasonably expected to be used within one (1) year from their most recent use. ( )

09. Contracts. A mortgage, deed of trust, promissory note, or any other form of sales contract if the purchase price and income produced are consistent with the property's fair market value. ( )

10. Life Insurance. The cash surrender value of a life insurance policy. ( )

11. Native American Payments. To the extent authorized, payments or purchases made with payments authorized by law based on Native American ancestry. ( )

12. Funeral Agreements. The cash value of an irrevocable funeral agreement. ( )

13. Education Accounts. Account with funds legally identified as monies to pay for educational expenses. ( )

14. Retirement and Tax Preferred Accounts. Accounts legally identified as monies for retirement. ( )

209. -- 213. (RESERVED)

214. COUNTABLE INCOME.
All earned and unearned income is counted in determining eligibility and grant amount, unless specifically excluded by rule. ( )

215. EXCLUDED INCOME.
The types of income listed in Subsections 215.01 through 215.40 of this rule, are excluded. ( )

01. Supportive Services. Supportive services payments. ( )

02. Work Reimbursements. Work-related reimbursements. ( )

03. Child's Earned Income. Earned income of a dependent child, who is attending school. ( )

04. Child Support. Child support payments assigned to the State and non-recurring child support payments received in excess of that amount. ( )

05. Child's Supplemental Security Income (SSI). Income received for a child from Supplemental Security Income (SSI). ( )

06. Loans. Loans with a signed, written repayment agreement. ( )

07. Third Party Payments. Payments made by a person directly to a third party on behalf of the household. ( )

08. Money Gifts. Money gifts, up to one hundred dollars ($100), per person per event, for celebrations typically recognized with an exchange of gifts. ( )

09. TAFI. Retroactive TAFI grant corrections. ( )

10. Social Security Overpayment. The amount withheld for a Social Security overpayment. Money withheld voluntarily or involuntarily to repay an overpayment from any other source is counted as income. ( )

11. Interest Income. Interest posted to a bank account. ( )

12. Tax Refunds. State and federal income tax refunds. ( )

13. EITC Payments. EITC payments. ( )

14. Disability Insurance Payments. Taxes withheld and attorney's fees paid to secure disability insurance payments. ( )

15. Sales Contract Income. Taxes and insurance costs related to sales contracts. ( )

16. Foster Care. Foster care payments. ( )

17. Adoption Assistance. Adoption assistance payments. ( )

18. Food Programs. Commodities and food stamps. ( )

19. Child Nutrition. Child nutrition benefits. ( )

20. Elderly Nutrition. Elderly nutrition benefits received under Title VII, Nutrition Program for the Elderly, of the Older Americans Act of 1965. ( )

21. Low Income Energy Assistance. Benefits paid under the Low Income Energy Assistance Act of 1981. ( )

22. Home Energy Assistance. Home energy assistance payments under Public Law 100-203, Section 9101. ( )

23. Utility Reimbursement Payment. Utility reimbursement payments. ( )

24. Housing Subsidies. An agency or housing authority pays a portion of or all of the housing costs for a participant. ( )

25. Housing and Urban Development (HUD) Interest. Interest earned on HUD household self-sufficiency escrow accounts established by Section 544 of the National Affordable Housing Act. ( )

26. Native American Payments. Payments authorized by law made to people of Native American ancestry. ( )

27. Educational Income. Educational income includes deferred repayment education loans, grants, scholarships, fellowships, and veterans' educational benefits. The school attended must be a recognized institution of post secondary education, a school for the handicapped, a vocational education program, or a program providing completion of a secondary school diploma, or equivalent. ( )

28. Work Study Income of Student. College work study income. ( )

29. VA Educational Assistance. VA Educational Assistance. ( )

30. Senior Volunteers. Senior volunteer program payments to individual volunteers under the Domestic Volunteer Services Act of 1979, 42 U.S.C. Sections 4950 through 5085. ( )

31. Relocation Assistance. Relocation assistance payments received under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970. ( )

32. Disaster Relief. Disaster relief assistance paid under the Disaster Relief Act of 1974 and aid provided under any federal statute for a President-declared disaster. Comparable disaster assistance provided by states, local governments, and disaster assistance organizations. ( )

33. Radiation Exposure Payments. Payments made to persons under the Radiation Exposure Compensation Act. ( )

34. Agent Orange. Agent Orange settlement payments. ( )

35. Spina Bifida. Spina bifida allowances paid to children of Vietnam veterans. ( )

36. Japanese-American Restitution Payments. Payments by the U.S. Government to Japanese-Americans, their spouses, or parents (or if deceased to their survivors) interned or relocated during World War II. ( )

37. Vista Payments. Volunteers in Service to America (VISTA) payments. ( )

38. Subsidized Employment. Employment for which the employer receives a subsidy from public funds to offset a portion or all of the wages and costs of employing an individual. This type of employment is a short-term placement, pays prevailing wage, and a specific skill is acquired. The employment is prescribed through a memorandum of agreement with no guarantee of permanent employment for the participant. ( )

39. Temporary Census Income. All wages paid by the Census Bureau for temporary employment related to U.S. Census activities are excluded for a time period not to exceed six (6) months during the regularly scheduled ten (10) year U.S. Census. ( )

40. Income Excluded By Federal Law. Income excluded by federal law is not counted in determining

income available to the participant. ( )

216. -- 220. (RESERVED)

221. DETERMINING ELIGIBILITY.
To determine initial and continuing eligibility, the countable monthly income that is or will be available to the household is used in the calculation of the grant. ( )

222. CONVERTING INCOME TO A MONTHLY AMOUNT.
Income received more often than once a month is converted to a monthly amount as listed in Subsections 222.01 through 222.03, if a full month's income is anticipated. Figures are not rounded when income is converted to a monthly amount. ( )

01. Weekly Payments. The projected weekly payment is multiplied by four point three (4.3). ( )

02. Biweekly Payments. The projected bi-weekly amount is multiplied by two point one five (2.15). ( )

03. Semi-Monthly Payments. The projected semi-monthly amount is multiplied by two (2). ( )

223. AVERAGING INCOME.
Income may be averaged for participants who receive income from a contract, from self-employment, or any other income that is intended to cover more than one (1) month, if it is expected to continue. The income is averaged over the number of months it is intended to cover. ( )

224. -- 228. (RESERVED)

229. SELF-EMPLOYMENT INCOME.
For the purposes of these rules, self-employment income is from a business that is a sole proprietorship. A sole proprietorship is a business owned by one (1) person. ( )

230. AVERAGING SELF-EMPLOYMENT INCOME.

01. Annual Self-Employment Income. When self-employment income is considered annual support by the household, the Department averages the self-employment income over a twelve (12) month period, even if: ( )

a. The income is received over a shorter period of time than twelve (12) months; and ( )

b. The household receives income from other sources in addition to self-employment. ( )

02. Seasonal Self-Employment Income. A seasonally self-employed individual receives income from self-employment during part of the year. When self-employment income is considered seasonal, the Department averages self-employment income for only the part of the year the income is intended to cover. ( )

231. CALCULATION OF SELF-EMPLOYMENT INCOME.
The Department calculates self-employment income by adding monthly income to capital gains and subtracting a deduction for expenses as determined in Subsection 231.03 of this rule. ( )

01. How Monthly Income is Determined. If no income fluctuations are expected, the average monthly income amount is projected for the certification period. If past income does not reflect expected future income, a proportionate adjustment is made to the expected monthly income. ( )

02. Capital Gains Income. Capital gains include profit from the sale or transfer of capital assets used in self-employment. The Department calculates capital gains using the federal income tax method. If the household expects to receive any capital gains income from self-employment assets during the certification period, this amount

is added to the monthly income, as determined in Subsection 231.01 of this rule, to determine the gross monthly income. ( )

03. Self-Employment Expense Deduction. The Department uses the standard self-employment deduction in Subsection 231.03.a. of this rule, unless the applicant claims that their actual allowable expenses exceed the standard deduction and provides proof of the expenses described in Subsection 231.03.b. of this rule. ( )

a. The self-employment standard deduction is determined by subtracting fifty percent (50%) of the gross monthly self-employment income as determined in Subsections 231.01 and 231.02 of this rule; or ( )

b. The self-employment actual expense deduction is determined by subtracting the actual allowable expenses from the gross monthly self-employment income. The following items are not allowable expenses and may not be subtracted from the gross monthly self-employment income: ( )

i. Net losses from previous tax years; ( )

ii. Federal, state, and local income taxes; ( )

iii. Money set aside for retirement; ( )

iv. Work-related personal expenses such as transportation to and from work; and ( )

v. Depreciation. ( )

232. RENTAL INCOME FROM REAL PROPERTY.
If a household member is managing the property twenty (20) hours or more per week, the rental income minus rental costs is earned income. If a household member is managing the property less than twenty (20) hours per week, the rental income minus rental costs is unearned income. Rental costs do not include the principal portion of the mortgage payment, depreciation or depletion, capital payments, and personal expenses not related to the rental income. ( )

233. -- 239. (RESERVED)

240. INDIVIDUALS EXCLUDED FROM HOUSEHOLD SIZE.
Individuals listed in Subsections 240.01 through 240.06 are excluded from the household size in determining eligibility and grant amount. Income and resources of these ineligible household members are counted unless otherwise excluded in Section 215 of these rules. ( )

01. Ineligible Non-Citizens. Individuals who are non-citizens and are not listed in Section 131. ( )

02. With Drug Related Conviction. Individuals convicted under federal or state law of any offense classified as a felony involving the possession, use or distribution of a controlled substance, when they do not comply with the terms of a withheld judgment, probation or parole, and whose felony occurred after August 22, 1996. ( )

03. Fleeing Felons. Felons who are fleeing to avoid prosecution, custody or confinement after conviction of a felony or an attempt to commit a felony. ( )

04. Felons Violating a Condition of Probation or Parole. Felons who are violating a condition of probation or parole imposed for a federal or state felony. ( )

05. Convicted of Fraudulent Misrepresentation of Residency. Individuals convicted in a federal or state court of fraudulently misrepresenting residence to get TANF, AABD, Food Stamps, Medicaid or SSI from two (2) or more states at the same time are ineligible for ten (10) years from the date of conviction. ( )

06. Children Receiving Supplemental Security Income (SSI). A child who is receiving

Supplemental Security Income (SSI). ( )

241. SPONSORED NON-CITIZEN.
The income and resources of a legal non-citizen's sponsor and the sponsor's spouse are counted in determining eligibility and grant amount in accordance with applicable federal law. ( )

242. ONE-HALF GRANT CHILD SUPPORT PENALTY AND SCHOOL OR WORK PENALTY.
If the grant amount is reduced by fifty percent (50%) for not establishing paternity within twelve (12) months and there are one (1) or more penalties for not attending school or work, the child support penalty is calculated first.
( )

243. -- 247. (RESERVED)

248. MAXIMUM GRANT AMOUNT.
The maximum grant is three hundred nine dollars ($309). ( )

249. GRANT AMOUNT FOR FAMILIES WITH NO INCOME.
The grant amount for eligible families with no income is the maximum grant minus penalties, if applicable.
( )

250. GRANT AMOUNT FOR FAMILIES WITH UNEARNED INCOME.
The grant amount for eligible families with unearned income only is the maximum grant minus the unearned income, and penalties if applicable. ( )

251. WORK INCENTIVE TABLE.
Work Incentive Table 251 is used in the calculation of the grant amount for households with earned income.

WORK INCENTIVE TABLE 251	
Number of Household **Members**	**Monthly Amount**
1	$309
2	$309
3	$389
4	$469
5	$547
6	$628
7	$708
8	$787
9	$867
10	$947
Over 10 Persons	Add $80 Each

( )

252. GRANT AMOUNT FOR FAMILIES WITH EARNED INCOME.
For eligible families with earned income, an amount is calculated by subtracting sixty percent (60%) of gross earned income, one hundred percent (100%) of any unearned income, and applicable penalties from the figure in the Work Incentive Table based on the household size. The grant amount is the result of this calculation rounded to the next lowest dollar or the maximum grant, whichever is less. ( )

253. PRORATING BENEFITS FOR THE APPLICATION MONTH.
The grant amount is prorated from the effective date. ( )

254. GRANT LESS THAN TEN DOLLARS NOT PAID.
A payment is not made when the grant amount is less than ten dollars ($10). ( )

255. -- 259. (RESERVED)

260. APPLICANT ONE-TIME CASH PAYMENT.
An applicant household may be eligible for a one-time cash assistance payment for any emergency need. The household must meet the income criteria in the first month of the one-time cash payment, but all income is excluded in calculating the monthly one-time cash payment amount. Eligibility criteria, except SSN, are verified at the discretion of the Department. ( )

261. APPLICANT ONE-TIME CASH PAYMENT ELIGIBILITY CRITERIA.
The applicant household must meet the following requirements: ( )

01. SSN. Provide SSN, or proof of application for an SSN, for each adult household member. ( )

02. Dependent Child. Have a dependent child or a pregnant woman in her last trimester who is medically unable to work. ( )

03. Residence. Live in Idaho with no adults in the household receiving a TANF payment in the same month from another state. ( )

04. Voluntary Quit. No adult household member who has voluntarily quit their most recent employment within sixty (60) days or has been on strike. ( )

05. Income and Resources. Be income eligible for TAFI without resources to meet the need. ( )

06. Period of Ineligibility. Not be in a period of TAFI ineligibility. ( )

07. Agreement. Complete a one-time cash agreement. ( )

08. Episode of Need Restriction. For households receiving Career Enhancement services or Emergency Assistance, no receipt of one-time cash payment for the same episode of need. ( )

262. PARTICIPANT ONE-TIME CASH PAYMENT.
A participant household may be eligible for a one-time cash assistance payment to obtain or maintain employment. A participant household must have at least two (2) months of the twenty-four (24) month TAFI time limit remaining for each month of the one-time cash payment. The participant household's income is excluded in calculating the monthly one-time cash payment amount. The participant household's PRC must be modified to include the one-time cash payment agreement. ( )

263. ONE-TIME CASH PAYMENT AGREEMENT.
The one-time cash agreement must include the information listed in Subsections 263.01 through 263.05. ( )

01. Reason. The reason for the one-time cash payment. ( )

02. Number of Months. The number of months included in the one-time cash payment. ( )

03. Penalty Months. The number of penalty months subtracted from the household's twenty-four (24) month time limit. ( )

04. Remaining Months. The number of months remaining in the twenty-four (24) month time limit. ( )

05. Ineligibility Period. The months the household will not be eligible for TAFI. ( )

264. AMOUNT OF ONE-TIME CASH PAYMENT.
The amount of the one-time cash payment is the amount of need or up to three (3) times the maximum monthly grant amount. ( )

265. INELIGIBILITY PERIOD.
A household who receives a one-time cash payment is ineligible for the number of full or partial months for which the one-time cash payment is made and one (1) additional month for each month included in the one-time cash payment. An applicant household who receives a one-time cash payment is ineligible for TAFI beginning the month of the one-time cash payment. A participant household who receives a one-time cash payment is ineligible for TAFI beginning the month after TAFI ends due to the one-time cash payment. The ineligibility period counts toward the twenty-four (24) month time limit. ( )

266. LIFETIME ELIGIBILITY.
A household can be eligible for a one-time cash payment only once in a lifetime in Idaho. ( )

267. -- 299. (RESERVED)

300. DEPARTMENT NOTIFICATION RESPONSIBILITY.
Notification will be provided to a household whenever eligibility or the grant amount changes. The notification will state the effective date and the reason for the action, the rule that supports the action, and the household's appeal rights. Notification may be delivered to the customer by hand, U.S. Mail, professional delivery service, or by any electronic means. ( )

301. ADVANCE NOTIFICATION RESPONSIBILITY.
Whenever a reported change results in a grant closure or decrease, the Department will provide notification at least ten (10) calendar days before the effective date of the action. ( )

302. ADVANCE NOTIFICATION NOT REQUIRED.
Notification must be provided by the date of the action, but advance notification is not required in the following circumstances: ( )

01. Household Request. The household requests closure of the grant. ( )

02. Household Member in Institution. A household member is admitted or committed to an institution. ( )

03. Household's Address Unknown. The household's whereabouts are unknown and Department mail is returned showing no known forwarding address. ( )

04. TANF Received in Another State. A household member is receiving TANF in another state. ( )

05. Child Removed. A child household member is removed from the home due to a judicial determination. ( )

06. Intentional Program Violation (IPV). An IPV disqualification begins the first month after the month the member receives written notice of disqualification. ( )

07. Failure to Comply with Personal Responsibility Contract. A participant fails to comply with activities agreed to in the participant's Personal Responsibility Contract. ( )

303. -- 307. (RESERVED)

308. HOUSEHOLD REPORTING RESPONSIBILITIES.
The household must report changes in circumstances to the Department, either verbally or in writing, within ten (10) calendar days from the date the change becomes known, unless good cause is established. ( )

309. PENALTY FOR FAILURE TO REPORT.
When a household member does not report a change in income, resources or household composition, without good cause, the household is ineligible as follows: ( )

01. First Occurrence. The household is ineligible for one (1) month. ( )

02. Additional Occurrence. The household is ineligible for three (3) months. ( )

310. CHANGES AFFECTING ELIGIBILITY OR GRANT AMOUNT.
If a household reports a change that results in an increase, the grant will be increased effective the month after the month of report. If a household reports a change that results in a decrease, the grant is decreased or ended effective the first month after advance notice to the household, unless the change does not require advance notice. ( )

311. TAFI ELIGIBILITY DURING SUBSTANCE ABUSE TREATMENT.
A participant may receive TAFI after showing a positive test result. They must agree to enter treatment and meet all other eligibility factors. Participants continuing to meet TAFI eligibility factors will remain eligible during substance abuse treatment. A participant absent from the home, due to residential treatment, continues to be a member of the TAFI assistance unit. ( )

312. FAILURE TO COMPLY WITH TREATMENT OR ENGAGING IN SUBSTANCE ABUSE AFTER TREATMENT.
The Department will deny TAFI benefits to any participant who leaves treatment before being released, or engages in substance abuse following treatment. ( )

313. CONTINUATION OF ELIGIBILITY FOR CHILDREN.
A dependent child's eligibility for TAFI is not affected if an adult in the assistance unit is ineligible for refusal to comply with the substance abuse screening, testing or treatment. ( )

314. PROTECTIVE PAYEE.
If an adult in the assistance unit is ineligible for TAFI for failure to comply with substance abuse screening, testing or treatment requirements, the Department may establish a protective payee for the benefit of the child. If the adult refuses to cooperate in establishing an appropriate protective payee for the child, the Department may appoint one. ( )

315. (RESERVED)

316. UNDERPAYMENT.
If the Department is at fault for issuing a payment less than the household should have received, the Department issues a supplemental benefit for the difference. ( )

317. FAIR HEARING REQUEST.
A household may request a fair hearing to contest a Department decision. The household must make the request for a fair hearing within thirty (30) days from the date the notification was mailed by the Department. ( )

318. CONTINUATION PENDING LOCAL HEARING DECISION.
The household may continue to receive assistance during the hearing process if the Department receives the request for continued benefits within ten (10) days from the date the notification was mailed. Assistance will be continued at the current month’s level while the hearing decision is pending, unless the twenty-four (24) month limit is reached or another change affecting the household’s eligibility occurs, including failure to cooperate with requirements of the Personal Responsibility Contract while waiting for the Fair Hearing decision. ( )

319. -- 323. (RESERVED)

324. INTENTIONAL PROGRAM VIOLATIONS (IPV).
An IPV is an intentionally false or misleading action or statement made to establish or maintain eligibility. The Department investigates and refers appropriate cases for IPV determination, which may include a referral for the prosecution of fraud. An IPV will be established as follows: ( )

01. Admission. When a household member admits the IPV in writing and waives the right to an administrative hearing. ( )

02. Hearing. By an administrative hearing. ( )

03. Court Decision. By a court decision. ( )

04. Deferred Adjudication. By deferred adjudication. ( )

325. DEFERRED ADJUDICATION.
Deferred adjudication exists when either of the following is met: ( )

01. Meets Terms of Court Order. The court does not issue a determination of guilt because the accused household member meets the terms of a court order. ( )

02. Agreement with Prosecutor. The court does not issue a determination of guilt because the accused household member meets the terms of an agreement with the prosecutor. ( )

326. DISQUALIFICATION FOR IPV.
The entire household is ineligible for the following periods on findings of an IPV for: ( )

01. First Offense. Twelve (12) months for the first IPV or fraud offense, or the length of time specified by the court. ( )

02. Second Offense. Twenty-four (24) months for the second IPV or fraud offense, or the length of time specified by the court. ( )

03. Third Offense. Permanent disqualification when a third or subsequent offense is committed, or for the length of time specified by the court. ( )

327. APPLYING PENALTIES FOR IPV.
IPV penalties apply to the entire household, but the number of individual occurrences follows the individual. The penalty period for the household is the greatest number of any individual's occurrences. If the individual leaves the household, any period of ineligibility caused by that individual ends. If an individual serving an IPV penalty returns to the household or joins another household, the remaining period of ineligibility is applied to the household.
( )

328. (RESERVED)

329. IPV OVERPAYMENTS.
An IPV overpayment is the portion of a monthly TAFI payment issued to a household that exceeds the amount for which the household is eligible. The overpayment must result from an IPV established as described in Section 324.
( )

330. IPV OVERPAYMENT AND EARNED INCOME.
If the IPV is the result of the household's failure to report earned income, the Department will use one hundred percent (100%) of the household's earned income to calculate the IPV overpayment. ( )

331. IPV OVERPAYMENT COLLECTION.
The Department will take all reasonable steps to collect an IPV overpayment. The remaining adult household members are responsible for an IPV overpayment resulting from one (1) member's IPV, regardless of the household's

current TAFI eligibility. ( )

332. NOTICE OF OVERPAYMENT.
The Department will notify the participant when an overpayment exists. The notice will inform the participant of mandatory recovery, the right to a hearing, the method for repayment and the need to arrange a repayment interview. ( )

333. INADVERTENT HOUSEHOLD ERROR AND AGENCY ERROR TAFI OVERPAYMENTS.
An overpayment exists when a household receives a TAFI payment that exceeds the amount they were eligible to receive. The Department will establish a claim against the household, to recover the value of the overpaid TAFI benefit. ( )

01. Inadvertent Household Error (IHE). An IHE is an error caused by an adult household member, without intent to cause an overpayment, which results in an overpayment. Examples of IHE claims are: ( )

a. Failure to Give Information. A household, without intent to cause an overpayment, fails to give correct or complete information. ( )

b. Failure to Report a Change that was required to be reported. A household, without intent to cause an overpayment, fails to report changes or to report at all. ( )

c. Failure to Comply. A household, without intent to cause an overpayment, fails to comply due to a language barrier, educational level, or not understanding written or verbal instructions. ( )

d. Benefits Paid Pending a Hearing. A household gets continued TAFI pending a fair hearing decision and the hearing decision, when made, is against the household. ( )

02. Agency Error (AE). An agency error overpayment claim results from an overpayment caused by a Department action, or failure to act. ( )

334. (RESERVED)

335. REVIEW OF PERSONAL RESPONSIBILITY CONTRACT AND ELIGIBILITY.
The PRC and eligibility are reviewed on an ongoing basis and when a change occurs that may affect eligibility. ( )

336. PRC MODIFICATIONS.
If the participant cannot meet a PRC condition, the participant must notify the Department. Either the participant or the Department may initiate renegotiation or modification of the PRC when conditions change. ( )

337. NOT COMPLYING WITH CONDITIONS OF PRC.
If the participant does not comply with a requirement of the PRC, without good cause, the penalty specified in the rules addressing the activity is imposed. The Department's non-compliance with a PRC requirement is good cause. ( )

338. -- 339. (RESERVED)

340. EXTENDED CASH ASSISTANCE (ECA).
Extended Cash Assistance (ECA) may be provided to families who have received twenty-four (24) months of assistance. All eligibility criteria apply to ECA. ( )

341. EXTENDED CASH ASSISTANCE APPLICATION.
No application is required for ECA for families receiving temporary cash assistance. For all other families an application is required. ( )

342. EXTENDED CASH ASSISTANCE ADDITIONAL ELIGIBILITY CRITERIA.
In addition to all the eligibility requirements for TAFI, all adults in the household must meet one (1) of the conditions

listed in Subsections 342.01 through 342.02. ( )

01. Physical Condition. A physical or mental condition expected to last at least three (3) months. The condition must prevent any employment that would generate earnings of at least one hundred sixty-seven percent (167%) of the maximum grant, per month. ( )

02. Care of Ill or Incapacitated Household Member. Care of an ill or incapacitated child or spouse in the home. The in-home care must be provided for a minimum of one (1) month and prevent any employment that would generate earnings of at least one hundred sixty-seven percent (167%) of the maximum grant, per month. ( )

343. (RESERVED)

344. EXTENDED CASH ASSISTANCE TIME LIMITS.
There are no time limits for ECA, but all adults in the household must continue to meet both ECA and temporary cash assistance eligibility criteria. ( )

345. -- 349. (RESERVED)

350. TRANSITIONAL ASSISTANCE.
Transitional Assistance may be provided to an individual whose household is no longer eligible for TAFI cash assistance due to employment or who requested TAFI closure because of employment. At the time of closure, the household's income must be below two hundred percent (200%) of the federal poverty guidelines. ( )

351. TRANSITIONAL ASSISTANCE ELIGIBILITY CRITERIA.
The following requirements must be met: ( )

01. TAFI Household. The household has received TAFI for one (1) partial month or one (1) full month within the past twelve (12) months. ( )

02. Need for Work-Related Services. The individual needs work-related services to maintain employment. ( )

03. Residence. The individual lives in the state of Idaho and is not a resident of another state. ( )

04. Controlled Substance Felon. Individuals convicted under federal or state law of any offense classified as a felony involving the possession, use or distribution of a controlled substance, can receive Transitional Assistance when they comply with the terms of a withheld judgment, probation or parole, and whose felony occurred after August 22, 1996. ( )

05. Fleeing Felons. Felons who are fleeing to avoid prosecution, custody or confinement after conviction of a felony or an attempt to commit a felony cannot receive Transitional Assistance. ( )

06. Parole Violation. Felons who are violating a condition of probation or parole imposed for a federal or state felony cannot receive Transitional Assistance. ( )

07. Fraud. Individuals convicted in a federal or state court of fraudulently misrepresenting residence to get TANF, AABD, Food Stamps, Medicaid, or SSI, from two (2) or more states at the same time, cannot receive Transitional Assistance for ten (10) years from the date of conviction. ( )

352. (RESERVED)

353. TRANSITIONAL ASSISTANCE TIME LIMIT.
Transitional Assistance may be provided up to twelve (12) months after TAFI ends due to employment. Transitional Assistance does not count toward the TAFI twenty-four (24) month time limit. If the Department pays Transitional Assistance in error, the month does not count towards the twenty-four (24) month TAFI time limit. ( )

354. -- 367. (RESERVED)

368. CAREER ENHANCEMENT ASSISTANCE.
Career Enhancement Assistance may be provided to an individual with dependent children. The individual must have a work-related need, that if unmet, would prevent them from maintaining employment or participating in work programs. Career Enhancement Assistance is non-recurrent, short-term, and designed to deal with a specific crisis situation or episode of need. ( )

369. CAREER ENHANCEMENT SERVICE PLAN.
All individuals receiving Career Enhancement Assistance must have a written Career Enhancement Service Plan. ( )

370. CAREER ENHANCEMENT ASSISTANCE ELIGIBILITY CRITERIA.
The following requirements must be met: ( )

01. Application and Service Plan. Submit a completed application form for Career Enhancement Assistance, unless the household already receives services from the Food Stamp Medicaid, Idaho Child Care or Child Support Services programs; all eligible individuals complete a Career Enhancement service plan. ( )

02. Verification of Career Enhancement Eligibility. Have SSN verified. Other eligibility criteria are verified at the discretion of the Department. ( )

03. Eligible Individual. No failure to comply with a previous Career Enhancement Service Plan without good cause. Be a parent or a caretaker relative with a dependent child in the home, a pregnant woman; or a non-custodial parent legally responsible to provide support for a dependent child who does not reside in the same home. ( )

04. Need for Work-Related Services. Be in need for work-related services to maintain employment or participate in work programs; participate in meeting that need to the extent possible. This requires the individual to meet a portion of the need if possible, and to explore other resources available to meet the need. ( )

05. Income Limit. Meet the income limit for only the first month of the service to receive Career Enhancement Assistance; have household income below two hundred percent (200%) of the federal poverty guidelines, be eligible for Food Stamps, Medicaid or ICCP. For non-custodial parents, have household income below four hundred percent (400%) of the federal poverty guidelines, or be eligible for Food Stamps or Medicaid. ( )

06. Citizenship and Legal Non-Citizen. Be a citizen or meet the legal non-citizenship requirements of Section 131. ( )

07. SSN. Provide an SSN, or proof of application for an SSN. ( )

08. Residence. Live in the state of Idaho and not a resident of another state. ( )

09. No Duplication of Services. No Career Enhancement Assistance for a need already met by Emergency Assistance under IDAPA 16.06.01, "Family and Children's Services," or by a one-time TAFI cash payment. ( )

10. TANF Restrictions. The household cannot be receiving TANF or TAFI benefits or be serving a TAFI sanction and participants cannot receive Career Enhancement Assistance if they have received five (5) years of TANF benefits. The household must not be receiving TANF Extended Cash Assistance. The participant cannot receive Career Enhancement Assistance if they have received it within the past twelve (12) months. ( )

11. Controlled Substance Felons. Individuals convicted under federal or state law of any offense classified as a felony involving the possession, use or distribution of a controlled substance can receive Career Enhancement Assistance when they comply with the terms of a withheld judgment, probation or parole and if their

felony occurred after August 22, 1996. ( )

12. Fleeing Felons. Felons who are fleeing to avoid prosecution, custody or confinement after conviction of a felony or an attempt to commit a felony cannot receive Career Enhancement Assistance. ( )

13. Probation or Parole Violation. Felons who are violating a condition of probation or parole imposed for a federal or state felony cannot receive Career Enhancement Assistance. ( )

14. Fraud. Individuals convicted in a federal or state court of fraudulently misrepresenting residence to get TANF, AABD, Food Stamps, Medicaid, or SSI, from two (2) or more states at the same time, cannot receive Career Enhancement Assistance for ten (10) years from the date of conviction. ( )

371. -- 372. (RESERVED)

373. FUNDING RESTRICTIONS.
If a funding shortfall is projected, the Department will take action to reduce Career Enhancement Assistance payments. ( )

374. CAREER ENHANCEMENT ASSISTANCE TIME LIMIT.
An individual may only receive one (1) Career Enhancement Assistance payment in a twelve (12) month period. Career Enhancement Assistance payments do not count towards the TAFI twenty-four (24) month time limit or the sixty (60) month TANF time limit. If the Department pays Career Enhancement Assistance in error, the month does not count towards the twenty-four (24) month TAFI time limit. ( )

375. SUPPORTIVE SERVICE EXPENDITURES.
Supportive Service expenditures may be provided to household members who receive TAFI Cash Assistance, Extended Cash Assistance, Transitional Assistance, or Career Enhancement Assistance. ( )

01. TAFI Cash Assistance or Extended Cash Assistance Expenditure Requirement. The Supportive Service expenditure must be needed to support an element of the Personal Responsibility Contract (PRC). ( )

02. Transitional Assistance Expenditure Requirement. The Supportive Service expenditure must be directly related to maintaining employment. ( )

03. Career Enhancement Assistance Expenditure Requirements. The Supportive Service expenditure must be directly related to maintaining employment or participating in a training program. Career Enhancement Assistance Supportive Services must be identified and authorized in a thirty (30) day period to meet needs that do not extend beyond a ninety (90) day period. All Supportive Services provided through Career Enhancement Assistance do not have to be identified at the same time, as long as the need is identified and authorized within thirty (30) days of the Service Plan. ( )

376. PROHIBITED SUPPORTIVE SERVICE EXPENDITURES.
Supportive Service expenditures must not be authorized for the following types of expenses: ( )

01. Child Care. Child care of any type. ( )

02. Medical Services. Medical services, including medical exams. ( )

03. Vehicles. Motorized vehicle purchases, and down payments. ( )

04. Services for Children. Services or payments for a child, such as counseling, clothing, and school supplies. ( )

05. Credit Card Accounts. Payments on charge cards. ( )

06. Household Items. Furniture and major home appliances. ( )

07. **Fines**. Any type. ( )

08. **Professional Union or Trade Dues**. Any type. ( )

09. **Any Service**. Available through another resource. ( )

377. ENHANCED WORK SERVICES.

01. **Time Period**. Enhanced Work Services may be provided for up to twelve (12) months to household members who receive Transitional Assistance or Career Enhancement Assistance. ( )

02. **Purpose**. Enhanced Work Services are to help individuals maintain employment and include the following: ( )

a. Screening; ( )

b. Job Placement Assessment; ( )

c. Case Management; and ( )

d. Job Readiness Services. ( )

378. -- 999. (RESERVED)

000. LEGAL AUTHORITY.

01. Rulemaking Authority. The Idaho Department of Health and Welfare has the authority to promulgate public assistance rules under Section 56-202(b), 56-264, 56-265, and 56-1610, Idaho Code. ( )

02. General Administrative Authority. Titles XIX and XXI of the Social Security Act, as amended, and the companion federal regulations, are the basic authority for administration of the federal program. General administrative duties for the Department are found under Section 56-202, Idaho Code. ( )

03. Administration of the Medical Assistance Program. ( )

a. Section 56-203(7), Idaho Code, empowers the Department to define persons entitled to medical assistance. ( )

b. Section 56-203(9), Idaho Code, empowers the Department to identify the amount, duration, scope of care, and services to be purchased as medical assistance on behalf of individuals eligible to receive benefits under the Medical Assistance Program. ( )

c. Sections 56-250 through 56-257, and 56-260 through 56-266, Idaho Code, establish minimum standards that enable these rules. ( )

04. Fiscal Administration. ( )

a. Fiscal administration of these rules is authorized by Titles XIX and XXI of the Social Security Act, as well as 42 CFR Part 447 and the Provider Reimbursement Manual (PRM) Part I and Part II found in CMS Publication 15-1 and 15-2. Provisions of the PRM, as incorporated in Section 004 of these rules, apply unless otherwise provided for in these rules. ( )

b. Title 56, Chapter 1, Idaho Code, establishes standards for provider payment for certain Medicaid providers. ( )

001. TITLE AND SCOPE.

01. Title. The title of these rules is IDAPA 16.03.09, "Medicaid Basic Plan Benefits." ( )

02. Scope. This chapter of rules contains the general provisions regarding the administration of the Medical Assistance Program. All goods and services not specifically included in this chapter are excluded from coverage under the Medicaid Basic Plan. A guide to covered services is found under Section 399 of these rules. These rules also contain requirements for provider procurement and provider reimbursement. ( )

002. WRITTEN INTERPRETATIONS.

This agency may have written statements that pertain to the interpretations of the rules of this chapter. These documents are available for public inspection. ( )

003. (RESERVED)

004. INCORPORATION BY REFERENCE.

The following are incorporated by reference in this chapter of rules: ( )

01. American Speech-Language-Hearing Association (ASHA): Medicaid Guidance for Speech-Language Pathology Services. The American Speech-Language-Hearing Association (2004) Medicaid Guidance for Speech-Language Pathology Services: Addressing the "Under the Direction of" Rule technical report is available on the internet at: https://www.asha.org/. The report may also be obtained at the ASHA National Office, 2200 Research Boulevard, Rockville, MD 20850-3289, telephone (301) 296-5700. ( )

02. DSM-5. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, (DSM-5) Arlington, VA, American Psychiatric Association, 2013. A copy of the manual is available for public review at the Department of Health and Welfare, 450 West State Street, Boise, Idaho, 83702. ( )

03. Estimated Useful Lives of Depreciable Hospital Assets, 2004 Revised Edition, Guidelines Lives. This document may be obtained from American Hospital Publishing, Inc., 211 East Chicago Avenue, Chicago,

IL, 60611. ( )

04. Medicare Durable Medical Equipment Medicare Administrative Contractor Jurisdiction D Supplier Manual 2016, As Amended (CMS/Medicare DME Coverage Manual). Since the supplier manual is amended on a quarterly basis by CMS, the current year's manual is being incorporated by reference, as amended, to allow for the incorporation of the most recent amendments to the manual. The full text of the CMS/Medicare DME Coverage Manual is available via the Internet at https://med.noridianmedicare.com/web/jddme/education/supplier-manual. ( )

05. Provider Reimbursement Manual (PRM). The Provider Reimbursement Manual (PRM), Part I and Part II (CMS Publication 15-1 and 15-2), is available on the CMS website at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals.html. ( )

06. Travel Policies and Procedures of the Idaho State Board of Examiners. The text of "Idaho State Travel Policies and Procedures of the Idaho State Board of Examiners," Appendices A and B, June 13, 2000, is available at the Office of the State Controller, 700 W. State St., 5th Fl., Box 83720, Boise, Idaho 83720-0011 or on the Internet at http://www.sco.idaho.gov. ( )

005. -- 007. (RESERVED)

008. AUDIT, INVESTIGATION, AND ENFORCEMENT.
In addition to any actions specified in these rules, the Department may audit, investigate, and take enforcement action under the provisions of IDAPA 16.05.07, "Investigation and Enforcement of Fraud, Abuse, and Misconduct." ( )

009. CRIMINAL HISTORY AND BACKGROUND CHECK REQUIREMENTS.

01. Compliance With Department Criminal History Check. Criminal history checks are required for certain types of providers under these rules. Providers who are required to have a criminal history check must comply with IDAPA 16.05.06, "Criminal History and Background Checks." Except, through the duration of the declared COVID-19 public health emergency, if the individuals working in the area listed in this rule are unable to complete a criminal background check in accordance with the timeframes set forth in IDAPA 16.05.06, then agencies may allow newly hired direct care staff to begin rendering services prior to completion of the criminal background check in accordance with the requirements specified by the Department in a COVID-19 information release posted on the Department's website at https://healthandwelfare.idaho.gov/providers/idaho-medicaid-providers/information-medicaid-providers. ( )

02. Department-Issued Variances to Requirements for a Criminal History Check Clearance. ( )

a. Notwithstanding those provider types required to obtain a criminal history check clearance or Department enhanced clearance under these rules or under IDAPA 16.05.06, "Criminal History and Background Checks," the Department at its discretion may allow variances to clearance requirements under certain circumstances. Providers who are subject to a criminal history and background check must still complete and notarize an application for a criminal history and background check. ( )

b. In cases where the application process results in a denial rather than a clearance, and the denial is due to the applicant's prior convictions for disqualifying drug and alcohol-related offenses, the applicant may, with prior written approval of the Department, deliver covered Medicaid Peer Support and Recovery Coaching services. ( )

c. A variance may be granted on a case-by-case basis upon review by the Department or its designee of any underlying facts and circumstances in each individual case. The Department will establish the process for the administrative review which will be conducted separate from the criminal history unit. During the Department's review, the following factors may be considered: ( )

i. The severity or nature of the crimes or other findings; ( )

ii. The period of time since the incidents occurred; ( )

iii. The number and pattern of incidents being reviewed; ( )

iv. Circumstances surrounding the incidents that would help determine the risk of repetition; ( )

v. The relationship between the incidents and the position sought; ( )

vi. Activities since the incidents, such as continuous employment, education, participation in treatment, completion of a problem-solving court or other formal offender rehabilitation, payment of restitution, or any other factors that may be evidence of rehabilitation; ( )

vii. A pardon that was granted by a state governor or the President of the United States; ( )

viii. The falsification or omission of information on the self-declaration form and other supplemental forms submitted; and ( )

ix. Any other factor deemed relevant to the review. ( )

d. A variance granted under these rules is not a criminal history and background check clearance and does not set a precedent for subsequent application for variance. The Department may revoke a variance when it identifies a risk to participants' health and safety. Providers who have been granted a variance must still meet all other Department requirements for Medicaid coverage and reimbursement of Peer Support and Recovery Coaching services, and are prohibited from delivering any other covered Medicaid service without the required clearance or Department enhanced clearance. ( )

03. Availability to Work or Provide Service. ( )

a. The employer, at its discretion, may allow an individual to provide care or services on a provisional basis once the application for a criminal history and background check is completed and notarized, and the employer has reviewed the application for any disqualifying crimes or relevant records. The employer determines whether the individual could pose a health and safety risk to the vulnerable participants it serves. The individual is not allowed to provide care or services when the employer determines the individual has disclosed a disqualifying crime or relevant records. ( )

b. Those individuals licensed or certified by the Department are not available to provide services or receive licensure or certification until the criminal history and background check is completed and a clearance issued by the Department. ( )

04. Additional Criminal Convictions. Once an individual has received a criminal history clearance, any additional criminal convictions must be reported by the agency to the Department when the agency learns of the conviction. ( )

05. Providers Subject to Criminal History Check Requirements. The following providers must receive a criminal history clearance: ( )

a. Contracted Non-Emergency Medical Transportation Providers. All staff of transportation providers having contact with participants must comply with IDAPA 16.05.06, "Criminal History and Background Checks," with the exception of individual contracted transportation providers defined in Subsection 870.02 of these rules. ( )

b. Provider types deemed by the Department to be at high risk for fraud, waste, and abuse under Subsection 200.02 of these rules must consent to comply with criminal background checks, including fingerprinting, in accordance with 42 CFR 455.434. ( )

010. DEFINITIONS: A THROUGH H.
For the purposes of these rules, the following terms are used as defined below: ( )

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. ( )

02. Amortization. The systematic recognition of the declining utility value of certain assets, usually not owned by the organization or intangible in nature. ( )

03. 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. ( )

04. Audit. An examination of provider records on the basis of which an opinion is expressed representing the compliance of a provider's financial statements and records with Medicaid law, regulations, and rules. ( )

05. Auditor. The individual or entity designated by the Department to conduct the audit of a provider's records. ( )

06. Audit Reports. ( )

a. Draft Audit Report. A preliminary report of the audit finding sent to the provider for the provider's review and comments. ( )

b. Final Audit Report. A final written report containing the results, findings, and recommendations, if any, from the audit of the provider, as approved by the Department. ( )

c. Interim Final Audit Report. A written report containing the results, findings, and recommendations, if any, from the audit of the provider, sent to the Department by the auditor. ( )

07. Bad Debts. Amounts due to provider as a result of services rendered, but which are considered uncollectible. ( )

08. Basic Plan. The medical assistance benefits included under this chapter of rules. ( )

09. Buy-In Coverage. The amount the State pays for Medicare Part B of Title XVIII of the Social Security Act on behalf of eligible participants. ( )

10. Certified Registered Nurse Anesthetist (CRNA). A Licensed 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. ( )

11. Claim. An itemized bill for services rendered to one (1) participant by a provider and submitted to the Department for payment. ( )

12. CFR. Code of Federal Regulations. ( )

13. Clinical Nurse Specialist (CNS). A licensed registered nurse who meets all the applicable requirements to practice as clinical nurse specialist according to the regulations in the state where services are provided. ( )

14. CMS. Centers for Medicare and Medicaid Services. ( )

15. CMS/Medicare DME Coverage Manual. Medicare Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Jurisdiction D Supplier Manual. ( )

16. **Co-Payment**. The amount a participant is required to pay to the provider for specified services. ( )

17. **Cost Report**. A fiscal year report of provider costs required by the Medicare program and any supplemental schedules required by the Department. ( )

18. **Customary Charges**. Customary charges are the rates charged to Medicare participants and to patients liable for such charges, as reflected in the facility's records. Those charges are adjusted downward, when the provider does not impose such charges on most patients liable for payment on a charge basis or, when the provider fails to make reasonable collection efforts. The reasonable effort to collect such charges is the same effort necessary for Medicare reimbursement as is needed for unrecovered costs attributable to certain bad debt as described in Chapter 3, Sections 310 and 312, PRM. ( )

19. **Department**. The Idaho Department of Health and Welfare or a person authorized to act on behalf of the Department. ( )

20. **Director**. The Director of the Idaho Department of Health and Welfare or their designee. ( )

21. **Dual Eligibles**. Medicaid participants who are also eligible for Medicare. ( )

22. **Durable Medical Equipment (DME)**. Equipment and appliances that: ( )

a. Are primarily and customarily used to serve a medical purpose; ( )

b. Are generally not useful to an individual in the absence of a disability, illness, or injury; ( )

c. Can withstand repeated use; ( )

d. Can be reusable or removable; ( )

e. Are suitable for use in any setting in which normal life activities take place; and ( )

f. Are reasonable and medically necessary for the treatment of a disability, illness, or injury for a Medicaid participant. ( )

23. **Emergency Medical Condition**. A medical condition manifesting itself by acute 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 the following: ( )

a. Placing the health of the individual, or, with respect to a pregnant woman, the health of the woman or unborn child, in serious jeopardy. ( )

b. Serious impairment to bodily functions. ( )

c. Serious dysfunction of any bodily organ or part. ( )

24. **EPSDT**. Early and Periodic Screening, Diagnostic, and Treatment services. ( )

25. **Facility**. Facility refers to a hospital, nursing facility, or intermediate care facility for individuals with intellectual disabilities. ( )

26. **Federally Qualified Health Center (FQHC)**. An entity that meets the requirements of 42 U.S.C Section 1395x(aa)(4). The FQHC may be located in either a rural or urban area designated as a shortage area or in an area that has a medically underserved population. ( )

27. **Fiscal Year**. An accounting period that consists of twelve (12) consecutive months. ( )

28. **Healthy Connections**. The primary care case management model of managed care under Idaho Medicaid. ( )

29. **Home Health Services**. Services and items that are: ( )

a. Ordered by a physician or licensed practitioner of the healing arts as part of a home health plan of care; ( )

b. Performed by a licensed or qualified professional; ( )

c. Typically received by a Medicaid participant at the participant's place of residence; and ( )

d. Reasonable and medically necessary for the treatment of a disability, illness, or injury for a Medicaid participant. ( )

30. **Hospital**. A hospital as defined in Section 39-1301(a), Idaho Code. ( )

31. **Hospital-Based Facility**. A nursing facility that is owned, managed, or operated by, or is otherwise a part of a licensed hospital. ( )

011. DEFINITIONS: I THROUGH O.
For the purposes of these rules, the following terms are used as defined below: ( )

01. **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)**. An ICF/IID is an entity licensed as an ICF/IID and federally certified to provide care to Medicaid and Medicare participants with developmental disabilities. ( )

02. **Idaho Behavioral Health Plan (IBHP)**. The Idaho Behavioral Health Plan is a prepaid ambulatory health plan (PAHP) that provides outpatient behavioral health coverage for Medicaid-eligible children and adults. Outpatient behavioral health services include mental health and substance use disorder treatment as well as case management services. The coordination and provision of behavioral health services as authorized through the IBHP contract are provided to qualified, enrolled participants by a statewide network of professionally licensed and certified behavioral health providers. ( )

03. **Idaho Infant Toddler Program (ITP)**. The Idaho Infant Toddler Program serves children from birth through the end of their 36th month of age, who meet the requirements and provisions of the Individuals with Disabilities Education Act (IDEA), Part C. ( )

04. **In-Patient Hospital Services**. Services that are ordinarily furnished in a hospital for the care and treatment of an in-patient under the direction of a physician or dentist except for those services provided in mental hospitals. ( )

05. **Intermediary**. Any organization that administers Title XIX or Title XXI; in this case the Department of Health and Welfare. ( )

06. **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. ( )

07. **Legal Representative**. A parent with custody of a minor child, one who holds a legally-executed and effective power of attorney for health decisions, or a court-appointed guardian whose powers include the power to make health care decisions. ( )

08. **Legend Drug**. A drug that requires, by federal regulation or state rule, the order of a licensed medical practitioner before dispensing or administration to the patient. ( )

09. Level of Care. The classification in which a participant is placed, based on severity of need for institutional care. ( )

10. Licensed, Qualified Professionals. Individuals licensed, registered, or certified by national certification standards in their respective discipline, or otherwise qualified within the state of Idaho. ( )

11. Licensed Practitioner of the Healing Arts. The term licensed practitioner of the healing arts comprises the following practitioner types: certified registered nurse anesthetists (CRNA), nurse practitioners (NP), nurse midwives (NM), clinical nurse specialists (CNS), and physician assistants (PA), as defined in these rules. ( )

12. Lock-In Program. An administrative sanction, required of a participant found to have misused the services provided by the Medical Assistance Program. The participant is required to select one (1) provider in the identified area(s) of misuse to serve as the primary provider. ( )

13. Locum Tenens/Reciprocal Billing. The practice of a physician to retain a substitute physician when the regular physician is absent for reasons such as illness, pregnancy, vacation, or continuing medical education. The substitute physician is called the "Locum Tenens" physician. Reimbursement to a Locum Tenens physician will be limited to a period of ninety (90) continuous days. Reciprocal billing occurs when a substitute physician covers the regular physician during an absence or on an on-call basis a period of fourteen (14) continuous days or less. ( )

14. Medical Assistance. Payments for part or all of the cost of services funded by Titles XIX or XXI of the federal Social Security Act, as amended. ( )

15. Medicaid. Idaho's Medical Assistance Program. ( )

16. Medicaid-Related Ancillary Costs. For the purpose of these rules, those services considered to be ancillary by Medicare cost reporting principles. Medicaid-related ancillary costs will be determined by apportioning direct and indirect costs associated with each ancillary service to Medicaid participants by dividing Medicaid charges into total charges for that service. The resulting percentage, when multiplied by the ancillary service cost, will be considered Medicaid-related ancillaries. ( )

17. Medical Necessity (Medically Necessary). A service is medically necessary if: ( )

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

b. There is no other equally effective course of treatment available or suitable for the participant requesting the service that is more conservative or substantially less costly. ( )

c. Medical services must be: ( )

i. Of a quality that meets professionally-recognized standards of health care; and ( )

ii. Substantiated by records including evidence of such medical necessity and quality. Those records must be made available to the Department upon request. ( )

18. Medical Supplies. Healthcare-related items that are consumable, disposable, or cannot withstand repeated use by more than one (1) individual, are suitable for use in any setting in which normal life activities take place, and are reasonable and medically necessary for the treatment of a disability, illness, or injury for a Medicaid participant. ( )

19. Medicare Durable Medical Equipment Medicare Administrative Contractor Jurisdiction D Supplier Manual (CMS/Medicare DME Coverage Manual). A publication that is incorporated by reference in Section 004 of these rules and contains information on DME supplier enrollment, documentation, claim submission, coverage, appeals, and overpayments. ( )

20. Nurse Midwife (NM). An advanced practice registered nurse who meets all the applicable requirements to practice as a nurse midwife according to the regulations in the state where the services are provided. ( )

21. Nominal Charges. A public provider's charges are nominal where aggregate charges amount to less than one-half (1/2) of the reasonable cost of the services provided. ( )

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

23. Non-Physician Practitioner (NPP). A non-physician practitioner, previously referred to as a midlevel practitioner, comprises the following practitioner types: certified registered nurse anesthetists (CRNA), nurse practitioners (NP), nurse midwives (NM), clinical nurse specialists (CNS), pharmacist (RPh), and physician assistants (PA), as defined in these rules. ( )

24. Nurse Practitioner (NP). A registered nurse or licensed professional nurse (RN) who meets all the applicable requirements to practice as a nurse practitioner according to the regulations in the state where the services are provided. ( )

25. Nursing Facility (NF). An institution, or distinct part of an institution, that is primarily engaged in providing skilled nursing care and related services for participants. It is an entity licensed as a nursing facility and federally certified to provide care to Medicaid and Medicare participants. Participants must require medical or nursing care, or rehabilitation services for injuries, disabilities, or sickness. ( )

26. Ordering, Rendering, Prescribing Providers. Providers who order services, refer for services or prescribe services, products, or prescription drugs for Medicaid participants. ( )

27. Orthotic. Pertaining to or promoting the support of an impaired joint or limb. ( )

28. Outpatient Hospital Services. Preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services furnished by or under the direction of a physician or dentist to a patient not in need of inpatient hospital care. ( )

29. Out-of-State Care. Medical service that is not provided in Idaho or bordering counties is considered out-of-state. Bordering counties outside Idaho are considered out-of-state for the purpose of authorizing long term care. ( )

012. DEFINITIONS: P THROUGH Z.

For the purposes of these rules, the following terms are used as defined below: ( )

01. Participant. A person eligible for and enrolled in the Idaho Medical Assistance Program. ( )

02. Patient. The person undergoing treatment or receiving services from a provider. ( )

03. Pharmacist. A person who meets all the applicable requirements to practice as a licensed pharmacist according to the regulations in the state where the services are provided. ( )

04. Physician. A person possessing a Doctor of Medicine degree or a Doctor of Osteopathy degree, and within the State or United States territory services are provided is either licensed to practice medicine or is a resident enrolled in a postgraduate medical training program. ( )

05. Physician Assistant (PA). A person who meets all the applicable requirements to practice as a licensed physician assistant according to the regulations in the state where the services are provided. ( )

06. Plan of Care. A written description of medical, remedial, or rehabilitative services to be provided

to a participant, developed by or under the direction and written approval of a physician. Medications, services and treatments are identified specifically as to amount, type and duration of service. ( )

07. Prepaid Ambulatory Health Plan (PAHP). As defined in 42 CFR 438.2, a PAHP is an entity that provides medical services to enrollees under contract with the Department on the basis of prepaid capitation payments, or other arrangements that do not use State Plan payment rates. The PAHP does not provide or arrange for, and is not responsible for the provision of any inpatient hospital or institutional services for its enrollees, and does not have a comprehensive risk contract. ( )

08. Private Rate. Rate most frequently charged to private patients for a service or item. ( )

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

a. Artificially replace a missing portion of the body; or ( )

b. Prevent or correct physical deformities or malfunctions; or ( )

c. Support a weak or deformed portion of the body. ( )

d. Computerized communication devices are not included in this definition of a prosthetic device. ( )

10. Provider. Any individual, partnership, association, corporation or organization, public or private, that furnishes medical goods or services in compliance with these rules and who has applied for and received a Medicaid provider number and who has entered into a written provider agreement with the Department in accordance with Section 205 of these rules. ( )

11. Provider Agreement. A written agreement between the provider and the Department, entered into in accordance with Section 205 of these rules. ( )

12. Provider Reimbursement Manual (PRM). A federal publication that specifies accounting treatments and standards for the Medicare program, CMS Publications 15-1 and 15-2, that are incorporated by reference in Section 004 of these rules. ( )

13. Prudent Layperson. A person who possesses an average knowledge of health and medicine. ( )

14. Psychologist, Licensed. A person licensed to practice psychology according to the regulations in the state where the services are provided. ( )

15. Psychologist Extender. A person who practices psychology under the supervision of a licensed psychologist who meets the regulations in the state where the services are provided. ( )

16. Public Provider. A public provider is one operated by a federal, state, county, city, or other local government agency or instrumentality. ( )

17. Qualified Interpreter. A qualified interpreter meets the definition of qualified interpreter consistent with 28 CFR 35.104. ( )

18. Quality Improvement Organization (QIO). An organization that performs utilization and quality control review of health care furnished to Medicare and Medicaid participants. A QIO is formerly known as a Peer Review Organization (PRO). ( )

19. Related Entity. An organization with which the provider is associated or affiliated to a significant extent, or has control of, or is controlled by, that furnishes the services, facilities, or supplies for the provider. ( )

20. Registered Nurse (RN). A person who meets all the applicable requirements and is licensed to practice as a Licensed Registered Nurse according to the regulations in the state where the services are provided. ( )

21. Rural Health Clinic (RHC). An outpatient entity that meets the requirements of 42 USC Section 1395x(aa)(2). It is primarily engaged in furnishing physicians and other medical and health services in rural, federally-defined, medically underserved areas, or designated health professional shortage areas. ( )

22. Rural Hospital-Based Nursing Facilities. Hospital-based nursing facilities not located within a metropolitan statistical area (MSA) as defined by the United States Bureau of Census. ( )

23. Social Security Act. 42 USC 101 et seq., authorizing, in part, federal grants to the states for medical assistance to low-income persons who meet certain criteria. ( )

24. State Plan. The contract between the state and federal government under 42 USC Section 1396a(a). ( )

25. Supervision. Procedural guidance by a qualified person and initial direction and periodic inspection of the actual act, at the site of service delivery. ( )

26. Title XVIII. Title XVIII of the Social Security Act, known as Medicare, for aged, blind, and disabled individuals administered by the federal government. ( )

27. Title XIX. Title XIX of the Social Security Act, known as Medicaid, is a medical benefits program jointly financed by the federal and state governments and administered by the states. This program pays for medical assistance for certain individuals and families with low income and limited resources. ( )

28. Title XXI. Title XXI of the Social Security Act, known as the State Children's Health Insurance Program (SCHIP). This is a program that primarily pays for medical assistance for low-income children. ( )

29. Third Party. Includes a person, institution, corporation, public or private agency that is liable to pay all or part of the medical cost of injury, disease, or disability of a medical assistance participant. ( )

30. Transportation. The physical movement of a participant to and from a medical appointment or service by the participant, another person, taxi or common carrier. ( )

013. MEDICAL CARE ADVISORY COMMITTEE.

The Director of the Department will appoint a Medical Care Advisory Committee to advise and counsel on all aspects of health and medical services. ( )

01. Membership. The Medical Care Advisory Committee will include, but not be limited to, the following: ( )

a. Licensed physicians and other representatives of the health professions who are familiar with the medical needs of low-income population groups and with the resources available and required for their care; and ( )

b. Members of consumer groups, including medical assistance participants and consumer organizations. ( )

02. Organization. The Medical Care Advisory Committee will: ( )

a. Consist of not more than twenty-two (22) members; and ( )

b. Be appointed by the Director to the Medical Care Advisory Committee to serve three (3) year terms, whose terms are to overlap; and ( )

c. Elect a chairman and a vice-chairman to serve a two (2) year term; and ( )

d. Meet at least quarterly; and ( )

e. Submit a report of its activities and recommendations to the Director at least once each year. ( )

03. Policy Function. The Medical Care Advisory Committee must be given opportunity to participate in medical assistance policy development and program administration. ( )

04. Staff Assistance. The Medical Care Advisory Committee must be provided staff assistance from within the Department and independent technical assistance as needed to enable them to make effective recommendations, and will be provided with travel and per diem costs, where necessary. ( )

014. -- 099. (RESERVED)

GENERAL PARTICIPANT PROVISIONS
(Sections 100-199)

100. ELIGIBILITY FOR MEDICAL ASSISTANCE.
Idaho Department of Health and Welfare Rules, IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children," and Idaho Department of Health and Welfare Rules, IDAPA 16.03.05, "Eligibility for the Aged, Blind and Disabled (AABD)," are applicable in determining eligibility for medical assistance. ( )

101. -- 124. (RESERVED)

125. MEDICAL ASSISTANCE PROCEDURES.

01. Issuance of Identification Cards. When a person is determined eligible for medical assistance, the Department will issue a Medicaid identification card to the participant. When requested, the Department will give providers of medical services eligibility information regarding participants so that services may be provided. ( )

02. Identification Card Information. An identification card will be issued to each participant and will contain the following information: ( )

a. The name of the participant to whom the card was issued; and ( )

b. The participant's Medicaid identification number; and ( )

c. The card number. ( )

03. Information Available for Participants. The following information will be available at each Field Office for use by each medical assistance participant: ( )

a. The amount, duration and scope of the available care and services; and ( )

b. The manner in which the care and services may be secured; and ( )

c. How to use the identification card. ( )

126. -- 149. (RESERVED)

150. CHOICE OF PROVIDERS.

01. Service Selection. Each participant may obtain any services available from any participating

institution, agency, pharmacy, or practitioner of their choice, unless enrolled in Healthy Connections or a Prepaid Ambulatory Health Plan (PAHP) that limits provider choice. This, however, does not prohibit the Department from establishing the fees that will be paid to providers for furnishing medical and remedial care available under the Medical Assistance Program, or from setting standards relating to the qualifications of providers of such care. ( )

02. Lock-In Option. ( )

a. The Department may implement a total or partial lock-in program for any participant found to be misusing the Medical Assistance Program according to provisions in Sections 910 through 918 of these rules. ( )

b. In situations where the participant has been restricted to a participant lock-in program, that participant may choose the physician and pharmacy of their choice. The providers chosen by the lock-in participant will be identified in the Department's Eligibility Verification System (EVS). This information will be available to any Medicaid provider who accesses the EVS. ( )

151. -- 159. (RESERVED)

160. RESPONSIBILITY FOR KEEPING APPOINTMENTS.
The participant is solely responsible for making and keeping an appointment with the provider. The Department will not reimburse providers when participants do not attend scheduled appointments. Providers may not bill participants for missed appointments. ( )

161. -- 164. (RESERVED)

165. COST-SHARING.

01. Co-Payments. When a participant accesses certain services inappropriately, the provider can require the participant to pay a co-payment as described in IDAPA 16.03.18, "Medicaid Cost-Sharing." ( )

02. Premiums. A participant can be required to share in the cost of basic plan benefits in the form of a premium as described in IDAPA 16.03.18, "Medicaid Cost-Sharing." ( )

166. -- 199. (RESERVED)

GENERAL PROVIDER PROVISIONS
(Sections 200-299)

200. PROVIDER APPLICATION PROCESS.

01. Provider Application. Providers who meet Medicaid enrollment requirements may apply for Idaho Medicaid provider status with the Department. All healthcare providers who are eligible for a National Provider Identifier (NPI) must apply using that identifying number. For providers not eligible for a NPI, the Department will assign a provider number upon approval of the application. ( )

02. Screening Levels. In accordance with 42 CFR 455.450, the Department will assign risk levels of "limited," "moderate," or "high" to defined groups of providers. These assignments and definitions will be published in the provider handbook. ( )

03. Medicare Enrollment Requirement for Specified Providers. The following providers must enroll as Medicare providers or demonstrate enrollment with another state's Medicaid agency prior to enrollment or revalidation as an Idaho Medicaid provider. ( )

a. Any providers classified in the "moderate" or "high" categorical risk level, as defined in the provider handbook. ( )

b. Any provider type classified as an institutional provider by Medicare. ( )

04. Disclosure of Information by Providers and Fiscal Agents. All enrolling providers and their fiscal agents must comply with the disclosure requirements as stated in 42 CFR 455, Subpart B, "Disclosure of Information by Providers and Fiscal Agents." ( )

05. Denial of Provider Agreement. The Department may deny provider status by refusing a request to enter into a provider agreement, refusing to extend an existing agreement, or refusing to enter into additional agreements with any individual or entity. Reasons for denying provider status include those described in IDAPA 16.05.07, "The Investigation and Enforcement of Fraud, Abuse, and Misconduct," Section 265. ( )

06. Mandatory Denial of Provider Agreement. The Department will deny a request for a provider agreement when: ( )

a. The provider fails to meet the qualifications required by rule or by any applicable licensing board; ( )

b. The provider was a managing employee, or had an ownership interest, as defined in 42 CFR Section 455.101, in any entity that was previously found by the Department to have engaged in fraudulent conduct, or abusive conduct related to the Medicaid program, or has demonstrated an inability to comply with the requirements related to the provider status for which application is made, including submitting false claims or violating provisions of any provider agreement; ( )

c. The provider was a managing employee, or had an ownership interest, as defined in 42 CFR Section 455.101, in any entity that failed to repay the Department for any overpayments, or to repay claims previously found by the Department to have been paid improperly, whether the failure resulted from refusal, bankruptcy, or otherwise, unless prohibited by law; ( )

d. The provider employs as a managing employee, contracts for any management services, shares any ownership interests, or would be considered a related party to any individual or entity identified in Subsections 200.06.a. through 200.06.c. of this rule. ( )

e. The provider fails to comply with any applicable requirement under 42 CFR 455. ( )

f. The provider is precluded from enrollment due to a temporary moratorium issued by the Secretary of Health and Human Services in accordance with 42 CFR 455.470. ( )

g. The provider is currently suspended from Medicare or Medicaid in any state, or has been terminated from Medicare or Medicaid in any state. ( )

201. -- 204. (RESERVED)

205. AGREEMENTS WITH PROVIDERS.

01. In General. All individuals or organizations must enter into a written provider agreement accepted by the Department prior to receipt of any reimbursement for services. Agreements may contain any terms or conditions deemed appropriate by the Department. All provider agreements must be signed by the provider or by an owner or officer who has the legal authority to bind the provider in the agreement. ( )

02. Federal Disclosure Requirements. To comply with the disclosure requirements in 42 CFR 455, Subpart B, each provider, other than an individual practitioner or a group of practitioners, must disclose to the Department: ( )

a. The full name and address of each individual who has either direct or indirect ownership interest in the disclosing entity or in any subcontractor of five percent (5%) or more prior to entering into an agreement or at the time of survey and certification; and ( )

b. Whether any person named in the disclosure is related to another person named in the disclosure as a spouse, parent, or sibling. ( )

03. Provider Agreement Enforcement Actions and Terminations. Provider agreements may be terminated with or without cause. Terminations for cause may be appealed as a contested case in accordance with the IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings." The Department may, at its discretion, take any of the following actions for cause based on the provider's conduct or the conduct of its employees or agents, or when the provider fails to comply with any term or provision of the provider agreement, or any applicable state or federal regulation: ( )

a. Require corrective actions as described in IDAPA 16.05.07, "The Investigation and Enforcement of Fraud, Abuse, and Misconduct," Section 270. ( )

b. Require a corrective action plan to be submitted by the provider to address noncompliance with the provider agreement; ( )

c. Reduce, limit, or suspend payment of claims pending the submission, acceptance, or completion of a corrective action plan; ( )

d. Limit or suspend provision of services to participants who have not previously established services with the provider pending the submission, acceptance, or completion of a corrective action plan; or ( )

e. Terminate the provider's agreement. ( )

04. Termination of Provider Agreements. Due to the need to respond quickly to state and federal mandates, as well as the changing needs of the State Plan, the Department may terminate provider agreements without cause by giving written notice to the provider as set forth in the agreement. If an agreement does not provide a notice period, the period is twenty-eight (28) days. Terminations without cause may result from elimination or change of programs or requirements, or the provider's inability to continue providing services due to the actions of another agency or board. Terminations without cause are not subject to contested case proceedings since the action will either affect a class of providers, or will result from the discretionary act of another regulatory body. ( )

206. -- 209. (RESERVED)

210. CONDITIONS FOR PAYMENT.

01. Participant Eligibility. The Department will reimburse providers for medical care and services, regardless of the current eligibility status of the medical assistance participant in the month of payment, provided a complete and properly submitted claim for payment has been received and each of the following conditions are met: ( )

a. The participant was found eligible for medical assistance for the month, day, and year during which the medical care and services were rendered; ( )

b. The participant received such medical care and services no earlier than the third month before the month in which application was made on such participant's behalf; and ( )

c. The provider verified the participant's eligibility on the date the service was rendered and can provide proof of the eligibility verification. ( )

d. Not more than twelve (12) months have elapsed since the month of the latest participant services for which such payment is being made. Medicare cross-over claims are excluded from the twelve (12) month submittal limitation. ( )

02. Time Limits. The time limit set forth in Subsection 210.01.d. of this rule does not apply with respect to retroactive eligibility adjustment. When participant eligibility is determined retroactively, the Department will reimburse providers for services within the period of retroactive eligibility if a claim for those services is

submitted within twelve (12) months of the date of the participant's eligibility determination. ( )

03. Acceptance of State Payment. By participating in the Medical Assistance Program, providers agree to accept, as payment in full, the amounts paid by the Department for services to Medicaid participants. Providers also agree to provide all materials and services without unlawfully discriminating on the grounds of race, age, sex, creed, color, national origin, or physical or intellectual disability. ( )

04. Payment in Full. If a provider accepts Medicaid payment for a covered service, the Medicaid payment must be accepted as full payment for that service, and the participant cannot be billed for the difference between the billed amount and the Medicaid allowed amount. ( )

05. Medical Care Provided Outside the State of Idaho. Out-of-state medical care is subject to the same utilization review and other Medicaid coverage requirements and restrictions as medical care received within the state of Idaho. ( )

06. Ordering, Prescribing, and Referring Providers. Any service or supply ordered, prescribed, or referred by a physician or other qualified professional who is not an enrolled Medicaid provider will not be reimbursed by the Department. ( )

07. Referral From Participant's Assigned Primary Care Provider. Medicaid services may require a referral from the participant's assigned primary care provider. Services requiring a referral are listed in the Idaho Medicaid Provider Handbook. Services provided without a referral, when one is required, are not covered and are subject to sanctions, recoupment, or both. The Department may change the services that require a referral after appropriate notification of Medicaid-eligible individuals and providers as specified in Section 563 of these rules. ( )

08. Follow-up Communication with Assigned Primary Care Provider. Medicaid services may require timely follow-up communication with the participant's assigned primary care provider. Services requiring post-service communication with the primary care provider and time frames for that communication are listed in the Idaho Medicaid Provider Handbook. Services provided without timely communication of care outcomes, when communication is required, are not covered and are subject to sanctions, recoupment, or both. The Department may change the services that require communication of care outcomes after appropriate notification of Medicaid eligible individuals and providers as specified in Section 563 of these rules. ( )

09. Services Delivered Via Telehealth. Services delivered via telehealth as defined in Title 54, Chapter 57, Idaho Code, must be identified as such in accordance with billing requirements published in the Idaho Medicaid Provider Handbook. Telehealth services billed without being identified as such are not covered. Services delivered via telehealth may be reimbursed within limitations defined by the Department in the Idaho Medicaid Provider Handbook. Fee for service reimbursement is not available for an electronic mail message (e-mail), or facsimile transmission (fax). ( )

10. Services Subject to Electronic Visit Verification (EVV). Services requiring EVV compliance are subject to quality review. Services billed without the minimum essential EVV elements, as defined by Section 1903(l)(2) of the Social Security Act, may be denied, delayed, or subject to sanctions or recoupment, or both, in accordance with IDAPA 16.05.07, "The Investigation and Enforcement of Fraud, Abuse, and Misconduct." ( )

211. -- 214. (RESERVED)

215. THIRD PARTY LIABILITY.

01. Determining Liability of Third Parties. The Department will take reasonable measures to determine any legal liability of third parties for medical care and services rendered to a participant. ( )

02. Third Party Liability as a Current Resource. The Department is to treat any third party liability as a current resource when such liability is found to exist and payment by the third party has been made or will be made within a reasonable time. ( )

03. Withholding Payment. The Department must not withhold payment on behalf of a participant because of the liability of a third party when such liability, or the amount thereof, cannot be currently established or is not currently available to pay the participant's medical expense. ( )

04. Seeking Third Party Reimbursement. The Department will seek reimbursement from a third party when the party's liability is established after reimbursement to the provider is made, and in any other case in which the liability of a third party existed, but was not treated as a current resource, with the exceptions provided in Subsection 215.05 of this rule. ( )

a. The Department will seek reimbursement from a participant when a participant's liability is established after reimbursement to the provider is made; and ( )

b. In any other situation in which the participant has received direct payment from any third party resource and has not forwarded the money to the Department for services or items received. ( )

05. Billing Third Parties First. Medicaid providers must bill all other sources of direct third party payment, with the following exceptions: ( )

a. When the resource is a court-ordered absent parent and there are no other viable resources available, the claims will be paid and the resources billed by the Department; ( )

b. Preventive pediatric care including early and periodic screening and diagnosis. Screening and diagnosis program services include: ( )

i. Regularly scheduled examinations and evaluations of the general physical, dental, and mental health, growth, development, and nutritional status of children under age twenty-one (21), provided according to guidance for child wellness exams published in the Medicaid General Provider and Participant Handbook; ( )

ii. Immunizations recommended by the American Academy of Pediatrics immunization schedule; ( )

iii. Diagnosis services to identify the nature of an illness or other problem by examination of the symptoms. ( )

c. When prior authorization has been approved according to Section 883 of these rules, treatment services to control, correct, or ameliorate health problems found through diagnosis and screenings; ( )

d. If the claim is for preventative pediatric care as described in Subsection 215.05.b of this rule, the Department will make payment for the service provided in its fee schedule and will seek reimbursement from the third party according to 42 U.S.C. 1396a(a)(25)(E). ( )

06. Accident Determination. When the participant's Medicaid card indicates private insurance or when the diagnosis indicates an accident for which private insurance is often carried, or both, the claim will be suspended or denied until it can be determined that there is no other source of payment. ( )

07. Third Party Payments. The Department will pay the provider the lowest amount of the following: ( )

a. The provider’s actual charge for the service; or ( )

b. The maximum allowable charge for the service as established by the Department in its pricing file. If the service or item does not have a specific price on file, the provider must submit supporting documentation to the Department. Reimbursement will be based on the documentation; or ( )

c. The third party-allowed amount minus the third party payment, or the patient liability as indicated by the third party. ( )

08. Subrogation of Third Party Liability. In all cases where the Department will be required to pay medical expenses for a participant and that participant is entitled to recover any or all such medical expenses from any third party, the Department will be subrogated to the rights of the participant to the extent of the amount of medical assistance benefits paid by the Department as the result of the occurrence giving rise to the claim against the third party. ( )

a. If litigation or a settlement in such a claim is pursued by the medical assistance participant, the participant must notify the Department. ( )

b. If the participant recovers funds, either by settlement or judgment, from such a third party, the participant must repay the amount of benefits paid by the Department on their behalf. ( )

09. Subrogation of Legal Fees. ( )

a. If a medical assistance participant incurs the obligation to pay attorney fees and court costs for the purpose of enforcing a monetary claim to which the Department is subrogated, the amount which the Department is entitled to recover, or any lesser amount which the Department may agree to accept in compromise of its claim, will be reduced by an amount which bears the same relation to the total amount of attorney fees and court costs actually paid by the participant as the amount actually recovered by the Department, exclusive of the reduction for attorney fees and court costs, bears to the total amount paid by the third party to the participant. ( )

b. If a settlement or judgment is received by the participant that does not specify which portion of the settlement or judgment is for payment of medical expenses, it will be presumed that the settlement or judgment applies first to the medical expenses incurred by the participant in an amount equal to the expenditure for benefits paid by the Department as a result of the payment or payments to the participant. ( )

216. -- 224. (RESERVED)

225. REPORTING TO THE INTERNAL REVENUE SERVICE (IRS).
In accordance with 26 U.S.C 6041, the Department must provide annual information returns to the IRS showing aggregate amounts paid to providers identified by name, address, and social security number or employer identification number. ( )

226. -- 229. (RESERVED)

230. GENERAL PAYMENT PROCEDURES.

01. Provided Services. ( )

a. Each participant may consult a participating physician or provider of their choice for care and receive covered services by presenting their identification card to the provider, subject to restrictions imposed by participation in Healthy Connections or enrollment in a Prepaid Ambulatory Health Plan (PAHP). ( )

b. The provider must obtain the required information by using the Medicaid number on the identification card from the Electronic Verification System and transfer the required information onto the appropriate claim form. Where the Electronic Verification System (EVS) indicates that a participant is enrolled in Healthy Connections, the provider must comply with referral or follow-up communication requirements defined in Section 210 of these rules. ( )

c. Upon providing the care and services to a participant, the provider or their agent must submit a properly completed claim to the Department. ( )

d. The Department is to process each claim received and make payment directly to the provider. ( )

e. The Department will not supply claim forms. Forms needed to comply with the Department's

unique billing requirements are included in Appendix D of the Idaho Medicaid Provider Handbook. ( )

02. Individual Provider Reimbursement. The Department will not pay the individual provider more than the lowest of: ( )

a. The provider's actual charge for service; or ( )

b. The maximum allowable charge for the service as established by the Department on its pricing file, if the service or item does not have a specific price on file, the provider must submit documentation to the Department and reimbursement will be based on the documentation; or ( )

c. The Medicaid-allowed amount minus the Medicare payment or the Medicare co-insurance and deductible amounts added together when a participant has both Medicare and Medicaid. ( )

03. Services Normally Billed Directly to the Patient. If a provider delivers services and it is customary for the provider to bill patients directly for such services, the provider must complete the appropriate claim form and submit it to the Department. ( )

04. Reimbursement for Other Noninstitutional Services. The Department will reimburse for all noninstitutional services that are not included in other Idaho Department of Health and Welfare Rules, but allowed under Idaho's Medical Assistance Program according to the provisions of 42 CFR Section 447.325. ( )

05. Review of Records. ( )

a. The Department, or its duly authorized agent, the U.S. Department of Health and Human Services, and the Bureau of Compliance have the right to review pertinent records of providers receiving Medicaid reimbursement for covered services. ( )

b. The review of participants' medical and financial records must be conducted for the purposes of determining: ( )

i. The necessity for the care; or ( )

ii. That treatment was rendered in accordance with accepted medical standards of practice; or ( )

iii. That charges were not in excess of the provider's usual and customary rates; or ( )

iv. That fraudulent or abusive treatment and billing practices are not taking place. ( )

c. Refusal of a provider to permit the Department to review records pertinent to medical assistance will constitute grounds for: ( )

i. Withholding payments to the provider until access to the requested information is granted; or ( )

ii. Suspending the provider's number. ( )

06. Lower of Cost or Charges. Payment to providers, other than public providers furnishing such services free of charge or at nominal charges to the public, is the lesser of the reasonable cost of such services or the customary charges with respect to such services. Public providers that furnish services free of charge, or at a nominal charge, are reimbursed fair compensation that is the same as reasonable cost. ( )

07. Procedures for Medicare Cross-Over Claims. ( )

a. If a medical assistance participant is eligible for Medicare, the provider must first bill Medicare for the services rendered to the participant. ( )

b. If a provider accepts a Medicare assignment, the Department will pay the provider for the services, up to the Medicaid allowable amount minus the Medicare payment, and forward the payment to the provider automatically based upon the Medicare Summary Notice (MSN) information on the computer tape that is received from the Medicare Part B Carrier on a weekly basis. ( )

c. If a provider does not accept a Medicare assignment, an MSN must be attached to the appropriate claim form and submitted to the Department. The Department will pay the provider for the services, up to the Medicaid allowable amount minus the Medicare payment. ( )

d. For all other services, an MSN must be attached to the appropriate claim form and submitted to the Department. The Department will pay the provider for the services up to the Medicaid allowable amount minus the Medicare payment. ( )

08. Services Reimbursable After the Appeals Process. Reimbursement for services originally identified by the Department as not medically necessary will be made if such decision is reversed by the appeals process required in IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings." ( )

231. HANDLING OF OVERPAYMENTS AND UNDERPAYMENTS FOR SPECIFIED PROVIDERS.
The provisions in Subsections 231.01 and 231.02 of this rule apply only to hospitals, FQHCs, RHCs and Home Health providers. ( )

01. Interest Charges on Overpayments and Underpayments. The Medicaid program will charge interest on overpayments, and pay interest on underpayments, as follows: ( )

a. Interest After Sixty Days of Notice. If full repayment from the indebted party is not received within sixty (60) days after the provider has received the Department reimbursement notice, interest will accrue from the date of receipt of the Department reimbursement notice, and will be charged on the unpaid settlement balance for each thirty (30) day period that payment is delayed. Periods of less than thirty (30) days will be treated as a full thirty (30) day period, and the thirty (30) day interest charge will be applied to any unpaid balance. Each payment will be applied first to accrued interest, then to the principal. Interest accrued on overpayments and interest on funds borrowed by a provider to repay overpayments are not an allowable interest expense. ( )

b. Waiver of Interest Charges. When the Department determines an overpayment exists, it may waive interest charges if it determines that the administrative costs of collecting them exceed the charges. ( )

c. Rate of Interest. The interest rate on overpayments and underpayments will be the statutory rate as set forth in Section 28-22-104(1), Idaho Code, compounded monthly. ( )

d. Retroactive Adjustment. The balance and interest will be retroactively adjusted to equal the amounts that would have been due based on any changes that occur as a result of the final determination in the administrative appeal and judicial appeal process. Interest penalties will only applied to unpaid amounts and will be subordinated to final interest determinations made in the judicial review process. ( )

02. Recovery Methods for Overpayments. One (1) of the following methods will be used for recovery of overpayments: ( )

a. Lump Sum Voluntary Repayment. Upon receipt of the notice of program reimbursement, the provider voluntarily refunds, in a lump sum, the entire overpayment to the Department. ( )

b. Periodic Voluntary Repayment. The provider must: ( )

i. Request in writing that recovery of the overpayment be made over a period of twelve (12) months or less; and ( )

ii. Adequately document the request by demonstrating that the financial integrity of the provider would be irreparably compromised if repayments occurred over a shorter period of time than requested. ( )

c. Department Initiated Recovery. The Department will recover the entire unpaid balance of the overpayment of any settlement amount in which the provider does not respond to the notice of program reimbursement within thirty (30) days of receiving the notice. ( )

d. Recovery from Medicare Payments. The Department can request that Medicare payments be withheld in accordance with 42 CFR Section 405.377. ( )

232. -- 234. (RESERVED)

235. PATIENT "ADVANCE DIRECTIVES."

01. Provider Participation. Hospitals, nursing facilities, providers of home health care services (home health agencies, federally qualified health clinics, rural health clinics), hospice providers, and personal care R.N. supervisors must: ( )

a. Provide all adults receiving medical care written and oral information (the information provided must contain all material found in the Department's approved advance directive form "Your Rights As A Patient To Make Medical Treatment Decisions") which defines their rights under state law to make decisions concerning their medical care. ( )

i. The provider must explain that the participant has the right to make decisions regarding their medical care which includes the right to accept or refuse treatment. If the participant has any questions regarding treatment, the facility or agency will notify the physician of those concerns. Their physician can answer any questions they may have about the treatment. ( )

ii. The provider will inform the participant of their rights to formulate advance directives, such as "Living Will" or "Durable Power of Attorney For Health Care," or both. ( )

iii. The provider must comply with Subsection 235.02 of this rule. ( )

b. Provide all adults receiving medical care written information on the providers' policies concerning the implementation of the participant's rights regarding "Durable Power of Attorney for Health Care," "Living Will," and the participant's right to accept or refuse medical and surgical treatment. ( )

c. Document in the participant's medical record whether the participant has executed an advance directive ("Living Will" or "Durable Power of Attorney for Health Care," or both), or have a copy of the Department's approved advance directive form ("Your Rights as a Patient to Make Medical Treatment Decisions") attached to the patient's medical record which has been completed acknowledging whether the patient/resident has executed an advance directive ("Living Will" or "Durable Power of Attorney for Health Care," or both). ( )

d. The provider cannot condition the provision of care or otherwise discriminate against an individual based on whether that participant has executed an "Advance Directive." ( )

e. If the provider cannot comply with the patient's "Living Will" or "Durable Power of Attorney for Health Care," or both, as a matter of conscience, the provider will assist the participant in transferring to a facility or agency that can comply. ( )

f. Provide education to their staff and the community on issues concerning advance directives. ( )

02. When "Advance Directives" Must Be Given. Hospitals, nursing facilities, providers of home health care (home health agencies, federally qualified health centers, rural health clinics), hospice agencies, and personal care R.N. supervisors, must give information concerning "Advance Directives" to adult participants in the following situations: ( )

a. Hospitals must give the information at the time of the participant's admission as an inpatient unless

Subsection 235.03 of this rule applies. ( )

b. Nursing facilities must give the information at the time of the participant's admission as a resident. ( )

c. Home health providers must give the information to the participant in advance of the participant coming under the care of the provider. ( )

d. The personal care R.N. supervisors will inform the participant when the R.N. completes the R.N. Assessment and Care Plan. The R.N. supervisor will inform the Qualified Intellectual Disabilities Professional (QIDP) and the personal care attendant of the participants decision regarding "Advance Directives." ( )

e. A hospice provider must give information at the time of initial receipt of hospice care by the participant. ( )

03. Information Concerning "Advance Directives" at the Time an Incapacitated Individual Is Admitted. An individual may be admitted to a facility in a comatose or otherwise incapacitated state and be unable to receive information or articulate whether they have executed an advance directive. In this case, to the extent that a facility issues materials about policies and procedures to the families or to the surrogates or other concerned persons of the incapacitated patient in accordance with state law, it must also include the information concerning advance directives. This does not relieve the facility from its obligation to provide this information to the patient once they are no longer incapacitated. ( )

04. Provider Agreement. A "Memorandum of Understanding Regarding Advance Directives" is incorporated within the provider agreement. By signing the Medicaid provider agreement, the provider is not excused from its obligation regarding advance directives to the general public per Section 1902(a) of the Social Security Act, as amended by Section 4751 of OBRA 1990. ( )

236. -- 244. (RESERVED)

245. PROVIDERS OF SCHOOL-BASED SERVICES.
Only school districts and charter schools can be reimbursed for the services described in Sections 850 through 856 of these rules. ( )

246. -- 249. (RESERVED)

250. SELECTIVE CONTRACTING.
The Department may contract with a limited number of providers of certain Medicaid products and services, including: dental services, eyeglasses, transportation, and some medical supplies. ( )

251. -- 299. (RESERVED)

GENERAL REIMBURSEMENT PROVISIONS FOR INSTITUTIONAL PROVIDERS (Sections 300-389)

300. COST REPORTING.
The provider's Medicaid cost report must be filed using the Department designated reporting forms, unless the Department has approved an exception. The request to use alternate forms must be sent to the Department in writing, with samples attached, a minimum of ninety (90) days prior to the due date for the cost report. The request for approval of alternate forms cannot be used as a reason for late filing. ( )

301. -- 304. (RESERVED)

305. REIMBURSEMENT SYSTEM AUDITS.

01. Scope of Reimbursement System Audits. The Department reserves the right to audit financial and other records of the provider, and, when warranted, the records of entities related to the provider. Audits consist of the

following types of records: ( )

a. Cost verification of actual costs for providing goods and services; ( )

b. Evaluation of provider's compliance with the provider agreement, reporting form instructions, and any applicable law, rule, or regulation; ( )

c. Effectiveness of the service to achieve desired results or benefits; and ( )

d. Reimbursement rates or settlement calculated under this chapter. ( )

02. Exception to Scope for Audits and Investigations. Audits as described in these rules do not apply to the audit processes used in conducting investigations of fraud and abuse under IDAPA 16.05.07, "The Investigation and Enforcement of Fraud, Abuse, and Misconduct." ( )

306. -- 329. (RESERVED)

330. PROVIDER'S RESPONSIBILITY TO MAINTAIN RECORDS.
The provider must maintain financial and other records in sufficient detail to allow the Department to audit them as described in Section 305 of these rules. ( )

01. Expenditure Documentation. Documentation of expenditures must include the amount, date, purpose, payee, and the invoice or other verifiable evidence supporting the expenditure. ( )

02. Cost Allocation Process. Costs such as depreciation or amortization of assets and indirect expenses are allocated to activities or functions based on the original identity of the costs. Documentation to support basis for allocation must be available for verification. The assets referred to in this Section of rule are economic resources of the provider recognized and measured in conformity with generally accepted accounting principles. ( )

03. Revenue Documentation. Documentation of revenues must include the amount, date, purpose, and source of the revenue. ( )

04. Availability of Records. Records must be available for and subject to audit by the auditor, with or without prior notice, during any working day between the hours of 8:00 a.m. and 5:00 p.m. at the provider's principal place of business in the state of Idaho. ( )

a. The provider is given the opportunity to provide documentation before the interim final audit report is issued. ( )

b. The provider is not allowed to submit additional documentation in support of cost items after the issuance of the interim final audit report. ( )

05. Retention of Records. Records required in Subsections 330.01 through 330.03 of this rule must be retained by the provider for a period of five (5) years from the date of the final payment under the provider agreement. Failure to retain records for the required period can void the Department's obligation to make payment for the goods or services. ( )

331. -- 339. (RESERVED)

340. DRAFT AUDIT REPORT.
Following completion of the audit field work and before issuing the interim final audit report to the Department, the auditor will issue a draft audit report and forward a copy to the provider for review and comment. ( )

01. Review Period. The provider will have a period of sixty (60) days, beginning on the date of transmittal, to review and provide additional comments or evidence pertaining to the draft audit report. The review period may be extended when the provider: ( )

a. Requests an extension prior to the expiration of the original review period; and ( )

b. Clearly demonstrates the need for additional time to properly respond. ( )

02. Evaluation of Provider's Response. The auditor will evaluate the provider's response to the draft audit report and will delete, modify, or reaffirm the original findings, as deemed appropriate, in preparing the interim final audit report. ( )

341. FINAL AUDIT REPORT.
The auditor will incorporate the provider's response and an analysis of the response into the interim final report as appendices and transmit it to the Department. The Department will issue a final audit report and a notice of program reimbursement, if applicable, that sets forth settlement amounts due to the Department or the provider. The final audit report and notice of program reimbursement, if applicable, will take into account the findings made in the interim final audit report and the response of the provider to the draft audit report ( )

342. -- 359. (RESERVED)

360. RELATED PARTY TRANSACTIONS.

01. Principle. Costs applicable to services, facilities and supplies furnished to the provider by organizations or persons related to the provider by common ownership, control, etc., are allowable at the cost to the related party. Such costs are allowable to the extent that they relate to patient care, are reasonable, ordinary, and necessary, and are not in excess of those costs incurred by a prudent cost-conscious buyer. ( )

02. Cost Allowability - Regulation. Allowability of costs is subject to the regulations prescribing the treatment of specific items as outlined in 42 CFR 413.17, et al., and the Providers Reimbursement Manual, PRM Chapter 10 and other applicable chapters of the PRM. ( )

361. APPLICATION.

01. Determination of Common Ownership or Control in the Provider Organization and Supply Organization. In determining whether a provider organization is related to a supplying organization, the tests of common ownership and control are to be applied separately. If the elements of common ownership or control are not present in both organizations, the organizations are deemed not to be related to each other. ( )

a. Common Ownership Rule. A determination as to whether an individual(s) possesses ownership or equity in the provider organization and the supplying organization, so that the organizations will be considered to be related by common ownership, will be made on the basis of the facts and circumstances in each case. ( )

b. Control Rule. The term "control" includes any kind of control whether or not it is legally enforceable and however it is exercisable or exercised. It is the reality of the control that is decisive, not its form or the mode of its exercise. ( )

02. Cost to Related Organizations. The charges to the provider from related organizations may not exceed the billing to the related organization for these services. ( )

03. Costs Not Related to Patient Care. All home office costs not related to patient care are not allowable under the Program. ( )

04. Interest Expense. Generally, interest expense on loans between related entities will not be reimbursable. See Chapters 2, 10, and 12, PRM, for specifics. ( )

362. EXCEPTION TO THE RELATED ORGANIZATION PRINCIPLE.
An exception is provided to the general rule applicable to related organizations. The exception applies if the provider demonstrates by convincing evidence to the satisfaction of the intermediary: ( )

01. Supplying Organization. That the supplying organization is a bona fide separate organization; ( )

02. Nonexclusive Relationship. That a substantial part of the supplying organization's business activity of the type carried on with the provider is transacted with other organizations not related to the provider and the supplier by common ownership or control and there is an open, competitive market. ( )

03. Lease or Rentals of Hospital. The exception is not applicable to sales, lease or rentals of hospitals. These transactions would not meet the requirement that there be an open, competitive market for the facilities furnished as described in Sections 1008 and 1012, PRM. ( )

a. Rentals. Rental expense for transactions between related entities will not be recognized. Costs of ownership will be allowed. ( )

b. Purchases. When a facility is purchased from a related entity, the purchaser's depreciable basis must not exceed the seller's net book value as described in Section 1005, PRM. ( )

363. -- 389. (RESERVED)

EXCLUDED SERVICES
(Section 390)

390. SERVICES, TREATMENTS, AND PROCEDURES NOT COVERED BY MEDICAL ASSISTANCE. The following services, treatments, and procedures are not covered for payment by the Medical Assistance Program: ( )

01. Service Categories Not Covered. The following service categories are not covered for payment by the Medical Assistance Program: ( )

a. Acupuncture services; ( )

b. Naturopathic services; ( )

c. Bio-feedback therapy; ( )

d. Group hydrotherapy; and ( )

e. Fertility-related services, including testing. ( )

02. Types of Treatments and Procedures Not Covered. The costs of physician and hospital services for the following types of treatments and procedures are not covered for payment by the Medical Assistance Program: ( )

a. Elective medical and surgical treatment, except for family planning services, without Departmental approval. Procedures that are generally accepted by the medical community and are medically necessary may not require prior approval and may be eligible for payment; ( )

b. Cosmetic surgery, excluding reconstructive surgery that has prior approval by the Department; ( )

c. Acupuncture; ( )

d. Bio-feedback therapy; ( )

e. Laetrile therapy; ( )

f. Procedures and testing for the inducement of fertility. This includes artificial inseminations,

consultations, counseling, office exams, tuboplasties, and vasovasostomies; ( )

g. New procedures of unproven value and established procedures of questionable current usefulness as identified by the Public Health Service and that are excluded by the Medicare program or major commercial carriers; ( )

h. Drugs supplied to patients for self-administration other than those allowed under the conditions of Section 662 of these rules; ( )

i. Services provided by psychologists and social workers who are employees or contract agents of a physician, or a physician's group practice association except for psychological testing on the order of the physician; ( )

j. The treatment of complications, consequences, or repair of any medical procedure where the original procedure was not covered by the Medical Assistance Program, unless the resultant condition is life-threatening as determined by the Department; ( )

k. Medical transportation costs incurred for travel to medical facilities for the purpose of receiving a noncovered medical service; ( )

l. Eye exercise therapy; or ( )

m. Surgical procedures on the cornea for myopia. ( )

03. Experimental Treatments or Procedures. Treatments and procedures used solely to gain further evidence or knowledge or to test the usefulness of a drug or type of therapy are not covered for payment by the Medical Assistance Program. This includes both the treatment or procedure itself, and the costs for all follow-up medical treatment directly associated with such a procedure. Treatments and procedures deemed experimental are not covered for payment by the Medical Assistance Program under the following circumstances: ( )

a. The treatment or procedure is in Phase I clinical trials in which the study drug or treatment is given to a small group of people for the first time to evaluate its safety, determine a safe dosage range, and identify side effects; ( )

b. There is inadequate available clinical or pre-clinical data to provide a reasonable expectation that the trial treatment or procedure will be at least as effective as non-investigational therapy; or ( )

c. Expert opinion suggests that additional information is needed to assess the safety or efficacy of the proposed treatment or procedure. ( )

391. -- 398. (RESERVED)

399. COVERED SERVICES UNDER BASIC PLAN BENEFITS.
Individuals who are eligible for Medicaid Basic Plan Benefits are eligible for the following benefits, subject to the coverage limitations contained in these rules. Those individuals eligible for services under IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," are also eligible for the services covered under this chapter of rules, unless specifically exempted. ( )

01. Hospital Services. The range of hospital services covered is described in Sections 400 through 449 of these rules. ( )

a. Inpatient and outpatient Hospital Services are described in Sections 400 through 416. ( )

b. Reconstructive Surgery services are described in Sections 420 through 426. ( )

c. Surgical procedures for weight loss are described in Sections 430 through 436. ( )

d. Investigational procedures or treatments are described in Sections 440 through 446. ( )

02. Ambulatory Surgical Centers. Ambulatory Surgical Center services are described in Sections 450 through 499 of these rules. ( )

03. Physician Services and Abortion Procedures. Physician services and abortion procedures are described in Sections 500 through 519 of these rules. ( )

a. Physician services are described in Sections 500 through 506. ( )

b. Abortion procedures are described in Sections 510 through 516. ( )

04. Other Practitioner Services. Other practitioner services are described in Sections 520 through 559 of these rules. ( )

a. Non-physician practitioner services are described in Sections 520 through 526. ( )

b. Chiropractic services are described in Sections 530 through 536. ( )

c. Podiatrist services are described in Sections 540 through 545. ( )

d. Licensed midwife (LM) services are described in Sections 546 through 552. ( )

e. Optometrist services are described in Sections 553 through 556. ( )

05. Primary Care Case Management. Primary care case management services are described in Sections 560 through 579 of these rules**.** ( )

a. Healthy Connections services are described in Sections 560 through 566. ( )

06. Prevention Services. The range of prevention services covered is described in Sections 570 through 649 of these rules. ( )

a. Children's habilitation intervention services are described in Sections 570 through 577. ( )

b. Child Wellness Services are described in Sections 580 through 584. ( )

c. Adult Physical Services are described in Sections 590 through 596. ( )

d. Screening mammography services are described in Sections 600 through 606. ( )

e. Diagnostic Screening Clinic services are described in Sections 610 through 614. ( )

f. Additional Assessment and Evaluation services are described in Section 615. ( )

g. Health Questionnaire Assessment is described in Section 618. ( )

h. Preventive Health Assistance benefits are described in Sections 620 through 626. ( )

i. Nutritional services are described in Sections 630 through 636. ( )

j. Diabetes Education and Training services are described in Sections 640 through 646. ( )

07. Laboratory and Radiology Services. Laboratory and radiology services are described in Sections 650 through 659 of these rules. ( )

08. Prescription Drugs. Prescription drug services are described in Sections 660 through 679 of these

rules. ( )

09. Family Planning. Family planning services are described in Sections 680 through 689 of these rules. ( )

10. Outpatient Behavioral Health Services. Community-based outpatient services for behavioral health treatment are described in Sections 707 through 711 of these rules. ( )

11. Inpatient Psychiatric Hospital Services. Inpatient Psychiatric Hospital services are described in Sections 700 through 706. ( )

12. Home Health Services. Home health services are described in Sections 720 through 729 of these rules. ( )

13. Therapy Services. Occupational therapy, physical therapy, and speech-language pathology services are described in Sections 730 through 739 of these rules. ( )

14. Audiology Services. Audiology services are described in Sections 740 through 749 of these rules. ( )

15. Durable Medical Equipment and Supplies. The range of covered durable medical equipment and supplies is described in Sections 750 through 779 of these rules. ( )

a. Durable Medical Equipment and supplies are described in Sections 750 through 756. ( )

b. Prosthetic and orthotic services are described in Sections 770 through 776. ( )

16. Vision Services. Vision services are described in Sections 780 through 789 of these rules. ( )

17. Dental Services. Medicaid dental services are covered under a selective contract as described in Section 800 through 819 of these rules. ( )

18. Essential Providers. The range of covered essential services is described in Sections 820 through 859 of these rules. ( )

a. Rural health clinic services are described in Sections 820 through 826. ( )

b. Federally Qualified Health Center services are described in Sections 830 through 836. ( )

c. Indian Health Services Clinic services are described in Sections 840 through 846. ( )

d. School-Based services are described in Sections 850 through 857. ( )

19. Transportation. The range of covered transportation services is described in Sections 860 through 879 of these rules. ( )

a. Emergency transportation services are described in Sections 860 through 866. ( )

b. Non-emergency medical transportation services are described in Sections 870 through 876. ( )

20. EPSDT Services. EPSDT services are described in Sections 880 through 889 of these rules. ( )

21. Specific Pregnancy-Related Services. Specific pregnancy-related services are described in Sections 890 through 899 of these rules. ( )

COVERED SERVICES
(Sections 400-899)

SUB AREA: HOSPITAL SERVICES
(Sections 400-449)

400. HOSPITAL SERVICES – DEFINITIONS.

01. Administratively Necessary Day (AND). An Administratively Necessary Day (AND) is intended to allow a hospital time for an orderly transfer or discharge of participant inpatients who are no longer in need of a continued acute level of care. ANDs may be authorized for inpatients who are awaiting placement for nursing facility level of care, or in-home services that are not available, or when catastrophic events prevent the scheduled discharge of an inpatient. ( )

02. Allowable Costs. The current year's Medicaid apportionment of a hospital's allowable costs determined at final or interim settlement if cost settlements are applicable, or determined using the version of the cost report used for prospective payment system (PPS) rate setting, consist of those costs permitted by the principles of reimbursement contained in the Provider Reimbursement Manual (PRM) and do not include costs already having payment limited by Medicaid rate file or any other Medicaid charge limitation. ( )

03. Apportioned Costs. Apportioned costs consist of the share of a hospital's total allowable costs attributed to Medicaid program participants and other patients so that the share borne by the program is based upon actual services received by program participants, as set forth in the applicable Title XVIII principles of cost reimbursement as specified in the PRM and in compliance with Medicaid reimbursement rules. ( )

04. Capital Costs. For the purposes of hospital reimbursement, capital costs are those allowable costs considered in the settlement that represent the cost to each hospital for its reasonable property related and financing expense, and property taxes. ( )

05. Case-Mix Index. The Case-Mix Index for a hospital is the average weight of values assigned to a range of diagnostic related groups and applied to Medicaid discharges. The index will measure the relative resources required to treat Medicaid inpatients. The Case-Mix Index of the current year will be divided by the index of the principal year to assess the percent change between the years. ( )

06. Charity Care. Charity care is care provided to individuals who have no source of payment, third-party or personal resources. ( )

07. Children's Hospital. A Medicare-certified hospital as set forth in 42 CFR Section 412.23(d). ( )

08. Critical Access Hospitals (CAH). A rural hospital with twenty-five (25) or less beds as set forth in 42 CFR Section 485.620. ( )

09. Current Year. Any hospital cost reporting period for which reasonable cost is being determined will be termed the current year. ( )

10. Inpatient Services Customary Hospital Charges. Customary inpatient hospital charges reflect the regular rates for inpatient services charged to patient(s) liable for payment for their services on a charge basis. Implicit in the use of charges as the basis for comparability (or for apportionment under certain apportionment methods) is the objective that services are related to the cost of services billed to the Department. Effective for service dates beginning July 1, 2021 reimbursement will be as follows: ( )

a. All in-state providers not described in b-d below will be paid a final prospective payment rate using the All Patient Refined Diagnosis Related Group (APR-DRG) classification system as described in Section 401 of these rules. ( )

b. Idaho state-owned hospitals and the Department of Veteran's Affairs Medical Center will be reimbursed at one hundred percent (100%) of allowable cost using a retrospective cost settlement upon receipt of a final Medicare cost report. ( )

c. In-state, Critical Access Hospitals (CAHs) will be reimbursed at one hundred one percent (101%) of allowable cost using a retrospective cost settlement upon receipt of a final Medicare cost report. ( )

d. All out-of-state providers not described in a through c above will be paid a final prospective payment rate with no retrospective cost settlement using the All Patient Refined Diagnosis Related Group (APR-DRG) classification system as described in Section 401 of these rules. The out-of-state APR-DRG rates were developed to provide a combined cost coverage of eighty-seven percent (87%) when all out-of-state providers are averaged together in keeping with Section 56-265(6)(b), Idaho Code. ( )

11. Outpatient Services Customary Hospital Charges. Customary outpatient hospital charges reflect the regular rates for outpatient services charged to patient(s) liable for payment for their services on a charge basis. Implicit in the use of charges as the basis for comparability (or for apportionment under certain apportionment methods) is the objective that services are related to the cost of services billed to the Department. Effective for service dates beginning July 1, 2021, reimbursement will be as follows: ( )

a. Idaho state-owned hospitals and the Department of Veteran's Affairs Medical Center will be reimbursed at one hundred percent (100%) of allowable cost. ( )

b. In-state, CAHs will be reimbursed at one hundred one percent (101%) of allowable cost. ( )

c. All hospitals that are not described in a through b above will be subject to the outpatient reimbursement parameters outlined in the Medicaid Provider Agreement and Section 56-265, Idaho Code. ( )

12. Disproportionate Share Hospital (DSH) Allotment Amount. The DSH allotment amount determined by CMS that is eligible for federal matching funds in any federal fiscal period for disproportionate share payments. ( )

13. Disproportionate Share Hospital (DSH) Survey. The DSH survey is an annual data request from the Department to the hospitals to obtain the information necessary to compute DSH in accordance with Subsection 405.06 of these rules. ( )

14. Disproportionate Share Threshold. The disproportionate share threshold is: ( )

a. The arithmetic mean plus one (1) standard deviation of the Medicaid Utilization Rates of all Idaho Hospitals; or ( )

b. A Low-Income Revenue Rate exceeding twenty-five percent (25%). ( )

15. Excluded Units. Excluded units are distinct units in hospitals that are certified by Medicare according to 42 CFR Sections 412.25, 412.27 and 412.29 for exclusion from the Medicare prospective payment system. ( )

16. Hospital Inflation Index. An index calculated through Department studies and used to adjust inpatient operating cost limits and interim rates for the current year. ( )

17. Low-Income Revenue Rate. The Low Income Revenue Rate is the sum of the following fractions, expressed as a percentage, calculated as follows: ( )

a. Total Medicaid inpatient revenues paid to the hospital, plus the amount of the cash subsidies received directly from state and local governments in a cost reporting period, divided by the total amount of revenues and cash subsidies of the hospital for inpatient services in the same cost reporting period; plus ( )

b. The total amount of the hospital's charges for inpatient hospital services attributable to charity care in the same cost reporting period, divided by the total amount of the hospital's charges for inpatient services in the hospital in the same period. The total inpatient charges attributed to charity care must not include contractual allowances and discounts and reduction in charges given to Medicare, Medicaid, other third-party payors, or cash for patient services received directly from state and local governments' county assistance programs. ( )

18. Medicaid Inpatient Day. For purposes of DSH payments, an inpatient day is defined as a Medicaid inpatient day in a hospital for which there is also no Medicare inpatient day counted. ( )

19. Medicaid Utilization Rate (MUR). The MUR for each hospital will be computed using the Department's record of paid inpatient days for the fiscal year divided by the total inpatient days for the same fiscal year as reported in the DSH survey. In this paragraph, the term "inpatient days" includes administratively necessary days, newborn days, days in specialized wards, days provided at an inappropriate level of care, and Medicaid inpatient days from other states. In this paragraph, "Medicaid inpatient days" includes paid days not counted in prior DSH threshold computations. ( )

20. Obstetricians. For purposes of an adjustment for hospitals serving a disproportionate share of low income patients, and in the case of a hospital located in a rural area, as defined by the federal Executive Office of Management and Budget, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures. ( )

21. On-Site. A service location over which the hospital exercises financial and administrative control. "Financial and administrative control" means a location whose relation to budgeting, cost reporting, staffing, policy-making, record keeping, business licensure, goodwill and decision-making are so interrelated to those of the hospital that the hospital has ultimate financial and administrative control over the service location. The service location must be in close proximity to the hospital where it is based, and both facilities serve the same patient population (e.g., from the same area, or catchment, within Medicare's defined Metropolitan Statistical Area (MSA) for urban hospitals or thirty-five (35) miles from a rural hospital). ( )

22. Operating Costs. For the purposes of hospital reimbursement, operating costs are the allowable costs included in the cost centers established in the finalized Medicare cost report to accumulate costs applicable to providing routine and ancillary services to patients for the purposes of cost assignment and allocation in the step-down process. ( )

23. Other Allowable Costs. Other allowable costs are those reasonable costs recognized under the Medicaid reasonable cost principles for services not subject to Medicaid limitations of coverage or reimbursement limits. Costs that are not reimbursed as operating costs, but recognized by Medicare principles as allowable costs will be included in the total reasonable costs. Other allowable costs include, but are not necessarily limited to, physician's component which was combined-billed, capital costs, ambulance costs, excess costs, carry-forwards and medical education costs. ( )

24. Reasonable Costs. Reasonable costs include all necessary and ordinary costs incurred in rendering the services related to patient care that a prudent and cost-conscious hospital would pay for a given item or service. ( )

25. Uninsured Patient Costs. For the purposes of determining the additional costs beyond uncompensated Medicaid costs that may be reimbursed as a DSH payment without exceeding the state Allotment Amount, only inpatient costs of uninsured patients will be considered. ( )

26. Upper Payment Limit. The Upper Payment Limit for hospital services is defined in the Code of Federal Regulations. ( )

27. Prior Service Period Claims Subject to Future Cost Settlement. For providers subject to cost settlement, claims from prior service periods that were not captured in a prior cost settlements will be cost settled in the current year using cost-to-charge ratios and routine cost per diems from the Medicare cost report currently being settled. ( )

401. HOSPITAL REIMBURSEMENT – PROSPECTIVE PAYMENT SYSTEMS.
Providers identified in Section 400.10.a. and 400.10.d will be reimbursed for inpatient services using an All Patient Refined Diagnosis Related Group (APR-DRG) as outlined in the Medicaid Provider Agreement otherwise beginning with service periods on or after July 1, 2021. ( )

402. INPATIENT HOSPITAL SERVICES: COVERAGE AND LIMITATIONS.
The policy, rules, and regulations to be followed will be those cited in 42 CFR 456.50 through 42 CFR 456.145. All hospital services must conform to federal and state laws and regulations. Services must be medically necessary as defined in Section 011 of these rules. ( )

01. Initial Length of Stay. Prior authorization requirement for an initial length of stay will be established by the Department, or its designee, in the Idaho Medicaid Provider Handbook for hospitals not reimbursed under DRG methodologies. ( )

02. Extended Stay. The Department, or its designee, will establish authorization requirements in the Idaho Medicaid Provider Handbook for hospitals not reimbursed under DRG methodologies. An authorization is necessary when the appropriate care of the participant indicates the need for hospital days in excess of the initial length of stay, or previously approved extended stay. ( )

03. Exceptions and Limitations. The following exceptions and limitations apply to in-patient hospital services for hospitals not reimbursed under DRG methodologies: ( )

a. Payment for accommodations is limited to the hospital's all-inclusive rate. The all-inclusive rate is a flat fee charge incurred on a daily basis that covers both room and board. ( )

b. The Department will not authorize reimbursement above the all-inclusive rate unless the attending physician orders a room that is not an all-inclusive rate room for the patient because of medical necessity. ( )

04. Diagnosis Related Group Review and Audits. All services performed under DRG are subject to QIO reviews, retrospective reviews, and audits. The Department reserves the right to execute reviews as described in the Idaho Medicaid Provider Handbook as amended. ( )

403. INPATIENT HOSPITAL SERVICES: PROCEDURAL REQUIREMENTS.

01. Prior Authorization. Some services may require a prior authorization from the Department or its designee. Documentation for the request must include the most recent plan of care and adequate documentation to demonstrate continued medical necessity. The Department will set additional documentation requirements in the Idaho Medicaid Provider Handbook to ensure quality of care and integrity of services. ( )

02. Certification of Need. At the time of admission, the physician must certify that inpatient services are necessary. Recertification must occur at least every sixty (60) days inpatient hospital services are required, but may be required more frequently as determined by the Department. ( )

03. Individual Plan of Care. The individual plan of care is a written plan developed for the participant upon admission to a hospital and updated at least every sixty (60) days, but may be required more frequently as determined by the Department. The plan must include: ( )

a. Diagnoses, symptoms, complaints, and complications indicating the need for admission; ( )

b. A description of the functional level of the individual; ( )

c. Any orders for medications, treatments, rehabilitative services, activities, social services, or diet; and ( )

d. Plans for continuing care or discharge, as appropriate. ( )

04. Request for Extended Stay. To qualify for reimbursement, authorization must be obtained from

the Department, or its designee. The request should be made before the initial length of stay or previously authorized extended stay ends, and submitted as designated by the Department, or its designee. Documentation for the request should include the most recent plan of care. The Department will set additional documentation requirements in the Idaho Medicaid Provider Handbook to ensure quality of care and integrity of services. ( )

404. INPATIENT HOSPITAL SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.
In addition to the provider enrollment agreement, each claim submitted by a hospital constitutes an agreement by which the hospital agrees to accept and abide by the Department's rules. Only a Medicare certified hospital, licensed by the state in which it operates, may enroll in the Idaho Medicaid program. Hospitals not participating as a Medicaid swing-bed provider, which are licensed for long-term care or as a specialty hospital that provides a nursing home level of care, will be reimbursed as a nursing facility. Hospitals not eligible for enrollment which render emergency care will be paid rates established in these rules. ( )

405. HOSPITAL SERVICES – PROVIDER REIMBURSEMENT.
Under the Medicaid provisions of the Social Security Act, in reimbursing hospitals, the Department will pay the lesser of customary hospital charges or Medicaid reimbursement for services established in accordance with the procedures detailed under this rule. The upper limits observed by the Department in reimbursing each individual hospital must not exceed the payment that would be determined as a reasonable cost under the policies, definitions and procedures observed under Medicare (Title XVIII) principles of cost reimbursement. ( )

01. Payment Procedures. The following procedures are applicable to in-patient hospitals: ( )

a. The participant's admission and length of stay may be subject to prior authorization, concurrent review, continued stay review, and retrospective review by a Quality Improvement Organization (QIO) designated by the Department. QIO review will be governed by provisions of the QIO Idaho Medicaid Provider Manual as amended. If a review identifies that an admission or continued stay is not medically necessary, then no Medicaid payment will be made. Failure to obtain a timely QIO review as required by Section 402 of these rules, and as outlined in the QIO Idaho Medicaid Provider Manual as amended, will result in the QIO conducting a late review. After a QIO review has determined that the hospital stay was medically necessary, Medicaid will assess a late review penalty to the hospital as outlined in this rule. ( )

i. All admissions for hospitals not reimbursed under DRG methodologies are subject to QIO review to determine if continued stay in inpatient status is medically necessary. A QIO continued stay review is required when the participant's length of stay exceeds the number of days certified by the QIO. If no initial length of stay certification was issued by the QIO, a QIO continued stay review is required when the admission exceeds a number of days as specified by the Department. ( )

ii. Reimbursement for services originally identified as not medically necessary by the QIO will be made if such decision is reversed by the appeals process required in IDAPA 16.05.03, “Contested Case Proceedings and Declaratory Rulings.” ( )

iii. Absent the Medicaid participant's informed decision to incur services deemed unnecessary by the QIO, or not authorized by the QIO due to the negligence of the provider, no payment for denied services may be obtained from the participant. ( )

b. In reimbursing licensed hospitals, the Department will pay the lesser of customary hospital charges or Medicaid reimbursement for in-patient hospital care as set forth in this rule, unless an exception applies as stated in Section 402 of these rules. The upper limits for payment must not exceed the payment that would be determined as reasonable cost using the Title XVIII standards and principles. ( )

02. Hospital Penalty Schedule. The following applies for hospitals not reimbursed under DRG methodologies: ( )

a. A request for a preadmission or continued stay QIO review, or for both, that is one (1) day late will result in a penalty of two hundred and sixty dollars ($260), from the total Medicaid paid amount of the inpatient hospital stay. ( )

b. A request for a preadmission or continued stay QIO review, or for both, that is two (2) days late will result in a penalty of five hundred and twenty dollars ($520), from the total Medicaid paid amount of the inpatient hospital stay. ( )

c. A request for a preadmission or continued stay QIO review, or for both, that is three (3) days late will result in a penalty of seven hundred and eighty dollars ($780), from the total Medicaid paid amount of the inpatient hospital stay. ( )

d. A request for a preadmission or continued stay QIO review, or for both, that is four (4) days late will result in a penalty of one thousand and forty dollars ($1,040), from the total Medicaid paid amount of the inpatient hospital stay. ( )

e. A request for a preadmission or continued stay QIO review, or for both, that is five (5) days late or greater will result in a penalty of one thousand three hundred dollars ($1,300), from the total Medicaid paid amount of the inpatient hospital stay. ( )

03. AND Reimbursement Rate. Reimbursement for an AND will be made at the weighted average Medicaid payment rate for all Idaho nursing facilities for routine services, as defined per 42 CFR 447.280(a)(1), furnished during the previous calendar year. ICF/IID rates are excluded from this calculation. ( )

a. The AND reimbursement rate will be calculated by the Department by March 15 of each calendar year and made effective retroactively for dates of service on or after January 1 of the respective calendar year. ( )

b. Hospitals with an attached nursing facility will be reimbursed the lesser of their Medicaid per diem routine rate or the established average rate for an AND; and ( )

c. The Department will pay the lesser of the established AND rate or a facility's customary hospital charge to private pay patients for an AND. ( )

04. Reimbursement for Services. Routine services as addressed in Subsection 405.05 of this rule include all medical care, supplies, and services that are included in the calculation of nursing facility property and non-property costs as described in these rules. Reimbursement of ancillary services will be determined in the same manner as hospital outpatient reasonable costs in accordance with Medicare reasonable cost principles, except that reimbursement for prescription drugs will be in accord with Section 665 of these rules. ( )

05. Hospital Swing-Bed Reimbursement. The Department will pay for nursing facility care in certain rural hospitals. Following approval by the Department, such hospitals may provide service to participants in licensed hospital "swing-beds" who require nursing facility level of care. ( )

a. Facility Requirements. The Department will approve hospitals for nursing facility care provided to eligible participants under the following conditions: ( )

i. The Department's Licensure and Certification Section finds the hospital in conformance with the requirements of 42 CFR 482.58 "Special Requirements" for hospital providers of long-term care services ("swing-beds"), or 42 CFR 485.645 – Special requirements for CAH providers of long-term services ("swing-beds") as applicable; and ( )

ii. The hospital is approved by the Medicare program for the provision of "swing-bed" services; and ( )

iii. The facility does not have a twenty-four (24) hour nursing waiver granted under 42 CFR 488.54(c); and ( )

iv. The hospital must not have had a swing-bed approval terminated within the two (2) years previous to application for swing-bed participation; and ( )

v. The hospital must be licensed for less than one hundred (100) beds as defined by 42 CFR 482.58(a)(1) for swing-bed purposes; and ( )

vi. Nursing facility services in swing-beds must be rendered in beds used interchangeably to furnish hospital or nursing facility-type services. ( )

b. Participant Requirements. The Department will reimburse hospitals for participants under the following conditions: ( )

i. The participant is determined to be entitled to such services in accordance with IDAPA 16.03.05, "Eligibility for Aid to the Aged, Blind, and Disabled"; and ( )

ii. The participant is authorized for payment in accordance with IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Subsection 222.02. ( )

c. Reimbursement for "Swing-Bed" Patient Days. The Department will reimburse swing-bed hospitals on a per diem basis utilizing a rate established as follows: ( )

i. Payment rates for routine nursing facility services will be at the weighted average Medicaid rate per patient day paid to hospital-based nursing facility/ICF facilities for routine services furnished during the previous calendar year. ICF/IID facilities' rates are excluded from the calculations. ( )

ii. The rate will be calculated by the Department by March 15 of each calendar year. The rate will be based on the previous calendar year and effective retroactively for dates of service on or after January 1 of the respective year. ( )

iii. The weighted average rate for nursing facility swing-bed days will be calculated by dividing total payments for routine services, including patient contribution amounts but excluding miscellaneous financial transactions relating to prior years, by total patient days for each respective level of care occurring in the previous calendar year. ( )

iv. Routine services include all medical care, supplies, and services that are included in the calculation of nursing facility property and nonproperty costs as described in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Subsection 225.01. ( )

v. The Department will pay the lesser of the established rate, the facility's charge, or the facility's charge to private pay patients for "swing-bed" services. ( )

vi. Reimbursement of ancillary services not included in the nursing facility rates furnished for extended care services will be billed and determined in the same manner as hospital outpatient reasonable costs in accordance with Medicare reasonable cost principles, except that reimbursement for prescription drugs will be in accord with Section 665 of these rules. ( )

vii. The number of swing-bed days that may be reimbursed to a provider in a twelve (12) month period will be limited to the greater of one thousand ninety-five (1,095) days which may be prorated over a shorter fiscal period or, fifteen percent (15%) of the product of the average number of available licensed beds in the hospital in the period and the number of days in the fiscal period. The Department may authorize additional critical access hospital swing-bed days for participants residing in a community without a nursing facility within thirty-five (35) miles contingent on a review of medical necessity, cost-effectiveness, residency, and quality of care. ( )

d. Computation of "Swing-Bed" Patient Contribution. The computation of the patient's contribution of swing-bed payment will be in accordance with IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Section 224. ( )

06. Adjustment for Disproportionate Share Hospitals (DSH). All Idaho hospitals serving a disproportionate share of low-income patients must qualify either as a Mandatory DSH or as Deemed DSH to receive a DSH payment. The Department will send each hospital a DSH survey on or before January 31 of each calendar

year. A hospital will not receive a DSH payment if the survey is not returned by the deadline, unless good cause is determined by the Department. ( )

a. Mandatory Eligibility. Mandatory Eligibility for DSH status will be provided for hospitals that: ( )

i. Meet or exceed the disproportionate share threshold as defined in Subsection 400.13 of these rules. ( )

ii. Have at least two (2) obstetricians with staff privileges at the hospital who have agreed to provide obstetric services. ( )

(1) Subsection 405.06.b.ii. of this rule does not apply to a hospital in which the inpatients are predominantly individuals under eighteen (18) years of age; or ( )

(2) Does not offer nonemergency inpatient obstetric services as of December 21, 1987. ( )

iii. The MUR will not be less than one percent (1%). ( )

iv. If an Idaho hospital exceeds both disproportionate share thresholds, as described in Subsection 400.13 of these rules, and the criteria of Subsections 405.06.b.ii. and 405.06.b.iii. of this rule are met, the payment adjustment will be the greater of the amounts calculated using the methods identified in Subsections 405.06.b.vi. through 405.06.b.x. of this rule. ( )

v. Hospitals qualifying for Mandatory DSH eligibility with Medicaid Inpatient Utilization Rates equal to or exceeding one (1) standard deviation and less than one and one-half (1 1/2) standard deviations above the mean of all Idaho hospitals will receive a DSH payment equal to two percent (2%) of the payments related to the Medicaid inpatient days included in the MUR computation. ( )

vi. Hospitals qualifying for Mandatory DSH eligibility with Medicaid Inpatient Utilization Rates equal to or exceeding one and one-half (1 1/2) standard deviations and less than two (2) standard deviations of the mean of all Idaho hospitals will receive a DSH payment equal to four percent (4%) of the payments related to the Medicaid inpatient days included in the MUR computation. ( )

vii. Hospitals qualifying for Mandatory DSH eligibility with Medicaid Inpatient Utilization Rates exceeding two (2) standard deviations of the mean of all Idaho hospitals will receive a DSH payment equal to six percent (6%) of the payments related to the Medicaid inpatient days included in the MUR computation. ( )

viii. Hospitals qualifying for Mandatory DSH eligibility with Low Income Utilization Rates equal to or exceeding twenty-five percent (25%) will receive a DSH payment equal to four percent (4%) of the payments related to the Medicaid inpatient days included in the MUR computation. ( )

ix. Hospitals qualifying for Mandatory DSH eligibility with Low Income Utilization Rates equal to, or exceeding, thirty percent (30%) will receive a DSH payment equal to six percent (6%) of the payments related to the Medicaid inpatient days included in the MUR computation. ( )

b. Deemed Disproportionate Share Hospital (DSH). All hospitals in Idaho that have inpatient utilization rates of at least one percent (1%) only in Idaho inpatient days, and meet the requirements unrelated to patient day utilization specified in Subsection 405.06.b. of this rule, will be designated a Deemed Disproportionate Share Hospital. The disproportionate share payment to a Deemed DSH hospital will be the greater of: ( )

i. Five dollars ($5) per Idaho Medicaid inpatient day included in the hospital's MUR computation; or ( )

ii. An amount per Medicaid inpatient day used in the hospital's MUR computation that equals the DSH allotment amount, less the Mandatory DSH payment amount, divided by the number of Medicaid inpatient days used in the MUR computation for all Idaho DSH hospitals. ( )

c. Insufficient DSH Allotment Amounts. When the DSH allotment amount is insufficient to make the aggregate amount of DSH payments to each DSH hospital, payments to each hospital will be reduced by the percentage by which the DSH allotment amount was exceeded. ( )

d. DSH Payments Will Not Exceed Costs. A DSH payment will not exceed the costs incurred during the year of furnishing services to individuals who are either eligible for medical assistance under the State Plan or were uninsured for health care services provided during the year. ( )

i. Payments made to a hospital for services provided to indigent patients by a state or a unit of local government within a state will not be considered a source of third party payment. ( )

ii. Claims of uninsured costs that increase the maximum amount that a hospital may receive as a DSH payment must be documented. ( )

e. DSH Will be Calculated on an Annual Basis. A change in a provider's allowable costs as a result of a reopening or appeal will not result in the recomputation of the provider's annual DSH payment. ( )

f. To the extent that audit findings demonstrate that DSH payments exceed the documented hospital specific cost limits, the Department will collect overpayments and redistribute DSH payments. ( )

i. If at any time during an audit the Department discovers evidence suggesting fraud or abuse by a provider, that evidence, in addition to the Department's final audit report regarding that provider, will be referred to the Medicaid Fraud Unit of the Idaho Attorney General's Office. ( )

ii. The Department will submit an independent certified audit to CMS for each completed Medicaid State plan rate year, consistent with 42 CFR Part 455, Subpart D, "Independent Certified Audit of State Disproportionate Share Hospital Payment Adjustments." ( )

iii. Beginning with FFY 2011, if based on the audit of the DSH allotment distribution, the Department determines that there was an overpayment to a provider, the Department will immediately: ( )

(1) Recover the overpayment from the provider; and ( )

(2) Redistribute the amount in overpayment to providers that had not exceeded the hospital-specific upper payment limit during the period in which the DSH payments were determined. The payments will be subject to hospital-specific upper payment limits. ( )

iv. Disproportionate share payments must not exceed the DSH state allotment, except as otherwise required by the Social Security Act. In no event is the Department obligated to use State Medicaid funds to pay more than the State Medicaid percentage of DSH payments due a provider. ( )

07. Out-of-State Hospitals. ( )

a. Cost Settlements for Certain Out-of-State Hospitals. For service periods through June 30, 2021, hospitals not located in the state of Idaho will have a cost settlement computed with the state of Idaho if the following conditions are met: ( )

i. Total inpatient and outpatient covered charges are more than fifty thousand dollars ($50,000) in the fiscal year; or ( )

ii. When less than fifty thousand dollars ($50,000) of covered charges are billed to the state by the provider, and a probable significant underpayment or overpayment is identifiable, and the amount makes it administratively economical and efficient for cost settlement to be requested by either the provider or the state, a cost settlement will be made between the hospital and the Department. ( )

b. Payment for Hospitals Without Cost Settlement. Those out-of-state hospitals not cost settling with

the state will have annually adjusted rates of payment no greater than seventy-five percent (75%) for inpatient covered charges and no greater than eighty percent (80%) of outpatient covered charges or, the Department's established fee schedule for certain outpatient services. These rates represent average inpatient and outpatient reimbursement rates paid to Idaho hospitals. ( )

08. Audit Function. Under a common audit agreement, the Medicare Intermediary may perform any audit required for both Title XVIII and Medicaid purposes. The Department may elect to perform an audit even though the Medicare Intermediary does not choose to audit the facility. ( )

09. Adequacy of Cost Information. Cost information as developed by the provider must be current, accurate, and in sufficient detail and in such form as needed to support payments made for services rendered to participants. This includes all ledgers, books, reports, records and original evidences of cost (purchase requisitions, purchase orders, vouchers, requisitions for materials, inventories, labor time cards, payrolls, bases for apportioning costs, etc.), which pertain to the determination of reasonable costs, leaving an audit trail capable of being audited. Financial and statistical records will be maintained in a consistent manner from one (1) settlement period to another. ( )

10. Availability of Records of Hospital Providers. A participating hospital provider of services must make available to the Department in the state in which the facility is licensed, the provider's fiscal and other necessary records for the purpose of determining its ongoing record keeping capability and to ascertain information pertinent to the determination of the proper amount of program payments due the provider. ( )

11. Interim Cost Settlements. The Department may initiate, or a hospital may request an interim cost settlement based on the Medicare cost report as submitted. ( )

a. Cost Report Data. Interim settlement cost report data will be adjusted to reflect Medicaid payments and statistical summary reports sent to providers before the filing deadline. ( )

b. Limit or Recovery of Payment. The Department may limit a recovery or payment of an interim settlement amount up to twenty-five percent (25%) of the total settlement amount when the cost report information is in dispute. ( )

12. Notice of Program Reimbursement. Following receipt of the finalized Medicare cost report and the timely receipt of any other information requested by the Department to fairly cost settle with the provider, a certified letter with the return receipt requested will be sent to the provider that sets forth the amounts of underpayment or overpayment made to the provider. The notice of the results of the final retroactive adjustment will be sent even though the provider intends to request a hearing on the determination, or has appealed the Medicare Intermediary's determination of cost settlement. Where the determination shows that the provider is indebted to the Medicaid program because total interim and other payments exceed cost limits, the state will take the necessary action to recover overpayment, including the suspension of interim payments sixty (60) days after the provider's receipt of the notice. Such action of recovery or suspension will continue even after a request for an informal conference or hearing is filed with the state. If the hearing results in a revised determination, appropriate adjustments will be made to the settlement amount. ( )

a. Timing of Notice. The Department will make every effort to issue a notice of program reimbursement within twelve (12) months of receipt of the cost report. ( )

b. Reopening of Completed Settlements. A Medicaid completed cost settlement may be reopened by the provider or the state within a three (3) year period from the date of the letter of notice of program reimbursement. The issues must have been raised, appealed and resolved through the reopening of the cost report by the Medicare Intermediary. Issues previously addressed and resolved by the Department's appeal process are not cause for reopening of the finalized cost settlement. ( )

13. Non Appealable Items. The formula for the determination of the hospital inflation index, the principles of reimbursement that define allowable cost, non-Medicaid program issues, interim rates that are in compliance with state and federal rules, and the preliminary adjustments prior to final cost settlement determinations as supported by properly completed cost reports and audits are not acceptable as appealable items. ( )

14. Interim Reimbursement Rates for Providers Subject to Cost Settlement. The interim reimbursement rates must be reasonable and adequate to meet the necessary costs that are incurred by economically and efficiently operated providers that provide services in conformity with applicable state and federal laws, rules, and quality and safety standards. ( )

a. Annual Adjustments. Interim rates will be adjusted at least annually based on the best information available to the Department. ( )

b. Retrospective Adjustments. Interim rates will not be adjusted retrospectively upon request for rate review by the provider. ( )

c. Basis for Adjustments. The Department may make an adjustment based on the Medicare cost report as submitted and accepted by the Intermediary after the provider's reporting year to bring interim payments made during the period into agreement with the tentative reimbursable amount due the provider at final settlement. If the settlement amount is equal to or greater than ten percent (10%) of the payments received or paid and equal to or greater than one hundred thousand dollars ($100,000), the interim rate will be adjusted to account for half (½) of the difference. ( )

d. Unadjusted Rate. The Medicaid interim reimbursement rate on file is synonymous with the term unadjusted rate used by other payors. ( )

15. Audits. All financial reports are subject to audit by Departmental representatives in accordance with Section 305 of these rules. ( )

406. INPATIENT HOSPITAL SERVICES: QUALITY ASSURANCE.
The designated QIO must prepare, distribute, and maintain a provider manual that is periodically updated. The manual must include the following: ( )

01. QIO Information. The QIO's policies, criteria, standards, operating procedures, and forms for performing: preadmission monitoring, assessment reviews, continued stay requests, and requests for retroactive medical reviews. ( )

02. Department Provisions. Department-selected diagnoses and elective procedures in which a hospital will request preauthorization of an admission, transfer, or continuing stay. ( )

03. Approval Timeframe. A provision that the QIO will inform the hospital of a certification within five (5) days, or other time frame as determined by the Department, of an approved admission, transfer, or continuing stay. ( )

04. Method of Notice. The method of notice to hospitals of QIO denials for specific admissions, transfers, continuing stays, or services rendered in post-payment reviews. ( )

05. Procedural Information. The procedures that providers or participants will use to obtain reconsideration of a denial by the QIO prior to appeal to the Department. Such requests for reconsideration by the QIO must be made in writing to the QIO within one hundred eighty (180) days of the issuance of the "Notice of Non-Certification of Hospital Days." ( )

407. -- 409. (RESERVED)

410. OUTPATIENT HOSPITAL SERVICES: DEFINITIONS.
Outpatient hospital services include preventive, diagnostic, therapeutic, rehabilitative or palliative items, and services furnished by or under the direction of a physician or dentist, unless excluded by any other provisions of this chapter. ( )

411. (RESERVED)

412. OUTPATIENT HOSPITAL SERVICES: COVERAGE AND LIMITATIONS.

01. Services Provided On-Site. Outpatient hospital services must be provided on-site. ( )

02. Exceptions and Limitations. ( )

a. Payment for emergency room service is limited to six (6) visits per calendar year. ( )

b. Emergency room services that are followed immediately by admission to inpatient status will be excluded from the six (6) visit limit. ( )

03. Co-Payments. ( )

a. When an emergency room physician conducts a medical screening and determines that an emergency condition does not exist, the hospital can require the participant to pay a co-payment as described in IDAPA 16.03.18, "Medicaid Cost-Sharing." ( )

b. A hospital may refuse to provide services to a participant when a medical screening has determined that an emergency condition does not exist and the participant does not make the required co-payment at the time of service. Under these circumstances, the hospital must provide notification to the participant as specified in Section 1916A(e) of the Social Security Act. ( )

413. OUTPATIENT HOSPITAL SERVICES: PROCEDURAL REQUIREMENTS.

01. Review Prior to Delivery of Outpatient Services. Failure to obtain a timely review from the Department or its quality improvement organization (QIO) prior to delivery of outpatient services, listed on the select procedure and diagnosis list in the QIO Idaho Medicaid Providers Manual and the Hospital Provider Handbook, as amended, for participants who are eligible at the time of service, will result in a retrospective review. The Department will assess a late review penalty, as outlined in Subsection 405.02 of these rules, when a review is conducted due to an untimely request. ( )

02. Follow-Up for Emergency Room Patients. Hospitals must establish procedures to refer Medicaid participants who are not enrolled in Healthy Connections to an Idaho Medicaid Healthy Connections provider, if one is available within a reasonable distance of the participant's residence. Hospitals must coordinate care of patients who already have a Healthy Connections provider with that PCP. ( )

414. (RESERVED)

415. OUTPATIENT HOSPITAL SERVICES: PROVIDER REIMBURSEMENT.

01. Outpatient Hospital. The Department will not pay more than the combined payments the provider is allowed to receive from the participants and carriers or intermediaries for providing comparable services under comparable circumstances under Medicare. For those providers subject to cost settlement, outpatient hospital services identified below that are not listed in the Department's fee schedules will be reimbursed reasonable costs based on a year-end cost settlement. ( )

a. Maximum payment for hospital outpatient diagnostic laboratory services will be limited to the Department's established fee schedule. ( )

b. Maximum payment for hospital outpatient partial care services will be limited to the Department's established fee schedule. ( )

c. Hospital-based ambulance services will be reimbursed at the lower of either the provider's actual charge for the service or the maximum allowable charge for the service as established by the Department in its pricing file. ( )

d. Hospital Outpatient Surgery. Those items furnished by a hospital to an outpatient in connection

with Ambulatory Surgical Center must be surgical procedures covered by Idaho Medicaid. The aggregate amount of payments for related facility services, furnished in a hospital on an outpatient basis, is equal to the lesser of: ( )

i. The hospital's reasonable costs as reduced by federal mandates for certain operating costs, capital costs, customary hospital charges; or ( )

ii. The blended payment amount that is based on hospital specific cost and charge data and Medicaid rates paid to free-standing Ambulatory Surgical Centers (ASC); or ( )

iii. The blended rate of costs and the Department's fee schedule for ambulatory surgical centers at the time of cost settlement; or ( )

iv. The blended rate for outpatient surgical procedures is equal to the sum of forty-two percent (42%) of the hospital specific amount and fifty-eight percent (58%) of the ASC amount. ( )

e. Hospital Outpatient Radiology Services include diagnostic and therapeutic radiology, CAT scan procedures, magnetic resonance imaging, ultrasound and other imaging services. The aggregate payment for hospital outpatient radiology services furnished will be equal to the lesser of: ( )

i. The hospital's reasonable costs; or ( )

ii. The hospital's customary charges; or ( )

iii. The blended payment amount for hospital outpatient radiology equal to the sum of forty-two percent (42%) of the hospital specific amount and fifty-eight percent (58%) of the Department's fee schedule amount. ( )

02. Reduction to Outpatient Hospital Costs. For services dates through June 30, 2021, outpatient costs not paid according to the Department's established fee schedule, including the hospital specific component used in the blended rates, will be reduced by five and eight-tenths percent (5.8%) of operating costs and ten percent (10%) of each hospital's capital costs component. This reduction will only apply to the following provider classes: ( )

a. In-state hospitals specified in Section 56-1408(2), Idaho Code, that are not a Medicare-designated sole community hospital or rural primary care hospital. ( )

b. Out-of-state hospitals that are not a Medicare-designated sole community hospital or rural primary care hospital. ( )

416. -- 421. (RESERVED)

422. RECONSTRUCTIVE SURGERY: COVERAGE AND LIMITATIONS.
Reconstruction or restorative procedures that may be rendered with prior approval by the Department include procedures that restore function of the affected or related body part(s). Approvable procedures include breast reconstruction after mastectomy, or the repair of other injuries resulting from physical trauma. ( )

423. -- 430. (RESERVED)

431. SURGICAL PROCEDURES FOR WEIGHT LOSS: PARTICIPANT ELIGIBILITY.
Surgery for the correction of obesity is covered when all of the following conditions are met: ( )

01. Participant Medical Condition. The participant must meet criteria for clinically severe obesity with a Body Mass Index (BMI) equal to or greater than forty (40), or a BMI equal to or greater than thirty-five (35) with comorbid conditions such as type 2 diabetes, hypothyroidism, atherosclerotic cardiovascular disease, or osteoarthritis of the lower extremities. The serious comorbid medical condition must be documented by the primary physician who refers the patient for the procedure, or a physician specializing in the participant's comorbid condition

who is not associated by clinic or other affiliation with the surgeons who will perform the surgery. ( )

02. Other Medical Condition Exists. The obesity is caused by the serious comorbid condition, or the obesity could aggravate the participant's cardiac, respiratory or other systemic disease. ( )

03. Psychiatric Evaluation. The participant must have a psychiatric evaluation to determine the stability of personality at least ninety (90) days prior to the date a request for prior authorization is submitted to Medicaid. ( )

432. SURGICAL PROCEDURES FOR WEIGHT LOSS: COVERAGE AND LIMITATIONS.

01. Non-Surgical Treatment for Obesity. Services in connection with non-surgical treatment of obesity are covered only when such services are an integral and necessary part of treatment for another medical condition that is covered by Medicaid. ( )

02. Abdominoplasty or Panniculectomy. Abdominoplasty or panniculectomy is covered when medically necessary, as defined in Section 011 of these rules, and when the surgery is prior authorized by the Department. The request for prior authorization must include the following documentation: ( )

a. Photographs of the front, side and underside of the participant's abdomen; ( )

b. Treatment of any ulceration and skin infections involving the panniculus; ( )

c. Failure of conservative treatment, including weight loss; ( )

d. That the panniculus severely inhibits the participant's walking; ( )

e. That the participant is unable to wear a garment to hold the panniculus up; and ( )

f. Other detrimental effects of the panniculus on the participant's health such as severe arthritis in the lower body. ( )

433. SURGICAL PROCEDURES FOR WEIGHT LOSS: PROCEDURAL REQUIREMENTS.

01. Medically Necessary. The Department must determine the surgery to be medically necessary, as defined in Section 011 of these rules. ( )

02. Prior Authorization. The surgery must be prior authorized by the Department. The Department will consider the guidelines of private and public payors, evidence-based national standards of medical practice, and the medical necessity of each participant's case when determining whether surgical correction of obesity will be prior authorized. ( )

434. SURGICAL PROCEDURES FOR WEIGHT LOSS: PROVIDER QUALIFICATIONS AND DUTIES.
Physicians and hospitals must meet national medical standards for weight loss surgery. ( )

435. -- 442. (RESERVED)

443. INVESTIGATIONAL PROCEDURES OR TREATMENTS: PROCEDURAL REQUIREMENTS.
The Department may consider Medicaid coverage for investigational procedures or treatments on a case-by-case basis for life-threatening medical illnesses when no other treatment options are available. For these cases, a focused case review is completed by a professional medical review organization to determine if an investigational procedure would be beneficial to the participant. The Department will perform a cost-benefit analysis on the procedure or treatment in question. The Department will determine coverage based on this review and analysis. ( )

01. Focused Case Review. A focused case review consists of assessment of the following: ( )

a. Health benefit to the participant of the proposed procedure or treatment; ( )

b. Risk to the participant associated with the proposed procedure or treatment; ( )

c. Result of standard treatment for the participant's condition, including alternative treatments other than the requested procedure or treatment; ( )

d. Specific inclusion or exclusion by Medicare national coverage guidelines of the proposed procedure or treatment; ( )

e. Phase of the clinical trial of the proposed procedure or treatment; ( )

f. Guidance regarding the proposed procedure or treatment by national organizations; ( )

g. Clinical data and peer-reviewed literature pertaining to the proposed procedure or treatment; and ( )

h. Ethics Committee review, if appropriate. ( )

02. Additional Clinical Information. For cases in which the Department determines that there is insufficient information from the focused case review to render a coverage decision, the Department may, at its discretion, seek an independent professional opinion. ( )

03. Cost-Benefit Analysis. The Department will perform a cost-benefit analysis that will include at least the following: ( )

a. Estimated costs of the procedure or treatment in question. ( )

b. Estimated long-term medical costs if this procedure or treatment is allowed. ( )

c. Estimated long-term medical costs if this procedure is not allowed. ( )

d. Potential long-term impacts approval of this procedure or treatment may have on the Medical Assistance Program. ( )

04. Coverage Determination. The Department will make a decision about coverage of the investigational procedure or treatment after consideration of the focused case review, cost-benefit analysis, and any additional information received during the review process. ( )

444. -- 449. (RESERVED)

**SUB AREA: AMBULATORY SURGICAL CENTERS
(Sections 450-499)**

450. -- 451. (RESERVED)

452. AMBULATORY SURGICAL CENTER SERVICES: COVERAGE AND LIMITATIONS.
Those surgical procedures identified by the Medicare program as appropriately and safely performed in an ASC will be reimbursed by the Department. In addition, the Department may add surgical procedures to the list developed by the Medicare program as required by 42 CFR 416.164 if the procedures meet the criteria identified in 42 CFR 416.166. ( )

453. (RESERVED)

454. AMBULATORY SURGICAL CENTER SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.

01. Provider Approval. The ASC must be surveyed as required by 42 CFR 416.25 through 416.52 and be approved by the U.S. Department of Health and Human Services for participation as a Medicare ASC provider. ( )

02. Cancellation. Grounds for cancellation of the provider agreement include: ( )

a. The loss of Medicare program approval; or ( )

b. Identification of any condition that threatens the health or safety of patients by the Department's Bureau of Facility Standards. ( )

455. AMBULATORY SURGICAL CENTER SERVICES: PROVIDER REIMBURSEMENT.

01. Payment Methodology. ASC services reimbursement is designed to pay for use of facilities and supplies necessary to safely care for the patient. Such services are reimbursed as follows: ( )

a. ASC service payments represent reimbursement for the costs of goods and services recognized by the Medicare program as described in 42 CFR, Part 416. Payment levels will be determined by the Department. Any surgical procedure covered by the Department, but which is not covered by Medicare will have a reimbursement rate established by the Department. ( )

b. ASC services include the following: ( )

i. Nursing, technician, and related services; ( )

ii. Use of ASC facilities; ( )

iii. Drugs, biologicals, surgical dressings, supplies, splints, casts, and appliances and equipment directly related to the provision of surgical procedures; ( )

iv. Diagnostic or therapeutic services or items directly related to the provision of a surgical procedure; ( )

v. Administration, record-keeping and housekeeping items and services; and ( )

vi. Materials for anesthesia. ( )

c. ASC services do not include the following services: ( )

i. Physician services; ( )

ii. Laboratory services, x-ray or diagnostic procedures (other than those directly related to the performance of the surgical procedure); ( )

iii. Prosthetic and orthotic devices; ( )

iv. Ambulance services; ( )

v. Durable medical equipment typically used in the participant’s place of residence, but may be suitable for use in any setting in which normal life activities take place, other than a hospital, nursing facility, or ICF/IID; and ( )

vi. Any other service not specified in Subsection 455.01.b. of this rule. ( )

02. Payment for Ambulatory Surgical Center Services. Payment is made at a rate established in accordance with Section 230 of these rules. ( )

456. -- 499. (RESERVED)

**SUB AREA: PHYSICIAN SERVICES AND ABORTION PROCEDURES
(Sections 500-519)**

500. PHYSICIAN SERVICES.
Physician services include the treatment of medical and surgical conditions by doctors of medicine or osteopathy subject to the limitations of practice imposed by state law, and to the restrictions and exclusions of coverage contained in Section 390 and Section 502 of these rules. ( )

501. (RESERVED)

502. PHYSICIAN SERVICES: COVERAGE AND LIMITATIONS.

01. Sterilization Procedures. Restrictions pertaining to payment for sterilization procedures are contained in Sections 680 through 686 of these rules. ( )

02. Abortions. Restrictions governing payment for abortions are contained in Sections 511 through 514 of these rules. ( )

03. Tonometry. Payment for tonometry is limited to one (1) examination for individuals over the age of forty (40) years during any twelve (12) month period (in addition to tonometry as a component of examination to determine visual acuity). In the event examination to determine visual acuity is not done, two (2) tonometry examinations per twelve (12) month period are allowed for participants over the age of forty (40). This limitation does not apply to participants receiving continuing treatment for glaucoma. ( )

04. Physical Therapy Services. Payment for physical therapy services performed in the physician's office is limited to those services that are described and supported by the diagnosis. ( )

05. Injectable Vitamins. Payment for allowable injectable vitamins will be allowed when supported by the diagnosis. Injectable vitamin therapy is limited to Vitamin B12 (and analogues), Vitamin K (and analogues), folic acid, and mixtures consisting of Vitamin B12, folic acid, and iron salts in any combination. ( )

06. Corneal Transplants and Kidney Transplants. Corneal transplants and kidney transplants are covered by the Medical Assistance Program. ( )

503. (RESERVED)

504. PHYSICIAN SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.

01. Misrepresentation of Services. Any representation that a service provided by a nurse practitioner, nurse midwife, physical therapist, physician assistant, psychologist, social worker, or other nonphysician professional as a physician service is prohibited. ( )

02. Locum Tenens Claims and Reciprocal Billing. ( )

a. In reimbursement for Locum Tenens/reciprocal billing, the patient's regular physician may submit the claim and receive payment for covered physician services (including emergency visits and related services) provided by a Locum Tenens physician who is not an employee of the regular physician if: ( )

i. The regular physician is unavailable to provide the visit services. ( )

ii. The Medicaid patient has arranged for or seeks to receive services from the regular physician. ( )

iii. The regular physician pays the Locum Tenens for their services on a per diem or similar fee-for-time basis. ( )

iv. The substitute physician does not provide the visit services to Medicaid patients over a continuous period of longer than ninety (90) days for Locum Tenens and over a continuous period of fourteen (14) days for reciprocal billing. ( )

v. The regular physician identifies the services as substitute physician services meeting the requirements of this rule by appending modifier-Q6 (service furnished by a Locum Tenens physician) to the procedure code or Q5 (services furnished by a substitute physician under reciprocal billing arrangements). ( )

vi. The regular physician must keep on file a record of each service provided by the substitute physician associated with the substitute physician's UPIN, and make this record available to the department upon request. ( )

vii. The claim identifies, in a manner specified by the Department, the physician who furnished the services. ( )

b. If the only Locum Tenens/reciprocal billing services a physician performs in connection with an operation are post-operative services furnished during the period covered by the global fee, those services may not be reported separately on the claim as substitution services, but must be deemed as included in the global fee payment. ( )

c. A physician may have Locum Tenens/reciprocal billing arrangements with more than one (1) physician. The arrangements need not be in writing. Locum Tenens/reciprocal billing services need not be provided in the office of the regular physician. ( )

505. PHYSICIAN SERVICES: PROVIDER REIMBURSEMENT.

01. Physician Penalties for Late QIO Review. Medicaid will assess the physician a penalty for failure to request a preadmission review from the Department, for procedures and diagnosis listed on the select list in the Department's Physician Provider Handbook and the QIO Idaho Medicaid Provider Manual. If a retrospective review determines the procedure was medically necessary, and the physician was late in obtaining a preadmission review the Department will assess a penalty according to Subsection 505.02 of this rule. The penalty will be assessed after payment for physician services has occurred. ( )

02. Physician Penalty Schedule. ( )

a. A request for preadmission QIO review that is one (1) day late will result in a penalty of fifty dollars ($50). ( )

b. A request for preadmission QIO review that is two (2) days late will result in a penalty of one hundred dollars ($100). ( )

c. A request for preadmission QIO review that is three (3) days late will result in a penalty of one hundred and fifty dollars ($150). ( )

d. A request for preadmission QIO review that is four (4) days late will result in a penalty of two hundred dollars ($200). ( )

e. A request for preadmission QIO review that is five (5) days late or later will result in a penalty of two hundred and fifty dollars ($250). ( )

03. Physician Excluded From the Penalty. Any physician who provides care but has no control over the admission, continued stay, or discharge of the patient will not be penalized. Assistant surgeons and multi-surgeons are not excluded from the penalty. ( )

506. -- 510. (RESERVED)

511. ABORTION PROCEDURES: PARTICIPANT ELIGIBILITY.
The Department will fund abortions under the Medical Assistance Program only under circumstances where the abortion is necessary to save the life of the woman, or in cases of rape or incest as determined by the courts, or, where no court determination has been made, if reported to a law enforcement agency. ( )

512. -- 513. (RESERVED)

514. ABORTION PROCEDURES: PROVIDER QUALIFICATIONS AND DUTIES.

01. Required Documentation in the Case of Rape or Incest. In the case of rape or incest, the following documentation must be provided to the Department: ( )

a. A copy of the court determination of rape or incest; or ( )

b. Where no court determination has been made, documentation that the rape or incest was reported to a law enforcement agency. ( )

c. Where the rape or incest was not reported to a law enforcement agency, a licensed physician must certify in writing that, in the physician's professional opinion, the woman was unable, for reasons related to her health, to report the rape or incest to a law enforcement agency. The certification must contain the name and address of the woman. ( )

02. Required Documentation in the Case Where the Abortion is Necessary to Save the Life of the Woman. In the case where the abortion is necessary to save the life of the woman, a licensed physician must certify in writing that the woman may die if the fetus is carried to term. The certification must contain the name and address of the woman. ( )

515. -- 519. (RESERVED)

SUB AREA: OTHER PRACTITIONER SERVICES
(Sections 520-559)

520. -- 521. (RESERVED)

522. NON-PHYSICIAN PRACTITIONER SERVICES: COVERAGE AND LIMITATIONS.
The Medicaid Program will pay for services provided by non-physician practitioners (NPPs), as defined in these rules and in accordance with the provisions found under Sections 523 through 525 of these rules. ( )

523. (RESERVED)

524. NON-PHYSICIAN PRACTITIONER SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.

01. Identification of Services. The required services must be covered under the legal scope of practice as identified by the appropriate State rules of the NPP. ( )

02. Deliverance of Services. The services must be delivered under physician supervision, if required by Idaho Statute. ( )

525. NON-PHYSICIAN PRACTITIONER SERVICES: PROVIDER REIMBURSEMENT.

01. Billing of Services. Billing for the services must be as provided by the NPP and not represented as a physician service. ( )

02. Payments Made Directly to CRNA. Payments under the fee schedule must be made directly to the CRNA under the individual provider number assigned to the CRNA. Rural hospitals that qualify for a Medicare exception and employ or contract CRNAs may be reimbursed on a reasonable cost basis. ( )

03. Reimbursement Limits. The Department will reimburse for each service to be delivered by the NP, NM, CNS, PA, or RPh as either the billed charge or reimbursement limit established by the Department, whichever is less. ( )

526. -- 529. (RESERVED)

530. CHIROPRACTIC SERVICES: DEFINITIONS.
Subluxation is partial or incomplete dislocation of the spine. ( )

531. (RESERVED)

532. CHIROPRACTIC SERVICES: COVERAGE AND LIMITATIONS.
Only treatment involving manipulation of the spine to correct a subluxation condition is covered. The Department will pay for a total of six (6) manipulation visits during any calendar year for remedial care by a chiropractor. ( )

533. (RESERVED)

534. CHIROPRACTIC SERVICES: PROVIDER QUALIFICATIONS.
A person who is qualified to provide chiropractic services is licensed according to the regulations in the state where the services are provided. ( )

535. -- 539. (RESERVED)

540. PODIATRIST SERVICES: DEFINITIONS.

01. Acute Foot Conditions. An acute foot condition, for the purpose of this provision, means any condition that hinders normal function, threatens the individual, or complicates any disease. ( )

02. Chronic Foot Diseases. Chronic foot diseases, for the purpose of this provision, include: ( )

a. Diabetes melitus; ( )

b. Peripheral neuropathy involving the feet; ( )

c. Chronic thrombophlebitis; and ( )

d. Peripheral vascular disease; ( )

e. Other chronic conditions that require regular podiatric care for the purpose of preventing recurrent wounds, pressure ulcers, or amputation; or ( )

f. Other conditions that have the potential to seriously or irreversibly compromise overall health. ( )

541. PODIATRIST SERVICES: PARTICIPANT ELIGIBILITY.
Participants eligible for podiatrist services are: ( )

01. Participants Who Have a Chronic Disease. Participants who have a chronic disease where the evidence-based guidelines recommend regular foot care. ( )

02. Participants with an Acute Condition. Participants with an acute condition that, if left untreated, may cause an adverse outcome to the participant's health. ( )

542. PODIATRIST SERVICES: COVERAGE AND LIMITATIONS.
Coverage for podiatrist services is limited to: ( )

01. Services Defined in Chronic Care Guidelines. Acute and preventive foot care services defined in chronic care guidelines; and ( )

02. Treatment of Acute Conditions. Treatment of acute conditions that if left untreated will result in chronic damage to the participant's foot. ( )

543. (RESERVED)

544. PODIATRIST SERVICES: PROVIDER QUALIFICATIONS.
A qualified podiatrist is licensed by the Board of Podiatry in the Idaho Board of Occupational Licensing, or licensed according to the regulations in the state where the services are provided. ( )

545. (RESERVED)

546. LICENSED MIDWIFE (LM) SERVICES.
The Department will reimburse licensed midwives for maternal and newborn services performed within the scope of their practice. This section of rule does not include non-physician practitioner services provided by a nurse midwife (NM) which are described in Sections 522 through 525 of these rules. ( )

547. LM SERVICES: DEFINITIONS.

01. Licensed Midwife. An individual who holds a current license issued by the Idaho Board of Midwifery. ( )

02. Board of Midwifery. The Idaho Board of Midwifery is located within the Idaho Bureau of Occupational Licensing and is the licensing authority for LM providers. ( )

548. LM SERVICES: PARTICIPANT ELIGIBILITY.
A participant is eligible for LM services if the participant is pregnant, in the six (6) week postpartum period, or is a newborn up to six (6) weeks old. ( )

549. LM SERVICES: COVERAGE AND LIMITATIONS.

01. Maternity and Newborn - Coverage. Antepartem, intrapartum, and up to six (6) weeks of postpartum maternity and newborn care are covered. ( )

02. Maternity and Newborn - Limitations. Maternal or newborn services provided after the sixth postpartum week are not covered when provided by a CPM. ( )

03. Medication - Coverage and Limitations. LM providers may administer medication and bill Medicaid if the medication is a Medicaid covered service, and is also listed in the LM formulary in IDAPA 24.26.01, "Rules of the Idaho Board of Midwifery." ( )

550. LM SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.
Each LM provider must: ( )

01. Licensed. Have a current license as a LM from the Idaho Board of Midwifery or be licensed according to the regulations in the state where the services are provided. ( )

02. Scope of Practice. Provide only those services that are within the scope of practice under IDAPA 24.26.01, "Rules of the Idaho Board of Midwifery." ( )

551. LM SERVICES: PROVIDER REIMBURSEMENT.
Reimbursement for LM services will be the lesser of the billed amount, or eighty-five percent (85%) of the Department's physician fee schedule, The physician fee schedule is available from the Central Office for the Division of Medicaid, see online at: http://www.idmedicaid.com. ( )

552. LM SERVICES: PROVIDER QUALITY ASSURANCE ACTIVITIES.
Each Licensed Midwife (LM) provider must: ( )

01. Informed Consent Form Required. Keep a signed copy of the participant's informed consent in the participant's record. ( )

02. Compliance with Board of Midwifery Requirements. Adhere to all regulations listed in IDAPA 24.26.01, "Rules of the Idaho Board of Midwifery." ( )

03. Department Access to Practice Data. Make all practice data submitted to the Board of Midwifery according to the provisions in IDAPA 24.26.01, "Rules of the Idaho Board of Midwifery," immediately available to the Department upon request. ( )

553. (RESERVED)

554. OPTOMETRIST SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.
Optometrist services are provided to the extent specified in the individual provider agreements entered into under the provisions of Section 205 of these rules. ( )

01. Payment Availability. Payment for services included in Sections 780 through 786 of these rules is available to all licensed optometrists. ( )

02. Provider Qualifications. Optometrists who have certification or licensure according to the regulations in the state where the services are provided, qualify for provider agreements allowing payment for the diagnosis and treatment of injury or disease of the eye to the extent allowed under Section 54-1501, Idaho Code, and to the extent payment is available to physicians as defined in these rules. ( )

555. -- 559. (RESERVED)

SUB AREA: PRIMARY CARE CASE MANAGEMENT
(Sections 560-579)

560. HEALTHY CONNECTIONS: DEFINITIONS.
Healthy Connections is a primary care case management program in which a primary care provider or team provides comprehensive medical care for participants with the goal of improving health outcomes. For purposes of this Sub Area that includes Sections 560 through 566 of these rules, the following terms and definitions apply: ( )

01. Capitated Payments. Payments to a primary care provider made on a per assigned participant per month basis for patient services. Capitated payments will vary to reflect the level of responsibility for services the provider elects to provide as described in Section 564 of these rules. Capitated payments may include payment for all provider services at a set rate per participant per month when that type of full-risk reimbursement is agreed to by the provider and the Department. ( )

02. Clinic. Two (2) or more qualified medical professionals who provide services jointly through an organization for which an individual is given authority to act on its behalf. It also includes Federally Qualified Health Centers (FQHCs), Certified Rural Health Clinics, and Indian Health Clinics. ( )

03. Grievance. The formal process by which problems and complaints related to Healthy Connections are addressed and resolved. Grievance decisions may be appealed as provided herein. ( )

04. Patient-Centered Medical Home. A model of primary care that is patient-centered, comprehensive, team-based, coordinated, accessible, and focused on quality and safety. This results in primary care being delivered at the right place, at the right time, and in the manner that best suits a patient's needs. ( )

05. Preventive Care. Medical care that focuses on disease prevention and health maintenance. ( )

06. Primary Care Case Management. A model of care in which primary care providers and their primary care team are responsible for direct care of a participant, and for coordinating access to services that improve the health of the participant. ( )

07. Primary Care Provider (PCP). A physician, physician assistant, or advanced practice registered nurse as defined in IDAPA 24.34.01,"Rules of the Idaho Board of Nursing," who contracts with Medicaid to coordinate and manage the care of participants enrolled in the Healthy Connections program. ( )

08. Primary Care Team. A multidisciplinary team of health care providers who work together to meet the physical, emotional, and psychological needs of their patients using a patient-centered and coordinated approach. ( )

09. Referral. A documented communication from a participant's primary care provider (PCP) to another Medicaid provider authorizing specific covered services subject to primary care case management that are not provided by the participant's PCP. ( )

10. Transitional Care. A set of actions designed to ensure the coordination and continuity of health care as patients transfer between different locations or different levels of care within the same location. ( )

561. HEALTHY CONNECTIONS: PARTICIPANT ELIGIBILITY.

01. Primary Care Case Management Enrollment. Each participant in Idaho Medicaid is enrolled in Healthy Connections, unless the participant is granted an exemption by the Department described in Subsections 561.02.a. through 561.02.h. of this rule. Each participant must choose a PCP within the Healthy Connections program. If a participant fails to choose a PCP, one will be assigned to the participant by the Department. Participants of the same family may choose different Healthy Connections providers. ( )

02. Exemption from Participation. An exemption from participation in Healthy Connections may be granted on a individual basis by the Department for a participant who: ( )

a. Is unable to access a Healthy Connections provider within a distance of thirty (30) miles, or within thirty (30) minutes to obtain primary care services; ( )

b. Has an eligibility period that is less than three (3) months; ( )

c. Has an eligibility period that is only retroactive; ( )

d. Is eligible only as a Qualified Medicare Beneficiary; ( )

e. Has an existing relationship with a primary care physician or clinic who is not participating in Healthy Connections; ( )

f. Is enrolled in the Medicare/Medicaid Coordinated Plan; ( )

g. Resides in a nursing facility or an ICF/IID; or ( )

h. Resides in a county where there are not an adequate number of providers to deliver primary care case management services. ( )

562. HEALTHY CONNECTIONS: PRIMARY CARE SERVICES.

01. Eligible Services. Participants enrolled with a primary care provider (PCP) are eligible to receive: ( )

a. Basic care management and care coordination; ( )

b. Timely access to routine primary care; ( )

c. A patient-centered health care decision making process; ( )

d. Twenty-four (24) hour, seven (7) days per week access to an on-call medical professional; and ( )

e. Referral to other medically necessary services as specified in Section 210 of these rules, based on the clinical judgment of their primary care provider. ( )

02. Selection or Change in Primary Care Provider. Participants may select or change their primary care provider as follows: ( )

a. When they become eligible for Idaho Medicaid benefits, or after a break in their eligibility for Idaho Medicaid benefits; ( )

b. For cause at any time ("for cause" reasons are listed in the Idaho Medicaid Provider Handbook). ( )

c. Without cause: ( )

i. During the ninety (90) days following the effective date of the participants enrollment with a PCP. ( )

ii. At least once every twelve (12) months thereafter during the open enrollment period. ( )

d. All approved PCP change requests will be effective the first of the following month. ( )

563. HEALTHY CONNECTIONS: PROCEDURAL REQUIREMENTS.

01. Changes to Requirements. The Department will provide sixty (60) day notice of any substantive and significant changes to requirements for referrals, primary care provider reimbursement, as specified in Section 565 of these rules, or provider duties on its website and provider portal. The Department will provide a method to allow providers to provide input and comment on proposed changes. ( )

02. Problem Resolution. ( )

a. To help assure the success of Healthy Connections, the Department provides a mechanism for timely and personal attention to problems and complaints related to the program. ( )

b. To facilitate problem resolution, the Department will have a designated representative who will receive and attempt to resolve all complaints and problems related to the program and function as a liaison between participants and providers. It is anticipated that most problems and complaints will be resolved informally at this level. ( )

c. A participant or a provider may register a complaint or notify the Department of a problem related to Healthy Connections either in writing, electronically, or by telephone to the designated representative. The designated representative will attempt to resolve conflicts and disputes whenever possible and refer the complainant to alternative forums where appropriate. ( )

d. If a participant or provider is not satisfied with the resolution of a problem or complaint addressed by the designated representative, they may file a formal grievance in writing to the representative. The manager of the managed care program may, where appropriate, refer the matter to a review committee designated by the Department to address issues such as quality of care or medical necessity. However, such decisions are not binding on the Department. The Department will respond in writing to grievances within thirty (30) days of receipt. ( )

e. Decisions in response to grievances may be appealed. Appeals are governed by the requirements of IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings," and must be filed according to the

provisions of that chapter. ( )

564. HEALTHY CONNECTIONS: PROVIDER QUALIFICATIONS AND DUTIES.

01. Primary Care Providers. Primary care services may be provided by enrolled physicians, physician assistants, advanced practice registered nurses, and by care teams under those providers' direction. ( )

02. Provider Duties. All Healthy Connections providers are responsible for delivering the services listed in Section 562 of these rules. ( )

03. Additional Services. Healthy Connections providers may also elect to provide specific additional sets of patient-centered medical home services in exchange for increased reimbursement as described in Section 565 of these rules. The definition and provision of additional patient-centered medical home services are subject to specific requirements as defined by the Department and described in the Idaho Medicaid Provider Handbook and individual provider agreements with the Department. Additional services may include: ( )

a. Connection to the Idaho Health Data Exchange; ( )

b. Maintaining third-party patient-centered medical home recognition or certification; ( )

c. Expanded patient access to services; ( )

d. Provision of an evidence-based primary care service model that enables improved patient health outcomes; ( )

e. Reporting clinical data to the Department to allow for assessment of provider abilities and impact of their services on patient health outcomes; ( )

f. Coordination of transitions of care between health care settings; ( )

g. Integration of behavioral health services; and ( )

h, Other indicators of improved patient health outcomes associated with primary care provider abilities. ( )

04. Provider Participation Conditions and Restrictions. ( )

a. Provider Agreements. Each independent provider or provider organization participating in primary care case management must: ( )

i. Sign an agreement; ( )

ii. Enroll with the Department all primary care providers and all clinic locations participating in the Healthy Connections program; and ( )

iii. Complete pre-enrollment requirements for participation in the Healthy Connections program as defined by the Department in the Idaho Medicaid Provider Handbook. ( )

b. Patient Limits. A provider may limit the number of participants they manage. Subject to this limit, the provider must accept all participants who either elect or are assigned to the provider, unless disenrolled in accordance with Subsection 564.02.d. of this rule. A provider may change the participant limit effective the first day of any month. The provider must make the request in writing to the Department thirty (30) days prior to the effective date of the change. ( )

c. Disenrollment. When the provider-patient relationship breaks down due to failure of the participant to follow the care plan or for other reasons, a provider may choose to withdraw as the participant's primary care

provider effective the first day of any month. The PCP must notify in writing, both the participant and the Department thirty (30) days prior to the date of withdrawal. This advance notice requirement may be waived by the Department. ( )

d. Record Retention. Each provider must: ( )

i. Retain patient and financial records and provide the Department access to those records for a minimum of six (6) years from the date of service; ( )

ii. Upon the reassignment of a participant to another PCP, the provider must transfer (if a request is made) a copy of the patient's medical record to the new PCP; and ( )

iii. Disclose information required by Subsection 205.01 of these rules, when applicable. ( )

e. Termination or Amendment of Provider Agreements. The Department may terminate a provider's agreement as provided in Subsection 205.03 of these rules. An agreement may be amended for the same reasons. ( )

565. HEALTHY CONNECTIONS: PROVIDER REIMBURSEMENT.

01. Capitated Payments. Healthy Connections providers are compensated for their patient care services on a per participant per month basis. ( )

02. Capitated Payment Amounts. Capitated payment amounts are determined by the Department and reflect the complexity of the patient's health combined with the provider's ability to impact patient health outcomes. This monthly payment to a provider is based on the number of participants assigned to the provider on the first day of each month. ( )

566. HEALTHY CONNECTIONS: QUALITY ASSURANCE.
The Department will establish performance measurements to evaluate the effectiveness of the primary care case management programs. The performance measurements will be reviewed at least annually and adjusted as necessary to provide quality assurance. ( )

567. -- 569. (RESERVED)

SUB AREA: PREVENTION SERVICES
(Sections 570-649)

570. CHILDREN'S HABILITATION INTERVENTION SERVICES (CHIS).
CHIS are medically necessary, evidence-informed or evidence-based therapeutic techniques based on applied behavior analysis principles used to result in positive outcomes. These intervention services are delivered directly to Medicaid-eligible participants with identified developmental limitations that impact the participant's functional skills and behaviors across an array of developmental domains. Case Management is an available option to assist participants accessing CHIS by the Department as described in the Medicaid Provider Handbook. ( )

571. CHIS: DEFINITIONS.

01. Annual. Every three hundred sixty-five (365), days except during a leap year which equals three hundred sixty-six (366) days. ( )

02. Aversive Intervention. Uses unpleasant physical or sensory stimuli in an attempt to reduce undesired behavior. The stimuli usually cannot be avoided, is pain inducing, or both. ( )

03. Community. Natural, integrated environments outside the participant’s home, outside of DDA center-based settings, or at school outside of school hours. ( )

04. Developmental Disabilities Agency (DDA). A DDA is an agency that is: ( )

a. A type of developmental disabilities facility, as defined in Section 39-4604, Idaho Code, that is non-residential and provides services on an outpatient basis; ( )

b. Certified by the Department to provide services to participants with developmental disabilities; and ( )

c. A business entity, open for business to the general public. ( )

05. Duplication of Services. Services are considered duplicate when: ( )

a. Goals are not separate and unique to each service provided; or ( )

b. When more than one (1) service is provided at the same time, unless otherwise authorized. ( )

06. Educational Services. Services that are provided in buildings, rooms or areas designated or used as a school or as educational facilities; that are provided during 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 that are included in the individual educational plan for the participant or required by federal and state educational statutes or regulations; are not related service; and such services are provided to school age individuals defined in Section 33-201, Idaho Code. ( )

07. Evidence-Based Interventions. Interventions that have been scientifically researched and reviewed in peer-reviewed journals, replicated successfully by multiple independent investigators, have been shown to produce measurable and substantiated beneficial outcomes, and are delivered with fidelity by certified or credentialed individuals trained in the evidence-based model. ( )

08. Evidence-Informed Interventions. Interventions that use elements or components of evidence-based techniques and are delivered by a qualified individual, who are not certified or credentialed in an evidence-based model. ( )

09. Human Services Field. A diverse field that is focused on improving the quality of life for participants. Areas of academic study include, but are not limited to, sociology, special education, counseling, and psychology or other areas of academic study as referenced in the Medicaid Provider Handbook. ( )

10. Recreational Services. 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, and special day parties (birthday, Christmas, etc.). ( )

11. Restrictive Intervention. Any intervention that is used to restrict the rights or freedom of movement of a person and includes chemical restraint, mechanical restraint, physical restraint, and seclusion. ( )

12. Treatment Fidelity. The consistent and accurate implementation of children's habilitation services accordance with the modality, manual, protocol or model. ( )

13. Vocational Services. Services or programs that 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 participant would be able to participate in a sheltered workshop or in the general workforce within one (1) year. ( )

572. CHIS: ELIGIBILITY REQUIREMENTS.

01. Medicaid Eligibility. Participants must be eligible for Medicaid and the service for which the CHIS provider is seeking reimbursement. ( )

02. Age of Participants. CHIS are available to participants from birth through the month of their twenty-first birthday. ( )

03. Eligibility Determination. Participants eligible to receive CHIS must have a demonstrated functional need or a combination of functional and behavioral needs that require intervention services; or requires intervention to correct or ameliorate their condition in accordance with Section 880 of these rules. A functional or behavioral need is determined by the Department approved screening tool when a deficit is identified in three (3) or more of the following areas: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, economic self-sufficiency, or maladaptive behavior. A deficit is defined as one-point-five (1.5) or more standard deviations below the mean for functional areas or above the mean for maladaptive behavior. ( )

573. CHIS: COVERAGE AND LIMITATIONS.

01. Excluded for Medicaid Payment. The following are excluded for Medicaid payment: ( )

i. Vocational services; ( )

ii. Educational services; and ( )

iii. Recreational services. ( )

02. Service Delivery. The CHIS allowed under the Medicaid state plan authority include evaluations, diagnostic and therapeutic treatment services provided on an outpatient basis. These services help improve individualized functional skills, develop replacement behaviors, and promote self-sufficiency of the participant. CHIS may be delivered in the community, the participant's home, or in a DDA in accordance with the requirements of this chapter. Duplication of services is not reimbursable. ( )

03. Required Recommendation. CHIS must be recommended by a physician or other licensed practitioner of the healing arts within his or her scope of practice, under state law. ( )

a. The CHIS provider may not seek reimbursement for services provided more than thirty (30) calendar days prior to the signed and dated recommendation. ( )

b. The recommendation is only required to be completed once and must be received prior to submitting the initial prior authorization request. If the participant has not accessed CHIS for more than three hundred sixty-five (365) calendar days, then and new recommendation must be received. ( )

04. Required Screening. Needs are determined through the current version of the Vineland Adaptive Behavior Scales or other Department-approved screening tools that are conducted by the family's chosen CHIS provider, the Department, or its designee, and are administered in accordance with the protocol of the tool. The screening tool is only required to be completed once and must be completed prior to submitting the initial prior authorization request. The following apply: ( )

a. If a screening tool has been completed by the Department, or its designee, a new screening is not required. ( )

b. If the participant has been determined eligible by the Department, a new screening tool is not required. ( )

c. If the participant has not accessed CHIS for more than three hundred sixty-five (365) calendar days, a new screening must be completed. ( )

d. The screening cannot be billed more than once unless an additional screening is required in accordance with guidelines as outlined in the Medicaid Provider Handbook. ( )

05. Services. All CHIS recommended on a participant's assessment and clinical treatment plan must be prior authorized by the Department, or its contractor. The following CHIS are available for eligible participants and are reimbursable services when provided in accordance with these rules: ( )

a. Habilitative Skill Building. This direct intervention service includes techniques used to develop, improve, and maintain, to the maximum extent possible, the developmentally appropriate functional abilities and daily living skills needed by a participant. This service may include teaching and coordinating methods of training with family members or others who regularly participate in caring for the eligible participant. Services include individual or group interventions. ( )

i. Group services must be provided by one (1) qualified staff providing direct services for up to six (6) participants. ( )

ii. As the number and needs of the participants increase, the participant ratio in the group must be adjusted accordingly. ( )

iii. Group services will only be reimbursed when the participant's objectives relate to benefiting from group interaction. ( )

b. Behavioral Intervention. This service utilizes direct intervention techniques used to produce positive meaningful changes in behavior that incorporate functional replacement behaviors and reinforcement-based strategies while also addressing any identified habilitative skill building needs. These services are provided to participants who exhibit interfering behaviors that impact the independence or abilities of the participant, such as impaired social skills and communication or destructive behaviors. Intervention services may include teaching and coordinating methods of training with family members or others who regularly participate in caring for the eligible participant. Evidence-based or evidence-informed practices are used to promote positive behaviors and learning while reducing interfering behaviors and developing behavioral self-regulation. Services include individual or group interventions. ( )

i. Group services must be provided by one (1) qualified staff providing direct services for up to six (6) participants. ( )

ii. As the number and severity of the participants with behavioral issues increase, the participant ratio in the group must be adjusted accordingly. ( )

iii. Group services should only be delivered when the participant's objectives relate to benefiting from group interaction. ( )

c. Interdisciplinary Training. This is a companion service to behavioral intervention and habilitative skill building and is used to assist with implementing a participant's health and medication monitoring, positioning and physical transferring, use of assistive equipment, and intervention techniques in a manner that meets the participant's needs. This service is to be utilized for collaboration, with the participant present, during the provision of services between the intervention specialist or professional and a Speech Language and Hearing Professional (SLP), Physical Therapist (PT), Occupational Therapist (OT), medical professional, behavioral or mental health professional. ( )

d. Crisis Intervention. This service may include providing training to staff directly involved with the participant, delivering intervention directly with the eligible participant, and developing a crisis plan that directly addresses the behavior occurring and the necessary intervention strategies to minimize the behavior and future occurrences. Crisis intervention is provided in the home or community on a short-term basis typically not to exceed thirty (30) days. Positive behavior interventions must be used prior to, and in conjunction with, the implementation of any restrictive intervention. Crisis intervention is available for participants who have an unanticipated event, circumstance, or life situation that places a participant at risk of at least one (1) of the following: ( )

i. Hospitalization; ( )

ii. Out of home placement; ( )

iii. Incarceration; or ( )

iv. Physical harm to self or others, including a family altercation or psychiatric relapse. ( )

e. Assessment and Clinical Treatment Plan (ACTP). The ACTP is a comprehensive assessment that guides the formation of the implementation plan(s) that include developmentally appropriate objectives and strategies related to identified needs. The qualified provider conducts an assessment to evaluate the participant's strengths, needs, and functional abilities across environments. This process guides the development of intervention strategies and recommendations for services related to the participant's identified needs. The ACTP must be monitored and adjusted to reflect the current needs of the participant. The CHIS provider must document that a copy of the ACTP was offered to the participant's parent or legal guardian. The ACTP must be completed on a Department approved form as referenced in the Medicaid Provider Handbook and contain the following minimum standards: ( )

i. Clinical interview(s) must be completed with the parent or legal guardian; ( )

ii. Administer or obtain an objective and validated comprehensive skills or developmental assessment approved by the Department. The most current version of the assessment must be used and the assessment must have been completed within the last three-hundred and sixty-five (365) days; ( )

iii. Review of assessments, reports, and relevant history; ( )

iv. Observations in at least one (1) environment; ( )

v. A reinforcement inventory or preference assessment; ( )

vi. A transition plan; and ( )

vii. Be signed by the individual completing the assessment and the parent or legal guardian. ( )

574. CHIS: PROCEDURAL REQUIREMENTS.
All CHIS identified on a participant's ACTP must be prior authorized by the Department, or its contractor, and must be maintained in each participant's file. The CHIS provider is responsible for documenting and submitting the participant's ACTP to obtain prior authorization before delivering any CHIS. ( )

01. Prior Authorization Request. The request must be submitted to the Department, or its contractor, who will review and approve or deny prior authorization requests and notify the provider and the parent or legal guardian of the decision. Prior authorization is intended to help ensure the provision of medically necessary services and will be approved according to the timeframes established by the Department and as described in the Medicaid Provider Handbook. ( )

a. Once the initial request for prior authorization is submitted, CHIS may be delivered for a maximum of twenty-four (24) total hours for up to thirty (30) calendar days or until the prior authorization is approved. Initial prior authorization requests must include: ( )

i. A recommendation from a physician or other practitioner of the healing arts; ( )

ii. The ACTP; and ( )

iii. Implementation plan(s). ( )

b. Ongoing prior authorization requests must include: ( )

i. A list of the participant's objectives; ( )

ii. Graphs showing change lines; ( )

iii. A brief analysis of data regarding progress or lack of progress to meeting each objective; ( )

iv. A list of all CHIS hours being requested and the qualification of the individual(s) who will provide them; ( )

v. Request for the annual ACTP, if applicable; ( )

vi. New implementation plans, if applicable; ( )

vii. An updated annual ACTP, if applicable; and ( )

viii. An annual written summary with an analysis of data regarding the participant's progress or lack of progress, justification for any changes made to implementation of programming for new objectives, discontinuation of objectives, if applicable, and a summary of parent(s) or caregiver(s) response to teaching of coordinated methods. ( )

c. The following services may be requested retroactively: ( )

i. The initial ATCP; ( )

ii. The screening tool; and ( )

iii. Crisis intervention within seventy-two (72) hours of the service initiation. ( )

02. Implementation Plan(s). An implementation plan will provide details on how intervention will be implemented and must be completed by a qualified provider. All implementation plan objectives must be related to a need identified on the ATCP. The provider must document that a copy of the participant's implementation plan(s) was offered to the participant's parent or legal guardian. The implementation plan(s) must include the following requirements: ( )

a. Participant's name; ( )

b. Measurable, behaviorally-stated objectives including criteria for successful achievement, and a baseline statement; ( )

c. Location(s) where objectives will be implemented; ( )

d. Precursor behaviors for participants receiving behavioral intervention; ( )

e. Description of the treatment modality to be utilized; ( )

f. Discriminative stimulus or direction; ( )

g. Targets, steps, task analysis or prompt level; ( )

h. Correction procedure; ( )

i. Data collection; ( )

j. Reinforcement, including type and frequency; ( )

k. A plan for generalization and a plan for family training; ( )

l. A behavior response plan for participants receiving behavioral intervention; ( )

m. Any restrictive or aversive interventions being implemented must be reviewed and approved by a licensed individual working within the scope of their practice; and ( )

n. A signature of the qualified provider who completed the document(s), date signed, and credential. ( )

03. Requirements for Program Documentation. Providers must maintain records for each participant served. Failure to maintain such documentation may result in the recoupment of funds paid for undocumented services. For each participant, the following program documentation is required for each visit made or service provided to the participant, including at a minimum the following information: ( )

a. Date, time, and duration; ( )

b. Summary of session or service provided, and if interdisciplinary training is provided, documentation must include who the service was delivered to and the content covered; ( )

c. Data documentation that corresponds to the implementation plans for habilitative skill building or behavioral intervention; ( )

d. Location of service delivery; and ( )

e. Signature of the individual providing the service, date signed, and credential. ( )

04. Supervision. Supervision includes both face-to-face observation and direction to the staff regarding developmental and behavioral techniques, progress measurement, data collection, function of behaviors, and generalization of acquired skills for a participant. Supervision is provided to ensure staff demonstrate the necessary skills to correctly provide the services as defined in this rule and informs of any modification needed to the methods implemented to support the accomplishment of outcomes identified in the ACTP. Supervision must be provided in accordance with the requirements of the evidence-based model or in accordance with each individual provider qualification. Intervention specialists providing services to children birth to three (3) years old must be supervised by an intervention specialist or intervention professional who also meets the birth to three (3) years old requirements. ( )

575. CHIS: PROVIDER QUALIFICATIONS AND DUTIES.
CHIS are delivered by individuals who meet or exceeds one (1) of the qualifying criteria below in Subsections 575.01 through 575.07 of this rule, and are employed by a certified DDA, or who meet the criteria as defined in Subsection 575.08 of this rule and is enrolled as an independent CHIS provider. All providers of CHIS must meet the continuing training requirements in Subsection 575.09 of this rule. ( )

01. Crisis Intervention Technician. A crisis intervention technician can deliver crisis intervention directly with the eligible participant and must meet the qualifications of a community- based supports staff as defined in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Section 526. The technician must be under the supervision of a specialist or professional who is observing and reviewing the direct crisis intervention services performed. Supervision must occur monthly, or more often as necessary, to ensure the technician demonstrates the necessary skills to correctly provide the crisis intervention service. ( )

02. Intervention Technician. An intervention technician can deliver habilitative skill building, behavioral intervention, and crisis intervention. This is a provisional position intended to allow an individual to gain the necessary degree, competency, or experience needed to qualify as an intervention specialist or higher. An intervention technician must be an employee of a DDA and be under the supervision of a specialist or professional who is observing and reviewing the direct services performed by the intervention technician. Supervision must occur monthly, or more often as necessary, to ensure the intervention technician demonstrates the necessary skills to correctly provide the intervention. Provisional status is limited to a single eighteen (18) successive month period. The qualifications for this type of provider can be met by one (1) of the following: ( )

a. An individual who is currently enrolled and is within twenty-four (24) semester credits, or equivalent, to complete their bachelor's degree or higher from an accredited institution in a human services field and working towards meeting the experience and competency requirements; or ( )

b. An individual who holds a bachelor's degree from an accredited institution in a human services field or has a bachelor's degree and a minimum of twenty-four (24) semester credits, or equivalent, in a human services field and working towards meeting the experience and competency requirements. ( )

03. Intervention Specialist. An intervention specialist can deliver all CHIS, complete assessments and implementation plans, and must be under the supervision of a specialist or professional who is observing and reviewing the direct CHIS performed. Supervision must occur monthly, or more often as necessary, to ensure the intervention specialist demonstrates the necessary skills to correctly provide the service. An intervention specialist who will complete assessments or supervise an individual completing assessments must have a minimum of ten (10) hours of documented training and five (5) hours of supervised experience in completing comprehensive assessments and implementation plans for participants with functional or behavioral needs. The qualifications for this type of provider can be met by one (1) of the following: ( )

a. An individual who holds a Habilitative Intervention Certificate of Completion in Idaho with an expiration date of July 1, 2019 or later, will be allowed to continue providing services as an intervention specialist as long as there is not a gap of more than three (3) successive years of employment as an intervention specialist; or ( )

b. An individual who holds a bachelor's degree from an accredited institution in a human services field or a has a bachelor's degree and a minimum of twenty-four (24) semester credits, or equivalent, in a human services field; and ( )

i. Can demonstrate one thousand forty (1,040) hours of supervised experience working with participants birth to twenty-one (21) years of age who demonstrate functional or behavioral needs; and ( )

ii. Meets the competency requirements by completing one (1) of the following: ( )

(1) A Department-approved competency checklist referenced in the Medicaid Provider Handbook; or ( )

(2) A minimum of forty (40) hours of applied behavior analysis training delivered by an individual who is certified or credentialed to provide the training; or ( )

(3) Other Department-approved competencies as defined in the Medicaid Provider Handbook. ( )

c. An individual who provides services to children birth to three (3) years of age must also demonstrate a minimum of two hundred forty (240) hours of professionally supervised experience providing assessment or evaluation, curriculum development, and service provision in the areas of communication, cognition, motor, adaptive (self-help), and social-emotional development with infants and toddlers birth to five (5) years of age with developmental delays or disabilities. Experience must be through paid employment or university internship or practicum experience and may be documented within the supervised experience listed in Subsection 575.02.b.i. of this rule, and have one (1) of the following: ( )

i. An elementary education certificate or special education certificate with an endorsement in early childhood special education; or ( )

ii. A blended Early Childhood or Early Childhood Special Education (EC or ECSE) certificate; or ( )

iii. A bachelor's or master's degree in special education, elementary education, speech-language pathology, early childhood education, physical therapy, occupational therapy, psychology, social work, counseling, or nursing. This individual must have a minimum of twenty-four (24) semester credits from an accredited college or university, which can be within their bachelor's or master's degree coursework, or can be in addition to the degree coursework. Courses must cover the following as defined in the Medicaid Provider Handbook: ( )

(1) Promotion of development and learning for children from birth to five (5) years of age. ( )

(2) Assessment and observation methods that are developmentally appropriate assessment of young children with developmental delays or disabilities; ( )

(3) Building family and community relationships to support early interventions; ( )

(4) Development of appropriate curriculum for young children; ( )

(5) Implementation of instructional and developmentally effective approaches for early learning, including strategies for children and their families; and ( )

(6) Demonstration of knowledge of policies and procedures in special education and early intervention and demonstration of knowledge of exceptionalities in children's development. ( )

04. Intervention Professional. An intervention professional can deliver all CHIS and complete assessments and implementation plans. Intervention professionals must meet the following minimum qualifications: ( )

a. Hold a master's degree or higher from an accredited institution in psychology, education, applied behavior analysis, or have a related discipline with one thousand five hundred (1,500) hours of relevant coursework or training, or both, in principles of child development, learning theory, positive behavior support techniques, dual diagnosis, psychology, education, or behavior analysis which may be documented within the individual's degree program, other coursework, or training; and ( )

b. Have one thousand two hundred (1,200) hours of relevant experience in completing and implementing comprehensive behavioral therapies for participants with functional or behavioral needs, which may be documented within the individual's degree program, other coursework, or training. ( )

c. An individual who provides services to children birth to three (3) years of age must meet the requirements defined in Subsection 575.03.c. of this rule. ( )

05. Evidence-Based Model (EBM) Intervention Paraprofessional. An EBM intervention paraprofessional can deliver habilitative skill building, crisis intervention, and behavioral intervention, and must be supervised in accordance with the evidence-based model. The qualifications for this type of provider are: ( )

a. An individual who holds a high school diploma or general equivalency diploma; and ( )

b. Holds a para-level certification or credential in an evidence-based model approved by the Department. ( )

06. Evidence-Based Model (EBM) Intervention Specialist. An EBM intervention specialist can deliver all CHIS and complete assessments and implementation plans. This individual must be supervised in accordance with the evidenced-based model and may also supervise the evidence-based paraprofessional working within the same evidence-based model. The qualifications for this type of provider are: ( )

a. An individual who holds a bachelor's degree from an accredited institution in accordance with their certification or credentialing requirements; and ( )

b. Holds a bachelor-level certification or credential in an evidence-based model approved by the Department. ( )

c. An individual who provides services to children birth to three (3) years of age must also have a minimum of two hundred forty (240) hours of professionally supervised experience providing assessment or evaluation, curriculum development, and service provision in the areas of communication, cognition, motor, adaptive (self-help), and social-emotional development with infants and toddlers birth to five (5) years of age with developmental delays or disabilities. Experience must be through paid employment or university activities. ( )

07. Evidence-Based Model (EBM) Intervention Professional. An EBM intervention professional can deliver all CHIS and complete assessments and implementation plans. The qualifications for this type of provider are: ( )

a. An individual who holds a master's degree or higher from an accredited institution in accordance with their certification or credentialing requirements; and ( )

b. Holds a masters-level certification or credential in an evidence-based model approved by the Department. ( )

c. An individual who provides services to children birth to three (3) years of age must meet the requirements defined in Subsection 575.06.c. of this rule. ( )

08. Independent CHIS Provider. This type of provider can deliver all types of CHIS, complete assessments and implementation plans in accordance with their provider qualification as defined in Subsections 575.03, 575.04, 575.06, and 575.07 of these rules. Documentation of supervision must be maintained in accordance with the Department's record retention requirements. The following must be met: ( )

a. Obtain an independent Medicaid provider agreement through the Department and maintain in good standing; ( )

b. Be certified in CPR and first aid prior to delivering services and maintain current certification thereafter; ( )

c. Compete a criminal history and background check, including clearance in accordance with IDAPA 16.05.06, “Criminal History and Background Checks”; ( )

d. Follow all applicable requirements in Sections 570 through 577 of these rules; and ( )

e. Not receive supervision from an individual that they are directly supervising. ( )

09. Continuing Training Requirements. Each individual providing CHIS must complete a minimum of twelve (12) hours of training each calendar year, including one (1) hour of ethics and six (6) hours of behavior methodology or evidence-based intervention. The following criteria applies: ( )

a. Training must be relevant to the services being delivered. ( )

b. Continuing training requirements for new independent providers or employees of a DDA who have not provided CHIS for a full calendar year, may be prorated as defined in the Medicaid Provider Handbook. ( )

c. Individuals who have not completed the required training during the previous calendar year, may not provide services in the current calendar year until the required number of training hours have been completed. ( )

d. Training hours may not be earned in the current calendar year to be applied to a future calendar year. ( )

e. Training topics can be repeated but the content of the continuing training must be different each calendar year; and ( )

576. CHIS: PROVIDER REIMBURSEMENT.

01. Reimbursement. The CHIS in Sections 570 through 577 of these rules are reimbursed as defined in IDAPA 16.03.10, Medicaid Enhanced Plan Benefits,” Section 038. ( )

02. Claim Forms. Provider claims for payment must be submitted on claim forms provided or

approved by the Department. General billing instructions will be provided by the Department. ( )

03. Rates. The reimbursement rates calculated for CHIS 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. ( )

577. CHIS: QUALITY ASSURANCE.
The Department will establish performance criteria to meet federal assurances that measure the outcomes and effectiveness of the CHIS. Quality assurance activities will include the observation of service delivery with participants, face-to-face visits to review program protocol, and review of participant records maintained by the provider. All CHIS providers must grant the Department immediate access to all information requested to review compliance with these rules. ( )

01. Quality Assurance. Quality assurance consists of reviews to assure compliance with the Department's rules and regulations for CHIS. The Department will visit providers to monitor outcomes, assure treatment fidelity, and assure health and safety. The Department will also gather information to assess family and participant satisfaction with services. These findings may lead to quality improvement activities to enhance provider processes and outcomes for the participant. If problems are identified that impact health and safety or are not resolved through quality improvement activities, implementation of a corrective action process will occur. ( )

02. Quality Improvement. Quality improvement consists of the Department working with the provider to resolve identified issues and enhance services provided. Quality improvement activities may include any of the following: ( )

a. Consultation; ( )

b. Technical assistance and recommendations; or ( )

c. A Corrective Action. ( )

03. Corrective Action. Corrective action is a formal process used by the Department to address significant, ongoing, or unresolved deficient practices identified during the review process as provided in Section 205.03 of these rules. Corrective action, as outlined in the Department's corrective action plan process, includes: ( )

a. Issuance of a corrective action plan; ( )

b. Referral to Medicaid Program Integrity Unit; or ( )

c. Action against a provider agreement. ( )

578. -- 579. (RESERVED)

SUB AREA: PREVENTION SERVICES
(Sections 580-649)

580. CHILD WELLNESS SERVICES: DEFINITIONS.

01. Interperiodic Medical Screens. Interperiodic medical screens are screens that are done at intervals other than those identified in the American Academy of Pediatrics periodicity schedule. ( )

02. Periodic Medical Screens. Interperiodic medical screens are screens done at intervals identified in the American Academy of Pediatrics periodicity schedule. ( )

581. CHILD WELLNESS SERVICES: PARTICIPANT ELIGIBILITY.
Child Wellness Services are available to all participants up to, and including, the month of their twenty-first (21st) birthday. ( )

582. CHILD WELLNESS SERVICES: COVERAGE AND LIMITATIONS.

01. Periodic Medical Screens. Periodic medical screens are to be completed according to the American Academy of Pediatrics periodicity schedule including blood lead tests at age twelve (12) months and twenty-four (24) months. The medical screen must include a blood lead test when the participant is age two (2) through age twenty-one (21) and has not been previously tested. ( )

02. Interperiodic Screens. Interperiodic screens will be performed when there are indications that it is medically necessary to determine whether a child has a physical or mental illness or condition that may require further assessment, diagnosis, or treatment. Interperiodic screens may occur in children who have already been diagnosed with an illness or condition, and there is indication that the illness or condition may have become more severe or changed sufficiently, so that the further examination is medically necessary ( )

03. Developmental Screens. Developmental screening is considered part of every routine initial and periodic examination. If the screening identifies a developmental problem, then a developmental assessment will be ordered by the physician, certified nurse midwife, PA, or NP and be conducted by qualified professionals. ( )

583. (RESERVED)

584. CHILD WELLNESS SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.

01. Interperiodic Medical Screens. Interperiod medical screens must be performed by a physician, NP, or PA. ( )

02. Periodic Medical Screens. Periodic medical screens can be performed by a physician, certified nurse midwife, PA, or NP. ( )

585. EARLY INTERVENTION SERVICES.
Early Intervention Services for infants and toddlers enrolled in Idaho Medicaid are provided by the Idaho Infant Toddler Program (ITP). Early Intervention Services must be provided in accordance with the Individuals with Disabilities Education Act (IDEA), Part C, and all Medicaid regulations. ( )

586. EARLY INTERVENTION SERVICES: PROGRAM REQUIREMENTS.
Idaho Medicaid and the ITP coordinate the delivery of Early Intervention Services through an intra-agency agreement published on the Department's website. Program requirements include: ( )

01. Physician Recommendation. The ITP can bill for health-related services provided to eligible children when the services are documented as medically necessary and provided under the recommendation of a physician, certified nurse midwife, PA, or NP. ITP may not seek reimbursement for services provided more than thirty (30) days prior to the signed and dated physician recommendation. The recommendation is valid for up to three hundred sixty-five (365) days.
( )

02. Individualized Family Service Plan (IFSP). The ITP may bill for Medicaid services covered by a current IFSP. The plan must be developed by a multi-disciplinary team and be based on the results of assessment(s).
( )

03. Qualified Staff. ITP staff qualifications must meet IDEA Part C requirements, and all Medicaid regulations as specified in the intra-agency agreement. ( )

587. EARLY INTERVENTION SERVICES: PROVIDER REIMBURSEMENT.
Medicaid will reimburse the Infant Toddler Program for covered medically necessary services. ( )

01. Fee Schedule. Reimbursement for Early Intervention Services will be based on the Idaho Medicaid Fee Schedule for Early Intervention. ( )

02. Payment Review. Reimbursement is subject to pre-payment and post-payment review in accordance with Section 56-209h(3), Idaho Code, and recoupment in accordance with IDAPA 16.05.07, "The Investigation and Enforcement of Fraud, Abuse, and Misconduct." ( )

588. -- 589. (RESERVED)

590. ADULT PHYSICALS.
Adult preventive physical examinations are limited to one (1) per year. ( )

591. -- 601. (RESERVED)

602. SCREENING MAMMOGRAPHIES: COVERAGE AND LIMITATIONS.

01. Screening Mammographies. Screening mammographies are limited to one (1) per year for women who are forty (40) or more years of age. ( )

02. Diagnostic Mammographies. Diagnostic mammographies are not subject to the limitations of screening mammographies. Diagnostic mammographies are covered when a physician or licensed practitioner of the healing arts orders the procedure for a participant of any age. ( )

603. (RESERVED)

604. SCREENING MAMMOGRAPHIES: PROVIDER QUALIFICATIONS AND DUTIES.
Idaho Medicaid will cover screening or diagnostic mammographies performed with mammography equipment by staff considered certifiable or certified by the Bureau of Laboratories or the equivalent for providers in other states. ( )

605. -- 609. (RESERVED)

610. CLINIC SERVICES: DIAGNOSTIC SCREENING CLINICS.
The Department will reimburse medical social service visits to clinics that coordinate the treatment between physicians and other medical professionals for participants which are diagnosed with cerebral palsy, myelomeningitis or other neurological diseases and injuries with comparable outcomes. ( )

01. Multidisciplinary Assessments and Consultations. The clinic must perform on site multidisciplinary assessments and consultations with each participant and responsible parent or guardian. Diagnostic and consultive services related to the diagnosis and treatment of the participant will be provided by board certified physician specialists in physical medicine, neurology and orthopedics. ( )

02. Billings. No more than five (5) hours of medical social services per participant may be billed by the specialty clinic each state fiscal year for which the medical social worker monitors and arranges participant treatments and provides medical information to providers who have agreed to coordinate the care of their participant. ( )

03. Services Performed. Services performed or arranged by the clinic will be subject to the amount, scope and duration for each service as set forth elsewhere in this chapter. ( )

04. The Clinic. The clinic is established as a separate and distinct entity from the hospital, physician or other provider practices. ( )

611. -- 617. (RESERVED)

618. HEALTH QUESTIONNAIRE.
The Health Questionnaire assesses the general health status and health behaviors of a participant. The information collected is used to provide customized health education to the participant. The Health Questionnaire is administered at initial program entry and at periodic intervals thereafter. Participant responses to the issues addressed in the Health Questionnaire may identify a participant's interest in the Preventive Health Assistance benefits described in Section

620 of these rules. ( )

619. (RESERVED)

620. PREVENTIVE HEALTH ASSISTANCE (PHA): DEFINITIONS.

01. Behavioral PHA. Benefits available to a participant specifically to support weight control. ( )

02. Benefit Year. A benefit year is twelve (12) continuous months. A participant's PHA benefit year begins the date their initial points are earned. ( )

03. PHA Benefit. A mechanism to reward healthy behaviors and good health choices of a participant eligible for preventive health assistance. ( )

04. Wellness PHA. Benefits available to a participant to support wellness. ( )

621. PREVENTIVE HEALTH ASSISTANCE (PHA): PARTICIPANT ELIGIBILITY.

01. Behavioral PHA. The participant must have a Health Questionnaire on file with the Department. The Health Questionnaire is used to determine eligibility for a Behavioral PHA. The participant must indicate on the Health Questionnaire that they want to change a behavior related to weight management. The participant must meet one (1) of the following criteria: ( )

a. For an adult, a body mass index (BMI) of thirty (30) or higher or eighteen and one-half (18 1/2) or lower. ( )

b. For a child, a body mass index (BMI) that falls in either the overweight or the underweight category as calculated using the Centers for Disease Control (CDC) Child and Teen BMI Calculator. ( )

02. Wellness PHA. A participant who is required to pay premiums to maintain eligibility under IDAPA 16.03.01, "Eligibility for Health Assistance for Families and Children," is eligible for Wellness PHA. ( )

622. PREVENTIVE HEALTH ASSISTANCE (PHA): COVERAGE AND LIMITATIONS.

01. Point System. The PHA benefit uses a point system to track points earned and used by a participant. Each point equals one (1) dollar. ( )

a. Maximum Benefit Points. ( )

i. The maximum number of points that can be earned for a Behavioral PHA is two hundred (200) points each benefit year. ( )

ii. The maximum number of points that can be earned for a Wellness PHA benefit is one hundred twenty (120) points each benefit year. ( )

b. Points expire and are removed from a participant's PHA benefit at the end of the participant's benefit year. ( )

c. Points earned for a specific participant's PHA benefit cannot be transferred to or combined with points in another participant's PHA benefit. ( )

02. Weight Management Program. Each program must provide weight management services and must include a curriculum that includes at least one (1) of the three (3) following areas: ( )

a. Physical fitness; ( )

b. Balanced diet; or ( )

c. Personal health education. ( )

03. Participant Request for Coverage. A participant can request that a previously unidentified service be covered. The Department will approve a request if the product or service meets the requirements described in this rule and the vendor meets the requirements in Section 624 of these rules. ( )

04. Premiums. ( )

a. Wellness PHA benefit points must be used to offset a participant's premiums. ( )

b. Only premiums that must be paid to maintain eligibility under IDAPA 16.03.01, "Eligibility for Health Assistance for Families and Children" can be offset by PHA benefit points. ( )

05. Hearing Rights. A participant does not have hearing rights for issues arising between the participant and a chosen vendor. ( )

623. PREVENTIVE HEALTH ASSISTANCE (PHA): PROCEDURAL REQUIREMENTS.

01. Behavioral PHA. ( )

a. A PHA benefit will be established for each participant who meets the eligibility criteria for Behavioral PHA. A participant must complete a PHA Benefit Agreement Form prior to earning any points. ( )

b. Each participant who chooses to enroll in weight management must participate in a physician approved or monitored weight management program. ( )

c. An initial one hundred (100) points are earned when the agreement form is received by the Department and the benefit is established. ( )

d. An additional one hundred (100) points can be earned by a participant who completes their program or reaches a chosen, defined goal. The vendor monitoring the participant's progress must verify that the program was completed or the goal was reached. ( )

02. Wellness PHA. ( )

a. A PHA benefit will be established for each participant who meets the eligibility criteria for Wellness PHA. Each participant must demonstrate that they have received recommended wellness visits and immunizations for their age prior to earning any points. ( )

b. Ten (10) points can be earned each month by a participant who receives all recommended wellness visits and immunizations for their age during the benefit year. ( )

624. PREVENTIVE HEALTH ASSISTANCE (PHA): PROVIDER QUALIFICATIONS AND DUTIES.

01. Provider Agreement. A behavioral PHA vendor must have a fully-executed provider agreement on file with the Department prior to providing services or products. ( )

02. Prior Authorization. A behavioral PHA vendor must request prior authorization from the Department for each product or service provided as a PHA benefit. ( )

03. Medications and Pharmaceutical Supplies Vendor. Each vendor must be a licensed pharmacy and must meet the criteria in Section 664 of these rules for prescription drug provider qualifications and duties. ( )

04. Weight Management Program Vendor. Each vendor must: ( )

a. Be established as a business that serves the general public; ( )

b. Meet all state, county, and local business licensing requirements: and ( )

c. Be able to provide a weight management program as described in Section 622 of these rules. ( )

625. PREVENTIVE HEALTH ASSISTANCE (PHA): PROVIDER REIMBURSEMENT.
With the prior agreement of the participant, the vendor may bill the participant for the difference between the Department's reimbursement and the vendor's usual and customary charge for Behavioral PHA products or services provided. ( )

626. PREVENTIVE HEALTH ASSISTANCE (PHA): QUALITY ASSURANCE.
The Department will establish performance measurements to evaluate the effectiveness of PHA. The performance measurements will be reviewed at least annually and adjusted as necessary to provide quality assurance. ( )

627. -- 629. (RESERVED)

630. NUTRITIONAL SERVICES: DEFINITIONS.
Nutritional services include intensive nutritional education, counseling, and monitoring. ( )

631. (RESERVED)

632. NUTRITIONAL SERVICES: COVERAGE AND LIMITATIONS.

01. Order. The need for nutritional services must be discovered by screening services and ordered by the physician or non-physician practitioner. ( )

02. Medically Necessary. The services must be medically necessary. ( )

633. (RESERVED)

634. NUTRITIONAL SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.
Nutritional services must be performed by a registered dietician or an individual who has a baccalaureate degree from a U.S. regionally accredited college or university and has met the academic and professional requirements in dietetics as approved by the American Dietetic Association. ( )

635. NUTRITIONAL SERVICES: PROVIDER REIMBURSEMENT.
Payment for nutritional services is made at a rate established in accordance with Section 230 of these rules. ( )

636. -- 639. (RESERVED)

640. DIABETES EDUCATION AND TRAINING SERVICES: DEFINITIONS.
For purposes of these rules, a Certified Diabetes Educator is a state-licensed health professional who is certified by the Certification Board for Diabetes Care and Education or the Association of Diabetes Care and Education Specialists (ADCES). ( )

641. DIABETES EDUCATION AND TRAINING SERVICES: PARTICIPANT ELIGIBILITY.
The medical necessity for diabetes education and training are evidenced by the following: ( )

01. Recent Diagnosis. A recent diagnosis of diabetes within ninety (90) days of enrollment with no history of prior diabetes education; or ( )

02. Uncontrolled Diabetes. Uncontrolled diabetes manifested by two (2) or more fasting blood sugar of greater than one hundred forty milligrams per decaliter (140 mg/dL), hemoglobin A1c greater than eight percent (8%), or random blood sugar greater than one hundred eighty milligrams per decaliter (180 mg/dL), in addition to the

manifestations; or ( )

03. Recent Manifestations. Recent manifestations resulting from poor diabetes control including neuropathy, retinopathy, recurrent hypoglycemia, repeated infections, or nonhealing wounds. ( )

642. DIABETES EDUCATION AND TRAINING SERVICES: COVERAGE AND LIMITATIONS.

01. Concurrent Diagnosis. Only training and education services that are reasonable and necessary for treatment of a current injury or illness will be covered. Covered professional and educational services will address each participant's medical needs through scheduled outpatient group or individual training or counseling concerning diet and nutrition, medications, home glucose monitoring, insulin administration, foot care, or the effects of other current illnesses and complications. ( )

02. No Substitutions. The physician may not use the formally structured program, or a Certified Diabetes Educator, as a substitute for basic diabetic care and instruction the physician must furnish to the participant, which includes the disease process and pathophysiology of diabetes mellitus, and dosage administration of oral hypoglycemic agents. ( )

03. Services Limited. Diabetes education and training services will be limited to twenty-four (24) hours of group sessions and twelve (12) hours of individual counseling every five (5) calendar years. ( )

643. DIABETES EDUCATION AND TRAINING SERVICES: PROCEDURAL REQUIREMENTS.
To receive diabetes counseling, the participant must have a written order from the primary care provider who referred the participant to the program. ( )

644. DIABETES EDUCATION AND TRAINING SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.
Outpatient diabetes education and training services will be covered under the following conditions: ( )

01. Meets Program Standards. The education and training services are provided through a diabetes management program recognized as meeting the program standards of the American Diabetes Association or the National Diabetes Prevention Program. ( )

02. Conducted by a Certified Diabetic Educator. The education and training services are provided by a Certified Diabetic Educator through a formal program. ( )

645. DIABETES EDUCATION AND TRAINING SERVICES: PROVIDER REIMBURSEMENT.
Diabetes education and training services will be reimbursed according to the Department's established fee schedule in accordance with Section 230 of these rules. ( )

646. -- 649. (RESERVED)

SUB AREA: LABORATORY AND RADIOLOGY SERVICES
(Sections 650-659)

650. LABORATORY AND RADIOLOGY SERVICES: DEFINITIONS.

01. Independent Laboratory. A laboratory that is not located in a physician’s office, and receives specimens from a source other than another laboratory. A physician is not an independent laboratory. ( )

02. Laboratory or Clinical Laboratory. A facility for the biological, microbiological, serological, chemical, immunohematological, hematological, biophysical, cytological, pathological, or other examinations of material derived from the human body for the purpose of providing information for the diagnosis, prevention, or treatment of any disease, or the impairment or assessment of human health. ( )

03. Proficiency Testing. Evaluation of a laboratory's ability to perform laboratory procedures within acceptable limits of accuracy through analysis of unknown specimens distributed at periodic intervals. ( )

04. Quality-Control. A day-to-day analysis of reference materials to ensure reproducibility and accuracy of laboratory results, and includes an acceptable system to assure proper functioning of instruments, equipment and reagents. ( )

05. Reference Laboratory. A laboratory that only accepts specimens from other laboratories. ( )

651. -- 652. (RESERVED)

653. LABORATORY AND RADIOLOGY SERVICES: COVERAGE AND LIMITATIONS.

01. Medical Necessity Criteria. Services must meet the definition of Medical Necessity in Section 011 of these rules as detailed in the Idaho Medicaid Provider Handbook. ( )

02. Prior Authorization of Services. The Department may require prior authorization of any laboratory or radiology service as detailed in the Idaho Medicaid Provider Handbook. ( )

654. LABORATORY AND RADIOLOGY SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.

01. Laboratory and Radiology Requirements. Providers of laboratory and radiology services must be eligible for Medicare certification for these services. ( )

02. Use of Reference Laboratories. Laboratories using reference laboratories must ensure that all requirements of Sections 650 through 659 of these rules are met by the reference laboratory. ( )

655. LABORATORY AND RADIOLOGY SERVICES: PROVIDER REIMBURSEMENT.

01. Provider of Service. Payment for laboratory tests can only be made to the actual provider of that service. An exception to the preceding is made in the case of: ( )

a. An independent laboratory that can bill for a reference laboratory; ( )

b. A transplant facility that can bill for histocompatibility testing; and ( )

c. Healthcare professionals acting within the licensure and scope of their practice to comply with IDAPA 16.02.12, "Newborn Screening." ( )

02. Tests Performed by or Personally Supervised by a Physician. The payment level for clinical diagnostic laboratory tests performed by or personally supervised by a physician will be at a rate established by the Department that is no higher than Medicare's fee schedule. The payment level for other laboratory tests will be a rate established by the Department. ( )

03. Tests Performed by an Independent Laboratory. The payment level for clinical diagnostic laboratory tests performed by an independent laboratory will be at a rate established by the Department that is no higher than Medicare's fee schedule. The payment level for other laboratory tests will be at a rate established by the Department. ( )

04. Tests Performed by a Hospital Laboratory. The payment level for clinical diagnostic laboratory tests performed by a hospital laboratory for anyone who is not an inpatient will be at a rate established by the Department that is no higher than Medicare's fee schedule. The payment level for other laboratory tests will be at a rate established by the Department. ( )

05. Specimen Collection Fee. Collection fees for specimens drawn by venipuncture or catheterization are payable only to the physician or laboratory who draws the specimen. If done during an office visit on the same day the service is ordered, specimen collection may be reimbursed even if prior authorization is not approved. ( )

656. LABORATORY AND RADIOLOGY SERVICES: QUALITY ASSURANCE.
Laboratories, as a condition of payment, must maintain a quality-control program, including proficiency testing consistent with federal requirements, as detailed in the Idaho Medicaid Provider Handbook. The laboratory must provide the results of proficiency testing to the Department or their Quality Improvement Organization vendor upon request. ( )

657. -- 659. (RESERVED)

SUB AREA: PRESCRIPTION DRUGS
(Sections 660-679)

660. (RESERVED)

661. PRESCRIPTION DRUGS: PARTICIPANT ELIGIBILITY.

01. Obtaining a Prescription Drug. To obtain a prescription drug, a Medicaid participant or authorized agent must present the participant's Medicaid identification card to a participating pharmacy together with a prescription from a licensed prescriber. ( )

02. Tamper-Resistant Prescription Requirements. Any written, non-electronic prescription for a Medicaid participant must be written on a tamper-resistant prescription form. The paper on which the prescription is written must have: ( )

a. One (1) or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form; ( )

b. One (1) or more industry-recognized features designed to prevent the erasure or modification of information written on the prescription by the prescriber; ( )

c. One (1) or more industry-recognized features designed to prevent the use of counterfeit prescription forms. ( )

03. Tamper-Resistant Prescription Requirements Not Applicable. The tamper-resistant prescription requirements do not apply when the prescription is communicated by the prescriber to the pharmacy electronically, verbally, by fax, or when drugs are provided in an inpatient hospital or a nursing facility where the patient and family do not have direct access to the paper prescription. ( )

04. Drug Coverage for Dual Eligibles. For Medicaid participants who are also eligible for Medicare known as “dual eligibles”, the Department will pay for Medicaid-covered drugs that are not covered by Medicare Part D. Dual eligibles will be subject to the same limits and processes used for any other Medicaid participants. ( )

662. PRESCRIPTION DRUGS: COVERAGE AND LIMITATIONS.

01. General Drug Coverage. The Department will pay for those prescription drugs not excluded by Subsections 662.06 and 662.07 of this rule that are legally obtainable by the order of a licensed prescriber whose licensing allows for the prescribing of prescription drugs or legend drugs, as defined under Section 54-1705, Idaho Code, and which are deemed medically necessary as defined in Section 011 of these rules. ( )

02. Preferred Drug List (PDL). ( )

a. The PDL identifies the preferred drugs and non-preferred drugs within a therapeutic class designated by the Department and reviewed by the Idaho Medicaid Pharmacy and Therapeutics Committee. ( )

b. A brand name drug may be designated as a preferred drug by the Department if the net cost of the brand name drug after consideration of all rebates is less than the cost of the generic equivalent. ( )

c. The Director of the Department makes final decisions regarding the designated preferred or non-preferred status of drugs based on therapeutic recommendations from the Pharmacy and Therapeutics Committee and cost analysis from the Idaho Medicaid Pharmacy Program. ( )

d. Drugs in a drug class on the Medicaid PDL may require therapeutic prior authorization regardless of preferred or non-preferred designation. ( )

03. Covered Drug Products. Idaho Medicaid provides coverage to Medicaid participants for the following drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under Section 1927(d)(2) of the Social Security Act: ( )

a. Agents, when used to promote smoking cessation. ( )

b. Prescription vitamins and mineral products. Covered agents include the following: ( )

i. Injectable vitamin B12 (cyanocobalamin and analogues); ( )

ii. Vitamin K and analogues; ( )

iii. Prescription vitamin D and analogues; ( )

iv. Prescription pediatric vitamins, minerals, and fluoride preparations; ( )

v. Prenatal vitamins for pregnant or lactating individuals; and ( )

vi. Prescription folic acid and oral prescription drugs containing folic acid in combination with vitamin B12 or iron salts, or both, without additional ingredients. ( )

c. Certain prescribed non-prescription products, including the following: ( )

i. Permethrin; ( )

ii. Oral iron salts; ( )

iii. Disposable insulin syringes and needles; and ( )

iv. Insulin. ( )

d. Barbiturates. ( )

e. Benzodiazepines. ( )

04. Additional Criteria for Coverage. ( )

a. Medical necessity is the primary determinant of whether a therapeutic agent will be covered. The Department will cover generic drugs, and also brand drugs when medically necessary and when that necessity is adequately documented. If case-specific indications of medical necessity are present, the Department may also issue prior authorization for otherwise excluded drugs. ( )

b. The Director of the Department of Health and Welfare, acting upon the recommendation of the Pharmacy and Therapeutics Committee, may determine that a non-prescription drug product is covered when the non-prescription product is found to be therapeutically interchangeable with prescription drugs in the same pharmacological class following evidence-based comparisons of efficacy, effectiveness, clinical outcomes, and safety, and the product is deemed by the Department to be a cost-effective alternative. Information regarding the Pharmacy and Therapeutics Committee and covered drug products is posted at http://medicaidpharmacy.idaho.gov. ( )

05. Excluded Drug Products. Idaho Medicaid excludes from coverage the following drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under Section 1927(d)(2) of the Social Security Act: ( )

a. Agents, when used to promote fertility. ( )

b. Agents, when used for cosmetic purposes or hair growth. ( )

c. Agents, when used for the symptomatic relief of cough and colds. ( )

d. Covered outpatient drugs for which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee. ( )

e. Agents, when used for the treatment of sexual or erectile dysfunction, unless such agents are used to treat a condition, other than sexual or erectile dysfunction, for which the agents have been approved by the Food and Drug Administration. ( )

06. Additional Excluded Drugs. Drugs are also not covered when any of the following circumstances apply: ( )

a. The participant's practitioner has written an order for a prescription drug for which federal financial participation is not available. ( )

b. The participant's practitioner has written an order for a prescription drug that is deemed to be experimental or investigational, as defined in Subsection 390.03 of these rules. Investigational drugs are not a covered service under the Idaho Medicaid pharmacy program. The Department may consider Medicaid coverage on a case-by-case basis for life-threatening medical illnesses when no other treatment options are available. When approved for payment, reimbursement will be at actual acquisition cost, plus the assigned professional dispensing fee. ( )

07. Limitation of Quantities. Medication refills provided before at least seventy-five percent (75%) of the estimated days' supply has been utilized are not covered, unless an increase in dosage is ordered. Days' supply is the number of days a medication is expected to last when used at the dosage prescribed for the participant. No more than a thirty-four (34) days' supply of continuously required medication is to be purchased in a calendar month as a result of a single prescription with the following exceptions: ( )

a. Maintenance Medications. Pharmacy providers may be reimbursed for up to a three (3) month supply of select medications or classes of medications for a participant who has received the same dose of the same select medication or class of medications for two months or longer. The Director of the Department of Health and Welfare, acting upon the recommendation of the Pharmacy and Therapeutics Committee, approves the list of covered maintenance medications, which targets medications that are administered continuously rather than intermittently, are used most commonly to treat a chronic disease state, and have a low probability for dosage changes. The list of covered maintenance medications is available on the Medicaid Pharmacy website at http://medicaidpharmacy.idaho.gov. ( )

b. Oral Contraceptive Products. Oral contraceptive products may be dispensed in a quantity sufficient for one (1), two (2), or three (3) cycles. ( )

663. PRESCRIPTION DRUGS: PROCEDURAL REQUIREMENTS.

In accordance with Section 1927(d)(1)(A) of the Social Security Act, the Idaho Medicaid Pharmacy Program may subject any covered outpatient drug to prior authorization. ( )

01. Drugs Requiring Prior Authorization. No payment for drugs requiring prior authorization will be issued until the prior authorization request has been reviewed and approved by the Department. ( )

02. Prior Authorization Criteria. Criteria for prior authorization for individual drugs and drug classes will be determined by the Department, and will include: ( )

a. Food and Drug Administration (FDA) indications and labeling, including dosage guidelines. ( )

b. Compendia of drug information recognized by the Centers for Medicare and Medicaid Services (CMS), including: ( )

i. American Hospital Formulary Service-Drug Information; ( )

ii. United States Pharmacopeia-Drug Information, or its successor publications; and ( )

iii. The DrugDex Information System. ( )

c. Evidence-based, peer-reviewed, published medical literature, including: ( )

i. Systematic reviews; ( )

ii. Randomized controlled trials; and ( )

iii. Meta-analysis studies. ( )

d. Guidelines and case-controlled studies may be considered where systematic reviews, randomized controlled trials and meta-analysis studies do not exist. ( )

e. The requested drug's preferred drug status. ( )

03. Request for Prior Authorization. ( )

a. The prior authorization procedure is initiated by the prescriber who must submit the request to the Department in the format prescribed by the Department. ( )

b. Whenever possible, the Department will use automated authorization, in which claims are adjudicated at point of sale using submitted National Council for Prescription Drug Programs (NCPDP) data elements or claims history to verify that the Department's authorization requirements have been satisfied, without the need for the prescriber to submit additional clinical information. ( )

04. Notice of Decision. The Department will determine coverage based on this request, and will notify the participant of a denial. The participant has twenty-eight (28) days from the date the denial letter is mailed to appeal the decision. Hearings will be conducted in accordance with IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings." ( )

05. Emergency Situation. The Department will provide for the dispensing of at least a seventy-two (72) hour supply of a covered outpatient prescription drug in an emergency situation as required in 42 U.S.C. 1396r-8(d)(5)(B). ( )

06. Response to Request. The Department will respond within twenty-four (24) hours to a request for prior authorization of a covered outpatient prescription drug as required in 42 U.S.C. 1396r-8(d)(5)(A). ( )

07. Prohibition Against Cash Payment for Controlled Substances. Pharmacy providers are prohibited from accepting cash as payment for controlled substances from persons known to be Medicaid participants. ( )

08. Supplemental Rebates. ( )

a. Purpose. The purpose of supplemental rebates is to enable the Department to purchase prescription

drugs provided to Medicaid participants in a cost-effective manner. The supplemental rebate may be one (1) factor considered in determining a drug's preferred drug status, but it is secondary to considerations of the safety, effectiveness, and clinical outcomes of the drug in comparison with other therapeutically interchangeable alternative drugs. ( )

b. Rebate Amount. The Department may negotiate with manufacturers supplemental rebates for prescription drugs that are in addition to those required by Title XIX of the Social Security Act. There is no upper limit on the dollar amounts of the supplemental rebates the Department may negotiate. ( )

09. Comparative Costs to be Considered. Whenever possible, physicians and pharmacists are encouraged to utilize less expensive drugs and drug therapies. ( )

664. PRESCRIPTION DRUGS: PROVIDER QUALIFICATIONS AND DUTIES.

01. Payment for Covered Drugs. Payment will be made, as provided in Section 665 of these rules, only to pharmacies 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. ( )

02. Dispensing Procedures. The following protocol must be followed for proper prescription filling. ( )

a. Prescription Drug Refills. Refills of prescription drugs must be authorized by the prescriber on the original or new prescription order on file and each refill must be recorded on the prescription or logbook, or computer print-out, or on the participant's medication profile. ( )

b. Automatic Refills. ( )

i. Automatic refills are not allowed for Idaho Medicaid participants. A request specific to each medication is required. ( )

ii. All prescription refills must be initiated by a request from the participant, the prescriber, or another person, such as a family member, acting as an agent of the participant. ( )

iii. Authorization for each prescription refill must be received prior to the beginning of the filling process by the pharmacy. ( )

c. Dispensing Prescription Drugs. Prescriptions must be dispensed according to: ( )

i. 21 CFR Section 1300, et seq.; ( )

ii. Title 54, Chapter 17, and Title 37, Chapters 1, 27, and 32, Idaho Code; ( )

iii. IDAPA 27.01.03, "Rules Governing Pharmacy Practice"; and ( )

iv. Sections 660 through 666 of these rules. ( )

d. Prescriptions on File. Prescriptions must be maintained on file in pharmacies in such a manner that they are available for immediate review by the Department upon written request. ( )

03. Return of Unused Prescription Drugs. When prescription drugs were dispensed in unit dose packaging, as defined by IDAPA 27.01.03, "Rules Governing Pharmacy Practice," and the participant for whom the drugs were prescribed no longer uses them: ( )

a. A licensed skilled nursing care facility may return unused drugs dispensed in unit dose packaging to the pharmacy provider that dispensed the medication. ( )

b. A residential or assisted living facility may return unused drugs dispensed in unit dose packaging to the pharmacy provider that dispensed the medication. ( )

04. Pharmacy Provider Receiving Unused Prescription Drugs. In order for a pharmacy provider to receive unused prescription drugs that it dispensed in unit dose packaging and that are being returned by a facility identified in Subsection 664.03 of this rule, the pharmacy provider: ( )

a. Must comply with IDAPA 27.01.03, "Rules Governing Pharmacy Practice," regarding unit dose packaging; ( )

b. Must credit the Department the amount billed for the cost of the drug less the professional dispensing fee; and ( )

c. May receive a fee for acceptance of returned unused prescription drugs. The value of the unused prescription drug being returned must be such that return of the drug is cost-effective as determined by the Department. ( )

665. PRESCRIPTION DRUGS: PROVIDER REIMBURSEMENT.
With specific exceptions as set forth in Subsections 665.01 through 665.04 of this rule, Idaho Medicaid pharmacy providers are reimbursed based on actual acquisition costs. Idaho Medicaid may require providers to supply documentation of their acquisition costs as described in the Medicaid Pharmacy Claims Submission Manual available at: https://idaho.fhsc.com/downloads/providers/IDRx_Pharmacy_Claims_Submission_Manual.pdf. Reimbursement is restricted to those drugs supplied from labelers that are participating in the CMS Medicaid Drug Rebate Program. ( )

01. Pharmacy Reimbursement. Prescriptions not filled in accordance with the provisions of Subsection 664.02 of these rules will be subject to nonpayment or recoupment. The following protocol must be followed for proper reimbursement. ( )

a. Filing Claims. Pharmacies must 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 must include information described in the pharmacy guidelines issued by the Department. ( )

b. 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. ( )

c. Reimbursement. Reimbursement to pharmacies is limited to the lowest of the following: ( )

i. Actual Acquisition Cost (AAC) based on results of the periodic state cost survey as defined in this rule, plus the assigned professional dispensing fee. In cases where no AAC is available, reimbursement will be the Wholesale Acquisition Cost (WAC). WAC will mean the price, for a given calendar quarter, paid by a wholesaler for the drugs purchased from the wholesaler's supplier. The wholesaler's supplier is typically the manufacturer of the drug as published by a recognized compendium of drug pricing for the same calendar quarter; ( )

ii. State Maximum Allowable Cost (SMAC), as established by the Department, plus the assigned professional dispensing fee; ( )

iii. Federal Upper Limit (FUL), as established by the Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services, plus the professional dispensing fee assigned by the Department; or ( )

iv. The provider's usual and customary charge to the general public. ( )

d. Periodic State Cost Surveys. The Department will utilize periodic state cost surveys to obtain the most accurate pharmacy drug acquisition costs in establishing a pharmacy reimbursement fee schedule. Pharmacies

participating in the Idaho Medicaid Pharmacy Program are required to participate in these periodic state cost surveys by disclosing the costs of all drugs. A pharmacy that is non-responsive to the periodic state cost surveys can be disenrolled as a Medicaid provider by the Department. ( )

e. Physician Administered Drugs. ( )

i. Reimbursement to providers that are not 340B covered entities for medications administered to Medicaid participants by physicians or other qualified and licensed providers will be ninety percent (90%) of the published Medicare Average Sales Price plus six percent (6%) rate (ASP+6% rate). If the ASP+6% rate is not available, payment will be at the Wholesale Acquisition Cost (WAC). ( )

ii. Reimbursement to 340B covered entities for medications administered to Medicaid participants by physicians or other qualified and licensed providers will be the actual 340B drug acquisition cost, not to exceed the 340B ceiling price. ( )

f. Clotting Factors. ( )

i. Reimbursement to specialty pharmacies will be at a state-based price equivalent to the published Medicare ASP+6% rate, plus the assigned professional dispensing fee. ( )

ii. Reimbursement to Hemophilia Treatment Centers will be the 340B actual acquisition cost, not to exceed the 340B ceiling price. ( )

g. Professional Dispensing Fee. Professional Dispensing Fee is defined as a tier-based amount paid on a pharmacy claim, over and above the ingredient cost, to compensate the provider for the pharmacist's professional services related to dispensing a prescription to a Medicaid participant, including: ( )

i. Looking up information about a participant’s coverage on the computer; ( )

ii. Performing drug use reviews and preferred drug list review activities; ( )

iii. Measuring or mixing the covered outpatient drug; ( )

iv. Filling the container; ( )

v. Participant counseling; ( )

vi. Physically providing the completed prescription to the Medicaid participant; ( )

vii. Special packaging; and ( )

viii. Overhead associated with maintaining the facility and equipment necessary to operate the dispensing entity. ( )

h. Limitations on Payment of Professional Dispensing Fee. Only one (1) professional dispensing fee per month will be allowed for the dispensing of each maintenance drug to any participant as an outpatient or a resident in a care facility except: ( )

i. 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; ( )

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

iii. 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 ( )

iv. When the dose is being titrated for maximum therapeutic response with a minimum of adverse effects. ( )

i. Tier-Based Professional Dispensing Fees. A professional dispensing fee for each pharmacy provider will be established in accordance with this rule. ( )

j. Claims Volume Survey for Tier-Based Professional Dispensing Fees. The Department will survey pharmacy providers to establish a professional dispensing fee for each provider. The professional dispensing fees will be paid based on the provider's total annual claims volume. The provider must return the claims volume survey to the Department no later than May 31st each year. Pharmacy providers who do not complete the annual claims volume survey will be assigned the lowest professional dispensing fee starting on July 1st until the next annual survey is completed. Based upon the annual claims volume of the enrolled pharmacy, the professional dispensing fee is provided online at: https://healthandwelfare.idaho.gov/providers/pharmacy-providers/idaho-medicaid-pharmacy-program. ( )

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

02. 340B Covered Entity Reimbursement. ( )

a. Participation as a 340B Covered Entity. Medicaid will reimburse 340B covered entities as defined in Section 340B of the Public Health Service Act, codified under 42 U.S.C. 256b(a)(4), when the provider meets the following requirements: ( )

i. A 340B covered entity may receive reimbursement for drugs provided to Idaho Medicaid participants through the 340B drug pricing program if the 340B covered entity submits its unique 340B identification number issued by the Health Resources and Services Administration (HRSA) and a copy of its completed HRSA 340B registration to Idaho Medicaid. ( )

ii. A 340B covered entity that elects to provide drugs to Idaho Medicaid participants through the 340B drug pricing program must use 340B covered outpatient drugs for all dispensed or administered drugs, including those dispensed through the 340B covered entity's retail pharmacy or administered in an outpatient clinic. A 340B covered entity must ensure that a contract pharmacy does not dispense drugs, or receive Medicaid reimbursement for drugs, acquired by the 340B covered entity through the 340B drug pricing program. An entity that does not use 340B covered outpatient drugs for all dispensed or administered drugs, including those dispensed through the 340B covered entity's retail pharmacy or administered in an outpatient clinic, will be deemed to be carved out of the 340B drug pricing program and will be reimbursed for brand name and generic drugs as provided in Subsection 665.01 of this rule. ( )

iii. A 340B covered entity must provide Idaho Medicaid with thirty (30) days advance written notice of its intent to discontinue the provision of drugs acquired through the 340B drug pricing program to Idaho Medicaid participants. ( )

b. Filing Claims. A 340B covered entity must file claims electronically with Department-approved software or by submitting the appropriate claim form to the fiscal contractor. The form must include information described in the pharmacy guidelines issued by the Department. ( )

c. Reimbursement Exclusions. Drugs acquired through the federal 340B drug pricing program and dispensed by 340B contract pharmacies are not covered. ( )

d. Reimbursement. Reimbursement to 340B covered entities is limited to their actual 340B drug acquisition cost submitted, not to exceed the 340B ceiling price, plus the assigned professional dispensing fee. ( )

e. Professional Dispensing Fee. Only one (1) professional dispensing fee per month will be allowed

for the dispensing of each maintenance drug to any participant as an outpatient or a resident in a care facility except: ( )

i. 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; ( )

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

iii. 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 ( )

iv. When the dose is being titrated for maximum therapeutic response with a minimum of adverse effects. ( )

f. Tier-Based Professional Dispensing Fees. A professional dispensing fee for each 340B covered entity will be established in accordance with this rule. ( )

g. Remittance Advice. Claims are processed by computer, and payments are made directly to the 340B covered entity or its designated bank through electronic funds transfer. A remittance advice with detailed information of each claim transaction will accompany each payment made by the Department. ( )

03. Reimbursement for Drugs Dispensed by Other Provider Types. ( )

a. Drugs acquired through non-340B Indian Health Service, Tribal, or Urban Indian pharmacies will be reimbursed at the actual acquisition cost to the entity, plus the assigned professional dispensing fee. ( )

b. Drugs acquired via the Federal Supply Schedule (FSS) will be reimbursed at the FSS actual acquisition cost, plus the assigned professional dispensing fee. ( )

c. Drugs acquired at nominal price, which is defined as pricing that is outside of 340B regulations or FSS, will be reimbursed at the actual acquisition cost, plus the assigned professional dispensing fee. ( )

d. Specialty drugs not dispensed by retail community pharmacies and dispensed primarily through the mail will be reimbursed at the Idaho actual acquisition cost, if such cost is available, plus the professional dispensing fee. If the actual acquisition cost is not available, drugs will be reimbursed at the lower of the Wholesale Acquisition Cost (WAC) or State Maximum Allowable Cost (SMAC) as established by the Department, plus the assigned professional dispensing fee. ( )

e. Drugs not distributed by a retail community pharmacy, such as drugs dispensed in a long-term care facility or dispensed to participants receiving swing-bed services, as described in Subsection 405.05 of these rules, will be reimbursed at the actual ingredient cost, plus the assigned professional dispensing fee. ( )

04. Limitations on Payment. Medicaid payment for prescription drugs will be limited as follows: ( )

a. Medication for Multiple Persons. When the medication dispensed is for more than one (1) person, Medicaid will only pay for the amount prescribed for the person or persons covered by Medicaid. ( )

b. No Prior Authorization. Medicaid will not pay for a covered drug or pharmacy item that requires, but has not received, prior authorization for Medicaid payment as required in Section 663 of these rules. ( )

c. Limitations to Discourage Waste. Medicaid may conduct drug utilization reviews and impose limitations for participants whose drug utilization exceeds the standard participant profile or disease management guidelines determined by the Department. ( )

05. Return of Drugs. Drugs dispensed in unit dose packaging as defined by IDAPA 27.01.01, "General Provisions," must be returned to the dispensing pharmacy when the participant no longer uses the medication as follows: ( )

a. A pharmacy provider using unit dose packaging must comply with IDAPA 27.01.03, "Rules Governing Pharmacy Practice." ( )

b. The pharmacy provider that receives the returned drugs must credit the Department the amount billed for the cost of the drug less the professional dispensing fee. ( )

c. The pharmacy provider may receive a fee for acceptance of returned unused drugs. The value of the unused drug being returned must be cost effective as determined by the Department. ( )

06. Cost Appeal Process. Cost appeals will be determined by the Department's process provided online at: https://healthandwelfare.idaho.gov/providers/pharmacy-providers/idaho-medicaid-pharmacy-program. ( )

666. PRESCRIPTION DRUGS: QUALITY ASSURANCE.

01. Pharmacy And Therapeutics Committee (P&T Committee). ( )

a. Membership. The P&T Committee is appointed by the Director and is composed of practicing pharmacists, physicians and other licensed health care professionals with authority to prescribe medications. ( )

b. Function. The P&T Committee has the following responsibilities for the prior authorization of drugs under Section 663 of these rules: ( )

i. To serve in evaluational, educational and advisory capacities to the Idaho Medicaid Pharmacy Program specific to the prior authorization of drugs. ( )

ii. To review evidence-based clinical and pharmacy economic data and recommend to the Department preferred and non-preferred drugs in classes designated for the Idaho Medicaid Preferred Drug List. ( )

iii. To recommend to the Department the classes of medications to be reviewed through evidence-based evaluation. ( )

iv. To review drug utilization outcome studies and intervention reports from the Drug Utilization Review Board as part of the process of reviewing and developing recommendations to the Department. ( )

c. Meetings. The P&T Committee meetings will be open to the public and a portion of each meeting will be set aside to hear and review public comment. The P&T Committee may adjourn to executive session to consider the following: ( )

i. Relative cost information for prescription drugs that could be used by representatives of pharmaceutical manufacturers or other people to derive the proprietary information of other pharmaceutical manufacturers; or ( )

ii. Participant-specific or provider-specific information. ( )

667. -- 679. (RESERVED)

SUB AREA: FAMILY PLANNING
(Sections 680-699)

680. (RESERVED)

681. FAMILY PLANNING SERVICES: PARTICIPANT ELIGIBILITY.

01. Sterilization Procedures -- General Restrictions. The following restrictions govern payment for sterilization procedures for eligible persons. ( )

a. No sterilization procedures will be paid on behalf of a participant who is not at least twenty-one (21) years of age at the time they sign the informed consent. ( )

b. No sterilization procedures will be paid on behalf of any participant who is twenty-one (21) years of age or over and who is incapable of giving informed consent. ( )

c. Each participant must voluntarily sign the properly completed "Consent Form" HW 0034, or its equivalent, in the presence of the person obtaining consent in accordance with Section 683 of these rules. ( )

d. Each participant must sign the "Consent Form" at least thirty (30) days but not more than one hundred eighty (180) days, prior to the sterilization procedures. Exceptions to these time requirements are described under Subsection 682.03 of these rules. ( )

02. Circumstances Under Which Payment Can be Made for a Hysterectomy. Payment can be made for a hysterectomy only if: ( )

a. It is medically necessary. A document must be attached to the claim to substantiate this requirement; and ( )

b. There was more than one (1) purpose in performing the hysterectomy, and the hysterectomy would not have been performed for the sole purpose of rendering an individual permanently incapable of reproducing; and ( )

c. The participant was advised orally and in writing that sterility would result and that she would no longer be able to bear children; and ( )

d. The participant signs and dates an "Authorization for Hysterectomy" form. The form must state "I have been informed orally and in writing that a hysterectomy will render me permanently incapable of reproducing. I was informed of these consequences prior to the surgery being performed." ( )

682. FAMILY PLANNING SERVICES: COVERAGE AND LIMITATIONS.

Family planning includes counseling and medical services prescribed or performed by an independent licensed physician, or a qualified certified nurse practitioner or physician's assistant. Specific items covered are diagnosis, treatment, contraceptive supplies, related counseling, and restricted sterilization. ( )

01. Contraceptive Supplies. ( )

a. Contraceptive supplies include condoms, foams, creams and jellies, prescription diaphragms, intrauterine devices, or oral contraceptives. ( )

b. Contraceptives requiring a prescription are payable subject to Section 662 of these rules. ( )

c. Payment for oral contraceptives is limited to purchase of a three (3) month supply. ( )

02. Sterilization. ( )

a. No sterilizations for individuals institutionalized in correctional facilities, mental hospitals, or other rehabilitative facilities are eligible for payment unless such sterilizations are ordered by a court of law. ( )

b. Hysterectomies performed solely for sterilization purposes are not eligible for payment (see Subsection 681.02 of these rules for those conditions under which a hysterectomy can be eligible for payment). ( )

c. All requirements of state or local law for obtaining consent, except for spousal consent, must be followed. ( )

d. Suitable arrangements must be made to insure that information as specified in Subsection 681.01 of these rules is effectively communicated to any individual to be sterilized who is blind, deaf, or otherwise disabled. ( )

03. Exceptions to Sterilization Time Requirements. If premature delivery occurs or emergency abdominal surgery is required, the physician must certify that the sterilization was performed because of the premature delivery or emergency abdominal surgery less than thirty (30) days, but no less than seventy-two (72) hours after the date of the participant's signature on the consent form; and ( )

a. In the case of premature delivery, the physician must also state the expected date of delivery and describe the emergency in detail; and ( )

b. Describe, in writing to the Department, the nature of any emergency necessitating emergency abdominal surgery; and ( )

c. Under no circumstance can the period between consent and sterilization exceed one hundred eighty (180) days. ( )

04. Requirements for Sterilization Performed Due to a Court Order. When a sterilization is performed after a court order is issued, the physician performing the sterilization must have been provided with a copy of the court order prior to the performance of the sterilization. In addition they must: ( )

a. Certify, by signing a properly completed "Consent Form" HW 0034, or its equivalent, and submitting the consent form with their claim, that all requirements have been met concerning sterilizations; and ( )

b. Submit to the Department a copy of the court order together with the "Consent Form" and claim. ( )

683. FAMILY PLANNING SERVICES: PROCEDURAL REQUIREMENTS.

01. Sterilization Consent Form Requirements. Informed consent exists when a properly completed "Consent Form" HW 0034, or its equivalent, is submitted to the Department together with the physician's claim for the sterilization. ( )

a. The consent form must be signed and dated by: ( )

i. The participant to be sterilized; and ( )

ii. The interpreter, if one (1) is provided; and ( )

iii. The individual who obtains the consent; and ( )

iv. The physician who will perform the sterilization procedure. ( )

v. If the individual obtaining the consent and the physician who will perform the sterilization procedure are the same person, that person must sign both statements on the consent form. ( )

b. Informed consent must not be obtained while the participant in question is: ( )

i. In labor or childbirth; or ( )

ii. Seeking to obtain or obtaining an abortion; or ( )

iii. Under the influence of alcohol or other substances that affect the individual's state of awareness. ( )

c. An interpreter must be provided if the participant does not understand the language used on the consent form or the language used by the person obtaining the consent. ( )

d. The person obtaining consent must: ( )

i. Offer to answer any questions the participant may have concerning the procedure; and ( )

ii. Orally advise the participant that they are free to withhold or withdraw consent to the procedure at any time before the sterilization without affecting their right to future care or treatment, and without loss or withdrawal of any federally funded program benefits to which the individual might otherwise be entitled; and ( )

iii. Provide a description of available alternative methods of family planning and birth control; and ( )

iv. Orally advise the participant that the sterilization procedure is considered to be irreversible; and ( )

v. Provide a thorough explanation of the specific sterilization procedure to be performed; and ( )

vi. Provide a full description of the discomfort and risks that may accompany and follow the performing of the procedure, including an explanation of the type and possible effects of any anesthetic to be used; and ( )

vii. Provide a full description of the benefits or advantages that can be expected as a result of the sterilization; and ( )

viii. Advise that the sterilization procedure will not be performed for at least thirty (30) days except under extreme circumstances as specified in Subsection 682.03 of these rules. ( )

e. The person securing the consent from the participant must certify by signing the “Consent Form” that: ( )

i. Before the participant signed the consent form, they were advised that no federal benefits would be withheld because of the decision to be or not to be sterilized; and ( )

ii. The requirements for informed consent as set forth on the consent form were orally explained; and ( )

iii. To the best of their knowledge and belief, the participant appeared mentally competent and knowingly and voluntarily consented to the sterilization. ( )

f. The physician performing the sterilization must certify by signing the “Consent Form” that: ( )

i. At least thirty (30) days have passed between the participant's signature on that form and the date the sterilization was performed; and ( )

ii. To the best of the physician's knowledge the participant is at least twenty-one (21) years of age; and ( )

iii. Before the performance of the sterilization the physician advised the participant that no federal

benefits will be withdrawn because of the decision to be or not to be sterilized; and ( )

iv. The physician explained orally the requirement for informed consent as set forth in the "Consent Form"; and ( )

v. To the best of their knowledge and belief the participant to be sterilized appeared mentally competent and knowingly and voluntarily consented to the sterilization. ( )

g. If an interpreter is provided, they must certify by signing the "Consent Form" that: ( )

i. They accurately translated the information and advice presented orally to the participant; and ( )

ii. They read the "Consent Form" and accurately explained its contents; and ( )

iii. To the best of their knowledge and belief, the participant understood the interpreter. ( )

h. The person obtaining consent must sign the "Consent Form" and certify that they have fulfilled specific requirements in obtaining the participant's consent. ( )

i. The physician who performs the sterilization must sign the "Consent Form" HW 0034, certifying that the requirements of this rule have been fulfilled. ( )

684. (RESERVED)

685. FAMILY PLANNING SERVICES: PROVIDER REIMBURSEMENT.
Payment to providers of family planning services for contraceptive supplies is limited to estimated acquisition cost. ( )

686. -- 699. (RESERVED)

SUB AREA: BEHAVIORAL HEALTH SERVICES
(Sections 700-719)

700. INPATIENT BEHAVIORAL HEALTH SERVICES: DEFINITIONS.

01. Freestanding Psychiatric Hospital. A hospital, nursing facility, or other institution of sixteen (16) beds or less that is primarily engaged in the diagnosis and treatment of mental diseases. The hospital is not considered freestanding if it shares a building or campus with another hospital, or is owned by another hospital. ( )

02. Hospital Psychiatric Unit. The psychiatric unit of a general hospital that furnishes inpatient care and treatment services for mental illness under a psychiatrist or other physician qualified to treat mental diseases. ( )

03. Institutions for Mental Disease (IMD). A hospital, nursing facility or other institution of seventeen (17) beds or more that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. A specific licensure is not necessary to meet this definition. This definition does not apply to ICF/IIDs. ( )

04. Substance Use Disorder. A substance use disorder is evidenced by a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using a substance despite significant substance-related problems. A diagnosis of a substance use disorder is based on a pathological pattern of behaviors related to use of the substance and the current DSM. ( )

701. INPATIENT BEHAVIORAL HEALTH SERVICES: PARTICIPANT ELIGIBILITY.

01. Inpatient Psychiatric Hospital Services. Participants are eligible who have a diagnosis from the

current DSM with substantial impairment in thought, mood, perception, or behavior. A court-ordered admission or physician's emergency certificate alone does not justify Medicaid reimbursement for these services. Medical necessity must be demonstrated for admission or extended stay by meeting the severity of illness and intensity of service criteria as found in Subsections 701.03 and 701.04 of this rule. Services may be provided in: ( )

a. A freestanding psychiatric hospital; ( )

b. A hospital psychiatric unit; and ( )

c. Subject to federal approval, an institution for mental diseases. ( )

02. Inpatient Substance Use Disorder Services. Participants are eligible when medical necessity is demonstrated by meeting the severity of illness and intensity of service criteria as found in Subsections 701.03 and 701.04 of this rule. A court-ordered admission or physician's emergency certificate alone does not justify Medicaid reimbursement for these services. ( )

03. Severity of Illness Criteria. Both severity of illness and intensity of services criteria must be met for admission to an IMD or psychiatric unit of a general hospital. ( )

a. Severity of illness criteria. The participant must meet one (1) of the following criteria related to the severity of their psychiatric illness: ( )

i. Is currently dangerous to self as indicated by at least one (1) of the following: ( )

(1) Has actually made an attempt to take their own life in the last seventy-two (72) hours (details of the attempt must be documented); or ( )

(2) Has demonstrated self-mutilative behavior within the past seventy-two (72) hours (details of the behavior must be documented); or ( )

(3) Has a clear plan to seriously harm himself, overt suicidal intent, and lethal means available to follow the plan (this information can be from the participant or a reliable source and details of the participant's plan must be documented); or ( )

(4) The participant has a current plan, specific intent, or recurrent thoughts to seriously harm himself or others, and is at significant risk of making an attempt without immediate intervention; or ( )

ii. Participant is actively violent or aggressive and exhibits homicidal ideation or other symptoms that indicate they are a probable danger to others as indicated by one (1) of the following: ( )

(1) The participant has engaged in, or threatened, behavior harmful or potentially harmful to others or caused serious damage to property that would pose a serious threat of injury or harm to others within the last twenty-four (24) hours (description of the behavior and extent of injury or damage must be documented, as well as the time the behavior occurred relative to the present); or ( )

(2) The participant has made threats to kill or seriously injure others or to cause serious damage to property that would pose a threat of injury or harm to others and has effective means to carry out the threats (details of threats must be documented); or ( )

(3) A mental health professional has information from the participant or a reliable source that the participant has a current plan, specific intent, or recurrent thoughts to seriously harm others or property and is at significant risk of making the attempt without immediate intervention (details must be documented); or ( )

iii. Participant is gravely impaired as indicated by at least one (1) of the following criteria: ( )

(1) The participant has such limited functioning that their physical safety and well being are in jeopardy due to their inability for basic self-care, judgment, and decision making (details of the functional limitations

must be documented); or ( )

(2) The acute onset of psychosis or severe thought disorganization or clinical deterioration has rendered the participant unmanageable and unable to cooperate in non-hospital treatment (details of the participant's behaviors must be documented); or ( )

(3) There is a need for treatment, evaluation, or complex diagnostic testing where the participant's level of functioning or communication precludes assessment or treatment, or both, in a non-hospital based setting, and may require close supervision of medication or behavior or both. ( )

(4) The participant is undergoing severe or medically complicated withdrawal from alcohol, opioids, stimulants, or sedatives. ( )

04. Intensity of Service Criteria. The participant must meet all of the following criteria related to the intensity of services needed for treatment. ( )

a. Documentation that ambulatory care resources available in the community do not meet the treatment needs of the participant; and ( )

b. The services provided can reasonably be expected to improve the participant's condition or prevent further regression so that inpatient services will no longer be needed; and ( )

c. Treatment of the participant's condition requires services on an inpatient basis, including twenty-four (24) hour nursing observation. ( )

d. Exceptions. The requirement to meet intensity of service criteria may be waived for first-time admissions if severity of illness is met and the physician is unable to make a diagnosis or treatment decision while the participant is in their current living situation. The waiver of the intensity of services requirement can be for no longer than forty-eight (48) hours and is not waivable for repeat hospitalizations. ( )

05. Exclusions. If a participant meets one (1) or more of the following criteria, Medicaid reimbursement will be denied: ( )

a. The participant is unable to actively participate in an outpatient treatment program solely because of a major medical condition, surgical illness or injury; or ( )

b. The participant has a primary diagnosis of being intellectually disabled and the primary treatment need is related to the intellectual disability. ( )

702. INPATIENT BEHAVIORAL HEALTH SERVICES: COVERAGE AND LIMITATIONS.

01. Initial Length of Stay. An initial length of stay, or a prior authorization requirement, will be established by the Department, or its designee, in the Idaho Medicaid Provider Handbook. Requirements for establishing length of stay will never be more restrictive than requirements for non-behavioral health services in a general hospital. ( )

02. Extended Stay. The Department, or its designee, will establish authorization requirements in the Idaho Medicaid Provider Handbook. An authorization is necessary when the appropriate care of the participant indicates the need for inpatient days in excess of the initial length of stay or previously approved extended stay. ( )

703. INPATIENT BEHAVIORAL HEALTH SERVICES: PROCEDURAL REQUIREMENTS.

01. Prior Authorization. Some services may require a prior authorization from the Department, or its designee. The Department will set documentation requirements in the Idaho Medicaid Provider Handbook to ensure quality of care and integrity of services. Requests for prior authorization must include: ( )

a. Diagnosis; and ( )

b. Summary of present medical findings including symptoms, complaints and complications indicating the need for admission; and ( )

c. Medical history; and ( )

d. Mental and physical functional capacity; and ( )

e. Prognosis. ( )

02. Individual Plan of Care – Content. The individual plan of care is a written plan developed for the participant upon admission. The objective of the plan is to improve their condition to the extent that acute psychiatric care is no longer necessary. It must be developed by an interdisciplinary team as defined in Subsection 703.03 of this rule. The plan of care must be implemented within seventy-two (72) hours of admission, and reviewed at least every three (3) days. The individual plan of care must contain: ( )

a. A diagnostic evaluation that includes examination of the medical, behavioral, and developmental aspects of the participant's situation and reflects the medical necessity for in-patient care; and ( )

b. Treatment objectives related to conditions that necessitated the admission; and ( )

c. An integrated program of therapies, treatments (including medications), activities (including special procedures to assure the health and safety of the participant), and experiences designed to meet the objectives; and ( )

d. A discharge plan designed to achieve the participant’s discharge at the earliest possible time that includes plans for coordination of community services to ensure continuity of care with the participant’s family, school, and community upon discharge. ( )

03. Individual Plan of Care – Interdisciplinary Team. The individual plan of care must be developed by an interdisciplinary team capable of assessing the participant's immediate and long range therapeutic needs, developmental priorities and personal strengths and liabilities, assessing the potential resources of the participant's family, setting the treatment objectives, and prescribing therapeutic modalities to achieve the plan's objectives. The team must include at a minimum: ( )

a. One (1) of the following: ( )

i. A board-certified psychiatrist; or ( )

ii. A licensed psychologist and a physician licensed to practice medicine or osteopathy; or ( )

iii. A physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental disease and a licensed clinical professional counselor; and ( )

b. One (1) of the following: ( )

i. A licensed, clinical or master’s social worker; or ( )

ii. A registered nurse with specialized training or one (1) year’s experience in treating individuals with behavioral health needs; or ( )

iii. A licensed occupational therapist who has had specialized training or one (1) year of experience in treating individuals with behavioral health needs, ( )

c. The participant and their parents, legal guardians, or others into whose care they will be released after discharge. ( )

704. INPATIENT BEHAVIORAL HEALTH SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.

01. Provider Qualifications. Inpatient hospital psychiatric services must be provided under the direction of a physician in a facility accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and licensed by the state of Idaho or the state in which they provide services. To provide services beyond emergency medical screening and stabilization treatment, the hospital must have a separate psychiatric unit with staff qualified to provide psychiatric services. General hospitals licensed to provide services in their state, but are not JCAHO certified, may not bill for psychiatric services beyond emergency screening and stabilization. ( )

02. Record Keeping. A written report of each evaluation and the plan of care must be entered into the participant's record at the time of admission or if the participant is already in the facility, immediately upon completion of the evaluation or plan. ( )

03. Utilization Review (UR). The facility must have in effect a written utilization review plan that provides for review of each participant's need for the services that the hospital furnishes them. The UR plan must meet the requirements under 42 CFR 456.201 through 456.245. ( )

705. INPATIENT BEHAVIORAL HEALTH SERVICES: PROVIDER REIMBURSEMENT.
Failure to request a prior authorization, concurrent review, or continued stay review in a timely manner will result in a retrospective review being conducted by the Department. If the retrospective review determines the stay is medically necessary, the Department will assess a penalty to the hospital as specified in Subsection 705.02 of this rule. The admitting physician will be assessed a penalty for failure to request a prior authorization, concurrent review, or continued stay review in a timely manner as specified in Subsection 705.03 of this rule. A physician who provides hospital care but has no control over the admission, continued stay, or discharge of the participant is not subject to this penalty. ( )

01. Payment. Reimbursement for the participant's admission and length of stay is subject to prior authorization, concurrent review, continued stay review, or retrospective review by the Department. The hospital and the participant's physician are responsible for obtaining the required review. If such review identifies that an admission or continued stay is not medically necessary, then no Medicaid payment will be made. ( )

a. In reimbursing for inpatient hospital psychiatric services the Department will pay the lesser of customary charges or the established Medicaid semi-private rates for inpatient hospital care in accordance with the rules set forth in IDAPA 16.03.10, “Medicaid Enhanced Plan Benefits.” ( )

b. The cost of services that would be the responsibility of the Department of Education for school age children cannot be considered in the cost of inpatient psychiatric hospital services. ( )

02. Hospital Penalty Schedule. Failure to request a prior authorization, concurrent review, or continued stay review from the Department in a timely manner will result in the hospital being assessed a penalty as follows. The penalty will be assessed after payment for hospital services for a medically necessary hospital admission. ( )

a. A request for a preadmission or continued stay review that is one (1) day late will result in a penalty of two hundred sixty dollars ($260). ( )

b. A request for a preadmission or continued stay review that is two (2) days late will result in a penalty of five hundred twenty dollars ($520). ( )

c. A request for a preadmission or continued stay review that is three (3) days late will result in a penalty of seven hundred eighty dollars ($780). ( )

d. A request for a preadmission or continued stay review that is four days (4) late will result in a penalty of one thousand forty dollars ($1,040). ( )

e. A request for a preadmission or continued stay review that is five (5) or more days late will result in a penalty of one thousand three hundred dollars ($1,300). ( )

03. Physician Penalty Schedule. Failure to request a preadmission review from the Department in a timely manner will result in the admitting physician being assessed a penalty as follows. The penalty will not be assessed against a physician who provides hospital care but has no control over the admission, continued stay, or discharge of the participant. The penalty will be assessed after payment for physician services for a medically necessary hospital admission: ( )

a. A request for a preadmission review that is one (1) day late will result in a penalty of fifty dollars ($50). ( )

b. A request for a preadmission review that is two (2) days late will result in a penalty of one hundred dollars ($100). ( )

c. A request for a preadmission review that is three (3) days late will result in a penalty of one hundred fifty dollars ($150). ( )

d. A request for a preadmission review that is four (4) days late will result in a penalty of two hundred dollars ($200). ( )

e. A request for a preadmission review that is five (5) or more days late will result in a penalty of two hundred fifty dollars ($250). ( )

706. INPATIENT BEHAVIORAL HEALTH SERVICES: QUALITY ASSURANCE.
The policy, rules, and regulations to be followed must be those cited in 42 CFR 456.480 through 42 CFR 456.482. ( )

707. (RESERVED)

708. OUTPATIENT BEHAVIORAL HEALTH SERVICES: PARTICIPANT ELIGIBILITY.
All participants who are eligible for Medicaid Basic or Enhanced Benchmark State Plan services, except for participants enrolled in the Idaho Medicare-Medicaid Coordinated Plan (MMCP), are automatically enrolled in the Idaho Behavioral Health Plan and may access behavioral health services that are determined to be medically necessary. ( )

709. OUTPATIENT BEHAVIORAL HEALTH SERVICES: COVERAGE AND LIMITATIONS.

01. Community-Based Outpatient Behavioral Health Services. The Community-Based Outpatient Behavioral Health Services included in the Idaho Behavioral Health Plan (IBHP) are medically necessary rehabilitation services that evaluate the need for and provide therapeutic and rehabilitative treatment to minimize symptoms of mental illness and substance use disorders and restore independent functioning. These services include: ( )

a. Assessments and Planning; ( )

b. Psychological and Neurological Testing; ( )

c. Psychotherapy (Individual, Group, and Family); ( )

d. Pharmacologic Management; ( )

e. Partial Care Treatment; ( )

f. Behavioral Health Nursing; ( )

g. Drug Screening; ( )

h. Community-Based Rehabilitation; ( )

i. Substance Use Disorder Treatment Services; and ( )

j. Case Management. ( )

02. Prior Authorization. Some behavioral health services may require prior authorization from the IBHP contractor. ( )

710. OUTPATIENT BEHAVIORAL HEALTH SERVICES: PROVIDER QUALIFICATIONS.
The IBHP services are delivered by network providers who are enrolled with the contractor and meet reimbursement, quality, and utilization standards. All community-based outpatient behavioral health service providers are subject to the limitations of practice imposed by state law, federal regulations, and by the various state boards that regulate professional competency requirements, and in accordance with applicable Department rules. The contractor will enter into agreements with enrolled providers to provide the services under the IBHP. These agreements will include the reimbursement methodology agreed upon by the contractor and Department. ( )

711. OUTPATIENT BEHAVIORAL HEALTH SERVICES: PROCEDURAL REQUIREMENTS.
Providers must enroll in the IBHP with the contractor and meet both the credentialing and quality assurance guidelines of the contractor. ( )

01. Administer IBHP. The contractor is responsible for administering the IBHP, including: eligibility verification, management of behavioral health service provision, behavioral health claims processing, payments to providers, data reporting, utilization management, and customer service. ( )

02. Authorization. The contractor is responsible for authorization of covered behavioral health services that require authorization prior to claim payment. ( )

03. Complaints, Grievances, and Appeals. Complaints, grievances, and appeals are handled through a process between the contractor and Department that is in compliance with state and federal requirements. Participants must utilize the complaint, grievance, and appeal process required by the contractor prior to initiating an administrative appeal with the Department. ( )

712 -- 719. (RESERVED)

SUB AREA: HOME HEALTH SERVICES
(Sections 720-729)

720. HOME HEALTH SERVICES: DEFINITIONS.

01. Aggregator. System that collects provider EVV information from multiple software platforms and standardizes the information in MMIS for EVV data validation. ( )

02. Claims Adjudication. The process of determining Medicaid financial responsibility for claims submitted to MMIS. ( )

03. Electronic Visit Verification (EVV). EVV is a software or device(s) that electronically captures information verifying service delivery. ( )

04. Home Health Plan of Care. A written description of home health services to be provided to a participant as defined in IDAPA 16.03.07, “Home Health Agencies.” ( )

05. Home Health Services. Home health services and items include nursing services, home health aide services, physical therapy, occupational therapy, speech-language pathology services, audiology services, and medical supplies, equipment, and appliances provided under a home health plan of care. ( )

721. (RESERVED)

722. HOME HEALTH SERVICES: COVERAGE AND LIMITATIONS.

01. Settings. Home health services are covered in a participant's place of residence and any setting in which normal life activities take place. Services are not covered when provided in a: ( )

a. Hospital; ( )

b. Nursing facility; ( )

c. ICF/IID, unless such services are not otherwise required to be provided by the ICF/IID; or ( )

d. Any setting in which Medicaid covers inpatient services, including room and board. ( )

02. Limitations. Home health services are limited to one hundred (100) visits per calendar year per person. ( )

03. Requirements. Services and items must be medically necessary and when appropriate, meet the requirements for: ( )

a. Audiology services under Sections 740 through 749 of these rules; ( )

b. Medical supplies, items, and appliances under Sections 750 through 779 of these rules; ( )

c. Physical therapy, occupational therapy, and speech-language pathology services under Sections 730 through 739 of these rules; and ( )

d. Early Periodic, Screening, Diagnosis, and Treatment Services under Sections 880 through 889 of these rules. ( )

723. HOME HEALTH SERVICES: PROCEDURAL REQUIREMENTS.

01. Orders. ( )

a. Home health services must be ordered by a physician, or a licensed practitioner of the healing arts. Orders must include at a minimum, the provider's National Provider Identifier (NPI), the services or items to be provided, the frequency, and, where applicable, the expected duration of time for which the home health services will be needed. Orders for medical supplies, equipment, and appliances are detailed in Section 753 of these rules. ( )

b. Home health services required for extended periods must be reordered at least every sixty (60) days for services and annually for medical supplies, equipment, and appliances. ( )

02. Face-to-Face Encounter for Home Health Services, Medical Supplies, Equipment, and Appliances. ( )

a. To initiate home health services, medical supplies, equipment, and appliances, the participant's physician, or a licensed practitioner of the healing arts as authorized in this rule, must document a face-to-face encounter related to the primary reason the patient requires home health services. Documentation must indicate the practitioner who conducted the encounter, and the date of the encounter as described in the CMS/Medicare DME coverage manual. ( )

i. For home health services, the face-to-face encounter must have occurred no more than ninety (90)

days before, or thirty (30) days after, the start of the home health services. ( )

ii. For home health medical supplies, equipment, and appliances, the face-to-face encounter must have occurred no more than six (6) months before the start of services. ( )

b. The face-to-face encounter may occur via telehealth, as defined in Subsection 210.09 of these rules. ( )

c. The face-to-face encounter may be performed by participant's physician, including an attending acute or post-acute physician, or licensed practitioner of the healing arts. ( )

03. Home Health Plan of Care. ( )

a. All home health services must be provided under a home health plan of care that is established prior to beginning treatment and must be signed by the licensed, qualified professional who established the plan. ( )

b. All home health plans of care must be reviewed by the ordering provider at least every sixty (60) days for services, and annually for medical supplies, equipment, and appliances. ( )

724. ELECTRONIC VISIT VERIFICATION (EVV).
Effective July 1, 2021, Home Health Agencies (HHAs) are required to submit claims using a compliant EVV system as mandated by Section 12006 of the 21st Century Cures Act for all services provided except for the provision of medical supplies and equipment. Providers must: ( )

01. Maintain System. Maintain an EVV system chosen by their agency that is certified as compliant with the MMIS aggregator, as determined by the Department and/or the MMIS Contractor; ( )

02. Document Consent. Document and retain participant consent for use of electronic verification methods; ( )

03. Develop Policies and Procedures. Develop and maintain policies and procedures outlining agency implementation and use of EVV technology, including strategies for safeguarding of participant information and privacy; and ( )

04. Submit EVV Data. Submit EVV data that captures these six (6) system-validated data elements for services rendered: ( )

a. Date of service; ( )

b, Time the service begins and ends; ( )

c. Individual providing the service; ( )

d. Participant receiving the service; ( )

e. Billable service performed; and ( )

f. Location of service delivery. ( )

725. HOME HEALTH SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.
In order to participate as a Home Health Agency (HHA) provider for Medicaid-eligible persons, the provider must be licensed as required by the state, and be certified to participate in the Medicare Program. Loss of either state license or Medicare Program certification is cause for termination of Medicaid provider status. ( )

726. HOME HEALTH SERVICES: PROVIDER REIMBURSEMENT.

01. Home Health Services. Payment for home health services is limited to the services authorized in

Sections 720 through 722 of these rules and must not exceed the lesser of reasonable cost as determined by Medicare or the Medicaid percentile cap. ( )

a. The Medicaid percentile cap is revised annually, effective at the beginning of each state fiscal year. Revisions are made using the data from the most recent finalized Medicare cost reports on hand thirty (30) days prior to the effective date. ( )

b. Payment by the Department for home health will include mileage as part of the cost of the visit. ( )

c. Provider claims for services requiring EVV will include the corresponding EVV data elements listed in Subsection 724.04 of these rules. Provider EVV data will be submitted to the state's aggregator prior to billing claims. Claims corresponding to EVV data submissions are subject to a quality review in accordance with Subsection 210.10 of these rules. ( )

d. If a person is eligible for Medicare, all services ordered by the physician or licensed practitioner of the healing arts will be purchased by Medicare, except for the deductible and co-insurance amounts that the Department will pay. ( )

02. Medical Supplies, Equipment, and Appliances. Payment for medical supplies, equipment, and appliances is detailed in Section 755 of these rules. ( )

727. -- 729. (RESERVED)

SUB AREA: THERAPY SERVICES
(Sections 730-739)

730. THERAPY SERVICES: DEFINITIONS.
For the purposes of these rules, the following terms are used as defined below: ( )

01. Duplicate Services. Services are considered duplicate: ( )

a. When participants receive any combination of physical therapy, occupational therapy, or speech-language pathology services with treatments, evaluations, treatment plans, or goals that are not separate and unique to each service provided; or ( )

b. When more than one (1) type of therapy is provided at the same time. ( )

02. Feeding Therapy. Feeding Therapy means those therapy services necessary for the treatment of feeding disorders. Feeding disorders include problems gathering food and getting ready to suck, chew, or swallow it. ( )

03. Maintenance Program. A program established by a therapist that requires the skills of a therapist or therapy professional and consists of activities and mechanisms to assist a participant in maximizing or maintaining the progress they have made during therapy or to prevent or slow further deterioration due to a disease or illness. ( )

04. Occupational Therapy Services. Therapy services that: ( )

a. Are provided within the scope of practice of licensed occupational therapy professionals; ( )

b. Are necessary for the evaluation and treatment of impairments, functional disabilities, or changes in physical function and health status; and ( )

c. Improve the individual's ability to perform those tasks required for independent functioning. ( )

05. Physical Therapy Services. Therapy services that: ( )

a. Are provided within the scope of practice of licensed physical therapy professionals; ( )

b. Are necessary for the evaluation and treatment of physical impairment or injury by the use of therapeutic exercise and the application of modalities that are intended to restore optimal function or normal development; and ( )

c. Focus on the rehabilitation and prevention of neuromuscular, musculoskeletal, integumentary, and cardiopulmonary disabilities. ( )

06. Speech-Language Pathology Services. Therapy services that are: ( )

a. Provided within the scope of practice of licensed speech-language pathologists; and ( )

b. Necessary for the evaluation and treatment of speech and language disorders that result in communication disabilities; or ( )

c. Necessary for the evaluation and treatment of swallowing disorders (dysphagia), regardless of the presence of a communication disability. ( )

07. Therapeutic Procedures. Therapeutic procedures are the application of clinical skills, services, or both, that attempt to improve function. ( )

08. Therapist. An individual licensed by the appropriate state licensing board as an occupational therapist, physical therapist, or speech-language pathologist. ( )

09. Therapy Professional. An individual licensed by the appropriate state licensing board as an occupational therapist or occupational therapist assistant, physical therapist or physical therapist assistant, or speech-language pathologist. ( )

10. Therapy Services. Occupational therapy, physical therapy, and speech-language pathology services are all considered to be therapy services. These services are ordered by the participant's attending physician, nurse practitioner, or physician assistant as part of a plan of care. ( )

11. Treatment Modalities. A treatment modality is any physical agent applied to produce therapeutic changes to biological tissue, including the application of thermal, acoustic, light, mechanical or electrical energy. ( )

731. THERAPY SERVICES: PARTICIPANT ELIGIBILITY.

To be eligible for therapy services, a participant must be eligible for Medicaid benefits and must have: ( )

01. Order. A physician or licensed practitioner of the healing arts order for therapy services; and ( )

02. A Therapy Evaluation Showing Need. A therapy evaluation of the participant showing a need for therapy due to a functional limitation, a loss or delay of skill, or both; and ( )

03. A Therapy Evaluation Establishing Participant Benefit. A therapy evaluation establishing that the participant will benefit and demonstrate progress as a result of the therapy services. ( )

732. THERAPY SERVICES: COVERAGE AND LIMITATIONS.

Therapy services are covered under these rules when delivered by a therapy professional and provided by one (1) of the following providers: outpatient hospitals, outpatient rehabilitation facilities, comprehensive outpatient rehabilitative facilities, nursing facilities, school-based services, independent practitioners, and home health agencies. Therapy services provided by a home health agency under a home health plan of care must meet the requirements found in Sections 730 through 739 of these rules, and the requirements found in Sections 720 through 729 of these

rules. ( )

01. Service Description: **Occupational Therapy and Physical Therapy**. Modalities, therapeutic procedures, tests, and measurements as described in the Idaho Medicaid Provider Handbook are covered with the following limitations: ( )

a. Any evaluation or re-evaluation may only be performed by the therapist. Any changes in the participant's condition not consistent with planned progress or treatment goals necessitate a documented re-evaluation by the therapist before further treatment is carried out. ( )

b. Any CPT procedure code that falls under the heading of either, "Active Wound Care Management," or "Tests and Measurements," requires the therapist to have direct, one-to-one (1:1) patient contact. ( )

c. The therapist may be reimbursed for the technical component of muscle testing, joint range of motion, electromyography, or nerve velocity determinations as described in the CPT Manual when ordered by a physician, nurse practitioner, or physician assistant. ( )

d. Any assessment provided under the heading "Orthotic Management and Prosthetic Management" must be completed by the therapist. ( )

e. The services of occupational or physical therapy assistants used when providing covered therapy benefits are included as part of the covered service. These services are billed by the supervising therapist. Therapy assistants may not provide evaluation services, or take responsibility for the service. The therapist has full responsibility for the service provided. ( )

02. Service Description: Speech-Language Pathology. Speech-language pathology services must be provided as defined in Section 730 of these rules. Services provided by speech-language pathology aides and assistants are considered unskilled services, and will be denied as not medically necessary if they are billed as speech-language pathology services. ( )

03. Non-Covered Services: Occupational Therapy, Physical Therapy, and Speech-Language Pathology. ( )

a. Continuing services for participants who do not exhibit the capability to achieve measurable improvement and who do not meet the criteria for a maintenance program. ( )

b. Services that address developmentally acceptable error patterns. ( )

c. Services that do not require the skills of a therapy professional. ( )

d. Massage, work hardening, and conditioning. ( )

e. Services that are not medically necessary, as defined in Section 011 of these rules. ( )

f. Duplicate services, as defined under Section 730 of these rules. ( )

g. Acupuncture (with or without electrical stimulation). ( )

h. Biofeedback, unless provided to treat urinary incontinence. ( )

i. Services that are considered to be experimental or investigational. ( )

j. Vocational Program. ( )

04. Service Limitations. ( )

a. Physical therapy (PT) and speech-language pathology (SLP) services are limited to a combined

annual dollar amount for all PT and SLP services. The Department will set the total amount based on the annual Medicare caps. The Department may allow additional therapy services, when the services are determined to be medically necessary and supporting documentation is provided upon request of the Department. ( )

b. Occupational therapy services are limited to an annual dollar amount set by the Department based on the annual Medicare caps. The Department may allow additional therapy services, when the services are determined to be medically necessary and supporting documentation is provided upon request of the Department. ( )

c. Exceptions to service limitations. ( )

i. Therapy provided by home health agencies is subject to the limitations on home health services contained in Section 722 of these rules. ( )

ii. Therapy provided through school-based services or the Idaho Infant Toddler Program is not included in the service limitations under Subsection 732.04 of this rule. ( )

iii. Therapy provided to EPSDT participants under the age of twenty-one (21) in accordance with the EPSDT requirements contained in Sections 881 through 883 of these rules, and in Section 1905(r) of the Social Security Act, will be authorized by the Department when additional therapy services are medically necessary. ( )

d. Feeding therapy services are covered for children with a diagnosed feeding disorder that results in a clinically significant deviation from normal childhood development. The provider of feeding therapy is an occupational therapist or speech therapist with training specific to feeding therapy. ( )

e. Maintenance therapy is covered when an individualized assessment of the participant's condition demonstrates that skilled care is required to carry out a safe and effective maintenance program. ( )

f. Telehealth modalities are covered to the extent they are allowed under the rules of the applicable board of licensing. The Department will define limitations on telehealth in the provider handbook to promote quality services and program integrity. ( )

733. THERAPY SERVICES: PROCEDURAL REQUIREMENTS.
The Department will pay for therapy services rendered by a therapy professional if such services are ordered by a physician, nurse practitioner, or physician assistant as part of a plan of care. ( )

01. Orders. ( )

a. All therapy must be ordered by a physician, nurse practitioner, or physician assistant. ( )

b. In the event that services are required for extended periods, these services must be reordered as necessary, but at least every ninety (90) days for all participants with the following exceptions: ( )

i. Therapy provided by home health agencies must be included in the home health plan of care and be reordered at least every sixty (60) days. ( )

ii. Therapy for individuals with long-term medical conditions, as documented by physician, nurse practitioner, or physician assistant, must be reordered at least every three hundred sixty-five (365) days. ( )

c. Therapy services provided under a home health plan of care must comply with the order requirements in Section 723 of these rules. ( )

02. Level of Supervision. Supervision of physical therapist assistants and occupational therapist assistants by the physical therapist or occupational therapist must be done according to the rules of the applicable licensure board. ( )

03. Face-to-Face Encounter for Home Health Therapy Services. Therapy services provided under a home health plan of care must comply with the face-to-face encounter requirements in Section 723 of these rules. ( )

04. Therapy Plan of Care. All therapy services must be provided under a therapy plan of care that is based on an evaluation and is established prior to beginning treatment. ( )

a. The plan of care must be signed by the person who established the plan, and the ordering provider within thirty (30) days of the evaluation to continue therapy services. ( )

b. The plan of care must be consistent with the therapy evaluation and must contain, at a minimum: ( )

i. Diagnoses; ( )

ii. Treatment goals that are measurable and pertain to the identified functional impairment(s); and ( )

iii. Type, frequency, and duration of therapy services. ( )

c. Therapy services provided under a home health plan of care must comply with the home health plan of care requirements in Section 723 of these rules. ( )

734. THERAPY SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.
The following providers are qualified to provide therapy services as Medicaid providers. ( )

01. Occupational Therapist, Licensed. A person licensed to conduct occupational therapy assessment and therapy according to the regulations in the state where the services are provided. ( )

02. Physical Therapist, Licensed. A person licensed to conduct physical therapy assessments and therapy according to the regulations in the state where the services are provided. ( )

03. Speech-Language Pathologist, Licensed. A person licensed to conduct speech-language assessments and therapy according to the regulations in the state where the services are provided who possesses a certificate of clinical competence in speech-language pathology from the American Speech, Language, and Hearing Association (ASHA) or who will be eligible for certification within one (1) year of employment. ( )

735. THERAPY SERVICES: PROVIDER REIMBURSEMENT.

01. Payment for Therapy Services. The payment for therapy includes the use of therapeutic equipment to provide the modality or therapy. No additional charge may be made to either the Medicaid program or the participant for the use of such equipment. ( )

02. Payment Procedures. Payment procedures are as follows: ( )

a. Therapy provided by home health agencies will be paid at a per visit rate as described in Section 725 of these rules and in accordance with IDAPA 16.03.07, "Home Health Agencies." ( )

b. Therapists enrolled with Medicaid as independent practitioners and licensed by the appropriate state licensing board will be reimbursed on a fee-for-service basis. Only those independent practitioners who have been enrolled as Medicaid providers can bill the Department directly for their services. A therapy assistant cannot bill Medicaid directly. The maximum fee will be based upon the Department's fee schedule, available from the central office for the Division of Medicaid. ( )

c. 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. ( )

d. Payment for therapy services rendered to participants in long-term care facilities is included in the facility reimbursement as described in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." ( )

e. Payment for therapy services rendered to participants in school-based services is described in Section 855 of these rules. ( )

736. THERAPY SERVICES: QUALITY ASSURANCE ACTIVITIES.

01. Unreimbursable Services and Penalties. Therapy services that are not medically necessary or that are not specifically covered by these rules are not reimbursable, and if paid are subject to recoupment and penalties under IDAPA 16.05.07, "The Investigation and Enforcement of Fraud, Abuse, and Misconduct." ( )

02. Therapist Conditions and Requirements. The therapist is required to formulate all therapy interventions in accordance with the applicable licensure rules in IDAPA 24.06.01, "Rules for the Licensure of Occupational Therapists and Occupational Therapy Assistants," or IDAPA 24.13.01, "Rules Governing the Physical Therapy Licensure Board," or IDAPA 24.23.01, "Rules of the Speech and Hearing Services Licensure Board," as well as the applicable association's professional Code of Ethics and Standards supporting best practice. ( )

03. Documentation. ( )

a. The provider must maintain financial and other records in sufficient detail to allow the Department to audit them as described in Section 305 of these rules. ( )

b. The following documentation must be maintained in the files of the provider: ( )

i. Physician, nurse practitioner, or physician assistant orders for therapy services; ( )

ii. Therapy plans of care; and ( )

iii. Progress or other notes documenting each assessment, each therapy session, and results of tests and measurements related to therapy services. ( )

c. The provider must grant the Department immediate access to all information required to review compliance with these rules, as required in Section 330 of these rules. The absence of such documentation is cause for recoupment of Medicaid payment. ( )

737. -- 739. (RESERVED)

SUB AREA: AUDIOLOGY SERVICES
(Sections 740-749)

740. AUDIOLOGY SERVICES.
Audiology services are diagnostic, screening, preventive, or corrective services provided by an audiologist. These services must be provided in accordance with Title 54, Chapter 29, Idaho Code, and require the order of a physician, nurse practitioner, or physician assistant. Audiology services do not include equipment needed by the patient such as communication devices or environmental controls. ( )

741. AUDIOLOGY SERVICES: PARTICIPANT ELIGIBILITY.

01. All Participants. All participants are eligible to receive diagnostic screening services necessary to obtain a differential diagnosis. ( )

02. Participants Under the Age of 21. Participants under the age of twenty-one (21) are eligible for all services listed in Section 742 of these rules. ( )

742. AUDIOLOGY SERVICES: COVERAGE AND LIMITATIONS.
All audiology services must be ordered by a physician or non-physician practitioner. The Department will pay for

routine audiometric examination and testing once in each calendar year, and audiometric services and supplies in accordance with the following guidelines and limitations: ( )

01. Non-Implantable Hearing Aids. When there is a documented hearing loss that meets the criteria of the Idaho Medicaid Provider Handbook, the Department will cover the purchase of non-implantable hearing aids for participants under the age of twenty-one (21) with the following requirements and limitations: ( )

a. Covered services included with the purchase of the hearing aid include proper fitting and refitting of the ear mold or aid, or both, during the first year, instructions related to the aid's use, and extended insurance coverage for two (2) years. ( )

b. The following services may be covered in addition to the purchase of the hearing aid for participants under the age of twenty-one (21): batteries purchased on a monthly basis, follow-up testing, necessary repairs resulting from normal use after the second year, and the refitting of the hearing aid or additional ear molds. ( )

c. Lost, misplaced, stolen or destroyed hearing aids are the responsibility of the participant. The Department has no responsibility for the replacement of any hearing aid. In addition, the Department has no responsibility for the repair of hearing aids that have been damaged as a result of neglect, abuse or use of the aid in a manner for which it was not intended. ( )

02. Implantable Hearing Aids. The Department may cover a surgically implantable hearing aid for participants under the age of twenty-one (21) when: ( )

a. There is a documented hearing loss as described in Subsection 742.01 of this rule; ( )

b. Non-implantable options have been tried, but have not been successful; and ( )

c. The Department has determined that a surgically implanted hearing aid is medically necessary through the prior authorization process. The Department will consider the guidelines of private and public payers, evidence-based national standards or medical practice, and the medical necessity of each participant's case. ( )

03. Provider Documentation Requirements. The following information must be documented and kept on file by the provider: ( )

a. The participant's diagnosis; ( )

b. The results of the basic comprehensive audiometric exam that include pure tone, air and bone conduction, speech reception threshold, most comfortable loudness, discrimination and impedance testing; and ( )

c. The brand name and model type of the hearing aid needed. ( )

04. Allowance to Waive Impedance Test. The Department will allow a medical doctor to waive the impedance test based on their documented judgment. ( )

743. AUDIOLOGY SERVICES: PROCEDURAL REQUIREMENTS.

01. Audiology Examinations. Basic audiometric testing by licensed audiologists or licensed physicians will be covered without prior approval. ( )

02. Additional Testing. Any hearing testing beyond the basic comprehensive audiometry and impedance testing must be ordered in writing before the testing is done and kept on file by the provider. ( )

744. AUDIOLOGY SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.
The following are qualified to provide audiology services as Medicaid providers: ( )

01. Audiologist, Licensed. A person licensed to conduct hearing assessment and therapy, according to the regulations in the state where the services are provided, who meets the requirements of 42 CFR 440.110(c)(3). ( )

02. Speech-Language Pathologist, Licensed. A person licensed to conduct speech-language assessment and therapy according to the regulations in the state where the services are provided, who possesses a certificate of clinical competence in speech-language pathology from the American Speech, Language and Hearing Association (ASHA) or who will be eligible for certification within one (1) year of employment. ( )

745. AUDIOLOGY SERVICES: PROVIDER REIMBURSEMENT.

01. Payment Procedures. The following procedures must be followed when billing the Department: ( )

a. The Department will only pay the hearing aid provider for an eligible Medicaid participant if a properly completed claim is submitted to the Department within the one (1) year billing limitation. ( )

b. Payment will be based upon the Department's fee schedule in accordance with Section 230 of these rules). ( )

02. Limitations. The following limitations apply to audiometric services and supplies: ( )

a. Hearing aid selection is restricted to the most cost-effective type and model that meets the participant's medical needs. ( )

b. Follow-up services are included in the purchase of the hearing aid for the first two (2) years including repair, servicing and refitting of ear molds. ( )

c. Providers are required to maintain warranty and insurance information on file on each hearing aid purchased from them by the Department and are responsible for exercising the use of the warranty or insurance during the first year following the purchase of the hearing aid. ( )

d. Providers must not bill participants for charges in excess of the fees allowed by the Department for materials and services. ( )

746. -- 749. (RESERVED)

**SUB AREA: DURABLE MEDICAL EQUIPMENT AND SUPPLIES
(Sections 750-779)**

750. (RESERVED)

751. DURABLE MEDICAL EQUIPMENT AND SUPPLIES: PARTICIPANT RESPONSIBILITY.
The participant has a responsibility to reasonably protect and preserve equipment issued to them. Replacement of medical equipment or supplies that are lost, damaged or broken due to participant misuse or abuse are the responsibility of the participant. ( )

752. DURABLE MEDICAL EQUIPMENT AND SUPPLIES: COVERAGE AND LIMITATIONS.
The Department will purchase or rent, when medically necessary, reasonable and cost-effective, durable medical equipment (DME) and medical supplies that are suitable for use in any setting in which normal life activities take place. Medical supplies, equipment, and appliances provided by a home health agency under a home health plan of care must meet the requirements found in Sections 750 through 779 of these rules and the requirements found in Sections 720 through 729 of these rules. ( )

01. Medical Necessity Criteria -- Equipment and Supplies. Department standards for medical necessity are those national standards set by Centers for Medicare and Medicaid Services (CMS) in the CMS/ Medicare DME coverage manual. Exceptions to Medicare coverage are described in the Idaho Medicaid Provider

Handbook available at: www.idmedicaid.com. Items for convenience, comfort, or cosmetic reasons are not covered. ( )

02. Prior Authorization -- Equipment and Supplies. ( )

a. The Department will specify in the Idaho Medicaid Provider Handbook, which durable medical equipment and medical supplies require prior authorization by the Department. ( )

b. Each request for prior authorization must include all medical necessity documentation required under Section 753 of these rules. ( )

03. Coverage Conditions -- Equipment and Supplies. ( )

a. Medical equipment and supplies are subject to coverage limitations in the CMS/Medicare DME coverage manual. Exceptions to these coverage conditions and coverage conditions for medically necessary items not included in that manual are described in the Idaho Medicaid Provider Handbook available at: www.idmedicaid.com. Exceptions must be established using evidence-based or best clinical practice standards as determined by the Department. ( )

b. The Department will purchase no more than three (3) months of necessary medical supplies in a three (3) month period for the treatment or amelioration of a medical condition identified by the attending physician or non-physician practitioner. Supplies in excess of coverage limitations must be prior authorized by the Department. ( )

753. DURABLE MEDICAL EQUIPMENT AND SUPPLIES: PROCEDURAL REQUIREMENTS.

01. Orders. ( )

a. All medical supplies, equipment, and appliances must be ordered by a physician or non-physician practitioner acting within the scope of their licensure. Such orders must meet the requirements described in the CMS/Medicare DME coverage manual. ( )

b. In the event that medical equipment and supplies are required for extended periods, these must be reordered as necessary, but at least annually, for all participants. ( )

c. The following information to support the medical necessity of the item(s) must be included in the order and accompany all requests for prior authorization, or be kept on file with the DME provider for items that do not require prior authorization: ( )

i. The participant's medical diagnosis, including current information on the medical condition that requires the use of the supplies or medical equipment, or both; ( )

ii. An estimate of the time period that the medical equipment or supply item will be necessary and frequency of use. As needed (PRN) orders must include the conditions for use and the expected frequency; ( )

iii. For medical equipment, a full description of the equipment needed. All modifications or attachments to the basic equipment must be supported; ( )

iv. For medical supplies, the type and quantity of supplies necessary must be identified; and ( )

v. Documentation of the participant's medical necessity for the item, that meets coverage criteria. ( )

vi. Additional information may be requested by the Department for specific equipment or supplies. ( )

02. Face-to-Face Encounter for Home Health Medical Supplies, Equipment, and Appliances.

Medical supplies, equipment, and appliances provided under a home health plan of care must comply with the face-to-face encounter requirements in Section 723 of these rules. ( )

03. Plan of Care Requirements for Home Health Medical Supplies, Equipment, and Appliances. Medical supplies, equipment, and appliances provided under a home health plan of care must comply with the home health plan of care requirements in Section 723 of these rules. ( )

04. Prior Authorizations. ( )

a. Prior authorization means a written, faxed, or electronic approval from the Department that permits payment or coverage of a medical item or service that is covered only by such authorization. ( )

i. Medicaid payment will be denied for the medical item or service or portions thereof that were provided prior to the submission of a valid prior authorization request. ( )

ii. The provider may not bill the Medicaid participant for services not reimbursed by Medicaid solely because the authorization was not requested or obtained in a timely manner. An exception may be allowed on a case-by-case basis where, despite diligent efforts on the part of the provider to submit a request, or events beyond the provider's control prevented it. ( )

b. An item or service will be deemed prior approved where the individual to whom the service was provided was not eligible for Medicaid at the time the service was provided, but was subsequently found eligible under IDAPA 16.03.05, "Eligibility for Aid to the Aged, Blind, and Disabled," or IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children," and the medical item or service provided is approved by the Department by the same guidance that applies to other prior authorization requests. ( )

c. A valid prior authorization request is a written, faxed, or electronic request from a provider of Medicaid for services that contains all information and documentation as required by these rules to justify the medical necessity, amount of and duration for the item or service. ( )

05. Notification of Changes to Prior Authorization Requirements. The Department will provide sixty (60) days notice of any substantive and significant changes to requirements for prior authorization in its provider handbook. The Department will provide a method to allow providers to provide input and comment on proposed changes. ( )

06. Equipment Rental -- Purchase Procedures. Unless specified by the Department, all equipment must be rented except when it would be more cost effective to purchase it. Rentals are subject to the following guidelines: ( )

a. Rental payments, including intermittent payments, are to be automatically applied to the purchase of the equipment. ( )

b. The Department may choose to continue to rent certain equipment without purchasing it. Such items include apnea monitors, ventilators, and other respiratory equipment. ( )

c. The total monthly rental cost of a DME item must not exceed one-tenth (1/10) of the total purchase price of the item. ( )

07. Notice of Decision. A Notice of Decision approving or denying a requested item will be issued to the participant by the Department. The participant has twenty-eight (28) days from the date of the denial to request a fair hearing on the decision. Hearings will be conducted in accordance with IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings." ( )

754. (RESERVED)

755. DURABLE MEDICAL EQUIPMENT AND SUPPLIES: PROVIDER REIMBURSEMENT.

01. Items Included in Per Diem Excluded. No payment will be made for any participant's DME or medical supplies that are included in the per diem payment while such an individual is an inpatient in a hospital nursing facility or ICF/IID. ( )

02. Least Costly Limitation. When multiple features, models or brands of equipment or supplies are available, coverage will be limited to the least costly version that will reasonably and effectively meet the minimum requirements of the individual's medical needs. ( )

03. Billing Procedures. The Department will provide billing instructions to providers of DME/medical supplies. When prior authorization by the Department is required, the authorization number must be included on the claim form. ( )

04. Fees and Upper Limits. The Department will reimburse according to Section 230 of these rules. ( )

05. Date of Service. Unless specifically authorized by the Department the date of services for durable medical equipment and supplies is the date of delivery of the equipment or supply(s) for items provided in-person or the date of shipment for supplies mailed through a third-party courier. ( )

06. Manually Priced Codes. For codes that are manually priced, including miscellaneous codes, a copy of the manufacturer's suggested retail pricing (MSRP) or an invoice or quote from the manufacturer is required. Reimbursement will be seventy-five percent (75%) of MSRP. If the pricing documentation is the invoice, reimbursement will be at cost plus ten percent (10%), plus shipping, if that documentation is provided. ( )

07. Warranties and Cost of Repairs. No reimbursement will be made for the cost of repairs (materials or labor, or both) covered under the manufacturer's warranty. The date of purchase and the warranty period must be kept on file by the DME vendor. The following warranty periods are required to be provided on equipment purchased by the Department: ( )

a. A power drive wheelchair must have a minimum one (1) year warranty period; ( )

b. An ultra-light or high-strength lightweight wheelchair must have a lifetime warranty period on the frame and crossbraces; ( )

c. All other wheelchairs must have a minimum one (1) year warranty period; ( )

d. All electrical components and new or replacement parts must have a minimum six (6) month warranty period; ( )

e. All other DME not specified in Subsections 755.07.a. through 755.07.d. of this rule must have a minimum one (1) year warranty period; ( )

f. If the manufacturer denies the warranty due to user misuse or abuse, or both, that information must be forwarded to the Department at the time of the request for repair or replacement; ( )

g. The monthly rental payment must include a full service warranty. All routine maintenance, repairs, and replacement of rental equipment are the responsibility of the provider. ( )

756. DURABLE MEDICAL EQUIPMENT AND SUPPLIES: QUALITY ASSURANCE.

The use or provision of DME/medical supply items to an individual other than the participant for which such items were ordered is prohibited. The provision of DME/medical supply items that is not supported by required medical necessity documentation is prohibited and subject to recoupment. Violators are subject to penalties for program fraud or abuse, or both, that will be enforced by the Department. The Department has no obligation to repair or replace any piece of durable medical equipment that has been damaged, defaced, lost, or destroyed as a result of neglect, abuse, or misuse of the equipment. Participants suspected of the same will be reported to the Surveillance and Utilization Review (SUR/S) committee. ( )

757. -- 770. (RESERVED)

771. PROSTHETIC AND ORTHOTIC SERVICES: PARTICIPANT ELIGIBILITY.
The Medical Assistance Program will purchase or repair, or both, medically necessary prosthetic and orthotic devices and related services that artificially replace a missing portion of the body or support a weak or deformed portion of the body within the limitations established by the Department. ( )

772. PROSTHETIC AND ORTHOTIC SERVICES: COVERAGE AND LIMITATIONS.

01. Program Requirements. The following program requirements will be applicable for all prosthetic and orthotic devices or services purchased by the Department: ( )

a. A temporary lower limb prosthesis will be purchased when documented by the attending physician or non-physician practitioner that it is in the best interest of the participant's rehabilitation to have a temporary lower limb prosthesis prior to a permanent limb prosthesis. A new permanent limb prosthesis will only be requested after the residual limb size is considered stable; ( )

b. A request for a replacement prosthesis or orthotic device must be justified to be the least costly alternative as opposed to repairing or modifying the current prosthesis or orthotic device; ( )

c. All prosthetic and orthotic devices that require fitting must be provided by an individual who is certified or registered by the American Board for Certification in Orthotics or Prosthetics, or both; ( )

d. All equipment that is purchased must be new at the time of purchase. Modification to existing prosthetic or orthotic equipment, or both, will be covered by the Department; ( )

e. Prosthetic limbs purchased by the Department must be guaranteed to fit properly for three (3) months from the date of service; therefore, any modifications, adjustments, or replacements within the three (3) months are the responsibility of the provider that supplied the item at no additional cost to the Department or the participant; ( )

f. Not more than ninety (90) days may elapse between the time of the order and the preauthorization request is presented to the Department for consideration; ( )

02. Program Limitations. The following limitations apply to all prosthetic and orthotic services and equipment: ( )

a. No replacement will be allowed for prosthetic or orthotic devices within sixty (60) months of the date of purchase except in cases where there is clear documentation that there has been major physical change to the residual limb, and ordered by the attending physician or non-physician practitioner; ( )

b. Refitting, repairs, or additional parts must be limited to once per calendar year for all prosthetics or orthotics, or both, unless it has been documented that a major medical change has occurred to the limb, and ordered by the attending physician; ( )

c. All refitting, repairs or alterations require preauthorization based on medical justification by the participant's attending physician; ( )

d. Prosthetic and orthotic devices provided for cosmetic or convenience purposes are not covered by the Department. ( )

e. Electronically powered or enhanced prosthetic devices are not covered; ( )

f. The Department will only authorize corrective shoes or modification to an existing shoe owned by the participant when they are attached to an orthosis or prosthesis or when specially constructed to provide for a totally or partially missing foot; ( )

g. Shoes and accessories such as mismatch shoes, comfort shoes following surgery, shoes to support an overweight individual, or shoes used as bandage following foot surgery, arch supports, foot pads, metatarsal head appliances or foot supports are not covered; and ( )

h. Corsets are not a benefit nor are canvas braces with plastic or metal bones. However, special braces enabling a participant to ambulate will be covered when the attending physician documents that the only other method of treatment for this condition would be application of a cast. ( )

773. PROSTHETIC AND ORTHOTIC SERVICES: PROCEDURAL REQUIREMENTS.
Prosthetic and orthotic devices and services will be paid for only if prescribed by a physician or non-physician practitioner. The following information must be included in the order and kept on file by the provider: ( )

01. Full Description of the Services Requested. ( )

02. Number of Months the Equipment Will Be Needed and the Participant's Prognosis. ( )

03. Participant's Medical Diagnosis and Condition. The participant's medical diagnosis and the condition that requires the use of the prosthetic or orthotic services, or both, supplies, equipment or modifications, or both; and ( )

04. Modifications to the Prosthetic or Orthotic Device. All modifications must be supported by the attending physician's description on the prescription. ( )

774. (RESERVED)

775. PROSTHETIC AND ORTHOTIC SERVICES: PROVIDER REIMBURSEMENT.
The Department will reimburse according to Section 230 of these rules. ( )

776. -- 779. (RESERVED)

SUB AREA: VISION SERVICES
(Sections 780-789)

780. -- 781. (RESERVED)

782. VISION SERVICES: COVERAGE AND LIMITATIONS.
The Department will pay for vision services and supplies in accordance with the guidelines and limitations listed below. ( )

01. Eye Examinations. ( )

a. The Department will pay participating physicians and optometrists for one (1) eye examination during any twelve (12) month period to determine the need for glasses to correct a refractive error. ( )

b. The Department will pay for eyeglasses within Department guidelines following a diagnosis of visual defects and a recommendation that eyeglasses are needed for correction of a refractive error. ( )

02. Lenses. Lenses, single vision or bifocal, will be purchased by the Department not more often than once every four (4) years except when there is documentation of a major visual change as defined by the Department. ( )

a. Scratch resistant coating is required for all plastic and polycarbonate lenses ( )

b. Payment for tinted lenses will only be made when there is a diagnosis of albinism or in the case of other extreme medical conditions as defined by the Department as defined in the Provider Handbook. Documentation must be kept on file by both the examining and supplying providers. ( )

c. All contact lenses require prior authorization by the Department. Contact lenses will be covered for participants only with documentation of: ( )

i. A need for correction equal to or greater than plus or minus ten (±10) diopters; or ( )

ii. An extreme medical condition that does not allow correction through the use of conventional lenses, such as cataract surgery, keratoconus, anisometropia, or other extreme conditions as defined by the Department. ( )

03. Replacement Lenses. Replacement lenses will be purchased for participants under the age of twenty-one (21) prior to the four (4) year limitation only with documentation of a major visual change as defined by the Department in the Idaho Medicaid Provider Handbook. Replacement lenses for participants age twenty-one (21) and older will be purchased when necessary to prevent permanent damage to the eye. ( )

04. Frames. Frames will be purchased according to the following guidelines: ( )

a. One (1) set of frames will be purchased by the Department for eligible participants not more often than once every four (4) years; ( )

b. When it is documented by the vision provider that there has been a major change in visual acuity that cannot be accommodated in lenses that will fit in the existing frames, new frames also may be authorized. ( )

05. Fitting Fees. Fitting fees for either contact lenses or conventional frames and lenses are covered only when the participant is eligible under the Medicaid program guidelines to receive the supplies associated with the fitting fee. ( )

06. Non-Covered Items. A Medicaid Provider may receive payment from a Medicaid participant for vision services that are either not covered by the State Plan, or include special features or characteristics that are desired by the participant but are not medically necessary. ( )

a. Non-covered items include Trifocal lenses, Progressive lenses, photo gray, and tint. ( )

b. Replacement of broken, lost, or missing glasses is the responsibility of the participant. ( )

783. -- 784. (RESERVED)

785. VISION SERVICES: PROVIDER REIMBURSEMENT.
All eyeglass frames and lenses provided to Medicaid participants and paid for by the Medicaid Program will be purchased from the supplier designated by the Department. ( )

786. -- 799. (RESERVED)

SUB AREA: DENTAL SERVICES
(Sections 800-819)

800. DENTAL SERVICES: SELECTIVE CONTRACT FOR DENTAL COVERAGE.
All participants eligible for Medicaid dental benefits are covered under a selective contract for a dental insurance program called Idaho Smiles at http://www.healthandwelfare.idaho.gov/Medical/Medicaid/MedicalCare/DentalServices/tabid/696/Default.aspx. ( )

801. DENTAL SERVICES: DEFINITIONS.
For the purposes of dental services covered in Sections 800 through 807 of these rules, the following definitions apply: ( )

01. Adult. A person who is past the month of their twenty-first birthday. ( )

02. **Child**. A person from birth through the month of their twenty-first birthday. ( )

03. **Idaho Smiles**. A dental insurance program provided to eligible Medicaid participants through a selective contract between the Department and a dental insurance carrier. ( )

802. DENTAL SERVICES: PARTICIPANT ELIGIBILITY.
Children and adults eligible for Medicaid are eligible for Idaho Smiles dental benefits described in Section 803 of these rules. ( )

803. DENTAL SERVICES: COVERAGE AND LIMITATIONS.
Some covered dental services may be subject to limitations, authorization from the Idaho Smiles contractor or benefit restrictions according to the terms of its contract with the Department, in addition to those specified in these rules. ( )

01. **Dental Coverage for Children**. Children are covered for dental services that include preventative screenings, problem-focused and comprehensive exams, diagnostic, restorative, endodontic services (including root canals and crowns), periodontics, prosthodontic, orthodontic treatments, dentures, and oral surgery; ( )

02. **Dental Limitation for Children**. Orthodontics are limited to children who meet Medicaid eligibility requirements and the Idaho Medicaid Handicapping Malocclusion Index as determined by the State's contractor. ( )

03. **Dental Coverage for Adults**. Adults are covered for dental services that include preventative screenings, problem-focused and comprehensive exams, diagnostic, restorative, periodontics, prosthodontic, dentures, oral surgery, and endodontic services with limitations. ( )

04. **Dental Limitation for Adults**. Root canals and crowns are not covered. ( )

804. DENTAL SERVICES: PROCEDURAL REQUIREMENTS.
Providers must enroll in the Idaho Smiles network with the dental insurance contractor and meet both credentialing and quality assurance guidelines of the contractor. ( )

01. **Administer Idaho Smiles**. The contractor is responsible for administering the Idaho Smiles program, including dental claims processing, payments to providers, customer service, eligibility verification, and data reporting. ( )

02. **Authorization**. The contractor is responsible for authorization of covered dental services that require authorization prior to claim payment. ( )

03. **Grievances**. The contractor is responsible for tracking and reporting all grievances to the State's contract monitor. ( )

04. **Appeals**. Appeals are handled by a process between the contractor and the Department as specified in IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings," and in compliance with state and federal requirements. ( )

805. DENTAL SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.
Providers are credentialed by the contractor to ensure they meet licensing requirements of the Idaho Board of Dentistry standards or the applicable state in which services are provided. Providers' duties are based on the contract requirements and are monitored and enforced by the contractor. ( )

806. DENTAL SERVICES: PROVIDER REIMBURSEMENT.
The Idaho Smiles administrator reimburses dental providers on a fee-for-service basis under a Department-approved fee schedule. The State will collaborate with the contractor to establish rates that promote and ensure adequate access to dental services. ( )

807. DENTAL SERVICES: QUALITY ASSURANCE.

Providers are subject to the contractor's Quality Assurance guidelines including monitoring for potential fraud, overutilization, or abuse of Medicaid. The contractor is required to share such potential cases with the Medicaid Fraud Unit as discovered. ( )

808. -- 819. (RESERVED)

SUB AREA: ESSENTIAL PROVIDERS
(Sections 820-859)

820. RURAL HEALTH CLINIC (RHC) SERVICES.
A Rural Health Clinic is located in a rural area designated as a physician shortage area, and is neither a rehabilitation agency nor does it primarily provide for the care and treatment of mental diseases. ( )

821. -- 822. (RESERVED)

823. RURAL HEALTH CLINIC (RHC) SERVICES: COVERAGE AND LIMITATIONS.
RHC services are defined as follows: ( )

01. Physician Services. Physician services; ( )

02. Services and Supplies Incident to a Physician Service. Services and supplies incident to a physician service, which cannot be self administered; ( )

03. Physician Assistant Services. Physician assistant services; ( )

04. Nurse Practitioner or Clinical Nurse Specialist Services. Nurse practitioner or clinical nurse specialist services; ( )

05. Clinical Psychologist Services. Clinical psychologist services; ( )

06. Clinical Social Worker Services. Clinical social worker services; ( )

07. Other Services and Supplies. Services and supplies incident to a nurse practitioner, physician's assistant, clinical psychologist, or clinical social worker as would otherwise be covered by a physician service; or ( )

08. Home Health Agency Shortage Area Services. Part-time or intermittent nursing care, and related medical services to a home bound individual, when an RHC located in an area with a shortage of home health agencies. ( )

824. -- 825. (RESERVED)

826. RURAL HEALTH CLINIC (RHC) SERVICES: REIMBURSEMENT METHODOLOGY.

01. Payment. Payment for Federally Qualified Health Center and Rural Health Clinic services must be made in accordance with Section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, P.L. 106-554, 42USC Section 1396a(bb), Subsections (1) through (4). ( )

02. RHC Encounter. An encounter, for RHC payment purposes, is a face-to-face contact for the provision of a medical or mental service between a clinic patient and a provider as specified in 823.01 through 823.06 of these rules. ( )

a. Each contact with a separate discipline of health professional (medical or mental) on the same day at the same location is considered a separate encounter. ( )

b. Reimbursement for services is limited to two (2) encounters per participant per day. ( )

c. As an exception to Subsection 826.02.a. of this rule, a second encounter with the same professional on the same day may be reimbursed; or ( )

d. As an exception to Subsection 826.02.b. of this rule, an additional encounter may be reimbursed, if the encounter is caused by an illness or injury that occurs later in time than the first encounter and requires additional diagnosis or treatment. ( )

e. A core service ordered by a health professional who did not perform the service but was performed by support staff is considered a single encounter. ( )

f. Multiple contacts with clinic staff of the same discipline (medical, mental) on the same day related to the same illness or injury are considered a single encounter. ( )

827. -- 829. (RESERVED)

830. FEDERALLY QUALIFIED HEALTH CENTER (FQHC) SERVICES: DEFINITIONS.

01. Change in Intensity of Services of an FQHC. A change in the intensity of services of an FQHC means a change in the quantity and complexity of services delivered that could change an FQHC's total allowable cost per encounter. This does not include an expansion or remodeling of an existing FQHC. This may include such things as the addition of new services or the deletion of existing services. ( )

02. Encounter. An encounter, for FQHC payment purposes, is a face-to-face contact for the provision of medical/mental or dental services between a FQHC patient and a provider as specified in Subsections 832.01 through 832.07 of these rules. For the purposes of establishing encounter rates, the term “medical/mental” refers to a single category of service. ( )

03. Encounter Rate. An encounter rate can be of two (2) types, either medical/mental or dental; either of these two (2) types can be either an interim rate or a finalized rate. An encounter rate is the total amount of annual costs for the type of encounter divided by the total number of encounters for that type of encounter for the FQHC’s fiscal year. ( )

a. Interim Encounter Rate. If the FQHC is new and historical cost information is not available, the Department sets the interim encounter rate using budgeted cost and encounter information submitted by the provider. If the FQHC is not able to obtain its financial budget information, the Department sets the interim encounter rate by referring to encounter rates paid to other FQHCs in the same or adjacent regional areas with similar caseloads. ( )

b. Finalized Encounter Rate. If the FQHC is an existing facility and has at least twenty-four (24) consecutive months of historical cost and encounter information, the Department uses the second full twelve (12) month audited Medicare cost report to calculate a finalized encounter rate. ( )

04. Federally Qualified Health Centers (FQHCs). Federally qualified health centers are defined in federal law at 42 USC Section 1396d(1)(2), which incorporates the definition at 42 USC Section 1395x(aa)(1), and includes community health centers, migrant health centers, providers of care for the homeless, and outpatient health programs or clinics operated by a tribe or tribal organization under the Indian Self-Determination Act (P.L. 93-638). It also includes clinics that qualify for, but are not actually receiving, grant funds according to Sections 329, 330, or 340 of the Public Health Service Act (42 USC Sections 201, et seq.) that may provide ambulatory services to medical assistance participants. ( )

05. Medicare Cost Report Period. The period of time covered by the Medicare-required annual report of an FQHC's costs. ( )

06. Medicare Economic Index (MEI). MEI is an annual measure of inflation designed to estimate the increase in the total cost for the average physician to operate a medical practice. The MEI takes into account cost categories such as a physician's own time, non-physician employees' compensation, rents, and medical equipment. The MEI is used in establishing the annual changes to the payment conversion factors used as part of the

methodology for determining FQHC reimbursement rates. ( )

831. (RESERVED)

832. FEDERALLY QUALIFIED HEALTH CENTER (FQHC) SERVICES: COVERAGE AND LIMITATIONS.
FQHC services are defined as follows: ( )

01. Physician Services. Physician services; or ( )

02. Incidental Services and Supplies to Physician Services. Services and supplies incidental to physician services, including drugs and pharmaceuticals that cannot be self-administered; or ( )

03. Physician Assistant Services. Physician assistant services; or ( )

04. Nurse Practitioner or Clinical Nurse Specialist Services. Nurse practitioner or clinical nurse specialist services; or ( )

05. Clinical Psychologist Services. Clinical psychologist services; or ( )

06. Clinical Social Worker Services. Clinical social worker services; or ( )

07. Licensed Dentist and Dental Hygienist Services. Licensed dentist and dental hygienist services; or ( )

08. Incidental Services and Supplies to Non-Physicians. Services and supplies incident to a nurse practitioner, physician's assistant, clinical psychologist, clinical social worker, or dentist or dental hygienist services that would otherwise be covered if furnished by or incident to physician services; or ( )

09. FQHC Services. In the case of an FQHC that is located in an area that has a shortage of home health agencies, FQHC services are part-time or intermittent nursing care and related medical services to a home-bound individual; and ( )

10. Other Payable Medical Assistance Ambulatory Services. Other payable medical assistance ambulatory services offered by the Idaho Medicaid program that the FQHC undertakes to provide, including pneumococcal or immunization vaccine and its administration. ( )

833. -- 834. (RESERVED)

835. FEDERALLY QUALIFIED HEALTH CENTER (FQHC) SERVICES: REIMBURSEMENT METHODOLOGY.

01. Payment. Payment for Federally Qualified Health Center and Rural Health Clinic services must be made in accordance with Section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, P.L. 106-554, 42 USC Section 1396a(bb), Subsections (1) through (4). ( )

02. FQHC Encounter Limitations and Exceptions. FQHC encounters have the following limitations and exceptions to these limitations as described in Subsections 835.02.a. through 835.02.d. of this rule: ( )

a. Each contact with a separate discipline of health professional (medical/mental or dental), on the same day at the same location, is considered a separate encounter. All contacts with all practitioners within a disciplinary category (medical/mental or dental) on the same day is one (1) encounter. ( )

b. Reimbursement for services is limited to three (3) encounters per participant per day. ( )

c. As an exception to Subsection 835.02.a. of this rule, a second encounter with the same professional on the same day may be reimbursed; or ( )

d. As an exception to Subsection 835.02.b. of this rule, an additional encounter may be reimbursed, if the encounter is caused by an illness or injury that occurs later in time than the first encounter and requires additional diagnosis or treatment. ( )

836. FEDERALLY QUALIFIED HEALTH CENTER (FQHC) SERVICES: RATE SETTING METHODOLOGY.

01. Prospective Payment System. ( )

a. For rate periods beginning on January 1, 2001, the Department will establish separate, finalized rates for medical/mental encounters and for dental encounters. The Department will prospectively set these finalized encounter rates using the FQHC's medical/mental and dental encounter costs. ( )

b. Beginning in federal fiscal year 2002, and for each federal fiscal year thereafter, the Department will pay each FQHC an encounter rate equal to the amount paid in the previous federal fiscal year. For the period starting with federal fiscal year 2002 and thereafter, the Department will adjust the encounter rate for inflation using the Medicaid Economic Index (MEI), as published by CMS. For both medical/mental encounters and dental encounters, FQHCs are paid on a per encounter basis, with the limitations and exceptions described under Subsection 835.02 of these rules. ( )

c. If an out-of-state FQHC becomes an Idaho Medicaid provider and provides less than one hundred (100) Idaho Medicaid encounters or receives less than ten thousand dollars ($10,000) in Idaho Medicaid payments in the first year after entering the program, the Department will deem the FQHC a low utilization provider. The finalized encounter rate for low utilization providers will be the same as the interim encounter rate as defined in Subsection 836.02.a. of this rule. If there is an increase in either the number of encounters or in the amount of payments over any twelve (12) month Medicare cost report period, the Department reserves the right to audit a low utilization provider's Medicare cost report in order to set a new interim encounter rate as defined in Subsection 836.02.a. of this rule. ( )

02. FQHCs That Become Idaho Medicaid Providers. ( )

a. If the FQHC is new and encounter rate information for other FQHCs in the same or adjacent regional areas with similar caseloads is not available, the Department will set the interim encounter rate using historical cost information. If historical cost information is not available, the Department will use budgeted cost and encounter information submitted by the provider. If the FQHC is not able to provide its financial budget information, the Department will set the interim encounter rate by referring to encounter rates paid to other FQHCs in the same or adjacent regional areas with similar caseloads. Regional areas are defined by the Department. ( )

b. If the FQHC has been designated as an FQHC for at least twenty-four (24) consecutive months and provides the historical cost and encounter information for this period to the Department, the Department will use the second full twelve (12) month audited Medicare cost report to calculate a finalized encounter rate. The Department will provide the FQHCs a supplemental information worksheet to complete. This worksheet will be used by the Department to identify dental encounters and other incidental costs related to either medical/mental or dental FQHC encounters. ( )

c. For both new and existing FQHCs that become Idaho Medicaid providers, the Department will audit the Medicare cost report for the twenty-four (24) consecutive months that represent two (2) complete fiscal years after the FQHC has become a Medicaid provider. The Department will also audit the Medicare cost report for any partial year prior to the twenty-four (24) consecutive months. ( )

d. For both new and existing FQHCs that become Idaho Medicaid providers, the Department will adjust the finalized encounter rate annually for inflation in accordance with Subsection 836.01.b. of this rule. ( )

e. The Department will adjust the claim payments for all FQHC claims paid at the interim encounter rate(s). These adjustments will reflect the payment at the finalized encounter rate(s). The Department will pay the

FQHC for any total adjustment amount over what was reimbursed. The FQHC must pay the Department for any total adjustment amount that is under what was reimbursed. ( )

03. Change in an FQHC Encounter Rate Due to a Change in the FQHC's Scope of Services. ( )

a. After an FQHC obtains approval for a change in scope of service from the federal Human Resources and Services Administration (HRSA), Bureau of Primary Healthcare, the FQHC must request the Department to review the encounter rate(s) for the FQHC. The review will include reviewing the addition of a new service(s), deletion of an existing service(s), or other changes in the intensity of services offered by an FQHC that could change an FQHC's total cost per encounter. The FQHC must request the Department to review the encounter rate(s) within sixty (60) days after the FQHC has gained approval from the HRSA Bureau of Primary Health Care for a change in scope of service. The Department requires the same supporting documentation required by the HRSA Bureau of Primary Health Care. ( )

b. When an FQHC does not have to file a change in scope of service with the HRSA Bureau of Primary Health Care, but plans an increase or decrease in the intensity of services to be offered that will result in a change the FQHC's scope of services, the FQHC must request the Department to review the request for a change in intensity and determine if there will be an increase or decrease in the encounter rate(s) for the FQHC. The Department will review the request for a change in intensity within 60 (sixty) days of the planned change in intensity of services. ( )

c. The Department reserves the right to audit the Medicare cost report and recalculate the encounter rates when the FQHC has reported a change in scope of service. ( )

d. The Department will determine the encounter rate in accordance with Subsection 836.02 of this rule when the FQHC has reported a change in scope of service. The Department will audit and cost settle the most recent twenty-four (24) consecutive months of Medicare cost reports following any change(s) in an FQHC's scope of service. The Department will also audit the Medicare cost report for any partial year prior to the twenty-four (24) consecutive months. The finalized encounter rate(s) for both medical/mental and dental encounters will be recalculated and audited using the Medicare cost report for the second full twelve (12) month period. ( )

04. Annual Filing Requirements. Each provider is required to file a copy of its Medicare cost report on an annual basis. Department deadlines are the same as those imposed by Medicare. ( )

05. Quarterly Supplemental Payments. In the case of any FQHC that contracts with a managed care organization, the Department will make quarterly supplemental payments to the FQHC for the difference between the payment amounts paid by the managed care organization and the amount to which the FQHC is entitled under the prospective payment system for Medicaid participants. ( )

837. -- 841. (RESERVED)

842. INDIAN HEALTH SERVICE (IHS) CLINIC SERVICES: COVERAGE AND LIMITATIONS.
Payment will be available to Indian Health Service (IHS) clinics for any service provided within the conditions of the scope of care and services described in Subsection 835.02 of these rules. ( )

843. -- 844. (RESERVED)

845. INDIAN HEALTH SERVICE (IHS) CLINIC SERVICES: PROVIDER REIMBURSEMENT.

01. Payment Procedure. Payment for services other than prescribed drugs will be made on a per visit basis at a rate not exceeding the outpatient visit rate established by the Federal Office of Management and Budget as published annually in the Federal Register. ( )

02. Payment for Prescribed Drugs. Payment for prescribed drugs will be available as described in Subsection 662.01 of these rules. ( )

03. Dispensing Fee for Prescriptions. The allowed dispensing fee used to compute maximum payment for each prescription will be the midpoint dispensing fee of the range of fees in effect at the date of service unless a higher fee is justified by a pharmacy cost of operations report on file with the Department. ( )

04. Third Party Liability Not Applicable. The provisions of Section 215 of these rules are not applicable to Indian health service clinics. ( )

846. -- 849. (RESERVED)

850. SCHOOL-BASED SERVICE: DEFINITIONS.

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

02. Children's Habilitation Intervention Services (CHIS). CHIS are medically necessary, evidence-informed or evidence-based therapeutic techniques based on applied behavior analysis principles used to result in positive outcomes. These intervention services are delivered directly to Medicaid eligible students with identified developmental limitations that impact the student's functional skills and behaviors across an array of developmental domains. CHIS include habilitative skill building, behavioral intervention, behavioral consultation, crisis intervention, and interdisciplinary training services. ( )

03. Educational Services. Services that are provided in buildings, rooms, or areas designated or used as a school or an educational setting, which are provided during the specific hours and time periods in which the educational instruction takes place in the school day and period of time for these students, which are included in the individual educational plan (IEP) for the student. ( )

04. Evidence-Based Interventions. Interventions that have been scientifically researched and reviewed in peer reviewed journals, replicated successfully by multiple independent investigators, have been shown to produce measurable and substantiated beneficial outcomes, and are delivered with fidelity by certified or credentialed individuals trained in the evidence-based model. ( )

05. Evidence-Informed Interventions. Interventions that use elements or components of evidence-based techniques and are delivered by a qualified individual who are not certified or credentialed in an evidence-based model. ( )

06. Human Services Field. A diverse field that is focused on improving the quality of life for participants. Areas of academic study include sociology, special education, counseling, and psychology. or other areas of academic study as referenced in the Medicaid Provider Handbook. ( )

07. School-Based Services. School-based services are health-related and rehabilitative services provided by Idaho public school districts and charter schools under the Individuals with Disabilities Education Act (IDEA). ( )

08. The Psychiatric Rehabilitation Association (PRA). An association that works to improve and promote the practice and outcomes of psychiatric rehabilitation and recovery. The PRA also maintains a certification program to promote the use of qualified staff to work for individuals with mental illness. http://www.psychrehabassociation.org. ( )

09. PRA Credential. Certificate or certification in psychiatric rehabilitation based upon the primary population with whom the individual works in accordance with the requirements set by the PRA. ( )

10. Serious Mental Illness (SMI). In accordance with 42 CFR 483.102(b)(1), a person with SMI: ( )

a. Currently or at any time during the year, must have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet the diagnostic criteria specified in the DSM-V; and ( )

b. Must have a functional impairment that substantially interferes with or limits one (1) or more major life activities. Functional impairment is defined as difficulties that substantially interfere with or limit role functioning with an individual's basic daily living skills, instrumental living skills, and functioning in social, family, vocational or educational contexts. Instrumental living skills include maintaining a household, managing money, getting around the community, and taking prescribed medication. An adult who met the functional impairment criteria during the past year without the benefit of treatment or other support services is considered to have a serious mental illness. ( )

11. Serious and Persistent Mental Illness (SPMI). A participant must meet the criteria for SMI, have at least one (1) additional functional impairment, and have a diagnosis under DSM-V with one (1) of the following: Schizophrenia, Schizoaffective Disorder, Bipolar I Disorder, Bipolar II Disorder, Major Depressive Disorder Recurrent Severe, Delusional Disorder, or Borderline Personality Disorder. The only Not Otherwise Specified (NOS) diagnosis included is Psychotic Disorder NOS for a maximum of one hundred twenty (120) days without a conclusive diagnosis. ( )

851. SCHOOL-BASED SERVICE: PARTICIPANT ELIGIBILITY.
To be eligible for medical assistance reimbursement for covered services, school districts and charter schools must ensure: ( )

01. Medicaid Eligibility. Eligible for Medicaid and the service for which the school district or charter school is seeking reimbursement; ( )

02. School Enrollment. Enrolled in an Idaho school district or charter school; ( )

03. Age. Twenty-one (21) years of age or younger and the semester in which their twenty-first birthday falls is not finished; ( )

04. Educational Disability. Identified as having an educational disability under the Department of Education standards in IDAPA 08.02.03, "Rules Governing Thoroughness." ( )

05. Parental Consent. Providers must obtain a one-time parental consent to access public benefits or insurance from a parent or legal guardian for school-based Medicaid reimbursement. ( )

852. SCHOOL-BASED SERVICE: SERVICE-SPECIFIC PARTICIPANT ELIGIBILITY.
Skills Building/Community Based Rehabilitation Services (CBRS). CHIS and Personal Care Services (PCS) have additional eligibility requirements. ( )

01. Skills Building/Community Based Rehabilitation Services (CBRS). To be eligible for Skills Building/CBRS, the student must meet one (1) of the following: ( )

a. A student who is a child under eighteen (18) years of age must meet the Serious Emotional Disturbance (SED) eligibility criteria for children in accordance with the Children's Mental Health Services Act, Section 16-2403, Idaho Code. A child who meets the criteria for SED must experience a substantial impairment in functioning. The child's level and type of functional impairment must be documented in the school record. A Department-approved assessment must be used to obtain the child's initial functional impairment score. Subsequent scores must be obtained at least annually in order to determine the child's change in functioning that occurs as a result of mental health treatment. ( )

b. A student who is eighteen (18) years old or older must meet the criteria of Serious and Persistent Mental Illness (SPMI). This requires that a student participant meet the criteria for SMI, as described in 42 CFR 483.102(b)(1), have at least one (1) additional functional impairment, and have a diagnosis under DSM-V, or later edition, with one (1) of the following: Schizophrenia, Schizoaffective Disorder, Bipolar I Disorder, Bipolar II Disorder, Major Depressive Disorder Recurrent Severe, Delusional Disorder, or Borderline Personality Disorder. The only Not Otherwise Specified (NOS) diagnosis included is Psychotic Disorder NOS for a maximum of one hundred twenty (120) days without a conclusive diagnosis. In addition, the psychiatric disorder must be of sufficient severity to affect the participant's functional skills negatively, causing a substantial disturbance in role performance or coping

skills in at least two (2) of the areas listed below on either a continuous or intermittent basis, at least once per year. The skill areas that are targeted must be consistent with the participant's ability to engage and benefit from treatment. The detail of the participant's level and type of functional impairment must be documented in the medical record in the following areas: ( )

i. Vocational or educational; ( )

ii Financial; ( )

iii. Social relationships or support; ( )

iv. Family; ( )

v. Basic living skills; ( )

vi. Housing; ( )

vii. Community or legal; or ( )

viii. Health or medical. ( )

02. CHIS. Students eligible to receive habilitative skill building, behavioral intervention, behavioral consultation, crisis intervention, and interdisciplinary training services must have a standardized Department-approved assessment to identify functional, or behavioral needs, or both, that interfere with the student's ability to access an education or require intervention services to correct or ameliorate their condition in accordance with Section 880 of these rules. ( )

a. A functional need is determined when the student exhibits a deficit in an overall adaptive composite or deficits in three (3) or more of the following areas: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency. A deficit is defined as one point five (1.5) or more standard deviations below the mean for all functional areas. ( )

b. A behavioral need is determined when the student exhibits maladaptive behaviors that include frequent disruptive behaviors, aggression, self-injury, criminal or dangerous behavior evidenced by a score of at least one point five (1.5) standard deviations from the mean in at least two (2) behavior domains and by a rater familiar with the student, or at least two (2) standard deviations from the mean in one (1) composite score that consists of at least three (3) behavior domains by a rater familiar with the student, on a standardized behavioral assessment approved by the Department. ( )

03. Personal Care Services. To be eligible for personal care services (PCS), the student must have a completed children's PCS assessment and allocation tool approved by the Department. To determine eligibility for PCS, the assessment results must find the student requires PCS due to a medical condition that impairs the physical or functional abilities of the student. ( )

853. SCHOOL-BASED SERVICE: COVERAGE AND LIMITATIONS.
The Department will pay school districts and charter schools for covered rehabilitative and health-related services. Services include medical or remedial services provided by school districts or other cooperative service agencies, as defined in Section 33-317, Idaho Code. ( )

01. Excluded Services. The following services are excluded from Medicaid payments to school-based programs: ( )

a. Vocational Services. ( )

b. Educational Services. Educational services (other than health related services) or education-based costs normally incurred to operate a school and provide an education. Evaluations completed for educational services only cannot be billed. ( )

c. Recreational Services. ( )

d. Payment for school-related services will not be provided to students who are inpatients in nursing homes or hospitals. ( )

02. Evaluation and Diagnostic Services. Evaluations to determine eligibility or the need for health-related services may be reimbursed even if the student is not found eligible for health-related services. Evaluations completed for educational services only cannot be billed. Evaluations completed must: ( )

a. Be recommended or referred by a physician or other licensed practitioner of the healing arts. A school district or charter school may not seek reimbursement for services provided more than thirty (30) days prior to the signed and dated recommendation or referral; ( )

b. Be conducted by qualified professionals for the respective discipline as defined in Section 855 of these rules; ( )

c. Be directed toward a diagnosis; ( )

d. Include recommended interventions to address each need; and ( )

e. Include name, title, and signature of the person conducting the evaluation. ( )

03. Reimbursable Services. School districts and charter schools can bill for the following health-related services provided to eligible students when the services are provided under the recommendation of a physician or other non-physician practitioner of the healing arts for the Medicaid services for which the school district or charter school is seeking reimbursement. A school district or charter school may not seek reimbursement for services provided more than thirty (30) days prior to the signed and dated recommendation or referral. The recommendations or referrals are valid up to three hundred sixty-five (365) days. ( )

a. Behavioral Intervention. Behavioral Intervention is a direct intervention used to promote positive, meaningful changes in behavior that incorporate functional replacement behaviors and reinforcement-based strategies, while also addressing any identified habilitative skill building needs and the student's ability to participate in educational services, as defined in Section 850 of these rules, through a consistent, assertive, and continuous intervention process to address behavior goals identified on the IEP. Behavioral intervention includes conducting a functional behavior assessment and developing a behavior implementation plan with the purpose of preventing or treating behavioral conditions. This service is provided to students who exhibit maladaptive behaviors. Services include individual or group behavioral interventions. ( )

i. Group services must be provided by one (1) qualified staff providing direct services for up to six (6) students. ( )

ii. As the number and severity of the students with behavioral issues increases, the student ratio in the group must be adjusted accordingly. ( )

iii. Group services should only be delivered when the student's goals relate to benefiting from group interaction. ( )

b. Behavioral Consultation. Behavioral consultation assists other service professionals by consulting with the IEP team during the assessment process, performing advanced assessment, coordinating the implementation of the behavior implementation plan and providing ongoing training to the behavioral interventionist and other team members. ( )

i. Behavioral consultation cannot be provided as a direct intervention service. ( )

ii. Behavioral consultation must be limited to thirty-six (36) hours per student per year. ( )

c. Crisis Intervention. Crisis intervention services may include providing training to staff directly involved with the student, delivering intervention directly with the eligible student, and developing a crisis plan that directly addresses the behavior occurring and the necessary intervention strategies to minimize the behavior and future occurrences. This service is provided on a short-term basis typically not to exceed thirty (30) school days and is available for students who have an unanticipated event, circumstance, or life situation that places a student at risk of at least one (1) of the following: ( )

i. Hospitalization; ( )

ii. Out-of-home placement; ( )

iii. Incarceration; or ( )

iv. Physical harm to self or others, including a family altercation or psychiatric relapse. ( )

d. Habilitative Skill Building. Habilitative skill building is a direct intervention service that includes techniques used to develop, improve and maintain, to the maximum extent possible, the developmentally appropriate functional abilities and daily living skills needed by a student. This service may include teaching and coordinating methods of training with family members or others who regularly participate in caring for the eligible student. Services include individual or group interventions. ( )

i. Group services must be provided by one (1) qualified staff providing direct services for up to six (6) students. ( )

ii. As the number and needs of the students increase, the student ratio in the group must be adjusted accordingly. ( )

iii. Group services should only be delivered when the student's goals relate to benefiting from group interaction. ( )

e. Interdisciplinary Training. Interdisciplinary training is a companion service to behavioral intervention and habilitative skill building and is used to assist with implementing a student's health and medication monitoring, positioning and physical transferring, use of assistive equipment, and intervention techniques in a manner that meets the student's needs. This service is to be utilized for collaboration, with the student present, during the provision of services between the intervention specialist or professional and a Speech Language and Hearing Professional (SLP), Physical Therapist (PT), Occupational Therapist (OT), medical professional, or behavioral or mental health professional. ( )

f. Medical Equipment and Supplies. Medical equipment and supplies that are covered by Medicaid must be medically necessary, ordered by a physician or non-physician practitioner, and prior authorized. Authorized items must be for use at the school where the service is provided. Equipment that is too large or unsanitary to transport from home to school and back may be covered, if prior authorized. The equipment and supplies must be for the student's exclusive use and must be transferred with the student if the student changes schools. All equipment purchased by Medicaid belongs to the student. ( )

g. Nursing Services. Skilled nursing services must be provided by a licensed nurse, within the scope of his or her practice. Emergency, first aid, or non-routine medications not identified on the plan as a health-related service are not reimbursed. ( )

h. Occupational Therapy and Evaluation. Occupational therapy and evaluation services for vocational assessment, training or vocational rehabilitation are not reimbursed. ( )

i. Personal Care Services. School based personal care services include medically oriented tasks having to do with the student's physical or functional requirements. Personal care services do not require a goal on the plan of service. The provider must deliver at least one (1) of the following services: ( )

i. Basic personal care and grooming to include bathing, care of the hair, assistance with clothing, and

basic skin care; ( )

ii. Assistance with bladder or bowel requirements that may include helping the student to and from the bathroom or assisting the student with bathroom routines; ( )

iii. Assistance with food, nutrition, and diet activities including preparation of meals if incidental to medical need; ( )

iv. Assisting the student with physician-ordered medications that are ordinarily self-administered, in accordance with IDAPA 24.34.01, "Rules of the Idaho Board of Nursing," Subsection 490.05; ( )

v. Non-nasogastric gastrostomy tube feedings, if the task is not complex and can be safely performed in the given student care situation, and the requirements are met in accordance with IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Subsection 303.01. ( )

j. Physical Therapy and Evaluation. ( )

k. Psychological Evaluation. ( )

l. Psychotherapy. ( )

m. Skills Building/Community Based Rehabilitation Services (CBRS). Skills Building/CBRS are interventions to reduce the student's disability by assisting in gaining and utilizing skills necessary to participate in school. They are designed to build competency and confidence while increasing mental health and/or decreasing behavioral symptoms. Skills Building/CBRS provides training in behavior control, social skills, communication skills, appropriate interpersonal behavior, symptom management, activities of daily living, and coping skills. These services are intended to prevent placement of the student into a more restrictive educational situation. ( )

n. Speech/Audiological Therapy and Evaluation. ( )

o. Social History and Evaluation. ( )

p. Transportation Services. School districts and charter schools can receive reimbursement for mileage for transporting a student to and from home and school when: ( )

i. The student requires special transportation assistance, a wheelchair lift, an attendant, or both, when medically necessary for the health and safety of the student; ( )

ii. The transportation occurs in a vehicle specifically adapted to meet the needs of a student with a disability; ( )

iii. The student requires and receives another Medicaid reimbursable service billed by the school-based services provider, other than transportation, on the day that transportation is being provided; ( )

iv. Both the Medicaid-covered service and the need for the special transportation are included on the student's plan; and ( )

v. The mileage, as well as the services performed by the attendant, are documented. See Section 855 of these rules for documentation requirements. ( )

q. Interpretive Services. Interpretive services needed by a student who is deaf or does not adequately speak or understand English and requires an interpreter to communicate with the professional or paraprofessional providing the student with a health-related service may be billed with the following limitations: ( )

i. Payment for interpretive services is limited to the specific time that the student is receiving the health-related service; documentation for interpretive service must include the Medicaid reimbursable health-related service being provided while the interpretive service is provided. ( )

ii. Both the Medicaid-covered service and the need for interpretive services must be included on the student's plan; and ( )

iii. Interpretive services are not covered if the professional or paraprofessional providing services is able to communicate in the student's primary language. ( )

854. SCHOOL-BASED SERVICE: PROCEDURAL REQUIREMENTS.
The following documentation must be maintained by the provider and retained for a period of five (5) years: ( )

01. Individualized Education Program (IEP) and Other Service Plans. School districts and charter schools may bill for Medicaid services covered by a current Individualized Education Program (IEP), transitional Individualized Family Service Plan (IFSP), or Services Plan (SP) defined in the Idaho Special Education Manual on the State Department of Education website for parentally placed private school students with disabilities when designated funds are available for special education and related services. The plan must be developed within the previous three hundred sixty-five (365) days which indicates the need for one (1) or more medically-necessary health-related service, and lists all the Medicaid reimbursable services for which the school district or charter school is requesting reimbursement. The IEP and transitional IFSP must include: ( )

a. Type, frequency, and duration of the service(s) provided; ( )

b. Title of the provider(s), including the direct care staff delivering services under the supervision of the professional; ( )

c. Measurable goals, when goals are required for the service; and ( )

d. Specific place of service, if provided in a location other than school. ( )

02. Evaluations and Assessments. Evaluations and assessments must: ( )

a. Support services billed to Medicaid; and ( )

b. Accurately reflect the student’s current status. ( )

03. Service Detail Reports. A service detail report that includes: ( )

a. Name of student; ( )

b. Name, title, and signature of the person providing the service; ( )

c. Date, time, and duration of service; ( )

d. Place of service, if provided in a location other than school; ( )

e. Category of service and brief description of the specific areas addressed; and ( )

f. Student’s response to the service when required for the service. ( )

04. One Hundred Twenty Day Review. A documented review of progress toward each service plan goal completed at least every one hundred twenty (120) days from the date of the annual plan. ( )

05. Documentation of Qualifications of Providers. ( )

06. Copies of Required Referrals and Recommendations. Copies of required referrals and recommendations. ( )

a. School-based services must be recommended or referred by a physician or other licensed practitioner of the healing arts for all Medicaid services for which the school district or charter school is receiving reimbursement. ( )

b. A recommendation or referral must be obtained within thirty (30) days of the provision of services for which the school district or charter school is seeking reimbursement. Therapy requirements for the order are identified in Section 733 of these rules. ( )

c. A recommendation or referral must be obtained for the service at least every three hundred sixty-five (365) days. ( )

07. Parental Notification. School districts and charter schools must document that parents were notified of the health-related services and equipment for which they will bill Medicaid. Notification must comply with the requirements in Subsection 854.08 of this rule. ( )

08. Requirements for Cooperation with and Notification of Parents and Agencies. Each school district or charter school billing for Medicaid services must act in cooperation with students' parent or guardian, and with community and state agencies and professionals who provide like Medicaid services to the student. ( )

a. Notification of Parents. For all students who are receiving Medicaid reimbursed services, school districts and charter schools must document that parents are notified of the Medicaid services and equipment for which they will bill Medicaid. Notification must describe the service(s), service provider(s), and state the type, location, frequency, and duration of the service(s). The school district must document that they provided the student's parent or guardian with a current copy of the child's plan and any pertinent addenda; and ( )

b. Primary Care Provider (PCP). School districts and charter schools must request the name of the student's PCP and request a written consent to release and obtain information between the PCP and the school from the parent or guardian. ( )

c. Other Community and State Agencies. Upon receiving a request for a copy of the evaluations or the current plan, the school district or charter school must furnish the requesting agency or professional with a copy of the plan or appropriate evaluation after obtaining consent for release of information from the student's parent or guardian. ( )

855. SCHOOL-BASED SERVICE: PROVIDER QUALIFICATIONS AND DUTIES.
Medicaid will only reimburse for services provided by qualified staff. The following are the minimum qualifications for providers of covered services: ( )

01. Behavioral Intervention. Behavioral intervention must be provided by, or under the supervision of, an intervention specialist or professional. Individuals providing behavioral intervention must be one (1) of the following: ( )

a. Intervention Paraprofessional. Intervention paraprofessionals may provide direct services. The specialist or professional must observe and review the direct services performed by the paraprofessional monthly, or more often as necessary, to ensure the paraprofessional demonstrates the necessary skills to correctly provide the direct service. An intervention paraprofessional under the direction of a qualified intervention specialist or professional must: ( )

i. Be at least eighteen (18) years of age; ( )

ii. Demonstrate the knowledge, have the skills needed to support the program to which they are assigned; and ( )

iii. Meet the paraprofessional requirements as defined in IDAPA 08.02.02, "Rules Governing Uniformity." ( )

b. Intervention Technician. Intervention technician is a provisional position intended to allow an

individual to gain the necessary degree, competency, or experience needed to qualify as an intervention specialist or higher. Provisional status is limited to a single eighteen (18) successive month period. The specialist or professional must observe and review the direct services performed by the technician monthly, or more often as necessary, to ensure the technician demonstrates the necessary skills to correctly provide the direct service. An intervention technician under the direction of a qualified intervention specialist or professional, must: ( )

i. Be an individual who is currently enrolled and is within twenty-four (24) semester credits, or equivalent, to complete their bachelor's degree or higher from an accredited institution in a human services field and working towards meeting the experience and competency requirements; or ( )

ii. Hold a bachelor's degree from an accredited institution in a human services field or a has a bachelor's degree and a minimum of twenty-four (24) semester credits, or equivalent, in a human services field and working towards meeting the experience and competency requirements. ( )

c. Intervention Specialist. Intervention specialists may provide direct services, complete assessments, and develop implementation plans. Intervention specialists who will complete assessments must have documented training and experience in completing assessments and designing and implementing comprehensive therapies for students with functional or behavioral needs, or both. The qualifications for this provider type can be met by one (1) of the following: ( )

i. An individual who holds an Idaho Standard Instructional Certificate who meets qualifications for an endorsement specific to special education as defined in IDAPA 08.02.02, “Rules Governing Uniformity,” Sections 021-024; or ( )

ii. An individual who holds a Habilitative Intervention Certificate of Completion in Idaho with an expiration date of July 1, 2019 or later, and does not have a gap of more than three (3) years of employment as an intervention specialist, or ( )

iii. An individual who holds a bachelor's degree from an accredited institution in a human services field or has a bachelor's degree and a minimum of twenty-four (24) semester credits in a human services field, can demonstrate one thousand forty (1,040) hours of supervised experience working with children who demonstrate functional or behavioral needs, and meets the competency requirements by completing one (1) of the following: ( )

(1) A Department-approved competency checklist referenced in the Medicaid Provider Handbook; ( )

(2) A minimum of forty (40) hours of applied behavior analysis training delivered by an individual who is certified or credentialed to provide the training; or ( )

(3) Other Department-approved competencies as defined in the Medicaid Provider Handbook. ( )

d. Intervention Professional. Intervention professionals may provide direct services, complete assessments, and develop implementation plans. Intervention professionals who will complete assessments must have documented training and experience in completing assessments and designing and implementing comprehensive therapies for students with functional or behavioral needs, or both. The qualifications for this provider type can be met by one (1) of the following: ( )

i. An individual who holds a master's degree or higher from an accredited institution in psychology, education, applied behavior analysis, or have a related discipline with one thousand five hundred (1,500) hours of relevant coursework or training, or both, in principles of child development, learning theory, positive behavior support techniques, dual diagnosis psychology, education, or behavior analysis which may be documented within the individual's degree program, other coursework, or training; and ( )

ii. Have one thousand two hundred (1,200) hours of relevant experience in completing and implementing comprehensive behavioral therapies for participants with functional or behavioral needs, which may be

documented within the individual's degree program, other coursework, or training. ( )

e. Evidence-Based Model (EBM) Intervention Paraprofessional. EBM intervention paraprofessionals may provide direct services. EBM intervention paraprofessionals must be supervised in accordance with the evidence-based model in which they are certified or credentialed. The EBM intervention specialist or professional must observe and review the direct services performed by the paraprofessional to ensure the paraprofessional demonstrates the necessary skills to correctly provide the direct service. An EBM intervention paraprofessional must: ( )

i. Hold a high school diploma; and ( )

ii. Hold a para-level certification or credential in an evidence-based model approved by the Department. ( )

f. Evidence- Based Model (EBM) Intervention Specialist. EBM intervention specialists may provide direct services, complete assessments, and develop implementation plans. EBM intervention specialists must be supervised in accordance with the evidence-based model in which they are certified or credentialed. The EBM intervention professional must observe and review the direct services performed by the specialist to ensure the specialist demonstrates the necessary skills to correctly provide the direct service. The specialist may supervise the EBM intervention paraprofessional working within the same evidence-based model. An EBM intervention specialist must: ( )

i. Hold a bachelor's degree from an accredited institution in accordance with their certification or credentialing requirements; and ( )

ii. Hold a bachelors-level certification or credential in an evidence-based model approved by the Department. ( )

g. Evidence-Based Model (EBM) Intervention Professional. EBM intervention professionals may provide direct services, complete assessments, and develop implementation plans. EBM intervention professionals may supervise EBM intervention paraprofessionals or specialists working within the same evidence-based model in which they are certified or credentialed. An EBM intervention professional must: ( )

i. Hold a master's degree or higher from an accredited institution in accordance with their certification or credentialing requirements; and ( )

ii. Hold a masters-level certification or credential in an evidence-based model approved by the Department. ( )

02. Behavioral Consultation. Behavioral consultation must be provided by a professional who has a Doctoral or Master’s degree in psychology, education, applied behavioral analysis, or has a related discipline with one thousand five hundred (1,500) hours of relevant coursework or training, or both, in principles of child development, learning theory, positive behavior support techniques, dual diagnosis psychology, education, or behavior analysis (may be included as part of degree program); and who meets one (1) of the following: ( )

a. An individual who holds an Idaho Standard Instructional Certificate who meets qualifications for an endorsement specific to special education as defined in IDAPA 08.02.02, “Rules Governing Uniformity”; ( )

b. An individual with a Pupil Personnel Certificate who meets the qualifications defined under IDAPA 08.02.02, “Rules Governing Uniformity,” excluding a licensed registered nurse or audiologist; ( )

c. An occupational therapist who is qualified and registered to practice in Idaho; ( )

d. An intervention professional, as defined in Subsection 855.01 of this rule; or ( )

e. An EBM intervention professional, as defined in Subsection 855.01 of this rule. ( )

03. Crisis Intervention. Crisis intervention must be provided by, or under the supervision of an intervention specialist or professional. Individuals providing crisis intervention must be one (1) of the following: ( )

a. An intervention paraprofessional, as defined in Subsection 855.01 of this rule; ( )

b. An intervention technician, as defined in Subsection 855.01 of this rule; ( )

c. An intervention specialist, as defined in Subsection 855.01 of this rule; ( )

d. An intervention professional, as defined in Subsection 855.01 of this rule; ( )

e. An EBM intervention paraprofessional, as defined in Subsection 855.01 of this rule; ( )

f. An EBM intervention specialist, as defined in Subsection 855.01 of this rule; ( )

g. An EBM intervention professional, as defined in Subsection 855.01 of this rule; ( )

h. A licensed physician, licensed practitioner of the healing arts; ( )

i. An advanced practice registered nurse; ( )

j. A licensed psychologist; ( )

k. A licensed clinical professional counselor or professional counselor; ( )

l. A licensed marriage and family therapist; ( )

m. A licensed masters social worker, licensed clinical social worker, or licensed social worker; ( )

n. A psychologist extender registered with the Bureau of Occupational Licenses; ( )

o. A licensed registered nurse (RN); ( )

p. A licensed occupational therapist; or ( )

q. An endorsed or certified school psychologist. ( )

04. Habilitative Skill Building. Habilitative skill building must be provided by, or under the supervision of, an intervention specialist or professional. Individuals providing habilitative skill building must be one (1) of the following: ( )

a. An intervention paraprofessional, as defined in Subsection 855.01 of this rule; ( )

b. An intervention technician, as defined in Subsection 855.01 of this rule; ( )

c. An intervention specialist, as defined in Subsection 855.01 of this rule; ( )

d. An intervention professional, as defined in Subsection 855.01 of this rule; ( )

e. An EBM intervention paraprofessional, as defined in Subsection 855.01 of this rule; ( )

f. An EBM intervention specialist, as defined in Subsection 855.01 of this rule; or ( )

g. An EBM intervention professional, as defined in Subsection 855.01 of this rule. ( )

05. Interdisciplinary Training. Interdisciplinary Training must be provided by one (1) of the following: ( )

a. An intervention specialist, as defined in Subsection 855.01 of this rule; ( )

b. An intervention professional, as defined in Subsection 855.01 of this rule; ( )

c. An EBM intervention specialist, as defined in Subsection 855.01 of this rule; ( )

d. An EBM intervention professional, as defined in Subsection 855.01 of this rule. ( )

06. Medical Equipment and Supplies. See Subsection 853.03 of these rules. ( )

07. Nursing Services. Nursing services must be provided by a licensed registered nurse (RN) or by a licensed practical nurse (LPN) licensed to practice in Idaho. ( )

08. Occupational Therapy and Evaluation. For therapy-specific rules, refer to Sections 730 through 739 of these rules. ( )

09. Personal Care Services. Personal care services must be provided by or under the direction of a registered nurse licensed by the State of Idaho. ( )

a. Providers of PCS must have at least one (1) of the following qualifications: ( )

i. Licensed Registered Nurse (RN). A person currently licensed by the Idaho State Board of Nursing as a licensed registered nurse; ( )

ii. Licensed Practical Nurse (LPN). A person currently licensed by the Idaho State Board of Nursing as a licensed practical nurse; ( )

iii. Certified Nursing Assistant (CNA). A person currently certified by the State of Idaho; or ( )

iv. Personal Assistant. A person who meets the standards of Section 39-5603, Idaho Code, and receives training to ensure the quality of services. The assistant must be at least age eighteen (18) years of age. ( )

b. The licensed registered nurse (RN) must review or complete, or both, the PCS assessment and develop or review, or both, the written plan of care annually. Oversight provided by the RN must include all of the following: ( )

i. Development of the written PCS plan of care; ( )

ii. Review of the treatment given by the personal assistant through a review of the student's PCS service detail reports as maintained by the provider; and ( )

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

c. The RN must conduct supervisory visits on a quarterly basis, or more frequently as determined by the IEP team and defined as part of the PCS plan of care. ( )

10. Physical Therapy and Evaluation. For therapy-specific rules, refer to Sections 730 through 739 of these rules. ( )

11. Psychological Evaluation. A psychological evaluation must be provided by a: ( )

a. Licensed psychiatrist; ( )

b. Licensed physician; ( )

c. Licensed psychologist; ( )

d. Psychologist extender registered with the Bureau of Occupational Licenses; or ( )

e. Endorsed or certified school psychologist. ( )

12. Psychotherapy. Provision of psychotherapy services must have, at a minimum, one (1) or more of the following credentials: ( )

a. Psychiatrist, M.D.; ( )

b. Physician, M.D.; ( )

c. Licensed psychologist; ( )

d. Licensed clinical social worker; ( )

e. Licensed clinical professional counselor; ( )

f. Licensed marriage and family therapist; ( )

g. Certified psychiatric nurse (R.N.), as described in Subsection 707.13 of these rules; ( )

h. Licensed professional counselor whose provision of psychotherapy is supervised in compliance with IDAPA 24.15.01, "Rules of the Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists"; ( )

i. Licensed masters social worker whose provision of psychotherapy is supervised as described in IDAPA 24.14.01, "Rules of the State Board of Social Work Examiners"; ( )

j. Licensed associate marriage and family therapist whose provision of psychotherapy is supervised as described in IDAPA 24.15.01, "Rules of the Idaho Licensing Board of Professional Counselors and Marriage and Family Therapists"; or ( )

k. Psychologist extender, registered with the Bureau of Occupational Licenses, whose provision of diagnostic services is supervised in compliance with IDAPA 24.12.01, "Rules of the Idaho State Board of Psychologist Examiners." ( )

13. Skills Building/Community Based Rehabilitation Services (CBRS). Skills Building/CBRS must be provided by one (1) of the following. Skills Building/Community Based Rehabilitation Services (CBRS) provider who is not required to have a PRA credential or credential required for CBRS specialists must be one (1) of the following: ( )

a. Licensed physician, licensed practitioner of the healing arts; ( )

b. Advanced practice registered nurse; ( )

c. Licensed psychologist; ( )

d. Licensed clinical professional counselor or professional counselor; ( )

e. Licensed marriage and family therapist; ( )

f. Licensed masters social worker, licensed clinical social worker, or licensed social worker; ( )

g. Psychologist extender registered with the Bureau of Occupational Licenses; ( )

h. Licensed registered nurse (RN); ( )

i. Licensed occupational therapist; ( )

j. Endorsed or certified school psychologist; ( )

k. Skills Building/Community Based Rehabilitation Services specialist. A Skills Building/CBRS specialist must: ( )

i. Be an individual who has a bachelor's degree and holds a current PRA credential; or ( )

ii. Be an individual who has a bachelor's degree or higher and is under the supervision of a licensed behavioral health professional, a physician, nurse, or an endorsed or certified school psychologist. The supervising practitioner is required to have regular one-to-one (1:1) supervision of the specialist to review treatment provided to student participants on an ongoing basis. The frequency of the one-to-one (1:1) supervision must occur at least monthly. Supervision can be conducted using telehealth when it is equally effective as direct on-site supervision; and ( )

iii. Have a credential required for CBRS specialists. ( )

14. Speech/Audiological Therapy and Evaluation. For therapy-specific rules, refer to Sections 730 through 739 of these rules. ( )

15. Social History and Evaluation. Social history and evaluation must be provided by a licensed registered nurse (RN), psychologist, M.D, school psychologist, certified school social worker, or by a person who is licensed and qualified to provide social work in the state of Idaho. ( )

16. Transportation. Transportation must be provided by an individual who has a current Idaho driver's license and is covered under vehicle liability insurance that covers passengers for business use. ( )

17. Therapy Paraprofessionals. The schools may use paraprofessionals to provide occupational therapy, physical therapy, and speech therapy if they are under the supervision of the appropriate professional. The services provided by paraprofessionals must be delegated and supervised by a professional therapist as defined by the appropriate licensure and certification rules. The portions of the treatment plan that can be delegated to the paraprofessional must be identified in the IEP or transitional IFSP. ( )

a. Occupational Therapy (OT). Refer to IDAPA 24.06.01, "Rules for the Licensure of Occupational Therapists and Occupational Therapy Assistants," for qualifications, supervision, and service requirements. ( )

b. Physical Therapy (PT). Refer to IDAPA 24.13.01, "Rules Governing the Physical Therapy Licensure Board," for qualifications, supervision and service requirements. ( )

c. Speech-Language Pathology (SLP). Refer to IDAPA 24.23.01, "Rule of the Speech and Hearing Services Licensure Board," and the American Speech-Language-Hearing Association (ASHA) guidelines for qualifications, supervision and service requirements for speech-language pathology. The guidelines have been incorporated by reference in Section 004 of these rules. ( )

i. Supervision must be provided by an SLP professional as defined in Section 734 of this chapter of rules. ( )

ii. The professional must observe and review the direct services performed by the paraprofessional monthly, or more often as necessary, to ensure the paraprofessional demonstrates the necessary skills to correctly provide the SLP service. ( )

856. SCHOOL-BASED SERVICE: PROVIDER REIMBURSEMENT.
Payment for health-related services provided by school districts and charter schools must be in accordance with rates established by the Department. ( )

01. Payment in Full. Providers of services must accept as payment in full the school district or charter school payment for such services and must not bill Medicaid or Medicaid participants for any portion of any charges. ( )

02. Third Party. For requirements regarding third party billing, see Section 215 of these rules. ( )

03. Recoupment of Federal Share. Failure to provide services for which reimbursement has been received or to comply with these rules will be cause for recoupment of the Federal share of payments for services, sanctions, or both. ( )

04. Matching Funds. Federal funds cannot be used as the State's portion of match for Medicaid service reimbursement. School districts and charter schools must, for their own internal record keeping, calculate and document the non-federal funds (maintenance of effort assurance) that have been designated as their certified match. This documentation needs to include the source of all funds that have been submitted to the State and the original source of those dollars. The appropriate matching funds will be handled in the following manner: ( )

a. Schools will estimate the amount needed to meet match requirements based on their anticipated monthly billings. ( )

b. School districts and charter schools will send the Department the matching funds, either by check or automated clearing house (ACH) electronic funds transfers. ( )

c. The Department will hold matching funds in an interest bearing trust account. The average daily balance during a month must exceed one hundred dollars ($100) in order to receive interest for that month. ( )

d. The payments to the districts will include both the federal and non-federal share (matching funds). ( )

e. Matching fund payments must be received and posted in advance of the weekly Medicaid payment cycle. ( )

f. If sufficient matching funds are not received in advance, all Medicaid payments to the school district will be suspended and the school district will be notified of the shortage. Once sufficient matching funds are received, suspended payments will be processed and reimbursement will be made during the next payment cycle. ( )

g. The Department will provide the school districts a monthly statement that will show the matching amounts received, interest earned, total claims paid, the matching funds used for the paid claims, and the balance of their funds in the trust account. ( )

h. The school districts will estimate the amount of their next billing and the amount of matching funds needed to pay the Department. ( )

i. The estimated match requirement may be adjusted up or down based on the remaining balance held in the trust account. ( )

857. SCHOOL-BASED SERVICE: QUALITY ASSURANCE AND IMPROVEMENT.
The provider will grant the Department immediate access to all information required to review compliance with these rules. ( )

01. Quality Assurance. Quality Assurance consists of reviews to assure compliance with the Department’s rules and regulations. If problems are identified during the review, the provider must implement a

corrective action plan within forty-five (45) days after the results are received. The Department will work with the school to answer questions and provide clear direction regarding the corrective action plan. ( )

02. Quality Improvement. The Department may gather and utilize information from providers to evaluate student satisfaction, outcomes monitoring, quality assurance, quality improvement activities, and health and safety. These findings may lead to quality improvement activities to improve provider processes and outcomes for the students. ( )

858. -- 859. (RESERVED)

SUB AREA: MEDICAL TRANSPORTATION SERVICES
(Sections 860-879)

860. (RESERVED)

861. EMERGENCY TRANSPORTATION SERVICES: PARTICIPANT ELIGIBILITY.
Ambulance services are medically necessary when an emergency condition exists. For purposes of reimbursement, an emergency condition exists when a participant manifests acute symptoms or signs, or both, which, by reasonable medical judgment of the Department, 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, or serious jeopardy to the overall health of the participant. If such condition exists, and treatment is required at the participant's location, or transport of the participant 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. ( )

862. EMERGENCY TRANSPORTATION SERVICES: COVERAGE AND LIMITATIONS.

01. Prior Authorization. Medically necessary ambulance services are reimbursable in emergency situations or when prior authorization has been obtained from the Department. ( )

02. Local Transport Only. Only local transportation by ambulance is covered. In exceptional situations where the ambulance transportation originates beyond the locality to which the participant 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. ( )

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

a. The point of pickup is inaccessible by land vehicle; or ( )

b. Great distances or other obstacles are involved in getting the participant to the nearest appropriate facility and speedy admission is essential; and ( )

c. Air ambulance service will be covered where the participant'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. ( )

04. Co-Payments. When the Department determines that the participant did not require emergency transportation, the provider can bill the participant for the co-payment amount as described in IDAPA 16.03.18, "Medicaid Cost-Sharing." ( )

863. EMERGENCY TRANSPORTATION SERVICES: PROCEDURAL REQUIREMENTS.

01. Services Subject to Review. Ambulance services are subject to review by the Department prior to the service being rendered, and on a retrospective basis. ( )

02. Non-Emergency Transport Prior Authorization Required. If an emergency does not exist, prior

written authorization to transport by ambulance must be secured from the Department. ( )

03. Air Ambulance. Air ambulance services must be approved in advance by the Department, except in emergency situations. Emergency air ambulance services will be authorized by the Department on a retrospective basis. ( )

864. EMERGENCY TRANSPORTATION SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.

01. Medically Necessary. For purposes of reimbursement, in non-emergency situations, the provider must provide justification to the Department that travel by ambulance is medically necessary due to the medical condition of the participant, and that any other mode of travel would, by reasonable medical judgment of the Department, result in death, serious impairment of a bodily function or major organ, or serious jeopardy to the overall health of the participant. ( )

02. Licensure Required. All Emergency Medical Services (EMS) Providers that provide services to Medicaid participants in Idaho must hold a current license issued by the Emergency Medical Services Bureau of the Department in accordance with IDAPA 16.01.03, "Emergency Medical Services (EMS) Agency Licensing Requirements," and IDAPA 16.01.07, "Emergency Medical Services (EMS) Personnel Licensing Requirements." 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. ( )

03. Usual Charges. Ambulance services providers cannot charge Medicaid participants more than is charged to the general public for the same service. ( )

04. Air Ambulance. The operator of the air service must bill the air ambulance service rather than the hospital or other facility receiving the participant. ( )

865. EMERGENCY TRANSPORTATION SERVICES: PROVIDER REIMBURSEMENT.

01. Scope of Coverage and General Requirements for Ambulance Services. 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 will be made if such decision is reversed by the appeals process required in IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings." Payment for ambulance services is subject to the following limitations: ( )

02. Ambulance Reimbursement. ( )

a. The base rate for ambulance services includes customary patient care equipment and items such as stretchers, clean linens, reusable devices and equipment. The base rate also includes nonreusable items, and disposable supplies such as oxygen, triangular bandages and dressings that may be required for the care of the participant during transport. In addition to the base rate, the Department will reimburse mileage. ( )

b. Charges for extra attendants are not covered except for justified situations and must be authorized by the Department. ( )

c. If a physician is in attendance during transport, they are responsible for the billing of their services. ( )

d. Reimbursement for waiting time will not be considered unless documentation submitted to the Department 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. ( )

e. 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 maintain. At least this level of personnel is required to be in the patient compartment of the vehicle for every ambulance trip. The Department will reimburse a

base rate according to the following: ( )

i. The level of personnel required to be in the patient compartment of the ambulance; ( )

ii. The level of ambulance license the unit has been issued; and ( )

iii. The level of life support authorized by the Department. ( )

f. Units with Emergency Medical Technician - Basic (EMT-B) or equivalent personnel in the patient compartment of the vehicle will be reimbursed up to 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 up to the Advanced Life Support, Level I (ALSI) rate. Units with Emergency Medical Technician - Paramedic (EMT-P) or equivalent personnel in the patient compartment of the vehicle will be reimbursed up to the Advanced Life Support, Level II (ALSII) rate. When a participant's condition requires hospital-to-hospital transport with ongoing care that must be furnished by one (1) or more health care professionals in an appropriate specialty area, including emergency or critical care nursing, emergency medicine, or a paramedic with additional training, Specialty Care Transport (SCT) may be authorized by the Department. ( )

g. If multiple licensed EMS providers are involved in the transport of a participant, only the ambulance provider who actually transports the participant will be reimbursed for the services. ( )

i. In situations where personnel and equipment from a licensed ALSII provider boards an ALSI or BLS ambulance, the transporting ambulance may bill for ALSII services as authorized by the Department. ( )

ii. In situations where personnel and equipment from a licensed ALSI provider boards an ALSII or BLS ambulance, the transporting ambulance may bill for ALSI services as authorized by the Department. ( )

iii. In situations where medical personnel and equipment from a medical facility are present during the transport of the participant, the transporting ambulance may bill at the ALSI or ALSII 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 ALSI, ALSII, or BLS ground ambulance at some point, and the air ambulance medical personnel also accompany and treat the participant 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. ( )

iv. The ground ambulance provider may also bill for their part of the trip as authorized by the Department. ( )

h. If multiple licensed EMS providers transport a participant for different legs of a trip, each provider must bill their base rate and mileage, as authorized by the Department. ( )

i. If a licensed transporting EMS provider responds to an emergency situation and treats the participant, but does not transport the participant, the Department may reimburse for the treat and release service. The Department will reimburse the appropriate base rate. This service requires authorization from the Department, usually on a retrospective basis. ( )

j. If an ambulance vehicle and crew have returned to a base station after having transported a participant to a facility and the participant's physician orders the participant 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. ( )

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 participant is an in-patient. The transport must be to and from a facility that is the nearest one with the specialized services. ( )

l. If a licensed transporting EMS provider responds to a participant's location and upon examination and evaluation of the participant, finds that their 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, usually on a retrospective basis. No payment will be made if the EMS provider responds and no evaluation is done, or the participant has left the scene. No payment will be made to an EMS provider who is licensed as a non-transporting provider. ( )

866. -- 869. (RESERVED)

870. NON-EMERGENCY MEDICAL TRANSPORTATION SERVICES: DEFINITIONS.
For the purposes of Sections 870 through 879 of these rules, the following definitions apply. ( )

01. Contracted Transportation Provider. A non-emergency medical transportation provider who is under contract with the transportation broker to provide non-emergency medical transportation for Medicaid participants. ( )

02. Individual Contracted Transportation Provider. An individual who is under contract with the transportation broker to provide non-emergency medical transportation for a Medicaid participant in the provider's personal vehicle. ( )

03. Non-Emergency Medical Transportation. Non-emergency medical transportation is transportation that is: ( )

a. Not of an emergency nature; and ( )

b. Required for a Medicaid participant to access medically necessary services covered by Medicaid when the participant's own transportation resources, family transportation resources, or community transportation resources do not allow the participant to reach those services. ( )

04. Transportation Broker. An entity under contract with the Department to administer, coordinate, and manage a statewide network of non-emergency medical transportation providers. ( )

05. Travel-Related Services. Travel-related services are meals, lodging, and attendant care required for non-emergency medical transportation to be completed for a Medicaid participant. ( )

871. NON-EMERGENCY MEDICAL TRANSPORTATION SERVICES: DUTIES OF THE TRANSPORTATION BROKER.
The transportation broker under contract with the Department is required to: ( )

01. Coordinate and Manage. Coordinate and manage all non-emergency medical transportation services for Medicaid participants statewide. ( )

02. Contract With Transportation Providers. Contract with transportation providers throughout the state to provide non-emergency medical transportation services for Medicaid participants. ( )

03. Call Center. Operate a call center to receive and review non-emergency medical transportation for Medicaid participants meeting the requirements in Section 872 of these rules. ( )

04. Authorize Non-Emergency Medical Transportation Services. Authorize non-emergency medical transportation services for Medicaid participants requesting transportation and who meet the requirements in Section 872 of these rules. ( )

05. Reimburse Contracted Transportation Providers. Reimburse contracted transportation providers for non-emergency medical transportation services meeting the requirements in Section 872 of these rules. ( )

06. Safe and Professional Transportation. Assure that contracted transportation providers deliver non-emergency medical transportation services in a safe and professional manner. ( )

872. NON-EMERGENCY MEDICAL TRANSPORTATION SERVICES: COVERAGE AND LIMITATIONS.

01. Non-Emergency Medical Transportation Services. The transportation broker will reimburse contracted transportation providers for non-emergency medical transportation services under the following conditions: ( )

a. The travel is essential to get to or from a medically necessary Medicaid covered service; ( )

b. The mode of transportation is the least costly that is appropriate for the medical needs of the participant; ( )

c. The transportation is to the nearest medical provider appropriate to perform the needed services, and transportation is by the most direct route practicable; ( )

d. Other modes of transportation, including personal vehicle, assistance by family, friends, and charitable organizations, are unavailable or impractical under the circumstances; ( )

e. The travel is authorized and scheduled by the transportation broker; and ( )

f. The contracted transportation provider is in compliance with the terms of its contract with the transportation broker. ( )

02. Travel-Related Services. The transportation broker will reimburse a contracted transportation provider for travel-related services under the following circumstances: ( )

a. The reasonable cost of meals actually incurred in transit will be reimbursed for the participant when there is no other practical means of obtaining food. ( )

b. The reasonable cost for lodging actually incurred for the participant will be reimbursed when: ( )

i. The round trip and the needed medical service cannot be completed in the same day; and ( )

ii. No less costly alternative is available. ( )

c. The reasonable cost of wages for an attendant will be reimbursed when: ( )

i. An attendant is medically necessary or when the vulnerability of the participant requires accompaniment for safety; and ( )

ii. No family member or other unpaid attendant is available to accompany the participant. ( )

d. The reasonable cost of meals actually incurred in transit will be reimbursed for one (1) family member or one (1) attendant, when: ( )

i. Attendant care is medically necessary or when the vulnerability of the participant requires accompaniment for safety; and ( )

ii. There is no other practical means of obtaining food. ( )

e. The reasonable cost of lodging actually incurred will be reimbursed for one (1) family member or one (1) attendant when: ( )

i. An overnight stay is required to receive the service; ( )

ii. It is medically necessary or the vulnerability of the participant requires accompaniment for safety; and ( )

iii. No less costly alternative is available. ( )

873. NON-EMERGENCY MEDICAL TRANSPORTATION SERVICES: REIMBURSEMENT METHODOLOGY.
The Department will reimburse the NEMT services broker a fixed, actuarially sound amount per member per month based on the cost of efficiently delivered, timely, and safe non-emergency medical transportation for eligible Idaho Medicaid participants and the cost for efficient administration of the brokerage program. ( )

874. -- 879. (RESERVED)

SUB AREA: EPSDT SERVICES
(Sections 880-889)

880. EARLY PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT) SERVICES: DEFINITION.
Medically necessary services for eligible Medicaid participants under the age of twenty-one (21) are health care, diagnostic services, treatment, and other measures described in Section 1905(a) of the Social Security Act (SSA) necessary to correct or ameliorate defects, physical and mental illness, and conditions discovered by the screening services as defined in Section 1905(r) of the SSA, whether or not such services are covered under the State Plan. Services must be considered safe, effective, and meet acceptable standards of medical practice. ( )

881. EARLY PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) SERVICES: PARTICIPANT ELIGIBILITY.
EPSDT services are available to child participants from birth through the month of their twenty-first birthday. ( )

882. EARLY PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) SERVICES: COVERAGE AND LIMITATIONS.

01. Additional Services. Any service required as a result of an EPSDT screen and which is currently covered under the scope of the Idaho Medicaid program will not be subject to the existing amount, scope, and duration, but will be subject to the authorization requirements of those rules. ( )

02. Medically Necessary. The need for additional services must be documented by the attending physician as medically necessary. ( )

03. Prior Authorization. Any service requested, that is covered under Title XIX or Title XXI of the Social Security Act, that is not identified in these rules specifically as a Medicaid-covered service will require prior authorization prior to payment for that service. ( )

04. Services Not Covered. The Department will not cover services for cosmetic, convenience, or comfort reasons. ( )

05. Hearing Aids Under EPSDT. ( )

a. When binaural aids are requested they will be authorized if documented to the Department's satisfaction, that the child's ability to learn would be severely restricted. ( )

b. When replacement hearing aids are requested, they may be authorized if the requirements in Subsections 742.01.a., 742.01.b., and 742.03 are met. ( )

c. The Department will purchase additional ear molds after the initial six (6) months to one (1) year

period if medically necessary. Requests in excess of every six (6) months will require prior authorization and documentation of medical need from either the attending physician or audiologist. ( )

06. Eyeglasses Under EPSDT. ( )

a. In the case of a major visual change, the Department can authorize purchase of a second pair of eyeglasses and can authorize a second eye examination to determine that visual change. ( )

b. The Department may pay for replacement of lost glasses or replacement of broken frames or lenses. New frames will not be purchased if the broken frame can be repaired for less than the cost of new frames if the provider indicates one (1) of these reasons on their claim. If repair costs are greater than the cost of new frames, new frames may be authorized. ( )

883. -- 889. (RESERVED)

**SUB AREA: SPECIFIC PREGNANCY-RELATED SERVICES
(Sections 890-899)**

890. PREGNANCY-RELATED SERVICES: DEFINITIONS.

01. Individual and Family Social Services. Services directed at helping a participant to overcome social or behavioral problems that may adversely affect the outcome of the pregnancy. ( )

02. Maternity Nursing Visit. Office visits by a licensed registered nurse, acting within the limits of the Nurses Practices Act, for the purpose of checking the progress of the pregnancy. ( )

03. Nursing Services. Home visits by a licensed registered nurse to assess the participant's living situation and provide appropriate education and referral during the covered period. ( )

04. Nutritional Services. Nutritional services are described in Sections 630 through 635 of these rules. ( )

05. Risk Reduction Follow-Up. Services to assist the participant in obtaining medical, educational, social and other services necessary to assure a positive pregnancy outcome. ( )

891. (RESERVED)

892. PREGNANCY-RELATED SERVICES: COVERAGE AND LIMITATIONS.
When ordered by the participant's attending physician or licensed practitioner of the healing arts, payment of the following services is available after confirmation of pregnancy and extending through the end of the month in which the sixtieth day following delivery occurs. ( )

01. Individual and Family Social Services. Limited to two (2) visits during the covered period. ( )

02. Maternity Nursing Visit. These services are only available to women unable to obtain a physician or licensed practitioner of the healing arts, to provide prenatal care. This service is to end immediately when a primary physician is found. A maximum of nine (9) visits can be authorized. ( )

03. Nursing Services. Limited to two (2) visits during the covered period. ( )

04. Nutrition Services. Nutritional services are described in Sections 630 through 632 of these rules. ( )

05. Qualified Provider Risk Assessment and Plan of Care. When prior authorized by the Department, payment is made for qualified provider services in completion of a standard risk assessment and plan of care for women unable to obtain a primary care physician, nurse practitioner, or nurse midwife for the provision of

antepartum care. ( )

893. PREGNANCY-RELATED SERVICES: PROCEDURAL REQUIREMENTS.
Pregnancy-related services described in Sections 890 through 892 of these rules must be prior authorized by the Department. ( )

894. PREGNANCY-RELATED SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.
Services must be: ( )

01. Risk Reduction Follow-Up. Provided by licensed social workers, licensed registered nurses, nurse midwife, physician, NP, or PA either in independent practice or as employees of entities that have current provider agreements with the Department. ( )

02. Individual and Family Social Services. Provided by a licensed social worker qualified to provide individual counseling in accordance with the provisions of IDAPA 24.14.01, "Rules of the State Board of Social Work Examiners." ( )

895. PREGNANCY-RELATED SERVICES: PROVIDER REIMBURSEMENT.

01. Rates. Rate of payment for pregnancy-related services is established under the provisions of Section 230 of these rules. ( )

02. Risk Reduction Followup Services. A single payment will be made for each month of service provided. ( )

896. -- 899. (RESERVED)

INVESTIGATIONS, AUDITS, AND ENFORCEMENT
(Sections 900 - 999)

SUB AREA: LIENS AND ESTATE RECOVERY
(Sections 900-909)

900. LIENS AND ESTATE RECOVERY.
In accordance with Sections 55-819, 56-218, 56-218A, and 56-225, Idaho Code, this Section of rule sets forth the provisions for recovery of medical assistance, the filing of liens against the property of deceased persons, the filing of liens against the property of permanently institutionalized participants, and the recording of requests for notice. ( )

01. Medical Assistance Incorrectly Paid. The Department may, in accordance with a judgment of a court, file a lien against the property of a living or deceased person of any age to recover the costs of medical assistance incorrectly paid. ( )

02. Administrative Appeals. Permanent institutionalization determination, undue hardship waiver, and request for notice hearings are governed by the fair hearing provisions of IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings." ( )

901. LIENS AND ESTATE RECOVERY: DEFINITIONS.
The following terms are applicable to Sections 900 through 909 of these rules: ( )

01. Authorized Representative. The person appointed by the court as the personal representative in a probate proceeding or, if none, the person identified by the participant to receive notice and make decisions on estate matters. ( )

02. Discharge From a Medical Institution. A medical decision made by a competent medical professional that the Medicaid participant no longer needs nursing home care because the participant's condition has

improved, or the discharge is not medically contraindicated. ( )

03. Equity Interest in a Home. Any equity interest in real property recognized under Idaho law. ( )

04. Estate. All real and personal property and other assets including those in which the participant had any legal or beneficial title or interest at the time of death, to the extent of such interest, including such assets conveyed to a survivor, heir, or assignee of the deceased participant through joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangement. ( )

05. Home. The dwelling in which the participant has an ownership interest, and which the participant occupied as their primary dwelling prior to, or subsequent to, their admission to a medical institution. ( )

06. Institutionalized Participant. An inpatient in a nursing facility (NF), intermediate care facility for people with intellectual disabilities (ICF/IID), or other medical institution, who is a Medicaid participant subject to post-eligibility treatment of income in IDAPA 16.03.05, "Eligibility for Aid to the Aged, Blind and Disabled (AABD)." ( )

07. Lawfully Residing. Residing in a manner not contrary to or forbidden by law, and with the participant's knowledge and consent. ( )

08. Permanently Institutionalized. An institutionalized participant of any age who the Department has determined cannot reasonably be expected to be discharged from the institution and return home. Discharge refers to a medical decision made by a competent medical professional that the participant is physically able to leave the institution and return to live at home. ( )

09. Personal Property. Any property not real property, including cash, jewelry, household goods, tools, life insurance policies, boats and wheeled vehicles. ( )

10. Real Property. Any land, including buildings or immovable objects attached permanently to the land. ( )

11. Residing in the Home on a Continuous Basis. Occupying the home as the primary dwelling and continuing to occupy such dwelling as the primary residence. ( )

12. Termination of a Lien. The release or dissolution of a lien from property. ( )

13. Undue Hardship. Conditions that justify waiver of all or a part of the Department's claim against an estate, described in Subsections 905.06 through 905.10 of these rules. ( )

14. Undue Hardship Waiver. A decision made by the Department to relinquish, limit, or defer its claim to any or all estate assets of a deceased participant based on good cause. ( )

902. LIENS AND ESTATE RECOVERY - NOTIFICATION TO DEPARTMENT.

All notification regarding liens, estate claims, and requests for notice must be directed to the Department of Health and Welfare, Estate Recovery Unit, 3272 Elder, Suite B, P.O. Box 83720, Boise, Idaho, 83720-0009. ( )

903. LIENS AND ESTATE RECOVERY: LIEN DURING LIFETIME OF PARTICIPANT.

01. Lien Imposed During Lifetime of Participant. During the lifetime of the permanently institutionalized participant, and subject to the restrictions set forth in Subsection 903.04 of this rule, the Department may impose a lien against the real property of the participant for medical assistance correctly paid on their behalf. The lien must be filed within ninety (90) days of the Department's final determination, after notice and opportunity for a hearing, that the participant is permanently institutionalized. The lien is effective from the beginning of the most recent continuous period of the participant's institutionalization, but not before July 1, 1995. Any lien imposed will dissolve upon the participant's discharge from the medical institution and return home. ( )

02. Determination of Permanent Institutionalization. The Department must determine that the participant is permanently institutionalized prior to the lien being imposed. An expectation or plan that the participant will return home with the support of Home and Community Based Services does not, in and of itself, justify a decision that they are reasonably expected to be discharged to return home. The following factors must be considered when making the determination of permanent institutionalization: ( )

a. The participant must meet the criteria for nursing facility or ICF/IID level of care and services as set forth in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Sections 220 through 299, and 580 through 649; ( )

b. The medical records must be reviewed to determine if the participant's condition is expected to improve to the extent that they will not require nursing facility or ICF/IID level of care; and ( )

c. Where the prognosis indicated in the medical records is uncertain or inconclusive, the Department may request additional medical information, or may delay the determination until the next utilization control review or annual Inspection of Care review, as appropriate. ( )

03. Notice of Determination of Permanent Institutionalization and Hearing Rights. The Department must notify the participant or their authorized representative, in writing, of its intention to make a determination that the participant is permanently institutionalized, and that they have the right to a fair hearing in accordance with Subsection 900.02 of these rules. This notice must inform the participant of the following information, at a minimum: ( )

a. The Department's decision that they cannot reasonably be expected to be discharged from the medical institution to return home is based upon a review of the medical records and plan of care, but that this does not preclude them from returning home with services necessary to support nursing facility or ICF/IID level of care; and ( )

b. They or their authorized representative may request a fair hearing prior to the Department's final determination that they are permanently institutionalized. The notice must include information that a pre-hearing conference may be scheduled prior to a fair hearing. The notice must include the time limits and instructions for requesting a fair hearing. ( )

c. If they or their authorized representative does not request a fair hearing within the time limits specified, their real property, including their home, may be subject to a lien, contingent upon the restrictions in Subsection 903.04 of this rule. ( )

04. Restrictions on Imposing Lien During Lifetime of Participant. A lien may be imposed on the participant's real property; however, no lien may be imposed on the participant's home if any of the following is lawfully residing in such home: ( )

a. The spouse of the participant; ( )

b. The participant's child who is under age twenty-one (21), or who is blind or disabled as defined in 42 U.S.C. 1382c as amended; or ( )

c. A sibling of the participant who has an equity interest in the participant's home and who was residing in such home for a period of at least one (1) year immediately before the date of the participant's admission to the medical institution, and who has been residing in the home on a continuous basis. ( )

05. Restrictions on Recovery on Lien Imposed During Lifetime of Participant. Recovery will be made on the lien from the participant's estate, or at any time upon the sale of the property subject to the lien, but only after the death of the participant's surviving spouse, if any, and only at a time when: ( )

a. The participant has no surviving child who is under age twenty-one (21); ( )

b. The participant has no surviving child of any age who is blind or disabled as defined in 42 U.S.C.

1382c as amended; and ( )

c. In the case of a lien on a participant's home, when none of the following is lawfully residing in such home who has lawfully resided in the home on a continuous basis since the date of the participant's admission to the medical institution: ( )

i. A sibling of the participant, who was residing in the participant's home for a period of at least one (1) year immediately before the date of the participant's admission to the medical institution; or ( )

ii. A son or daughter of the participant, who was residing in the participant's home for a period of at least two (2) years immediately before the date of the participant's admission to the medical institution, and who establishes by a preponderance of the evidence that they provided necessary care to the participant, and the care they provided allowed the participant to remain at home rather than in a medical institution. ( )

06. Recovery Upon Sale of Property Subject to Lien Imposed During Lifetime of Participant. Should the property upon which a lien is imposed be sold prior to the participant's death, the Department will seek recovery of all medical assistance paid on behalf of the participant, subject to the restrictions in Subsection 903.05 of this rule. Recovery of the medical assistance paid on behalf of the participant from the proceeds from the sale of the property does not preclude the Department from recovering additional medical assistance paid from the participant's estate as described in Subsection 904.01 of these rules. ( )

07. Filing of Lien During Lifetime of Participant. When appropriate, the Department will file, in the office of the Recorder of the county in which the real property of the participant is located, a verified statement, in writing, setting forth the following: ( )

a. The name and last known address of the participant; and ( )

b. The name and address of the official or agent of the Department filing the lien; and ( )

c. A brief description of the medical assistance received by the participant; and ( )

d. The amount paid by the Department, as of a given date, and, if applicable, a statement that the amount of the lien will increase as long as medical assistance benefits are paid on behalf of the participant. ( )

08. Renewal of Lien Imposed During Lifetime of Participant. The lien, or any extension thereof, must be renewed every five (5) years by filing a new verified statement as required in Subsection 903.07 of this rule, or as required by Idaho law. ( )

09. Termination of Lien Imposed During Lifetime of Participant. The lien will be released as provided by Idaho Code, upon satisfaction of the Department's claim. The lien will dissolve in the event of the participant's discharge from the medical institution and return home. Such dissolution of the lien does not discharge the underlying debt and the estate remains subject to recovery under estate recovery provisions in Sections 904 and 905 of these rules. ( )

904. LIENS AND ESTATE RECOVERY: REQUIREMENTS FOR ESTATE RECOVERY.

01. Estate Recovery Requirements. In accordance Sections 56-218 and 56-218A, Idaho Code, the Department is required to recover the following: ( )

a. The costs of all medical assistance correctly paid on or after July 1, 1995, on behalf of a participant who was permanently institutionalized; ( )

b. The costs of medical assistance correctly paid on behalf of a participant who received medical assistance at age fifty-five (55) or older on or after July 1, 1994; and ( )

c. The costs of medical assistance correctly paid on behalf of a participant who received medical assistance at age sixty-five (65) or older on or after July 1, 1988. ( )

02. Recovery From Estate of Spouse. Recovery from the estate of the spouse of a Medicaid participant may be made as permitted in Sections 56-218 and 56-218A, Idaho Code. ( )

03. Lien Imposed Against Estate of Deceased Participant. Liens may be imposed against the estates of deceased Medicaid participants and their spouses as permitted by Section 56-218, Idaho Code. ( )

04. Notice of Estate Claim. The Department will notify the authorized representative of the amount of the estate claim after the death of the participant, or after the death of the surviving spouse. The notice must include instructions for applying for an undue hardship waiver. ( )

05. Assets in Estate Subject to Claims. The authorized representative will be notified of the Department's claim against the assets of a deceased participant. Assets in the estate from which the claim can be satisfied must include all real or personal property that the deceased participant owned or in which they had an ownership interest, including the following: ( )

a. Payments to the participant under an installment contract will be included among the assets of the deceased participant. This includes an installment contract on any real or personal property to which the deceased participant had a property right. The value of a promissory note, loan or property agreement is its outstanding principal balance at the date of death of the participant. When a promissory note, loan, or property agreement is secured by a Deed of Trust, the Department may request evidence of a reasonable and just underlying debt. ( )

b. The deceased participant's ownership interest in an estate, probated or not probated, is an asset of their estate when: ( )

i. Documents show the deceased participant is an eligible devisee or donee of property of another deceased person; or ( )

ii. The deceased participant received income from property of another person; or ( )

iii. State intestacy laws award the deceased participant a share in the distribution of the property of another estate. ( )

c. Any trust instrument that is designed to hold or to distribute funds or property, real or personal, in which the deceased participant had a beneficial interest is an asset of the estate. ( )

d. Life insurance is considered an asset when it has reverted to the estate. ( )

e. Burial insurance is considered an asset when a funeral home is the primary beneficiary or when there are unspent funds in the burial contract. Any funds remaining after payment to the funeral home will be considered assets of the estate. ( )

f. Checking and savings accounts that hold and accumulate funds designated for the deceased participant, are assets of the estate, including joint accounts that accumulate funds for the benefit of the participant. ( )

g. In a conservatorship situation, if a court order under state law specifically requires funds be made available for the care and maintenance of a participant prior to their death, absent evidence to the contrary, such funds are an asset of the deceased participant's estate, even if a court has to approve release of the funds. ( )

h. Shares of stocks, bonds and mutual funds to the benefit of the deceased participant are assets of the estate. The current market value of all stocks, bonds and mutual funds must be proved as of the month preceding settlement of the estate claim. ( )

06. Value of Estate Assets. The Department will use fair market value as the value of the estate assets. ( )

905. LIENS AND ESTATE RECOVERY: LIMITATIONS AND EXCLUSIONS.

01. Limitations on Estate Claims. Limits on the Department's claim against the assets of a deceased participant or spouse are subject to Sections 56-218 and 56-218A, Idaho Code. A claim against the estate of a spouse of a participant is limited to the value of the assets of the estate that had been, at any time after October 1, 1993, community property, or the deceased participant's share of the separate property, and jointly owned property. Recovery will not be made until the deceased participant no longer is survived by a spouse, a child who is under age twenty-one (21), or a blind or disabled child, as defined in 42 U.S.C. 1382c as amended and, when applicable, as provided in Subsection 903.05 of these rules. No recovery will be made if the participant received medical assistance as the result of a crime committed against the participant. ( )

02. Expenses Deducted From Estate. The following expenses may be deducted from the available assets to determine the amount available to satisfy the Department's claim: ( )

a. Burial expenses, which include only those reasonably necessary for embalming, transportation of the body, cremation, flowers, clothing, and services of the funeral director and staff may be deducted. ( )

b. Other legally enforceable and necessary debts with priority may be deducted. The Department's claim is classified and paid as a debt with preference as defined in Section 15-03-805, Idaho Code. Debts of the deceased participant that may be deducted from the estate prior to satisfaction of the Department's claim must be legally enforceable debts given preference over the Department's claim under Section 15-03-805, Idaho Code. ( )

03. Interest on Claim. The Department's claim does not bear interest except as otherwise provided by statute or agreement. ( )

04. Excluded Land. Restricted allotted land, owned by a deceased participant who was an enrolled member of a federally recognized American Indian tribe, or eligible for tribal membership, which cannot be sold or transferred without permission from the Indian tribe or an agency of the Federal Government, will not be subject to estate recovery. ( )

05. Certain Life Estates. The value of a life estate owned by a Medicaid participant or their spouse will not be subject to estate recovery if: ( )

a. Neither the Medicaid participant or their spouse ever owned the remainder interest; or ( )

b. The life estate was created prior to July 1, 1995. ( )

06. Marriage Settlement Agreement or Other Such Agreement. A marriage settlement agreement or other such agreement that separates assets for a married couple does not eliminate the debt against the estate of the deceased participant or the spouse. Transfers under a marriage settlement agreement or other such agreement may be voided if not for adequate consideration. ( )

07. Release of Estate Claims. The Department will release a claim when the Department's claim has been fully satisfied and may release its claim under the following conditions: ( )

a. When an undue hardship waiver as defined in Subsection 905.07 of this rule has been granted; or ( )

b. When a written agreement with the authorized representative to pay the Department's claim in thirty-six (36) monthly payments or less has been achieved. ( )

08. Purpose of the Undue Hardship Exception. The undue hardship exception is intended to avoid the impoverishment of the deceased participant's family due to the Department exercising its estate recovery right. The fact that family members anticipate or expect an inheritance, or will be inconvenienced economically by the lack of an inheritance, is not cause for the Department to declare an undue hardship. ( )

09. Application for Undue Hardship Waiver. An applicant for an undue hardship waiver must have a beneficial interest in the estate and must apply for the waiver within ninety (90) days of the death of the participant or within thirty (30) days of receiving notice of the Department's claim, whichever is later. The filing of a claim by the Department in a probate proceeding constitutes notice to all heirs. ( )

10. Basis for Undue Hardship Waiver. Undue hardship waivers will be considered in the following circumstances: ( )

a. The estate subject to recovery is income-producing property that provides the primary source of support for other family members; or ( )

b. Payment of the Department's claim would cause heirs of the deceased participant to be eligible for public assistance; or ( )

c. The Department's claim is less than five hundred dollars ($500) or the total assets of the entire estate are less than five hundred dollars ($500), excluding trust accounts or other bank accounts. ( )

d. The participant received medical assistance as the result of a crime committed against the participant. ( )

11. Limitations on Undue Hardship Waiver. Any beneficiary of the estate of a deceased participant may apply for waiver of the estate recovery claim based on undue hardship. Any claim may be waived by the Department, partially or fully, because of undue hardship. An undue hardship does not exist if action taken by the participant prior to their death, or by their legal representative, divested or diverted assets from the estate. The Department grants undue hardship waivers on a case by case basis upon review of all facts and circumstances, including any action taken to diminish assets available for estate recovery or to circumvent estate recovery. ( )

12. Set Aside of Transfers. Transfers of real or personal property of the participant without adequate consideration are voidable and may be set aside by the district court whether or not the asset transfer resulted, or could have resulted, in a period of ineligibility. ( )

906. LIENS AND ESTATE RECOVERY: REQUEST FOR NOTICE.

01. Request for Notice - Notice - Hearing. The Department must notify the participant or their authorized representative, in writing, of its intention to record a request for notice, and that they have the right to a fair hearing in accordance with Subsection 900.02 of these rules. The notice must inform the participant of the following information, at a minimum: ( )

a. The Department's determination that they are the record titleholder or purchaser under a land sale contract of real property subject to a request for notice; ( )

b. They or their authorized representative may request a fair hearing prior to the Department's recording a request for notice. The notice must include the time limits and instructions for requesting a fair hearing; and ( )

c. If they or their authorized representative do not request a fair hearing within the time limits specified, a request for notice applying to their real property, including their home, may be recorded. ( )

02. Request for Notice - Forms - Content. The notices must include, at a minimum, the following information: ( )

a. The name of the public assistance recipient and the spouse of such public assistance recipient, if any; ( )

b. The Medicaid number for the public assistance recipient and spouse, if any; ( )

c. The legal description of the real property affected or to be affected; ( )

d. The mailing address at which the Department is to receive notice as provided in Section 902 of these rules; ( )

e. If the document is a Notice of Transfer or Encumbrance, the name and address of the transferee or lien holder; and ( )

f. A fully executed acknowledgment as required for recording under Section 55-805, Idaho Code. ( )

03. Webpages for Forms. The forms may be found at: ( )

a. Notice of Transfer or Encumbrance at http://healthandwelfare.idaho.gov. ( )

b. Request for Notice at http://healthandwelfare.idaho.gov. ( )

c. Termination of Request for Notice at http://healthandwelfare.idaho.gov. ( )

907. -- 909. (RESERVED)

SUB AREA: PARTICIPANT LOCK-IN
(Sections 910 - 918)

910. PARTICIPANT UTILIZATION CONTROL PROGRAM.
This Program is designed to promote improved and cost-efficient medical management of essential health care by monitoring participant activities and taking action to correct abuses. Participants demonstrating unreasonable patterns of utilization or exceeding reasonable levels of utilization, or both, will be reviewed for restriction. The Department may require a participant to designate a primary physician or a single pharmacy or both for exclusive provider services in an effort to protect the individual's health and safety, provide continuity of medical care, avoid duplication of services by providers, avoid inappropriate or unnecessary utilization of medical assistance, and avoid excessive utilization of prescription medications. ( )

911. LOCK-IN DEFINED.
Lock-in is the process of restricting the access of a participant to a specific provider or providers. ( )

912. DEPARTMENT EVALUATION FOR LOCK-IN.
The Department will review participants to determine if services are being utilized at a frequency or amount that results in a level of utilization or a pattern of services that is not medically necessary. Evaluation of utilization patterns can include review by the Department staff of medical records or computerized reports, or both, generated by the Department reflecting claims submitted for physician visits, drugs/prescriptions, outpatient and emergency room visits, lab or diagnostic procedures, or both, hospital admissions, and referrals. ( )

913. CRITERIA FOR LOCK-IN.
Since it is impossible to identify all possible patterns of over utilization, and since a particular pattern may be justified based on individual conditions, no specific criteria for lock-in will be developed. However, the Department may develop guidelines for purposes of uniformity. The guidelines will not be binding on the Department and will not limit or restrict the ability of the Department to impose lock-in when any pattern of over utilization is identified. The following utilization patterns may be considered abusive, not medically necessary, potentially endangering the participant's health and safety, or over utilization of Medicaid services, and may result in the restriction of Medicaid reimbursement for a participant to a single provider or providers: ( )

01. Unnecessary Use of Providers or Services. Unnecessary use of providers or Medicaid services, including excessive provider visits. ( )

02. Demonstrated Abusive Patterns. Recommendation from a medical professional or the

participant's primary care physician that the participant has demonstrated abusive patterns and would benefit from the lock-in program. ( )

03. Use of Emergency Room Facilities. Frequent use of emergency room facilities for non-emergent conditions. ( )

04. Multiple Providers. Use of multiple providers. ( )

05. Controlled Substances. Use of multiple controlled substances. ( )

06. Prescribing Physicians or Pharmacies. Use of multiple prescribing physicians or pharmacies, or both. ( )

07. Prescription Drugs and Therapeutic Classes. Overlapping prescription drugs with the same therapeutic class. ( )

08. Drug Abuse. Diagnosis of drug abuse or drug withdrawal, or both. ( )

09. Drug Behavior. Drug-seeking behavior as identified by a medical professional. ( )

10. Other Abusive Utilization. Use of drugs or other Medicaid services determined to be abusive by the Department's medical or pharmacy consultant. ( )

914. LOCK-IN PARTICIPANT NOTIFICATION.

A participant who has been designated by the Department for the Participant Utilization Control Program will be notified in writing by the Department of the action and the participant's right of appeal by means of a fair hearing. ( )

915. LOCK-IN PROCEDURES.

01. Participant Responsibilities. The participant will be given thirty-five (35) days to contact the Regional Program Manager or designee and complete and sign the lock-in agreement form and select designated provider(s) in each area of misuse. ( )

02. Appeal Stays Restriction. The Department will not implement the participant restriction if a valid appeal is noted in accordance with Section 917 of these rules. ( )

03. Lock-In Duration. The Department will restrict participants to their designated providers for a time period determined by the Department. Upon review at the end of that period, lock-in may be extended for an additional period determined by the Department. ( )

04. Payment to Providers. Payment to provider(s) other than the designated lock-in physician or pharmacy is limited to documented emergencies or written referrals from the primary physician. ( )

05. Regional Programs Manager. The Regional Programs Manager, or designee will: ( )

a. Clearly describe the participant's appeal rights in accordance with the provisions in IDAPA 16.05.03, “Contested Case Proceedings and Declaratory Rulings”; ( )

b. Specify the effective date and length of the restriction; ( )

c. Have the participant choose a designated provider or providers; and ( )

d. Mail the completed lock-in agreement to the Surveillance and Utilization Unit. Upon receipt of the lock-in agreement, the participant's Medicaid services will be immediately restricted to the designated provider(s). ( )

916. PENALTIES FOR LOCK-IN NONCOMPLIANCE.
If a participant fails to respond to the notification of medical restriction(s), fails to sign the lock-in agreement, or fails to select a primary physician within the specified time period, the Medicaid benefits will be restricted to documented emergencies only. If a participant continues to abuse or over-utilize items or services after being identified for lock-in, the Department may terminate medical assistance benefits for a specified period of time as determined by the Department. ( )

917. APPEAL OF LOCK-IN.
Department determinations to lock-in a participant may be appealed in accordance with the fair hearings provisions of IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings," of the Department. ( )

918. RECIPIENT EXPLANATION OF MEDICAID BENEFITS (REOMBS).

01. Monthly Surveys. The Department will conduct monthly surveys of services rendered to medical assistance participants using REOMBs. ( )

02. Participant Response. A medical assistance participant is required to respond to the Department's explanation of medical benefits survey whenever they are aware of discrepancies. ( )

03. Participant Unable to Respond. If the participant is unable, because of medical or physical limitations, to respond to the survey personally, then a responsible family member or friend can respond on their behalf. ( )

04. Medicare-to-Medicaid Cross-Over Claims. All claims processed through the cross-over system will be subject to these rules. All providers submitting cross-over claims must comply with the terms of their provider agreements. ( )

919. -- 999. (RESERVED)

APPENDIX A

IDAHO MEDICAID HANDICAPPING MALOCCLUSION INDEX

OVERBITE:	MEASUREMENT/POINTS:	SCORE:
Lower incisors: striking lingual of uppers at incisal	1/3 = 0	
Striking lingual of uppers at middle	1/3 = 1	
Striking lingual of uppers at gingival	1/3 = 2	
OPENBITE: (millimeters) *a,b		
Less than……	2 mm = 0	
	2-4 mm = 1	
	4+ mm = 2	
OVERJET: (millimeters) *a		
Upper……	2-4 mm = 0	
Measure horizontally parallel to occlusal plane.	5-9 mm = 1	
	9+ mm = 2	

OVERBITE:	MEASUREMENT/POINTS:	SCORE:
Lower……	0-1 mm = 0	
	2 mm = 1	
	3+ mm = 2	
POSTERIOR X-BITE: (teeth) *b		
Number of teeth in x-bite:	0-2 = 0	
	3 = 1	
	4 = 2	
TOOTH DISPLACEMENT: (teeth) *c, d, e		
Number of teeth rotated 45 degrees or displaced 2mm from normal position in arch.	0-2 = 0 3-6 = 1 7+ = 2	
BUCCAL SEGMENT RELATIONSHIP:		
One side distal or mesial ½ cusp	= 0	
Both sides distal or mesial or one side full cusp	= 1	
Both sides full cusp distal or mesial	= 2	

TOTAL SCORE:_____

Scoring Definitions:

a. Impacted or blocked cuspids are scored 1 open bite and 1 over jet for two teeth. Score 2 for open bite and 2 for over jet for 4 blocked cuspids.

b. Cross bites are scored for the teeth in cross bite, not the teeth in the opposing arch.

c. Missing teeth count as 1, if the space is still present.

d. Do not score teeth that are not fully erupted.

e. Displaced teeth are based on where they are in their respective arch line, not their relationship with the opposing arch.

16.03.10 – MEDICAID ENHANCED PLAN BENEFITS

000. LEGAL AUTHORITY.

01. Rulemaking Authority. The Idaho Department of Health and Welfare has the authority to promulgate public assistance rules under Section 56-202(b), 56-264, and 56-1610, Idaho Code. ( )

02. General Administrative Authority. Title XIX and Title XXI, of the Social Security Act, as amended, and the companion federal regulations, are the basic authority for administration of the federal program. General administrative duties for the Department are found under Section 56-202, Idaho Code. ( )

03. Administration of the Medical Assistance Program. ( )

a. Section 56-203(7), Idaho Code, empowers the Department to define persons entitled to medical assistance. ( )

b. Section 56-203(9), Idaho Code, empowers the Department to identify the amount, duration, scope of care, and services to be purchased as medical assistance on behalf of individuals eligible to receive benefits under the Medical Assistance Program. ( )

c. Sections 56-250 through 56-257, and 56-260 through 56-266, Idaho Code, establish minimum standards that enable these rules. ( )

04. Fiscal Administration. ( )

a. Fiscal administration of these rules is authorized by Title XIX and Title XXI of the Social Security Act, as well as 42 CFR Part 447 and the Provider Reimbursement Manual (PRM) Part I and Part II found in CMS Publication 15-1 and 15-2. Provisions of the PRM, as incorporated by reference in Section 004 of these rules, apply unless otherwise provided for in these rules. ( )

b. Title 56, Chapter 1, Idaho Code, establishes standards for provider payment for certain Medicaid providers. ( )

001. TITLE AND SCOPE.

01. Title. The title of these rules is IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." ( )

02. Scope. These rules establish the Medicaid Enhanced Plan Benefits covered under Title XIX and Title XXI. Participants who are eligible for Enhanced Plan Benefits are also eligible for benefits under IDAPA 16.03.09, "Medicaid Basic Plan Benefits." Dental benefits and outpatient behavioral health benefits are contained in IDAPA 16.03.09. "Medicaid Basic Plan Benefits." ( )

03. Scope of Reimbursement System Audits. These rules also provide for the audit of providers' claimed costs against these rules and Medicare standards. The Department reserves the right to audit financial and other records of the provider, and, when warranted, the records of entities related to the provider. Audits consist of the following types of records: ( )

a. Cost verification of actual costs for providing goods and services; ( )

b. Evaluation of provider's compliance with the provider agreement, reporting form instructions, and any applicable law, rule, or regulation; ( )

c. Effectiveness of the service to achieve desired results or benefits; and ( )

d. Reimbursement rates or settlement calculated under this chapter. ( )

04. Exception to Scope for Audits and Investigations. Audits as described in these rules do not apply to the audit processes used in conducting investigations of fraud and abuse under IDAPA 16.05.07, "Investigation and Enforcement of Fraud, Abuse, and Misconduct." ( )

002. WRITTEN INTERPRETATIONS.

This agency may have written statements that pertain to the interpretations of the rules of this chapter. These documents are available for public inspection. ( )

003. (RESERVED)

004. INCORPORATION BY REFERENCE.
The Department has incorporated by reference the following document: ( )

01. 42 CFR Part 447. 42 CFR Part 447, "Payment for Services," revised as of October 1, 2001, is available from CMS, 7500 Security Blvd, Baltimore, M.D., 21244-1850 or on the Code of Federal Regulations website at http://www.ecfr.gov/cgi-bin/text-idx?SID=3ec1965dbf5044d8f79b25d4d58c4cd1&mc=true&tpl=/ecfrbrowse/Title42/42cfrv4_02.tpl#0. ( )

02. Estimated Useful Lives of Depreciable Hospital Assets, 2004 Revised Edition, Guidelines Lives. This document may be obtained from American Hospital Publishing, Inc., 211 E. Chicago Ave., Chicago, IL. 60611. ( )

03. Medicare Region D Durable Medical Equipment Regional Carrier (DMERC) Supplier Manual or Its Successor. The full text of the Medicare Region D DMERC Supplier Manual Chapters IX and X, date April 2001, is available via the Internet at www.cignamedicare.com. A copy is also available at the Idaho State Supreme Court Law Library. ( )

04. Provider Reimbursement Manual (PRM). The Provider Reimbursement Manual (PRM), Part I and Part II CMS Publication 15-1 and 15-2), is available on the CMS website at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals.html. ( )

05. Resource Utilization Groups (RUG) Grouper. The RUG III, version 5.12, 34 Grouper, nursing weights only, with index maximization. The RUG Grouper is available from CMS, 7500 Security Blvd., Baltimore, MD, 21244-1850. ( )

06. Travel Policies and Procedures of the Idaho State Board of Examiners. The text of "Idaho State Travel Policies and Procedures of the Idaho State Board of Examiners," Appendices A and B, June 13, 2000, is available at the Office of the State Controller, 700 W. State St., 5th Fl., Box 83720, Boise, Idaho 83720-0011 or on the Internet at http://www.sco.idaho.gov/. ( )

005. -- 007. (RESERVED)

008. AUDIT, INVESTIGATION AND ENFORCEMENT.
In addition to any actions specified in these rules, the Department may audit, investigate and take enforcement action under the provisions of IDAPA 16.05.07, "Investigation and Enforcement of Fraud, Abuse, or Misconduct." ( )

009. CRIMINAL HISTORY AND BACKGROUND CHECK REQUIREMENTS.

01. Compliance With Department Criminal History Check. Agencies must verify that individuals working in the area listed in Subsection 009.03 of these rules whom are employed or whom they contract have complied with the provisions in IDAPA 16.05.06, "Rules Governing Mandatory Criminal History Checks." Except, through the duration of the declared COVID-19 public health emergency, if the individuals working in the area listed in this rule are unable to complete a criminal background check in accordance with the timeframes set forth in IDAPA 16.05.06, then agencies may allow newly hired direct care staff to begin rendering services prior to completion of the criminal background check in accordance with the requirements specified by the Department in a COVID-19 information release posted on the Department's website at https://healthandwelfare.idaho.gov/providers/idaho-medicaid-providers/information-medicaid-providers. ( )

02. Additional Criminal Convictions. Once an individual has received a criminal history clearance, any additional criminal convictions must be reported by the agency to the Department when the agency learns of the conviction. ( )

03. Providers Subject to Criminal History and Background Check Requirements. The following

providers are required to have a criminal history and background check: ( )

a. Adult Day Health Providers. The criminal history and background check requirements applicable to providers of adult day health as provided in Sections 329 and 705 of these rules. ( )

b. Adult Residential Care Providers. The criminal history and background check requirements applicable to adult residential care providers as provided in Section 329 of these rules. ( )

c. Attendant Care Providers. The criminal history and background check requirements applicable to attendant care providers as provided in Section 329 of these rules. ( )

d. Behavior Consultation or Crisis Management Providers. The criminal history and background check requirements applicable to behavior consultation or crisis management providers as provided in Section 705 of these rules. ( )

e. Certified Family Home Providers and All Adults in the Home. The criminal history and background check requirements applicable to certified family homes are found in Sections 305, 329 and 705 of these rules, and as provided in IDAPA 16.03.19, "Rules Governing Certified Family Homes." ( )

f. Chore Services Providers. The criminal history and background check requirements applicable to chore services providers as provided in Sections 329 and 705 of these rules. ( )

g. Companion Services Providers. The criminal history and background check requirements applicable to companion services providers as provided in Section 329 of these rules. ( )

h. Day Habilitation Providers. The criminal history and background check requirements applicable to day habilitation providers as provided in Section 329 of these rules. ( )

i. Developmental Disabilities Agencies (DDA). The criminal history and background check for DDA and staff as provided in IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)," Section 009. ( )

j. Homemaker Services Providers. The criminal history and background check requirements applicable to homemaker services providers as provided in Section 329 of these rules. ( )

k. Personal Assistance Agencies Acting As Fiscal Intermediaries. The criminal history and background check requirements applicable to the staff of personal assistance agencies acting as fiscal intermediaries as provided in Subsection 329.02 of these rules. ( )

l. Personal Care Providers. The criminal history and background check requirements applicable to personal care providers as provided in Subsection 305.06 of these rules. ( )

m. Residential Habilitation Providers. The criminal history and background check requirements applicable to residential habilitation providers as provided in Sections 329 and 705 of these rules, and IDAPA 16.04.17 "Rules Governing Residential Habilitation Agencies," Sections 202 and 301. ( )

n. Respite Care Providers. The criminal history and background check requirements applicable to respite care providers as provided in Sections 329, 665, and 705 of these rules. ( )

o. Service Coordinators and Paraprofessionals. The criminal history and background check requirements applicable to service coordinators and paraprofessionals working for an agency as provided in Section 729 of these rules. ( )

p. Skilled Nursing Providers. The criminal history and background check requirements applicable to skilled nursing providers as provided in Sections 329 and 705 of these rules. ( )

q. Supported Employment Providers. The criminal history and background check requirements applicable to supported employment providers as provided in Sections 329 and 705 of these rules. ( )

r. Therapeutic Consultant. The criminal history and background check requirements applicable to therapeutic consultation providers as provided in Section 685 of these rules. ( )

010. DEFINITIONS: A THROUGH D.
For the purposes of these rules, the following terms are used as defined below: ( )

01. Accrual Basis. An accounting system based on the principle that revenues are recorded when they are earned; expenses are recorded in the period incurred. ( )

02. Active Treatment. Active treatment is the continuous participation, during all waking hours, by an individual in an aggressive, consistently implemented program of specialized and generic training, treatment, health and related services, and provided in accordance with a treatment plan developed by an interdisciplinary team and monitored by a Qualified Intellectual Disabilities Professional (QIDP) directed toward: the acquisition of the behaviors necessary for the resident to function with as much self-determination and independence as possible; or the prevention or deceleration of regression or loss of current functional status. ( )

03. Activities of Daily Living (ADL). The performance of basic self-care activities in meeting an individual's needs for sustaining them in a daily living environment, including bathing, washing, dressing, toileting, grooming, eating, communication, continence, mobility, and associated tasks. ( )

04. Allowable Cost. Costs that are reimbursable, and sufficiently documented to meet the requirements of audit. ( )

05. Amortization. The systematic recognition of the declining utility value of certain assets, usually not owned by the organization or intangible in nature. ( )

06. Appraisal. The method of determining the value of property as determined by an Appraisal Institute appraisal. The appraisal must specifically identify the values of land, buildings, equipment, and goodwill. ( )

07. Assets. Economic resources of the provider recognized and measured in conformity with generally accepted accounting principles. ( )

08. Attendant Care. Services provided under a Medicaid Home and Community-Based Services waiver that involve personal and medically-oriented tasks dealing with the functional needs of the participants and accommodating the participant's needs for long-term maintenance, supportive care, or activities of daily living (ADL). These services may include personal assistance and medical tasks that can be done by unlicensed persons or delegated to unlicensed persons by a health care professional or the participant. Services are based on the person's abilities and limitations, regardless of age, medical diagnosis, or other category of disability. This assistance may take the form of hands-on assistance (actually performing a task for the person) or cuing to prompt the participant to perform a task. ( )

09. Audit. An examination of provider records on the basis of which an opinion is expressed representing the compliance of a provider’s financial statements and records with Medicaid law, regulations, and rules. ( )

10. Auditor. The individual or entity designated by the Department to conduct the audit of a provider’s records. ( )

11. Audit Reports. ( )

a. Draft Audit Report. A preliminary report of the audit finding sent to the provider for the provider’s review and comments. ( )

b. Final Audit Report. A final written report containing the results, findings, and recommendations, if any, from the audit of the provider, as approved by the Department. ( )

12. **Bad Debts**. Amounts due to provider as a result of services rendered, but that are considered uncollectible. ( )

13. **Bed-Weighted Median**. A numerical value determined by arraying the average per diem cost per bed of all facilities from high to low and identifying the bed at the point in the array at which half of the beds have equal or higher per diem costs and half have equal or lower per diem costs. The identified bed is the median bed. The per diem cost of the median bed is the bed-weighted median. ( )

14. **Budget Adjustment Factor (BAF)**. A total budget for nursing facility reimbursement will be established by legislative appropriation and will be effective on July 1 of each year. The budget will be compared to the annual expected Medicaid reimbursement rates for the same rate year. A budget adjustment factor will be established to adjust the expected Medicaid reimbursement rates to meet the approved budget. The BAF may be positive or negative and will apply to all nursing facility rates calculated under the established prospective rate system. The BAF will not be applied to the calculated customary charge for each nursing facility and will not apply to any nursing facility that is retrospectively settled. ( )

15. **Capitalize**. The practice of accumulating expenditures related to long-lived assets that will benefit later periods. ( )

16. **Case Mix Adjustment Factor**. The factor used to adjust a provider's direct care rate component for the difference in the average Medicaid acuity and the average nursing facility-wide acuity. The average Medicaid acuity is from the picture date immediately preceding the rate period. The average nursing facility-wide acuity is the average of the indexes that correspond to the cost reporting period. ( )

17. **Case Mix Index (CMI)**. A numeric score assigned to each nursing facility resident, based on the resident's physical and mental condition, that projects the amount of relative resources needed to provide care to the resident. ( )

a. Nursing Facility Wide Case Mix Index. The average of the entire nursing facility's case mix indexes identified at each picture date during the cost reporting period. If case mix indexes are not available for applicable quarters due to lack of data, case mix indexes from available quarters will be used. ( )

b. Medicaid Case Mix Index. The average of the weighting factors assigned to each Medicaid resident in the facility on the picture date, based on their RUG classification. Medicaid or non-Medicaid status is based upon information contained in the MDS databases. To the extent that Medicaid identifiers are found to be incorrect, the Department may adjust the Medicaid case mix index and reestablish the reimbursement rate. ( )

c. State-Wide Average Case Mix Index. The simple average of all nursing facilities "facility wide" case mix indexes used in establishing the reimbursement limitation July 1st of each year. The state-wide case mix index will be calculated annually during each July 1st rate setting. ( )

18. **Certified Family Home**. A home certified by the Department to provide care to one (1) or two (2)adults, who are unable to reside on their own and require help with activities of daily living, protection and security, and need encouragement toward independence. ( )

l9. **Chain Organization**. A proprietorship, partnership, or corporation that leases, manages, or owns two (2) or more facilities that are separately licensed. ( )

20. **Claim**. An itemized bill for services rendered to one (1) participant by a provider and submitted to the Department for payment. ( )

21. **Clinical Nurse Specialist**. A licensed registered nurse who meets all the applicable requirements to practice as clinical nurse specialist under Title 54, Chapter 14, Idaho Code, and IDAPA 24.34.01, "Rules of the Idaho Board of Nursing." ( )

22. **Common Ownership**. An individual, individuals, or other entities who have equity or ownership

in two (2) or more organizations that conduct business transactions with each other. Common ownership exists if an individual or individuals possess significant ownership or equity in the provider and the institution or organization serving the provider. ( )

23. Compensation. The total of all remuneration received, including cash, expenses paid, salary advances, etc. ( )

24. Control. Control exists where an individual or an organization has the power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or institution. ( )

25. Cost Center. A "collection point" for expenses incurred in the rendering of services, supplies, or materials that are related or so considered for cost-accounting purposes. ( )

26. Cost Component. The portion of the nursing facility's rate that is determined from a prior cost report, including property rental rate. The cost component of a nursing facility's rate is established annually at July 1st of each year. ( )

27. Cost Reimbursement System. A method of fiscal administration of Title XIX and Title XXI that compensates the provider on the basis of expenses incurred. ( )

28. Cost Report. A fiscal year report of provider costs required by the Medicare program and any supplemental schedules required by the Department. ( )

29. Cost Statements. An itemization of costs and revenues, presented on the accrual basis, that is used to determine cost of care for facility services for a specified period of time. These statements are commonly called income statements. ( )

30. Costs Related to Patient Care. All necessary and proper costs that are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. Necessary and proper costs related to patient care are usually costs that are common and accepted occurrences in the field of the provider's activity. They include costs such as depreciation, interest expenses, nursing costs, maintenance costs, administrative costs, costs of employee pension plans, and normal standby costs. ( )

31. Costs Not Related to Patient Care. Costs that are not appropriate or necessary and proper in developing and maintaining the operation of patient care facilities and activities. Such costs are nonallowable in computing reimbursable costs. They include, for example, cost of meals sold to visitors or employees; cost of drugs sold to other than patients; cost of operation of a gift shop; and similar items. Travel and entertainment expenses are nonallowable unless it can be specifically shown that they relate to patient care and for the operation of the nursing facility. ( )

32. Customary Charges. Customary charges are the rates charged to Medicare participants and to patients liable for such charges, as reflected in the facility's records. Those charges are adjusted downward, when the provider does not impose such charges on most patients liable for payment on a charge basis or, when the provider fails to make reasonable collection efforts. The reasonable effort to collect such charges is the same effort necessary for Medicare reimbursement as is needed for unrecovered costs attributable to certain bad debt under PRM, Chapter 3, Sections 310 and 312. ( )

33. Day Treatment Services. Day treatment services are developmental services provided regularly during normal working hours on weekdays by, or on behalf of, the Intermediate Care Facility for Persons with Intellectual Disabilities (ICF/IID). However, day treatment services do not include recreational therapy, speech therapy, physical therapy, occupational therapy, or services paid for or required to be provided by a school or other entity. ( )

34. Department. The Idaho Department of Health and Welfare or a person authorized to act on behalf of the Department. ( )

35. Depreciation. The systematic distribution of the cost or other basis of tangible assets, less salvage,

over the estimated life of the assets. ( )

36. Developmental Disability (DD). A developmental disability, as defined in Section 66-402, Idaho Code, means a chronic disability of a person that appears before the age of twenty-two (22) years of age; and ( )

a. Is attributable to an impairment, such as an intellectual disability, cerebral palsy, epilepsy, autism or other condition found to be closely related to or similar to one (1) of these impairments, that requires similar treatment or services or is attributable to dyslexia resulting from such impairments; ( )

b. Results in substantial functional limitations in three (3) or more of the following areas of major life activity; self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency; and ( )

c. Reflects the need for a combination or sequence of special, interdisciplinary or generic care, treatment or other services that are of lifelong or extended duration and individually planned and coordinated. ( )

37. Direct Care Costs. Costs directly assigned to the nursing facility or allocated to the nursing facility through the Medicare cost finding principles and consisting of the following: ( )

a. Direct nursing salaries that include the salaries of licensed registered nurses (RN), certified nurse's aides, and unit clerks; ( )

b. Routine nursing supplies; ( )

c. Nursing administration; ( )

d. Direct portion of Medicaid related ancillary services; ( )

e. Social services; ( )

f. Raw food; ( )

g. Employee benefits associated with the direct salaries: and ( )

h. Medical waste disposal, for rates with effective dates beginning July 1, 2005. ( )

38. Director. The Director of the Department of Health and Welfare or their designee. ( )

39. Durable Medical Equipment (DME). Equipment other than prosthetics or orthotics that can withstand repeated use by one (1) or more individuals, is primarily and customarily used to serve a medical purpose, is generally not useful to a person in the absence of an illness or injury, is appropriate for use in the home, and is reasonable and necessary for the treatment of an illness or injury for a Medicaid participant. ( )

011. DEFINITIONS: E THROUGH K.
For the purposes of these rules, the following terms are used as defined below: ( )

01. Educational Services. Services that are provided in buildings, rooms or areas designated or used as a school or as educational facilities; that 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 that are included in the individual educational plan for the participant or required by federal and state educational statutes or regulations; are not related services**;** and such services are provided to school age individuals as defined in Section 33-201, Idaho Code. ( )

02. Eligibility Rules. IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children," and IDAPA 16.03.05, "Eligibility for Aid to the Aged, Blind and Disabled (AABD)." ( )

03. Emergency Medical Condition. A medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent lay person, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: ( )

a. Placing the health of the individual, or, with respect to a pregnant woman, the health of the woman or unborn child, in serious jeopardy. ( )

b. Serious impairment to bodily functions. ( )

c. Serious dysfunction of any bodily organ or part. ( )

04. Enhanced Plan. The medical assistance benefits included under this chapter of rules. ( )

05. EPSDT. Early and Periodic Screening Diagnosis and Treatment. ( )

06. Equity. The net book value of all tangible and intangible assets less the recorded value of all liabilities, as recognized and measured in conformity with generally accepted accounting principles. ( )

07. Facility. Facility refers to a hospital, nursing facility, or an intermediate care facility for persons with intellectual disabilities. ( )

a. "Free-standing and Urban Hospital-based Behavioral Care Unit" means the same as Subsection 011.07.b. or 011.07.h. of this rule, and qualifies as a behavioral care unit nursing facility provider described in Section 266 of these rules. ( )

b. "Free-standing Nursing Facility" means a nursing facility that is not owned, managed, or operated by, nor is otherwise a part of a licensed hospital. ( )

c. "Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)" means an entity as defined in Subsection 011.30 in this rule. ( )

d. "Nursing Facility (NF)" means a facility licensed as a nursing facility and federally certified to provide care to Medicaid and Medicare patients. ( )

e. "Rural Hospital-based Provider" means a hospital-based nursing facility not located within a metropolitan statistical area (MSA) as defined by the United States Bureau of the Census. ( )

f. "Rural Hospital-based Behavioral Care Unit" means the same as Subsection 011.07.e., and qualifies as a behavioral care unit nursing facility provider described in Section 266 of these rules. ( )

g. Skilled Nursing Facility" means a nursing facility licensed by the Department to provide twenty-four (24) hour skilled nursing services and federally certified as a "Nursing Facility" under Title XVIII. ( )

h. "Urban Hospital-based Nursing Facility" means a hospital-based nursing facility located within a metropolitan statistical area (MSA) as defined by the United States Bureau of the Census. ( )

08. Fiscal Intermediary Agency. An entity that provides services that allow the participant receiving personal assistance services, or their designee or legal representative, to choose the level of control they will assume in recruiting, selecting, managing, training, and dismissing their personal assistant regardless of who the employer of record is, and allows the participant control over the manner in which services are delivered. ( )

09. Fiscal Year. An accounting period that consists of twelve (12) consecutive months. ( )

10. Forced Sale. A forced sale is a sale required by a bankruptcy, foreclosure, the provisions of a will or estate settlement pursuant to the death of an owner, physical or mental incapacity of an owner that requires

ownership transfer to existing partner or partners, or a sale required by the ruling of a federal agency or by a court order. ( )

11. Funded Depreciation. Amounts deposited or held that represent recognized depreciation. ( )

12. Generally Accepted Accounting Principles (GAAP). A widely accepted set of rules, conventions, standards, and procedures for reporting financial information as established by the Financial Standards Accounting Board. ( )

13. Goodwill. The amount paid by the purchaser that exceeds the value of the net tangible assets. The value of goodwill is derived from the economic benefits that a going concern may enjoy, as compared with a new one, from established relations in the related markets, with government departments and other noncommercial bodies and with personal relationships. These intangible assets cannot be separated from the business and sold as can plant and equipment. Under the theory that the excess payment would be made only if expected future earnings justified it, goodwill is often described as the price paid for excess future earnings. The amortization of goodwill is a nonallowable, nonreimbursable expense. ( )

14. Healthy Connections. The primary care case management model of managed care under Idaho Medicaid. ( )

15. Historical Cost. The actual cost incurred in acquiring and preparing an asset for use, including feasibility studies, architects' fees, and engineering studies. ( )

16. Home and Community-Based Services (HCBS). HCBS are those long-term services and supports that assist eligible participants to remain in their home and community. ( )

17. ICF/IID Living Unit. The physical structure that an ICF/IID uses to house patients. ( )

18. Improvements. Improvements to assets that increase their utility or alter their use. ( )

19. Indirect Care Costs. The following costs either directly coded to the nursing facility or allocated to the nursing facility through the Medicare step-down process described in the PRM: ( )

a. Activities; ( )

b. Administrative and general care costs; ( )

c. Central service and supplies; ( )

d. Dietary (non-"raw food" costs); ( )

e. Employee benefits associated with the indirect salaries; ( )

f. Housekeeping; ( )

g. Laundry and linen; ( )

h. Medical records; ( )

i. Other costs not included in direct care costs, or costs exempt from cost limits; and ( )

j. Plant operations and maintenance (excluding utilities). ( )

20. Inflation Adjustment. The cost used in establishing a nursing facility's prospective reimbursement rate is indexed forward from the midpoint of the cost report period to the midpoint of the rate year using the inflation factor. ( )

21. Inflation Factor. For use in establishing nursing facility prospective rates, the inflation factor is the Skilled Nursing Facility Market Basket as established by IHS Markit, or its successor. If subsequent to the effective date of these rules, IHS Markit, or its successor develops an Idaho-specific nursing facility index, it will be used. The Department is under no obligation to enter into an agreement with IHS Markit or its successor to have an Idaho-specific index established. The national index is used when there is no state or regional index. ( )

22. 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. ( )

23. Inspection of Care Team (IOCT). An interdisciplinary team that provides inspection of care in intermediate care facilities for persons with intellectual disabilities approved by the Department as providers of care for eligible medical assistance participants. Such a team is composed of: ( )

a. At least one (1) licensed registered nurse; and ( )

b. One (1) Qualified Intellectual Disabilities Professional (QIDP); and when required, one (1) of the following: ( )

i. A consultant physician; or ( )

ii. A consultant social worker; or ( )

iii. When appropriate, other health and human services personnel responsible to the Department as employees or consultants. ( )

24. 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. ( )

25. Interest. The cost incurred for the use of borrowed funds. ( )

26. Interest on Capital Indebtedness. The cost incurred for borrowing funds used for acquisitions of capital assets, improvements, etc. These costs are reported under property costs. ( )

27. Interest on Working Capital. The costs incurred for borrowing funds that will be used for "working capital" purposes. These costs are reported under administrative costs. ( )

28. Interest Rate Limitation. The interest rate allowed for working capital loans and for loans for major movable equipment for ICF/IID facilities is the prime rate as published in the western edition of the Wall Street Journal or successor publication, plus one percent (+1%) at the date the loan is made. ( )

29. Interim Reimbursement Rate (IRR). A rate paid for each Medicaid patient day that is intended to result in total Medicaid payments approximating the amount paid at audit settlement. The interim reimbursement rate is intended to include any payments allowed in excess of the percentile cap. ( )

30. Intermediary. Any organization that administers the Title XIX and Title XXI program; in this case the Department of Health and Welfare. ( )

31. Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID). An entity licensed as an ICF/IID and federally certified to provide care to Medicaid and Medicare participants with developmental disabilities. ( )

32. Keyman Insurance. Insurance on owners or employees with extraordinary talents in which the direct or indirect beneficiary is the facility or its owners. Premiums related to keyman insurance are not allowable. ( )

012. DEFINITIONS: L THROUGH O.
For the purposes of these rules, the following terms are used as defined below: ( )

01. Lease. A contract arrangement for use of another's property, usually for a specified time period, in return for period rental payments. ( )

02. Leasehold Improvements. Additions, adaptations, corrections, etc., made to the physical components of a building or construction by the lessee for their use or benefit. Such additions may revert to the owner. Such costs are usually capitalized and amortized over the life of the lease. ( )

03. 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. ( )

04. Level of Care. The classification in which a participant is placed, based on severity of need for institutional care. ( )

05. Licensed Bed Capacity. The number of beds that are approved by the Licensure and Certification Agency for use in rendering patient care. ( )

06. Licensed, Qualified Professionals. Individuals licensed, registered, or certified by national certification standards in their respective discipline, or otherwise qualified within the state of Idaho. ( )

07. Lower of Cost or Charges. Payment to providers (other than public providers furnishing such services free of charge or at nominal charges to the public) is the lesser of the reasonable cost of such services or the customary charges with respect to such services. Public providers that furnish services free of charge or at a nominal charge are reimbursed fair compensation; which is the same as reasonable cost. ( )

08. MAI Appraisal. An appraisal that conforms to the standards, practices, and ethics of the Appraisal Institute and is performed by a member of the Appraisal Institute. ( )

09. Major Movable Equipment. Major movable equipment means such items as beds, wheelchairs, desks, furniture, vehicles, etc. The general characteristics of this equipment are: ( )

a. A relatively fixed location in the building; ( )

b. Capable of being moved, as distinguished from building equipment; ( )

c. A unit cost of five thousand dollars ($5000) or more; ( )

d. Sufficient size and identity to make control feasible by means of identification tags; and ( )

e. A minimum life of three (3) years. ( )

10. Margin Payment. A potential addition to each provider's cost for indirect costs and direct costs, if their cost is below the price set for each of these cost components. The margin payment will be separately calculated for indirect care costs and direct care cost and will be capped at an agreed upon maximum. ( )

11. Medical Assistance. Payments for part or all of the cost of services funded by Titles XIX or XXI of the federal Social Security Act, as amended. ( )

12. Medicaid. Idaho's Medical Assistance Program. ( )

13. Medicaid Related Ancillary Costs. For the purpose of these rules, those services provided in nursing facilities considered to be ancillary by Medicare cost reporting principles. Medicaid related ancillary costs will be determined by apportioning direct and indirect costs associated with each ancillary service to Medicaid residents by dividing Medicaid charges into total charges for that service. The resulting percentage, when multiplied

by the ancillary service cost, will be considered Medicaid related ancillaries. ( )

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

15. Medical Necessity (Medically Necessary). A service is medically necessary if: ( )

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

b. There is no other equally effective course of treatment available or suitable for the participant requesting the service that is more conservative or substantially less costly. ( )

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

16. 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. ( )

17. Medicare Savings Program. The program formerly known as "Buy-In Coverage," where the state pays the premium amount for participants eligible for Medicare Parts A and B of Title XVIII. ( )

18. Minimum Data Set (MDS). A set of screening, clinical, and functional status elements, including common definitions and coding categories, that forms the foundation of the comprehensive assessment for all residents of long term care facilities certified to participate in Medicare or Medicaid. The version of the assessment document used for rate setting is version 2.0. Subsequent versions of the MDS will be evaluated and incorporated into rate setting as necessary. ( )

19. Minor Movable Equipment. Minor movable equipment includes such items as wastebaskets, bedpans, syringes, catheters, silverware, mops, buckets, etc. Oxygen concentrators used in lieu of bottled oxygen may, at the facility's option, be considered minor movable equipment with the cost reported as a medical supply. The general characteristics of this equipment are: ( )

a. No fixed location and subject to use by various departments of the provider's facility; ( )

b. Comparatively small in size and unit cost under five thousand dollars ($5000); ( )

c. Subject to inventory control; ( )

d. Fairly large quantity in use; and ( )

e. A useful life of less than three (3) years. ( )

20. Necessary. The purchase of goods or services that is required by law, prudent management, and for normal, efficient and continuing operation of patient related business. ( )

21. Negotiated Service Agreement (NSA). The plan reached by the resident and their representative, or both, and the facility or certified family home based on the assessment, physician or authorized provider's orders, admissions records, and desires of the resident. The NSA must outline services to be provided and the obligations of the facility or certified family home and the resident. ( )

22. Net Book Value. The historical cost of an asset, less accumulated depreciation. ( )

23. **Nominal Charges**. A public provider's charges are nominal where aggregate charges amount to less than one-half (1/2) of the reasonable cost of the related services. ( )

24. **Nonambulatory**. Unable to walk without assistance. ( )

25. **Nonprofit Organization**. An organization whose purpose is to render services without regard to gains. ( )

26. **Normalized Per Diem Cost**. Refers to direct care costs that have been adjusted based on the nursing facility's case mix index for purposes of making the per diem cost comparable among nursing facilities. Normalized per diem costs are calculated by dividing the nursing facility's direct care per diem costs by its nursing facility-wide case mix index, and multiplying the result by the statewide average case mix index. ( )

27. **Nurse Practitioner**. A licensed registered nurse (RN) who meets all the applicable requirements to practice as nurse practitioner under Title 54, Chapter 14, Idaho Code, and IDAPA 24.34.01, "Rules of the Idaho Board of Nursing." ( )

28. **Nursing Facility (NF)**. An institution, or distinct part of an institution, that is primarily engaged in providing skilled nursing care and related services for participants. It is an entity licensed as a nursing facility and federally certified to provide care to Medicaid and Medicare participants. The participants require medical or nursing care, or rehabilitation services for injuries, disabilities, or illness. ( )

29. **Nursing Facility Inflation Rate**. See the definition of Inflation Factor in Subsection 011.20 of these rules. ( )

30. **Ordinary**. Ordinary means that the costs incurred are customary for the normal operation of the business. ( )

31. **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. ( )

013. DEFINITIONS: P THROUGH Z.
For the purposes of these rules, the following terms are used as defined below: ( )

01. **Patient Day**. ( )

a. For ICF/IID, a calendar day of care includes the day of admission and excludes the day of discharge, unless discharge occurs after 3:00 p.m. or it is the date of death. When admission and discharge occur on the same day, one (1) day of care is deemed to exist. ( )

b. For a nursing facility, a calendar day of care includes the day of admission and excludes the day of discharge, unless it is the date of death. When admission and discharge occur on the same day, one (1) day of care is deemed to exist. ( )

02. **Participant**. A person eligible for and enrolled in the Idaho Medical Assistance Program. ( )

03. **Patient**. The person undergoing treatment or receiving services from a provider. ( )

04. **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, and is the employer of record as well as the actual employer. ( )

05. **Personal Assistance Services (PAS)**. Services that include both attendant care for participants under an HCBS waiver and personal care services for participants under the Medicaid State Plan. PAS means services

that involve personal and medically-oriented tasks dealing with the functional needs of the participant and accommodating the participant's needs for long-term maintenance, supportive care, or instrumental activities of daily living (IADLs). These services may include personal assistance and medical tasks that can be done by unlicensed persons or delegated to unlicensed persons by a health care professional or participant. Services are based on the participant's abilities and limitations, regardless of age, medical diagnosis, or other category of disability. ( )

06. 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. ( )

07. Physician's Assistant. A person who meets all the applicable requirements to practice as licensed physician assistant under Title 54, Chapter 18, Idaho Code, and IDAPA 24.33.02, "Rules for the Licensure of Physician Assistants." ( )

08. Picture Date. A point in time when case mix indexes are calculated for every nursing facility based on the residents in the nursing facility on that day. The picture date to be used for rate setting will be the first day of the first month of a quarter. The picture date from that quarter will be used to establish the nursing facility's rate for the next quarter. ( )

09. Plan of Care. A written description of medical, remedial, or rehabilitative services to be provided to a participant, developed by or under the direction and written approval of a physician. Medications, services and treatments are identified specifically as to amount, type and duration of service. ( )

10. Private Rate. Rate most frequently charged to private patients for a service or item. ( )

11. Property. The homestead and all personal and real property in which the participant has a legal interest. ( )

12. Property Costs. Property costs are the total of allowable interest expense, plus depreciation, property insurance, real estate taxes, amortization, and allowable lease/rental expense. The Department may require and utilize an appraisal to establish which components are an integral part of property costs. ( )

13. Property Rental Rate. A rate paid per Medicaid patient day to free-standing nursing facilities and ICF/IIDs in lieu of reimbursement for property costs other than property taxes, property insurance, and the property costs of major movable equipment at ICF/IID facilities. ( )

14. Provider. Any individual, partnership, association, corporation or organization, public or private, that furnishes medical goods or services in compliance with these rules and who has applied for and received a Medicaid provider number and has entered into a written provider agreement with the Department in accordance with IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 205. ( )

15. Provider Agreement. A written agreement between the provider and the Department, in accordance with IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 205. ( )

16. Provider Reimbursement Manual (PRM). The Providers Reimbursement Manual, a federal publication that specifies accounting treatments and standards for the Medicare program, CMS Publications 15-1 and 15-2, that are incorporated by reference in Section 004 of these rules. ( )

17. Psychologist, Licensed. A person licensed to practice psychology in Idaho under Title 54, Chapter 23, Idaho Code, and as outlined by IDAPA 24.12.01, "Rules of the Idaho State Board of Psychologist Examiners." ( )

18. Psychologist Extender. A person who practices psychology under the supervision of a licensed psychologist as required under Title 54, Chapter 23, Idaho Code, and as outlined by IDAPA 24.12.01, "Rules of the Idaho State Board of Psychologist Examiners," and who is registered with the Bureau of Occupational Licenses. ( )

19. Public Provider. A public provider is one operated by a federal, state, county, city, or other local

government agency or instrumentality. ( )

20. Raw Food. Food used to meet the nutritional needs of the residents of a facility, including liquid dietary supplements, liquid thickeners, and tube feeding solutions. ( )

21. Reasonable Property Insurance. Reasonable property insurance means that the consideration given is an amount that would ordinarily be paid by a cost-conscious buyer for comparable insurance in an arm's length transaction. Property insurance per licensed bed in excess of two (2) standard deviations above the mean of the most recently reported property insurance costs per licensed bed of all facilities in the reimbursement class as of the end of a facility's fiscal year cannot be considered reasonable. ( )

22. Recreational Therapy (Services). Those activities or services that are generally perceived as recreation such as fishing, hunting, camping, attendance or participation in sporting events or practices, attendance at concerts, fairs or rodeos, skiing, sightseeing, boating, bowling, swimming, and special day parties (birthday, Christmas, etc.). ( )

23. Regional Nurse Reviewer (RNR). A licensed registered nurse who reviews and makes determinations on applications for entitlement to and continued participation in Title XIX and Title XXI long term care for the Department. ( )

24. Registered Nurse - R.N. Which in the state of Idaho is known as a Licensed Registered Nurse and who meets all the applicable requirements to practice as a licensed registered nurse under Title 54, Chapter 14, Idaho Code, and IDAPA 24.34.01 "Rules of the Idaho Board of Nursing." ( )

25. Related Entity. An organization with which the provider is associated or affiliated to a significant extent, or has control of, or is controlled by, that furnishes services, facilities, or supplies for the provider. ( )

26. Related to Provider. The provider, to a significant extent, is associated or affiliated with, or has control of, or is controlled by, the organization furnishing the services, facilities, or supplies. ( )

27. Residential Assisted Living Facility. A facility or residence, however named, operated on either a profit or nonprofit basis for the purpose of providing necessary supervision, personal assistance, meals, and lodging to three (3) or more adults not related to the owner. In this chapter, Residential Assisted Living Facilities are referred to as "facility." Distinct segments of a facility may be licensed separately, provided each segment functions independently and meets all applicable rules. ( )

28. Resource Utilization Groups (RUG). A process of grouping residents according to the clinical and functional status identified by the responses to key elements of the MDS. The RUG Grouper is used for the purposes of rate setting and determining nursing facility level of care. ( )

29. Skilled Nursing Care. The level of care for patients requiring twenty-four (24) hour skilled nursing services. ( )

30. 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. ( )

31. State Plan. The contract between the state and federal government under 42 U.S.C. section 1396a(a). ( )

32. Supervision. Procedural guidance by a qualified person and initial direction and periodic inspection of the actual act, at the site of service delivery. ( )

33. Title XVIII. Title XVIII of the Social Security Act, known as Medicare, for the aged, blind, and disabled administered by the federal government. ( )

34. Title XIX. Title XIX of the Social Security Act, known as Medicaid, is a medical benefits program jointly financed by the federal and state governments and administered by the states. This program pays for medical

assistance for certain individuals and families with low income and limited resources. ( )

35. Title XXI. Title XXI of the Social Security Act, known as the State Children's Health Insurance Program (SCHIP). This is a program that primarily pays for medical assistance for low-income children. ( )

36. 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 participant of medical assistance. ( )

37. Transportation. The physical movement of a participant to and from a medical appointment or service by the participant, another person, taxi or common carrier. ( )

38. Uniform Assessment. A set of standardized criteria to assess functional and cognitive abilities. ( )

39. Uniform Assessment Instrument (UAI). A set of standardized criteria adopted by the Department of Health and Welfare to assess functional and cognitive abilities as described in IDAPA 16.03.23 "Uniform Assessments of State-Funded Clients." ( )

40. Updated Assessments. Assessments are considered updated and current when a qualified professional with the same credential or the same qualifications of that professional who completed the assessment has reviewed such assessment and verified by way of their signature and date in the participant's file that the assessment continues to reflect the participant's current status and assessed needs. ( )

41. Utilities. All expenses for heat, electricity, water and sewer. ( )

42. 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 or participants to Title XIX and Title XXI benefits in a nursing facility. ( )

43. Utilization Control Team (UCT). A team of Regional Nurse Reviewers that conducts on-site reviews of the care and services in the nursing facilities approved by the Department as providers of care for eligible medical assistance participants. ( )

44. Vocational Services. Services or programs that 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 participant would be able to participate in a sheltered workshop or in the general work force within one (1) year. ( )

014. -- 019. (RESERVED)

GENERAL PARTICIPANT PROVISIONS

020. PARTICIPATION IN THE COST OF WAIVER SERVICES.

01. Waiver Services and Income Limit. A participant is not required to participate in the cost of Home and Community-Based (HCBS) waiver services unless: ( )

a. The participant's eligibility for medical assistance is based on approval for and receipt of a waiver service; and ( )

b. The participant is eligible for Medicaid if they meet the conditions referred to under IDAPA 16.03.05, "Eligibility for Aid to the Aged, Blind, and Disabled (AABD)," Section 787. ( )

02. Waiver Cost-Sharing. Participation in the cost of HCBS waiver services is determined as described in IDAPA 16.03.18, "Medicaid Cost-Sharing." ( )

021. MEDICARE SAVINGS PROGRAM FOR PARTICIPANTS COVERED BY MEDICARE.

The Department has an agreement with the Centers for Medicare and Medicaid Services (CMS) to pay the premiums for Parts A and B of Title XVIII for each participant eligible for Medicare and medical assistance regardless of whether the participant receives a financial grant from the Department. ( )

01. AABD Effective Date. The effective date of the Medicare Savings Program for a participant approved for medical assistance and an AABD grant is the first month of eligibility for the AABD grant. ( )

02. SSI Effective Date. The effective date of the Medicare Savings Program for a participant approved for medical assistance who also receives SSI, but not AABD, is the first month of eligibility for medical assistance. ( )

03. Neither AABD or SSI Effective Date. The effective date of the Medicare Savings Program for a participant approved for medical assistance who does not receive an AABD grant or SSI is the first day of the second month following the month in which they became eligible for medical assistance. This would mean the third month of medical assistance eligibility for the participant. ( )

04. Update of Records. After the effective date of the Medicare Savings Program it takes the Social Security Administration up to one (1) month to update its records to show the Department's payment of the Medicare Savings Program premium. ( )

05. Policies for Treatment of the Medicare Savings Program. The Department advises each participant who is paying Parts A and B Medicare premiums to discontinue payments beginning the month the Medicare Savings Program becomes effective. Policies for treatment of the Medicare Savings Program for determining eligibility for medical assistance or AABD, grant amount for AABD, or patient liability are in IDAPA 16.03.05, "Eligibility for Aid to the Aged, Blind and Disabled (AABD)." Policies for treatment of the Medicare Savings Program for determining participation of an HCBS participant are found in Section 020 of these rules. ( )

022. PARTICIPANT'S REQUIREMENTS FOR ESTATE RECOVERY.
A participant's estate may be obligated to pay the Medicaid program back for the amount Medicaid paid out for medical assistance during the participant's life. The requirements for that estate recovery are found in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 900. ( )

023. -- 024. (RESERVED)

025. GENERAL SERVICE LIMITATIONS.
Service limitations stated in these rules include any services received by a participant under IDAPA 16.03.09, "Medicaid Basic Plan Benefits." ( )

026. SELECTIVE CONTRACTING.
The Department may contract with a limited number of providers of certain Medicaid products and services. ( )

027. -- 029. (RESERVED)

GENERAL REIMBURSEMENT PROVISIONS

030. COST REPORTING.
The provider's Medicaid cost report must be filed using the Department designated reporting forms, unless the Department has approved an exception. The request to use alternate forms must be sent to the Department in writing, with samples attached, a minimum of ninety (90) days prior to the due date for the cost report. The request for approval of alternate forms cannot be used as a reason for late filing. ( )

031. -- 035. (RESERVED)

036. GENERAL REIMBURSEMENT.

01. Long-Term Care Facility Payment. Long-term care facilities will be reimbursed the lower of their customary charges, their actual reasonable costs, adjusted by a budget adjustment factor (BAF) for nursing facilities, or the standard costs for their class as set forth in the Provider Reimbursement Manual, but the upper limits for payment must not exceed the payment that would be determined as reasonable costs using the Title XVIII Medicare standards and principles. ( )

02. Individual Provider Payment. The Department will not pay the individual provider more than the lowest of: ( )

a. The provider's actual charge for service; or ( )

b. The maximum allowable charge for the service as established by the Department on its pricing file, if the service or item does not have a specific price on file, the provider must submit documentation to the Department and reimbursement will be based on the documentation; or ( )

c. The Medicaid upper limitation of payment on those services, minus the Medicare payment, where a participant is eligible for both Medicare and Medicaid. The Department will not reimburse providers an amount in excess of the amount allowed by Medicaid, minus the Medicare payment. ( )

037. GENERAL REIMBURSEMENT: PARTICIPANT SERVICES.
The Department will evaluate provider reimbursement rates that comply with 42 U.S.C. 1396a(a)(30)(A). This evaluation will assure payments are consistent with efficiency, economy, and quality of care and safeguards against unnecessary utilization of care and services. Reimbursements will be sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area. ( )

01. Applicable Participant Services. Unless otherwise provided in this chapter of rules, the following types of services are reimbursed as provided in this rule: ( )

a. The Personal Care Services (PCS) described in Sections 300-308 of these rules. ( )

b. The Aged and Disabled Waiver services described in Sections 320-330 of these rules. ( )

c. The Children's Developmental Disabilities Home and Community-Based State Plan Option Services described in Sections 520-528 of these rules. ( )

d. The Adult Developmental Disabilities Waiver services described in Sections 700-706 of these rules. ( )

e. The Adult Developmental Disabilities Home and Community-Based State Plan Option Services described in Sections 645-657 of these rules. ( )

02. Review Reimbursement Rates. The Department will review provider reimbursement rates and conduct cost surveys when an access or quality indicator reflects a potential access or quality issue described in this rule. ( )

03. Access. The Department will review annual statewide and regional access reports by service type comparing the previous twelve (12) months to the base-line year of State Fiscal Year 2012. The following measures will be used to determine when there is potential for access issues. ( )

a. Compare the change in total number of provider locations for service type to the change in eligible participants; or ( )

b. When participant complaints and critical incidence logs reveal outcomes that identify access issues for a service type. ( )

04. Quality. The Department will review quality reports required by each program used to monitor for

patterns indicating an emerging quality issue. ( )

05. Cost Survey. The Department will survey one hundred percent (100%) of providers. Providers that refuse or fail to respond to the periodic state surveys may be disenrolled as Medicaid providers. The Department will derive reimbursement rates using direct care staff costs, employment related expenditures, program related costs, and indirect general and administrative costs in the reimbursement methodology, when these costs are incurred by a provider. The Department will conduct cost surveys customized for each of the services identified in this rule. ( )

a. Wage rates will be used in the reimbursement methodology when the expenditure is incurred by the provider type executing the program. Wages will be identified in the Bureau of Labor Statistics website at www.bls.gov when there is a comparable occupation title for the direct care staff. When there is no comparable occupation title for the direct care staff, then a weighted average hourly rate methodology will be used. ( )

b. For employer related expenditures: ( )

i. The Bureau of Labor Statistics's report for employer costs per hour worked for employee compensation and costs as a percent of total compensation for Mountain West Divisions will be used to determine the incurred employer related costs by each provider type. The website for access to this report is at www.bls.gov. ( )

ii. The Internal Revenue Service employer cost for social security benefit and Medicare benefit will be used to determine the incurred employer related costs by provider type. The website for access to this information is at www.irs.gov. ( )

c. Cost surveys to collect indirect general, administrative, and program related costs will be used when these expenditures are incurred by the provider type executing the program. The costs will be ranked by costs per provider, and the Medicaid cost used in the reimbursement rate methodology will be established at the seventy-fifth percentile in order to efficiently set a rate. ( )

038. SPECIALIZED REIMBURSEMENT: CERTAIN HOME AND COMMUNITY-BASED SERVICES. The Department will review provider reimbursement rates to ensure compliance with 42 U.S.C. 1396a(a)(30)(A). This review will assure payments are consistent with efficiency, economy, quality of care, and safeguard against unnecessary utilization of care and services. Reimbursements will be sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area. ( )

01. Applicable Home and Community-Based Services. The home and community-based services provided by the following types of providers are reimbursed as described in this rule: ( )

a. Developmental Disability Agencies providing services to adults; ( )

b. Developmental Disability Agencies providing services to children; ( )

c. Residential Habilitation Agencies; ( )

d. Supported Employment Agencies; and ( )

e. Targeted Service Coordination Agencies. ( )

02. Timing, Description, and Results of Rate Reviews. ( )

a. Standard Rate Reviews. The Department will conduct a cost survey and review reimbursement rates at least once every five (5) years for each type of provider specified in this rule. Cost surveys will be conducted in the order and on the schedule established by the Department. ( )

b. Interim Rate Reviews. The Department will prepare an annual trigger analysis and publish the

report on its Medicaid Providers webpage, http://healthandwelfare.idaho.gov/Providers/MedicaidProviders/tabid/214/Default.aspx. This annual report will describe the triggers for interim rate review, a summary of the data reviewed for each trigger, and the Department's determination and rationale of whether each trigger was met. The Department will conduct an interim rate review upon the occurrence of one (1) or more of the following triggers: ( )

i. When substantiated participant complaints, critical incidents, or both, related to a lack of qualified providers indicate an emerging access issue; ( )

ii. When quality reports prepared by the Department or substantiated participant complaints and critical incidents related to the quality of services provided indicate an emerging quality issue; or ( )

iii. When the federal or Idaho state minimum wage requirement in effect at the time of the standard rate review significantly increases or decreases. ( )

c. No Obligation to Revise Rates. The Department is not required to revise reimbursement rates each time a rate review or cost survey is conducted. The results of a rate review or cost survey do not guarantee a change to the reimbursement rate. ( )

03. Cost Survey Procedures. ( )

a. Participation. The Department will survey one hundred percent (100%) of providers. A provider who refuses or fails to respond to the periodic cost surveys may be disenrolled as a Medicaid provider. ( )

b. Customization. The Department will conduct cost surveys customized for each type of provider identified in this rule. ( )

c. Independent Consultant. The Department will engage an independent cost survey consultant with expertise and experience in fee-for-service home and community-based services, including services for individuals with developmental disabilities. ( )

d. Provider Engagement. ( )

i. The Department will establish reimbursement advisory workgroups to advise on matters related to the specialized reimbursement specified in this rule, including notice and development of cost surveys, recommendation of Bureau of Labor and Statistics occupation profile or profiles utilized when setting new reimbursement rates, and other reimbursement-related matters presented by the Department. The Department will retain final decision-making authority over all matters presented to or reviewed by the workgroups. ( )

ii. The Department will provide reasonable prior notice of pending cost surveys to impacted providers. ( )

iii. The Department or its cost survey consultants will train providers how to complete the cost survey, and provide technical assistance to providers during the cost survey response period. ( )

04. Reimbursement Rate Setting Methodology. Reimbursement rates will be derived using a combination of four (4) cost components - direct care staff wages or targeted service coordinator wages, employee-related expenses, program-related expenses, and general and administrative expenses. Each provider must demonstrate that the average percent of wage and benefits paid to their direct care staff (or targeted service coordinators) meets or exceeds the percent of wages and employee-related expenses utilized in establishing the reimbursement rate for the service type. The Department will utilize the reimbursement advisory workgroup established in this rule to collaboratively develop monitoring and enforcement procedures for this minimum allocation requirement. The cost components and new reimbursement rate are established in accordance with the following: ( )

a. Direct Care Staff Wages and Targeted Service Coordinator Wages. ( )

i. Direct care staff and targeted service coordinator wages are wages paid to individuals employed or contracted by an agency who perform duties described in the applicable service coverage description for at least seventy-five percent (75%) of the total annual amount of time they are compensated. ( )

ii. The wage component (Wage) used to establish the new reimbursement rate is set using the mean hourly wage of one (1) or more occupation profiles from the most current Bureau of Labor and Statistics (BLS) State Occupational Employment and Wage Estimates table for the state of Idaho found on the BLS website at www.bls.gov. The BLS occupation profile that most closely aligns with the duties, education level, and supervision requirements of the direct care staff (or targeted service coordinator) providing the service is utilized. If more than one (1) occupation profile aligns with the duties, education level, and supervision requirements of the direct care staff (or the targeted service coordinator) providing the service, then a weighted average of the mean hourly wage of multiple BLS occupation profiles is utilized. ( )

iii. When there is no comparable occupation profile or profiles for the direct care staff (or targeted service coordinator), then the wage component used to establish the new reimbursement rate is set using the weighted average hourly rate (WAHR) of the surveyed wages included in the final cost survey results. ( )

iv. The Department will make the final determination of BLS occupation profile or profiles after consideration of advice from the relevant Reimbursement Advisory Workgroup. ( )

v. The Department will evaluate an appropriate wage inflation factor based on the economic data available at the time the reimbursement rate is set. ( )

b. Employee-Related Expenses (ERE). ( )

i. ERE are the expenses incurred by the provider agency for the benefit of the direct care staff (or targeted service coordinators) of an agency in the following six (6) categories: (1) paid leave, (2) supplemental pay, (3) payroll taxes, (4) workers' compensation, (5) insurance coverage, and (6) retirement contributions. ( )

ii. The ERE component percentage (ERE%) used to establish the new reimbursement rate is set using the cumulative percentage of employer costs for employee compensation from the most current BLS Employer Costs for Employee Compensation table for the West Region in the Mountain Division and IRS Publication 15. ( )

c. Program-Related Expenses (PRE). ( )

i. PRE are wages and other expenses that support the objectives and provision of the service but cannot be tied to any particular person receiving the service. Requirements related to the delivery of services in accordance with statute and rule are PRE. ( )

ii. Program-related staff are individuals employed by an agency who perform program-related duties as required by statute or rule for at least seventy-five percent (75%) of the total annual amount of time they are compensated. ( )

iii. Utilizing data in the final cost survey results, each agency's PRE component percentage (PRE%) is calculated by dividing the agency's total PRE by the agency's total wages. Each agency's PRE% is ranked, and the PRE% used to calculate the new reimbursement rate is set at the mean of the agency PRE%. ( )

d. General and Administrative (G&A) Expenses. ( )

i. G&A expenses are wages and other expenses related to day-to-day operations common across all businesses. ( )

ii. G&A staff are individuals employed by an agency who perform administrative duties for at least seventy-five percent (75%) of the total annual amount of time they are compensated. ( )

iii. Utilizing data in the final cost survey results, each agency's G&A component percentage (G&A%) is calculated by dividing the agency's total G&A expenses by the sum of the agency's total wages, plus the total ERE,

plus the total PRE, plus the total G&A expenses. Each agency's G&A% is ranked, and the G&A% used to calculate the new reimbursement rate is set at the mean of the agency G&A%. ( )

iv. The G&A% used to calculate the new reimbursement rate will not exceed ten percent (10%) of the total reimbursement rate per staff hour. ( )

e. Total Reimbursement Rate Per Staff Hour of Service = ((Wage + (ERE% x Wage) + (PRE% x Wage)) /(1- (G&A%)). ( )

f. The Department is not obligated to make budget requests based on the total reimbursement rate per staff hour. The Department will take into consideration the factors of efficiency, economy, quality of care, and access to care when determining rates. Reimbursement rates may be set at a percentage of the total reimbursement rate per staff hour. All reimbursement rate increases are subject to approval by the Idaho State Legislature. ( )

05. Quality Performance Incentives. ( )

a. Based on the quality of services provided to its Medicaid participants, a provider may become eligible to receive incentive payments. ( )

b. Quality measures and associated payment percentages will be established by the Department, in collaboration with the Idaho Council on Developmental Disabilities and DisAbility Rights Idaho (or such other organization designated by the Governor as the state's protection and advocacy system), and will be described in the Idaho Medicaid Provider Handbook available at www.idmedicaid.com. The Department will provide sixty (60) days prior notice of any substantive changes to the quality measures and associated payment percentages described in its provider handbook. ( )

c. Incentive payments will be subject to the availability of State and federal funds, and may be rescinded if the quality of services declines. ( )

039. ACCOUNTING TREATMENT.
Generally accepted accounting principles, concepts, and definitions will be used except as otherwise specified. Where alternative treatments are available under GAAP, the acceptable treatment will be the one that most clearly attains program objectives. ( )

01. Final Payment. A final settlement will be made based on the reasonable cost of services as determined by audit, limited in accordance with other sections of this chapter. ( )

02. Overpayments. As a matter of policy, recovery of overpayments will be attempted as quickly as possible consistent with the financial integrity of the provider. ( )

03. Other Actions. Generally, overpayment will result in two (2) circumstances: ( )

a. If the cost report is not filed, the sum of the following will be due: ( )

i. All payments included in the period covered by the missing report(s). ( )

ii. All subsequent payments. ( )

b. Excessive reimbursement or non-covered services may precipitate immediate audit and settlement for the period(s) in question. Where such a determination is made, it may be necessary that the interim reimbursement rate (IRR) will be reduced. This reduction will be designated to effect at least one (1) of the following: ( )

i. Discontinuance of overpayments (on an interim basis). ( )

ii. Recovery of overpayments. ( )

040. PROVIDER'S RESPONSIBILITY TO MAINTAIN RECORDS.

The provider must maintain financial and other records in sufficient detail to allow the Department to audit them as described in Subsection 001.03 of these rules. ( )

01. Expenditure Documentation. Documentation of expenditures must include the amount, date, purpose, payee, and the invoice or other verifiable evidence supporting the expenditure. ( )

02. Cost Allocation Process. Costs such as depreciation or amortization of assets and indirect expenses are allocated to activities or functions based on the original identity of the costs. Documentation to support basis for allocation must be available for verification. ( )

03. Revenue Documentation. Documentation of revenues must include the amount, date, purpose, and source of the revenue. ( )

04. Availability of Records. Records must be available for and subject to audit by the auditor, with or without prior notice, during any working day between the hours of 8:00 a.m. and 5:00 p.m. at the provider's principal place of business in the state of Idaho. ( )

a. The provider is given the opportunity to provide documentation before the interim final audit report is issued. ( )

b. The provider is not allowed to submit additional documentation in support of cost items after the issuance of the interim final audit report. ( )

05. Retention of Records. Records required in Subsections 040.01 through 040.03 of these rules must be retained by the provider for a period of five (5) years from the date of the final payment under the provider agreement. Failure to retain records for the required period can void the Department's obligation to make payment for the goods or services. ( )

041. SPECIALIZED REIMBURSEMENT: ELECTRONIC VISIT VERIFICATION (EVV).

01. Services Subject to EVV Requirement. Effective July 1, 2021, agencies providing the following services are required to submit claims using a compliant EVV system as mandated by Section 12006 of the 21st Century Cures Act: ( )

a. Private Duty Nursing Services as described in Sections 200 through 210 of these rules; ( )

b. Personal Care Services (PCS) as described in Sections 300 through 309 of these rules; ( )

c. The following Aged and Disabled Waiver Services as described in Sections 320 through 329 of these rules: ( )

i. Attendant Care; ( )

ii. Homemaker; and ( )

iii. Respite. ( )

02. EVV Definitions. ( )

a. Aggregator. System that collects provider EVV information from multiple software platforms and standardizes the information in MMIS for EVV data validation. ( )

b. Claims Adjudication. The process of determining Medicaid financial responsibility for claims submitted to MMIS. ( )

c. Electronic Visit Verification (EVV). EVV is software or device(s) that electronically captures information verifying service delivery information. ( )

03. Claims Subject to EVV Requirements. To submit eligible claims for services with EVV requirements, providers must: ( )

a. Maintain an EVV system chosen by their agency and certified as compliant with the MMIS aggregator, as determined by the Department and/or the MMIS Contractor; ( )

b. Document and retain participant consent for use of electronic verification methods; ( )

c. Develop and maintain policies and procedures outlining agency implementation and use of EVV technology, including strategies for safeguarding of participant information and privacy; and ( )

d. Submit EVV data that captures these six (6) system-validated data elements for services rendered: ( )

i. Date of service; ( )

ii. Time the service begins and ends; ( )

iii. Individual providing the service; ( )

iv. Participant receiving the service; ( )

v. Billable service performed; and ( )

vi. Location of service delivery. ( )

e. Provider claims for services requiring EVV will include the corresponding EVV data elements listed above. Provider EVV data will be submitted to the state's aggregator prior to billing claims. These claims are subject to a quality review in accordance with Subsection 210.10 of IDAPA 16.03.09, "Medicaid Basic Plan Benefits." ( )

042. -- 049. (RESERVED)

050. DRAFT AUDIT REPORT.
Following completion of the audit field work on a hospital, nursing facility, or an ICF/IID, and before issuing the interim final audit report to the Department, the auditor will issue a draft audit report and forward a copy to the provider for review and comment. ( )

01. Review Period. The provider will have a period of forty-five (45) days, beginning on the date of transmittal, to review and provide additional comments or evidence pertaining to the draft audit report. The review period may be extended, to a maximum of an additional fifteen (15) days past the original due date, when the provider: ( )

a. Requests an extension prior to the expiration of the original review period; and ( )

b. Clearly demonstrates the need for additional time to properly respond. ( )

02. Evaluation of Provider's Response. The auditor will evaluate the provider's response to the draft audit report and will delete, modify, or reaffirm the original findings, as deemed appropriate, in preparing the interim final audit report. ( )

051. FINAL AUDIT REPORT.
The auditor will incorporate the provider's response and an analysis of the response into the interim final report as appendices and transmit it to the Department. The Department will issue a final audit report and a notice of program reimbursement, if applicable, that sets forth settlement amounts due to the Department or the provider. The final audit report and notice of program reimbursement, if applicable, will take into account the findings made in the final audit

report and the response of the provider to the draft audit report ( )

052. -- 059. (RESERVED)

060. CRITERIA FOR PARTICIPATION IN THE IDAHO TITLE XIX AND TITLE XXI PROGRAMS.

01. Application for Participation and Reimbursement. Prior to participation in the Medical Assistance Program, facilities must be licensed or certified by the Department. The Department issues a provider number to the facility that becomes the primary provider identification number. The Division of Medicaid will establish an interim rate for the new applicant facility. This facility is now authorized to offer services at the level for which the provider agreement was issued. ( )

02. Reimbursement. The reimbursement mechanism for payment to provider facilities is specified in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," and in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." The Medical Assistance Program will not reimburse a facility until it is certified, has a signed agreement for participation and an established interim per diem rate. ( )

061. -- 069. (RESERVED)

070. EXCEPTION TO THE RELATED ORGANIZATION PRINCIPLE.
An exception is provided to the general rule applicable to related organizations. The exception applies if the provider demonstrates by convincing evidence to the satisfaction of the intermediary: ( )

01. Supplying Organization. That the supplying organization is a bona fide separate organization; ( )

02. Nonexclusive Relationship. That a substantial part of the supplying organization's business activity of the type carried on with the provider is transacted with other organizations not related to the provider and the supplier by common ownership or control and there is an open, competitive market. ( )

03. Sales and Rental of Extended Care Facilities. The exception is not applicable to sales, lease or rentals of nursing homes or extended care facilities. These transactions would not meet the requirement that there be an open, competitive market for the facilities furnished. See PRM, Sections 1008 and 1012. ( )

a. Rental expense for transactions between related entities will not be recognized. Costs of ownership will be allowed. ( )

b. When a facility is purchased from a related entity, the purchaser's depreciable basis will not exceed the seller's net book value. See PRM, Section 1005. ( )

071. -- 074. (RESERVED)

COVERED SERVICES
(Sections 075)

075. ENHANCED PLAN BENEFITS: COVERED SERVICES.
Individuals who are eligible for the Medicaid Enhanced Plan are enrolled in all benefits covered under IDAPA 16.03.09, "Medicaid Basic Plan Benefits." In addition to those benefits, individuals in the enhanced plan are eligible for enhanced benefits as described in this chapter of rules. ( )

076. MANAGED CARE FOR DUALS: DEFINITIONS.
For the purposes of the managed care service delivery system for dual eligible beneficiaries described in Sections 076 through 079 of these rules, the following definitions apply: ( )

01. Dual Eligible. A participant who is eligible for medical assistance under IDAPA 16.03.05, "Eligibility for Aid to the Aged, Blind, and Disabled (AABD)." The participant's Medicaid eligibility must not be based solely on the requirements found under IDAPA 16.03.05, "Eligibility for Aid to the Aged, Blind, and Disabled

(AABD)," Section 802. In addition, the participant must be eligible for and enrolled in both Medicare Part A and Medicare Part B. ( )

02. Health Plan. A health insurance company responsible for administering Medicaid benefits to dual eligible participants under a provider agreement with the Department. ( )

03. Idaho Medicaid Plus. A managed care program designed to administer Medicaid benefits for dual eligible participants administered under a provider agreement between the Department and participating health plans. ( )

04. Medicare/Medicaid Coordinated Plan. A managed care program as defined in IDAPA 16.03.17, "Medicare/Medicaid Coordinated Plan Benefits." ( )

05. Passive Enrollment. An enrollment process in which a participant is assigned to a participating health plan in a managed care service delivery structure unless the participant actively opts out of the enrollment process. ( )

077. MANAGED CARE FOR DUALS: PROGRAM AUTHORITY AND IMPLEMENTATION.

01. Program Authority. Idaho Medicaid Plus is a managed care program for dual eligible participants administered with approval from the Centers for Medicare and Medicaid Services (CMS). The Idaho Medicaid Plus program allows for a health plan to administer Medicaid benefits to dual eligible participants. ( )

02. Implementation. Idaho Medicaid Plus will be implemented using a phased-in approach. ( )

a. Idaho Medicaid Plus will be implemented in a pilot county upon approval from CMS and after the Department determines that participating health plans have passed a readiness review for implementation. ( )

b. Implementation in additional counties will occur in a phased-in manner upon successful implementation in the pilot county as determined by the Department. Phased-in implementation in any and all additional counties will be subject to Department approval. ( )

c. Participating health plans must meet established performance benchmarks prior to Idaho Medicaid Plus implementation in each successive geographic service area. ( )

078. MANAGED CARE FOR DUALS: PARTICIPANT ELIGIBILITY AND ENROLLMENT.
Idaho Medicaid Plus will be made available to dual eligible participants over age twenty-one (21) who reside in a county with at least one (1) participating health plan. ( )

01. Excluded Populations. Idaho Medicaid Plus is not available to the following populations: ( )

a. Dual eligible participants who have elected to enroll in the Medicare Medicaid Coordinated Plan as defined in IDAPA 16.03.17, "Medicare/Medicaid Coordinated Plan Benefits." ( )

b. Individuals enrolled in the Adult Developmental Disabilities 1915(c) waiver program as defined in Section 702 of these rules. ( )

02. Optional Populations. Tribal members and pregnant women who are dual eligible participants can elect to voluntarily enroll in Idaho Medicaid Plus if it is available in their county of residence. These participants retain the right to disenroll from Idaho Medicaid Plus at any time. ( )

03. Mandatory Enrollment. Dual eligible participants that are not members of an excluded population and reside in a county with two (2) or more participating health plans must select a health plan to administer their Idaho Medicaid Plus program. Mandatory enrollment procedures will occur in accordance with 42 CFR 438 Subpart B. ( )

04. Passive Enrollment. Dual eligible participants that are not members of an excluded population and reside in a county with only one (1) participating health plan will be enrolled into that health plan to administer their Idaho Medicaid Plus program unless they opt out by contacting the Department using the instructions on the enrollment notice. These dual eligible participants may opt out of Idaho Medicaid Plus at any time. ( )

079. MANAGED CARE FOR DUALS: COVERED SERVICES.

01. Coverage and Limitations. ( )

a. Idaho Medicaid Plus covered services include Medicaid benefits as described in this chapter and IDAPA 16.03.09, "Medicaid Basic Plan Benefits." ( )

b. Services for adults with developmental disabilities as described in Sections 511, 580, and 703 of these rules are excluded from Idaho Medicaid Plus. ( )

c. Services administered under the managed care or brokerage contracts as described in Section 080 of these rules, and IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Sections 870 through 872 are excluded from Idaho Medicaid Plus. ( )

02. Provider Reimbursement. Idaho Medicaid Plus participating health plans are required to reimburse network providers, at minimum, the established Medicaid fee schedule rates published on the Medicaid provider webpage and developed in accordance with Idaho Code and Department rule. ( )

080. -- 089. (RESERVED)

SUB AREA: ENHANCED HOSPITAL SERVICES
(Sections 090-099)

090. ORGAN TRANSPLANTS.
The Department will reimburse for organ transplant services as detailed in the Idaho Medicaid Provider Handbook, when medically necessary and provided by hospitals approved by the Centers for Medicare and Medicaid for the Medicare program that have completed a provider agreement with the Department. ( )

091. -- 092. (RESERVED)

093. ORGAN TRANSPLANTS: COVERAGE AND LIMITATIONS.

01. Coverage Limitations. No organ transplant will be covered by the Medical Assistance Program unless prior authorized by the Department, or its designee. Coverage is limited to organ transplants performed for the treatment of medical conditions in accordance with evidence-based standards of care. ( )

02. Living Donor Costs. The transplant costs for actual or potential living donors are fully covered by Medicaid and include all medically necessary preparatory, operation, and post-operation recovery expenses associated with the donation. Payments for post-operation expenses of a donor will be limited to the period of actual recovery. ( )

094. -- 095. (RESERVED)

096. ORGAN TRANSPLANTS: PROVIDER REIMBURSEMENT.
Organ transplant, procurement services, and follow-up care by facilities will be reimbursed as specified in the provider agreement. Reimbursement for organ procurement and histocompatibility laboratory tests will be made to the facility performing the transplant. ( )

097. -- 099. (RESERVED)

SUB AREA: ENHANCED INPATIENT BEHAVIORAL HEALTH SERVICES
(Sections 100-199)

100. INPATIENT BEHAVIORAL HEALTH SERVICES.
The Medicaid Enhanced Plan Benefits include psychiatric services covered under inpatient hospital services and inpatient behavioral health services covered in IDAPA 16.03.09 "Medicaid Basic Plan Benefits." ( )

101. INPATIENT BEHAVIORAL HEALTH SERVICES: PARTICIPANT ELIGIBILITY.
The rules for Inpatient Behavioral Health Services are found in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Sections 700 through 706 and apply to Inpatient Behavioral Health Services in these rules. Individuals over age sixty-five (65) are eligible for inpatient behavioral health services under these rules. ( )

102. -- 199. (RESERVED)

SUB AREA: ENHANCED HOME HEALTH CARE
(Sections 200-214)

200. PRIVATE DUTY NURSING SERVICES.

01. Description of Private Duty Nursing (PDN) Services. Private Duty Nursing (PDN) services are nursing services provided by a licensed registered nurse or licensed practical nurse to a non-institutionalized child under the age of twenty-one (21) requiring care for conditions of such medical severity or complexity that skilled nursing care is necessary. Sections 200 through 209 of these rules cover requirements for private duty nursing services.
( )

02. Temporary Changes to PDN Rules During Declared State of Emergency Related to Novel Coronavirus Disease (COVID-19). In response to Idaho's declaration on 3/13/20 of a state of emergency related to COVID-19, the Department reserves the right to temporarily alter requirements and processes related to PDN services in order to mitigate spread of disease and to ensure the health and safety of our participants under the guidance and authority of the provisions in a CMS-approved 1135 waiver through the duration of the emergency state. Guidance for approved flexibilities is posted on the Medicaid Information Releases website at https://www.idmedicaid.com/default.aspx. ( )

201. PRIVATE DUTY NURSING: DEFINITIONS.
The following definitions apply to Sections 200 through Section 209 of these rules. ( )

01. Primary RN. The RN identified by the family to be responsible for development, implementation, and maintenance of the Medical Plan of Care. ( )

02. Private Duty Nursing (PDN) RN Supervisor. An RN providing oversight of PDN services delegated to LPN's providing the child's care, in accordance with IDAPA 24.34.01, "Rules of the Board of Nursing." ( )

202. PRIVATE DUTY NURSING: ELIGIBILITY.
To be eligible for PDN, the nursing needs must be of such a nature that the Idaho Nursing Practice Act, Rules, Regulations, or policy require the service to be provided by an Idaho Licensed Registered Nurse (RN), or by an Idaho Licensed Practical Nurse (LPN), and require more individual and continuous care than is available from Home Health nursing services. PDN service will be authorized by the Department prior to delivery of service. ( )

203. PRIVATE DUTY NURSING: FACTORS ASSESSED FOR ELIGIBILITY AND REDETERMINATION.
Factors assessed for eligibility/redetermination include: ( )

01. Age for Eligibility. The individual is under the age of twenty-one (21) years. ( )

02. Maintained in Personal Residence. That the child is maintained in their personal residence and receives safe and effective services through PDN services. ( )

03. Medical Justification. The child receiving PDN services has medical justification and physician's orders. ( )

04. Written Plan of Care. That there is an updated written plan of care signed by the attending physician, the parent or legal guardian, PDN, RN supervisor, and a representative from the Department. ( )

05. Attending Physician. That the attending physician has determined the number of PDN hours needed to ensure the health and safety of the child in their home. ( )

06. Redetermination. Redetermination will be at least annually. The purpose of an annual redetermination for PDN is to: ( )

a. Determine if the child continues to meet the PDN criteria in Subsection 203.01 through 203.05 of these rules; and ( )

b. Assure that services and care are medically necessary and appropriate. ( )

204. PRIVATE DUTY NURSING: COVERAGE AND LIMITATIONS.
PDN services are functions that cannot be delegated to an Unlicensed Assistive Personnel (UAP) as defined by Idaho Code and IDAPA 23.01.01, "Rules of the Idaho Board of Nursing." ( )

01. Ordered by a Physician. PDN Services must be ordered by a physician and include: ( )

a. A medical status that is so complex or unstable, as determined by the attending physician, that licensed or professional nursing assessment is needed to determine the need for changes in medications or other interventions; or ( )

b. An assessment by a licensed registered nurse of a child's health status for unstable chronic conditions that includes an evaluation of the child's responses to interventions or medications. ( )

02. Plan of Care. PDN Services require a Plan of Care that: ( )

a. Is developed by a multi-disciplinary team to include, at a minimum, the parent or legal guardian, the primary PDN, RN, or RN Supervisor, and a representative from the Department; ( )

b. Includes all aspects of the medical, licensed, and personal care services medically necessary to be performed, including the amount, type, and frequency of such service; ( )

c. Is approved and signed by the attending physician, parent or legal guardian, and primary PDN, RN, or RN supervisor, and a representative from the Department; and ( )

d. Is revised and updated as child's needs change or upon significant change of condition, but at least annually, and is submitted to the Department for review and prior authorization of service. ( )

03. Status Updates. Status updates must be completed every ninety (90) days from the start of services. The Status Update is intended to document any change in the child's health status. Annual plan reviews will replace the fourth quarter Status Update. The Status Update must be signed by both the parent or legal guardian and the primary RN supervisor completing the form. ( )

04. Limitations. PDN Services may be provided only in the child's personal residence or when normal life activities take the child outside of this setting. However, if service is requested only to attend school or other activities outside of the home, but does not need such services in the home, private duty nursing will not be authorized. The following are specifically excluded as personal residences: ( )

a. Licensed Nursing Facilities (NF); ( )

b. Licensed Intermediate Care Facilities for Persons with Intellectual Disabilities (ICF/IID); ( )

c. Residential Assisted Living Facilities; ( )

d. Licensed hospitals; and ( )

e. Public or private school. ( )

205. – 208. (RESERVED)

209. PRIVATE DUTY NURSING: PROVIDER QUALIFICATIONS AND DUTIES.

01. Primary RN Responsibility For PDN Redetermination. Primary RN responsibility for PDN redetermination is to submit a current plan of care to the Department at least annually or as the child's needs change. Failure to submit an updated plan of care to the Department prior to the end date of the most recent authorization will cause payments to cease until completed information is received and evaluated and authorization given for further PDN services. The plan of care must include all requested material outlined in Subsection 204.02 of these rules. ( )

02. Physician Responsibilities. Physician responsibilities include: ( )

a. Medical Information. Provide the Department the necessary medical information in order to establish the child's medical eligibility for services based on an EPSDT screen. ( )

b. Order Services. Order all services to be delivered by the private duty nurse. ( )

c. Sign Medical Plan of Care. Review, sign, and date child's Medical Plan of Care and orders at least annually or as condition changes. ( )

d. Community Resources. Determine if the combination of PDN Services along with other community resources are sufficient to ensure the health or safety of the child. If it is determined that the resources are not sufficient to ensure the health and safety of the child, notify the family and the Department and facilitate the admission of the child to the appropriate medical facility. ( )

03. Private Duty Nurse Responsibilities. RN supervisor or an RN providing PDN services responsibilities include: ( )

a. Notify the physician immediately of any significant changes in the child's medical condition or response to the service delivery; ( )

b. Notify the Department within forty-eight (48) hours or on the first business day following a weekend or holiday of any significant changes in the child's condition or if the child is hospitalized at any time; ( )

c. Evaluate changes of condition; ( )

d. Provide services in accordance with the nursing care plan; and ( )

e. Must ensure copies of records are maintained in the child's home including: ( )

i. The date; ( )

ii. Time of start and end of service delivery each day; ( )

iii. Comments on child's response to services delivered; ( )

iv. Nursing assessment of child's status and any changes in that status per each working shift; ( )

v. Services provided during each working shift; and ( )

vi. The Medical Plan of Care signed by the physician, primary RN, the parent or legal guardian and a representative from the Department. ( )

04. LPN Providers. LPN providers, document that oversight of services by an RN is in accordance with the Idaho Nursing Practice Act and IDAPA 23.01.01, "Rules of the Board of Nursing." RN Supervisor visits must occur at least once every thirty (30) days when services are provided by an LPN. ( )

05. Ensure Health and Safety of Children. PDN providers must notify the physician if the combination of PDN Services along with other community resources are not sufficient to ensure the health or safety of the child. ( )

210. PRIVATE DUTY NURSING SERVICES: PROVIDER REIMBURSEMENT.
Provider claims for PDN Services require EVV compliance as described in Section 041 of these rules in order to be eligible for payment. ( )

211. - 214. (RESERVED)

SUB AREA: THERAPIES
(Sections 215-219)

215. - 219. (RESERVED)

SUB AREA: LONG-TERM CARE
(Sections 220-330)

220. NURSING FACILITY.
The Enhanced Plan Benefit includes nursing facilities services permitted under Section 1905(a)(4)(A) of the Social Security Act. These services include nursing facilities services (other than services in an institution for mental diseases) for individuals determined to be in need of such care. ( )

221. (RESERVED)

222. NURSING FACILITY SERVICES: ELIGIBILITY.
Entitlement to medical assistance participation in the cost of long-term care exists when the individual is eligible for medical assistance and the Department has determined that the individual meets the criteria for nursing facility services. Entitlement will be determined prior to authorization of payment for such care for an individual who is either a participant of or an applicant for medical assistance. ( )

01. Criteria for Determination. The criteria for determining a medical assistance participant's need for nursing facility care is described in Section 223. In addition, the Inspection of Care/Utilization Control (IOC/UC) nurse must determine whether a medical assistance participant's needs could be met by alternatives other than residing in a nursing facility, such as an independent living arrangement or residing in a room and board situation. ( )

a. The participant can select any certified facility to provide the care required. ( )

b. The final decision as to the level of care required by a medical assistance participant must be made by the IOC/UC Nurse. ( )

c. The final decision as to the need for developmental disability (DD) or mental illness (MI) active

treatment will be made by the appropriate Department staff as a result of the Level II screening process. ( )

d. No payment will be made by the Department on behalf of any eligible medical assistance participant to any long-term care facility that, in the judgment of the IOC/UC Team, is admitting individuals for care or services that are beyond the facility's licensed level of care or capability. ( )

02. Authorization of Long-Term Care Payment. If it has been determined that a person eligible for medical assistance is entitled to medical assistance participation in the cost of long-term care, and that the facility selected by the participant is licensed and certified to provide the level of care the participant requires, the Field Office will forward to such facility an "Authorization for Long-Term Care Payment" form HW 0459. ( )

223. NURSING FACILITY: CRITERIA FOR DETERMINING NEED.
The participant requires nursing facility level of care when an adult meets one (1) of the Resource Utilization Group (RUG III) classifications or when a child meets one (1) or more of the criteria described in Subsections 223.02, 223.03, 223.04 or 223.05 of this rule. A child is an individual from age zero (0) through eighteen (18) years; an adult is an individual more than eighteen (18) years of age. ( )

01. Required Assessment for Adults. A standard assessment will be approved by the Department for all adults requesting services with requirements for nursing facility level of care. The Department will specify the instrument to be used. ( )

02. Supervision Required for Children. Where the inherent complexity of a service prescribed by the physician is such that it can be safely and effectively performed only by or under the supervision of a licensed nurse or licensed physical or occupational therapist. ( )

03. Preventing Deterioration for Children. Skilled care is needed to prevent, to the extent possible, deterioration of the child's condition or to sustain current capacities, regardless of the restoration potential of a child, even where full recovery or medical improvement is not possible. ( )

04. Specific Needs for Children. When the plan of care, risk factors, and aggregate of health care needs is such that the assessments, interventions, or supervision of the child necessitates the skills of a licensed nurse or a licensed physical therapist or licensed occupational therapist. In such cases, the specific needs or activities must be documented by the physician's orders, progress notes, plan of care, and nursing and therapy notes. ( )

05. Nursing Facility Level of Care for Children. Using the criteria found in Subsections 223.02, 223.03, and 223.04 of these rules, plus consideration of the developmental milestones, based on the age of the child, the Department's BLTC will determine nursing facility level of care. ( )

06. Conditions of Payment. ( )

a. As a condition of payment by the Department for long-term care on behalf of medical assistance participants, each fully licensed long-term care facility is to be under the supervision of an administrator who is currently licensed under the laws of the state of Idaho and in accordance with the rules of the Bureau of Occupational Licenses. ( )

b. Payment by the Department for the cost of long-term care excludes the date of the participant's discharge, unless the day of discharge occurs on the same day as admission; then, one (1) day of care is deemed to exist. When a Medicaid patient dies in a nursing home, the date of death is covered, regardless of the time of death. ( )

224. NURSING FACILITY: POST-ELIGIBILITY TREATMENT OF INCOME.
Where an individual is determined eligible for medical assistance participation in the cost of their long term care, the Department will reduce its payment to the long term care facility by the amount of their income considered available to meet the cost of their care. This determination is made in accordance with IDAPA 16.03.05, "Eligibility for Aid to the Aged, Blind, and Disabled (AABD)," Sections 721 through 726. The amount that the medical assistance participant receives from SSA as reimbursement for their payment of the premium for Part B of Title XVIII (Medicare) is not considered income for patient liability under IDAPA 16.03.05, "Eligibility for Aid to the Aged,

Blind, and Disabled (AABD)," Section 317. ( )

225. NURSING FACILITY: COVERAGE AND LIMITATIONS.
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. ( )

01. Nursing Facility Care. The minimum content of care and services for nursing facility patients must include the following: ( )

a. Room and board; ( )

b. Bed and bathroom linens; ( )

c. Nursing care, including special feeding if needed; ( )

d. Personal services; ( )

e. Supervision as required by the nature of the patient's illness and duration of their stay in the nursing facility; ( )

f. Special diets as prescribed by a patient's physician; ( )

g. All common medicine chest supplies that are over-the-counter including mouthwashes, analgesics, laxatives, emollients, burn ointments, first aid cream, protective creams and liquids, cough and cold preparations, and simple eye preparations; ( )

h. Dressings; ( )

i. Administration of intravenous, subcutaneous, or intramuscular injections and infusions, enemas, catheters, bladder irrigations, and oxygen; ( )

j. Application or administration of all drugs; ( )

k. All medical supplies including gauzes, bandages, tapes, compresses, cottons, sponges, hot water bags, ice bags, disposable syringes, thermometers, cellucotton, incontinent supplies, or any other type of pads used to save labor or linen, and disposable gloves; ( )

l. Social and recreational activities; and ( )

m. Each item that is utilized by individual patients and is reusable and expected to be available, such as bed rails, canes, crutches, walkers, wheel chairs, traction equipment, and other durable medical equipment. ( )

02. Skilled Services. Skilled services include services that could qualify as either skilled nursing or skilled rehabilitative services, that include: ( )

a. Overall management and evaluation of the care plan. The development, management, and evaluation of a resident's care plan, based on the physician's orders, constitute skilled services when, in terms of the patient's physical or mental condition, such development, management, and evaluation necessitate the involvement of technical or professional personnel to meet their needs, promote their recovery, and assure their medical safety. This would include the management of a plan involving only a variety of personal care services where, in light of the patient's condition, the aggregate of such services necessitates the involvement of technical or professional personnel. Where the patient's overall condition would support a finding that their recovery and safety could be assured only if the total care they require is planned, managed, and evaluated by technical or professional personnel, it would be appropriate to infer that skilled services are being provided. ( )

b. Observation and assessment of the resident's changing condition. When the resident's condition is

such that the skills of a licensed nurse or other technical or professional person are required to identify and evaluate the patient's need for possible modification of treatment and the initiation of additional medical procedures until their condition is stabilized, such services constitute skilled services. ( )

03. Direct Skilled Nursing Services. Direct skilled nursing services include the following: ( )

a. Intravenous injections; intravenous feedings; intramuscular or subcutaneous injection required on more than one (1) shift; ( )

b. Nasopharyngeal feedings; ( )

c. Nasopharyngeal and tracheotomy aspiration; ( )

d. Insertion and sterile irrigation and replacement of catheters; ( )

e. Application of dressings involving prescription medications or aseptic techniques; ( )

f. Treatment of extensive decubitus ulcers or other widespread skin disorders; ( )

g. Heat treatments that have been specifically ordered by a physician as part of treatment and that require observation by nurses to adequately evaluate the resident's progress; and ( )

h. Initial phases of a regimen involving administration of oxygen. ( )

04. Direct Skilled Rehabilitative Services. Direct skilled rehabilitative services include the following: ( )

a. Ongoing assessment of rehabilitation needs and potential, services concurrent with the management of a resident's care plan, including tests and measurements of range of motion, strength, balance, coordination, endurance, functional ability, activities of daily living, perceptual deficits, speech and language or hearing disorders; ( )

b. Therapeutic exercises or activities that, because of the type of exercises employed or the condition of the resident, must be performed by or under the supervision of a qualified physical therapist or occupational therapist to ensure the safety of the resident and the effectiveness of the treatment; ( )

c. Gait evaluation and training furnished by a physical or occupational therapist to restore function in a resident whose ability to walk has been impaired by neurological, muscular, or skeletal abnormality; and ( )

d. Ultrasound, short-wave, and microwave therapy treatments by a licensed physical therapist. ( )

05. Other Treatment and Modalities. Other treatment and modalities that include hot pack, hydroculator, infrared treatments, paraffin baths, and whirlpool, in cases where the resident's condition is complicated by circulatory deficiency, areas of desensitization, open wounds, fractures, or other complications, and the skills, knowledge, and judgement of a licensed physical therapist are required. ( )

226. NURSING FACILITY: PROCEDURAL RESPONSIBILITIES.

01. Nursing Facility Responsibility. Each nursing facility administrator, or their authorized representative must report the following information to the appropriate BLTC within three (3) working days of the date the facility has knowledge of the following. ( )

a. Any readmission or discharge of a participant, and any temporary absence of a participant due to hospitalization or therapeutic home visit. ( )

b. Any changes in the amount of a participant's income. ( )

c. When a participant's account has exceeded the following amount; ( )

i. For a single individual, one thousand eight hundred dollars ($1,800);or ( )

ii**.** For a married couple, two thousand eight hundred dollars ($2,800). ( )

02. Other Financial Information for Participant. Other information about a participant's finances that may potentially affect eligibility for medical assistance must be reported if the nursing facility has any knowledge of the participant's financial information. ( )

227. PREADMISSION SCREENING AND RESIDENT REVIEW PROGRAM (PASRR).
All Medicaid certified nursing facilities must participate in, cooperate with, and meet all requirements imposed by, the Preadmission Screening and Resident Review program, (PASRR) as set forth in 42 CFR, Part 483, Subpart C. ( )

01. Background and Purpose. The purpose of these provisions is to comply with and implement the PASRR requirements imposed on the state by federal law. The purpose of those requirements is to prevent the placement of individuals with mental illness (MI) or intellectual disabilities (ID) in a nursing facility unless their medical needs clearly indicate that they require the level of care provided by a nursing facility. This is accomplished by both pre-admission screening (PAS) and resident review (RR). Individuals, for whom it appears that a diagnosis of MI or ID is likely, are identified for further screening by means of a Level I screen. The actual PASRR is accomplished through a Level II screen where it is determined whether, because of the individual's physical and mental condition, they require the level of services provided by a nursing facility. If the individual with MI or ID is determined to require a nursing facility level of care, it must also be determined whether the individual requires specialized services. PASRR applies to all individuals entering or residing in a nursing facility, regardless of payment source. ( )

02. Policy. It is the policy of the Department that the difficulty in providing specialized services in the nursing facility setting makes it generally inappropriate to place individuals needing specialized services in an nursing facility. This policy is supported by the background and development of the federal PASRR requirements, including the narrow definition of mental illness adopted by federal law. While recognizing that there are exceptions, it is envisioned that most individuals appropriate for nursing facility placement will not require services in excess of those required to be provided by nursing facilities by 42 CFR 483.45. ( )

03. Inter-Agency Agreement. The state Medicaid agency will enter into a written agreement with the state mental health and intellectual disabilities authorities as required in 42 CFR 431.621(c). This agreement will, among other things, set forth respective duties and delegation of responsibilities, and any supplemental criteria to be used in making determinations. ( )

a. The "State Mental Health Authority" (SMHA) in the Division of Behavioral Health of the Department, or its successor entity. ( )

b. The "State Intellectual Disabilities or Developmental Disabilities Authority" (SDDA) in the Division of Family and Community Services of the Department, or its successor entity. ( )

04. Coordination for PASRR. The PASRR process is a coordinated effort between the state Medicaid agency, the SMHA and SDDA, independent evaluators and the nursing facility. PASRR activities will be coordinated through the Bureau of Long Term Care (BLTC). BLTC is responsible for record retention and tracking functions. However, the nursing facility is responsible for assuring that all screens are obtained and for coordination with the BLTC, independent MI evaluators, the SMHA and SDDA, and their designees. ( )

a. All required Level I screens and reviews must be completed and submitted to the BLTC prior to admission to the facility. ( )

b. When a nursing facility identifies an individual with MI or ID through a Level I screen, or otherwise, the nursing facility is responsible for contacting the SMHA or SDDA (as appropriate), and assuring that a

Level II screen is completed prior to admission to the facility, or in the case of an existing resident, completed in order to continue residing in the facility. ( )

c. Resident Reviews (RR). An individual identified with MI or ID must be reviewed and a new determination made promptly after a significant change in their physical or mental condition. The facility must notify the BLTC of any such change within two (2) working days of its occurrence. For the purpose of this section, significant change for the participant's mental condition means a change that may require the provision of specialized services or an increase in such services. A significant change in physical condition is a change that renders the participant incapable of responding to MI or D.D. program interventions. ( )

228. NURSING FACILITY: COORDINATION OF NURSING FACILITY ELIGIBILITY AND THE NEED FOR SPECIALIZED SERVICES.
Determinations as to the need for nursing facility care and determinations as to the need for specialized services should not be made independently. Such determinations will often be made on an individual basis, taking into account the condition of the resident and the capability of the facility to which admission is proposed to furnish the care needed. When an individual identified with MI and ID is admitted to a nursing facility, the nursing facility is responsible for meeting that individual's needs, except for the provision of specialized services. ( )

01. Level of Care. ( )

a. Individual determinations must be based on evaluations and data as required by these rules. ( )

b. Categorical determinations. Recognizing that individual determinations of level of care are not always necessary, those categories set forth as examples at 42 CFR 483.130(d) are hereby adopted as appropriate for categorical determinations. When nursing facility level of care is determined appropriate categorically, the individual may be conditionally admitted prior to completion of the determination for specialized services. However, conditional admissions cannot exceed seven (7) days, except for respite admissions which cannot exceed thirty (30) consecutive days in one (1) calendar year. ( )

02. Specialized Services. Specialized services for mental illness as defined in 42 CFR 483.120(a)(1), and for intellectual disabilities as defined in 42 CFR 483.120(a)(2), are those services provided by the state that due to the intensity and scope can only be delivered by personnel and programs that are not included in the specialized rehabilitation services required of nursing facilities under 42 CFR 483.45. The need for specialized services must be documented and included in both the resident assessment instrument and the plan of care. ( )

a. Individual determinations must be based on evaluations and data as required by these rules. ( )

b. Categorical determinations that specialized services are not needed may be made in those situations permitted by 42 CFR 483.130. ( )

03. Penalty for Non-Compliance. No payment will be made for any services rendered by a nursing facility prior to completion of the Level I screen and, if required, the Level II screen. Failure to comply with PASRR requirements for all individuals admitted or seeking admission may also subject a nursing facility to other penalties as part of certification action under 42 CFR 483.20. ( )

04. Appeals. Discharges, transfers, and preadmission PASRR determinations may be appealed to the extent required by 42 CFR, Part 483, Subpart E, and under Section 67-5229, Idaho Code. Appeals under this paragraph are made in accordance with the fair hearing provisions in IDAPA 16.05.03, “Contested Case Proceedings and Declaratory Rulings.” ( )

a. A Level I finding of MI or ID is not an appealable determination. It may be disputed as part of a Level II determination appeal. ( )

b. In the event that the PASRR program is eliminated or made non-mandatory by an act of Congress, the provisions of Section 227 of these rules will cease to be operative on the effective date of any such act, without

further action. ( )

229. NURSING FACILITY: PREPAYMENT SCREEN AND DETERMINATION OF ENTITLEMENT TO MEDICAID PAYMENT FOR NURSING FACILITY CARE AND SERVICES.
The level of care for Title XIX and Title XXI payment purposes is determined by the Department. Necessity for payment is determined in accordance with 42 CFR 483 Subpart C and Section 1919(e) (7) of the Social Security Act. In the event a required Level II screen was not accomplished prior to admission, entitlement for Medicaid payment as established by the BLTC will not be earlier than the date the Level II screen is completed, indicating that nursing facility placement is appropriate. ( )

01. Information Required for Medical Evaluation Determination. A current Minimum Data Set (MDS) assessment will be provided to the Department. Additional supporting information may be requested. ( )

02. Information Required for Level I and II Screen Determination. An accurate Level I screen and when required, a Level II screen. ( )

230. NURSING FACILITY: PROVIDER QUALIFICATIONS AND DUTIES.

01. Provider Application and Certification. A facility must apply to participate as a nursing facility. ( )

02. Licensure and Certification. ( )

a. Upon receipt of an application from a facility, the Licensing and Certification Agency determines the facility's compliance with certification standards for the type of care the facility proposes to provide to medical assistance participants. ( )

b. If a facility proposes to participate as a skilled nursing facility, Medicare (Title XVIII) certification and program participation is required before the facility can be certified for Medicaid. The Licensing and Certification Agency will determine the facility's compliance with Medicare requirements and recommend certification to the Medicare Agency. ( )

c. If the Licensing and Certification Agency determines that a facility meets Title XIX certification standards for nursing facility care. The Department will certify to the appropriate branch of government that the facility meets the standards for nursing facility level of care. ( )

d. Upon receipt of the certification from the Licensing and Certification Agency, the Department may enter into a provider agreement with the long-term care facility. ( )

e. After the provider agreement has been executed by the Facility Administrator and by the Department, one (1) copy will be sent by certified mail to the facility and the original is to be retained by the Department. ( )

231. -- 234. (RESERVED)

235. NURSING FACILITY: PROVIDER REIMBURSEMENT.

01. Payment Methodology. Nursing facilities will be reimbursed in accordance with the payment methodologies as described in Sections 236 through 295 of these rules. ( )

02. Date of Discharge. Payment by the Department for the cost of long term care is to exclude the date of the participant's discharge. If a Medicaid patient dies in a nursing home, their date of death is covered regardless of the time of occurrence. If an admission and a discharge occur on the same date, then one (1) day of care will be deemed to exist. ( )

236. NURSING FACILITY: REASONABLE COST PRINCIPLES.

To be allowable, costs must be reasonable, ordinary, necessary and related to patient care. It will be expected that providers will incur costs in such a manner that economical and efficient delivery of quality health care to participants will result. ( )

01. Application of Reasonable Cost Principles. ( )

a. Reasonable costs of any services are determined in accordance with this chapter of rules found in Sections 236 through 295 of these rules, and Provider Reimbursement Manual (PRM), Sections 100 through 2600, as modified by the exceptions contained herein, is used to identify cost items to be included on Idaho's Uniform Cost Report. ( )

i. Reasonable cost takes into account both direct and indirect costs of providers of services, including normal standby costs. ( )

ii. The objectives of these methods are that: first, the costs with respect to individuals covered by the program will not be borne by others not so covered. Second, the costs with respect to individuals not covered will not be paid by the program. ( )

b. Costs may vary from one institution to another because of a variety of factors. It is the intent of the program that providers will be reimbursed the actual operating costs of providing high quality care, unless such costs exceed the applicable maximum base rate developed pursuant to provisions of Title 56, Idaho Code, or are unallowable by application of promulgated regulation. ( )

c. Implicit in the intention that actual operating costs be paid to the extent they are reasonable is the expectation that the provider seeks to minimize its costs and that its actual operating costs do not exceed what a prudent and cost-conscious buyer pays for a given item or service. ( )

d. If costs are determined to exceed the level that such buyers incur, in the absence of clear evidence that the higher costs were unavoidable, the excess costs are not reimbursable. ( )

02. Costs Related to Patient Care. These include all necessary and proper costs in developing and maintaining the operation of patient care facilities. Necessary and proper costs related to patient care are usually costs that are common and accepted occurrences in the field of the provider's activity. They include costs such as depreciation, interest expense, nursing costs, maintenance costs, administrative costs, costs of employee pension plans, normal standby costs, and others. ( )

03. Costs Not Related to Patient Care. Costs not related to patient care are costs that are not appropriate or necessary and proper in developing and maintaining the operation of patient care facilities and activities. Such costs are not allowable in computing reimbursable costs. ( )

04. Form and Substance. Substance of transactions will prevail over the form. Financial transactions will be disallowed to the extent that the substance of the transaction fails to meet reasonable cost principles or comply with rules and policy. ( )

237. NURSING FACILITY: NOTICE OF PROGRAM REIMBURSEMENT.

Following receipt of the finalized Medicare Cost Report and the timely receipt of any other information requested by the Department to fairly cost settle with the provider, a certified letter with the return receipt requested will be sent to the provider that sets forth the amounts of underpayment or overpayment made to the provider. ( )

01. Notice. The notice of the results of the final retroactive adjustment will be sent even though the provider intends to request a hearing on the determination, or has appealed the Medicare Intermediary's determination of cost settlement. Where the determination shows that the provider is indebted to the Medicaid program because total interim and other payments exceed cost limits, the state will take the necessary action to recover overpayment, including the suspension of interim payments sixty (60) days after the provider's receipt of the notice. ( )

02. Recovery or Suspension. Such action of recovery or suspension will continue even after a request for an informal conference or hearing is filed with the state. If the hearing results in a revised determination,

appropriate adjustments will be made to the settlement amount. ( )

03. Timing of Notice. The Department will make every effort to issue a notice of program reimbursement within twelve (12) months of receipt of the Cost Report from the Medicare Intermediary. ( )

04. Reopening of Completed Settlements. A Medicaid completed cost settlement may be reopened by the provider or the state within a three-year (3) period from the date of the letter of notice of program reimbursement. The issues must have been raised, appealed and resolved through the reopening of the Cost Report by the Medicare Intermediary. Issues previously addressed and resolved by the Department's appeal process are not cause for reopening of the finalized cost settlement. ( )

238. NURSING FACILITY: INTEREST CHARGES ON OVERPAYMENTS AND UNDERPAYMENTS.
The Title XIX and Title XXI programs will charge interest on overpayments, and pay interest on underpayments. ( )

01. Interest After Sixty Days of Notice. If full repayment from the indebted party is not received within sixty (60) days after the provider has received notice of program reimbursement, interest will accrue from the date of receipt of the notice of program reimbursement, and will be charged on the unpaid settlement balance for each thirty- day (30) period that payment is delayed. Periods of less than thirty (30) days will be treated as a full thirty-day (30) period, and the thirty-day (30) interest charge will be applied to any unpaid balance. Each payment will be applied first to accrued interest, then to the principal. Interest accrued on overpayments and interest on funds borrowed by a provider to repay overpayments are not an allowable interest expense. ( )

02. Waiver of Interest Charges. When the Department determines an overpayment exists, it may waive interest charges if it determines that the administrative costs of collecting them exceed the charges. ( )

03. Rate of Interest. The interest rate on overpayments and underpayments will be the statutory rate as set forth in Section 28-22-104(1), Idaho Code, compounded monthly. ( )

04. Retroactive Adjustment. The balance and interest will be retroactively adjusted to equal the amounts that would have been due based on any changes that occur as a result of the final determination in the administrative appeal and judicial appeal process. Interest penalties will only be applied to unpaid amounts and will be subordinated to final interest determinations made in the judicial review process. ( )

239. NURSING FACILITY: RECOVERY METHODS FOR OVERPAYMENTS.
One (1) of the following methods will be used for recovery of overpayments: ( )

01. Lump Sum Voluntary Repayment. Upon receipt of the notice of program reimbursement, the provider voluntarily refunds, in a lump sum, the entire overpayment to the Department. ( )

02. Periodic Voluntary Repayment. The provider must request in writing that recovery of the overpayment be made over a period of twelve (12) months or less. The provider must adequately document the request by demonstrating that the financial integrity of the provider would be irreparably compromised if repayments occurred over a shorter period of time than requested. ( )

03. Department Initiated Recovery. The Department will recover the entire unpaid balance of the overpayment of any settlement amount in which the provider does not respond to the notice of program reimbursement within thirty (30) days of receiving the notice. ( )

04. Recovery From Medicare Payments. The Department can request that Medicare payments be withheld in accordance with 42 CFR, Section 405.377. ( )

240. – 241. (RESERVED)

242. NURSING FACILITY: HOME OFFICE COST PRINCIPLES.
The reasonable cost principles will extend to the home office costs allocated to individual providers. In addition, the home office, through the provider, will provide documentation as to the basis used to allocate its costs among the

various entities it administers or otherwise directs. ( )

243. NURSING FACILITY: RELATED PARTY TRANSACTIONS.

01. Principle. Costs applicable to services, facilities and supplies furnished to the provider by organizations or persons related to the provider by common ownership, control, etc., are allowable at the cost to the related party. Such costs are allowable to the extent that they relate to patient care, are reasonable, ordinary, and necessary, and are not in excess of those costs incurred by a prudent cost-conscious buyer. ( )

02. Cost Allowability - Regulation. Allowability of costs is subject to the regulations prescribing the treatment of specific items as outlined in 42 CFR 413.17, et al, and the Providers Reimbursement Manual, PRM Chapter 10 and other applicable chapters of the PRM. ( )

244. NURSING FACILITY: APPLICATION OF RELATED PARTY TRANSACTIONS.

01. Determination of Common Ownership or Control in the Provider Organization and Supply Organization. In determining whether a provider organization is related to a supplying organization, the tests of common ownership and control are to be applied separately. If the elements of common ownership or control are not present in both organizations, the organizations are deemed not to be related to each other. ( )

a. A determination as to whether an individual(s) possesses ownership or equity in the provider organization and the supplying organization, so that the organizations will be considered to be related by common ownership, will be made on the basis of the facts and circumstances in each case. ( )

b. The term "control" includes any kind of control whether or not it is legally enforceable and however it is exercisable or exercised. It is the reality of the control that is decisive, not its form or the mode of its exercise. ( )

02. Cost to Related Organizations. The charges to the provider from related organizations may not exceed the billing to the related organization for these services. ( )

03. Costs Not Related to Patient Care. All home office costs not related to patient care are not allowable under the program. ( )

04. Interest Expense. Generally, interest expense on loans between related entities will not be reimbursable. See the PRM, Chapters 2, 10, and 12 for specifics. ( )

245. NURSING FACILITY: COMPENSATION OF RELATED PERSONS.
Compensation paid to persons related to owners or administrators is allowable only to the extent that services are actually performed and are necessary and adequately documented and the compensation for the services is reasonable. ( )

01. Compensation Claimed. Compensation claimed for reimbursement must be included in compensation reported for tax purposes and be actually paid. ( )

a. Where such persons perform services without pay, no cost may be imputed. ( )

b. Time records documenting actual hours worked are required in order that the compensation be allowable for reimbursement. ( )

c. Compensation for undocumented hours worked will not be a reimbursable cost. ( )

02. Related Persons. A related person is defined as having one (1) of the following relationships with the provider: ( )

a. Husband or wife; ( )

b. Son or daughter or a descendant of either; ( )

c. Brother, sister, stepbrother, stepsister or descendant thereof; ( )

d. Father, mother, stepfather, stepmother, an ancestor thereof, or a brother or sister thereof; ( )

e. Son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law or sister-in-law; ( )

f. A descendant of a brother or sister of the provider's father or mother; ( )

g. Any other person with whom the provider does not have an arms length relationship. ( )

246. NURSING FACILITY: INTEREST EXPENSE.
Generally interest on loans between related entities is not an allowable expense. The loan will usually be considered invested capital. See PRM, Chapter 2 for specifics. ( )

247. -- 249. (RESERVED)

250. NURSING FACILITY: COST LIMITS.
Sections 250 through 267 of these rules and the Idaho Medicaid Provider Agreement Additional Terms – Nursing Facility, provide procedures and specifications necessary to implement the provisions and accomplish the objectives of the nursing home reimbursement system as specified in Sections 56-101 through 56-135, Idaho Code. All audits related to fiscal years ending on or before December 31, 1999, are subject to rules in effect before July 1, 1999. ( )

251. – 254. (RESERVED)

255. NURSING FACILITY: RATE SETTING.
The objectives of the rate setting mechanism for nursing facilities are: ( )

01. Payments. To make payments to nursing facilities through a prospective price-based system, which includes facility-specific case mix adjustments, separate margin payments for indirect care costs and direct care costs, and applied BAF. ( )

02. Rate Adjustment. To set rates based on each facility's case mix index on a quarterly basis and establishing rates that reflect the case mix of that facility's Medicaid residents as of a certain date during the preceding quarter. ( )

256. NURSING FACILITY: PRINCIPLE FOR RATE SETTING.
Reimbursement rates will be set based on projected cost data from cost reports and audit reports. Reimbursement is to be set for freestanding and hospital-based facilities. In general, the methodology will be a cost-based prospective reimbursement system with an acuity adjustment for direct care costs, allowances for margin payments related to the indirect and direct care costs, and subject to the application of a BAF. ( )

257. NURSING FACILITY: DEVELOPMENT OF THE RATE.
Nursing facility rates are prospective, with new rates effective July 1st of each year, and are recalculated annually with quarterly adjustments for case mix. In no case will the rate be set higher than the charge for like services to private pay patients in effect for the period for which payment is made as computed by the lower of costs or customary charges. For the rate year of July 1, 2021, through June 30, 2022, rates will be calculated using audited cost reports ended in the calendar year 2019, including an inflation factor applied from the mid-point of the cost reporting period to the mid-point of the rate period. Inflation will be applied to all rate components, with the exception of property costs. For the rate years beginning July 1, 2022, and annually thereafter, rates will be calculated using audited cost reports for the periods ending in the calendar year two (2) years prior to each July 1 (July 1, 2022, rates will use cost reports ended in calendar year 2020 and so forth), including inflation adjustments from the mid-point of the cost report period to the mid-point of the rate period, with the exception of property costs. ( )

258. (RESERVED)

259. NURSING FACILITY: TREATMENT OF NEW BEDS.
Facilities that add beds after July 1, 1999, will have their reimbursement rate subjected to an additional limitation for the next three (3) years. This limitation will apply beginning with the first rate setting period that utilizes a cost report that includes the date when the beds were added. This provision will be the same for either behavioral care unit facilities or non-behavioral care units. ( )

260. – 261. (RESERVED)

262. NURSING FACILITY: OUT-OF-STATE NURSING HOMES.
The Idaho Medicaid Program will reimburse for out-of-state nursing home placements when services are not available in Idaho to meet the participant's medical need, or in a temporary situation for a limited period of time required to safely transport the participant to an Idaho facility. Reimbursement for out-of-state nursing homes will be at the per diem rate set by the Medicaid Program in the state where the nursing home is located. Special rates will be allowed according to Section 270 of these rules. ( )

263. NURSING FACILITY: DISTRESSED FACILITY.

01. Determination. If the Department determines that a facility is located in an under-served area, or addresses an under-served need, the Department may negotiate a reimbursement rate different than the rate then in effect for that facility. ( )

02. Discretionary Factors. The fact that a facility may be located in an under-served area or meets an under-served need does not guarantee increased reimbursement. In exercising its discretion to apply a higher rate, the Department will consider the factors as described in Subsections 263.02.a. through 263.02.e. of this rule. ( )

a. Prudent Spending Patterns. The facility has exercised prudent spending and cost allocation practices, as evidenced by a thorough and comprehensive review of the facility's accounts by the Department. ( )

b. Reasonable Attempts to Remedy Problems. The facility must persuade the Department that it has conscientiously and diligently attempted to cover its costs of care, hire qualified staff and otherwise operate effectively and efficiently, but for causes beyond the facility's reasonable control, it has not been able to do so. ( )

c. Facility Already Receives Special Rates. When a facility already receives special rates for certain difficulty-of-care patients from the Department, the same costs of care that were used to determine special rates will not be applied toward a determination of distressed facility status, because the special rate meets that need. ( )

d. Direct and Indirect Costs of Care Apportioned to Patient Care. The Department reimburses the costs of patient care, and does not pay for indirect costs not associated with patient care. The determination of distressed status will focus on whether the facility's distress stems from patient care costs, or whether the distress arises from expenses unrelated to patient care costs. ( )

e. Existing Cost Limits.Under no circumstances may a facility's reimbursement exceed the lower of its actual costs or customary charge to private-pay patients, as required by federal law, subject to the exceptions in federal law. The Department's cost caps can be exceeded through the distressed facility process, but to an amount no greater than the federal upper payment limit. ( )

03. Annual Review. Distressed facility payments are assumed to be short-term in nature. Each distressed payment must be re-requested and re-justified for each subsequent fiscal year that the facility desires the distressed facility rate. ( )

04. Prospective Application. Distressed facility status will be applied only to facilities that are currently distressed or entering a period of distress. Distressed facility status will not be applied to retroactive rate years. ( )

05. Facility-by-Facility Basis. Each facility must independently establish distress on its own merits, whether or not other facilities with a common owner may also be experiencing distress. ( )

264. NURSING FACILITY: INTERIM ADJUSTMENTS TO RATES AS A RESULT OF NEW MANDATES.
Certain costs may be excluded from the cost limit calculations, may be subject to retrospective settlement at the discretion of the Department, and may result in changes to the prospective rates as provided in this Section to assure equitable reimbursement: ( )

01. Changes of More Than Fifty Cents Per Patient Day in Costs. Changes of more than fifty cents ($.50) per patient day in costs otherwise subject to the cost limitations incurred by a facility as a result of changes in state or federal laws or rules will be reported separately on the cost report until such time as they can be properly reflected in the cost limits. ( )

a. The provider will report these costs on a separate schedule or by notations on the cost report so that these costs can be identified and reconciled to the provider's general ledger. These costs will be reported separately and will not be reimbursed through the rate setting process until the costs are fully represented in the cost data used to establish the cost limitations and rates. ( )

b. If more than one (1) increase occurs as a result of one (1) or more law or rule changes, the costs from each event are to be reported separately. ( )

c. The computation of the cost increase amount or amounts is to be presented in detail on a supplementary schedule or schedules unless the Department states otherwise. ( )

02. Future Treatment of Costs. After the initial deadline has passed for all providers to file cost reports for reporting periods beginning on or after the date certain cost increases were first required, the Department will, at it's option, include all of the previously excluded costs related to those increases in the calculation of costs subject to the cost center limits. The intent of this provision is for costs to be exempt from the cost limits until these costs are able to be fully and equitably incorporated into the data base used to project the cost limits. When cost increases that have been excluded from the cap are incorporated in the inflation indices used to set the cost limits, the cost indices will be adjusted to exclude the influence of such changes if the amount included in the index is identified. When the cost limits are set to include previously excluded amounts, any adjustments made to the indices related to the previously excluded costs will be removed. ( )

265. NURSING FACILITY: MDS REVIEWS.
The following Minimum Data Set (MDS) reviews will be conducted: ( )

01. Facility Review. Subsequent to the picture date, each facility will be sent a copy of its resident roster (a listing of residents, their RUG classification, case mix index, and identification as Medicaid or other). It will be the facility's responsibility at that time to review the roster for accuracy. If the roster is accurate, the facility will sign and return the roster for rate setting. If any errors are detected, those errors will be communicated to the Department in writing along with any supporting documentation. If the signed resident roster is not returned and no errors are communicated to the Department, the original resident roster will be used for rate setting. Once the resident roster has been used for rate setting, it will be considered final unless modified by subsequent Departmental review. ( )

02. Departmental Review. If a departmental review of the MDS data reveals errors that result in an incorrect case mix index, the provider's rate will be retroactively adjusted, for all quarters containing the incorrect assessment, and an amount due to or from the Department will be calculated. This does not include residents who received the default classification due to incomplete or inconsistent MDS data. ( )

266. NURSING FACILITY: BEHAVIORAL CARE UNIT (BCU) AND RATE STRUCTURE.
Effective October 1, 2012, the additional direct care costs associated with BCU residents will remain in direct care costs subject to the direct care cost limitation. Those qualifying BCU nursing facility providers may have a direct care cost limitation higher than non-BCU nursing facility providers. BCU nursing facility providers will not receive an

increased indirect care cost limitation. ( )

267. NURSING FACILITY: TREATMENT OF NEWLY LICENSED FACILITIES WITH BEHAVIORAL CARE UNITS.
Facilities licensed on or after September 1, 2017, must meet the qualifications for a BCU described in Idaho Medicaid Provider Agreement Additional Terms – Behavioral Care Units. BCU facilities existing prior to this date that receive a new license due to a change in ownership will not be subject to the provisions of this rule. ( )

268. NURSING FACILITY: EXISTING PROVIDER ELECTS TO ADD BEHAVIORAL CARE UNIT (BCU).
An existing nursing facility provider that elects to add a BCU on or after September 1, 2017, may be deemed eligible after meeting the following requirements: ( )

01. Meet Criteria for BCU. The nursing facility provider must meet the criteria for a BCU described in Section 266 of these rules. ( )

02. BCU Eligible Days. The provider must demonstrate that BCU days from a minimum of sixty (60) calendar days, regardless of payer source, divided by total census days for that same sixty (60) day period, equals or exceeds a minimum of thirty percent (30%). ( )

269. NURSING FACILITY: NEW OWNER OF AN EXISTING NURSING FACILITY WITH A BEHAVIORAL CARE UNIT (BCU).

01. New Owner Elects to Continue BCU. An existing nursing facility that is considered a BCU will continue to be a BCU, if the new owner elects to continue to provide these services. The new owner will receive a rate calculated according to the current change of ownership rules in Section 261 of these rules. The prior owner's cost report will be used until the new owner has a qualifying cost report. They BCU will continue to qualify for the higher direct care cost limit the previous owner was allowed. ( )

02. New Owner Does Not Elect to Continue BCU. If the new owner does not elect to operate the BCU, the prior owner's cost report will be used. The direct care cost limit will be adjusted down to that of the non-BCU nursing facility. ( )

270. NURSING FACILITY: SPECIAL RATES.
A special rate consists of a facility's daily reimbursement rate for a patient plus an add-on amount. Section 56-117, Idaho Code, provides authority for the Department to pay facilities an amount in addition to the daily rate when a patient has needs that are beyond the scope of facility services and when the cost of providing for those additional needs is not adequately reflected in the rates calculated. This special rate add-on amount for such specialized care is in addition to any payments made in accordance with other provisions of this chapter and is excluded from the computation of payments or rates under other provisions in these rules. ( )

01. Determination. The Department determines to approve a special rate on a patient-by-patient basis. No rate will be allowed if reimbursement for these needs is available from a non-Medicaid source. A special rate request will be based on an identified condition that will continue for a period greater than thirty (30) days. ( )

02. Effective Date. Upon approval, a special rate is effective on the date the application was received. ( )

03. Reporting. Costs equivalent to payments for special rate add-on amounts must be removed from the cost components subject to limits, and be reported separately by the provider. ( )

04. Limitation. A special rate cannot exceed the provider's charges to other patients for similar services. ( )

05. Prospective Rate Treatment. Prospective treatment of special rates became effective July 1, 2000. Subsections 270.06 and 270.07 of this rule provide clarification of how special rates are paid under the prospective payment system. ( )

06. Determination of Payment for Qualifying Residents. Special rate add-on amounts are calculated using one (1) of the methods described in Subsections 270.06.a. through 270.06.c. of this rule. ( )

a. One Hundred Percent (100%) Special Care Facility Existing July 1, 2000. If on July 1, 2000, an entire facility was a special care unit that included Medicaid residents, the facility's direct care cost per diem will not be subject to the direct care cost limit. However, the direct care costs are case mix adjusted based on the ratio of the facility's Medicaid CMI for the rate period to the facility-wide CMI for the cost reporting period. ( )

b. Equipment and Non-Therapy Supplies. Equipment and non-therapy supplies not addressed in Section 225 of these rules as determined by the Department, are reimbursed in accordance with IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 755, as an add-on amount. ( )

c. Ventilator Dependent Residents and Residents Receiving Tracheostomy Care. Nursing facilities providing care to residents who are ventilator-dependent or who receive tracheostomy care are eligible to submit requests for the fixed add-on amount, in addition to the facility's rate for residents receiving this type of care. Approved requests are effective the date the type of care is needed by the participant, or no earlier than sixty (60) days prior to the date the request is received by the Department. The rate includes the cost for equipment and supplies and for additional registered nurse and certified nursing assistant hours, as appropriate for each type of care. Costs for equipment and supplies will be adjusted annually for inflation, and registered nursing and certified nursing assistant costs will be adjusted according to the annual Weighted Average Hourly Rates (WAHR) survey results. ( )

i. Approved add-on rates for ventilator-dependent residents and residents receiving tracheostomy care are subject to annual reviews by the Department to ensure that the add-on rate remains necessary for the type of care needed by the resident. ( )

ii. The provider must inform the department if an approved add-on rate is no longer needed or if the resident requires a change from one type of care to another. ( )

d. Ventilator Dependent Residents and Residents Receiving Tracheostomy Care in Out-of-State Nursing Facilities. For residents who are ventilator-dependent or receive tracheostomy care in an out-of-state facility, the add-on amount to the facility's rate is effective the date this type of care is needed by the participant or no earlier than sixty (60) days prior to the date the request is received by the Department. The add-on rate will include: ( )

i. Calculation of a staffing add-on for the cost, if any, for additional direct care staff required in meeting the exceptional needs of these residents. The hourly add-on rate is equal to the current WAHR CNA or current WAHR RN wage rate plus a benefits allowance based on annual cost report data, then weighted to remove the CNA minimum daily staffing time adjusted for the appropriate skill level of care staff; and ( )

ii. Calculation of an add-on for equipment and non-therapy supplies following the provisions in Subsection 270.06.b. of this rule. ( )

07. Treatment of the Special Rate Cost for Future Rate Setting Periods. Special rates are established on a prospective basis similar to the overall facility rate. When the cost report used to set a prospective rate contains special rate costs, an adjustment is made to "offset," or reduce costs by an amount equal to total incremental revenues, or add-on payments received by the provider during the cost reporting period. The amount received is calculated by multiplying the special rate add-on amount paid for each qualifying resident by the number of days that were paid. No related adjustment is made to the facility's CMIs. ( )

08. Special Rate for Providers that Change Ownership or Close. When a facility changes ownership or closes, a closing cost report is not required. Special rate payments made in the closing cost reporting period may be reviewed by the Department. ( )

271. (RESERVED)

272. NURSING FACILITY: LEGAL CONSULTANT FEES AND LITIGATION COSTS.

Costs of legal consultant fees and litigation costs incurred by the provider will be handled in accordance with the following: ( )

01. In General. Legal consultant fees unrelated to the preparation for or the taking of an appeal of an audit performed by the Department of Health and Welfare, or litigation costs incurred by the provider in an action unrelated to litigation with the Department of Health and Welfare, will be allowed as a part of the total per diem costs of which the Medicaid Program will reimburse a portion according to the percentage of Medicaid patient days. ( )

02. Administrative Appeals. In the case of the provider contesting in administrative appeal the findings of an audit performed by the Department of Health and Welfare, the costs of the provider's legal counsel will be reimbursed by the Medicaid Program only to the extent that the provider prevails on the issues involved. The determination of the extent that the provider prevails will be based on the ratio of the total dollars at issue for the audit period at issue in the hearing to the total dollars ultimately awarded to the provider for that audit period by the hearing officer or subsequent adjudicator. ( )

03. Other. All other litigation costs incurred by the provider in actions against the Department of Health and Welfare will not be reimbursable either directly or indirectly by the Medicaid Program except where specifically ordered by a court of law. ( )

273. NURSING FACILITY: PATIENT FUNDS.

The safekeeping of patient funds, under the program, is the responsibility of the provider. Accordingly, the administration of these funds requires scrupulous care in recording all transactions for the patient. ( )

01. Use. Generally, funds are provided for personal needs of the patient to be used at the patient's discretion. The provider agrees to manage these funds and render an accounting but may not use them in any way. ( )

02. Provider Liability. The provider is subject to legal and financial liabilities for committing any of the following acts. This is only a partial listing of the acts contrary to federal regulations: ( )

a. Management fees may not be charged for managing patient trust funds. These charges constitute double payment as management is normally performed by an employee of the provider and their salary is included in reasonable cost reimbursement. ( )

b. Nothing is to be deducted from these funds, unless such deductions are authorized by the patient or their agent in writing. ( )

c. Interest accruing to patient funds on deposit is the property of the patients and is part of the personal funds of each patient. The interest from these funds is not available to the provider for any use, including patient benefits. ( )

03. Fund Management. Proper management of such funds would include the following as minimum: ( )

a. Savings accounts, maintained separately from facility funds. ( )

b. An accurate system of supporting receipts and disbursements to patients. ( )

c. Written authorization for all deductions. ( )

d. Signature verification. ( )

e. Deposit of all receipts of the same day as received. ( )

f. Minimal funds kept in the facility. ( )

g. As a minimum these funds must be kept locked at all times. ( )

h. Statement of policy regarding patient's funds and property. ( )

i. Periodic review of these policies with employees at training sessions and with all new employees upon employment. ( )

j. System of periodic review and correction of policies and financial records of patient property and funds. ( )

274. NURSING FACILITY: IDAHO OWNER-ADMINISTRATIVE COMPENSATION.
Allowable compensation to owners and persons related to owners who provide any administrative services will be limited based on the schedule in this **s**ection. ( )

01. Allowable Owner Administrative Compensation. The following schedule will be used in determining the maximum amount of owner administrative compensation allowable for the calendar year ending December 31, 2002.

Licensed Bed Range	Upper limit
51 - 100	86,951
101 - 150	95,641
151 - 250	129,878
251 - up	186,435

( )

02. The Administrative Compensation Schedule. The administrative compensation schedule in this Section will be adjusted annually based upon the change in average hourly earnings in nursing and personal care facilities as published by IHS Markit, its successor organization or, if unavailable, another nationally recognized forecasting firm. ( )

03. The Maximum Allowable Compensation. The maximum allowable compensation for an owner providing administrative services is determined from the schedule in Subsection 274.01 of these rules**.** Allowable compensation will be determined as follows: ( )

a. In determining the number of beds applicable on the schedule, all licensed beds for which the individual provides administrative services will be counted, regardless of whether they are in the same facility. ( )

b. For an owner providing services to more than fifty (50) beds, the amounts shown on the schedule for the applicable number of beds will determine the upper limit for allowable compensation. ( )

c. For owners providing services to less than fifty-one (51) beds, such services related to administrative duties will be reimbursed at the hourly rate allowable if the owner was providing services to fifty-one (51) beds. Additionally, services other than administrative services may be performed by the owner and will be allowable at the reasonable market rate for such services. To be allowable, hours for each type of service will be documented. In no event will the total compensation for administrative and non-administrative duties paid to an owner or related party to an owner of a facility or facilities with fifty (50) licensed beds or less exceed the limit that would be applicable to an owner with the same number of points providing administrative services to facilities with fifty-one (51) beds as set forth in the schedule of Subsection 274.01 of these rules. ( )

04. Compensation for Persons Related to an Owner. Compensation for persons related to an owner will be evaluated in the same manner as for an owner. ( )

05. When an Owner Provides Services to More Than One Provider. When an owner provides services to more than one (1) provider compensation will be distributed on the same basis as costs are allocated for non-owners. ( )

06. More Than One Owner or Related Party May Receive Compensation for Hours Actually Worked. Services must be actually performed, documented and necessary. Total compensation must be reasonable, and not greater than the amount for which the same services could be obtained on the open market. The standard by which full time compensation is measured will be two thousand eighty (2,080) hours. Compensation of an owner or a party related to an owner is subject to other provisions of this chapter, and will not exceed the compensation determined from the Administrative Compensation Schedule, and, on an hourly basis, will not exceed the compensation determined in the Administrative Compensation Schedule divided by two thousand eighty (2,080). ( )

275. NURSING FACILITY: PROPERTY RENTAL RATE REIMBURSEMENT.
Free standing nursing facilities other than hospital based nursing facilities will be paid a property rental rate. Property taxes and property insurance will be reimbursed as costs exempt from limitations. The property rental rate includes compensation for major movable equipment but not for minor movable equipment. The property rental rate is paid in lieu of payment for amortization, depreciation, and interest for financing the cost of land and depreciable assets. Prior to final audit for free-standing nursing facilities, an interim rate for property reimbursement will be set to approximate the property rental rate as determined by Sections 56-108 and 56-109, Idaho Code. ( )

01. Property Rental Rate. The property rental rate is based upon current construction costs, the age of the facility, the type of facility, and major expenditures made to improve the facility, or a rate based upon property costs as of January 1, 1985. The amount paid for each Medicaid day of care will be phased in according to Section 275.01 of these rules, and, beginning April 1, 1985, will be: ( )

R = "Property Base" x 40 - "Age" / 40 x "change in building costs" where: ( )

a. "R" = the property rental rate. ( )

b. "Property Base" = thirteen dollars and nineteen cents ($13.19) beginning October 1, 1996 for all freestanding nursing facilities. ( )

c. "Change in building costs" = 1.0 from October 1, 1996, through December 31, 1996. Beginning January 1, 1997, "change in building costs" will be adjusted each calendar year to reflect the reported annual change in the building cost index for a class D building in the western region, as published by the Marshall Swift Valuation Service or the consumer price index for renter's costs whichever is greater. For freestanding nursing facilities, the index available in September of the prior year will be used. ( )

d. "Age" of facility - The effective age of the facility in years will be set by subtracting the year in which the facility, or portion thereof, was constructed from the year in which the rate is to be applied. No facility or portion thereof will be assigned an age of more than thirty (30) years, however: ( )

i. If adequate information is not submitted by the facility to document that the facility, or portion thereof, is newer than thirty (30) years, the age will be set at thirty (30) years. Adequate documentation will include, but not be limited to, such documents as copies of building permits, tax assessors' records, receipts, invoices, building contract, and original notes of indebtedness. An age will be determined for each building. A weighted average using the age and square footage of the buildings will become the effective age of the facility. The age of each building will be based upon the date when construction on that building was completed. This age will be adjusted to reflect major building expansion or remodeling prior to April 1, 1985, if that expenditure was large enough to reduce the age of the facility by two (2) or more years according to the following formula: ( )

$$r = A \times E / S \times C$$

Where:

r = Reduction in the age of the facility in years.

A	=	Age of the building at the time when construction was completed.
E	=	Actual expenses for the construction provided that the total costs must have been incurred within twenty-four (24) months of the completion of the construction.
S	=	The number of square feet in the building at the end of construction.
C	=	The cost of construction for the buildings in the year when construction was completed according to the schedule in Subsection 275.01.d.ii.

If the result of this calculation, "r" is equal to or greater than 2.0, the age of the building in years will be reduced by this number, rounded to the nearest whole number for rate setting purposes. In no case will the age be less than zero (0). ( )

ii. Historical nursing home construction cost per square foot for purposes of evaluating facility age.

Age	Year	Cost	Age	Year	Cost	Age	Year	Cost
1	2004	82.41	**2**	2003	80.80	**3**	2002	79.06
4	2001	78.43	**5**	2000	74.34	**6**	1999	71.55
7	1998	71.34	**8**	1997	68.20	**9**	1996	67.59
10	1995	66.19	**11**	1994	64.14	**12**	1993	60.56
13	1992	59.03	**14**	1991	56.13	**15**	1990	54.61
16	1989	53.17	**17**	1988	52.03	**18**	1987	51.66
19	1986	51.56	**20**	1985	50.55			

( )

iii. For rates paid after June 30, 1989, the effective age of a facility will be further adjusted when the cost of major repairs, replacement, remodeling, or renovation of a building initiated after April 1, 1985, results in the change in age by at least one (1) year when applied to the formula in Subsection 275.01.d.i. of these rules. However, such change will not decrease the effective age of a facility beyond the point where the increase in the property rental rate is greater than three-fourths (3/4) of the difference between the property rental rate "r" for a new facility at the time of the proposed rate revision and the property rental rate for which the facility was eligible immediately before the adjustment. The cost used for "C" will be adjusted according to costs published by Marshall Swift Valuation Service to reflect current construction costs for average Class D convalescent hospitals. It is the provider's responsibility to notify the Department and document costs. The Department will adjust the age after documentation of costs. ( )

iv. In the event that new requirements are imposed by state or federal agencies, the Department will reimburse the expenditures directly related to these requirements as an increase in the property rental rate if the expense is in excess of one hundred dollars ($100) per bed. If the cost related to the requirement is less than one hundred dollars ($100) per bed, the Department will, within twelve (12) months of verification of expenditure, reimburse the Medicaid share of the entire cost of such new requirements, as a one (1) time payment to the facility. ( )

v. At no time will the property rental rate paid to a facility be less than the greater of the rate allowable to that facility on December 31, 1988, the rate allowable immediately following the first opening of a new facility after December 31, 1988, or the rate allowable immediately following the last, if any, age revision after December 31, 1988. However, subsequent to the application of this provision, before any property rental rate increase may be made for current or successor operators, the final settlement amount of any increase in the property rental rate will first be offset by an amount equal to the impact on final settlement of any rate decrease that would have occurred if the provisions of Subsections 275.01.d.iii. and 275.01.d.iv. of these rules had not been applied. This is intended to allow the postponement of the financial burden to providers of property rental rate decreases and to allow an equal offset of

the financial burden to the state of subsequent property rate increases for a current or successor provider. ( )

vi. Effective July 1, 1991, for freestanding nursing facilities, "age of facility" will be a revised age that is the lesser of the age established under other provisions of this Section or the age that most closely yields the rate allowable to existing facilities as of June 30, 1991, under Subsection 275.01 of these rules. This revised age will not increase over time. ( )

02. Grandfathered Rate. A "grandfathered property rental rate" for existing free-standing nursing facilities will be determined by dividing the audited allowable annualized property costs, exclusive of taxes and insurance, for assets on hand as of January 1, 1985, by the total patient days in the period July 1, 1984, through June 30, 1985. ( )

a. Prior to audit settlement, the interim rate for property costs allowable as of January 1, 1985, will be used to approximate the grandfathered rate. ( )

b. The grandfathered property rental rate will be adjusted to compensate the facility for the property costs of major repairs, replacement, expansion, remodeling or renovation initiated prior to April 1, 1985, and completed during calendar year 1985. ( )

c. Beginning July 1, 1989, facilities receiving grandfathered rates may have those rates adjusted for modifications related to major repairs, replacement, expansion, remodeling, or renovation initiated after January 1, 1986, if the cost of these modifications would be sufficient to reduce the age of the facility by one (1) year or more according to Subsection 275.01.d.i.of these rules. The grandfathered rate will be revised after completion of modifications and will be the greater of: ( )

i. The grandfathered rate previously allowed; or ( )

ii. The actual per diem property costs of amortization, depreciation and interest not applicable to the modifications for the audit period in which the modifications were completed plus the per diem rate of the first year amortization of the cost of these modifications when amortized over American Hospital Association guideline useful life or lives. However, no change in the grandfathered rate will be allowed to change that rate by more than three-fourths (3/4) of the difference between the previous grandfathered rate and the property rental rate that would be paid for a new building at the time of the proposed rate revision. ( )

d. The facility will be reimbursed a rate that is the higher of the grandfathered property rental rate as determined according to provisions of Subsection 275.02 of these rules or the property rental rate determined according to Subsections 275.01, 275.03, or 275.05 of these rules. ( )

03. Leased Freestanding Nursing Facilities. Freestanding nursing facilities with leases will not be reimbursed in the same manner specified in Subsections 275.01 and 275.02 of these rules. Provisions in this section do not apply to reimbursement of home office costs. Home office costs will be paid based on reasonable cost principles. ( )

a. Facilities with leases entered into on or after March 30, 1981, are to be reimbursed in the same way as owned facilities with ownership costs being recognized instead of lease costs. ( )

b. Facilities with leases entered into prior to March 30, 1981, will not be subject to reimbursement according to the provisions of Subsections 275.01 or 275.02 of these rules. Their property rental rate per day of care will be the sum of the annualized allowed lease costs and the other annualized property costs for assets on hand as of January 1, 1985, exclusive of taxes and insurance when paid separately, divided by total patient days in the period June 30, 1983, through July 1, 1984. ( )

i. Effective July 1, 1989, the property rental rates of leased nursing facilities with leases entered into prior to March 30, 1981, may be adjusted to compensate for increased property costs resulting from facility modifications related to major repairs, replacement, expansion, remodeling, or renovation initiated after January 1, 1985, if the cost would be sufficient to reduce the age of the facility by one (1) year or more according to Subsection 275.01.d.i. of these rules. The rate will be revised after the completion of such modifications and will be the greater of

the property rental rate previously allowed under Subsection 275.03, or the actual per diem property costs for the amortization, depreciation, and interest not applicable to the modifications for the reporting period in which the modifications were completed, plus the per diem of the first year amortization of the modification expenses using the American Hospital Association guideline useful life of lives. However, no such rate change will increase the allowable property rental rate by more than three-fourths (3/4) of the difference between the previous rate and the property rental rate that would be allowed for a new building at the time of the proposed rate revision. ( )

ii. Where such leases contain provisions that bind the lessee to accept an increased rate, reimbursement will be at a rate per day of care that reflects the increase in the lease rate. ( )

iii. Where such leases bind the lessee to the lease and allow the rate to be renegotiated, reimbursement will be at a rate per day of care that reflects an annual increase in the lease rate not to exceed the increase in the consumer price index for renters' costs. After April 1, 1985, if such a lease is terminated or if the lease allows the lessee the option to terminate other than by an option to purchase the facility, the property rental rate will become the amount "R" determined by the formula in Subsection 275.01 of these rules as of the date on which the lease is or could be terminated. ( )

04. Sale of a Facility. In the event of the sale of a facility, or asset of a facility, the buyer will receive the property rental rate of Subsection 275.01 of these rules, except in the event of a forced sale or except in the event of a first sale of a facility receiving a "grandfathered rate" after June 30, 1991, whereupon the property rental rate of the new owner will be computed as if no sale had taken place. ( )

05. Forced Sale of a Facility. In the event of a forced sale of a facility, or asset of a facility, where the seller has been receiving a grandfathered rate, the buyer will receive a rate based upon their incurred property costs, exclusive of taxes and insurance, for the twelve (12) months following the sale, divided by the facility's total patient days for that period, or the property rental rate, not modified by Section 275 of these rules**,** whichever is higher, but not exceeding the rate that would be due the seller. ( )

276. -- 277. (RESERVED)

278. NURSING FACILITY: OCCUPANCY ADJUSTMENT FACTOR.
In order to equitably allocate fixed costs to the Medicaid patients in cases where a facility is not maintaining reasonable occupancy levels, an adjustment will be made. No occupancy adjustment will be made against the costs that are used to calculate the property rental rate; however adjustment will be made against all other property costs. The adjustment will be made as follows: ( )

01. Occupancy Levels. If a facility maintains an average occupancy of less than eighty percent (80%) of a facility's capacity, the total property costs not including cost paid under the property rental rate, will be prorated based upon an eighty percent (80%) occupancy rate. Property costs and property rental rates are defined in Section 013 of these rules. The facility's average occupancy percentage will be subtracted from eighty percent (80%) and the resultant percentage will be taken times the total fixed costs to determine the nonallowable fixed costs. ( )

02. Occupancy Adjustment. For purposes of an occupancy adjustment, facility capacity will be computed based upon the greater of the largest number of beds for which the facility was licensed during the period being reported on or the largest number of beds for which the facility was licensed during calendar year 1981, except where a portion of the facility has been converted to use for nonroutine nursing home activities or the facility is newly constructed and has entered the Medicaid Program subsequent to January 1, 1982. If the facility's designed capacity has been changed, the number of beds used to determine occupancy will be lowered by the amount of capacity being converted to nonroutine nursing home activities. Facility capacity for a new facility will be based on the number of beds approved by the certificate of need process less any capacity converted to nonroutine nursing home activities. ( )

03. Fixed Costs. For purposes of an occupancy adjustment fixed costs will be considered all allowable and reimbursable costs reported under the property cost categories. ( )

04. Change in Designed Capacity. In cases where a provider changes the designed capacity of a facility, the average occupancy for the period prior to the change and subsequent to the change will be computed and

each period will be adjusted separately. If the designed capacity is increased, the increased number of beds will not be subject to this adjustment for the first six (6) months following their licensure. ( )

05. New Facility. In the case of a new facility being licensed and occupied, the first six (6) months occupancy level will not be subject to this adjustment. ( )

279. NURSING FACILITY: RECAPTURE OF DEPRECIATION.
Where depreciable assets that were reimbursed based on cost and were used in the Medicaid Program by a facility subsequent to January 1, 1982, and for which depreciation has been reimbursed by the Program, are sold for an amount in excess of their net book value, depreciation so reimbursed will be recaptured from the buyer of the facility in an amount equal to reimbursed depreciation after January 1, 1982, or gain on the sale, whichever is less. ( )

01. Amount Recaptured. Depreciation will be recaptured in full if a sale of a depreciated facility takes place within the first five (5) years of a seller's ownership. Credit will be given for the period of ownership prior to January 1, 1982. For every year the asset is held beyond the first five (5) years, the total depreciation recaptured will be reduced by ten percent (10%) per year of the total depreciation taken. ( )

02. Time Frame. Depreciation will be recaptured by the Medicaid Program from the buyer of the facility over a period of time not to exceed five (5) years from the date of sale, with not less than one-fifth (1/5) of the total amount being recaptured for each year after such date. ( )

280. – 282. (RESERVED)

283. NURSING FACILITY: FILING DATES.

01. Deadlines. Deadlines for annual cost reports will be the last day of the third month following the fiscal year end or the deadline imposed by Medicare if the provider is required to file a Medicare cost report. ( )

02. Waivers. A delay of thirty (30) days may be granted for annual cost reports in unusual circumstances. Requests for such deferrals and reasons therefore must be in writing and should be made prior to the deadline. A written decision will be rendered in writing within ten (10) days. ( )

284. NURSING FACILITY: FAILURE TO FILE.
Failure to submit timely reports may result in a reduction in the interim rate. Failure to file the required cost reports, including required supplemental information, unless a waiver is granted, may result in a reduction of ten percent (10%) in the provider's rate(s) the first day of the month following the deadline date. Continued failure to comply will result in complete payment suspension on the first day of the following month. When suspension or reduction has occurred and the provider has filed the required cost reports, amounts accruing to the provider during the period of suspension or reduction will be restored. Loss of license or certification will result in immediate termination of reimbursement, full scope audit and settlement for the cost period. ( )

285. NURSING FACILITY: ACCOUNTING SYSTEM.
Reports must be filed using the accrual basis and conform with generally accepted accounting principles or within provisions of the guidelines as specified. In any case, the recorded transaction must be capable of verification by Departmental audit. ( )

286. NURSING FACILITY: AUDITS.
All financial reports are subject to audit by Departmental representatives. ( )

01. Accuracy of Recording. To determine whether the transactions recorded in the books of record are substantially accurate and reliable as a basis for determining reasonable costs. ( )

02. Reliability of Internal Control. To determine that the facilities internal control is sufficiently reliable to disclose the results of the to the provider's operations. ( )

03. Economy and Efficiency. To determine if Title XIX and Title XXI participants have received the

required care on the a basis of economy and efficiency. ( )

04. Application of GAAP. To determine if GAAP is applied on a consistent basis in conformance with applicable federal and state regulations. ( )

05. Patient Trust Fund Evaluation. To evaluate the provider's policy and practice regarding their fiduciary responsibilities for patients, funds and property. ( )

06. Enhancing Financial Practices. To provide findings and recommendations aimed at better financial practices to allow the most economical delivery of patient care. ( )

07. Compliance. To provide recommendations that will enable the provider to conform more closely with state and federal regulations in the delivery of health care to program participants. ( )

08. Final Settlement. To effect final settlement when required by **Sections** 250 through 296 of these rules. ( )

287. NURSING FACILITY: AUDIT APPLICATION.

01. Annual Audits. Normally, all annual statements will be audited within the following year. ( )

02. Limited Scope Audit. Other statements and some annual audit recommendations may be subject to limited scope audits to evaluate provider compliance. ( )

03. Additional Audits. In addition, audits may be required where: ( )

a. A significant change of ownership occurs. ( )

b. A change of management occurs. ( )

c. An overpayment of twenty-five percent (25%) or more has resulted for a completed cost period. ( )

04. Audit Appointment. Annual field audits will be by appointment. Auditors will identify themselves with a letter of authorization or Departmental I.D. cards. ( )

288. NURSING FACILITY: AUDIT STANDARDS AND REQUIREMENTS.

01. Review of New Provider Fiscal Records. Before any program payments can be made to a prospective provider the intermediary will review the provider's accounting system and its capability of generating accurate statistical cost data. Where the provider's record keeping capability does not meet program requirements the intermediary will offer limited consultative services or suggest revisions of the provider's system to enable the provider to comply with program requirements. ( )

02. Requirements. Providers Reimbursement Manual (PRM), Section 2404.3, states: “Examination of Pertinent Data and Information -- Providers asking to participate as well as those currently participating must permit the intermediary to examine such records and documents as are deemed necessary. ( )

03. Examination of Records. Examination of records and documents may include: ( )

a. Corporate charters or other documents of ownership including those of a parent or related companies. ( )

b. Minutes and memos of the governing body including committees and its agents. ( )

c. All contracts. ( )

d. Tax returns and records, including workpapers and other supporting documentation. ( )

e. All insurance contracts and policies including riders and attachments. ( )

f. Leases. ( )

g. Fixed asset records (see audit section - Capitalization of Assets). ( )

h. Schedules of patient charges. ( )

i. Notes, bonds and other evidences of liability. ( )

j. Capital expenditure records. ( )

k. Bank statements, cancelled checks, deposit slips and bank reconciliations. ( )

l. Evidence of litigations the facility and its owners are involved in. ( )

m. Documents of ownership including attachments that describe the property. ( )

n. All invoices, statements and claims. ( )

o. Providers Accounting Firm. Where a provider engages an accounting firm to maintain its fiscal records, the financial audit work papers prepared by the accounting firm are considered to be the property of the provider and must be made available to the intermediary upon request, under PRM, Subparagraph 2404.4(Q). ( )

p. Ledgers, journals, all working papers, subsidiary ledgers, records and documents relating to financial operation. ( )

q. All patient records, including trust funds and property. ( )

r. Time studies and other cost determining information. ( )

s. All other sources of information needed to form an audit opinion. ( )

04. Adequate Documentation. ( )

a. Adequate cost information as developed by the provider must be current, accurate, and in sufficient detail to support payment made for services rendered to beneficiaries. This includes all ledgers, books, records and original evidences of cost including purchase requisitions, purchase orders, vouchers, requisitions for material, inventories, labor time cards, payrolls, bases for apportioning costs, and other documentation that pertains to the determination of reasonable cost, capable of being audited under PRM, Section 2304. ( )

b. Adequate expenses documentation including an invoice, or a statement with invoices attached that support the statement. All invoices should meet the following standards: ( )

i. Date of service or sale; ( )

ii. Terms and discounts; ( )

iii. Quantity; ( )

iv. Price; ( )

v. Vendor name and address; ( )

vi. Delivery address if applicable; ( )

vii. Contract or agreement references; and ( )

viii. Description, including quantity, sizes, specifications brand name, services performed. ( )

c. Capitalization of assets for major movable equipment will be capitalized. Minor movable equipment cannot be capitalized. The cost of fixed assets and major movable equipment must be capitalized and depreciated over the estimated useful life of the asset under PRM, Section 108.1. This rule applies except for the provisions of PRM, Section 106 for small tools. ( )

d. Completed depreciation records must meet the following criteria for each asset: ( )

i. Description of the asset including serial number, make, model, accessories, and location. ( )

ii. Cost basis should be supported by invoices for purchase, installation, etc. ( )

iii. Estimated useful life. ( )

iv. Depreciation method such as straight line, double declining balance, etc. ( )

v. Salvage value. ( )

vi. Method of recording depreciation on a basis consistent with accounting policies. ( )

vii. Report additional information, such as additional first year depreciation, even though it isn't an allowable expense. ( )

viii. Reported depreciation expense for the year and accumulated depreciation will tie to the asset ledger. ( )

e. Depreciation methods such as straight line depreciation is always acceptable. Methods of accelerated depreciation are acceptable only upon authorization by the Office of Audit or its successor organization. Additional first year depreciation is not allowable. ( )

f. The depreciable life of any asset may not be shorter than the useful life stated in the publication, Estimated Useful Lives of Depreciable Hospital Assets, 1993 revised edition. Guidelines Lives, which is incorporated by reference under Section 004 of these rules. Deviation from these guidelines will be allowable only upon authorization from the Department. ( )

g. Lease purchase agreements may generally be recognized by the following characteristics: ( )

i. Lessee assumes normal costs of ownership, such as taxes, maintenance, etc.; ( )

ii. Intent to create security interest; ( )

iii. Lessee may acquire title through exercise of purchase option that requires little or no additional payment or, such additional payments are substantially less than the fair market value at date of purchase; ( )

iv. Non-cancelable or cancelable only upon occurrence of a remote contingency; and ( )

v. Initial loan term is significantly less than the useful life and lessee has option to renew at a rental price substantially less than fair rental value. ( )

h. Assets acquired under such agreements will be viewed as contractual purchases and treated accordingly. Normal costs of ownership such as depreciation, taxes and maintenance will be allowable as determined in this chapter. Rental or lease payments will not be reimbursable. ( )

i. Complete personnel records normally contain the following: ( )

i. Application for employment. ( )

ii. W-4 Form. ( )

iii. Authorization for other deductions such as insurance, credit union, etc. ( )

iv. Routine evaluations. ( )

v. Pay raise authorization. ( )

vi. Statement of understanding of policies, procedures, etc. ( )

vii. Fidelity bond application (where applicable). ( )

05. Internal Control. ( )

a. A system of internal control is intended to provide a method of handling all routine and nonroutine tasks for the purpose of: ( )

i. Safeguarding assets and resources against waste, fraud, and inefficiency. ( )

ii. Promoting accuracy and reliability in financial records. ( )

iii. Encouraging and measuring compliance with company policy and legal requirements. ( )

iv. Determining the degree of efficiency related to various aspects of operations. ( )

b. An adequate system of internal control over cash disbursements would normally include: ( )

i. Payment on invoices only, or statements supported by invoices. ( )

ii. Authorization for purchase such as a purchase order. ( )

iii. Verification of quantity received, description, terms, price, conditions, specifications, etc. ( )

iv. Verification of freight charges, discounts, credit memos, allowances, and returns. ( )

v. Check of invoice accuracy. ( )

vi. Approval policy for invoices. ( )

vii. Method of invoice cancellation to prevent duplicating payment. ( )

viii. Adequate separation of duties between ordering, recording, and paying. ( )

ix. System separation of duties between ordering, recording, and paying. ( )

x. Signature policy. ( )

xi. Pre-numbered checks. ( )

xii. Statement of policy regarding cash or check expenditures. ( )

xiii. Adequate internal control over the recording of transactions in the books of record. ( )

xiv. An imprest system for petty cash. ( )

06. Accounting Practices. Sound accounting practices normally include the following: ( )

a. Written statement of accounting policies and procedures, including policies of capitalization, depreciation and expenditure classification criteria. ( )

b. Chart of accounts. ( )

c. A budget or operating plan. ( )

289. -- 290. (RESERVED)

291. NURSING FACILITY: COSTS FOR THE COMPLETION OF NURSE AIDE TRAINING AND COMPETENCY EVALUATION PROGRAMS (NATCEPS) AND FOR COMPLYING WITH CERTAIN OTHER REQUIREMENTS.
Provisions of federal law require the state to give special treatment to costs related to the completion of training and competency evaluation of nurse aides and to increase rates related to other new requirements. Treatment will be as follows: ( )

01. Cost Reimbursement. Effective for cost reports filed and for payments made after April 1, 1990, NATCEP costs will be outside the content of nursing facility care and will be reported separately as exempt costs. ( )

02. Costs Subject to Audit. Such NATCEP costs are subject to audit, and must be reported by all nursing facilities, including those that are hospital-based, and are not included in the percentile cap. ( )

292. NURSING FACILITY: PAYMENTS FOR PERIODS OF TEMPORARY ABSENCE.
Payments may be made for reserving beds in long-term care facilities for participants during their temporary absence if the facility charges private paying patients for reserve bed days, subject to the following limitations: ( )

01. Facility Occupancy Limits. Payment for periods of temporary absence from long term care facilities will not be made when the number of unoccupied beds in the facility on the day preceding the period of temporary absence in question is equal to or greater than: ( )

a. If licensed beds are less than one hundred (<100) and they have five (5) or more beds unoccupied, leave of absence payments are not allowed. ( )

b. If licensed beds are greater than or equal to one hundred (>100), they must have a minimum occupancy rate of ninety-five percent (95%) for leave of absence payments to be allowed. ( )

02. Time Limits. Payments for periods of temporary absence from long term care facilities will be made for therapeutic home visits for nursing facility residents of up to three (3) days per visit and not to exceed a total of fifteen (15) days per calendar year so long as the days are part of a treatment plan ordered by the attending physician. ( )

03. Limits on Amount of Payments. Payment for reserve bed days will be the lesser of the following: ( )

i. Seventy-five percent (75%) of the audited allowable costs of the facility; or ( )

ii. The rate charged to private paying patients for reserve bed days. ( )

04. Payment Procedures. Each long term care facility must submit its claims to the Department in accordance with the procedures established by the Department. The Department will not pay for a claim on behalf of a medical assistance participant unless the information on the claim is consistent with the information in the Department's computer eligibility file. ( )

293. -- 299. (RESERVED)

300. PERSONAL CARE SERVICES (PCS).

01. Description of Personal Care Services (PCS). Under Sections 39-5601 through 39-5607, Idaho Code, it is the intent of the Department to provide personal care services (PCS) to eligible participants in their own homes or personal residences to prevent unnecessary institutional placement, to provide for the greatest degree of independence possible, to enhance quality of life, to encourage individual choice, and to maintain community integration. ( )

02. Temporary Changes to PCS Rules During Declared State of Emergency Related to Novel Coronavirus Disease (COVID-19). In response to Idaho's declaration on 3/13/20 of a state of emergency related to COVID-19, the Department reserves the right to temporarily alter requirements and processes related to PCS services, currently and through the duration of the emergency state, in order to mitigate spread of disease and to ensure the health and safety of our participants under the guidance and authority of the provisions in a CMS approved 1135 waiver. Guidance for approved flexibilities is posted on the Medicaid Information Releases website at https://healthandwelfare.idaho.gov/providers/idaho-medicaid-providers/information-medicaid-providers. ( )

301. PERSONAL CARE SERVICES: DEFINITIONS.

01. Children's PCS Assessment. A set of standardized criteria adopted by the Department to assess functional and cognitive abilities of children to determine eligibility for children's PCS. ( )

02. Natural Supports. Personal associations and relationships that enhance the quality and security of life for people, such as family, friends, neighbors, volunteers, church, or others. ( )

03. Personal Care Services (PCS). A range of medically-oriented care services related to a participant's physical or functional requirements. These services are provided in the participant's home or personal residence, but do not include housekeeping or skilled nursing care. ( )

04. PCS Family Alternate Care Home. The private home of an individual licensed by the Department to provide PCS to one (1) or two (2) children, who are unable to reside in their own home and require assistance with medically-oriented tasks related to the child's physical or functional needs. ( )

302. PERSONAL CARE SERVICES: ELIGIBILITY.

01. Financial Eligibility. The participant must be financially eligible for medical assistance under IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children," or 16.03.05, "Eligibility for Aid to the Aged, Blind, and Disabled (AABD)." ( )

02. Other Eligibility Requirements. Bureau of Long Term Care (BLTC) will prior authorize payment for the amount and duration of all services when all of the following conditions are met: ( )

a. The BLTC finds that the participant is capable of being maintained safely and effectively in their own home or personal residence using PCS. ( )

b. The participant is an adult for whom a Uniform Assessment Instrument (UAI) has been completed, or a child for whom a children's PCS assessment has been completed; ( )

c. The BLTC reviews the documentation for medical necessity; and ( )

d. The participant has a plan of care that meets the person-centered planning requirements described in Sections 316 and 317 of these rules. ( )

03. State Plan Option. A participant who receives medical assistance is eligible for PCS under the State Medicaid Plan option if the Department finds they require PCS due to a medical condition that impairs their physical, mental function, or independence. ( )

04. Annual Eligibility Redetermination. The participant's eligibility for PCS must be redetermined at least annually under Subsections 302.01. through 302.03 of these rules. ( )

a. The annual financial eligibility redetermination must be conducted under IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children," or 16.03.05, "Eligibility for Aid to the Aged, Blind, and Disabled (AABD)." BLTC will make the medical eligibility redetermination. The redetermination can be completed more often than once each year at the request of the participant, the Self-Reliance Specialist, the Personal Assistance Agency, the personal assistant, the supervising RN, the QIDP, or the physician. ( )

b. The medical redetermination assesses the following factors: ( )

i. The participant's continued need for PCS; ( )

ii. Discharge from PCS; and ( )

iii. Referral of the participant from PCS to a nursing facility. ( )

303. PERSONAL CARE SERVICES: COVERAGE AND LIMITATIONS.

01. Medical Care and Services. PCS services include medically-oriented tasks related to a participant's physical or functional requirements, as opposed to housekeeping or skilled nursing care, provided in the participant's home or personal residence. The provider must deliver at least one (1) of the following services: ( )

a. Basic personal care and grooming to include bathing, care of the hair, assistance with clothing, and basic skin care; ( )

b. Assistance with bladder or bowel requirements that may include helping the participant to and from the bathroom or assisting the participant with bedpan routines; ( )

c. Assistance with food, nutrition, and diet activities including preparation of meals if incidental to medical need; ( )

d. The continuation of active treatment training programs in the home setting to increase or maintain participant independence for the participant with developmental disabilities; ( )

e. Assisting the participant with physician-ordered medications that are ordinarily self-administered, in accordance with IDAPA 24.34.01, "Rules of the Idaho Board of Nursing," Subsection 490.05; ( )

f. Non-nasogastric gastrostomy tube feedings if authorized by BLTC prior to implementation and if the following requirements are met: ( )

i. The task is not complex and can be safely performed in the given participant care situation; ( )

ii. A Licensed Registered Nurse (RN) has assessed the participant's nursing care needs and has developed a written standardized procedure for gastrostomy tube feedings, individualized for the participant's characteristics and needs; ( )

iii. Individuals to whom the procedure can be delegated are identified by name. The RN must provide proper instruction in the performance of the procedure, supervise a return demonstration of safe performance of the procedure, state in writing the strengths and weaknesses of the individual performing the procedure, and evaluate the performance of the procedure at least monthly; ( )

iv. Any change in the participant's status or problem related to the procedure must be reported immediately to the RN; ( )

v. 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 participant's record; and ( )

vi. Routine medication may be given by the personal assistant through the non-nasogastric tube if authorized by the supervising RN. ( )

02. Non-Medical Care and Services. PCS services may also include non-medical tasks. In addition to performing at least one (1) of the services listed in Subsections 303.01.a. through 303.01.f. of this rule, the provider may also perform the following services, if no natural supports are available: ( )

a. Incidental housekeeping services essential to the participant's comfort and health, including changing bed linens, rearranging furniture to enable the participant to move around more easily, laundry, and room cleaning incidental to the participant's treatment. Cleaning and laundry for any other occupant of the participant's residence are excluded. ( )

b. Accompanying the participant to clinics, physicians' office visits or other trips that are reasonable for the purpose of medical diagnosis or treatment. ( )

c. Shopping for groceries or other household items specifically required for the health and maintenance of the participant. ( )

03. Place of Service Delivery. PCS may be provided in the participant's own home or personal residence. The participant's personal residence may be a Certified Family Home or a Residential Assisted Living Facility, or a PCS Family Alternate Care Home. The following living situations are specifically excluded as a personal residence: ( )

a. Certified nursing facilities or hospitals. ( )

b. Licensed Intermediate Care Facilities for Persons with Intellectual Disabilities (ICFs/IID). ( )

c. A home that receives payment for specialized foster care, professional foster care or group foster care, as described in IDAPA 16.06.01, “Child and Family Services.” ( )

04. Type of Service Limitations. The provider is excluded from delivering the following services: ( )

a. Irrigation or suctioning of any body cavities that require sterile procedures or the application of dressings involving prescription medication and aseptic techniques; ( )

b. Insertion or sterile irrigation of catheters; ( )

c. Injecting fluids into the veins, muscles or skin; and ( )

d. Administering medication. ( )

05. Participant Service Limitations. ( )

a. Adults who receive PCS under the State Medicaid Plan option are limited to a maximum of sixteen

(16) hours per week per participant. ( )

b. Children who meet the necessity criteria for EPSDT services under IDAPA 16.03.09 "Medicaid Basic Plan Benefits," Section 882, may receive up to twenty-four (24) hours per day of PCS per child through the month of their twenty-first birthday. ( )

06. Provider Coverage Limitations. ( )

a. The provider must not bill for more time than was actually spent in service delivery. ( )

b. No provider home, regardless of the number of providers in the home, may serve more than two (2) children who are authorized for eight (8) or more hours of PCS per day. ( )

304. PERSONAL CARE SERVICES: PROCEDURAL REQUIREMENTS.

01. Service Delivery Based on Plan of Care or NSA. All PCS services are provided based on a written plan of care or a negotiated service agreement (NSA). The requirements for the NSA for participants in Residential Assisted Living Facilities are described in IDAPA 16.03.22, "Residential Assisted Living Facilities." The requirements for the NSA for participants in Certified Family Homes are described in IDAPA 16.03.19, "Certified Family Homes." The Personal Assistance Agency and the participant who lives in their own home are responsible to prepare the plan of care. ( )

a. The plan of care for participants who live in their own homes or in a PCS Family Alternate Care Home is based on: ( )

i. The physician's or authorized provider's information if applicable; ( )

ii. The results of the UAI for adults, the children's PCS assessment and, if applicable, the QIDP's assessment and observations of the participant; and ( )

iii. Information obtained from the participant. ( )

b. The plan of care must include all aspects of medical and non-medical care that the provider needs to perform, including the amount, type and frequency of necessary services. ( )

c. The plan of care must be revised and updated based upon treatment results or a change(s) in the participant's needs, or both, but at least annually. ( )

d. The plan of care or NSA must meet the person-centered planning requirements described in Sections 316 and 317 of these rules. ( )

02. Service Supervision. The delivery of PCS is overseen by a licensed registered nurse (RN) or Qualified Intellectual Disabilities Professional (QIDP). The BLTC will identify the need for supervision. ( )

a. Oversight must include all of the following: ( )

i. Assistance in the development of the written plan of care; ( )

ii. Review of the treatment given by the personal assistant through a review of the participant's PCS record as maintained by the provider; ( )

iii. Reevaluation of the plan of care as necessary; and ( )

iv. Immediate notification of the guardian, emergency contact, or family members of any significant changes in the participant's physical condition or response to the services delivered. ( )

b. All participants who are developmentally disabled, other than those with only a physical disability

as determined by the BLTC, may receive oversight by a QIDP as defined in 42 CFR 483.430. Oversight must include: ( )

i. Assistance in the development of the plan of care for those aspects of active treatment that are provided in the participant's personal residence by the personal assistant; ( )

ii. Review of the care or training programs given by the personal assistant through a review of the participant's PCS record as maintained by the provider and through on-site interviews with the participant; ( )

iii. Reevaluation of the plan of care as necessary, but at least annually; and ( )

iv. An on-site visit to the participant to evaluate any change of condition when requested by the personal assistant, the Personal Assistance Agency, the nurse supervisor, the service coordinator or the participant. ( )

03. Prior Authorization Requirements. All PCS services must be prior authorized by the Department. Authorizations will be based on the information from: ( )

a. The children's PCS assessment or Uniform Assessment Instrument (UAI) for adults; ( )

b. The individual service plan developed by the Personal Assistance Agency; and ( )

c. Any other medical information that supports the medical need. ( )

04. PCS Record Requirements for a Participant in Their Own Home. PCS records must be maintained for all participants receiving PCS in their own homes or in a PCS Family Alternate Care Home. ( )

a. Documentation Requirements. PCS provider must maintain documentation of every visit made to the participant's home and must record the following minimum information: ( )

i. Date and time of visit; ( )

ii. Length of visit; ( )

iii. Services provided during the visit; and ( )

iv. Documentation of any changes noted in the participant's condition or any deviations from the plan of care. ( )

b. Participant's Signature. The participant or legal guardian must verify services were delivered. ( )

c. Provider Signature. The Plan of Care must be signed by the provider indicating that they will deliver services according to the authorized service plan and consistent with home and community-based requirements. ( )

d. Copy Requirement. A copy of the information required in Subsection 304.04 of these rules must be maintained and available in a format accessible to the participant in their home. Failure to maintain this information may result in recovery of funds paid for undocumented services. ( )

e. Electronic Visit Verification (EVV) System. EVV systems as described in Section 041 of these rules will not take the place of documentation requirements of Subsection 304.04 of these rules but may be used to generate documentation retained in the participant's home. ( )

05. PCS Record Requirements for a Participant in a Residential Assisted Living Facility or Certified Family Home. The PCS records must be maintained on all participants who receive PCS in a Residential

Assisted Living Facility (RALF) or Certified Family Home (CFH). ( )

a. Participant in a RALF. The additional PCS record requirements for participants in RALF are described in IDAPA 16.03.22, "Residential Assisted Living Facilities." ( )

b. Participant in a CFH. The additional PCS record requirements for participants in CFHs are described in IDAPA 16.03.19, "Certified Family Homes." ( )

c. Participant's Signature. The participant or legal guardian must sign the NSA agreeing to the delivery of services as specified. ( )

d. Provider Signature. The NSA must be signed by the supervisory nurse or agency personnel responsible for developing the NSA with the participant, and must indicate that they will deliver services according to the authorized NSA and consistent with home and community-based requirements. ( )

06. Provider Responsibility for Notification. The Personal Assistance Agency is responsible to notify the BLTC and physician or authorized provider when any significant changes in the participant's condition are noted during service delivery. This notification must be documented in the Personal Assistance Agency record. ( )

07. COVID-19. The sections of this rule may be subject to amendment by the BLTC for the duration of the COVID-19 state of emergency. Please consult Medicaid Information Release MA20-15 for additional guidance. ( )

305. PERSONAL CARE SERVICES: PROVIDER QUALIFICATIONS.

01. Provider Qualifications for Personal Assistants. All personal assistants must have at least one (1) of the following qualifications: ( )

a. Licensed Registered Nurse (RN). A person currently licensed by the Idaho State Board of Nursing as a licensed registered nurse; ( )

b. Licensed Practical Nurse (LPN). A person currently licensed by the Idaho State Board of Nursing as a licensed practical nurse; or ( )

c. Personal Assistant. A person who meets the standards of Section 39-5603, Idaho Code, and receives training to ensure the quality of services. The assistant must be at least age eighteen (18) years of age. The BLTC may require a certified nursing assistant (CNA) if, in their professional judgment, the participant's medical condition warrants a CNA. ( )

02. Provider Training Requirements. In the case where care is provided in the participant's own home, and the participant has a developmental disability that is not physical only and requires more than physical assistance, all those who provide care must have: ( )

a. Completed one (1) of the Department-approved developmental disabilities training courses; or ( )

b. Experience providing direct services to people with developmental disabilities. ( )

c. BLTC determines whether developmental disability training is required. Providers who are qualified as QIDPs are exempted from the Department-approved developmental disabilities training course. ( )

d. In order to serve a participant with a developmental disability, a region may temporarily approve a PCS provider who meets all qualifications except for the required training course or experience, if all the following conditions are met: ( )

i. The BLTC verifies that there are no other qualified providers available; ( )

ii. The provider is enrolled in the next available training course with a graduation date no later than six (6) months from the date of the request for temporary provider status; and ( )

iii. The supervising QIDP makes monthly visits until the provider graduates from the training program. ( )

03. Provider Exclusion. If PCS is paid for by Medicaid, a PCS service provider cannot be the spouse of any participant or be the parent of a participant if the participant is a minor child. ( )

04. Care Delivered in Provider's Home for a Child. When care for a child is delivered in the provider's home, the provider must be licensed or certified for the appropriate level of child foster care or day care. The provider must be licensed for care of individuals under age eighteen (18), as defined in Section 39-1213, Idaho Code. Noncompliance with these standards is cause for termination of the provider's provider agreement. ( )

05. Care Delivered in Provider's Home for an Adult. When care for an adult is provided in a home owned or leased by the provider, the provider must be certified as a Certified Family Home under IDAPA 16.03.19, "Certified Family Homes." ( )

06. Criminal History Check. All PCS providers, including service coordinators, RN supervisors, QIDP supervisors and personal assistants, must participate in a criminal history check as required by Section 39-5604, Idaho Code. The criminal history check must be conducted in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." ( )

07. Health Screen. Each Personal Assistance Agency employee who serves as a personal assistant must complete a health questionnaire. Personal Assistance Agencies must retain the health questionnaire in their personnel files. If the personal assistant indicates on the questionnaire that they have a medical problem, they are required to submit a statement from a physician or authorized provider that their medical condition does not prevent them from performing all the duties required of a personal care provider. Misrepresentation of information submitted on the health questionnaire may be cause for termination of employment for the personal assistant and would disqualify the employee to provide services to Medicaid participants. ( )

306. PERSONAL ASSISTANCE AGENCY (PAA): QUALIFICATIONS AND DUTIES.

01. Provider Agreement Required. A Personal Assistance Agency is an organization that has signed the Medicaid Provider General Agreement and the Additional Terms-Personal Assistance Agencies, Aged and Disabled Waiver Provider Agreement with the Department. The PAA agrees to comply with all conditions within the agreements. A Personal Assistance Agency may also provide fiscal intermediary services in accordance with Section 329 of these rules. Each Personal Assistance Agency must direct, control, and monitor the work of each of its personal assistants. ( )

02. Responsibilities of a Personal Assistance Agency. A Personal Assistance Agency must be capable of and is responsible for all of the following, no matter how the PAA is organized or the form of the business entity it has chosen: ( )

a. Recruitment, hiring, firing, training, supervision, scheduling and payroll for personal assistants and the assurance that all providers are qualified to provide quality service; ( )

b. Participation in the provision of worker's compensation, unemployment compensation and all other state and federal tax withholdings; ( )

c. Maintenance of liability insurance coverage. Termination of either worker's compensation or professional liability insurance by the provider is cause for termination of the provider's provider agreement; ( )

d. Provision of a licensed registered nurse (RN) or, where applicable, a QIDP supervisor to develop

and complete plans of care and provide ongoing supervision of a participant's care; ( )

e. Assignment of qualified personal assistants to eligible participants after consultation with and approval by the participants; ( )

f. Assuring that all personal assistants meet the qualifications in Subsection 305.01 of these rules; ( )

g. Billing Medicaid for services approved and authorized by the BLTC; ( )

h. Collecting any participant contribution due; ( )

i. Conducting, at least annually, participant satisfaction or quality control reviews that are available to the Department and the general public; and ( )

307. PERSONAL CARE SERVICES: PROVIDER REIMBURSEMENT.

01. Reimbursement Rate. Personal assistance providers will be paid a uniform reimbursement rate for service as established by the Department. Provider claims for payment will be submitted on claim forms provided or approved by the Department. Billing instructions will be provided by the Department. ( )

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 transportation, unless approved by the Department or its contractor under a Home and Community-Based Services (HCBS) waiver, or provider transportation to and from the participant's home. Fees will be calculated as provided in Subsections 307.03 through 307.08 of this rule. ( )

03. Weighted Average Hourly Rate Methodology. Annually Medicaid will conduct a poll of all Idaho nursing facilities and ICFs/IID, and establish the weighted average hourly rates (WAHR) for nursing facility industry employees in comparable positions (i.e. RN, certified and non-certified nurse's aides) in Idaho to be used in calculating the reimbursement rate to be effective on July 1st of that year. ( )

04. Payment for Personal Assistance Agency. Payment for personal assistance agency services will be paid according to rates established by the Department. ( )

a. The Department will establish Personal Assistance Agency rates for personal assistance services based on the WAHR.

Personal Assistance Agencies	WAHR x supplemental component	=	$ amount/hour

( )

b. The Department will calculate a supplemental component using costs reported for travel, administration, training, and all payroll taxes and fringe benefits. The survey data is the cost information collected during the prior State Fiscal Year. ( )

c. The Department will survey one hundred percent (100%) of PCS providers. Cost surveys are unaudited, but a provider that refuses or fails to respond to the periodic state surveys may be disenrolled as a Medicaid provider. The Department will derive reimbursement rates using direct care staff costs, employment related expenditures, program related costs, and indirect general and administrative costs in the reimbursement methodology, when these costs are incurred by a provider. ( )

05. Payment Levels for Adults in a RALF or CFH. Adult participants living in RALFs or CFHs will receive PCS at a rate based on their care level. Each level will convert to a specific number of hours of PCS. ( )

a. Reimbursement Level I -- One point twenty-five (1.25) hours of PCS per day or eight point

seventy-five (8.75) hours per week. ( )

b. Reimbursement Level II -- One point five (1.5) hours of PCS per day or ten point five (10.5) hours per week. ( )

c. Reimbursement Level III -- Two point twenty-five (2.25) hours of PCS per day or fifteen point seventy-five (15.75) hours per week. ( )

d. Reimbursement Level IV - One point seventy-nine (1.79) hours of PCS per day or twelve point five (12.5) hours per week. This level will be assigned based on a documented diagnosis of mental illness, intellectual disability, or Alzheimer's disease. If an individual is assessed as Level III with a diagnosis of mental illness, intellectual disability, or Alzheimer's disease the provider reimbursement rate will be the higher amount as described in Subsection 307.05.c. of these rules. ( )

06. Attending Physician Reimbursement Level. The attending physician or authorized provider are reimbursed for services provided using current payment levels and methodologies for other services provided to eligible participants. ( )

07. Supervisory RN and QIDP Reimbursement Level. The supervisory RN and QIDP are reimbursed at a per visit amount established by the Department for supervisory visits. Participant evaluations and Care Plan Development will be reimbursed at a rate established by the Department, following authorization by the Department or its contractor. ( )

a. The number of supervisory visits by the RN or QIDP to be conducted per calendar quarter will be approved as part of the PCS care plan by the Department or its contractor. ( )

b. Additional evaluations or emergency visits in excess of those contained in the approved care plan will be authorized when needed by the Department or its contractor. ( )

08. Payment for PCS Family Alternate Care Home. The Department will establish PCS Family Alternate Care Home rates for personal assistance services based on the WAHR. Based on the survey conducted, the Department will calculate a supplemental component using costs reported for administration, and training. The survey data is the cost information collected during the prior State Fiscal Year.

PCS Family Alternate Care Home	Children's PCS Assessment Weekly Hours x (WAHR x supplemental component)	=	$ amount/week

( )

09. EVV Compliance. Provider claims for PCS require EVV compliance as described in Section 041 of these rules in order to be eligible for payment. ( )

308. PERSONAL CARE SERVICES (PCS): QUALITY ASSURANCE.

01. Responsibility for Quality. Personal Assistance Agencies, RALFs, and CFHs furnishing PCS are responsible for assuring that they provide quality services in compliance with applicable rules. ( )

02. Review Results. Results of quality assurance reviews conducted by the Department must be transmitted to the provider within forty-five (45) days after the review is completed. ( )

03. Quality Improvement Plan. The provider must respond within forty-five (45) days after the results are received. If problems are identified, the provider must implement a quality improvement plan and report the results to the Department upon request. ( )

04. HCBS Compliance. Personal Assistance Agencies are responsible for ensuring they meet the setting requirements described in Section 313 of these rules. RALFs, and CFHs are responsible for ensuring that they meet the setting requirements described in Sections 313 and 314 of these rules. All providers furnishing PCS are

responsible for ensuring they meet the person-centered planning requirements described in Sections 316 through 317 of these rules. PCS providers must comply with associated Department quality assurance activities. The Department may take enforcement actions as described in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 205, if the provider fails to comply with any term or provision of the provider agreement, or any applicable state or federal regulation. ( )

05. COVID-19. The sections of this rule may be subject to amendment by the BLTC for the duration of the COVID-19 state of emergency. Please consult Medicaid Information Release MA20-15 for additional guidance. ( )

309. (RESERVED)

SUB AREA: HOME AND COMMUNITY-BASED SERVICES
(Sections 310-317)

310. HOME AND COMMUNITY-BASED SERVICES.
Home and Community-Based Services (HCBS) are those services and supports that assist eligible participants to remain in their home and community. The federal authorities under 42 CFR 441.301, 42 CFR 441.710, and 42 CFR 441.725 require the state to deliver HCBS in accordance with the rules described in Sections 310 through 319 of these rules. HCBS include the following: ( )

01. Children's Developmental Disability Services. Children's developmental disability services as defined in Sections 663 and 683 of these rules. ( )

02. Adult Developmental Disability Services. Adult developmental disability services as defined in Sections 645 through 659, 703, and 705 of these rules. ( )

03. Consumer-Directed Services. Consumer-directed services as defined in IDAPA 16.03.13, "Consumer-Directed Services." ( )

04. Aged and Disabled Waiver Services. Aged and disabled waiver services as defined in Section 326 of these rules. ( )

05. Personal Care Services. Personal care services as defined in Section 303 of these rules. ( )

06. Services for Children with Serious Emotional Disturbance (SED). SED services, as defined in Section 368 of these rules, for children who are enrolled in the Medicaid SED program in support of Youth Empowerment Services (YES). ( )

311. HCBS REQUIREMENTS AND DECISION-MAKING AUTHORITY.
HCBS requirements, contained in Sections 312 through Sections 317 of these rules, do not supersede decision-making authority legally assigned to another individual or entity on the participant's behalf. This includes: ( )

01. Payee. A representative payee appointed by the Social Security Administration; ( )

02. Restrictions (Probation or Parole). Court-imposed restrictions related to probation or parole; ( )

03. Restrictions (When Committed). Court-imposed restrictions when committed to the Director of Health and Welfare; and ( )

04. Legal Guardians Who Retain Full Decision-making Authority. It is presumed that the parent or parents of participants birth through seventeen (17) years of age have full decision-making authority unless the minor child has another legally assigned decision-making authority. ( )

312. HOME AND COMMUNITY-BASED SETTINGS.
Home and community-based settings include all locations where participants who receive HCBS live or receive their

services. ( )

01. Home and Community-Based Settings Not Included. Home and community-based settings do not include the following: ( )

a. A nursing facility; ( )

b. An institution for mental diseases; ( )

c. An intermediate care facility for Individuals with intellectual disabilities (ICF/IID); ( )

d. A hospital; or ( )

e. Any other location that has the qualities of an institutional setting. These institutional qualities include: ( )

i. Any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment; or ( )

ii. A building on the grounds of, or immediately adjacent to, a state or federally operated inpatient treatment facility; or ( )

iii. Any setting that has the effect of isolating participants receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS. ( )

313. REQUIRED HOME AND COMMUNITY-BASED QUALITIES.
Home and community-based settings must support eligible participants to have the same opportunities for integration, independence, choice, and rights as individuals who do not require supports or services to remain in their home or community. If a setting requirement described in this rule presents a health or safety risk to the participant or those around the participant, goals must be identified with strategies to mitigate the risk. These goals and strategies must be documented in the person-centered plan. Providers must develop and implement policies and procedures to address the following HCBS setting requirements. ( )

01. Required Home and Community-Based Qualities. Home and community-based settings are required to have the following qualities: ( )

a. Integration and Access. The setting is integrated in and supports full access to the greater community for participants receiving HCBS. Typical, age-appropriate activities include opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community in the same manner as individuals who do not require supports or services to remain in their home or community. ( )

b. Selection of Setting. Home and community-based settings are selected by the participant or the participant's decision-making authority from among disability-specific and non-disability-specific settings, and are based on the participant's needs and preferences including consideration of the participant's safety and the safety of those around the participant. ( )

c. Participant Rights. The setting ensures a participant's rights of privacy, dignity, and respect, and freedom from coercion and unauthorized restraint are honored. ( )

d. Autonomy and Independence. The setting optimizes, but does not regiment, an individual's initiative, autonomy, and independence in making life choices, including daily activities, physical environment, and with whom to interact. ( )

e. Choice. The setting promotes opportunities for participant choice regarding the services and supports provided in the setting. ( )

02. Services Delivered in the Participant's Own Home. It is presumed that services delivered in the participant's own home, that is not a provider-owned or controlled residence, meet the HCBS setting requirements described in this rule. Providers may not impose restrictions on HCBS setting qualities in a participant's own home without goals and strategies to mitigate risk described in this rule that have been agreed to through the person-centered planning process. ( )

314. RESIDENTIAL PROVIDER-OWNED OR CONTROLLED SETTING QUALITIES.
In addition to the setting requirements described in Section 313 of these rules, provider-owned or controlled settings, including Residential Assisted Living Facilities and Certified Family Homes that provide services to HCBS participants, must also meet the following conditions: ( )

01. Written Agreement. A lease, residency agreement, admission agreement, or other form of written agreement will be in place for each HCBS participant at the time of occupancy. The lease or residency agreement must provide protections that address eviction processes and appeals comparable to those provided under Idaho landlord tenant law. ( )

02. Privacy. Participants have the right to privacy within their residence. Each participant must have privacy in their sleeping or living unit to include the following: ( )

a. The right to entrance doors that are lockable by the individual, with only appropriate staff having keys to doors. ( )

b. Participants sharing units have a choice of roommates in that setting. ( )

03. Décor. Participants have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement. ( )

04. Schedules and Activities. Participants have the freedom and support to control their own schedules and activities. ( )

05. Access To Food. Participants have access to food at any time. ( )

06. Visitors. Participants are able to have visitors of their choosing at any time in accordance with the applicable requirements under IDAPA 16.03.19, "Certified Family Homes," and IDAPA 16.03.22, "Residential Assisted Living Facilities." Except, through the duration of the declared COVID-19 public health emergency, CFH providers may restrict visitation to minimize the spread of the COVID-19 infection. ( )

07. Accessibility. The setting is physically accessible to the participant. ( )

315. EXCEPTIONS TO RESIDENTIAL PROVIDER-OWNED OR CONTROLLED SETTING QUALITIES.
Exceptions to residential setting requirements outlined in Section 314 of these rules must be made based on the needs of the participant that are identified through person-centered planning. Service plans with exceptions to residential setting requirements must be submitted to the Department or its designee for review and approval. When an exception is made, the following information must be documented in the person-centered service plan: ( )

01. Assessed Needs. Specific and individualized assessed needs that are related to the exception. ( )

02. Interventions and Supports. Positive interventions and supports used prior to any exceptions to the person-centered service plan. ( )

03. Prior Methods. List less intrusive methods previously implemented that were unsuccessful in addressing the needs of the participant. ( )

04. Description of Intervention. A clear description of the intervention for the exception that is directly proportionate to the specific assessed needs. ( )

05. Data Collection. Regular collection and review of data to measure the ongoing effectiveness of the exception. ( )

06. Time Limits. Established time limits for periodic reviews to determine if the exception is still necessary, if a transition plan can be developed, or if the exception can be terminated. ( )

07. Informed Consent. Informed consent of the participant or legal guardian for the exception. ( )

08. Assurance of No Harm. An assurance that interventions and supports will cause no harm to the participant. ( )

316. HOME AND COMMUNITY-BASED PERSON-CENTERED PLANNING REQUIREMENTS.
All participants or their decision-making authority must direct the development of their service plan through a person-centered planning process. Information and support must be given to the HCBS participant to maximize their ability to make informed choices and decisions. Individuals invited to participate in the person-centered planning process should be identified by the participant or the participant's decision-making authority. Legal guardians who do not have full decision-making authority as described in Section 311 of these rules will have a participatory role as needed and defined by the participant. The person-centered planning process must: ( )

01. Timely and Convenient. Be conducted timely and occur at convenient times and locations to the participant and the participant's decision-making authority in accordance with program requirements. ( )

02. Cultural Considerations. Reflect cultural considerations of the participant. ( )

03. In Plain Language and Accessible. Be conducted by providing information in plain language and in a manner that is accessible to participants with disabilities and persons who are limited English proficient as defined in 42 CFR 435.905(b). ( )

04. Conflict Resolution. Utilize strategies for solving conflict or disagreement within the process, and follow clear conflict-of-interest guidelines for all planning participants. ( )

317. HOME AND COMMUNITY-BASED PERSON-CENTERED SERVICE PLAN REQUIREMENTS.
All person-centered service plans must reflect the following components: ( )

01. Services And Supports. Clinical services and supports that are important for the participant's behavioral, functional, and medical needs as identified through an assessment. ( )

02. Service Delivery Preferences. Indication of what is important to the participant with regard to the service provider and preferences for the delivery of such services and supports. ( )

03. Setting Selection. HCBS settings selected by the participant or the participant's decision-making authority are chosen from among a variety of setting options, as required in Section 313 of these rules. The person-centered service plan must identify and document the alternative home and community setting options that were considered by the participant, or the participant's decision-making authority. ( )

04. Participant Strengths and Preferences. ( )

05. Individually Identified Goals and Desired Outcomes. ( )

06. Paid and Unpaid Services and Supports. Paid and unpaid services and supports that will assist the participant to achieve identified goals, and the providers of those services and supports, including natural supports. ( )

07. Risk Factors. Risk factors to the participant as well as people around the participant and measures in place to minimize them, including individualized back-up plans and strategies when needed. ( )

08. Understandable Language. Be understandable to the participant receiving services and supports, and the individuals important in supporting them. At a minimum, the written plan must be understandable, and written in plain language in a manner that is accessible to participants with disabilities and persons who are limited English proficient, consistent with 42 CFR 435.905(b). ( )

09. Plan Monitor. Identify the name of the individual or entity responsible for monitoring the plan. ( )

10. Plan Signatures. Be finalized and agreed to, by the participant, or the participant's decision-making authority, in writing, indicating informed consent. The plan must also be signed by all individuals and providers responsible for its implementation indicating they will deliver services according to the authorized plan of service and consistent with home and community-based requirements. ( )

a. Children's DD service providers responsible for implementation of the plan include the providers of those services defined in Section 523 of these rules. ( )

b. Adult DD service providers responsible for implementation of the plan include those required to develop a provider implementation plan as defined in Sections 513 and 654 of these rules. ( )

c. Consumer-directed service providers responsible for implementation of the plan include the participant, Support Broker, and Fiscal Employment Agency as identified in IDAPA 16.03.13, "Consumer-Directed Services." ( )

d. Personal Care and Aged and Disabled Waiver service providers responsible for the implementation of the plan include the providers of those services defined in Sections 303 and 326 of these rules. Alternate format signatures may be used; refer to Medicaid Information Release MA20-15 for guidance. ( )

11. Plan Distribution. Be distributed to the participant and the participant's decision-making authority, if applicable, and other people involved in the implementation of the plan. At a minimum, the following providers will receive a copy of the plan: ( )

a. Children's DD providers of services defined in Section 523 of these rules as identified on the plan of service developed by the family-centered planning team. ( )

b. Adult DD service providers required to develop a provider implementation plan as defined in Sections 513 and 654 of these rules. Additionally, the participant will determine during the person-centered planning process whether the service plan, in whole or in part, will be distributed to any other developmental disability service provider. ( )

c. Consumer-Directed service providers as defined in IDAPA 16.03.13, "Consumer-Directed Services," Section 110. Additionally, the participant, or the participant's decision-making authority will determine during the person-centered planning process whether the service plan, in whole or in part, will be distributed to any other community support worker or vendors. ( )

d. Personal Care and Aged and Disabled Waiver service providers furnishing those services defined in Sections 303 and 326 of these rules. ( )

12. Residential Requirements. For participants living in residential provider owned or controlled settings as described in Section 314 of these rules, the following additional requirements apply: ( )

a. Options described in Subsection 317.03 of this rule must include a residential setting option that allows for private units. Selection of residential settings will be based on the participant's needs, preferences, and resources available for room and board. ( )

b. Any exception to residential provider owned or controlled setting qualities as described in Section 314 of these rules must be documented in the person-centered plan as described in Section 315 of these rules.

( )

318. HCBS TRANSITION PLAN.
As required by the Department, all current providers of HCBS must complete a Department-approved self assessment form related to the setting requirements and qualities described in Sections 311 through 314 of these rules. ( )

01. Provider Transition Plan. As part of the self-assessment process, providers not in compliance with any portion of the new requirements and qualities must develop a plan for coming into compliance. Self-assessment forms are subject to review and validation by the Department via quality assurance activities. ( )

02. New HCBS Providers or Service Settings. New HCBS providers or service settings are expected to fully comply with the HCBS requirements and qualities as a condition of becoming a Medicaid provider. ( )

03. Quality Assurance. The Department will begin enforcement of quality assurance compliance with Sections 311 through 314 of these rules on January 1, 2017. ( )

319. HCBS -- TERMINATION OF PARTICIPANT ENROLLMENT.

01. Federal and State Eligibility Requirements. To be enrolled in an HCBS waiver or State Plan option program as provided in 42 CFR 441 and Section 1915 of the Social Security Act, a participant must meet the following eligibility requirements that include: ( )

a. An independent assessment; ( )

b. A state-approved person-centered plan; ( )

c. At least an annual redetermination of eligibility; and ( )

d. Other state-established criteria for determining eligibility under the State Plan for medical assistance. ( )

02. Failure to Meet Requirements. A participant who fails to meet any of the conditions of participation required by state established eligibility criteria is subject to termination of enrollment. ( )

03. Conditions for Termination of Enrollment. The Department will terminate the enrollment of a participant who is enrolled in an HCBS waiver or State Plan option, or who has accessed Medicaid coverage through an HCBS waiver or State Plan option under any of the following conditions. The participant: ( )

a. Does not have an identified need for a waiver or State Plan option service; ( )

b. Elects not to use services offered under the HCBS waiver or State Plan option; ( )

c. Declines to engage in person-centered planning; ( )

d. Does not meet other HCBS requirements provided in Section 319.01 of this rule; or ( )

e. Is non-responsive to three or more contact attempts by the Department or its designee to engage the participant in fulfilling requirements. ( )

04. Continuous Eligibility for Children Under Age Nineteen. Continuous health care assistance eligibility for children under age nineteen (19), as provided in IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children," does not apply for a participant under the age of nineteen (19) who is enrolled in an HCBS waiver or State Plan option program or who has accessed Medicaid coverage through an HCBS waiver or State Plan option program. ( )

320. AGED AND DISABLED WAIVER SERVICES.

01. Description of Aged and Disabled Services. Idaho's elderly and physically disabled citizens should be able to maintain self-sufficiency, individuality, independence, dignity, choice, and privacy in a cost-effective home-like setting. When possible, services should be available in the participant's own home and community regardless of their age, income, or ability and should encourage the involvement of natural supports, such as family, friends, neighbors, volunteers, church, and others. ( )

02. Temporary Changes to Aged and Disabled Rules During Declared State of Emergency Related to Novel Coronavirus Disease (COVID-19). In response to Idaho's declaration on 3/13/20 of a state of emergency related to COVID-19, the Department reserves the right to temporarily alter requirements and processes related to Aged and Disabled waiver services, currently and through the duration of the emergency state, in order to mitigate spread of disease and to ensure the health and safety of our participants under the guidance and authority of the provisions in a CMS-approved 1135 waiver or HCBS Attachment K amendment to the existing Aged and Disabled waiver. Guidance for approved flexibilities is posted at https://healthandwelfare.idaho.gov/providers/idaho-medicaid-providers/information-medicaid-providers. ( )

321. AGED AND DISABLED WAIVER SERVICES: DEFINITIONS.
The following definitions apply to Sections 320 through 330 of these rules: ( )

01. Uniform Assessment Instrument (UAI). A set of standardized criteria adopted by the Department to assess functional and cognitive abilities. ( )

02. Individual Service Plan. A document that outlines all services including activities of daily living (ADL) and instrumental activities of daily living (IADL), required to maintain the individual in their home and community. The plan is initially developed by the Department or its contractor for services provided under the Home and Community-Based Services Waiver. This plan must be approved by the Department or its contractor, and all Medicaid reimbursable services must be contained in the plan. ( )

03. 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. ( )

04. Employer of Record. An entity that 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 agency. ( )

05. 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. ( )

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

322. AGED AND DISABLED WAIVER SERVICES: ELIGIBILITY.
The Department provides waiver services to eligible participants: 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 achieve and maintain community integration. For a participant to be eligible, the Department must find that the participant: ( )

01. Has a Disabling Condition. Requires services due to a disabling condition that impairs their mental or physical function or independence; and ( )

02. Safe in a Non-Institutional Setting. Be capable of being maintained safely and effectively in a non-institutional setting; and ( )

03. Requires Such Services. Would, in the absence of such services, require the level of care provided in a Nursing Facility. ( )

04. Functional Level for Adults. Based on the results of the assessment, the level of impairment of the individual will be established by the Department or its contractor. In determining need for nursing facility care an adult must require the level of assistance listed in Subsections 322.04 through 322.07 of this rule, according to the formula described in Subsection 322.08 of this rule. ( )

05. Critical Indicator - 12 Points Each. ( )

a. Total assistance with preparing or eating meals. ( )

b. Total or extensive assistance in toileting. ( )

c. Total or extensive assistance with medications that require decision making prior to taking, or assessment of efficacy after taking. ( )

06. High Indicator - 6 Points Each. ( )

a. Extensive assistance with preparing or eating meals. ( )

b. Total or extensive assistance with routine medications. ( )

c. Total, extensive or moderate assistance with transferring. ( )

d. Total or extensive assistance with mobility. ( )

e. Total or extensive assistance with personal hygiene. ( )

f. Total assistance with supervision from Section II of the Uniform Assessment Instrument (UAI). ( )

07. Medium Indicator - 3 Points Each. ( )

a. Moderate assistance with personal hygiene. ( )

b. Moderate assistance with preparing or eating meals. ( )

c. Moderate assistance with mobility. ( )

d. Moderate assistance with medications. ( )

e. Moderate assistance with toileting. ( )

f. Total, extensive, or moderate assistance with dressing. ( )

g. Total, extensive or moderate assistance with bathing. ( )

h. Extensive or moderate assistance with supervision from Section II No. 18 of the UAI. ( )

08. Nursing Facility Level of Care, Adults. In order to qualify for nursing facility level of care, the individual must score twelve (12) or more points in one (1) of the following ways. ( )

a. One (1) or more critical indicators = Twelve (12) points. ( )

b. Two (2) or more high indicators = Twelve (12) points. ( )

c. One (1) high and two (2) medium indicators = Twelve (12) points. ( )

d. Four (4) or more medium indicators = Twelve (12) points. ( )

323. AGED AND DISABLED WAIVER SERVICES: PARTICIPANT ELIGIBILITY DETERMINATION.
Waiver eligibility will be determined by the Department or its contractor. The participant must be eligible for Medicaid as described in IDAPA 16.03.05, "Eligibility for Aid to the Aged, Blind, and Disabled (AABD)." In addition, waiver participants must meet the following requirements. ( )

01. Requirements for Determining Participant Eligibility. The Department or its contractor must determine that: ( )

a. The participant would qualify for nursing facility level of care under Sections 222 and 223 of these rules**,** if the waiver services listed in Section 326 of these rules were not made available; and ( )

b. The participant could be safely and effectively maintained in the requested or chosen community residence with appropriate waiver services. Prior to any denial of services on this basis, the Department or its contractor must verify that services to correct the concerns of the team are not available. ( )

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 nursing facility care. ( )

d. Following the approval by the Department or its contractor 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. ( )

02. Admission to a Nursing Facility. A participant who is determined by the Department or its contractor to be eligible for services under the waiver may elect to not utilize waiver services and may choose admission to a nursing facility. ( )

03. Redetermination Process. Case Redetermination will be conducted by the Department or its contractor. The redetermination process will verify that the participant continues to meet nursing facility level of care and the participant's continued need for waiver services. ( )

324. AGED AND DISABLED WAIVER SERVICES: TARGET GROUP.
Persons who would be Medicaid eligible if residing in a nursing facility, require the level of care provided in a nursing facility, are over the age of eighteen (18), demonstrate significant disability on the UAI, and have deficits that affect their ability to function independently. ( )

325. HOME AND COMMUNITY-BASED SERVICES (HCBS) WAIVER: PARTICIPANT LIMITATIONS.
The number of Medicaid participants to receive waiver services under the HCBS waiver for the aged and disabled will be limited to the projected number of users identified in the Department's approved waiver. If necessary, participants who apply for waiver services after the waiver maximum has been reached will be placed on a waiting list and will have their applications processed after September 30th of each new waiver year. The earliest effective date of waiver service delivery for these participants will be October 1st of each new waiver year. ( )

326. AGED AND DISABLED WAIVER SERVICES: COVERAGE AND LIMITATIONS.

01. Adult Day Health. Adult day health is a supervised, structured service generally furnished four (4) or more hours per day on a regularly scheduled basis, for one (1) or more days per week. It is provided outside the home of the participant in a non-institutional, community-based setting, and it encompasses health services, social services, recreation, supervision for safety, and assistance with activities of daily living needed to ensure the optimal functioning of the participant. Adult day health services provided under this waiver will not include room and board payments. ( )

02. Adult Residential Care Services. Adult residential care services consist of a range of services provided in a homelike, non-institutional setting that include RALFs and CFHs. Payment is not made for the cost of room and board, including the cost of building maintenance, upkeep and improvement. ( )

a. Adult residential care services consist of a range of services provided in a congregate setting licensed under IDAPA 16.03.22, "Residential Assisted Living Facilities," that include: ( )

i. Medication assistance, to the extent permitted under State law; ( )

ii. Assistance with activities of daily living; ( )

iii. Meals, including special diets; ( )

iv. Housekeeping; ( )

v. Laundry; ( )

vi. Transportation; ( )

vii. Opportunities for socialization; ( )

viii. Recreation; and ( )

ix. Assistance with personal finances. ( )

x. Administrative oversight must be provided for all services provided or available in this setting. ( )

xi. A documented individual service plan must be negotiated between the participant or their legal representative, and a facility representative. ( )

b. Adult residential care services also consist of a range of services provided in a setting licensed under IDAPA 16.03.19, "Certified Family Homes," that include: ( )

i. Medication assistance, to the extent permitted under State law; ( )

ii. Assistance with activities of daily living; ( )

iii. Meals, including special diets; ( )

iv. Housekeeping; ( )

v. Laundry; ( )

vi. Transportation; ( )

vii. Recreation; and ( )

viii. Assistance with personal finances. ( )

ix. Administrative oversight must be provided for all services provided or available in this setting. ( )

x. A documented individual service plan must be negotiated between the participant or their legal representative, and a facility representative. ( )

03. Specialized Medical Equipment and Supplies. ( )

a. Specialized medical equipment and supplies include: ( )

i. Devices, controls, or appliances that enable a participant to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live; and ( )

ii. Items necessary for life support, ancillary supplies and equipment necessary for the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State Plan. ( )

b. Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the Medicaid State plan and exclude those items that are not of direct medical or remedial benefit to the participant. ( )

04. Non-Medical Transportation. Non-medical transportation enables a waiver participant to gain access to waiver and other community services and resources. ( )

a. Non-medical transportation is offered in addition to medical transportation required in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," and will not replace it. ( )

b. Whenever possible, family, neighbors, friends, or community agencies who can provide this service without charge, or public transit providers will be utilized. ( )

05. Attendant Care. Services provided under a Medicaid Home and Community-Based Services waiver that involve personal and medically oriented tasks dealing with the functional needs of the participant and accommodating the participant's needs for long-term maintenance, supportive care, or activities of daily living (ADL). These services may include personal assistance and medical tasks that can be done by unlicensed persons, or delegated to an unlicensed person by a licensed health care professional or the participant. Services are based on the participant's abilities and limitations, regardless of age, medical diagnosis, or other category of disability. This assistance may take the form of hands-on assistance (actually performing a task for the person) or cuing to prompt the participant to perform a task. ( )

06. Chore Services. Chore services include the following services when necessary to maintain the functional use of the home, or to provide a clean, sanitary, and safe environment: ( )

a. Intermittent assistance may include the following. ( )

i. Yard maintenance; ( )

ii. Minor home repair; ( )

iii. Heavy housework; ( )

iv. Sidewalk maintenance; and ( )

v. Trash removal to assist the participant to remain in the home. ( )

b. Chore activities may include the following: ( )

i. Washing windows; ( )

ii. Moving heavy furniture; ( )

iii. Shoveling snow to provide safe access inside and outside the home; ( )

iv. Chopping wood when wood is the participant's primary source of heat; and ( )

v. Tacking down loose rugs and flooring. ( )

c. These services are only available when neither the participant, nor anyone else in the household is capable of performing or financially providing for them, and where no other relative, caregiver, landlord, community volunteer, agency, or third-party payer is willing to provide them or is responsible for their provision. ( )

d. In the case of rental property, the landlord's responsibility under the lease agreement will be examined prior to any authorization of service. Chore services are limited to the services provided in a home rented or owned by the participant. ( )

07. Companion Services. Companion services include non-medical care, supervision, and socialization provided to a functionally impaired adult. Companion services are in-home services to ensure the safety and well-being of a person who cannot be left alone because of frail health, a tendency to wander, inability to respond to emergency situations, or other conditions that would require a person on-site. The service provider, who may live with the participant, may provide voice cuing and occasional assistance with toileting, personal hygiene, dressing, and other activities of daily living. Providers may also perform light housekeeping tasks that are incidental to the care and supervision of the participant. However, the primary responsibility is to provide companionship and be there in case they are needed. ( )

08. Consultation. Consultation services are services to a participant or family member. Services are provided by a Personal Assistance Agency to a participant or family member to increase their skills as an employer or manager of their own care. Such services are directed at achieving the highest level of independence and self-reliance possible for the participant and the participant's family. Services include consulting with the participant and family to gain a better understanding of the special needs of the participant and the role of the caregiver. ( )

09. Home Delivered Meals. Home delivered meals are meals that are delivered to the participant's home to promote adequate participant nutrition. One (1) to two (2) meals per day may be provided to a participant who: ( )

a. Rents or owns a home; ( )

b. Is alone for significant parts of the day; ( )

c. Has no caregiver for extended periods of time; and ( )

d. Is unable to prepare a meal without assistance. ( )

10. Homemaker Services. Homemaker services consist of performing for the participant, or assisting them with, or both, the following tasks: laundry, essential errands, meal preparation, and other routine housekeeping duties if there is no one else in the household capable of performing these tasks. ( )

11. Environmental Accessibility Adaptations. Environmental accessibility adaptations include minor housing adaptations that are necessary to enable the participant to function with greater independence in the home, or without which, the participant would require institutionalization or have a risk to health, welfare, or safety. Such adaptations may include: ( )

a. The installation of ramps and lifts, widening of doorways, modification of bathroom facilities, or installation of electric and plumbing systems that are necessary to accommodate the medical equipment and supplies necessary for the welfare of the waiver participant, but must exclude those adaptations or improvements to the home that are not of direct medical or remedial benefit to the participant, such as carpeting, roof repair, or central air conditioning. ( )

b. Unless otherwise authorized by the Department, permanent environmental modifications are limited to a home that is the participant's principal residence, and is owned by the participant or the participant's non-paid family. ( )

c. Portable or non-stationary modifications may be made when such modifications can follow the participant to their next place of residence or be returned to the Department. ( )

12. Personal Emergency Response System (PERS). PERS is an electronic device that enables a waiver participant to secure help in an emergency. The participant may also wear a portable "help" button to allow for mobility. The system is connected to the participant's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals. This service is limited to participants who: ( )

a. Rent or own a home, or live with unpaid caregivers; ( )

b. Are alone for significant parts of the day; ( )

c. Have no caregiver for extended periods of time; and ( )

d. Would otherwise require extensive, routine supervision. ( )

13. Respite Care. Respite care includes short-term breaks from care giving responsibilities to non-paid caregivers. The caregiver or participant is responsible for selecting, training, and directing the provider. While receiving respite care services, the waiver participant cannot receive other services that are duplicative in nature. Respite care services provided under this waiver do not include room and board payments. Respite care services may be provided in the participant's residence, a CFH, a developmental disabilities agency, a RALF, or an adult day health facility. ( )

14. Skilled Nursing. Skilled nursing includes intermittent or continuous oversight, training, or skilled care that is within the scope of the Nurse Practice Act. Such care must be provided by a licensed registered nurse, or licensed practical nurse under the supervision of a licensed registered nurse, licensed to practice in Idaho. These services are not appropriate if they are less cost effective than a Home Health visit. ( )

15. Habilitation. Habilitation services assist the participant to reside as independently as possible in the community, or maintain family unity. ( )

a. Residential habilitation. Residential habilitation services consist of an integrated array of individually tailored services and supports furnished to eligible participants. These services and supports are designed to assist the participants to reside successfully in their own homes, with their families, or in certified family homes. The services and supports that may be furnished consist of the following: ( )

i. Self-direction consists of identifying and responding to dangerous or threatening situations, making decisions and choices affecting the individual's life, and initiating changes in living arrangements or life activities; ( )

ii. Money management consists of training or assistance in handling personal finances, making purchases, and meeting personal financial obligations; ( )

iii. Daily living skills consist of training in accomplishing routine housekeeping tasks, meal preparation, dressing, personal hygiene, self-administration of medications, and other areas of daily living including proper use of adaptive and assistive devices, appliances, as well as following home safety, first aid, and emergency procedures; ( )

iv. Socialization consists of training or assistance in participation in general community activities and establishing relationships with peers with an emphasis on connecting the participant to their community. Socialization training associated with participation in community activities includes assisting the participant to identify activities of interest, working out arrangements to participate in such activities, and identifying specific training activities necessary to assist the participant to continue to participate in such activities on an on-going basis. Socialization training does not include participation in nontherapeutic activities that are merely diversional or recreational in nature; ( )

v. Mobility consists of training or assistance aimed at enhancing movement within the person's living arrangement, mastering the use of adaptive aids and equipment, accessing and using public transportation, independent travel, or movement within the community; or ( )

vi. Behavior shaping and management consist of training and assistance in appropriate expressions of emotions or desires, assertiveness, acquisition of socially appropriate behaviors, or extension of therapeutic services that consist of reinforcing physical, occupational, speech, and other therapeutic programs. ( )

vii. Personal assistance services necessary to assist the individual in daily living activities, household tasks, and such other routine activities as the person or the person's primary caregiver(s) are unable to accomplish on their own behalf. Personal assistance activities include direct assistance with grooming, bathing, and eating, assistance with medications that are ordinarily self-administered, supervision, communication assistance, reporting changes in the waiver participant's condition and needs, household tasks essential to health care at home to include general cleaning of the home, laundry, meal planning and preparation, shopping, and correspondence. ( )

b. Day habilitation. Day habilitation consists of assistance with acquisition, retention, or improvement in self-help, socialization, and adaptive skills that take place in a non-residential setting, separate from the home or facility in which the participant resides. Services will normally be furnished four (4) or more hours per day on a regularly scheduled basis, for one (1) or more days per week, unless provided as an adjunct to other day activities included in a participant's plan of care. Day habilitation services will focus on enabling the participant to attain or maintain their maximum functional level and will be coordinated with any physical therapy, occupational therapy, or speech-language pathology services listed in the plan of care. In addition, day habilitation services may serve to reinforce skills or lessons taught in school, therapy, or other settings. ( )

16. Supported Employment. Supported employment consists of competitive work in integrated work settings for individuals with the most severe disabilities for whom competitive employment has not traditionally occurred, or for whom competitive employment has been interrupted or intermittent as a result of a severe disability. Because of the nature and severity of their disability, these individuals need intensive supported employment services or extended services in order to perform such work. ( )

a. Supported employment services rendered under this waiver are not available under a program funded by either the Rehabilitation Act of 1973, as amended, or the Individuals with Disabilities Education Act (IDEA). Documentation must be maintained in the file of each individual receiving this service verifying that the service is not otherwise available or funded under the Rehabilitation Act of 1973, as amended, or the IDEA. ( )

b. Federal Financial Participation (FFP) cannot be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following: incentive payments made to an employer of waiver participants to encourage or subsidize the employer's participation in a supported employment program, payments that are passed through to beneficiaries of a supported employment program, or payments for vocational training that is not directly related to a waiver participant's supported employment program. ( )

17. Transition Services. Transition services include goods and services that enable a participant residing in a nursing facility, hospital, IMD, or ICF/IID to transition to a community-based setting. A participant is eligible to receive transition services immediately following discharge from a qualified institution after residing within that institution for a minimum of forty-five (45) days. ( )

a. Qualified Institutions include the following: ( )

i. Skilled, or Intermediate Care Facilities; ( )

ii. Nursing Facilities; ( )

iii. Licensed Intermediate Care Facilities for Persons with Intellectual Disabilities (ICF/IID); ( )

iv. Hospitals; and ( )

v. Institutions for Mental Diseases (IMDs). ( )

b. Transition services may include the following goods and services: ( )

i. Security deposits that are required to obtain a lease on an apartment or home; ( )

ii. Cost of essential household furnishings, including furniture, window coverings, food preparation items, and bed/bath linens; ( )

iii. Set-up fees or deposits for utility or service access, including telephone, electricity, heating and water; ( )

iv. Services necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy; ( )

v. Moving expenses; and ( )

vi. Activities to assess need, arrange for and procure transition services. ( )

c. Excluded goods and services. Transition services do not include ongoing expenses, real property, ongoing utility charges, décor, or diversion/recreational items such as televisions, DVDs, and computers. ( )

d. Service limitations. Transition services are limited to a total cost of two thousand dollars ($2,000) per participant and can be accessed every two (2) years, contingent upon a qualifying transition from an institutional setting. Transition services are furnished only to the extent that the participant is unable to meet such expense or when the support cannot be obtained from other sources. ( )

327. AGED AND DISABLED WAIVER SERVICES: PLACE OF SERVICE DELIVERY.

01. Place of Service Delivery. Waiver services may be provided in the participant's: ( )

a. Personal residence; ( )

b. Employment program; or ( )

c. Community. ( )

02. Excluded Living Situations. Living situations specifically excluded as a personal residence are: ( )

a. Skilled, or Intermediate Care Facilities; ( )

b. Nursing Facility; ( )

c. Licensed Intermediate Care Facility for the Persons with Intellectual Disabilities (ICF/IID); and ( )

d. Hospitals. ( )

328. AGED AND DISABLED WAIVER SERVICES: PROCEDURAL REQUIREMENTS.

01. Role of the Department. The Department or its contractor will provide for the administration of the UAI, and the development of the initial individual service plan. This will be done either by Department staff or a contractor. The Department or its contractor will review and approve all individual service plans, and will authorize Medicaid payment by type, scope, and amount. ( )

a. Services that are not in the individual service plan approved by the Department or its contractor are not eligible for Medicaid payment. ( )

b. Services in excess of those in the approved individual service plan are not eligible for Medicaid payment. ( )

c. The earliest date that services may be approved by the Department or its contractor for Medicaid payment is the date that the participant's individual service plan is signed by the participant or their designee. ( )

02. Pre-Authorization Requirements. All waiver services must be pre-authorized by the Department. Authorization will be based on the information from: ( )

a. The UAI; ( )

b. The individual service plan developed by the Department or its contractor; and ( )

c. Any other medical information that verifies the need for nursing facility services in the absence of the waiver services. ( )

03. UAI Administration. The UAI will be administered, and the initial individual service plan developed, by the Department or its contractor. ( )

04. Individual Service Plan. All waiver services must be authorized by the Department or its contractor in the Region where the participant will be residing and services provided based on a documented individual service plan. ( )

a. The initial individual service plan is developed by the Department or its contractor, based on the UAI, in conjunction with: ( )

i. The waiver participant (with efforts made by the Department or its contractor to maximize the participant's involvement in the planning process by providing them with information and education regarding their rights); ( )

ii. The guardian, when appropriate; ( )

iii. The supervising nurse or case manager, when appropriate; and ( )

iv. Others identified by the waiver participant. ( )

b. The individual service plan must include the following: ( )

i. The specific type, amount, frequency, and duration of Medicaid reimbursed waiver services to be provided; ( )

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

iii. The providers of waiver services when known; ( )

iv. Documentation that the participant has been given a choice between waiver services and institutional placement; and ( )

v. The signature of the participant or their legal representative, agreeing to the plan. ( )

c. The individual service plan must be revised and updated at least annually, based upon treatment results or a change in the participant's needs. ( )

d. All services reimbursed under the Aged and Disabled Waiver must be authorized by the Department or its contractor prior to the payment of services. ( )

e. The individual service plan, which includes all waiver services, is monitored by the Personal

Assistance Agency, participant, family, and the Department or its contractor. ( )

05. Service Delivered Following a Documented Plan of Care. All services that are provided must be based on a documented plan of care. ( )

a. The plan of care is developed by the plan of care team that includes: ( )

i. The waiver participant with efforts made to maximize their participation on the team by providing them with information and education regarding their rights; ( )

ii. The guardian when appropriate; ( )

iii. Service provider identified by the participant or guardian; and ( )

iv. May include others identified by the waiver participant. ( )

b. The plan of care must be based on an assessment process approved by the Department. ( )

c. The plan of care must include the following: ( )

i. The specific types, amounts, frequency and duration of Medicaid reimbursed waiver services to be provided; ( )

ii. Supports and service needs that are to be met by the participant's family, friends and other community services; ( )

iii. The providers of waiver services; ( )

iv. Goals to be addressed within the plan year; ( )

v. Activities to promote progress, maintain functional skills, or delay or prevent regression; and ( )

vi. The signature of the participant or their legal representative. ( )

vii. The signature of the agency or provider indicating that they will deliver services according to the authorized service plan and consistent with home and community-based requirements. ( )

d. The plan must be revised and updated by the plan of care team based upon treatment results or a change in the participant's needs. A new plan must be developed and approved annually. ( )

e. The Department's Nurse Reviewer monitors the plan of care and all waiver services. ( )

f. The plan of care may be adjusted during the year with an addendum to the plan. These adjustments must be based on changes in a participant’s need or demonstrated outcomes. Additional assessments or information may be clinically necessary. Adjustment of the plan of care is subject to prior authorization by the Department. ( )

06. Individual Service Plan and Plan of Care. The development and documentation of the individual service plan and plan of care must meet the person-centered planning requirements described in Sections 316 and 317 of these rules. ( )

07. Provider Records. Records will be maintained on each waiver participant. ( )

a. Each service provider must document each visit made or service provided to the participant, and will record at a minimum the following information: ( )

i. Date and time of visit; ( )

ii. Services provided during the visit; ( )

iii. Provider observation of the participant's response to the service, if appropriate to the service provided, including any changes in the participant's condition; and ( )

iv. Length of visit, including time in and time out, if appropriate to the service provided. Unless the Department or its contractor determines that the participant is unable to do so, the service delivery will be verified by the participant as evidenced by their signature on the service record. ( )

b. The provider is required to keep the original service delivery record. A copy of the service delivery record will be maintained and available in a format accessible to the participant. Failure to maintain documentation according to these rules will result in the recoupment of funds paid for undocumented services. ( )

c. The individual service plan initiated by the Department or its contractor must specify which waiver services are required by the participant. The plan will contain all elements required by Subsection 328.04.a. of these rules and a copy of the most current individual service plan will be maintained in the participant's home and will be available to all service providers and the Department. A copy of the current individual service plan and UAI will be available from the Department or its contractor to each individual service provider with a release of information signed by the participant or legal representative. ( )

d. Record requirements for participants in RALFs are described in IDAPA 16.03.22, "Residential Assisted Living Facilities." ( )

e. Record requirements for participants in CFHs are described in IDAPA 16.03.19, "Certified Family Homes." ( )

f. EVV Systems as described in Section 041 of these rules will not take the place of documentation requirements of Subsection 328.07 of this rule, but maybe used to generate documentation retained in the participant's home. ( )

08. Provider Responsibility for Notification. The service provider is responsible to notify the Department or its contractor, physician or authorized provider, or case manager, and family if applicable, when any significant changes in the participant's condition are noted during service delivery. Such notification will be documented in the service record. ( )

09. Records Retention. Personal Assistance Agencies, and other providers are responsible to retain their records for five (5) years following the date of service. ( )

10. Requirements for an Fiscal Intermediary (FI). Participants of PCS will have one (1) year from the date that services begin in their geographic region to obtain the services of an FI and become an employee in fact or to use the services of an agency. Provider qualifications are in accordance with Section 329 of these rules. ( )

11. COVID-19. The sections of this rule may be subject to amendment by the BLTC for the duration of the COVID-19 state of emergency. Please consult Medicaid Information Release MA20-15 for additional guidance. ( )

329. AGED AND DISABLED WAIVER SERVICES: PROVIDER QUALIFICATIONS AND DUTIES. Each provider must have a signed provider agreement with the Department for each of the services it provides. ( )

01. Employment Status. Unless otherwise specified by the Department, each individual service provider must be an employee of record or fact of an agency. The Department may enter into provider agreements with individuals in situations in which no agency exists, or no fiscal intermediary agency is willing to provide services. Such agreements will be reviewed annually to verify whether coverage by a personal assistance agency or

fiscal intermediary agency is still not available. ( )

02. Fiscal Intermediary Services. An agency that has responsibility for the following: ( )

a. To directly assure compliance with legal requirements related to employment of waiver service providers; ( )

b. To offer supportive services to enable participants or their families to perform the required employer tasks themselves; ( )

c. To bill the Medicaid program for services approved and authorized by the Department; ( )

d. To collect any participant participation due; ( )

e. To pay personal assistants and other waiver service providers for service; ( )

f. To perform all necessary withholding as required by state and federal labor and tax laws, rules and regulations; ( )

g. To assure that personal assistants providing services meet the standards and qualifications under in this rule; ( )

h. To maintain liability insurance coverage; ( )

i. To conduct, at least annually, participant satisfaction or quality control reviews that are available to the Department and the general public; ( )

j. To obtain such criminal background checks and health screens on new and existing employees of record and fact as required. ( )

03. Provider Qualifications. All providers of homemaker services, respite care, adult day health, transportation, chore services, companion services, attendant care, adult residential care, and home delivered meals must meet, either by formal training or demonstrated competency, the training requirements contained in the provider training matrix and the standards for direct care staff and allowable tasks or activities in the Department's Aged and Disabled waiver as approved by CMS. ( )

a. A waiver provider cannot be a relative of any participant to whom the provider is supplying services. ( )

b. For the purposes of Section 329 of these rules, a relative is defined as a spouse or parent of a minor child. ( )

c. Individuals who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." ( )

04. Quality Assurance. Providers of Aged and Disabled waiver services are responsible for ensuring that they provide quality services in compliance with applicable rules. ( )

a. The results of a quality assurance review conducted by the Department must be transmitted to the provider within forty-five (45) days after the review is completed. ( )

b. The provider must respond to the quality assurance review within forty-five (45) days after the results are received from the Department. If problems are identified, the provider must implement a quality improvement plan and report the results to the Department upon request. ( )

c. The Department may take enforcement actions as described in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 205, if the provider fails to comply with any term or provision of the provider agreement, or

any applicable state or federal regulation. ( )

05. HCBS Setting Compliance. Providers of Aged and Disabled waiver services are responsible for ensuring that they meet the person-centered planning and setting quality requirements described in Sections 311 through 318 of these rules, as applicable, and must comply with associated Department quality assurance activities. ( )

06. Specialized Medical Equipment and Supplies. Providers of specialized medical equipment and supplies must be enrolled in the Medicaid program as participating medical vendor providers. Providers must ensure all items meet applicable standards of manufacture, design and installation. Preference will be given to equipment and supplies that are the most cost-effective option to meet the participant's needs. ( )

07. Skilled Nursing Service. Skilled nursing service providers must be licensed in Idaho as a licensed registered nurse or licensed practical nurse in good standing, or must be practicing on a federal reservation and be licensed in another state. Skilled nursing providers who provide direct care and services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." ( )

08. Consultation Services. Consultation services must be provided through a Personal Assistance Agency by a person who has demonstrated skills in training participants/family members in hiring, firing, training, and supervising their own care providers. ( )

09. Adult Residential Care. Adult residential care providers 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. Adult residential care providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.03.19, "Certified Family Homes," or IDAPA 16.03.22, "Residential Assisted Living Facilities." ( )

10. Home Delivered Meals. Providers of home delivered meals must be a public agency or private business, and must exercise supervision to ensure that: ( )

a. Each meal meets one-third (1/3) of the Recommended Daily Allowance, as defined by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences; ( )

b. Meals are delivered in accordance with the service plan, in a sanitary manner, and at the correct temperature for the specific type of food; ( )

c. Documentation is maintained demonstrating that the meals served are made from the highest USDA grade for each specific food served; ( )

d. The agency or business is inspected and licensed as a food establishment under IDAPA 16.02.19, "Idaho Food Code"; ( )

e. A Registered Dietitian documents the review and approval of menus, menu cycles, and any changes or substitutions; and ( )

f. Either by formal training or demonstrated competency, the training requirements contained in the Idaho provider training matrix and the standards for direct care staff in accordance with Subsection 329.03 of this rule have been met. ( )

11. Personal Emergency Response Systems. Personal emergency response system providers must demonstrate that the devices installed in a waiver participant's home meet Federal Communications Standards, or Underwriter's Laboratory Standards, or equivalent standards. ( )

12. Adult Day Health. Providers of adult day health must meet the following requirements: ( )

a. Services provided in a facility must be provided in a facility that meets the building and health

standards identified in IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)." ( )

b. Services provided in a home must be provided in a home that meets the standards of home certification identified in IDAPA 16.03.19, "Certified Family Homes." ( )

c. Services provided in a RALF must be provided in a facility that meets the standards identified in IDAPA 16.03.22, "Residential Assisted Living Facilities." ( )

d. Adult day health providers who provide direct care or services must satisfactorily complete a criminal history check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." ( )

e. Providers of adult day health must notify the Department on behalf of the participant, if the adult day health is provided in a CFH other than the participant's primary residence. The adult day health provider must provide care and supervision appropriate to the participant's needs as identified on the plan. ( )

f. Adult day health providers who provide direct care or services must be free from communicable disease. ( )

g. All providers of adult day health services must meet, either by formal training or demonstrated competency, the training requirements contained in the Idaho provider training matrix and the standards for direct care staff in accordance with Subsection 329.03 of this rule. ( )

13. Non-Medical Transportation Services. Providers of non-medical transportation services must: ( )

a. Possess a valid driver's license; ( )

b. Possess valid vehicle insurance; and ( )

c. Meet, either by formal training or demonstrated competency, the training requirements contained in the Idaho provider training matrix and the standards for direct care staff in accordance with Subsection 329.03 of this rule. ( )

14. Attendant Care. Attendant care providers who provide direct care and services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." All providers of attendant care must meet, either by formal training or demonstrated competency, the training requirements contained in the Idaho provider training matrix and the standards for direct care staff in accordance with Subsection 329.03 of this rule. ( )

15. Homemaker Services. The homemaker must be an employee of record or fact of an agency. Homemaker service providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." All providers of homemaker services must meet, either by formal training or demonstrated competency, the training requirements contained in the Idaho provider training matrix and the standards for direct care staff in accordance with Subsection 329.03 of this rule. ( )

16. Environmental Accessibility Adaptations. All services must be provided in accordance with applicable state or local building codes and meet state or local building, plumbing, and electrical requirements for certification. ( )

17. Residential Habilitation Supported Living. When residential habilitation services are provided by an agency, the agency must be certified by the Department as a residential habilitation agency under IDAPA 16.04.17, "Residential Habilitation Agencies," and supervise the direct services provided. Individuals who provide residential habilitation services in the home of the participant (supported living) must be employed by a residential habilitation agency. Providers of residential habilitation services must meet the following requirements: ( )

a. Direct service staff must meet the following minimum qualifications: ( )

i. Be at least eighteen (18) years of age; ( )

ii. Be a high school graduate, or have a GED, or demonstrate the ability to provide services according to a plan of service; ( )

iii. Have current CPR and First Aid certifications; ( )

iv. Be free from communicable disease; ( )

v. Each staff person assisting with participant medications must successfully complete and follow the "Assistance with Medications" course available through the Idaho Professional Technical Education Program approved by the Idaho State Board of Nursing or other Department-approved training. ( )

vi. Residential habilitation service providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks;" ( )

vii. Have appropriate certification or licensure if required to perform tasks that require certification or licensure. Direct service staff must also have taken a traumatic brain injury training course approved by the Department. ( )

b. The provider agency is responsible for providing direct service staff with a traumatic brain injury training course approved by the Department, and training specific to the needs of the participant. ( )

c. Prior to delivering services to a participant, agency direct service staff must complete an orientation program. The orientation program must include the following subjects: ( )

i. Purpose and philosophy of services; ( )

ii. Service rules; ( )

iii. Policies and procedures; ( )

iv. Proper conduct in relating to waiver participants; ( )

v. Handling of confidential and emergency situations that involve the waiver participant; ( )

vi. Participant rights; ( )

vii. Methods of supervising participants; ( )

viii. Working with individuals with traumatic brain injuries; and ( )

ix. Training specific to the needs of the participant. ( )

d. Additional training requirements must be completed within six (6) months of employment with the residential habilitation agency and include at a minimum: ( )

i. Instructional techniques: Methodologies for training in a systematic and effective manner; ( )

ii. Managing behaviors: Techniques and strategies for teaching adaptive behaviors; ( )

iii. Feeding; ( )

iv. Communication; ( )

v. Mobility; ( )

vi. Activities of daily living; ( )

vii. Body mechanics and lifting techniques; ( )

viii. Housekeeping techniques; and ( )

ix. Maintenance of a clean, safe, and healthy environment. ( )

e. The provider agency will be responsible for providing on-going training specific to the needs of the participant as needed. ( )

18. Day Habilitation. Providers of day habilitation services must have a minimum of two (2) years of experience working directly with persons with a traumatic brain injury, must provide documentation of standard licensing specific to their discipline, and must have taken a traumatic brain injury course approved by the Department. Day habilitation providers who provide direct care and services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." ( )

19. Respite Care. Providers of respite care services must meet the following minimum qualifications: ( )

a. Have received care giving instructions in the needs of the person who will be provided the service; ( )

b. Demonstrate the ability to provide services according to a plan of service; ( )

c. Be free of communicable disease; and ( )

d. Respite care service providers who provide direct care and services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." ( )

20. Supported Employment. Supported employment services must be provided by an agency that supervises the direct service and is accredited by the Commission on Accreditation of Rehabilitation Facilities, other comparable standards, or meet State requirements to be a State-approved provider. Supported employment service providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." ( )

21. Chore Services. Providers of chore services must meet the following minimum qualifications: ( )

a. Be skilled in the type of service to be provided; and ( )

b. Demonstrate the ability to provide services according to a plan of service. ( )

c. Chore service providers who provide direct care and services must satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." ( )

d. Meet, either by formal training or demonstrated competency, the training requirements in the Idaho provider training matrix and the standards for direct care staff in accordance with Subsection 329.03 of this rule. ( )

22. Transition Services. Transition managers as described in Section 350.01 of these rules are

responsible for administering transition services. ( )

23. COVID-19. The sections of this rule may be subject to amendment by the BLTC for the duration of the COVID-19 state of emergency. Please consult Medicaid Information Release MA20-15 for additional guidance. ( )

330. AGED AND DISABLED WAIVER SERVICES: PROVIDER REIMBURSEMENT.
The criteria used in reimbursing providers for waiver services are listed in Subsections 330.01 through 330.03 of these rules. ( )

01. Fee for Services. Waiver service providers will be paid on a fee for service basis as established by the Department, or as agreed upon by the Department's contractor and the provider, 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 assistance required by the participant as identified in the UAI. ( )

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

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. ( )

04. EVV Compliance. Provider claims for the following Aged and Disabled Waiver Services require EVV compliance as described in Section 041 of these rules in order to be eligible for payment: ( )

a. Attendant Care; ( )

b. Homemaker; and ( )

c. Respite. ( )

331. -- 349. (RESERVED)

350. TRANSITION MANAGEMENT.
Transition management provides relocation assistance and intensive service coordination activities to assist nursing facility, hospital, IMD and ICF/IID residents to transition to community settings of their choice. Transition managers provide oversight and coordination activities for participants during a transitional period up to twelve (12) months following a return to the community. This provider type will function as a liaison between the participant, institutional or facility discharge staff, and other individuals as designated by the participant and the Department to support a successful and sustainable transition to the community. A participant is eligible to receive transition management when planning to discharge from a qualifying institution after residing within that institution for a minimum of forty-five (45) days. ( )

01. Provider Qualifications. Transition managers must: ( )

a. Satisfactorily complete a criminal history and background check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks"; ( )

b. Have documented successful completion of the Department approved Transition Manager training prior to providing any transition management and transition services; ( )

c. Have a Bachelor's Degree in a human services field from a nationally accredited university or college, or three (3) years' supervised work experience with the population being served; and ( )

d. Be employed with a provider type approved by the Department. ( )

02. **Service Description**. Transition management includes the following activities: ( )

a. A comprehensive assessment of health, social, and housing needs; ( )

b. Development of housing options with each participant, including assistance with housing choices, applications, waitlist follow-up, roommate selection, and introductory visits; ( )

c. Assistance with tasks necessary to accomplish a move from the institutional setting; ( )

d. Securing Transition Services in accordance with Subsection 326.17 or Subsection 703.15 of these rules in order to make arrangements necessary to move, including: ( )

i. Obtaining durable medical equipment, assistive technology, and medical supplies, if needed; ( )

ii. Arranging for home modifications, if needed; ( )

iii. Applying for public assistance, if needed; ( )

iv. Arranging household preparations including scheduling moving and/or cleaning services, utility set-up, purchasing furniture, and household supplies, if needed; ( )

e. Coordinating with others involved in plan development for the participant to ensure successful transition and establishment in a community setting; ( )

f. Providing post-transition support, including assistance with problem solving, dependency and isolation concerns, consumer-directed services and supports, Post Secondary Educational Institutions & Proprietary Schools when applicable, and community inclusion. ( )

03. **Service Limitations**. Transition management is limited to seventy-two (72) hours per participant per qualifying transition. ( )

04. **Temporary Changes to Transition Management Rules During Declared State of Emergency Related to Novel Coronavirus Disease (COVID-19)**. In response to Idaho's declaration on 3/13/20 of a state of emergency related to COVID-19, the Department reserves the right to temporarily alter requirements and processes related to Transition Management services, currently and through the duration of the emergency state, in order to mitigate spread of disease and to ensure the health and safety of our participants under the guidance and authority of the provisions in a CMS approved 1135 waiver. Guidance for approved flexibilities is posted at https://healthandwelfare.idaho.gov/providers/idaho-medicaid-providers/information-medicaid-providers. ( )

351. -- 449. (RESERVED)

SUB AREA: HOSPICE
(Sections 450-459)

450. HOSPICE.
Medical assistance will provide payment for hospice services for eligible participants. Reimbursement will be based on Medicare program coverage as set out in Sections 450 through 456 of these rules. ( )

451. HOSPICE: DEFINITIONS.
The following definitions apply to Sections 450 through 456 of these rules. ( )

01. **Attending Physician**. A physician who: ( )

a. Is a doctor of medicine or osteopathy; and ( )

b. Is identified by the participant, at the time they elect to receive hospice care, as having the most significant role in the determination and delivery of the participant's medical care. ( )

02. Benefit Period. A period of time that begins on the first day of the month the participant elects hospice and ends on the last day of the eleventh successive calendar month. ( )

03. Bereavement Counseling. Counseling services provided to the participant's family after the participant's death. ( )

04. Cap Amount. The maximum amount of reimbursement the Idaho Medicaid Program will pay a designated hospice for providing services to Medicaid participants per Section 459 of these rules. ( )

05. Cap Period. The twelve (12) month period beginning November 1 and ending October 31 of the next year. See overall hospice reimbursement cap referred to in Section 459 of these rules. ( )

06. Election Period. One (1) of eight (8) periods within the benefit period that an participant may elect to receive Medicaid coverage of hospice care. Each period consists of any calendar month, or portion thereof, chosen within the benefit period. ( )

07. Employee. An individual serving the hospice or, if the hospice is a subdivision of an agency or organization, an employee of the agency or organization that is appropriately trained and assigned to the hospice unit. Employee also refers to a volunteer under the jurisdiction of the hospice. ( )

08. Freestanding Hospice. A hospice that is not part of any other type of participating provider. ( )

09. Hospice. A public agency or private organization or a subdivision that: ( )

a. Is primarily engaged in providing care to terminally ill participants; and ( )

b. Meets the conditions specified for certification for participation in the Medicare and Medicaid programs and has a valid provider agreement. ( )

10. Independent Physician. An attending physician who is not an employee of the hospice. ( )

11. Representative. A person who is, because of the participant's mental or physical incapacity, legally authorized in accordance with state law to execute or revoke an election for hospice care or terminate medical care on behalf of the terminally ill participant. ( )

12. Social Worker. A person who has at least a bachelor's degree from a school accredited or approved by the Council on Social Work Education. ( )

13. Terminally Ill. When a participant has a certified medical prognosis that life expectancy is six (6) months or less per Subsection 454.01 of these rules. ( )

452. HOSPICE: ELIGIBILITY.

Inherent in the Hospice program is that a participant understands the nature and basis for eligibility for hospice care without an inappropriate and explicit written statement about how the impending death will affect care. Though only written acknowledgment of the election periods is mandated, it is required that the participant or their representative be fully informed by a hospice before the beginning of a participant's care about the reason and nature of hospice care. The following are the eligibility requirements for Hospice: ( )

01. Certification. A certification that the participant is terminally ill must have been completed in accordance with Section 454.01 of these rules. ( )

02. Medically Necessary. Hospice services must be reasonable and necessary for the palliation and management of the terminal illness and related conditions. ( )

03. Election of Services.The participant must elect hospice care in accordance with Section 454.02 of these rules**.** ( )

453. HOSPICE: COVERAGE REQUIREMENTS AND LIMITATIONS.
The following services are required: ( )

01. Nursing Care. Nursing care provided by or under the supervision of a licensed registered nurse. ( )

02. Medical Social Services. Medical social services provided by a social worker who has at least a bachelor's degree from a school accredited or approved by the Council on Social Work Education, and who is working under the direction of a physician. ( )

03. Physician Services. Physician's services performed by a physician as defined in Subsection 451.01 of these rules. ( )

04. Counseling Services. Counseling services provided to the terminally ill participant and the family members or other persons caring for the participant at home. Counseling, including bereavement and dietary counseling, are core hospice services provided both for the purpose of training the participant's family or other care-giver to provide care, and for the purpose of helping the participant and those caring for them to adjust to the participant's approaching death. ( )

05. Inpatient Care. Short-term inpatient care provided in a participating hospice inpatient unit, or a participating hospital, or a nursing facility that additionally meets the hospice standards regarding staff and patient areas. Services provided in an inpatient setting must conform to the written plan of care. General inpatient care may be required for procedures necessary for pain control or acute or chronic symptom management that cannot be provided in other settings. Inpatient care may also be furnished to provide respite for the participant's family or other persons caring for the participant at home. ( )

06. Medical Equipment and Supplies. Medical equipment and supplies include drugs and biologicals. Only drugs as defined in Subsection 1861(t) of the Social Security Act and that are used primarily for the relief of pain and symptom control related to the patient's terminal illness are required. Appliances include durable medical equipment as well as other self-help and personal comfort items related to the palliation or management of the patient's terminal illness. Equipment is provided by the hospice for use in the patient's home while they are under hospice care. Medical supplies include only those that are part of the written plan of care. ( )

07. Home Health Services. Home health aide and homemaker services furnished by qualified aides. Home health aides will provide personal care services and will also perform household services necessary to maintain a safe and sanitary environment in areas of the home used by the patient. Aide services must be provided under the general supervision of a licensed registered nurse. Homemaker services include assistance in maintenance of a safe and healthy environment and services to enable the participant to carry out the plan of care. ( )

08. Therapies. Physical therapy, occupational therapy and speech-language pathology services provided for purposes of symptom control or to enable the participant to maintain activities of daily living and basic functional skills. ( )

09. Core Services. Nursing care, physician's services, medical social services, and counseling are core hospice services and must be routinely provided by hospice employees. Supplemental core services may be contracted for during periods of peak patient loads and to obtain physician specialty services. ( )

454. HOSPICE: PROCEDURAL REQUIREMENTS.

01. Physician Certification. The hospice must obtain the certification that a participant is terminally ill in accordance with the following procedures: ( )

a. For the first period of hospice coverage, the hospice must obtain, no later than two (2) calendar days after hospice care is initiated, written certification statements signed by the medical director of the hospice or the

physician member of the hospice interdisciplinary group and the participant's attending physician (if the participant has one). The certification must include the statement that the participant's medical prognosis is that their life expectancy is six (6) months or less and the signature(s) of the physician(s). In the event the participant's medical prognosis or the appropriateness of hospice care is questionable, the Department has the right to obtain another physician's opinion to verify a participant's medical status. ( )

b. For any subsequent election period, the hospice must obtain, no later than two (2) calendar days after the beginning of that period, a written certification statement prepared by the medical director of the hospice or the physician member of the interdisciplinary group. The certification must include the statement that the participant's medical prognosis is that their life expectancy is six (6) months or less and the signature(s) of the physician(s). ( )

c. The hospice must maintain the monthly certification statements for review. ( )

d. The hospice will submit a physician listing with their provider application and update changes in the listing of physicians that are hospice employees, including physician volunteers, to the Bureau of Facility Standards. The designated hospice must also notify the Medicaid program when the designated attending physician of a participant in their care is not a hospice employee. ( )

02. Election Procedures. If an participant elects to receive hospice care, they must file an election statement with a particular hospice. An election statement may also be filed by a legal representative or guardian per Section 15-5-312, Idaho Code. ( )

a. An election to receive hospice care will be automatically renewed after the initial election period and through any subsequent election periods without a break in care as long as the participant remains in the care of a designated hospice and does not revoke the election. ( )

b. A participant who elected less than eight (8) monthly election periods within the benefit period may request the availability of the remaining election periods. When the following conditions are met, the request will be granted. ( )

i. The hospice days available did not exceed two hundred ten (210) days in the benefit period due to the loss of financial eligibility. ( )

ii. The participant or the legal representative did not change hospices excessively per Subsection 454.05 of these rules. ( )

iii. The participant or the legal representative did not revoke hospice election periods more than eight (8) times per Subsection 454.04 of these rules. ( )

c. A participant may receive hospice services from the first day of hospice care or any subsequent day of hospice care, but a participant cannot designate an effective date that is earlier than the date that the election is made. ( )

d. A participant must waive all rights to Medicaid payments for the duration of the election period of hospice care, with the following exceptions: ( )

i. Hospice care and related services provided either directly or under arrangements by the designated hospice to the participant. ( )

ii. Any Medicaid services that are not related or equivalent to the treatment of the terminal condition or a related condition for which hospice care was elected. ( )

iii. Physician services provided by the participant's designated attending physician if that physician is not an employee of the designated hospice or receiving compensation from the hospice for those services. ( )

03. Election of Hospice. The election statement must include the following items of information:

( )

a. Identification of the particular hospice that will provide care to the participant. ( )

b. The participant's or representative's acknowledgment that they have been given a full understanding of hospice care. ( )

c. The participant's or representative's acknowledgment that they understand that all Medicaid services except those identified in Subsection 454.02.d. of these rules, are waived by the election during the hospice benefit period. ( )

d. The effective date of the election. ( )

e. The signature of the participant or the representative and the date of that signature. ( )

04. Revocation of Hospice Election. A participant or representative may revoke the election of hospice care at any time. ( )

a. To revoke the election of hospice care, the participant must file a signed statement with the hospice that includes that the participant revokes the election for Medicaid coverage of hospice care effective as of the date of the revocation. ( )

b. Upon revocation of the hospice election, other Medicaid coverage is reinstated. ( )

05. Change of Hospice. A participant may at any time change their designated hospice during election periods for which they are eligible. ( )

a. A participant may change designated hospices no more than six (6) times during the hospice benefit period. ( )

b. The change of the designated hospice is not considered a revocation of the election. To change the designation of hospice programs, the participant must file during the monthly election period, with the hospice from which they have received care and with the newly designated hospice, a dated and signed statement that includes the following information: ( )

i. The name of the hospice from which the participant has received care; ( )

ii. The name of the hospice from which they plan to receive care; and ( )

iii. The effective date of the change in hospices. ( )

c. A change in ownership of a hospice is not considered a change in the patient's designation of a hospice, and requires no action on the patient's part. ( )

06. Plan of Care. A plan of care must be established and reviewed at least monthly. To be covered, services must be consistent with the plan of care. ( )

a. In establishing the initial plan of care, the member of the basic interdisciplinary group who assesses the patient's needs must meet or call at least one (1) other group member (nurse, physician, medical social worker, or counselor) before writing the initial plan of care. ( )

b. At least one (1) of the persons involved in developing the initial plan must be a nurse or a physician. This plan must be established on the same day as the assessment if the day of assessment is to be a covered day of hospice care. ( )

c. The other two (2) members of the basic interdisciplinary group must review the initial plan of care and provide their input to the process of establishing the plan of care within two (2) calendar days following the day

of assessment; input may be provided by telephone. ( )

455. HOSPICE: PROVIDER QUALIFICATIONS AND DUTIES.
All services must be performed by appropriately qualified personnel, but it is the nature of the service, rather than the qualification of the person who provides it, that determines the category of the service. ( )

456. HOSPICE: PROVIDER REIMBURSEMENT.
With the exception of payment for physician services under Section 458 of these rules, Medicaid reimbursement for hospice care will be made at one (1) of five (5) predetermined rates for each day in which a participant receives the respective type and intensity of the services furnished under the care of the hospice. The five (5) rates are prospective rates; there will be no retroactive rate adjustments other than the application of the "cap" on overall payments, the service intensity add-on, and the limitation on payments for inpatient care, if applicable. A description of the payment for each level of care is described in Subsections 456.01 through 456.04 of these rules. ( )

01. Routine Home Care. The hospice provider will be paid one (1) of two (2) routine home care rates for each day the patient is in residence, under the care of the hospice, and not receiving continuous home care. The rate is paid without regard to the volume or intensity of routine home care services provided on any given day. The two-rate payment methodology will result in a higher based payment for days one (1) through sixty (60) of hospice care and a reduced rate for days sixty-one (61) to end-of-care. If a participant leaves hospice care and then later is placed back on hospice care, regardless of hospice provider, a minimum of a sixty (60) day gap in hospice services is required in order for the routine home care rate to be paid at the higher base payment rate. If there is not a minimum of a sixty (60) day gap in hospice services being provided, the hospice provider will be paid at the rate for which the participant is qualified. ( )

02. Continuous Home Care. Continuous home care is to be provided only during a period of crisis. A period of crisis is a period in which a patient requires continuous care that is primarily nursing care to achieve palliation and management of acute medical symptoms. Care must be provided by either a licensed registered nurse or a licensed practical nurse and a nurse must provide care for at least half the total period of care. A minimum of eight (8) hours of care must be provided during a twenty-four (24) hour day that begins and ends at midnight. This care need not be continuous and uninterrupted. If less skilled care is needed on a continuous basis to enable the person to remain at home, this is covered as routine home care. For every hour or part of an hour of continuous care furnished, the hourly rate will be reimbursed to the hospice up to twenty-four (24) hours per day. ( )

03. Inpatient Respite Care. The hospice will be paid at the inpatient respite care rate for each day that the participant is in an approved inpatient facility and is receiving respite care. Payment for respite care may be made for a maximum of five (5) days at a time including the date of admission but not counting the date of discharge in any monthly election period. Payment for the sixth and any subsequent day is to be made at the appropriate rate routine, continuous, or general inpatient rate. ( )

04. General Inpatient Care. Payment at the inpatient rate will be made when general inpatient care is provided. No other fixed payment rates will be applicable for a day on which the participant receives hospice general inpatient care except as described in Section 458 of these rules. ( )

a. Date of discharge. For the day of discharge from an inpatient unit, the appropriate home care rate is to be paid unless the patient dies as an inpatient. When the patient is discharged as deceased, the inpatient rate, either general or respite, is to be paid for the discharge date. ( )

b. Hospice payment rates. The Medicaid hospice payment rates are the same as the Medicare hospice rates, adjusted to disregard cost offsets attributable to Medicare coinsurance amounts. Under the Medicaid hospice benefit, no cost sharing may be imposed with respect to hospice services rendered to Medicaid participants. ( )

c. Obligation of continuing care. After the participant's hospice benefit expires, the patient's Medicaid hospice benefits do not expire. The hospice must continue to provide that participant's care until the patient expires or until the participant revokes the election of hospice care. ( )

05. Service Intensity Add-On. For hospice services with dates of service on and after January 1, 2016,

a service intensity add-on payment will be made for a visit by a licensed registered nurse (RN) or social worker when provided in the last seven (7) days of life. Payment for the service intensity add-on is in addition to the routine home care rate and is calculated by multiplying the continuous home care rate per fifteen (15) minutes by the number of units for the combined visits for the day. Payment must not exceed sixteen (16) units per day, and is adjusted for geographic differences in wages. Phone time for a provider's social worker is not eligible for a service intensity add-on payment. ( )

457. HOSPICE: LIMITATION ON PAYMENTS FOR INPATIENT CARE.
Payments to a hospice for inpatient care must be limited according to the number of days of inpatient care furnished to Medicaid patients. During the twelve (12) month period beginning November 1st of each year and ending October 31st of the next year, the aggregate number of inpatient days (both general inpatient days and inpatient respite care) may not exceed twenty percent (20%) of the total number of days of hospice care provided to all Medicaid participants during the same period by the designated hospice or its contracted agent(s). ( )

01. For Purposes of Computation. If it is determined that the inpatient rate should not be paid, any days for which the hospice receives payment at a home care rate will not be counted as inpatient days. The limitations on payment for inpatient days are as follows: ( )

a. The maximum number of allowable inpatient days will be calculated by multiplying the total number of a provider's Medicaid hospice days by twenty percent (20%). ( )

b. If the total number of days of inpatient care to Medicaid hospice patients is less than or equal to the maximum number of inpatient days computed in Subsection 457.01 of these rules then no adjustment is made. ( )

c. If the total number of days of inpatient care exceeds the maximum number of allowable inpatient days computed in Subsection 457.01 of these rules then the payment limitation will be determined by: ( )

i. Calculating the ratio of the maximum allowable inpatient days to the number of actual days of inpatient care, and multiplying this ratio by the total reimbursement for inpatient care that was made. ( )

ii. Multiplying excess inpatient care days by the routine home care rate. ( )

iii. Adding the amounts calculated in Subsections 457.01.c.i. and 457.01.c.ii. of these rules. ( )

iv. Comparing the amount in Subsection 457.01.c.iii. of these rules with interim payments made to the hospice for inpatient care during the "cap period." ( )

02. The amount by which interim payments for inpatient care exceeds the amount calculated as in Section 459 of these rules is due from the hospice. ( )

458. HOSPICE: PAYMENT FOR PHYSICIAN SERVICES.
The basic rates for hospice care represent full reimbursement to the hospice for the costs of all covered services related to the treatment of the participant's terminal illness, including the administrative and general activities performed by physicians who are employees of or working under arrangements made with the hospice. These activities would generally be performed by the physician serving as the medical director and the physician member of the hospice interdisciplinary group. Group activities include participation in the establishment of plans of care, supervision of care and services, periodic review and updating of plans of care, and establishment of governing policies. The costs for these services are included in the reimbursement rates for routine home care, continuous home care, and inpatient respite care. ( )

01. Hospice Employed Physician Direct Patient Service. Reimbursement for a hospice employed physician's direct patient services that are not rendered by a hospice volunteer is made in accordance with the usual Idaho Medicaid reimbursement methodology for physician services. These services will be billed by the hospice under the hospice provider number and, the related payments will be counted in determining whether the overall hospice cap amount per Section 459 of these rules has been exceeded. The only physician services to be billed by a hospice for such services are direct patient care services. Laboratory and X-ray services are included in the hospice

daily rate. ( )

02. Volunteer Physician Services. Volunteer physician services are excluded from Medicaid reimbursement with the following exceptions: ( )

a. A hospice may be reimbursed on behalf of a volunteer physician for specific direct patient care services that are not rendered on a volunteer basis. The hospice must have a liability to reimburse the physician for those services rendered. In determining whether a service is provided on a volunteer basis, a physician must not distinguish which services are provided voluntarily on the basis of the patient's ability to pay. ( )

b. Reimbursement for an independent physician's direct patient services that are not rendered by a hospice volunteer is made in accordance with the usual Idaho Medicaid reimbursement methodology for physician services. These services will not be billed by the hospice under the hospice provider number and they will not be counted in determining whether the overall hospice cap amount per Section 459 of these rules has been exceeded. The only services to be billed by an attending physician are the physician's personal professional services. Costs for services such as laboratory or X-rays are not to be included on the attending physician's billed charges to the Medicaid program. The aforementioned charges are included in the daily rates paid and are expressly the responsibility of the hospice. ( )

459. HOSPICE: CAP ON OVERALL REIMBURSEMENT.
Aggregate payments to each hospice will be limited during a hospice cap period per Subsection 451.05 of these rules. The total payments made for services furnished to Medicaid participants during this period will be compared to the "cap amount" for this period. Any payments in excess of the cap must be refunded by the hospice. ( )

01. Overall Cap. The overall cap will be compared to reimbursement after the inpatient limitation is computed and subtracted from total reimbursement due the hospice. ( )

02. Total Payment for Services. Total payment made for services furnished to Medicaid participants during this period means all payments for services rendered during the cap year, regardless of when payment is actually made. ( )

03. Calculation of Cap Amount. The "cap amount" is calculated by multiplying the number of participants electing certified hospice care during the period by six thousand five hundred dollars ($6,500). This amount will be adjusted for each subsequent cap year beginning November 1, 1983, to reflect the percentage increase or decrease in the medical care expenditure category of the Consumer Price Index (CPI) for all urban consumers as published by the Bureau of Labor Statistics. It will also be adjusted as per Subsection 459.07 of these rules. ( )

04. Computation and Application of Cap Amount. The computation and application of the "cap amount" is made by the Department after the end of the cap period. ( )

05. Report Number of Medicaid Participants. The hospice must report the number of Medicaid participants electing hospice care during the period to the Department. ( )

a. This must be done within thirty (30) days after the end of the cap period: and ( )

b. If the participant is transferred to a non-certified hospice no payment to the non-certified hospice will be made and the certified hospice may count a complete participant benefit period in their cap amount. ( )

06. Certified in Mid-Month. If a hospice certifies in mid-month, a weighted average cap amount based on the number of days falling within each cap period would be used. ( )

07. Adjustment of the Overall Cap. Cap amounts in each hospice's cap period will be adjusted to reflect changes in the cap periods and designated hospices during a participant's election period. The proportion of each hospice's days of service to the total number of hospice days rendered to the participant during their election period will be multiplied by the cap amount to determine each hospice's adjusted cap amount. ( )

a. After each cap period has ended, the Department will calculate the overall cap within a reasonable time for each hospice participating in the Idaho Medicaid Program. ( )

b. Each hospice's cap amount will be computed as follows: ( )

i. The share of the "cap amount" that each hospice is allowed will be based on the proportion of total covered days provided by each hospice in the "cap period." ( )

ii. The proportion determined in Section 457 of these rules for each certified hospice will be multiplied by the "cap amount" specified for the "cap period" in which the participant first elected hospice. ( )

c. The participant must file an initial election during the period beginning September 28 of the previous year through September 27 of the current cap year in order to be counted as an electing Medicaid participant during the current cap year. ( )

08. Additional Amount for Nursing Facility Residents. An additional per diem amount will be paid for "room and board" of hospice residents in a certified nursing facility receiving routine or continuous care services. In this context, the term "room and board" includes all assistance in the activities of daily living, in socializing activities, administration of medication, maintaining the cleanliness of a resident's room, and supervision and assisting in the use of durable medical equipment and prescribed therapies. The additional payments and the related days are not subject to the caps specified in Sections 457 and 459 of these rules. The room and board rate will be ninety-five percent (95%) of the per diem interim reimbursement rate assigned to the facility for those dates of service on which the participant was a resident of that facility. ( )

460. HOSPICE: POST-ELIGIBILITY TREATMENT OF INCOME.
Where a participant is determined eligible for medical assistance participation in the cost of long term care, the Department will reduce its payments for all costs of the hospice benefit, including the supplementary amounts for room and board, by an amount determined according to Section 227 of these rules. ( )

461. -- 499. (RESERVED)

SUB PART: ENHANCED DEVELOPMENTAL DISABILITY SERVICES
(Sections 500-719)

500. DEVELOPMENTAL DISABILITY DETERMINATION STANDARDS.
Prior to receiving developmental disability services as provided in Sections 507 through 719 of these rules, the participant must be determined to have a developmental disability. ( )

501. DEVELOPMENTAL DISABILITY DETERMINATION STANDARDS: ELIGIBILITY.
The definitions and standards in the table below must be used to determine whether a participant meets criteria as a person with a developmental disability under Section 66-402, Idaho Code.

TABLE 501 - DEVELOPMENTAL DISABILITY DETERMINATION STANDARDS

Definition	Standards
"Developmental Disability" means a chronic disability of a person that appears before the age of 22 years and:	Age of 22 means through the day before the individual's 22nd birthday. AND

TABLE 501 - DEVELOPMENTAL DISABILITY DETERMINATION STANDARDS	
Definition	**Standards**
(a) is attributable to an impairment, such as an intellectual disability;	"Is attributable to an impairment" means that there is a causal relationship between the presence of an impairing condition and the developmental disability. **Age 5 through Adult:** There is a presumption that an intellectual disability exists when a full scale IQ score up to 75 exists. (IQ of 70 with a standard error of measurement of 5 points.) **Birth to Age 5:** An IQ test score is not required below the age of 5. In these cases it may be necessary to rely on the results of a functional assessment. There is a presumption that an intellectual disability exists when there is a standard score of 75 or below or a delay of 30% overall.
cerebral palsy;	Medical Diagnosis that requires documentation.
epilepsy;	Medical Diagnosis that requires documentation. On medication controlled or uncontrolled. Does not include a person who is seizure-free and not on medication for 3 years.
autism;	Includes the diagnosis of pervasive developmental disorder.
or other condition found to be closely related to or similar to one of these impairments that requires similar treatment or services;	For related or similar conditions, documentation must be present to show the causal relationship between the impairing condition and the developmental disability. (Does not include mental illness) **Intellectual Disability:** A full scale IQ score above 75 can in some circumstances be considered a related or similar condition to an intellectual disability when additional supporting documentation exists showing how the individual's functional limitations make their condition similar to an intellectual disability. **Cerebral Palsy:** Conditions related or similar to cerebral palsy include disorders that cause a similar disruption in motor function. **Epilepsy:** Conditions related or similar to epilepsy include disorders that interrupt consciousness.
or is attributable to dyslexia resulting from such impairments; and	AND
(b) results in substantial functional limitations in three (3) or more of the following major life activities:	"Results in" means that the substantial limitation must be because of the impairment. A "substantial" limitation is one in which the total effect of the limitation results in the need for a "combination and sequence of special interdisciplinary, or generic care, treatment or other services that need to be individually planned and coordinated." Listed below are standards for substantial functional limitations in each major life area. **Age 3 through Adult:** A score of 2 standard deviations below the mean creates a presumption of a functional limitation. **Birth to Age 3:** The following criteria must be utilized to determine a substantial functional limitations for children under 3: **a.** The child scores 30% below age norm; or **b.** The child exhibits a 6 month delay; or **c.** The child scores 2 standard deviations below the mean.

TABLE 501 - DEVELOPMENTAL DISABILITY DETERMINATION STANDARDS	
Definition	**Standards**
self care;	**Adult:** A substantial functional limitation is manifest when the person requires physical or non-physical assistance in performing eating, hygiene, grooming, or health care skills, or when the time required for a person to perform these skills him/her self is so substantial as to impair their ability to conduct other activities of daily living or retain employment. **Birth to Age 21:** A functional limitation is manifest when the child's skills are limited according to age-appropriate responses such that the parent, caregiver, or school personnel is required to provide care that is substantially beyond that typically required for a child of the same age (such as excessive time lifting, diapering, supervision).
receptive and expressive language;	**Age 3 through Adult:** A substantial functional limitation is manifest when a person is unable to communicate effectively without the aid of a third person, a person with special skills, or without an assistive device (such as sign language). **Birth to Age 3:** A substantial functional limitation is manifest when they have been diagnosed by a qualified professional who determines that the child performs 30% below age norm (adjusted for prematurity up to 2 years) or demonstrates at least 2 standard deviations below the mean in either area or 1 1/2 below in both areas of language development.
learning;	**Birth through Adult:** A substantial functional limitation is manifest when cognition, retention, reasoning, visual or aural communications, or other learning processes or mechanisms are impaired to the extent that special (interventions that are beyond those that an individual normally needs to learn) intervention is required for the development of social, self care, language, academic, or vocational skills.
mobility;	**Adult:** A substantial functional limitation is manifest when fine or gross motor skills are impaired to the extent that the assistance of another person or an assistive device is required for movement from place to place. **Birth to Age 21:** A substantial limitation would be measured by an age appropriate instrument that compares the child's skills for postural control and movement and coordinated use of the small muscles with those skills expected of children of the same age.
self-direction;	**Adult:** A substantial functional limitation is manifest when a person requires assistance in managing their personal finances, protecting their self interest, or making decisions that may affect their well being. **Birth to Age 21:** A substantial limitation is manifest when the child is unable to help themself or cooperate with others age appropriate assistance to meet personal needs, learn new skills, follow rules, and adapt to environments.

TABLE 501 - DEVELOPMENTAL DISABILITY DETERMINATION STANDARDS	
Definition	**Standards**
capacity for independent living; or	**Adult:** A substantial functional limitation is manifest when, for a person's own safety or well-being, supervision or assistance is required, at least on a daily basis, in the performance of health maintenance, housekeeping, budgeting, or leisure time activities and in the utilization of community resources. **Birth to Age 21:** A substantial limitation would be measured by an age-appropriate instrument that compares the child's personal independence and social responsibility expected of children of comparable age and cultural group.
economic self-sufficiency; and	**Adult:** A substantial functional limitation is manifest when a person is unable to perform the tasks necessary for regular employment or is limited in productive capacity to the extent that their earned annual income, after extraordinary expenses occasioned by the disability, is insufficient for self-support. **Age 5 to Age 21:** Use the pre-vocational area of a standardized functional assessment to document a limitation in this area. **Birth to Age 5:** A substantial limitation in this area is evidenced by the child's eligibility for SSI, early intervention, or early childhood special education under the Individuals with Disabilities Education Act (IDEA). AND
(c) reflects the needs for a combination and sequence of special, interdisciplinary or generic care, treatment or other services that are of life-long or extended duration and individually planned and coordinated.	**Age 5 through Adult:** Life-long or extended duration means the developmental disability is one that has the reasonable likelihood of continuing for a protracted period of time, including a reasonable likelihood that it will continue throughout life. **Birth to Age 5:** The expected duration may be frequently unclear. Therefore, determination of eligibility by a multi-disciplinary team for early intervention services through SSI, an IFSP, child study team or early childhood special education services through an IEP will be an indicator of this criteria.

( )

502. (RESERVED)

503. DEVELOPMENTAL DISABILITY DETERMINATION: TEST INSTRUMENTS.
A variety of standardized test instruments are available. Tests used to determine a developmental disability must reflect the current functional status of the individual being evaluated. Tests over one (1) year old must be verified to reflect the current status of the individual by an appropriate professional. Instruments designed only for screening purposes must not be used to determine eligibility. ( )

01. Test Instruments For Adults. A Department-approved assessment tool for conducting cognitive and functional assessments must be used to determine eligibility. ( )

02. Test Instruments for Children. The assessments utilized to determine eligibility must be based on age appropriate criteria. Evaluations must be performed by qualified personnel with experience and expertise with children; selected evaluation tools and practices should be age appropriate, based on consideration of the child's language and motor skills. A Department-approved assessment tool for conducting cognitive and functional assessments must be used with children. ( )

504. -- 506. (RESERVED)

507. ADULT DEVELOPMENTAL DISABILITY SERVICES PRIOR AUTHORIZATION (PA).
The purpose of adult developmental disability services prior authorization is to assure the provision of the right care, in the right place, at the right price, and with the right outcomes in order to enhance health and safety, and to promote participants' rights, self-determination, and independence. Prior authorization involves the assessment of the need for services, development of a budget, development of a plan of services, prior approval of services, and a quality improvement program. Services are reimbursable if they are identified on the authorized plan of service and are consistent with the purpose and rule for prior authorization as well as rules for the specific service. ( )

508. ADULT DEVELOPMENTAL DISABILITY SERVICES PRIOR AUTHORIZATION: DEFINITIONS.
For the purposes of these rules the following terms are used as defined below. ( )

01. Adult. A person who is eighteen (18) years of age or older. ( )

02. Assessment. A process that is described in Section 509 of these rules for program eligibility and in Section 512 of these rules for plan of service. ( )

03. Clinical Review. A process of professional review that validates the need for continued services. ( )

04. Community Crisis Support. Intervention for participants who are at risk of losing housing, employment or income, or who are at risk of incarceration, physical harm, family altercations or other emergencies. ( )

05. Concurrent Review. A clinical review to determine the need for continued prior authorization of services. ( )

06. Department-Approved Assessment Tool. Any standardized assessment tool approved by the Department for use in determining developmental disability eligibility, waiver eligibility, skill level to identify the participant's needs for the plan of service, and for determining the participant’s budget. ( )

07. Exception Review. A clinical review of a plan that falls outside the established standards. ( )

08. Interdisciplinary Team. For purposes of these rules, the interdisciplinary team is a team of professionals, determined by the Department, that reviews requests for reconsideration. ( )

09. Level of Support. An assessment score derived from a Department-approved assessment tool that indicates types and amounts of services and supports necessary to allow the individual to live independently and safely in the community. ( )

10. Person-Centered Planning Process. A meeting facilitated by the participant or plan developer, comprised of family and individuals significant to the participant who collaborate with the participant to develop the plan of service. ( )

11. Person-Centered Planning Team. The group who develops the plan of service. This group includes, at a minimum, the participant and the service coordinator or plan developer chosen by the participant. The person-centered planning team may include others identified by the participant or agreed upon by the participant and the Department as important to the process. ( )

12. Plan Developer. A paid or non-paid person identified by the participant who is responsible for developing one (1) plan of service and subsequent addenda that cover all services and supports, based on a person-centered planning process. ( )

13. Plan Monitor. A person who oversees the provision of services on a paid or non-paid basis.

( )

14. Plan of Service. An initial or annual plan that identifies all services and supports based on a person-centered planning process. Plans are authorized annually every three hundred sixty-five (365) days.
( )

15. Prior Authorization (PA). A process for determining a participant's eligibility for services and medical necessity prior to the delivery or payment of services as provided by these rules. ( )

16. Provider Status Review. The written documentation that identifies the participant's progress toward goals defined in the plan of service. ( )

17. Right Care. Accepted treatment for defined diagnosis, functional needs and abilities to achieve the desired outcome. The right care is consistent with best practice and continuous quality improvement. ( )

18. Right Place. Services delivered in the most integrated setting in which they normally occur, based on the participant's choice to promote independence. ( )

19. Right Price. The most integrated and least expensive services that are sufficiently intensive to address the participant's needs. The amount is based on the individual's needs for services and supports as identified in the assessment. ( )

20. Right Outcomes. Services based on assessed need that ensure the health and safety of the participant and result in progress, maintenance, or delay or prevention of regression for the participant. ( )

21. Service Coordination. Service coordination is an activity which assists individuals eligible for Medicaid in gaining and coordinating access to necessary care and services appropriate to the needs of an individual.
( )

22. Service Coordinator. An individual who provides service coordination to a Medicaid-eligible participant, is employed by a service coordination agency, and meets the training, experience, and other requirements under Sections 729 through 732 of these rules. ( )

23. Services. Services paid for by the Department that enable the individual to reside safely and effectively in the community. ( )

24. Supports. Formal or informal services and activities, not paid for by the Department, that enable the individual to reside safely and effectively in the setting of their choice. ( )

509. ADULT DEVELOPMENTAL DISABILITY SERVICES PRIOR AUTHORIZATION: ELIGIBILITY DETERMINATION.

The Department will make the final determination of an individual's eligibility, based upon the assessments and evaluations administered by the Department. Initial and annual assessments will be performed by the Department. The purpose of the assessment is to determine a participant's eligibility for developmental disabilities services in accordance with Section 66-402, Idaho Code, and Sections 500 through 506 of these rules and for ICF/IID level of care for waiver services in accordance with Section 584 of these rules. ( )

01. Initial Assessment. For new applicants, an assessment will be completed within thirty (30) days from the date a completed application is submitted. ( )

02. Annual Assessments. Assessments will also be completed for current participants at the time of their annual eligibility redetermination. The assessor will evaluate whether assessments are current and accurately describe the status of the participant. At least sixty (60) days before the expiration of the current plan of service:
( )

a. The assessment process will be completed; and ( )

b. The assessor will provide the results of the assessment to the participant. ( )

03. Determination of Developmental Disability Eligibility. The evaluations or assessments that are required for determining developmental disabilities for a participant's eligibility for developmental disabilities services will include a medical/social history and a functional assessment. Participants must provide the results of psychometric testing if eligibility for developmental disabilities services is based on an intellectual disability and they have no prior testing or prior testing is inconclusive. Documentation of diagnosis is required for participants whose eligibility is based on developmental disabilities other than an intellectual disability. A Department-approved assessment tool will be administered by the Department for use in this determination. ( )

04. ICF/IID Level of Care Determination for Waiver Services. The assessor will determine ICF/IID level of care for adults in accordance with Section 584 of these rules. ( )

510. (RESERVED)

511. ADULT DEVELOPMENTAL DISABILITY SERVICES PRIOR AUTHORIZATION: COVERAGE AND LIMITATIONS.
The scope of these rules defines prior authorization for the following Medicaid developmental disability services for adults: ( )

01. DD Waiver Services. DD Waiver services as described in Sections 700 through 719 of these rules; and ( )

02. Developmental Therapy. Developmental therapy as described in Sections 649 through 657 of these rules and IDAPA 16.03.21, “Developmental Disabilities Agencies (DDA)”; and ( )

03. Service Coordination. Service Coordination for persons with developmental disabilities as described in Sections 720 through 779 of these rules. ( )

512. ADULT DEVELOPMENTAL DISABILITY SERVICES PRIOR AUTHORIZATION: PROCEDURAL REQUIREMENTS.

01. Assessment for Plan of Service. The assessment for a plan of service is required for all participants prior to the development of the plan of service. This assessment must include the following in Subsections 512.02 through 512.06 of these rules. ( )

02. Physician's History and Physical. The history and physical must include a physician's referral for nursing services under the DD waivers and for developmental disabilities agencies' services, if they are anticipated to be part of the plan of service. A physician's history and physical is required within the year prior to the initiation of service and thereafter on a frequency determined by the physician. For participants in Healthy Connections: ( )

a. The Healthy Connections physician may delegate to the Department the authority to approve developmental disability services. ( )

b. The Healthy Connections physician must conduct the history and physical, and may refer the participant for other evaluations. ( )

03. Medical, Social, and Developmental History. The medical, social and developmental history is used to document the participant’s medical social and developmental history information. A current medical social and developmental history must be evaluated prior to the initiation of developmental therapy and must be reviewed annually to assure it continues to reflect accurate information about the participant’s status. ( )

a. A medical, social and developmental history for each adult participant is completed by the Department or its contractor. ( )

b. Providers should obtain and utilize the medical, social developmental history documents generated

by the Department or its contractor when one is necessary for adult program or plan development. ( )

04. Department-Approved Assessment Tool. The results of a Department-approved assessment tool are used to determine the level of support for the participant. A current Department-approved assessment will be evaluated prior to the initiation of service and reviewed annually to assure it continues to reflect the functional status of the participant. A department-approved assessment tool for adults is completed by the Department or its contractor. Providers must obtain and utilize the document generated by the Department or its contractor when one is necessary for program or plan development. ( )

05. Medical Condition. The participant's medical conditions, risk of deterioration, living conditions, and individual goals. ( )

06. Behavioral or Psychiatric Needs. Behavioral or psychiatric needs that require special consideration. ( )

513. ADULT DEVELOPMENTAL DISABILITY SERVICES PRIOR AUTHORIZATION: PLAN OF SERVICE.

In collaboration with the participant, the Department will assure that the participant has one (1) plan of service. This plan of service is based on the individualized participant budget referred to in Section 514 of these rules and must identify all services and supports. Participants may develop their own plan or designate a paid or non-paid plan developer. In developing the plan of service, the plan developer and the participant must identify services and supports available outside of Medicaid-funded services that can help the participant meet desired goals. Authorized services must be delivered by providers who are selected by the participant. ( )

01. Qualifications of a Paid Plan Developer. Neither a provider of direct service to the participant nor the assessor may be chosen to be the paid plan developer. Family members and all others who wish to be paid for plan development must be employed as a service coordinator as defined in Sections 729 through 732 of these rules. ( )

02. Plan Development. All participants must direct the development of their service plan through a person-centered planning process. Individuals invited to participate in the person-centered planning process will be identified by the participant and may include family members, guardian, or individuals who are significant to the participant. In developing the plan of service, the plan developer and participant must identify any services and supports available outside of Medicaid-funded services that can help the participant meet desired goals and outcomes. ( )

a. The plan of service must be submitted within forty-five (45) days prior to the expiration of the existing plan of service unless delayed because of participant unavailability due to extenuating circumstances. If the plan is not submitted within this time period, authorization for provider payments may be terminated. ( )

b. The plan development process must meet the person-centered planning requirements described in Section 316 of these rules. ( )

c. The participant may facilitate their own person-centered planning meeting, or designate a paid or non-paid plan developer to facilitate the meeting. Individuals responsible for facilitating the person-centered planning meeting cannot be providers of direct services to the participant. ( )

03. Prior Authorization Outside of These Rules. The plan developer must ensure that all services that require prior authorization outside of these rules are submitted to the appropriate unit of the Department. These services include: ( )

a. Durable Medical Equipment (DME); ( )

b. Transportation; and ( )

c. Physical therapy, occupational therapy, and speech-language pathology services. ( )

04. No Duplication of Services. The plan developer will ensure that there is no duplication of services. Duplicate services will not be authorized. ( )

05. Plan Monitoring. The participant, service coordinator or plan monitor must monitor the plan. The plan developer is the plan monitor unless there is a service coordinator, in which case the service coordinator assumes the roles of both service coordinator and plan monitor. The planning team must identify the frequency of monitoring, which must be at least every ninety (90) days. Plan monitoring must include the following: ( )

a. Review of the plan of service in a face-to-face contact with the participant to identify the current status of programs and changes if needed. The face-to-face encounter may occur via synchronous interaction telehealth, as defined in Title 54, Chapter 57, Idaho Code; ( )

b. Contact with service providers to identify barriers to service provision; ( )

c. Discuss with participant satisfaction regarding quality and quantity of services; and ( )

d. Review of provider status reviews. ( )

e. The provider will immediately report all allegations or suspicions of mistreatment, abuse, neglect, or exploitation, as well as injuries of unknown origin to the agency administrator, the Department, the adult protection authority, and any other entity identified under Section 39-5303, Idaho Code, or federal law. ( )

06. Provider Status Reviews. Service providers, with exceptions identified in Subsection 513.09 of these rules, must report the participant's progress toward goals to the plan monitor on the provider status review when the plan has been in effect for six (6) months and at the annual person-centered planning meeting. The semi-annual and annual reviews must include: ( )

a. The status of supports and services to identify progress; ( )

b. Maintenance; or ( )

c. Delay or prevention of regression. ( )

07. Content of the Plan of Service. The plan of service must identify the type of service to be delivered, goals to be addressed within the plan year, frequency of supports and services, and identified service providers. The plan of service must include activities to promote progress, maintain functional skills, or delay or prevent regression. ( )

a. The written plan of service must meet the person-centered planning requirements described in Section 317 of these rules. ( )

b. The written plan of service must be finalized and agreed to according to procedural requirements described in Section 704 of these rules. ( )

c. The Department will distribute a copy of the plan of service to adult DD service providers defined in Section 317 of these rules. Additionally, the plan developer will be responsible to distribute a copy of the plan of service, in whole or part, to any other developmental disability service provider identified by the participant during the person-centered planning process. ( )

08. Informed Consent. Unless the participant has a guardian who retains full decision-making authority, the participant must make decisions regarding the type and amount of services required. Prior to plan development, the plan developer must document that they have provided information and support to the participant to maximize their ability to make informed choices regarding the services and supports they receive and from whom. During plan development and amendment, planning team members must each indicate whether they believe the plan meets the needs of the participant, and represents the participant's choice. If there is a conflict that cannot be resolved among person-centered planning members or if a member does not believe the plan meets the participant’s needs or represents the participant’s choice, the plan or amendment may be referred to the Bureau of Developmental Disability

Services to negotiate a resolution with members of the planning team. ( )

09. Provider Implementation Plan. Each provider of Medicaid services must develop an implementation plan that complies with home and community-based setting requirements and identifies specific objectives that relate to goals finalized and agreed to in the participant's authorized plan of service. These objectives must demonstrate how the provider will assist the participant to meet the participant's goals, desired outcomes, and needs identified in the plan of service. ( )

a. Exceptions. An implementation plan is not required for waiver providers of: ( )

i. Specialized medical equipment; ( )

ii. Home delivered meals; ( )

iii. Environmental accessibility adaptations; ( )

iv. Non-medical transportation; ( )

v. Personal emergency response systems (PERS); ( )

vi. Respite care; and ( )

vii. Chore services. ( )

b. Time for Completion. Implementation plans must be completed within fourteen (14) days of receipt of the authorized plan of service or the service start date, whichever is later. ( )

i. If the authorized plan of service is received after the service start date, service providers must support billing by documenting service provision as agreed to by the participant and consistent with Section 704 of these rules. ( )

ii. Implementation plan revision must be based on changes to the needs of the participant. ( )

c. Documentation of Changes. Documentation of Implementation Plan changes will be included in the participant's record. This documentation must include, at a minimum, the reason for the change, documentation of coordination with other service providers (where applicable), the date the change was made, the signature of the person making the change complete with the date and title. ( )

10. Home and Community-Based Services Plan of Service Signature. Upon receipt of the authorized plan of service, HCBS providers responsible for the implementation of the plan as identified in Section 317 of these rules must sign the plan indicating they will deliver services according to the finalized and authorized plan of service, and consistent with home and community-based requirements. Each HCBS provider responsible for the implementation of the plan must maintain their signed plan in the participant's record. Documentation of signature must include the signature of the professional responsible for service provision complete with their title and the date signed. Provider signature will be completed each time an initial or annual plan of service is implemented. ( )

11. Addendum to the Plan of Service. ( )

a. A plan of service may be adjusted during the year with an addendum to the plan. These adjustments must be based on a change to a cost, addition of a service or increase to a service, or a change of provider. Additional assessments or information may be clinically necessary. Adjustment of the plan of service is subject to prior authorization by the Department. ( )

b. When a service plan has been adjusted, the Department will distribute a copy of the addendum to HCBS providers responsible for the implementation of the plan of service as identified in Section 317 of these rules. ( )

c. Upon receipt of the addendum, the HCBS provider must sign the addendum indicating they have reviewed the plan adjustment and will deliver services accordingly. Documentation must include the signature of the professional responsible for service provision complete with their title and the date signed, and must be maintained in the participant's record. Provider signature will be completed each time an addendum is authorized. ( )

12. Annual Reauthorization of Services. A participant's plan of service must be reauthorized annually. The Department will review and authorize the new plan of service prior to the expiration of the current plan. ( )

a. Plan Developer Responsibilities for Annual Reauthorization. A new plan of service must be provided to the Department by the plan developer at least forty-five (45) days prior to the expiration date of the current plan. Prior to this, the plan developer must: ( )

i. Notify the providers who appear on the plan of service of the annual review date. ( )

ii. Obtain a copy of the current annual provider status review from each provider for use by the person-centered planning team. Each provider status review must meet the requirements in Subsection 513.06 of these rules. ( )

iii. Convene the person-centered planning team to develop a new plan of service; inviting individuals to participate that have been identified by the participant. ( )

b. Evaluation and Prior Authorization of the Plan of Service. The plan of service will be evaluated and prior authorized in accordance with the requirements in Sections 507 and 513 of these rules. ( )

c. Adjustments to the Annual Budget and Services. The annual budget and services may be adjusted by the Department based on demonstrated outcomes, progress toward goals and objectives, and benefit of services. ( )

d. Annual Status Reviews Requirement. If the provider's annual status reviews are not submitted with the annual plan, services will not be authorized at the time of the annual reauthorization. These services may be added to the plan of service only by means of an addendum to the plan in accordance with Subsection 513.10 of these rules. ( )

e. Reapplication After a Lapse in Service. For participants who are re-applying for service after a lapse in service, the assessor will evaluate whether assessments are current and accurately describe the status of the participant. ( )

f. Annual Assessment Results. An annual assessment will be completed in accordance with Section 512 of these rules. ( )

13. Complaints and Administrative Appeals. ( )

a. Participant complaints about the assessment process, eligibility determination, plan development, quality of service, and other relevant concerns may be referred to the Division of Medicaid. ( )

b. A participant who disagrees with a Department decision regarding program eligibility and authorization of services under these rules may file an appeal. Administrative appeals are governed by provisions of IDAPA 16.05.03, “Contested Case Proceedings and Declaratory Rulings.” ( )

514. ADULT DEVELOPMENTAL DISABILITY SERVICES PRIOR AUTHORIZATION: PROVIDER REIMBURSEMENT.
Providers are reimbursed on a fee for service basis based on a participant budget. ( )

01. Individualized Budget Beginning on October 1, 2006. Beginning October 1, 2006, for DD waiver participants, and beginning January 1, 2007, for all other adult DD participants, the Department sets an

individualized budget for each participant according to an individualized measurement of the participant's functional abilities, behavioral limitations, and medical needs, related to the participant's disability. Using these specific participant factors, the budget-setting methodology will correlate a participant's characteristics with the participant's individualized budget amount, so participants with higher needs will be assigned a higher individualized budget amount. ( )

a. The Department notifies each participant of their set budget amount as part of the eligibility determination process or annual redetermination process. The notification will include how the participant may appeal the set budget amount. ( )

b. Individualized budgets will be re-evaluated annually. At the request of the participant, the Department will also re-evaluate the set budget amount when there are documented changes in the participant's condition resulting in a need for services that meet medical necessity criteria, and this is not reflected on the current inventory of individual needs. ( )

02. Residential Habilitation - Supported Living Acuity-Based Levels of Support. Reimbursement for residential habilitation - supported living is based on the participant's assessed level of support need. All plans of service that include supported living must include community integration goals that provide for maintained or enhanced independence, quality of life, and self-determination. As a participant’s independence increases and they are less dependent on supports, they must transition to less intense supports. ( )

a. High support is for those participants who require twenty-four (24) hour per day supports and supervision as determined by a Department-approved assessment tool. High support allows for a blend of one-to-one and group staffing. Participants authorized at the high support daily rate will not be authorized to receive developmental therapy services, adult day care, or non-medical transportation. These services are included in the high support daily rate. ( )

b. Intense support is for those exceptional participants who require intense, twenty-four (24) hour per day supports and supervision. This support level typically requires one-on-one staffing, but requests for a blend of one-on-one and group staffing will be reviewed on a case-by-case basis. Participants authorized at the intense support daily rate will not be authorized to receive developmental therapy services, adult day care, or non-medical transportation. These services are included in the intense support daily rate. To qualify for this level of support, participants must be evaluated to meet one or more of the following criteria: ( )

i. Recent felony convictions or charges for offenses related to the serious injury or harm of another person. These participants must have been placed in a supported living setting directly from incarceration or directly after being diverted from incarceration. ( )

ii. History of predatory sexual offenses and are at high risk to re-offend based on a sexual offender risk assessment completed by an appropriate professional. ( )

iii. Documented, sustained history of serious aggressive behavior showing a pattern of causing harm to themselves or others. The serious aggressive behavior must be such that the threat or use of force on another person makes that person reasonably fear bodily harm. The participant must also have the capability to carry out such a threat. The frequency and intensity of this type of aggressive behavior must require continuous monitoring to prevent injury to themselves or others. ( )

iv. Chronic or acute medical conditions that are so complex or unstable that one-to-one staffing is required to provide frequent interventions and constant monitoring. Without this intervention and monitoring the participant would require placement in a nursing facility, hospital, or ICF/IID with twenty-four (24) hour on-site nursing. Verification of the complex medical condition and the need for this level of service requires medical documentation. ( )

c. Hourly support is for those individuals that do not meet criteria for either high or intense supports or those individuals who qualify for a daily rate but whose needs can be met with less than twenty-four (24) per day support. The combination of hourly supported living, developmental therapy, community supported employment, and adult day care will not be authorized to exceed the maximum set daily amount established by the Department except

when all of the following conditions are met: ( )

i. The participant is eligible to receive the high support daily rate; ( )

ii. Community supported employment is included in the plan and is causing the combination to exceed the daily limit; ( )

iii. There is documentation that the Person-Centered Planning team has explored other options including using lower cost services and natural supports; and ( )

iv. The participant's health and safety needs will be met using hourly services despite having been assessed to qualify for twenty-four (24) hour care. ( )

515. ADULT DEVELOPMENTAL DISABILITY SERVICES: QUALITY ASSURANCE AND IMPROVEMENT.

01. Quality Assurance. Quality Assurance consists of audits and reviews to assure compliance with the Department's rules and regulations. If problems are identified during the review or audit, the provider must implement a corrective action plan within forty-five (45) days after the results are received. The Department may take enforcement actions as described in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 205, if the provider fails to comply with the corrective action plan, any term or provision of the provider agreement, or any applicable state or federal regulation. ( )

02. Quality Improvement. The Department may gather and utilize information from providers to evaluate customer satisfaction, participant satisfaction, participant experience related to home and community-based setting qualities, outcomes monitoring, care management, quality assurance, quality improvement activities, and health and safety. These findings may lead to quality improvement activities to improve provider processes and outcomes for participants. ( )

03. Exception Review. The Department will complete an exception review of plans or addendums requesting services that exceed the assigned budget authorized by the assessor. Requests for these services will be authorized when one (1) of the following conditions are met: ( )

a. Services are needed to assure the health or safety of participants and the services requested on the plan or addendum are required based on medical necessity as defined in Section 012 of these rules. ( )

b. Supported employment services as defined in Section 703 of these rules are needed for the participant to obtain or maintain employment. The request must be submitted on the Department-approved Exception Review Form and is reviewed and approved based on the following: ( )

i. A supported employment service recommendation must be submitted that includes: recommended amount of service, level of support needed, employment goals, and a transition plan. When the participant is transitioned from the Idaho Division of Vocational Rehabilitation (IDVR) services, the recommendation must be completed by IDVR. When a participant is in an established job, the recommendation must be completed by the supported employment agency identified on the plan of service or addendum; ( )

ii. The participant's plan of service was developed by the participant and their person-centered planning team and includes a goal for supported employment services. Prior to the submission of an exception review with an addendum, a comprehensive review of all services on the participant's plan must occur. The participant's combination of services must support the increase or addition of supported employment services; and ( )

iii. An acknowledgment signed by the participant and their legal guardian, if one exists, that additional budget dollars approved to purchase supported employment services must not be reallocated to purchase any other Medicaid service. ( )

04. Concurrent Review. The Department will obtain the necessary information to determine that participants continue to meet eligibility criteria, participant rights are maintained services continue to be clinically

necessary, services continue to be the choice of the participant, services support participant integration, and services constitute appropriate care to warrant continued authorization or need for the service. ( )

05. Abuse, Fraud, or Substandard Care. Reviewers finding suspected abuse, fraud, or substandard care must refer their findings for investigation to the Department and other regulatory or law enforcement agencies for investigation. ( )

516. -- 519. (RESERVED)

**SUB-PART: CHILDREN'S DEVELOPMENTAL DISABILITIES (DD)
HOME AND COMMUNITY-BASED SERVICES (HCBS) STATE PLAN OPTION
(Sections 520-528)**

520. CHILDREN'S DD HCBS STATE PLAN OPTION.
In accordance with Section 1915(i) of the Social Security Act, the Department will pay for home and community-based services provided by individuals or agencies that have entered into a provider agreement with the Department. ( )

521. CHILDREN'S DD HCBS STATE PLAN OPTION: DEFINITIONS.
For the purposes of Sections 520 through 528 of these rules, the following terms are used as defined below. ( )

01. Annual. Every three hundred sixty-five (365) days, except during a leap year which equals three hundred sixty-six (366) days. ( )

02. Community. Natural, integrated environments outside of the participant's home, outside of DDA center-based settings, or at school outside of school hours. ( )

03. Developmental Disabilities Agency (DDA). ( )

a. A type of developmental disabilities facility, as defined in Section 39-4604, Idaho Code, that is non-residential and provides services on an outpatient basis; ( )

b. Certified by the Department to provide services to participants with developmental disabilities; and ( )

c. A business entity, open for business to the general public. ( )

04. Family-Centered Planning Process. A participant-focused planning process directed by the participant or the participant's decision-making authority and facilitated by the paid or non-paid plan developer. The family-centered planning team discusses the participant's strengths, needs, and preferences, including the participant's safety and the safety of those around the participant. This discussion helps the participant or the participant's decision-making authority make informed choices about the services and supports included on the plan of service. ( )

05. Family-Centered Planning Team. The planning group who helps inform the participant about available services to develop the participant's plan of service. This group includes, at a minimum, the participant, the participant's decision-making authority, and the plan developer. The family-centered planning team must include people chosen by the participant and the family. ( )

06. HCBS State Plan Option. The federal authority under Section 1915(i) of the Social Security Act that allows a state to provide through a state plan amendment, medical assistance for home and community-based services for elderly and participants with disabilities who without the provision of services the participants would require institutional level of care. ( )

07. Integration. The process of promoting a lifestyle for participants with developmental disabilities that is as much as possible like that of other citizens of the community, including living in the community and having

access to community resources. A further goal of this process is to enhance the social image and personal competence of participants with developmental disabilities. ( )

08. Level of Support. The amount of services and supports necessary to allow the participant to live independently and safely in the community. ( )

09. Medical, Social, and Developmental Assessment Summary. A form used by the Department or its contractor to gather a participant's medical, social and developmental history and other summary information. It is required for all participants receiving home and community-based services under a plan of service. The information is used in the assessment and authorization of a participant's services. ( )

10. Plan Developer. A paid or non-paid person who, under the direction of the participant or the participant's decision-making authority, is responsible for developing a single plan of service and subsequent addenda. The plan of service must cover all services and supports identified during the family-centered planning process and must meet the HCBS person-centered plan requirements as described in Section 317 of these rules. ( )

11. Plan Monitor. A person who oversees the provision of services on a paid or non-paid basis and is identified on the participant's plan of service. ( )

12. Plan of Service. An initial or annual plan of service, developed by the participant, the participant's decision-making authority, and the family-centered planning team, that identifies all services that were determined through a family-centered planning process. Plan development is required in order to provide DD services to children from birth through seventeen (17) years of age. This plan must be developed in accordance with Sections 316 and 317 of these rules. ( )

13. Practitioner of the Healing Arts, Licensed. A licensed physician, physician assistant, or nurse practitioner. ( )

14. Prior Authorization (PA). A process for determining a participant's eligibility for services and medical necessity prior to the delivery or payment of services as described in Sections 520 through 528 of these rules. ( )

15. Provider Status Review. The written documentation that identifies the participant's progress toward goals defined in the plan of service, and demonstrates the continued need for the service. ( )

16. Right Care. Accepted treatment for defined diagnosis, functional needs and abilities to achieve the desired outcome. The right care is consistent with best practice and continuous quality improvement. ( )

17. Right Place. Services delivered in the most integrated setting in which they normally occur, based on the participant's choice to promote independence. ( )

18. Right Price. The most integrated and least expensive services that are sufficiently intensive to address the participant's needs. The amount is based on the individual's needs for services and supports as identified in the assessment. ( )

19. Right Outcomes. Services based on assessed need that ensure the health and safety of the participant and result in progress, maintenance, or delay or prevention of regression for the participant. ( )

20. Supervisor. An individual responsible for the supervision of DDA staff or independent providers that must meet the intervention specialist or professional qualifications as outlined in IDAPA 16.03.09, "Medicaid Basic Plan Benefits", Section 570. ( )

21. Support Services. Services that provide supervision and assistance to a participant or facilitates integration into the community. ( )

522. CHILDREN'S DD HCBS STATE PLAN OPTION: ELIGIBILITY DETERMINATION.

Final determination of a participant's eligibility will be made by the Department. ( )

01. Initial Eligibility Assessment Developmental Disability Determination. The Department, or its contractor, will determine if a child meets established criteria for a developmental disability by completing the following: ( )

a. Documentation of a participant's developmental disability diagnosis, demonstrated by: ( )

i. A medical assessment that contains medical information that accurately reflects the current status of the participant or establishes categorical eligibility in accordance with Section 66-402(5)(a), Idaho Code; or ( )

ii. The results of psychometric testing, if eligibility for developmental disabilities services is based on intellectual disability and there is no prior testing, or prior testing is inconclusive or invalid. Initial eligibility determinations also require documentation of diagnosis for a participant whose eligibility is based on developmental disabilities other than intellectual disability. ( )

b. An assessment of functional skills that reflects the participant's current functioning. The Department, or its contractor, will administer a functional assessment for use in initial eligibility determination of developmental disability eligibility. Annually, a new functional assessment may be required if the assessor determines that additional documentation is necessary to determine the participant's level of care criteria and must be completed sixty (60) calendar days before the expiration of the current plan of service. ( )

c. Medical, social, and developmental assessment (MSDA) summary. ( )

02. Determination for Children's DD HCBS State Plan Option. The Department, or its contractor, will determine if a child meets the established criteria necessary to receive children's DD HCBS state plan option services by verifying: ( )

a. The participant is birth through seventeen (17) years of age; and ( )

b. The participant has a developmental disability as defined under Sections 500, 501, and 503 these rules and Section 66-402, Idaho Code, and has a demonstrated need for Children's DD HCBS state plan option services; and ( )

c. The participant qualifies for Medicaid under an eligibility group who meets the needs-based criteria of the 1915(i) benefit for children with developmental disabilities and falls within the income requirements as specified in Attachment 2.2-A of the Idaho State Plan under Title XIX. ( )

03. Individualized Budget Methodology.
The following four (4) categories are used when determining individualized budgets for children with developmental disabilities. ( )

a. Children's DD - Level I. Children meeting developmental disabilities criteria. ( )

b. Children's DD - Level II. ( )

i. Children who qualify based on functional limitations when their composite full-scale standard score of less than fifty (50); or ( )

ii. Children who have an overall standard score up to fifty-three (53) when combined with a maladaptive behavior score of greater than one (1) to less than two (2) standard deviations from the mean. ( )

c. Children's DD - Level III. ( )

i. Children who qualify based on functional limitations when their composite full-scale standard score is less than fifty (50); and ( )

ii. Have an autism spectrum disorder diagnosis. ( )

d. Children's DD - Level IV. Children who qualify based on maladaptive behaviors when their maladaptive behavior score is two (2) standard deviations or greater from the mean. ( )

04. Participant Notification of Budget Amount. The Department, or its contractor, will notify each participant of his set budget amount as part of the eligibility determination process. The notification will include how the participant may appeal the set budget amount. ( )

05. Annual Re-Evaluation. Individualized budgets will be re-evaluated annually. At the request of the participant, the Department, or its contractor, will also re-evaluate the set budget amount when there are documented changes that may support placement in a different budget category as outlined in Subsection 522.03 of this rule. ( )

523. CHILDREN'S DD HCBS STATE PLAN OPTION: COVERAGE AND LIMITATIONS.
All children's DD HCBS must be identified on a plan of service developed by the family-centered planning team. The following services must be prior authorized and are reimbursable when provided in accordance with these rules. ( )

01. Respite. Respite provides supervision to the participant on an intermittent or short-term basis because of the need for relief of the primary unpaid caregiver or in response to a family emergency or crisis. Respite may be provided by a DDA or by an independent respite provider. An independent respite provider may be a relative of the participant. Payment for respite does not include room and board. Respite may be provided in the participant's home, the private home of the independent respite provider, a DDA, or in the community. The following limitations apply: ( )

a. Respite must not be provided on a continuous, long-term basis as a daily service that would enable an unpaid caregiver to work. ( )

b. Respite must only be offered to participants living with an unpaid caregiver who requires relief. ( )

c. Respite cannot exceed fourteen (14) consecutive days. ( )

d. Respite must not be provided at the same time other Medicaid services are being provided with the exception of when an unpaid caregiver is receiving family education. ( )

e. The respite provider must not use restraints on participants, other than physical restraints in the case of an emergency. Physical restraints may be used in an emergency to prevent injury to the participant or others and must be documented in the participant's record. ( )

f. When respite is provided as group respite, the following applies: ( )

i. When group respite is center-based, there must be a minimum of one (1) qualified staff providing direct services to every two (2) to six (6) participants. As the number and severity of the participants with functional impairments or behavioral needs increase, the participant ratio must be adjusted accordingly. ( )

ii. When group respite is community-based, there must be a minimum of one (1) qualified staff providing direct services to every two (2) to six (6) participants. As the number and severity of the participants with functional impairments or behavioral needs increase, the participant ratio in the group must be adjusted accordingly. ( )

g. Respite cannot be provided as center-based by an independent respite provider. An independent respite provider may only provide group respite when the following are met: ( )

i. The independent respite provider is a relative; and ( )

ii. The service is delivered in the home of the participants or the independent respite provider. ( )

02. Community-Based Supports. Community-based supports provides assistance to a participant by facilitating the participant's independence and integration into the community. This service provides an opportunity for participants to explore their interests, practice skills learned in other therapeutic environments, and learn through interactions in typical community activities. Integration into the community enables participants to expand their skills related to activities of daily living and reinforces skills to achieve or maintain mobility, sensory-motor, communication, socialization, personal care, relationship building, and participation in leisure and community activities. Community-based supports must: ( )

a. Not supplant services provided in school or therapy, or supplant the role of the primary caregiver; ( )

b. Ensure the participant is involved in age-appropriate activities in environments typical peers access according to the ability of the participant; and ( )

c. Have a minimum of one (1) qualified staff providing direct services for up to six (6) participants when provided as group community-based supports. As the number and severity of the participants with functional impairments or behavioral needs increase, the staff participant ratio must be adjusted accordingly. ( )

03. Family Education. Family education is professional assistance to family members, or others, who participate in caring for the eligible participant to help them better meet the needs of the participant by providing an orientation to developmental disabilities and to educate families on generalized strategies for behavioral modification and intervention techniques specific to the participant's diagnosis. It offers education that is specific to the needs of the family and participant as identified on the plan of service. ( )

a. Family education providers must maintain documentation of the training in the participant's record including the provision of activities outlined in the plan of service. ( )

b. Family education may be provided in a group setting not to exceed five (5) participants' families. ( )

04. Family-Directed Community Supports (FDCS). Families of participants eligible for the children's DD HCBS state plan option may choose to direct their individualized budget rather than receive the traditional services described in Subsections 523.01 through 523.04 of this rule when the participant lives at home with their parent or legal guardian. All services provided under FDCS option must be delivered on a one-to-one basis, must be identified on a plan of service developed by the family-centered planning team, and must be prior authorized. Additional requirements for this option are outlined in Sections 520 through 522, Subsections 523.05-06 524.01-03, 524.07-10, and 525.01, and Section 528, of these rules, and IDAPA 16.03.13, "Consumer-Directed Services." ( )

05. Limitations. ( )

a. Children's DD HCBS state plan option services are limited by the participant's individualized budget amount. ( )

b. Services offered in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," may not be authorized under these rules. ( )

c. Duplication of services cannot be provided. Services are considered duplicate when: ( )

i. An adaptive equipment and support service address the same goal; ( )

ii. Multiple adaptive equipment items address the same goal; ( )

iii. Goals are not separate and unique to each service provided; or ( )

iv. When more than one (1) service is provided at the same time, unless otherwise authorized. ( )

d. For the children's DD HCBS state plan option listed in Subsections 523.01, 523.02, and 523.03 of this rule, the following are excluded for Medicaid payment: ( )

i. Vocational services; ( )

ii. Educational services; and ( )

iii. Recreational services. ( )

06. HCBS Compliance. Providers of children's DD HCBS are responsible for ensuring that they meet the setting quality requirements described in Section 313 of these rules, as applicable, and must comply with associated Department quality assurance activities. The Department may take enforcement actions as described in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 205, if the provider fails to comply with any term or provision of the provider agreement, or any applicable state or federal regulation. ( )

524. CHILDREN'S DD HCBS STATE PLAN OPTION: PLAN OF SERVICE PROCESS.
In collaboration with the participant, the Department must ensure that the participant has one (1) plan of service. This plan of service is developed within the individualized participant budget referred to in Section 522 of these rules and must identify all services. The plan of service must identify services and supports if available outside of Medicaid-funded services that can help the participant meet desired goals. Paid plan development must be provided by the Department, or its contractor, in accordance with Section 316 of these rules. ( )

01. History and Physical. Prior to the development of the plan of service, the plan developer must obtain a current history and physical completed by a practitioner of the healing arts. This is required at least annually or more frequently as determined by the practitioner. For participants in Healthy Connections, the Healthy Connections physician may conduct the history and physical and refer the participant for other evaluations. ( )

02. Plan of Service Development. The plan of service must be developed with the child participant, the participant's decision-making authority, and facilitated by the Department, or its designee. If the participant is unable to attend the family-centered planning meeting, the plan of service must contain documentation to justify the participant's absence. With the decision-making authority's consent, the family-centered planning team may include other family members or participants who are significant to the participant. ( )

03. Requirements for Collaboration. Providers of children's DD HCBS must coordinate with the family-centered planning team as specified on the plan of service. ( )

04. Plan Monitoring. The family-centered planning team must identify the frequency of monitoring, which must be at least every six (6) months and document the plan monitor's name along with the monitoring frequency on the plan. The plan developer is considered the plan monitor and must meet face-to-face with the participant and the participant's decision-making authority at least annually. Plan monitoring includes reviewing the plan of service with the participant and the participant's decision-making authority to identify the current status of services, any barriers to services, and any necessary changes to the plan of service. ( )

05. Provider Status Reviews. The service providers identified in Section 526 of these rules must report the participant's progress toward goals to the plan monitor. The provider must complete a six (6) month and annual provider status review. The six (6) month status review must be submitted thirty (30) days prior to the six (6) month date listed on the plan of service. The annual provider status review must be submitted to the plan monitor forty-five (45) calendar days prior to the expiration of the existing plan of service. ( )

06. Addendum to the Plan of Service. A plan of service may be adjusted during the year with an addendum to the plan and these adjustments must be based on changes in a participant's need and requested by the parent or legal guardian. Adjustment of the plan of service requires the decision-making authority's signature and

prior authorization by the Department. The Department will distribute the addendum to the providers involved in the addendum's implementation. Upon receipt by the provider, the addendum must be reviewed, signed, and returned to the Department, with a copy maintained in the participant's record. ( )

07. Annual Reauthorization of Services. A participant's plan of service must be reauthorized annually. The Department must review and authorize the new plan of service prior to the expiration of the current plan. ( )

08. Annual Eligibility Determination Results. An annual determination must be completed in accordance with Section 522 of these rules. ( )

09. Adjustments to the Annual Budget and Services. The annual budget may be adjusted when there are documented changes that may support placement in a different budget category as identified in Section 522 of these rules. Services may be adjusted at any time during the plan year. ( )

10. Reapplication After a Lapse in Service. For participants who are re-applying for service, the assessor must evaluate whether assessments are current and accurately describe the status of the participant. ( )

525. CHILDREN'S DD HCBS STATE PLAN OPTION: PROCEDURAL REQUIREMENTS.

01. Requirements for Prior Authorization. Prior authorization is to ensure the provision of the right care, in the right place, at the right price, and with the right outcomes in order to enhance health and safety, and to promote participants' rights, self-determination, and independence. Prior authorization is intended to help ensure the provision of necessary and appropriate services and supports. Services are reimbursable if they are identified on the authorized plan of service and are consistent with rules for HCBS as described in Sections 310 through 313 and 316 and 317 of these rules, and for the specific services included on the plan. Delivery of each service identified on the plan of service cannot be initiated until the plan has been signed by the parent or participant's decision-making authority, the provider responsible for service provision, and has been authorized by the Department. ( )

02. Requirements for Supervision. All children’s DD HCBS provided by a DDA or independent provider must be supervised. The supervisor must meet the intervention specialist or professional qualifications as outlined in IDAPA 16.03.09, “Medicaid Basic Plan Benefits,” Section 575, “Children's Habilitation Intervention Services.” The observation and review of the direct services must be performed by all staff on at least a monthly basis, or more often as necessary, to ensure staff demonstrate the necessary skills to correctly provide the services as defined in this rule set. ( )

03. Requirements for Quality Assurance. Providers of DD HCBS state plan option must demonstrate high quality of services through an internal quality assurance review process. ( )

04. General Requirements for Program Documentation. The provider must maintain records for each participant served. Program documentation must be maintained by the independent provider or DDA in accordance with IDAPA 16.05.07, “Investigation and Enforcement of Fraud, Abuse, and Misconduct,” Section 101. Failure to maintain such documentation will result in the recoupment of funds paid for undocumented services. For each participant, the following program documentation is required: ( )

a. Date and time of visit; ( )

b. Support services provided during the visit; ( )

c. A summary of session or services provided; ( )

d. Length of visit, including time in and time out; ( )

e. Location of service; and ( )

f. Signature of the individual providing the service and date signed. ( )

05. Community-Based Supports Documentation. In addition to the general requirements listed in Subsection 525.04 of this rule, the supervisor must complete at a minimum, six (6) month and annual provider status reviews for community-based support services provided. These provider status reviews must be completed more frequently when required on the plan of service and must: ( )

a. Be submitted to the plan monitor; and ( )

b. Be submitted on Department-approved forms. ( )

06. Family Education Documentation. In addition to the general requirements listed in Subsection 525.04 of this rule, the DDA or independent provider must survey the parent or legal guardian's satisfaction of the service immediately following a family education session. ( )

526. CHILDREN'S DD HCBS STATE PLAN OPTION: PROVIDER QUALIFICATIONS AND DUTIES. All providers of children's DD HCBS state plan option must have a valid provider agreement with the Department. Performance under this agreement will be monitored by the Department. ( )

01. Respite. Respite may be provided by an agency that is certified as a DDA or by an independent respite provider. An independent respite provider is an individual who has entered into a provider agreement with the Department. Providers of respite must meet the following minimum qualifications: ( )

a. Be at least sixteen (16) years of age when employed by a DDA; or ( )

b. Be at least eighteen (18) years of age and be a high school graduate, or have a GED, to act as an independent respite provider; and ( )

c. Have received instructions in the needs of the participant who will be provided the service; ( )

d. Demonstrate the ability to provide services according to a plan of service; ( )

e. Satisfactorily complete a criminal history background check in accordance with Section 009 of these rules and IDAPA 16.05.06, "Criminal History and Background Checks,"; and ( )

f. When employed by a DDA, be certified in CPR and first aid in accordance with the general training requirements under IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)." Independent respite providers must be certified in CPR and first aid prior to delivering services and must maintain current certification thereafter. ( )

02. Community-Based Support. Community-based supports may be provided by a DDA or an independent provider. An independent provider is an individual who has entered into a provider agreement with the Department. Providers of community-based supports must meet the following minimum qualifications: ( )

a. Be at least eighteen (18) years of age; ( )

b. Have received instructions in the needs of the participant who will be provided the service; ( )

c. Demonstrate the ability to provide services according to a plan of service; ( )

d. Have six (6) months supervised experience working with children with developmental disabilities. This can be achieved in the following ways: ( )

i. Have previous work experience gained through paid employment, university practicum experience, or internship; or ( )

ii. Have on-the-job supervised experience gained through employment with increased supervision. Experience is gained by completing at least six (6) hours of job shadowing prior to the delivery of direct support services, and a minimum of weekly face-to-face supervision with the supervisor for a period of six (6) months while delivering services. ( )

iii. For individuals providing community-based supports to children birth to age three (3), the six (6) months of documented experience must be with infants, toddlers, or children birth to age three (3) years of age with developmental delays or disabilities. ( )

e. Complete competency coursework approved by the Department to demonstrate competencies related to the requirements to provide community-based supports. ( )

f. Satisfactorily complete a criminal history background check in accordance with Section 009 of these rules and IDAPA 16.05.06, "Criminal History and Background Checks,"; and ( )

g. When employed by a DDA, be certified in CPR and first aid in accordance with the general training requirements under IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)." Independent providers must be certified in CPR and first aid prior to delivering services and must maintain current certification thereafter. ( )

03. Family Education. Family Education can be provided by an agency certified as a DDA or an individual who holds an independent habilitation intervention provider agreement with the Department and meets the intervention specialist or professional qualifications as outlined in IDAPA 16.03.09, "Medicaid Basic Plan Benefits". ( )

527. CHILDREN'S DD HCBS STATE PLAN OPTION: PROVIDER REIMBURSEMENT.
Providers are reimbursed on a fee-for-service basis for services identified on the participant's plan of service and within the participant's individualized budget. The Department will monitor the budget setting methodology on an ongoing basis to ensure that participant needs are accurately reflected in the methodology. ( )

01. Claim Forms. Provider claims for payment will be submitted on claim forms provided or approved by the Department. Billing instructions will be provided by the Department. ( )

02. Rates. The reimbursement rates calculated for children's HCBS 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 transportation. ( )

528. CHILDREN'S DD HCBS STATE PLAN OPTION: DEPARTMENT'S QUALITY ASSURANCE AND IMPROVEMENT PROCESSES.
Quality assurance activities will include the observation of service delivery with participants, review of participant records, and complete satisfaction interviews. All providers of support services must grant the Department immediate access to all information required to review compliance with these rules. ( )

01. Quality Assurance. The Department will conduct quality assurance by collaborating with providers to complete audits and reviews to ensure compliance with the Department's rules and regulations. These findings may lead to quality improvement activities to enhance provider processes and outcomes for the child. If problems are identified that impact health and safety or are not resolved through quality improvement activities, implementation of a corrective action process may occur. ( )

02. Quality Improvement. Quality improvement consists of the Department working with the provider to resolve identified issues and enhance services provided. Quality improvement activities must include: ( )

a. Consultation; ( )

b. Technical assistance and recommendations; or ( )

c. Corrective Action. ( )

03. Corrective Action. Corrective action is a formal process used by the Department to address significant, ongoing, or unresolved deficient practice identified during the review process as provided in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 205, and includes: ( )

a. Issuance of a corrective action plan; ( )

b. Referral to Medicaid Program Integrity Unit; or ( )

c. Action against a provider agreement. ( )

529. -- 579. (RESERVED)

580. INTERMEDIATE CARE FACILITIES FOR PERSONS WITH INTELLECTUAL DISABILITIES (ICF/IID).
The Department will pay for services in an ICF/IID. An ICF/IID is an intermediate care facility whose primary purpose is to provide habilitative services and maintain optimal health status for individuals with intellectually disabilities or persons with related conditions. ( )

581. ICF/IID: ELIGIBILITY.
Entitlement to medical assistance participation in the cost of long-term care exists when the individual is eligible for medical assistance and the Department has determined that the individual meets the criteria for ICF/IID services. Entitlement will be determined prior to authorization of payment for such care for an individual who is either a participant of or an applicant for medical assistance. ( )

582. ICF/IID: DETERMINATION OF ENTITLEMENT FOR MEDICAID PAYMENT.
Applications for Medicaid payment of an individual with an intellectual disability or related condition, in an ICF/IID will be through the Department. All required information necessary for a medical entitlement determination must be submitted to the Department before a determination and approval for payment is made. The effective date of Medicaid payment will be no earlier than the physician's signed and dated certification for ICF/IID level of care. ( )

583. ICF/IID: INFORMATION REQUIRED FOR DETERMINATION.
Required information includes a medical evaluation, an initial plan of care, social evaluation, psychological evaluation, and initial plan of care by ICF/IID. ( )

01. Medical Evaluation. A complete medical evaluation, current within ninety (90) days of admission, signed and dated by the physician, an electronic physician's signature is permissible, that includes: ( )

a. Diagnosis (primary and secondary); ( )

b. Medical findings and history; ( )

c. Mental and physical functional capacity; ( )

d. Prognosis; mobility status; and ( )

e. A statement by the physician certifying the level of care needed as ICF/IID for a specific participant. ( )

02. Initial Plan of Care by Physicians. An initial plan of care, current within ninety (90) days of admission and signed and dated by the physician that includes: ( )

a. Orders for medications and treatments; ( )

b. Diet; and ( )

c. Professional rehabilitative and restorative services and special procedures, where appropriate. ( )

03. Social Evaluation. A social evaluation, current within ninety (90) days of admission, that includes : ( )

a. Condition at birth; ( )

b. Age at onset of condition; ( )

c. Summary of functional status, such as skills level, activities of daily living; and ( )

d. Family social information. ( )

04. Psychological Evaluation. A psychological evaluation conducted by a psychologist current within ninety (90) days of admission, that includes: ( )

a. Diagnosis; ( )

b. Summary of developmental findings. Instead of a psychological, infants under three (3) years of age may be evaluated by a developmental disability specialist utilizing the developmental milestones congruent with the age of the infant; ( )

c. Mental and physical functioning capacity; and ( )

d. Recommendation concerning placement and primary need for active treatment. ( )

05. Initial Plan of Care by ICF/IID. An initial plan of care developed by the admitting ICF/IID. ( )

584. ICF/IID: CRITERIA FOR DETERMINING ELIGIBILITY.
Individuals who have intellectual disabilities or a related condition as defined in Section 66-402, Idaho Code, and Sections 500 through 503 of these rules, must be determined by an interdisciplinary team to need the consistent, intense, frequent services including active treatment provided in an ICF/IID or receive services under one of Idaho's programs to assist individuals with intellectual disabilities or a related condition to avoid institutionalization in an ICF/IID, as indicated in Section 584.02 of these rules. To meet Title XIX and Title XXI entitlement for ICF/IID level of care and be eligible for services provided in an ICF/IID. The following must be met in Subsections 584.01 through 584.08 of these rules. ( )

01. Diagnosis. Persons must be financially eligible for Medicaid; must have a primary diagnosis of being intellectually disabled or have a related condition defined in Section 66-402, Idaho Code and Section 500 through 506 of these rules; and persons must qualify based on functional assessment, maladaptive behavior, a combination of both, or medical condition. ( )

02. Active Treatment. Persons living in an ICF/IID, must require and receive intensive inpatient active treatment as defined in Section 010 of these rules, to advance or maintain their functional level. ( )

a. Active treatment does not include: parenting activities directed toward the acquisition of age-appropriate developmental milestones; services to maintain generally independent individuals who are able to function with little supervision or in the absence of a continuous active treatment program or services; interventions that address age-appropriate limitations; or general supervision of children whose age is such that such supervision is required by all children of the same age. ( )

b. The following criteria/components will be utilized when evaluating the need for active treatment: ( )

i. Evaluation. Complete medical, social, and psychological evaluations. These evaluations must clearly indicate the functional level of the participant and the interventions needed; and ( )

ii. Plan of Care. A written plan of care which sets forth initial goals and objectives, specifies further evaluations to be done, and training programs to be developed. ( )

03. Require Certain Level of Care. Persons living in the community must require the level of care provided in an ICF/IID, including active treatment, and in the absence of available intensive alternative services in the community, would require institutionalization, other than services in an institution for mental disease, in the near future. ( )

04. Care for a Child. The department may provide Medicaid to a child eighteen (18) years of age or younger, who would be eligible for Medicaid if they were in a medical institution and who are receiving, while living at home, medical care that would be provided in a medical institution, if the Department determines that the child requires the level of care provided in an ICF/IID. ( )

05. Functional Limitations. ( )

a. Persons Sixteen Years of Age or Older. Persons sixteen (16) years of age or older may qualify based on their functional skills. Persons with an age equivalency composite score of eight (8) years and zero (0) months or less on a full scale functional assessment using a Department-approved assessment tool would qualify; or ( )

b. Persons Under Sixteen Years of Age. Persons under sixteen (16) years of age qualify if their composite full scale functional age equivalency is less than fifty percent (50%) of their chronological age; or ( )

06. Maladaptive Behavior. ( )

a. A Minus Twenty-Two (-22) or Below Score. Individuals may qualify for ICF/IID level of care based on maladaptive behavior. Persons will be eligible if their General Maladaptive Index on a Department-approved assessment tool is minus twenty-two (-22) or less; or ( )

b. Above a Minus Twenty-Two (-22) Score. Individuals who score above minus twenty-two (-22) may qualify for ICF/IID level of care if they engage in aggressive or self injurious behaviors of such intensity that the behavior seriously endangers the safety of the individual or others, the behavior is directly related to developmental disability, and the person requires active treatment to control or decrease the behavior; or ( )

07. Combination Functional and Maladaptive Behaviors. Persons may qualify for ICF/IID level of care if they display a combination of criteria as described in Subsections 584.05 and 584.06 of these rules at a level that is significant and it can been determined they are in need of the level of services provided in an ICF/IID, including active treatment services. Significance would be defined as: ( )

a. Persons Sixteen Years of Age or Older. For persons sixteen (16) years of age or older, an overall age equivalency up to eight and one-half (8 1/2) years is significant in the area of functionality when combined with a General Maladaptive Index on a Department-approved assessment tool up to minus seventeen (-17), minus twenty-two (-22) inclusive; or ( )

b. Persons Under Sixteen Years of Age. For persons under sixteen (16) years of age, an overall age equivalency up to fifty-three percent (53%) of their chronological age is considered significant when combined with a General Maladaptive Index on a Department-approved assessment tool between minus seventeen (-17), and minus twenty-one (-21) inclusive; or ( )

08. Medical Condition. Individuals may meet ICF/IID level of care based on their medical condition if the medical condition significantly affects their functional level/capabilities and it can be determined that they are in need of the level of services provided in an ICF/IID, including active treatment services. ( )

09. Annual Redetermination for ICF/IID Level of Care for Community Services. The BLTC staff

will redetermine the participant's continuing need for ICF/IID level of care for community services. Documentation will consist of the completion of a redetermination statement on the "Level of Care" form HW0083. Such documentation will be accomplished no later than every three hundred sixty-five (365) days from the most recent determination. ( )

a. Home Care for Certain Disabled Children (HCDC). Persons receiving HCDC Medicaid services through ICF/IID eligibility, will receive services until the end of the month in which the redetermination was made. These individuals must receive ten (10) days notification of termination of services. If the redetermination is made less than ten (10) days from the end of the month, payment continues until the end of the following month. ( )

b. Developmentally Disabled Waiver. Individuals receiving developmentally disabled waiver services will have thirty (30) days from the time of the determination to transition to other community supports. ( )

585. ICF/IID: COVERAGE REQUIREMENTS AND LIMITATIONS.
The minimum content of care and services for ICF/IID must include the services listed below and social and recreational activities. ( )

01. Care and Services Provided. ( )

a. The minimum content of care and services for ICF/IID participants must include the following: ( )

i. Room and board; and ( )

ii. Bed and bathroom linens; and ( )

iii. Nursing care, including special feeding if needed; and ( )

iv. Personal services; and ( )

v. Supervision as required by the nature of the participant's illness; and ( )

vi. Special diets as prescribed by a participant's physician; and ( )

vii. All common medicine chest supplies that do not require a physician's prescription including mouthwashes, analgesics, laxatives, emollients, burn ointments, first aid cream, protective creams and liquids, cough and cold preparations, and simple eye preparations; and ( )

viii. Dressings; and ( )

ix. Administration of intravenous, subcutaneous, or intramuscular injections and infusions, enemas, catheters, bladder irrigations, and oxygen; and ( )

x. Application or administration of all drugs; and ( )

xi. All medical supplies including gauzes, bandages, tapes, compresses, cottons, sponges, hot water bags, ice bags, disposable syringes, thermometers, cellucotton or any other type of pads used to save labor or linen, and disposable gloves; and ( )

xii. Social and recreational activities; and ( )

xiii. Items that are utilized by individual participants but that are reusable and expected to be available, such as bed rails, canes, crutches, walkers, wheel chairs, traction equipment, and other durable medical equipment. ( )

02. Wheelchairs. DHW authorized purchases of specialized wheelchair and seating systems, and any authorized repairs related to the seating system, that are paid to a medical vendor directly by DHW will not be

included in the content of care of ICFs/IID. The specialized wheelchairs and seating systems must be designed to fit the needs of a specific ICF/IID resident and cannot be altered to fit another participant cost effectively. ( )

586. ICF/IID: PROCEDURAL RESPONSIBILITIES.
Each long term care facility administrator, or their authorized representative, must report to the appropriate Field Office within three (3) working days of the date the facility has knowledge of the following. ( )

01. Readmissions or Discharges. Any readmission or discharge of a participant, and any temporary absence of a participant due to hospitalization or therapeutic home visit. ( )

02. Changes to Participant's Income. Any changes in the amount of a participant's income. ( )

03. Participant's Account Exceeds Limitations. When a participant's account has exceed the following amount; ( )

a. For a single individual, one thousand eight hundred dollars ($1,800);or ( )

b. For a married couple, two thousand eight hundred dollars ($2,800). ( )

04. Other Financial Information for Participant. Other information about a participant's finances that may potentially affect eligibility for medical assistance. ( )

05. Annual Recertification Requirement. It is the responsibility of the ICF/IID to assure that the recertification is accomplished by the physician, physician's assistant or nurse practitioner no later than every three hundred sixty-five (365) days. ( )

a. Should the Medicaid Program receive a financial penalty from the Department of Health and Human Services due to the lack of appropriate recertification on the part of an ICF/IID, then such amount of money will be withheld from facility payments for services provided to Medicaid participants. For audit purposes, such financial losses are not reimbursable as a reasonable cost of participant care. Such losses cannot be made the financial responsibility of the Department's participant. ( )

b. Persons living in an ICF/IID will be transitioned to a less restrictive environment within thirty (30) days of the determination that the participant does not meet ICF/IID level of care. ( )

06. Level of Care Change. If during an on-site review of a resident's medical record and an interview with or observation of the resident an IOC/UC reviewer determines there is a change in the resident's status and the resident no longer meets criteria for ICF/IID care, the tentative decision is: ( )

a. Discussed with the facility administrator or the director of nursing services; ( )

b. The resident's physician is notified of the tentative decision; ( )

c. The case is submitted to the Regional Review Committee for a final decision; and ( )

d. The effective date of loss of payment will be no earlier than ten (10) days following the date of mailing of notice to the participant by the Eligibility Examiner. ( )

07. Appeal of Determinations. The resident or their representative may appeal the decisions under IDAPA 16.05.03, “Contested Case Proceedings and Declaratory Rulings.” ( )

08. Supplemental On-Site Visit. The Regional Nurse Reviewer may conduct utilization control supplemental on-site visits in an ICF/IID when indicated. Some indications may be: ( )

a. Follow-up activities; ( )

b. A verification of a participant's appropriateness of placement or services; and ( )

c. Conduct complaint investigations at the Department's request. ( )

09. Determination of Entitlement to Long-Term Care. Entitlement to medical assistance participation in the cost of long-term care exists when the individual is eligible for medical assistance and the Regional Nurse Reviewer has determined that the individual meets the criteria for ICF/IID care and services. Entitlement will be determined prior to authorization of payment for such care for an individual who is either a participant of or an applicant for medical assistance. ( )

a. The criteria for determining a Participant's need for intermediate care for the intellectually disabled is described in Sections 583 and 584 of these rules. In addition, the IOC/UC nurse must determine whether a Participant's needs could be met by non-participant inpatient alternatives including remaining in an independent living arrangement or residing in a room and board situation. ( )

b. The participant can select any certified facility to provide the care required. ( )

c. The final decision as to the level of care required by a participant must be made by the IOC/UC Nurse. ( )

d. The final decision as to the need for DD or MI active treatment will be made by the appropriate Department staff as a result of the Level II screening process. ( )

e. No payment will be made by the Department on behalf of any eligible participant to any long-term care facility that, in the judgment of the Inspection Of Care/Utilization Control Team is admitting individuals for care or services that are beyond the facility's licensed level of care or capability. ( )

10. Authorization of Long-Term Care Payment. If it has been determined that a person eligible for medical assistance is entitled to medical assistance participation in the cost of long-term care, and that the facility selected by the participant is licensed and certified to provide the level of care the participant requires, the Field Office will forward to such facility an "Authorization for Long-Term Care Payment" form HW 0459. ( )

587. ICF/IID: PROVIDER QUALIFICATIONS AND DUTIES.

01. Provider Application and Certification. A facility must apply to participate as an ICF/IID facility. ( )

02. Licensure and Certification. ( )

a. Upon receipt of an application from a facility, the Licensing and Certification Agency will conduct a survey to determine the facility's compliance with certification standards for the type of care the facility proposes to provide to participants. ( )

b. If the Licensing and Certification Agency determines that a facility meets Title XIX certification standards for ICF/IID, the Department will certify to the appropriate branch of government that the facility meets the standards for ICF/IID types of care. ( )

c. Upon receipt of the certification from the Licensing and Certification Agency, the Bureau may enter into a provider agreement with the long-term care facility. ( )

d. After the provider agreement has been executed by the Facility Administrator and by the bureau chief, one (1) copy will be sent by certified mail to the facility and the original is to be retained by the Bureau. ( )

03. Direct Care Staff. Direct Care staff in an ICF/IID are defined as the present on-duty staff calculated over all shifts in a twenty-four (24) hour period for each defined residential living unit. Direct care staff in an ICF/IID include those employees whose primary duties include the provision of hands-on, face-to-face contact with the participants of the facility. This includes both regular and live-in/sleep-over staff. It excludes professionals

such as psychologists, nurses, and others whose primary job duties are not the provision of direct care, as well as managers/ supervisors who are responsible for the supervision of staff. ( )

04. Direct Care Staffing Levels. The reasonable level of direct care staffing provided to a participant in an ICF/IID setting will be dependent upon the level of involvement and the need for services and supports of the participant as determined by the Department. Level of involvement relates to the severity of a participant's intellectual disability. Those levels, in decreasing level of severity, are: profound, severe, moderate, and mild. Staffing levels will be subject to the following constraints: ( )

a. Direct care staffing for a severely and profoundly intellectually disabled participant residing in an ICF/IID must be a maximum of sixty-eight point twenty five (68.25) hours per week. ( )

b. Direct care staffing for a moderately intellectually disabled participant residing in an ICF/IID must be limited to a maximum of fifty-four point six (54.6) hours per week. ( )

c. Direct care staffing for a mildly intellectually disabled participant residing in an ICF/IID must be limited to a maximum of thirty four point one two five (34.125) hours per week. ( )

05. Direct Care Staff Hours. The annual sum total level of allowable direct care staff hours for each residential living unit will be determined in the aggregate as the sum total of the level of staffing allowable for each resident residing in that residential living unit as determined in Subsection 587.04 of these rules. ( )

06. Phase-In Period. If enactment of Subsection 587.04 of these rules requires a facility to reduce its level of direct care staffing, a six (6) month phase-in period will be allowed from the date of the enactment of this section, without any resulting disallowances. Should disallowances result, the hourly rate of direct care staff used in determining disallowances will be the weighted average of the hourly rates paid to a facility's direct care staff, plus the associated benefits, at the end of the phase-in period. ( )

07. Exceptions. Should a provider be able to show convincing evidence documenting that the annual aggregate direct care hours as allowed under this section will compromise their ability to supply adequate care to the participants, as required by federal regulations and state rules, within an ICF/IID residential living unit and that other less costly options would not alleviate the situation, the Department will approve an additional amount of direct care hours sufficient to meet the extraordinary needs. This adjustment will only be available up through September 30, 1996. ( )

588. ICF/IID: PROVIDER REIMBURSEMENT.

01. Payment Methodology. ICF/IID facilities will be reimbursed in accordance with the methodology listed in Sections 588 through 633 of these rules. ( )

02. Date of Discharge. Payment by the Department for the cost of ICF/IID care is to include the date of the participant’s discharge only if the discharge occurred after 3 p.m. and is not discharged to a related provider. If a Medicaid patient dies in an ICF/IID, their date of death is covered regardless of the time of occurrence. If an admission and a discharge occur on the same date, then one (1) day of care will be deemed to exist. ( )

589. ICF/IID: REASONABLE COST PRINCIPLES.

To be allowable, costs must be reasonable, ordinary, necessary and related to patient care. It will be expected that providers will incur costs in such a manner that economical and efficient delivery of quality health care to beneficiaries will result. ( )

01. Application of Reasonable Cost Principles. ( )

a. Reasonable costs of any services are determined in accordance with rules found in the Provider Reimbursement Manual (PRM), Sections 100 through 2600, as modified by the exceptions contained herein, is used to identify cost items to be included on Idaho's Uniform Cost Report. ( )

i. Reasonable cost takes into account both direct and indirect costs of providers of services, including

normal standby costs. ( )

ii. The objectives of these methods are that: first, the costs with respect to individuals covered by the program will not be borne by others not so covered. Second, the costs with respect to individuals not covered will not be paid by the program. ( )

b. Costs may vary from one institution to another because of a variety of factors. It is the intent of the program that providers will be reimbursed the actual operating costs of providing high quality care, unless such costs exceed the applicable maximum base rate developed pursuant to provisions of Title 56, Chapter 1, Idaho Code, or are unallowable by application of promulgated regulation. ( )

c. Implicit in the intention that actual operating costs be paid to the extent they are reasonable is the expectation that the provider seeks to minimize its costs and that its actual operating costs do not exceed what a prudent and cost-conscious buyer pays for a given item or service. ( )

d. If costs are determined to exceed the level that such buyers incur, in the absence of clear evidence that the higher costs were unavoidable, the excess costs are not reimbursable. ( )

02. Costs Related to Patient Care. These include all necessary and proper costs in developing and maintaining the operation of patient care facilities. Necessary and proper costs related to patient care are usually costs that are common and accepted occurrences in the field of the provider's activity. They include costs such as depreciation, interest expense, nursing costs, maintenance costs, administrative costs, costs of employee pension plans, normal standby costs, and others. ( )

03. Costs Not Related to Patient Care. Costs not related to patient care are costs that are not appropriate or necessary and proper in developing and maintaining the operation of patient care facilities and activities. Such costs are not allowable in computing reimbursable costs. ( )

04. Form and Substance. Substance of transactions will prevail over the form. Financial transactions will be disallowed to the extent that the substance of the transaction fails to meet reasonable cost principles or comply with rules and policy. ( )

590. ICF/IID: ALLOWABLE COSTS.
The following definitions and explanations apply to allowable costs: ( )

01. Accounts Collection. The costs related to the collection of past due program related accounts, such as legal and bill collection fees, are allowable. ( )

02. Auto and Travel Expense. Maintenance and operating costs of a vehicle used for patient care purposes and travel expense related to patient care are reimbursable. The allowance for mileage reimbursement cannot exceed the amount determined reasonable by the Internal Revenue Service for the period being reported. Meal reimbursement is limited to the amount that would be allowed by the state for a state employee. ( )

03. Bad Debts. Payments for efforts to collect past due Title XIX and Title XXI accounts are reimbursable. This may include the fees for lawyers and collection agencies. Other allowances for bad debt and bad debt write-off are not allowable. However, Title XIX and Title XXI coinsurance amounts are one hundred percent (100%) reimbursable as provided in PRM, Section 300. ( )

04. Bank and Finance Charges. Charges for routine maintenance of accounts are allowable. Penalties for late payments, overdrafts, etc., are not allowable. ( )

05. Compensation of Owners. An owner may receive reasonable compensation for services subject to the limitations in this chapter, to the extent the services are actually performed, documented, reasonable, ordinary, necessary, and related to patient care. Allowable compensation cannot exceed the amount necessary to attract assistance from parties not related to the owner to perform the same services. The nature and extent of services must be supported by adequate documentation including hours performing the services. Where an average industry wide rate for a particular function can be determined, reported allowable owner compensation cannot exceed the average

rate. Compensation to owners, or persons related to owners, providing administrative services is further limited by provisions in Section 597 of these rules. In determining the reasonableness of compensation for services paid to an owner or a person related to an owner, compensation is the total of all benefits or remuneration paid to or primarily for the benefit of the owner regardless of form or characterization. It includes, but is not limited to, the following: ( )

a. Salaries wages, bonuses and benefits that are paid or are accrued and paid for the reporting period within one (1) month of the close of the reporting period. ( )

b. Supplies and services provided for the owner's personal use. ( )

c. Compensation paid by the facility to employees for the sole benefit of the owner. ( )

d. Fees for consultants, directors, or any other fees paid regardless of the label. ( )

e. Keyman life insurance. ( )

f. Living expenses, including those paid for related persons. ( )

06. Contracted Service. All services that are received under contract arrangements are reimbursable to the extent that they are related to patient care or the sound conduct and operation of the facility. ( )

07. Depreciation. Depreciation on buildings and equipment is an allowable property expense subject to Section 630 of these rules. Depreciation expense is not allowable for land. Lease-hold improvements may be amortized. Generally, depreciation and amortization must be calculated on a straight line basis and prorated over the estimated useful life of the asset. ( )

08. Dues, Licenses and Subscriptions. Subscriptions to periodicals related to patient care and for general patient use are allowable. Fees for professional and business licenses related to the operation of the facility are allowable. Dues, tuition, and educational fees to promote quality health care services are allowable when the provisions of PRM, Section 400, are met. ( )

09. Employee Benefits. Employee benefits including health insurance, vacation, and sick pay are allowable to the extent of employer participation. See PRM, Chapter 21 for specifics. ( )

10. Employee Recruitment. Costs of advertising for new employees, including applicable entertainment costs, are allowable. ( )

11. Entertainment Costs Related to Patient Care. Entertainment costs related to patient care are allowable only when documentation is provided naming the individuals and stating the specific purpose of the entertainment. ( )

12. Food. Costs of raw food are allowable. The provider is only reimbursed for costs of food purchased for patients. Costs for nonpatient meals are nonreimbursable. If the costs for nonpatient meals cannot be identified, the revenues from these meals are used to offset the costs of the raw food. ( )

13. Home Office Costs. Reasonable costs allocated by related entities for home office services are allowable in their applicable cost centers. ( )

14. Insurance. Premiums for insurance on assets or for liability purposes, including vehicles, are allowable to the extent that they are related to patient care. ( )

15. Interest. Interest on working capital loans is an allowable administrative expense. When property is reimbursed based on cost, interest on related debt is allowable. However, interest payable to related entities is not normally an allowable expense. Penalties are not allowable. ( )

16. Lease or Rental Payments. Payments for the property cost of the lease or rental of land, buildings,

and equipment are allowable according to Medicare reasonable cost principles when property is reimbursed based on cost for leases entered into before March 30, 1981. Such leases entered into on or after March 30, 1981, will be reimbursed in the same manner as an owned asset. The cost of leases related to home offices and ICF/IID day treatment services will not be reported as property costs and will be allowable based on reasonable cost principles subject to other limitations contained herein. ( )

17. Malpractice or Public Liability Insurance. Premiums for malpractice and public liability insurance must be reported as administrative costs. ( )

18. Payroll Taxes. The employer's portion of payroll taxes is reimbursable. ( )

19. Property Costs. Property costs related to patient care are allowable subject to other provisions of this chapter. Property taxes and reasonable property insurance are allowable for all facilities. For ICFs/IID, the property rental rate is paid as described in Section 630 of these rules. ( )

a. Amortization of leasehold improvements will be included in property costs. ( )

i. Straight line depreciation on fixed assets is included in property costs. ( )

ii. Depreciation of moveable equipment is an allowable property cost. ( )

b. Interest costs related to the purchase of land, buildings, fixtures or equipment related to patient care are allowable property costs only when the interest costs are payable to unrelated entities. ( )

20. Property Insurance. Property insurance per licensed bed is limited to no more than two (2) standard deviations above the mean of the most recently reported property insurance costs, as used for rate setting purposes, per licensed bed of all facilities in the reimbursement class of the end of a facility's fiscal year. ( )

21. Repairs and Maintenance. Costs of maintenance and minor repairs are allowable when related to the provision of patient care. ( )

22. Salaries. Salaries and wages of all employees engaged in patient care activities or operation and maintenance are allowable costs. However, non-nursing home wages are not an allowable cost. ( )

23. Supplies. Cost of supplies used in patient care or providing services related to patient care is allowable. ( )

24. Taxes. The cost of property taxes on assets used in providing patient care are allowable. Other taxes are allowable costs as provided in the PRM, Chapter 21. Tax penalties are nonallowable costs. ( )

591. ICF/IID: NONALLOWABLE COSTS.
The following definitions and explanations apply to nonallowable costs: ( )

01. Accelerated Depreciation. Depreciation in excess of calculated straight line depreciation, except as otherwise provided is nonallowable. ( )

02. Acquisitions. Costs of corporate acquisitions, such as purchase of corporate stock as an investment, are nonallowable. ( )

03. Charity Allowances. Cost of free care or discounted services are nonallowable. ( )

04. Consultant Fees. Costs related to the payment of consultant fees in excess of the lowest rate available to a facility are nonallowable. It is the provider's responsibility to make efforts to obtain the lowest rate available to that facility. The efforts may include personally contacting possible consultants or advertising. The lowest rate available to a facility is the lower of the actual rate paid by the facility or the lowest rate available to the facility, as determined by departmental inquiry directly to various consultants. Costs in excess of the lowest rate available will be disallowed effective thirty (30) days after a facility is notified, unless the provider shows by clear

and convincing evidence it would have been unable to comply with state and federal standards had the lowest rate consultant been retained or that it tried to but was unable to retain the lowest rate consultant. This subsection in no way limits the Department's ability to disallow excessive consultant costs under other sections of this chapter, such as Section 589 or 595 of these rules, when applicable. ( )

05. Fees. Franchise fees are nonallowable, see PRM, Section 2133.1. ( )

06. Fund Raising. Certain fund raising expenses are nonallowable, see PRM, Section 2136.2. ( )

07. Goodwill. Costs associated with goodwill as defined in Section 011 of these rules are nonallowable. ( )

08. Holding Companies. All home office costs associated with holding companies are nonallowable see PRM, Section 2150.2A. ( )

09. Interest. Interest to finance nonallowable costs are nonallowable. ( )

10. Medicare Costs. All costs of Medicare Part A or Part B services incurred by Medicare certified facilities, including the overhead costs relating to these services are nonallowable. ( )

11. Nonpatient Care Related Activities. All activities not related to patient care are nonallowable. ( )

12. Organization. Organization costs are nonallowable, see PRM, Section 2134. ( )

13. Pharmacist Salaries. Salaries and wages of pharmacists are nonallowable. ( )

14. Prescription Drugs. Prescription drug costs are nonallowable. ( )

15. Related Party Interest. Interest on related party loans are nonallowable, see PRM, Sections 218.1 and 218.2. ( )

16. Related Party Nonallowable Costs. All costs nonallowable to providers are nonallowable to a related party, whether or not they are allocated. ( )

17. Related Party Refunds. All refunds, allowances, and terms, will be deemed to be allocable to the members of related organizations, on the basis of their participation in the related purchases, costs, etc. ( )

18. Self-Employment Taxes. Self-employment taxes, as defined by the Internal Revenue Service, that apply to facility owners are nonallowable. ( )

19. Telephone Book Advertising. Telephone book advertising costs in excess of the base charge for a quarter column advertisement for each telephone book advertised in are nonallowable. ( )

20. Vending Machines. Costs of vending machines and cost of the product to stock the machine are nonallowable costs. ( )

592. ICF/IID: HOME OFFICE COST PRINCIPLES.

The reasonable cost principles will extend to the home office costs allocated to individual providers. In addition, the home office, through the provider, will provide documentation as to the basis used to allocate its costs among the various entities it administers or otherwise directs. ( )

593. ICF/IID: RELATED PARTY TRANSACTIONS.

01. Principle. Costs applicable to services, facilities and supplies furnished to the provider by organizations or persons related to the provider by common ownership, control, etc., are allowable at the cost to the

related party. Such costs are allowable to the extent that they relate to patient care, are reasonable, ordinary, and necessary, and are not in excess of those costs incurred by a prudent cost-conscious buyer. ( )

02. Cost Allowability - Regulation. Allowability of costs is subject to the regulations prescribing the treatment of specific items as outlined in 42 CFR 413.17, et al, and the Providers Reimbursement Manual, PRM Chapter 10 and other applicable chapters of the PRM. ( )

594. ICF/IID: APPLICATION OF RELATED PARTY TRANSACTIONS.

01. Determination of Common Ownership or Control in the Provider Organization and Supply Organization. In determining whether a provider organization is related to a supplying organization, the tests of common ownership and control are to be applied separately. If the elements of common ownership or control are not present in both organizations, the organizations are deemed not to be related to each other. ( )

a. A determination as to whether an individual(s) possesses ownership or equity in the provider organization and the supplying organization, so that the organizations will be considered to be related by common ownership, will be made on the basis of the facts and circumstances in each case. ( )

b. The term "control" includes any kind of control whether or not it is legally enforceable and however it is exercisable or exercised. It is the reality of the control that is decisive, not its form or the mode of its exercise. ( )

02. Cost to Related Organizations. The charges to the provider from related organizations may not exceed the billing to the related organization for these services. ( )

03. Costs Not Related to Patient Care. All home office costs not related to patient care are not allowable under the program. ( )

04. Interest Expense. Generally, interest expense on loans between related entities will not be reimbursable. See the PRM, Chapters 2, 10, and 12 for specifics. ( )

595. ICF/IID: COMPENSATION OF RELATED PERSONS.
Compensation paid to persons related to owners or administrators is allowable only to the extent that services are actually performed and are necessary and adequately documented and the compensation for the services is reasonable. ( )

01. Compensation Claimed. Compensation claimed for reimbursement must be included in compensation reported for tax purposes and be actually paid. ( )

a. Where such persons perform services without pay, no cost may be imputed. ( )

b. Time records documenting actual hours worked are required in order that the compensation be allowable for reimbursement. ( )

c. Compensation for undocumented hours worked will not be a reimbursable cost. ( )

02. Related Persons. A related person is defined as having one (1) of the following relationships with the provider: ( )

a. Husband or wife; ( )

b. Son or daughter or a descendant of either; ( )

c. Brother, sister, stepbrother, stepsister or descendant thereof; ( )

d. Father, mother, stepfather, stepmother, an ancestor thereof, or a brother or sister thereof; ( )

e. Son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law or sister-in-law; ( )

f. A descendant of a brother or sister of the provider's father or mother; ( )

g. Any other person with whom the provider does not have an arms length relationship. ( )

596. ICF/IID: INTEREST EXPENSE.
Generally interest on loans between related entities is not an allowable expense. The loan will usually be considered invested capital. See PRM, Chapter 2 for specifics. ( )

597. ICF/IID: IDAHO OWNER-ADMINISTRATIVE COMPENSATION.
Allowable compensation to owners and persons related to owners who provide any administrative services will be limited based on the schedule in this section. ( )

01. Allowable Owner Administrative Compensation. The following schedule will be used in determining the maximum amount of owner administrative compensation allowable for the calendar year ending December 31, 2002.

Licensed Bed Range	Upper limit
51 - 100	86,951
101 - 150	95,641
151 - 250	129,878
251 - up	186,435

( )

02. The Administrative Compensation Schedule. The administrative compensation schedule in this Section will be adjusted annually based upon the change in average hourly earnings in nursing and personal care facilities as published by Data Resources Incorporated, its successor organization or, if unavailable, another nationally recognized forecasting firm. ( )

03. The Maximum Allowable Compensation. The maximum allowable compensation for an owner providing administrative services is determined from the schedule in Subsection 597.01. of these rules. Allowable compensation will be determined as follows: ( )

a. In determining the number of beds applicable on the schedule, all licensed beds for which the individual provides administrative services will be counted, regardless of whether they are in the same facility. ( )

b. For an owner providing services to more than fifty (50) beds, the amounts shown on the schedule for the applicable number of beds will determine the upper limit for allowable compensation. ( )

c. For owners providing services to less than fifty-one (51) beds, such services related to administrative duties will be reimbursed at the hourly rate allowable if the owner was providing services to fifty-one (51) beds. Additionally, services other than administrative services may be performed by the owner and will be allowable at the reasonable market rate for such services. To be allowable, hours for each type of service will be documented. In no event will the total compensation for administrative and non-administrative duties paid to an owner or related party to an owner of a facility or facilities with fifty (50) licensed beds or less exceed the limit that would be applicable to an owner with the same number of points providing administrative services to facilities with fifty-one (51) beds as set forth in the schedule of Subsection 597.01 of these rules. ( )

04. Compensation for Persons Related to an Owner. Compensation for persons related to an owner will be evaluated in the same manner as for an owner. ( )

05. When an Owner Provides Services to More Than One Provider. When an owner provides services to more than one (1) provider compensation will be distributed on the same basis as costs are allocated for

non-owners. ( )

06. More Than One Owner or Related Party May Receive Compensation for Hours Actually Worked. Services must be actually performed, documented and necessary. Total compensation must be reasonable, and not greater than the amount for which the same services could be obtained on the open market. The standard by which full time compensation is measured will be two thousand eighty (2,080) hours. Compensation of an owner or a party related to an owner is subject to other provisions of this chapter, and will not exceed the compensation determined from the Administrative Compensation Schedule, and, on an hourly basis, will not exceed the compensation determined in the Administrative Compensation Schedule divided by two thousand eighty (2,080). ( )

598. -- 599. (RESERVED)

600. ICF/IID: OCCUPANCY ADJUSTMENT FACTOR.
In order to equitably allocate fixed costs to the Medicaid patients in cases where a facility is not maintaining reasonable occupancy levels, an adjustment will be made. No occupancy adjustment will be made against the costs that are used to calculate the property rental rate; however adjustment will be made against all other property costs. The adjustment will be made as follows: ( )

01. Occupancy Levels. If a facility maintains an average occupancy of less than eighty percent (80%) of a facility's capacity, the total property costs not including cost paid under the property rental rate, will be prorated based upon an eighty percent (80%) occupancy rate. Property costs and property rental rates are defined in Section 013 of these rules. The facility's average occupancy percentage will be subtracted from eighty percent (80%) and the resultant percentage will be taken times the total fixed costs to determine the nonallowable fixed costs. ( )

02. Occupancy Adjustment. For purposes of an occupancy adjustment, facility capacity will be computed based upon the greater of the largest number of beds for which the facility was licensed during the period being reported on or the largest number of beds for which the facility was licensed during calendar year 1981, except where a portion of the facility has been converted to use for nonroutine nursing home activities or the facility is newly constructed and has entered the Medicaid Program subsequent to January 1, 1982. If the facility's designed capacity has been changed, the number of beds used to determine occupancy will be lowered by the amount of capacity being converted to nonroutine nursing home activities. Facility capacity for a new facility will be based on the number of beds approved by the certificate of need process less any capacity converted to nonroutine nursing home activities. ( )

03. Fixed Costs. For purposes of an occupancy adjustment fixed costs will be considered all allowable and reimbursable costs reported under the property cost categories. ( )

04. Change in Designed Capacity. In cases where a provider changes the designed capacity of a facility, the average occupancy for the period prior to the change and subsequent to the change will be computed and each period will be adjusted separately. If the designed capacity is increased, the increased number of beds will not be subject to this adjustment for the first six (6) months following their licensure. ( )

05. New Facility. In the case of a new facility being licensed and occupied, the first six (6) months occupancy level will not be subject to this adjustment. ( )

601. ICF/IID: RECAPTURE OF DEPRECIATION.
Where depreciable assets that were reimbursed based on cost and were used in the Medicaid Program by a facility subsequent to January 1, 1982, and for which depreciation has been reimbursed by the Program, are sold for an amount in excess of their net book value, depreciation so reimbursed will be recaptured from the buyer of the facility in an amount equal to reimbursed depreciation after January 1, 1982, or gain on the sale, whichever is less. ( )

01. Amount Recaptured. Depreciation will be recaptured in full if a sale of a depreciated facility takes place within the first five (5) years of a seller's ownership. Credit will be given for the period of ownership prior to January 1, 1982. For every year the asset is held beyond the first five (5) years, the total depreciation recaptured will be reduced by ten percent (10%) per year of the total depreciation taken. ( )

02. Time Frame. Depreciation will be recaptured by the Medicaid Program from the buyer of the facility over a period of time not to exceed five (5) years from the date of sale, with not less than one-fifth (1/5) of the total amount being recaptured for each year after such date. ( )

602. ICF/IID: REPORTING SYSTEM.
The objective of the reporting requirements is to provide a uniform system of periodic reports that will allow: ( )

01. Basis for Reimbursement. A basis of provider reimbursement approximating actual costs. ( )

02. Disclosure. Adequate financial disclosure. ( )

03. Statistical Resources. Statistical resources, as a basis for measurement of reasonable cost and comparative analysis. ( )

04. Criteria. Criteria for evaluating policies and procedures. ( )

603. ICF/IID: REPORTING SYSTEM PRINCIPLE AND APPLICATION.
The provider will be required to file mandatory annual cost reports. ( )

01. Cost Report Requirements. The fiscal year end cost report filing must include: ( )

a. Annual income statement (two (2) copies); ( )

b. Balance sheet; ( )

c. Statement of ownership; ( )

d. Schedule of patient days; ( )

e. Schedule of private patient charges; ( )

f. Statement of additional charges to residents over and above usual monthly rate; and ( )

g. Other schedules, statements, and documents as requested. ( )

02. Special Reports. Special reports may be required. Specific instructions will be issued, based upon the circumstance. ( )

03. Criteria of Reports. All reports must meet the following criteria: ( )

a. State-approved formats are used. ( )

b. Presented on accrual basis. ( )

c. Prepared in accordance with generally accepted accounting principles and principles of reimbursement. ( )

d. Appropriate detail is provided on supporting schedules or as requested. ( )

04. Preparer. It is not required that any statement be prepared by an independent, licensed or certified public accountant. ( )

05. Reporting by Chain Organizations or Related Party Providers. PRM, Section 2141.7, prohibits the filing of combined or consolidated cost reports as a basis for cost reimbursement. Each facility so related must file a separate set of reports. These cost reports will be required for each level of organization that allocates expenses to

the provider. Consolidated financial statements will be considered supplementary information and are not acceptable as fulfilling the primary reporting requirements. ( )

06. Change of Management or Ownership. To properly pay separate entities or individuals when a change of management or ownership occurs, the following requirements will be met: ( )

a. Outgoing management or administration will file an adjusted-period cost report if it is necessary. This report will meet the criteria for annual cost reports, except that it will be filed not later than sixty (60) days after the change in management or ownership. ( )

b. The Department may require an appraisal at the time of a change in ownership. ( )

07. Reporting Period. When required for establishing rates, new ICF/IID providers will be required to submit cost projections for the first year of operations. Thereafter, the normal reporting period coincides with the provider's standard fiscal year. If a provider withdraws from the program and subsequently re-enters, the new provider reporting requirements will apply. ( )

604. (RESERVED)

605. ICF/IID: FILING DATES.

01. Deadlines. Deadlines for annual cost reports will be the last day of the third month following the fiscal year end or the deadline imposed by Medicare if the provider is required to file a Medicare cost report. ( )

02. Waivers. A delay of thirty (30) days may be granted for annual cost reports in unusual circumstances. Requests for such deferrals and reasons therefore must be in writing and should be made prior to the deadline. A written decision will be rendered in writing within ten (10) days. ( )

606. ICF/IID: FAILURE TO FILE.
Failure to submit timely reports may result in a reduction in the interim rate. Failure to file the required cost reports, including required supplemental information, unless a waiver is granted, may result in a reduction of ten percent (10%) in the provider's interim rate(s) the first day of the month following the deadline date. Continued failure to comply will result in complete payment suspension on the first day of the following month. When suspension or reduction has occurred and the provider has filed the required cost reports, amounts accruing to the provider during the period of suspension or reduction will be restored. Loss of license or certification will result in immediate termination of reimbursement, full scope audit and settlement for the cost period. ( )

607. ICF/IID: ACCOUNTING SYSTEM.
Reports must be filed using the accrual basis and conform with generally accepted accounting principles or within provisions of the guidelines as specified. In any case, the recorded transaction must be capable of verification by Departmental audit. ( )

608. -- 609. (RESERVED)

610. ICF/IID: AUDITS.
All financial reports are subject to audit by Departmental representatives. ( )

01. Accuracy of Recording. To determine whether the transactions recorded in the books of record are substantially accurate and reliable as a basis for determining reasonable costs. ( )

02. Reliability of Internal Control. To determine that the facilities internal control is sufficiently reliable to disclose the results of the to the provider's operations. ( )

03. Economy and Efficiency. To determine if Title XIX and Title XXI participants have received the required care on the a basis of economy and efficiency. ( )

04. Application of GAAP. To determine if GAAP is applied on a consistent basis in conformance with applicable federal and state regulations. ( )

05. Patient Trust Fund Evaluation. To evaluate the provider's policy and practice regarding their fiduciary responsibilities for patients, funds and property. ( )

06. Enhancing Financial Practices. To provide findings and recommendations aimed at better financial practices to allow the most economical delivery of patient care. ( )

07. Compliance. To provide recommendations that will enable the provider to conform more closely with state and federal regulations in the delivery of health care to program participants. ( )

08. Final Settlement. To effect final settlement when required by Sections 587 through 632 of these rules. ( )

611. ICF/IID: AUDIT APPLICATION.

01. Annual Audits. Normally, all annual statements will be audited within the following year. ( )

02. Limited Scope Audit. Other statements and some annual audit recommendations may be subject to limited scope audits to evaluate provider compliance. ( )

03. Additional Audits. In addition, audits may be required where: ( )

a. A significant change of ownership occurs. ( )

b. A change of management occurs. ( )

c. An overpayment of twenty-five percent (25%) or more has resulted for a completed cost period. ( )

04. Audit Appointment. Annual field audits will be by appointment. Auditors will identify themselves with a letter of authorization or Departmental I.D. cards. ( )

612. ICF/IID: AUDIT STANDARDS AND REQUIREMENTS.

01. Review of New Provider Fiscal Records. Before any program payments can be made to a prospective provider the intermediary will review the provider's accounting system and its capability of generating accurate statistical cost data. Where the provider's record keeping capability does not meet program requirements the intermediary will offer limited consultative services or suggest revisions of the provider's system to enable the provider to comply with program requirements. ( )

02. Requirements. Providers Reimbursement Manual (PRM), Section 2404.3 states: “Examination of Pertinent Data and Information -- Providers asking to participate as well as those currently participating must permit the intermediary to examine such records and documents as are deemed necessary. ( )

03. Examination of Records. Examination of records and documents may include: ( )

a. Corporate charters or other documents of ownership including those of a parent or related companies. ( )

b. Minutes and memos of the governing body including committees and its agents. ( )

c. All contracts. ( )

d. Tax returns and records, including workpapers and other supporting documentation. ( )

e. All insurance contracts and policies including riders and attachments. ( )

f. Leases. ( )

g. Fixed asset records (see audit section - Capitalization of Assets). ( )

h. Schedules of patient charges. ( )

i. Notes, bonds and other evidences of liability. ( )

j. Capital expenditure records. ( )

k. Bank statements, cancelled checks, deposit slips and bank reconciliations. ( )

l. Evidence of litigations the facility and its owners are involved in. ( )

m. Documents of ownership including attachments that describe the property. ( )

n. All invoices, statements and claims. ( )

o. Providers Accounting Firm. Where a provider engages an accounting firm to maintain its fiscal records, the financial audit work papers prepared by the accounting firm are considered to be the property of the provider and must be made available to the intermediary upon request, under PRM, paragraph 2404.4(Q). ( )

p. Ledgers, journals, all working papers, subsidiary ledgers, records and documents relating to financial operation. ( )

q. All patient records, including trust funds and property. ( )

r. Time studies and other cost determining information. ( )

s. All other sources of information needed to form an audit opinion. ( )

04. Adequate Documentation. ( )

a. Adequate cost information as developed by the provider must be current, accurate, and in sufficient detail to support payment made for services rendered to participants. This includes all ledgers, books, records and original evidences of cost including purchase requisitions, purchase orders, vouchers, requisitions for material, inventories, labor time cards, payrolls, bases for apportioning costs, and other documentation that pertains to the determination of reasonable cost, capable of being audited under PRM, Section 2304. ( )

b. Adequate expenses documentation including an invoice, or a statement with invoices attached that support the statement. All invoices should meet the following standards: ( )

i. Date of service or sale; ( )

ii. Terms and discounts; ( )

iii. Quantity; ( )

iv. Price; ( )

v. Vendor name and address; ( )

vi. Delivery address if applicable; ( )

vii. Contract or agreement references; and ( )

viii. Description, including quantity, sizes, specifications brand name, services performed. ( )

c. Capitalization of assets for major movable equipment will be capitalized. Minor movable equipment cannot be capitalized. The cost of fixed assets and major movable equipment must be capitalized and depreciated over the estimated useful life of the asset under PRM, Section 108.1. This rule applies except for the provisions of PRM, Section 106 for small tools. ( )

d. Completed depreciation records must meet the following criteria for each asset: ( )

i. Description of the asset including serial number, make, model, accessories, and location. ( )

ii. Cost basis should be supported by invoices for purchase, installation, etc. ( )

iii. Estimated useful life. ( )

iv. Depreciation method such as straight line, double declining balance, etc. ( )

v. Salvage value. ( )

vi. Method of recording depreciation on a basis consistent with accounting policies. ( )

vii. Report additional information, such as additional first year depreciation, even though it isn't an allowable expense. ( )

viii. Reported depreciation expense for the year and accumulated depreciation will tie to the asset ledger. ( )

e. Depreciation methods such as straight line depreciation is always acceptable. Methods of accelerated depreciation are acceptable only upon authorization by the Office of Audit or its successor organization. Additional first year depreciation is not allowable. ( )

f. The depreciable life of any asset may not be shorter than the useful life stated in the publication, Estimated Useful Lives of Depreciable Hospital Assets, 2004 revised edition. Guidelines Lives, that is hereby incorporated by reference into these rules. Deviation from these guidelines will be allowable only upon authorization from the Department. This document may be obtained from American Hospital Publishing, Inc., 211 E. Chicago Ave., Chicago, IL. 60611. ( )

g. Lease purchase agreements may generally be recognized by the following characteristics: ( )

i. Lessee assumes normal costs of ownership, such as taxes, maintenance, etc.; ( )

ii. Intent to create security interest; ( )

iii. Lessee may acquire title through exercise of purchase option that requires little or no additional payment or, such additional payments are substantially less than the fair market value at date of purchase; ( )

iv. Non-cancelable or cancelable only upon occurrence of a remote contingency; and ( )

v. Initial loan term is significantly less than the useful life and lessee has option to renew at a rental price substantially less than fair rental value. ( )

h. Assets acquired under such agreements will be viewed as contractual purchases and treated accordingly. Normal costs of ownership such as depreciation, taxes and maintenance will be allowable as determined in this chapter. Rental or lease payments will not be reimbursable. ( )

i. Complete personnel records containing the following: ( )

i. Application for employment. ( )

ii. W-4 Form. ( )

iii. Authorization for other deductions such as insurance, credit union, etc. ( )

iv. Routine evaluations. ( )

v. Pay raise authorization. ( )

vi. Statement of understanding of policies, procedures, etc. ( )

vii. Fidelity bond application (where applicable). ( )

05. Internal Control. ( )

a. A system of internal control is intended to provide a method of handling all routine and nonroutine tasks for the purpose of: ( )

i. Safeguarding assets and resources against waste, fraud, and inefficiency. ( )

ii. Promoting accuracy and reliability in financial records. ( )

iii. Encouraging and measuring compliance with company policy and legal requirements. ( )

iv. Determining the degree of efficiency related to various aspects of operations. ( )

b. An adequate system of internal control over cash disbursements would normally include: ( )

i. Payment on invoices only, or statements supported by invoices. ( )

ii. Authorization for purchase such as a purchase order. ( )

iii. Verification of quantity received, description, terms, price, conditions, specifications, etc. ( )

iv. Verification of freight charges, discounts, credit memos, allowances, and returns. ( )

v. Check of invoice accuracy. ( )

vi. Approval policy for invoices. ( )

vii. Method of invoice cancellation to prevent duplicating payment. ( )

viii. Adequate separation of duties between ordering, recording, and paying. ( )

ix. System separation of duties between ordering, recording, and paying. ( )

x. Signature policy. ( )

xi. Pre-numbered checks. ( )

xii. Statement of policy regarding cash or check expenditures. ( )

xiii. Adequate internal control over the recording of transactions in the books of record. ( )

xiv. An imprest system for petty cash. ( )

06. Accounting Practices. Sound accounting practices normally include the following: ( )

a. Written statement of accounting policies and procedures, including policies of capitalization, depreciation and expenditure classification criteria. ( )

b. Chart of accounts. ( )

c. A budget or operating plan. ( )

613. ICF/IID: PATIENT FUNDS.
The safekeeping of patient funds, under the program, is the responsibility of the provider. Accordingly, the administration of these funds requires scrupulous care in recording all transactions for the patient. ( )

01. Use. Generally, funds are provided for personal needs of the patient to be used at the patient's discretion. The provider agrees to manage these funds and render an accounting but may not use them in any way. ( )

02. Provider Liability. The provider is subject to legal and financial liabilities for committing any of the following acts. This is only a partial listing of the acts contrary to federal regulations: ( )

a. Management fees may not be charged for managing patient trust funds. These charges constitute double payment as management is normally performed by an employee of the provider and their salary is included in reasonable cost reimbursement. ( )

b. Nothing is to be deducted from these funds, unless such deductions are authorized by the patient or their agent in writing. ( )

c. Interest accruing to patient funds on deposit is the property of the patients and is part of the personal funds of each patient. The interest from these funds is not available to the provider for any use, including patient benefits. ( )

03. Fund Management. Proper management of such funds would include the following as minimum: ( )

a. Savings accounts, maintained separately from facility funds. ( )

b. An accurate system of supporting receipts and disbursements to patients. ( )

c. Written authorization for all deductions. ( )

d. Signature verification. ( )

e. Deposit of all receipts of the same day as received. ( )

f. Minimal funds kept in the facility. ( )

g. As a minimum these funds must be kept locked at all times. ( )

h. Statement of policy regarding patient's funds and property. ( )

i. Periodic review of these policies with employees at training sessions and with all new employees upon employment. ( )

j. System of periodic review and correction of policies and financial records of patient property and funds. ( )

614. (RESERVED)

615. ICF/IID: POST-ELIGIBILITY TREATMENT OF INCOME.

01. Treatment of Income. Where an individual is determined eligible for medical assistance participation in the cost of their long term care, the Department will reduce its payment to the long term care facility by the amount of their income considered available to meet the cost of his care. This determination is made in accordance IDAPA 16.03.05, "Eligibility for Aid for the Aged, Blind, and Disabled (AABD)," Sections 721 through 725. ( )

02. SSA Income. The amount that the Participant receives from SSA as reimbursement for their payment of the premium for Part B of Title XVIII (Medicare) is not considered income for participant liability in accordance with IDAPA 16.03.05, "Eligibility for Aid for the Aged, Blind, and Disabled (AABD)." ( )

616. -- 619. (RESERVED)

620. ICF/IID: PAYMENTS FOR PERIODS OF TEMPORARY ABSENCE.
Payments may be made for reserving beds in ICFs/IID for participants during their temporary absence if the facility charges private paying participants for reserve bed days, subject to the following limitations: ( )

01. Prior Approval for Absence. Therapeutic home visits for ICF/IID residents of up to thirty-six (36) days per calendar year so long as the days are part of a written treatment plan ordered by the attending physician. Prior approval from the BLTC must be obtained for any home visits exceeding fourteen (14) consecutive days. ( )

02. Limits on Amount of Payments. Payment for reserve bed days will be lesser of the following: ( )

a. One hundred percent (100%) of the audited allowable costs of the facility; or ( )

b. The rate charged to private paying participants for reserve bed days. ( )

621. ICF/IID: PAYMENT PROCEDURES.
Each ICF/IID must submit its claims to the Department in accordance with the procedures established by the Department. The Department will not pay for a claim in behalf of a Participant unless the information on the claim is consistent with the information in the Department's computer eligibility file. ( )

622. ICF/IID: PRINCIPLE PROSPECTIVE RATES.
Providers of ICF/IID facilities will be paid a per diem rate that, with certain exceptions, is not subject to an audit settlement. The per diem rate for a fiscal period will be based on audited historical costs adjusted for inflation. The provider must report these cost items in accordance with other provisions of this chapter or the applicable provisions of PRM consistent with this chapter. Sections 622 through 628 of these rules provide procedures and specifications necessary to implement the provisions and accomplish the objectives of the payment system for ICF/IID providers. Total payment will include the following components: Property reimbursement, capped costs, exempt costs, and excluded costs. Except as otherwise provided in this section, rates calculated for state fiscal year 2012 (July 1, 2011 through June 30, 2012) will be calculated by using finalized cost reports ended in calendar year 2009 with no cost or cost limit adjustments for inflation to the rate period of July 1, 2011, through June 30, 2012. Rates effective July 1, 2012, and every July 1 thereafter, will be calculated by using audited cost reports ended in the calendar year two (2) years prior to each July 1 (July 1, 2012, rates will use cost reports ended in calendar year 2010 and so forth), with no cost or cost limit adjustments for inflation. ( )

623. ICF/IID: PROPERTY REIMBURSEMENT.
Beginning October 1, 1996, ICF/IID property costs are reimbursed by a rental rate or based on cost. The following will be reimbursed based on cost as determined by the provisions of this chapter and applicable provisions of PRM to the extent not inconsistent with this chapter: ICF/IID living unit property taxes, ICF/IID living unit property insurance, and major movable equipment not related to home office or day treatment services. Reimbursement of

other property costs is included in the property rental rate. Any property cost related to home offices and day treatment services are not considered property costs and will not be reported in the property cost portion of the cost report. These costs will be reported in the home office and day treatment section of the cost report. Property costs, including costs that are reimbursed based on a rental rate, will be reported in the property cost portion of the cost report. The Department may require and utilize an appraisal to establish those components of property costs that are identified as an integral part of an appraisal. Property costs include the following components: ( )

01. Depreciation. Allowable depreciation based on straight line depreciation. ( )

02. Interest. All allowable interest expense that relates to financing depreciable assets. Interest on working capital loans is not a property cost and is subject to the cap. ( )

03. Property Insurance. All allowable property insurance. Malpractice insurance, workmen's compensation and other employee-related insurances are not property costs. ( )

04. Lease Payments. All allowable lease or rental payments. ( )

05. Property Taxes. All allowable property taxes. ( )

06. Costs of Related Party Leases. Costs of related party leases are to be reported in the property cost categories based on the owner's costs. ( )

624. ICF/IID: CAPPED COST.

Beginning October 1, 1996, this cost area includes all allowable costs except those specifically identified as property costs in Section 623 of these rules and exempt costs or excluded costs in Section 627 or 628 of these rules. This Section defines items and procedures to be followed in determining allowable and exempt costs and provides the procedures for extracting cost data from historical cost reports, applying a cost forecasting market basket to project cost forward, procedures to be followed to project costs forward, and procedures for computing the median of the range of costs and the ICF/IID cap. ( )

01. Costs Subject to the Cap. Items subject to the cap include all allowable costs except property costs identified in Section 623 of these rules and exempt costs or excluded costs identified in Section 627 or 628 of these rules. Property costs related to a home office are administrative costs, will not be reported as property costs, and are subject to the cap. ( )

02. Per Diem Costs. Costs to be included in this category will be divided by the total participant days for the facility for the cost reporting period to arrive at allowable per diem costs. If costs for services provided some or all non-Medicaid residents are not included in the total costs submitted, the provider must determine the costs and combine them with the submitted costs in order that a total per diem cost for that facility can be determined both for both the purposes of determining the ICF/IID cap and of computing final reimbursement. ( )

03. Cost Data to Determine the Cap. Cost data to be used to determine the cap for ICF/IID facilities will be taken from each provider's most recent final cost report available sixty (60) days before the beginning of the period for which the cap is being set. Cost reports are final when the final audit report is issued, or earlier if the Department informs the facility the report is final for rate setting purposes. The selected final cost report will be used to establish the facility's prospective reimbursement rate. However, the final cost reports covering a period of less than twelve (12) months will be included in the data for determining the cap at the option of the Department. ( )

04. Projection. Per diem allowable costs will be inflated forward using a cost forecasting market basket and forecasting indices according to the same table as used for free standing facilities. ( )

a. The projection method used in Section 624 of these rules to set the cap will also be used to set non property portions of the prospective rate that are not subject to the cap. ( )

b. Forecasting indices as developed by Data Resources, Incorporated, will be used unless they are unavailable. In such case, indices supplied by some other nationally recognized forecaster will be used. ( )

05. Costs That Can be Paid Directly by the Department to Non ICF/IID Providers. Costs that can be paid directly by the Department to non ICF/IID providers are excluded from the ICF/IID prospective rates and ICF/IID cap: ( )

a. Direct physician care costs. Physicians who provide these services must bill the Medicaid program directly using their own provider numbers. ( )

b. Costs of services covered under the Early and Periodic Screening Diagnosis and Treatment (EPSDT) portion of the Medicaid Program. Items such as eyeglasses and hearing aids are covered under IDAPA 16.03.09, "Medicaid Basic Plan Benefits." The cost of these services is not included as a part of ICF/IID costs. Reimbursement can be made to a professional providing these services through their billing the Medicaid Program on their own provider number. ( )

c. Costs of services covered by other parts of the Medicaid Program. Examples of these items include legend drugs and ambulance transportation. These items must be billed to the Medicaid Program directly by the provider using their own provider number. ( )

06. Cost Projection. Allowable per diem costs will be projected forward from the midpoint of the Base Period to the midpoint of the Target Period. "Base Period" is defined as the last available final cost report period. "Target Period" is defined as the effective period of the prospective rate. Procedures for inflating these costs are as follows: ( )

a. The percentage change for each cost category in the market basket will be computed from the beginning to the end of the Base Period. These percentages will then be divided by two (2) and the resultant percentages will be used to project forward allowable per diem costs for each cost category from the midpoint to the end of the Base Period. ( )

b. The percentage change for each cost category in the market basket will be computed for the period from the end of the Base Period to the beginning of the Target Period. These percentages will then be used to project forward the allowable per diem costs for each cost category, as determined in Subsection 624.06.a. of these rules, from the end of the Base Period to the beginning of the Target Period. ( )

c. The percentage change for each cost category in the market basket will be computed for the beginning to the end of the Target Period. These percentages will then be divided by two (2) and the resultant percentages will be used to project forward the allowable per diem costs as determined in Subsection 624.06.b. of these rules from the beginning to the midpoint of the Target Period. ( )

07. Cost Ranking. Prior to October 1st of each year the Director will determine the that percent above the median that will assure aggregate payments to ICF/IID providers will approximate but not exceed amounts that would be incurred using Medicare cost principles of reimbursement. That percentage will apply to caps and rates set after September 30th of each year. Projected per diem costs as determined in this section and subject to the cap will be ranked from the highest to the lowest. The cap will be set at a percent of the bed-weighted median for each rate period. The initial cap will be set as of October 1, 1996. ( )

a. The median of the range will be computed based on the available data points being considered as the total population of data points. ( )

b. The cap for each ICF/IID facility with a fiscal year beginning October 1, 1996, will be computed prior to the beginning of that year. For those facilities with a fiscal year ending on a date other than September 30th, the first cap will be computed for the period beginning October 1, 1996, and ending on the fiscal year end date. ( )

c. Facilities with cost reports that transcend the period from October 1, 1996, through September 30, 1997, will be retrospectively settled using the previous reimbursement system for the period of the report up to September 30, 1996. There will not be a retrospective settlement on the portion of these cost reports attributed to October 1, 1996 through the end of the cost report period unless provisions of Section 626 of these rules apply. ( )

d. Cost reports for periods beginning on or after October 1, 1996, will not be subject to retrospective settlement except as required by other provisions of this chapter. ( )

e. A new cap and rate will be set on an annual basis for each facility the first of July every year. ( )

f. The cap and prospective rate will be determined and set on an annual basis for each facility July first of every year and will not be changed by any subsequent events or information with the exception that if the computations were found to contain mathematical or clerical errors, these errors will be corrected and the cap will be adjusted using the corrected figures. ( )

g. Payment of costs subject to the cap will be limited to the cap unless the Department determines the exclusions found in Section 628 of these rules apply. ( )

h. A facility that commences to offer participant care services as an ICF/IID on or after October 1, 1996, will be subject to retrospective settlement until the first prospective rate is set. Such facility will be subject to the ICF/IID cap as determined in this chapter. The first prospective rate for this provider will be set by the Department based on quarterly cost statements and final cost reports submitted for periods following the first three (3) months of operation. This first prospective rate may be set after the beginning of the second fiscal year of the provider. For the second year the provider will be paid a rate to be settled retrospectively unless both the Department and the provider agree to a prospective rate or rates covering that fiscal period. ( )

625. (RESERVED)

626. ICF/IID: RETROSPECTIVE SETTLEMENT.
When retrospective settlement is applicable, it is based on allowable reimbursement in accordance with this chapter and based on an audit report. Retrospective settlement will be subject to the same caps and limits determined for prospective payments. ( )

01. A Provider's Failure to Meet Any of the Conditions. A provider's failure to meet any of the conditions of participation set forth in 42 CFR 483, Subpart I, may subject that provider to retrospective reimbursement for the fiscal year, or any portion thereof, during which the condition is not met. The provider's projected per diem rate may be adjusted to reflect actual reimbursable costs subject to cost limits. ( )

02. A First Time Provider. A first time provider operating a new ICF/IID living unit will be subject to a retrospective settlement for the first fiscal year and until the first subsequent period wherein a prospective rate is set in accordance with Sections 603, 605, and 606 of these rules and this chapter. A budget based on the best available information is required prior to opening for participant care so an interim rate can be set. ( )

03. New ICF/IID Living Unit. A new ICF/IID living unit for an existing operator is subject to first time facility requirements if the new living unit reflects a net increase in licensed beds, otherwise the Department may set a prospective rate with the non-property rate components based on similar components of rates most recently paid for the participants moving into the facility. The property rental rate will be set according to applicable provisions of this chapter. ( )

04. Change of Ownership of Existing ICF/IID Living Unit. Where there is a change of ownership of an existing ICF/IID living unit, the provider operating the ICF/IID living unit will not receive an adjustment of the provider's prospective rate except that the property rental portion of the rate will be adjusted subject to property rental provisions of this chapter. However, new facility reporting requirements and the cap will apply. ( )

05. Fraudulent or False Claims. Providers who have made fraudulent or false claims are subject to retrospective settlement as determined by the Department. ( )

06. Excluded Costs. Excluded costs may be retrospectively settled according to the provisions of Section 247 of these rules. ( )

627. ICF/IID: EXEMPT COSTS.
Exempt costs are not subject to the ICF/IID cap. ( )

01. Day Treatment Services. As specified in this Section, the cost of day treatment services may be reimbursed in this category and may not be subject to the ICF/IID cap. ( )

a. This category includes the direct costs of labor, benefits, contracted services, property, utilities and supplies for such services up to the limitations provided in this Subsection. ( )

b. When a school or another agency or entity is responsible for or pays for services provided to a participant regularly during normal working hours on weekdays, no costs will be assigned to this category for such services. The Department will not reimburse for the cost of services that are paid for or should be paid for by an other agency. ( )

c. When ICF/IID day treatment services are performed for participants in a licensed Developmental Disability Center, the allowable cost of such services will be included in this category, but not more than the amount that would be paid according to the Department's fee schedule for individual or group therapy for similar services. Amounts incurred or paid by the ICF/IID in excess of what would be paid according to the Department's fee schedule for like services are not allowable costs and will be reported as non-reimbursable. ( )

d. For day treatment services provided in a location other than a certified developmental disability center, the maximum amount reportable in this category will also be limited. Total costs for such services reported by each provider in this category will be limited to the number of hours, up to thirty (30) hours per week per participant, of individual or group developmental therapy times the hourly rate that would be paid according to the most recent Department fee schedule for the same services if provided in a developmental disability center. Costs in excess of the limits determined in this Subsection will be classified and reported as subject to the ICF/IID cap. Initial rates established under the prospective system effective October 1, 1996, and not later than October 1, 1997, will not include a limitation of day treatment costs based on the hourly rate, when the hours of individual or group therapy were not obtained or audited by the Department at the time the rate was published. However, if a provider believes that the day treatment cost used to establish the day treatment portion of its prospective rate was misstated for rates set for periods beginning October 1, 1996, through rates beginning October 1, 1997, revisions to the prospective rate may be made to the extent the provider demonstrates, to the satisfaction of the Department, that the cost used was misstated. Such a revision will be considered only if the provider requests a revision and provides adequate documentation within sixty (60) days of the date the rate was set. At the option of the Department it may negotiate fixed rates for these day treatment services. Such rates will be set so the aggregate related payments are lower than would be paid with a limitation based on schedules used for licensed Developmental Disability Centers. ( )

e. Financial data including expenses and labor hours incurred by or on behalf of the provider in providing day treatment services, must be identifiable and separate from the costs of other facility operations. Reasonable property costs related to day treatment services and not included in the property rental rate, will be separately identified, will be reported as day treatment services costs, and will not include property costs otherwise reimbursed. Property costs related to day treatment services will be separately identified as not related to living unit costs by a final audit determination issued prior to October 1, 1996, or will be separate and distinct from any property used for ICF/IID services that are or were day treatment services. ( )

f. In the event a provider has a change in the number of participants requiring day treatment services, the prospective rate may be adjusted by the Department to reflect a change in costs related to such a change. Providers receiving such changes may be required to provide added documentation to the Department to assure that further changes can be identified and the prospective rate adjusted accordingly. ( )

02. Major Movable Equipment. Costs related to major movable equipment, as defined in this chapter will be exempt from the ICF/IID cap and will be reimbursed prospectively based on Medicare principles of cost reimbursement. ( )

628. ICF/IID: COSTS EXCLUDED FROM THE CAP.
Certain costs may be excluded from the ICF/IID cap, may be subject to retrospective settlement at the discretion of the Department, and may result in changes to the prospective rate as provided in this Section to assure equitable

reimbursement: ( )

01. Increases of More Than One Dollar Per Participant Day in Costs. Increases of more than one dollar ($1) per participant day in costs otherwise subject to the cap incurred by a facility as a result of changes in State or Federal laws or rules will be reported separately on the cost report for reports filed less than thirty (30) months, or a greater length of time if so directed by the Department, from the date such increases were first required. Such costs will be subdivided into the component parts of wages, benefits, contracted services and other costs in the amounts equal to costs removed from the respective cost categories subject to the cap. The Department may adjust the forecasted rate to include the projected per diem related to such costs. ( )

a. The provider will report these costs on a separate schedule or by notations on the cost report so that these costs can be identified and reconciled to the provider's general ledger. ( )

b. If more than one (1) increase occurs as a result of one (1) or more law or rule change, the costs from each event are to be reported separately. ( )

c. The computation of the cost increase amount or amounts is to be presented in detail on a supplementary schedule or schedules unless the Department states otherwise. ( )

d. For interim rate purposes the provider's prospective rate may be granted an increase to cover such cost increases. A cost statement covering a recent period may be required with the justification for the increased costs. The actual amount related to such increases will be determined at audit and may be retrospectively settled. ( )

e. After the initial deadline has passed for all providers to file cost reports for reporting periods beginning on or after the date certain cost increases were first required, the Department will, at it's option, include all of the previously excluded costs related to those increases with costs subject to the cap when setting rates or increase the cap and individual facility prospective rates following such cost increases. If a cap is set with these particular costs included in the cap category, providers subject to that cap will not have these costs excluded from the cap for prospective rate purposes. The intent of this provision is for costs to be exempt from the cap until these costs are able to be fully and equitably incorporated in the data base used to project the cap and for these costs to be exempt only when they are not included in the data base. In those cases, when costs are not incurred immediately after a change in rule or law, delays in incorporating the new costs in the cap are warranted. ( )

f. When cost increases that have been excluded from the cap are incorporated in the inflation indices used to set the cap, the cost indices will be adjusted to exclude the influence of such changes if the amount is included in the index is identified. When the cap is set to include previously excluded amounts, any adjustments previously made to the indexes related to the previously excluded costs will be removed. ( )

02. Excess Inflation. Reimbursement of costs subject to the cap will be limited to the cap unless the Department determines the inflation indices used to set the prospective rates for a reporting period understated actual inflation by more than seven (7%) percentage points. In such case, prospective rates and the cap will be increased by the amount that actual inflation indices exceeded projected inflation indices and may be retrospectively adjusted by the department. ( )

03. Cost Increases Greater Than Three Percent. When cost increases of greater than three percent (3%) of the projected interim rate that result from disasters such as fire, flood, or earthquake, epidemic or similar unusual and unpredictable circumstances over which a provider has no control. Prospective rates will be increased and they will not be subject to the cap. However, they may be retrospectively adjusted by the Department. For the purposes of this Subsection, disaster does not include personal or financial problems. ( )

04. Decreases. In the event of state or federal law, rule, or policy changes that result in clearly identifiable reductions in required services, the Department may reduce the prospective rate to reflect the identified per diem amount related to such reductions. ( )

05. Prospective Negotiated Rates. Notwithstanding the provisions of Section 622 of these rules, the Director will have the authority to negotiate prospective rates for providers who would otherwise be subject to accept

retrospective settlement. Such rates will not exceed the projected allowable rate that would otherwise be reimbursed based on provisions of this chapter. ( )

629. ICF/IID: LEGAL CONSULTANT FEES AND LITIGATION COSTS.
Costs of legal consultant fees and litigation costs incurred by the provider will be handled in accordance with the following: ( )

01. In General. Legal consultant fees unrelated to the preparation for or the taking of an appeal of an audit performed by the Department of Health and Welfare, or litigation costs incurred by the provider in an action unrelated to litigation with the Department of Health and Welfare, will be allowed as a part of the total per diem costs of which the Medicaid Program will reimburse a portion according to the percentage of Medicaid patient days. ( )

02. Administrative Appeals. In the case of the provider contesting in administrative appeal the findings of an audit performed by the Department of Health and Welfare, the costs of the provider's legal counsel will be reimbursed by the Medicaid Program only to the extent that the provider prevails on the issues involved. The determination of the extent that the provider prevails will be based on the ratio of the total dollars at issue for the audit period at issue in the hearing to the total dollars ultimately awarded to the provider for that audit period by the hearing officer or subsequent adjudicator. ( )

03. Other. All other litigation costs incurred by the provider in actions against the Department of Health and Welfare will not be reimbursable either directly or indirectly by the Medicaid Program except where specifically ordered by a court of law. ( )

630. ICF/IID: PROPERTY RENTAL RATE REIMBURSEMENT.
ICFs/IID will be paid a property rental rate. Property taxes, property insurance, and depreciation expense or major moveable equipment will be reimbursed as costs exempt from limitations. The property rental rate does not include compensation for minor movable equipment. The property rental rate is paid in lieu of payment for amortization, depreciation, and interest for financing the cost of land and depreciable assets. See Sections 56-108 and 56-109, Idaho Code, for further clarification. ( )

01. Property Rental Rate. The property rental rate is based upon current construction costs, the age of the facility, the type of facility, and major expenditures made to improve the facility, or a rate based upon property costs as of January 1, 1985. The amount paid for each Medicaid day of care will be phased in according to the following: ( )

a. R = "Property Base" x 40 - "Age" / 40 x "change in building costs" where: ( )

b. "R" = the property rental rate. ( )

c. "Property Base" = eleven dollars and twenty-two cents ($11.22) except for ICF/IID living units not able to accommodate residents requiring wheelchairs beginning October 1, 1996. Property base = seven dollars and twenty-two cents ($7.22) for ICF/IID living units not able to accommodate residents requiring wheelchairs. ( )

d. "Change in building costs" = 1.0 from October 1, 1996, through December 31, 1996. For ICF/IID facilities, the most recent index available when it is first necessary to set a prospective rate for a period that includes all or part of the calendar year, will be used. ( )

e. "Age" of facility - The effective age of the facility in years will be set by subtracting the year in which the facility, or portion thereof, was constructed from the year in which the rate is to be applied. No facility or portion thereof will be assigned an age of more than thirty (30) years, however: ( )

i. If adequate information is not submitted by the facility to document that the facility, or portion thereof, is newer than thirty (30) years, the age will be set at thirty (30) years. Adequate documentation will include, but not be limited to, such documents as copies of building permits, tax assessors' records, receipts, invoices, building contract, and original notes of indebtedness. An age will be determined for each building. A weighted average using the age and square footage of the buildings will become the effective age of the facility. The age of each building will

be based upon the date when construction on that building was completed. This age will be adjusted to reflect major building expansion or remodeling prior to April 1, 1985, if that expenditure was large enough to reduce the age of the facility by two (2) or more years according to the following formula:

$$r = A \times E / S \times C$$

Where:

r	=	Reduction in the age of the facility in years.
A	=	Age of the building at the time when construction was completed.
E	=	Actual expenses for the construction provided that the total costs must have been incurred within twenty-four (24) months of the completion of the construction.
S	=	The number of square feet in the building at the end of construction.
C	=	The cost of construction for the buildings in the year when construction was completed according to the schedule in Subsection 630.01.d.ii.

If the result of this calculation, "r" is equal to or greater than two point zero (2.0), the age of the building in years will be reduced by this number, rounded to the nearest whole number for rate setting purposes. In no case will the age be less than zero (0). ( )

ii. For rates paid after June 30, 1989, the effective age of a facility will be further adjusted when the cost of major repairs, replacement, remodeling, or renovation of a building initiated after April 1, 1985, results in the change in age by at least one (1) year when applied to the formula in Subsection 630.01.d.i. However, such change will not decrease the effective age of a facility beyond the point where the increase in the property rental rate is greater than three-fourths (3/4) of the difference between the property rental rate "r" for a new facility at the time of the proposed rate revision and the property rental rate for which the facility was eligible immediately before the adjustment. The cost used for "C" will be adjusted according to costs published by Marshall Swift Valuation Service to reflect current construction costs for average Class D convalescent hospitals. It is the provider's responsibility to notify the Department and document costs. The Department will adjust the age after documentation of costs. ( )

iii. In the event that new requirements are imposed by state or federal agencies, the Department will reimburse the expenditures directly related to these requirements as an increase in the property rental rate if the expense is in excess of one hundred dollars ($100) per bed. If the cost related to the requirement is less than one hundred dollars ($100) per bed, the Department will, within twelve (12) months of verification of expenditure, reimburse the Medicaid share of the entire cost of such new requirements, as a one (1) time payment to the facility. ( )

iv. At no time will the property rental rate paid to a facility be less than the greater of the rate allowable to that facility on December 31, 1988, the rate allowable immediately following the first opening of a new facility after December 31, 1988, or the rate allowable immediately following the last, if any, age revision after December 31, 1988. However, subsequent to the application of this provision, before any property rental rate increase may be made for current or successor operators, the final settlement amount of any increase in the property rental rate will first be offset by an amount equal to the impact on final settlement of any rate decrease that would have occurred if the provisions of Subsections 630.01.d.iii. and 630.01.d.iv. of these rules had not been applied. This is intended to allow the postponement of the financial burden to providers of property rental rate decreases and to allow an equal offset of the financial burden to the state of subsequent property rate increases for a current or successor provider. ( )

v. Effective October 1, 1996, for ICF/IID facilities, "age of facility" will be a revised age that is the lesser of the age established under other provisions of this Section or the age that most closely yields the rate allowable to existing facilities as of September 30, 1996, under Subsection 630.01 of these rules. This revised age will not increase over time. ( )

02. Sale of a Facility. In the event of the sale of a facility, or asset of a facility, the buyer will receive the property rental rate of Subsection 630.01 of these rules. ( )

631. ICF/IID: PROPERTY REIMBURSEMENT LIMITATIONS.
Beginning October 1, 1996, property costs of an ICF/IID will be reimbursed in accordance with Section 630 of these rules except as follows: ( )

01. Restrictions. No grandfathered rates or lease provisions other than lease provisions in Section 630 of these rules will apply to ICF/IID facilities. ( )

02. Home Office and Day Treatment Property Costs. Distinct parts of buildings containing ICF/IID living units may be used for home office or day treatment purposes. Reimbursement for the property costs of such distinct parts may be allowed if these areas are used exclusively for home office or day treatment services. The portion of property cost attributed to these areas may be reimbursed as part of home office or day treatment costs without a reduction in the property rental rate. Reimbursement for home office and day treatment property costs will not include costs reimbursed by, or covered by the property rental rate. Such costs will only be reimbursed as property cost if the facility clearly included space in excess of space normally used in such facilities. At a minimum to qualify for such reimbursement, a structure would have square feet per licensed bed in excess of the average square feet per licensed bed for other ICF/IID living units within four (4) licensable beds. ( )

03. Leases for Property. Beginning October 1, 1996, ICF/IID facilities with leases will be reimbursed as follows: ( )

a. The property costs related to ICF/IID living units other than costs for major movable equipment will be paid by a property rental rate in accordance with Section 630 of these rules. ( )

b. Leases for property other than ICF/IID living units will be allowable based on lease cost to the facility not to exceed a reasonable market rate, subject to other provisions of this chapter, and PRM principles including principles associated with related party leases. ( )

632. ICF/IID: SPECIAL RATES.
Section 56-117, Idaho Code, provides that the Department may pay facilities a special rate for care given to consumers who have medical or behavior long-term care needs beyond the normal scope of facility services. These individuals must have one (1) or more of the following behavior needs; additional personnel for supervision, additional behavior management, or additional psychiatric or pharmacology services. A special rate may also be given to consumers having medical needs that may include individuals needing ventilator assistance, certain medical pediatric needs, or individuals requiring nasogastric or intravenous feeding devices. These medical and behavior needs are not adequately reflected in the rates calculated pursuant to the principles set in Section 56-265, Idaho Code. The payment for such specialized care will be in addition to any payments made in accordance with other provisions of this chapter and will be based on a per diem rate applicable to the incremental additional costs incurred by the facility. Payment for special rates will start with approval by the Department and be and reviewed at least yearly for continued need. The incremental cost to a facility that exceeds the rate for services provided pursuant to the provisions of Section 632 of these rules, will be excluded from the computation of payments or rates under other provisions of Section 56-265, Idaho Code, IDAPA 16.03.09, "Medicaid Basic Plan Benefits," and IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." ( )

01. Determinations. A determination to approve or not approve a special rate will be made on a consumer-by-consumer basis. No rate will be allowed if reimbursement for these needs is available from a non-Medicaid source. ( )

02. Approval. Special rates will not be paid unless prior authorized by the Department. A special rate may be used in the following circumstances: ( )

a. New admissions to a community ICF/IID; ( )

b. For individuals currently living in a community ICF/IID when there has been a significant change in condition not reflected in the current rate; or ( )

c. The facility has altered services to achieve and maintain compliance with state licensing or federal

certification requirements that have resulted in additional cost to the facility not reflected in their current rate. ( )

d. For the purpose of this rule, an emergency exists when the facility must incur additional behavioral or medical costs to prevent a more restrictive placement. ( )

03. Reporting. Costs equivalent to payments at the special rate will be removed from the cost components subject to limits, and will be reported separately. ( )

04. Limitations. The reimbursement rate paid will not exceed the provider's charges to other participants for similar services. ( )

633. REIMBURSEMENT PROVISIONS FOR STATE OWNED OR OPERATED ICF/IID FACILITIES.
Provisions of these rules do not apply to ICF/IID facilities owned or operated by the state of Idaho. Reimbursement of such facilities will be governed by the principles set forth in the PRM, with the exception of depreciation. Assets of such facilities need not be depreciated if they have an acquisition or historical cost of less than five thousand dollars ($5,000). ( )

634. (RESERVED)

YOUTH EMPOWERMENT SERVICES (YES)
HOME AND COMMUNITY-BASED SERVICES (HCBS) STATE PLAN OPTION
(Sections 635-638)

635. YOUTH EMPOWERMENT SERVICES (YES) HOME AND COMMUNITY-BASED SERVICES (HCBS) STATE PLAN OPTION.
Home and community-based services are provided through the HCBS State Plan option, as allowed in Section 1915(i) of the Social Security Act, for children who are YES program participants. HCBS state plan option services must be delivered in accordance with Sections 635 through 638 of these rules. ( )

636. YOUTH EMPOWERMENT SERVICES (YES) HCBS STATE PLAN OPTION: DEFINITIONS.
For the purposes of Sections 635 through 638 of these rules, the following terms are used as defined below. ( )

01. Idaho Behavioral Health Plan (IBHP). The Idaho Behavioral Health Plan is defined in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 011. ( )

02. Independent Assessment. A comprehensive clinical diagnostic assessment and a Department-approved assessment tool to identify the child's needs, strengths, and degree of functional impairment, administered by a Department-designated independent assessor. The assessment process also includes the following activities: ( )

a. Evaluation of the child's current behavioral health, living situation, relationships, and family functioning; ( )

b. Contacts, as necessary, with significant individuals such as family and teachers; and ( )

c. A review of information regarding the child's clinical, educational, social, and behavioral health, and juvenile/criminal justice history. ( )

03. Person-centered Service Plan. The person-centered service plan identifies the participant's physical and behavioral health services and supports needs. The person-centered service plan will be reviewed and updated by the Department or its designated representative at least every twelve (12) months, upon the participant's request, when new services are needed, or when there is a significant change in the participant's condition. ( )

04. Serious Emotional Disturbance (SED). The term "serious emotional disturbance" is defined in Section 16-2403, Idaho Code. ( )

05. YES Program Participant. A YES program participant is an Idaho resident under eighteen (18) years of age with a serious emotional disturbance as determined by an independent assessment. ( )

637. YOUTH EMPOWERMENT SERVICES (YES) HCBS STATE PLAN OPTION: ELIGIBILITY REDETERMINATION.
YES program participant eligibility will be redetermined by an independent assessment every twelve (12) months. The Department may extend participant eligibility to allow for redetermination if the independent assessment is unavoidably delayed. ( )

638. YOUTH EMPOWERMENT SERVICES (YES) HCBS STATE PLAN OPTION: COVERAGE AND LIMITATIONS.
The following services are covered for YES participants: ( )

01. Respite Care. Respite care provides supervision to the participant on an intermittent or short-term basis because of the need for relief of the primary unpaid caregiver of a YES program participant. Respite care is available in response to a family emergency or crisis, or may be used on a regular basis to provide relief to the caregiver. Payment and administration of respite care services will be done through the IBHP and will be established by the Department in the IBHP contract. ( )

02. Person-Centered Planning. A person-centered planning team, comprised of the participant, family members, and other support persons significant to the participant, will direct the development of the person-centered service plan through a process approved by the Department. The process will include support necessary to enable the participant and their family to make informed choices and decisions concerning the person-centered service plan. ( )

639. -- 644. (RESERVED)

ADULT DEVELOPMENTAL DISABILITIES HOME AND COMMUNITY BASED SERVICES (HCBS) STATE PLAN OPTION
(Sections 645-659)

645. HOME AND COMMUNITY-BASED SERVICES (HCBS) STATE PLAN OPTION.
Home and community-based services are provided through the HCBS State Plan option as allowed in Section 1915(i) of the Social Security Act for adults with developmental disabilities who do not meet the ICF/IID level of care. HCBS state plan option services must comply with Sections 310 through 319, and Sections 645 through 657 of these rules. Through the duration of the COVID-19 public health emergency, the Department reserves the right to temporarily alter requirements and processes related to the Adult Developmental Disabilities HCBS State Plan Option program to mitigate spread of disease and to ensure the health and safety of our participants under the guidance and authority of the provisions in a CMS approved 1135 waiver or a state plan amendment to the existing Adult Developmental Disabilities HCBS State Plan Option benefit. In the event additional changes are required in the future, guidance will be posted on the Medicaid Information Releases webpage. ( )

646. COMMUNITY CRISIS SUPPORTS.
Community crisis supports are interventions for participants who have been determined eligible for developmental disability services and who are at risk of losing housing, employment, or income, or are at risk of incarceration, physical harm, family altercation, or other emergencies. ( )

647. COMMUNITY CRISIS SUPPORTS: ELIGIBILITY.
Prior to receiving community crisis supports, an individual must be determined by the Department or its contractor to have a developmental disability under Sections 500 through 506 of these rules and Section 66-402, Idaho Code, be eighteen (18) years of age or older, and live in the community. ( )

648. COMMUNITY CRISIS SUPPORTS COVERAGE AND LIMITATIONS.
Community crisis support may be authorized the following business day after the intervention if there is a documented need for immediate intervention, no other means of support are available, and the services are appropriate to rectify the crisis. Community crisis support is limited to a maximum of twenty (20) hours during any

consecutive five (5) day period. ( )

01. Emergency Room. Crisis services may be provided in an emergency room during the ER evaluation process if the goal is to prevent hospitalization and return the participant to the community. ( )

02. Before Plan Development. Community crisis support may be provided before or after the completion of the assessment and plan of service. If community crisis support is provided before the completion of the assessment and plan of service, the plan of service must include an identification of the factors contributing to the crisis and a strategy for addressing those factors in the future. ( )

03. Crisis Resolution Plan. After community crisis support has been provided, the provider of the community crisis support service must complete a crisis resolution plan and submit it to the Department for approval within seventy-two (72) hours of providing the service. ( )

649. DEVELOPMENTAL THERAPY.
The Department will pay for developmental therapy provided by facilities that have entered into a provider agreement with the Department and are certified as developmental disabilities agencies by the Department. ( )

650. DEVELOPMENTAL THERAPY: ELIGIBILITY.
Prior to receiving developmental therapy in a DDA an individual must be determined by the Department or its contractor to have a developmental disability under Sections 500 through 506 of these rules and Section 66-402, Idaho Code be eighteen (18) years of age or older, and live in the community. ( )

651. DEVELOPMENTAL THERAPY: COVERAGE REQUIREMENTS AND LIMITATIONS.
Developmental therapy must be recommended by a physician or other practitioner of the healing arts. ( )

01. Requirements to Deliver Developmental Therapy. Developmental therapy may be delivered in a developmental disabilities agency center-based program, the community, or the home of the participant. Developmental therapy includes individual developmental therapy and group developmental therapy. Developmental therapy must be delivered by Developmental Specialists or paraprofessionals qualified in accordance with these rules, based on an assessment completed prior to the delivery of developmental therapy. ( )

a. Areas of Service. These services must be directed toward the rehabilitation or habilitation of physical or developmental disabilities in the areas of self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency. ( )

b. Age-Appropriate. Developmental therapy includes instruction in daily living skills the participant has not gained at the normal developmental stages in their life, or is not likely to develop without training or therapy. Developmental therapy must be age-appropriate. ( )

c. Tutorial Activities and Educational Tasks are Excluded. Developmental therapy does not include tutorial activities or assistance with educational tasks associated with educational needs that result from the participant's disability. ( )

d. Settings for Developmental Therapy. Developmental Therapy may be provided in home and community-based settings as described in Section 312 of these rules. Developmental therapy, in both individual and group formats, must be available in both community-based and home-based settings, and be based on participant needs, interests, or choices. ( )

e. Staff-to-Participant Ratio. When group developmental therapy is center-based, there must be a minimum of one (1) qualified staff, who may be a paraprofessional or a Developmental Specialist, providing direct services for every twelve (12) participants. The community-based services must occur in integrated, inclusive settings and with no more than three (3) participants per qualified staff at each session. Additional staff must be added, as necessary, to meet the needs of each individual served. ( )

02. Excluded Services. The following services are excluded for Medicaid payments: ( )

a. Vocational services; ( )

b. Educational services; and ( )

c. Recreational services. ( )

03. Limitations on Developmental Therapy. Developmental therapy may not exceed the limitations as follows: only one (1) type of therapy will be reimbursed during a single time period by the Medicaid program. Developmental therapy will not be reimbursed during periods when the participant is being transported to and from the agency. ( )

652. DEVELOPMENTAL THERAPY: PROCEDURAL REQUIREMENTS FOR INDIVIDUALS WITH AN ISP.

01. Eligibility Determination. Prior to the delivery of developmental therapy, the person must be determined by the Department or its contractor to be eligible as defined under Section 66-402, Idaho Code, be eighteen (18) years of age or older, and live in the community. ( )

02. Intake. Prior to the delivery of developmental therapy: ( )

a. A DDA will obtain a participant's current medical, social, and developmental information from the Department or its designee. ( )

b. The participant must have an ISP that is authorized in accordance with IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Sections 507 through 515. Developmental therapy provided by the DDA must be included on the plan of service and be prior authorized by the Department or its designee before a participant can receive the service from the agency. ( )

03. Documentation of Plan Changes. Documentation of changes in the required plan of service or Program Implementation Plan must be included in the participant's record. This documentation must include, at a minimum, the reason for the change, the date the change was made, and the signature of the professional making the change complete with date, credential, and title. If there are changes to a Program Implementation Plan that affect the type or amount of service on the plan of service, an addendum to the plan of service must be completed. ( )

653. DEVELOPMENTAL THERAPY: PROCEDURAL REQUIREMENTS FOR INDIVIDUALS WITH AN IPP.

01. Eligibility Determination. Prior to the delivery of developmental therapy, the person must be determined by the Department or its contractor to be eligible as defined under Section 66-402, Idaho Code, be eighteen (18) years of age or older, and live in the community. ( )

02. Intake. Individuals using the Home and Community-Based Services (HCBS) waiver for the Aged and Disabled (A&D) or State Plan Personal Care Services and only requesting DDA services, have the option to access services through an Individual Program Plan. Individuals who select this option are not required to have a developmental disability plan developer. Services delivered through an Individual Program Plan must be authorized by the Department or its contractor and be based on the Aged and Disabled written Individual Service Plan as defined in Section 328 of these rules. Prior to the delivery of developmental therapy, a DDA must complete an Individual Program Plan (IPP) that meets the standards described below. ( )

03. Individual Program Plan (IPP) Definitions. The delivery of developmental therapy on a written plan of care must be defined in terms of the type, amount, frequency, and duration of the service. ( )

a. Type of service refers to the kind of service described in terms of: ( )

i. Group, individual, or family; and ( )

ii. Whether the service is home, community, or center-based. ( )

b. Amount of service is the total number of service hours during a specified period of time. This is typically indicated in hours per week. ( )

c. Frequency of service is the number of times service is offered during a week or month. ( )

d. Duration of service is the length of time. This is typically the length of the plan year. For ongoing services, the duration is one (1) year; services that end prior to the end of the plan year must have a specified end date. ( )

04. Individual Program Plan (IPP). ( )

a. The IPP must be developed following obtainment or completion of all applicable assessments consistent with the requirements of this chapter. ( )

b. The planning process must include the participant, their legal guardian if one exists, and others the participant or their legal guardian chooses. The participant and their legal guardian if one exists must sign the IPP indicating they directed the person-centered planning process. The participant and their legal guardian if one exists must be provided a copy of the completed IPP by the DDA. A physician or other practitioner of the healing arts, the participant, and their legal guardian if one exists, must sign the IPP prior to initiation of any services identified within the plan. ( )

c. The planning process must occur at least annually, or more often if necessary, to review and update the plan to reflect any changes in the needs or status of the participant. Revisions to the IPP requiring a change in type, amount, or duration of the service provided must be recommended by the physician or other practitioner of the healing arts prior to implementation of the change. Such recommendations require written authorization by the participant, their legal guardian if one exists, and must be maintained in the participant's file. ( )

d. The IPP must be supported by the documentation required in the participant's record in accordance with IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)" record requirements. ( )

e. The IPP must promote self-sufficiency, the participant's choice in program objectives and activities, encourage the participant's participation and inclusion in the community, and contain objectives that are age-appropriate. The IPP must include: ( )

i. The participant's name and medical diagnosis; ( )

ii. The name of the assigned Developmental Specialist, the date of the planning meeting, and the names and titles of those present at the meeting; ( )

iii. The dated signature of the physician or other practitioner of the healing arts indicating their recommendation of the services on the plan; ( )

iv. The type, amount, frequency, and duration of therapy to be provided. For developmental therapy, the total hours of services provided cannot exceed the amount recommended on the plan. The amount and frequency of the type of therapy must not deviate from the IPP more than twenty percent (20%) over a period of a four (4) weeks, unless there is documentation of a participant-based reason; ( )

v. A list of the participant's current personal goals and desired outcomes, interests, and choices; ( )

vi. An accurate, current, and relevant list of the participant's specific developmental and behavioral strengths and needs. The list will identify which needs are priority based on the participant's choices and preferences. An IPP objective must be developed for each priority need; ( )

vii. A list of measurable behaviorally stated objectives that correspond to the list of priority needs. A Program Implementation Plan must be developed for each objective; ( )

viii. The Developmental Specialist responsible for each objective; ( )

ix. The target date for completion of each objective; ( )

x. The review date; and ( )

xi. A transition plan. The transition plan is designed to facilitate the participant's independence, personal goals, and interests. The transition plan must specify criteria for participant transition into less restrictive, more integrated settings. These settings may include community-based organizations and activities, vocational training, supported or independent employment, volunteer opportunities, or other less restrictive settings. The implementation of some components of the plan may necessitate decreased hours of service or discontinuation of services from a DDA. ( )

05. Documentation of Plan Changes. Documentation of required Program Implementation Plan changes must be included in the participant's record. This documentation must include, at a minimum: ( )

a. The reason for the change; ( )

b. Documentation of coordination with other services providers, where applicable; ( )

c. The date the change was made; and ( )

d. The signature of the professional making the change complete with date, credential, and title. Changes to the IPP require documented notification of the participant and their legal guardian if one exists. Changes in type, amount, or duration of services must be recommended by a physician or other practitioner of the healing arts. Such recommendations require written authorization by the participant and their legal guardian if one exists prior to the change. If the signatures of the participant or their legal guardian cannot be obtained, then the agency must document in the participant's record the reason the signatures were not obtained. ( )

06. Home and Community-Based Person-Centered Planning. Individual Program Plans completed by a DDA must meet the person-centered planning requirements described in Sections 316 and 317 of these rules and must be included in the participant's individual service plan as described in Section 328 of these rules. ( )

654. DEVELOPMENTAL THERAPY: PROCEDURAL REQUIREMENTS.

01. Assessment and Diagnostic Services. DDAs must obtain assessments required under Sections 507 through 515 of these rules. Four (4) hours is the maximum Medicaid reimbursable time allowed for the combination of all assessment, evaluation, or diagnostic services provided in any calendar year. The following assessment and diagnostic services are reimbursable when provided in accordance with these rules: ( )

a. Comprehensive Developmental Assessment; and ( )

b. Specific Skill Assessment. ( )

02. Comprehensive Developmental Assessments. Assessments must be conducted by qualified professionals defined under Section 655 of these rules. ( )

a. Comprehensive Assessments. A comprehensive assessment must: ( )

i. Determine the necessity of the service; ( )

ii. Determine the participant's needs; ( )

iii. Guide treatment; ( )

iv. Identify the participant's current and relevant strengths, needs, and interests when these are

applicable to the respective discipline; and ( )

b. Date, Signature, and Credential Requirements. Assessments must be signed and dated by the professional completing the assessment and include the appropriate professional credential or qualification of that person. ( )

c. Requirements for Current Assessments. Assessments must accurately reflect the current status of the participant. To be considered current, assessments must be completed or updated at least every two (2) years for service areas in which the participant is receiving services on an ongoing basis. ( )

d. Comprehensive Developmental Assessment. A comprehensive developmental assessment must reflect a person's developmental status in the following areas: ( )

i. Self-care; ( )

ii. Receptive and expressive language; ( )

iii. Learning; ( )

iv. Gross and fine motor development; ( )

v. Self-direction; ( )

vi. Capacity for independent living; and ( )

vii. Economic self-sufficiency. ( )

03. Specific Skill Assessments. Specific skill assessments must: ( )

a. Further assess an area of limitation or deficit identified on a comprehensive assessment. ( )

b. Be related to a goal on the IPP or ISP. ( )

c. Be conducted by qualified professionals. ( )

d. Be conducted for the purposes of determining a participant’s skill level within a specific domain. ( )

e. Be used to determine baselines and develop the program implementation plan. ( )

04. DDA Program Documentation Requirements. Each DDA must maintain records for each participant the agency serves. Each participant's record must include documentation of the participant's involvement in and response to the services provided. ( )

a. General Requirements for Program Documentation. For each participant the following program documentation is required: ( )

i. Daily entry of all activities conducted toward meeting participant objectives. ( )

ii. Sufficient progress data to accurately assess the participant's progress toward each objective; and ( )

iii. A review of the data, and, when indicated, changes in the daily activities or specific implementation procedures by the qualified professional. The review must include the qualified professional’s dated initials. ( )

iv. Documentation of six (6) month and annual reviews by the Developmental Specialist that includes

a written description of the participant's progress toward the achievement of therapeutic goals, and the reason(s) why they continue to need services. ( )

v. Signed, authorized plan as described in Section 513 of these rules. ( )

b. DDAs must also submit provider status reviews to the plan monitor in accordance with Sections 507 through 515 of these rules. ( )

05. DDA Program Implementation Plan Requirements. For each participant, the DDA must develop a Program Implementation Plan for each DDA objective included on the participant's required plan of service. All Program Implementation Plans must be related to a goal or objective on the participant's plan of service. The Program Implementation Plan must be developed within fourteen (14) days from the plan of service start date or receipt of the authorized plan of service and be revised whenever participant needs change. If the Program Implementation Plan is not completed within this time frame, the participant's records must contain participant-based documentation justifying the delay. If consistent with the timeframes above, a participant's annual Program Implementation Plan is completed after the start date of the annual plan of service, the provider will address goals and objectives as agreed to by the participant until the annual Program Implementation Plan is complete and must document service provision related to these interim goals and objectives consistent with Section 654 of these rules. The Program Implementation Plan must include the following requirements: ( )

a. Name. The participant's name. ( )

b. Baseline Statement. A baseline statement addressing the participant's skill level and abilities related to the specific skill to be learned. ( )

c. Objectives. Measurable, behaviorally-stated objectives that correspond to those goals or objectives authorized and agreed to in the required plan of service. ( )

d. Written Instructions to Staff. These instructions may include curriculum, interventions, task analyses, activity schedules, type and frequency of reinforcement, and data collection including probe, directed at the achievement of each objective. These instructions must be individualized and revised as necessary to promote participant progress toward the stated objective. ( )

e. Service Environments. Identification of the type of environment(s) where services will be provided. ( )

f. Target Date. Target date for completion. ( )

g. Results of the Psychological or Psychiatric Assessment. When a participant has had a psychological or psychiatric assessment, the results of the psychological or psychiatric assessment must be used when developing objectives to ensure therapies provided in the DDA accommodate the participant's mental health needs and to ensure that none of the therapeutic methods are contra-indicated or delivered in a manner that presents a risk to the participant's mental health status. ( )

h. Home and Community-Based Services Requirements. All program implementation plans must meet home and community-based setting qualities defined in Section 313 of these rules. ( )

655. DEVELOPMENTAL THERAPY: PROVIDER QUALIFICATIONS AND DUTIES.

01. Developmental Specialist for Adults. To be qualified as a Developmental Specialist for adults, a person must have a minimum of two hundred forty (240) hours of professionally-supervised experience with individuals who have developmental disabilities and either: ( )

a. Possess a bachelor's or master's degree in special education, early childhood special education, speech and language pathology, applied behavioral analysis, psychology, physical therapy, occupational therapy, social work, or therapeutic recreation; or ( )

b. Possess a bachelor's or master's degree in an area not listed above in Subsection 657.05.a. of this rule and have: ( )

i. Completed a competency course jointly approved by the Department and the Idaho Association of Developmental Disabilities Agencies that relates to the job requirements of a Developmental Specialist; and ( )

ii. Passed a competency examination approved by the Department. ( )

c. Any person employed as a Developmental Specialist in Idaho prior to May 30, 1997, unless previously disallowed by the Department, will be allowed to continue providing services as a Developmental Specialist as long as there is not a gap of more than three (3) years of employment as a Developmental Specialist. ( )

d. Through the duration of the COVID-19 public health emergency, Development Specialists for adults may begin rendering services prior to completing the training requirements provided that they complete the training requirements within thirty (30) days of first rendering services, advise the participant or legal guardian that the individual has not yet completed the applicable trainings, and comply with any other requirements specified by the Department in a COVID-19 information release posted on the Department's website at https://healthandwelfare.idaho.gov/Providers/Providers-Medicaid/InformationReleases/tabid/264/Default.aspx. ( )

02. Developmental Therapy Paraprofessionals. Paraprofessionals, such as aides or therapy technicians, may be used by an agency to provide developmental therapy if they are under the supervision of a Developmental Specialist. A developmental therapy paraprofessional must be at least seventeen (17) years of age. ( )

03. Requirements for Collaboration with Other Providers. When participants are receiving rehabilitative or habilitative services from other providers, each DDA must coordinate each participant's DDA program with these providers to maximize skill acquisition and generalization of skills across environments, and to avoid duplication of services. The DDA must maintain documentation of this collaboration. This documentation includes other plans of services such as the Individual Education Plan (IEP), Personal Care Services (PCS) plan, Residential Habilitation plan, and the outpatient behavioral health service plan. The participant's file must also reflect how these plans have been integrated into the DDA's plan of service for each participant. ( )

656. GENERAL STAFFING REQUIREMENTS.

01. Standards for Paraprofessionals Providing Developmental Therapy. When a paraprofessional provides developmental therapy, the agency must ensure adequate supervision by a qualified professional during its service hours. All paraprofessionals must meet the training requirements under IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)," Section 410 and must meet the qualifications under Section 655 of these rules. A paraprofessional providing developmental therapy must be supervised by a Developmental Specialist. For paraprofessionals to provide developmental therapy in a DDA, the agency must adhere to the following standards: ( )

a. Limits to Paraprofessional Activities. The agency must ensure that paraprofessionals do not conduct participant assessments, establish a plan of service or develop a Program Implementation Plan. These activities must be conducted by a professional qualified to provide the service. ( )

b. Frequency of Supervision. The agency must ensure that a professional qualified to provide the service must, for all paraprofessionals under their supervision, on a weekly basis or more often if necessary: ( )

i. Give instructions; ( )

ii. Review progress; and ( )

iii. Provide training on the program(s) and procedures to be followed. ( )

c. Professional Observation. The agency must ensure that a professional qualified to provide the service must, on a monthly basis or more often if necessary, observe and review the work performed by the paraprofessional under their supervision, to ensure the paraprofessional has been trained on the program(s) and demonstrates the necessary skills to correctly implement the program(s). ( )

02. General Staffing Requirements for Agencies. Each DDA must have an agency administrator who is accountable for all service elements of the agency and who must be employed on a continuous and regularly scheduled basis. The agency administrator is accountable for the overall operations of the agency including ensuring compliance with this chapter of rules, overseeing and managing staff, developing and implementing written policies and procedures, and overseeing the agency's quality assurance program. ( )

a. When the administrator is not a Developmental Specialist as defined in these rules, the DDA must employ a Developmental Specialist on a continuous and regularly scheduled basis who is responsible for the service elements of the agency; and ( )

b. The Developmental Specialist responsible for the service elements of the agency must have two (2) years of supervisory or management experience providing developmental disabilities services to individuals with developmental disabilities. ( )

657. DEVELOPMENTAL THERAPY: PROVIDER REIMBURSEMENT.
Payment for developmental therapy provided by a DDA must be in accordance with rates established by the Department. ( )

658. COVID-19 PUBLIC HEALTH EMERGENCY RESIDENTIAL HABILITATION.
Through the duration of the COVID-19 public health emergency, the Department will pay for residential habilitation services, as described in Subsection 703.01 of these rules, provided by facilities that have entered into a provider agreement with the Department and are certified as developmental disabilities agencies by the Department. Prior to receiving residential habilitation services from a DDA, an individual must be determined by the Department, or its contractor, to have a developmental disability under Sections 500 through 506 of these rules and Section 66-402, Idaho Code, be eighteen (18) years of age or older, and live in the community. DDA's providing residential habilitation services must comply with any additional requirements specified by the Department in a COVID-19 information release posted on the Department's website at https://healthandwelfare.idaho.gov/Providers/Providers-Medicaid/InformationReleases/tabid/264/Default.aspx. ( )

659. -- 699. (RESERVED)

ADULTS WITH DEVELOPMENTAL DISABILITIES WAIVER SERVICES (Sections 700-719)

700. ADULTS WITH DEVELOPMENTAL DISABILITIES WAIVER SERVICES.
Under 42 CFR Section 440.180, it is the intention of the Department to provide waiver services to eligible adult participants to prevent unnecessary institutional placement, provide for the greatest degree of independence possible, enhance the quality of life, encourage individual choice, and achieve and maintain community integration. For an adult participant to be eligible, the Department must find that the participant requires services due to a developmental disability that impairs their mental or physical function or independence, is capable of being maintained safely and effectively in a non-institutional setting, and would, in the absence of such services, need to reside in an ICF/IID. Through the duration of the COVID-19 public health emergency, the Department reserves the right to temporarily alter requirements and processes related to the Adult DD waiver program to mitigate spread of disease and to ensure the health and safety of our participants under the guidance and authority of the provisions in a CMS approved 1135 waiver or HCBS Attachment K amendment to the existing Adult Developmental Disability waiver. In the event additional changes are required in the future, guidance will be posted on the Medicaid Information Releases webpage. ( )

701. (RESERVED)

702. ADULT DD WAIVER SERVICES: ELIGIBILITY.

Waiver eligibility will be determined by the Department as described in Section 509 of these rules. The participant must be financially eligible for Medical Assistance as described in IDAPA 16.03.05, "Eligibility for Aid for the Aged, Blind, and Disabled (AABD)," Section 787. The cited chapter implements and is in accordance with the Financial Eligibility Section of the Idaho State Plan. In addition, waiver participants must meet the following requirements: ( )

01. Age of Participants. DD waiver participants must be eighteen (18) years of age or older. ( )

02. Eligibility Determinations. The Department must determine that: ( )

a. The participant would qualify for ICF/IID level of care as set forth in Section 584 of these rules, if the waiver services listed in Section 703 of these rules were not made available; and ( )

b. The participant could be safely and effectively maintained in the requested or chosen community residence with appropriate waiver services. This determination must: be made by a team of individuals with input from the person-centered planning team; and prior to any denial of services on this basis, be determined by the plan developer that services to correct the concerns of the team are not available. ( )

c. The average annual cost of waiver services and other medical services to the participant would not exceed the average annual cost to Medicaid of ICF/IID care and other medical costs. ( )

03. Home and Community-Based Services Waiver Eligible Participants. A participant who is determined by the Department to be eligible for services under the Home and Community-Based Services Waivers for DD may elect not to utilize waiver services but may choose admission to an ICF/IID. ( )

04. Processing Applications. The participant's self-reliance staff will process the application in accordance with IDAPA 16.03.05, "Eligibility for Aid to the Aged, Blind, and Disabled (AABD)," as if the application was for admission to an ICF/IID, except that the self-reliance staff will forward potentially eligible applications immediately to the Department for review. The Medicaid application process cited above conforms to all statutory and regulatory requirements relating to the Medicaid application process. ( )

05. Transmitted Decisions to Self-Reliance Staff. The decisions of the Department regarding the acceptance of the participants into the waiver program will be transmitted to the self-reliance staff. ( )

06. Case Redetermination. ( )

a. Financial redetermination will be conducted pursuant to IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children," and IDAPA 16.03.05, "Eligibility for Aid to the Aged, Blind, and Disabled (AABD)." Medical redetermination will be made at least annually by the Department, or sooner at the request of the participant, the self-reliance staff, provider agency, or physician. The sections cited implement and are in accordance with Idaho's approved State Plan with the exception of deeming of income provisions. ( )

b. The redetermination process will assess the following factors: ( )

i. The participant's continued need and eligibility for waiver services; and ( )

ii. Discharge from the waiver services program. ( )

07. Home and Community-Based Waiver Participant Limitations. The number of Medicaid participants to receive waiver services under the home and community-based waiver for developmentally disabled participants will be limited to the projected number of users contained in the Department's approved waiver. Individuals who apply for waiver services after the waiver maximum has been reached will be placed on a waiting list and will have their applications processed after September 30th for the DD waiver of each new waiver year. ( )

703. ADULT DD WAIVER SERVICES: COVERAGE AND LIMITATIONS.

01. Residential Habilitation. Residential habilitation services consist of an integrated array of individually tailored services and supports furnished to eligible participants. These services and supports are designed to assist the participants to reside successfully in their own homes, with their families, or in certified family homes. The services and supports that may be furnished consist of the following: ( )

a. Habilitation services aimed at assisting the individual to acquire, retain, or improve their ability to reside as independently as possible in the community or maintain family unity. Habilitation services include training in one (1) or more of the following areas: ( )

i. Self-direction, including the identification of and response to dangerous or threatening situations, making decisions and choices affecting the individual's life, and initiating changes in living arrangements or life activities; ( )

ii. Money management including training or assistance in handling personal finances, making purchases, and meeting personal financial obligations; ( )

iii. Daily living skills including training in accomplishing routine housekeeping tasks, meal preparation, dressing, personal hygiene, self-administration of medications, and other areas of daily living including proper use of adaptive and assistive devices, appliances, home safety, first aid, and emergency procedures; ( )

iv. Socialization including training or assistance in participation in general community activities and establishing relationships with peers with an emphasis on connecting the participant to their community. (Socialization training associated with participation in community activities includes assisting the participant to identify activities of interest, working out arrangements to participate in such activities and identifying specific training activities necessary to assist the participant to continue to participate in such activities on an on-going basis. Socialization training does not include participation in non-therapeutic activities that are merely diversional or recreational in nature); ( )

v. Mobility, including training or assistance aimed at enhancing movement within the person's living arrangement, mastering the use of adaptive aids and equipment, accessing and using public transportation, independent travel, or movement within the community; ( )

vi. Behavior shaping and management includes training and assistance in appropriate expressions of emotions or desires, assertiveness, acquisition of socially appropriate behaviors; or extension of therapeutic services that consist of reinforcing physical, occupational, speech and other therapeutic programs. ( )

b. Personal Assistance Services necessary to assist the individual in daily living activities, household tasks, and such other routine activities as the participant or the participant's primary caregiver(s) are unable to accomplish on their own behalf. ( )

c. Skills training to teach waiver participants, family members, alternative family caregiver(s), or a participant's roommate or neighbor to perform activities with greater independence and to carry out or reinforce habilitation training. Services are focused on training and are not designed to provide substitute task performance. Skills training is provided to encourage and accelerate development in independent daily living skills, self-direction, money management, socialization, mobility and other therapeutic programs. ( )

02. Chore Services. Chore services include the following services when necessary to maintain the functional use of the home or to provide a clean, sanitary, and safe environment. ( )

a. Intermittent Assistance may include the following: ( )

i. Yard maintenance; ( )

ii. Minor home repair; ( )

iii. Heavy housework; ( )

iv. Sidewalk maintenance; and ( )

v. Trash removal to assist the participant to remain in the home. ( )

b. Chore activities may include the following: ( )

i. Washing windows; ( )

ii. Moving heavy furniture; ( )

iii. Shoveling snow to provide safe access inside and outside the home; ( )

iv. Chopping wood when wood is the participant's primary source of heat; and ( )

v. Tacking down loose rugs and flooring. ( )

c. These services are only available when neither the participant, nor anyone else in the household, is capable of performing or financially providing for them, and where no other relative, caregiver, landlord, community volunteer, agency, or third-party payer is willing to provide them, or is responsible for their provision. ( )

d. In the case of rental property, the landlord's responsibility under the lease agreement will be examined prior to any authorization of service. Chore services are limited to the services provided in a home rented or owned by the participant. ( )

03. Respite Care. Respite care includes short-term breaks from care giving responsibilities to non-paid caregivers. The caregiver or participant is responsible for selecting, training, and directing the provider. While receiving respite care services, the waiver participant cannot receive other services that are duplicative in nature. Respite care services provided under this waiver do not include room and board payments. Respite care services may be provided in the participant's residence, the private home of the respite provider, the community, a developmental disabilities agency, or an adult day health facility. ( )

04. Supported Employment. Supported employment consists of competitive work in integrated work settings for individuals with the most severe disabilities for whom competitive employment has not traditionally occurred; or for whom competitive employment has been interrupted or intermittent as a result of a severe disability. Because of the nature and severity of their disability, these individuals need intensive supported employment services or extended services in order to perform such work. ( )

a. Supported employment services rendered under the waiver are not available under a program funded by either the Rehabilitation Act of 1973, as amended, or the Individuals with Disabilities Education Act (IDEA). Documentation must be maintained in the file of each individual receiving this service verifying that the service is not otherwise available or funded under the Rehabilitation Act of 1973 as amended, or the IDEA. ( )

b. Federal Financial Participation (FFP) cannot be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following: incentive payments made to an employer of waiver participants to encourage or subsidize the employers' participation in a supported employment program; payments that are passed through to beneficiaries of supported employment programs; or payments for vocational training that are not directly related to a waiver participant's supported employment program. ( )

05. Non-Medical Transportation. Non-medical transportation enables a waiver participant to gain access to waiver and other community services and resources. ( )

a. Non-medical transportation is offered in addition to medical transportation required in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," and will not replace it. ( )

b. Whenever possible, family, neighbors, friends, or community agencies who can provide this service without charge or public transit providers will be utilized. ( )

06. Environmental Accessibility Adaptations. Environmental accessibility adaptations include minor housing adaptations that are necessary to enable the participant to function with greater independence in the home, or without which, the participant would require institutionalization or have a risk to health, welfare, or safety. Such adaptations may include: ( )

a. The installation of ramps and lifts, widening of doorways, modification of bathroom facilities, or installation of electric and plumbing systems that are necessary to accommodate the medical equipment and supplies necessary for the welfare of the waiver participant, but must exclude those adaptations or improvements to the home that are not of direct medical or remedial benefit to the participant, such as carpeting, roof repair, or central air conditioning. ( )

b. Unless otherwise authorized by the Department, permanent environmental modifications are limited to a home that is the participant's principal residence, and is owned by the participant or the participant's non-paid family. ( )

c. Portable or non-stationary modifications may be made when such modifications can follow the participant to their next place of residence or be returned to the Department. ( )

07. Specialized Medical Equipment and Supplies. ( )

a. Specialized medical equipment and supplies include: ( )

i. Devices, controls, or appliances that enable a participant to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live; and ( )

ii. Items necessary for life support, ancillary supplies and equipment necessary for the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State Plan. ( )

b. Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the Medicaid State Plan and exclude those items that are not of direct medical or remedial benefit to the participant. ( )

08. Personal Emergency Response System (PERS). PERS is an electronic device that enables a waiver participant to secure help in an emergency. The participant may also wear a portable "help" button to allow for mobility. The system is connected to the participant's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals. This service is limited to participants who: ( )

a. Rent or own a home, or live with unpaid caregivers; ( )

b. Are alone for significant parts of the day; ( )

c. Have no caregiver for extended periods of time; and ( )

d. Would otherwise require extensive, routine supervision. ( )

09. Home Delivered Meals. Home delivered meals are meals that are delivered to a participant's home to promote adequate participant nutrition. One (1) to two (2) meals per day may be provided to a participant who: ( )

a. Rents or owns a home; ( )

b. Is alone for significant parts of the day; ( )

c. Has no caregiver for extended periods of time; and ( )

d. Is unable to prepare a meal without assistance. ( )

10. Skilled Nursing. Skilled nursing includes intermittent or continuous oversight, training, or skilled care that is within the scope of the Nurse Practice Act. Such care must be provided by a licensed registered nurse, or licensed practical nurse under the supervision of a licensed registered nurse licensed to practice in Idaho. ( )

11. Behavior Consultation/Crisis Management. Behavior Consultation/Crisis Management services that provide direct consultation and clinical evaluation of participants who are currently experiencing or may be expected to experience, a psychological, behavioral, or emotional crisis. This service may provide training and staff development related to the needs of a participant. These services also provide emergency back-up involving the direct support of the participant in crisis. ( )

12. Adult Day Health. Adult day health is a supervised, structured service generally furnished four (4) or more hours per day on a regularly scheduled basis, for one (1) or more days per week. It is provided outside the home of the participant in a non-institutional, community-based setting, and it encompasses health services, social services, recreation, supervision for safety, and assistance with activities of daily living needed to ensure the optimal functioning of the participant. Adult day health services provided under this waiver will not include room and board payments. ( )

13. Self-Directed Community Supports. Participants eligible for the DD Waiver may choose to self-direct their individualized budget rather than receive the traditional waiver services described in this section of rule. The requirements for this option are outlined in IDAPA 16.03.13, "Consumer-Directed Services." ( )

14. Place of Service Delivery. Waiver services may be provided in home and community settings as described in Section 312 of these rules. Approved places of services include the participant's personal residence, a certified family home, day habilitation/supported employment program, or community. The following living situations are specifically excluded as a place of service for waiver services: ( )

a. Licensed skilled, or intermediate care facilities, certified nursing facility (NF) or hospital; and ( )

b. Licensed Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID); and ( )

c. Residential Assisted Living Facility. ( )

d. Additional limitations to specific services are listed under that service definition. ( )

15. Transition Services. Transition Services include goods and services that enable a participant residing in a nursing facility, hospital, IMD, or ICF/IID to transition to a community-based setting. A participant is eligible to receive transition services immediately following discharge from a qualified institution after residing within that institution for a minimum of forty-five (45) days. ( )

a. Qualified Institutions include the following: ( )

i. Skilled, or Intermediate Care Facilities; ( )

ii. Nursing Facility; ( )

iii. Licensed Intermediate Care Facility for the Persons with Intellectual Disabilities (ICF/IID); ( )

iv. Hospitals; and ( )

v. Institutions for Mental Diseases (IMD). ( )

b. Transition services may include the following goods and services: ( )

i. Security deposits that are required to obtain a lease on an apartment or home; ( )

ii. Cost of essential household furnishings, including furniture, window coverings, food preparation items, and bed/bath linens; and ( )

iii. Set-up fees or deposits for utility or service access, including telephone, electricity, heating and water; ( )

iv. Services necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy; ( )

v. Moving expenses; and ( )

vi. Activities to assess need, arrange for and procure transition services. ( )

c. Excluded goods and services. Transition services do not include ongoing expenses, real property, ongoing utility charges, décor, or diversion/recreational items such as televisions, DVDs, and computers. ( )

d. Service limitations. Transition services are limited to a total cost of two thousand dollars ($2,000) per participant and can be accessed every two (2) years, contingent upon a qualifying transition from an institutional setting. Transition services are furnished only to the extent that the person is unable to meet such expense or when the support cannot be obtained from other sources. ( )

704. ADULT DD WAIVER SERVICES: PROCEDURAL REQUIREMENTS.

01. Authorization of Services on a Written Plan. All waiver services must be identified on the plan of service and authorized by the process described in Sections 507 through 520 of these rules. The plan of service must be reviewed by a plan monitor or targeted service coordinator at a frequency determined by the person-centered planning team, but at least every ninety (90) days. ( )

02. Provider Records. Three (3) types of record information will be maintained on all participants receiving waiver services: ( )

a. Direct Service Provider Information that includes written documentation of each visit made or service provided to the participant, and will record at a minimum the following information: ( )

i. Date and time of visit; and ( )

ii. Services provided during the visit; and ( )

iii. A statement of the participant's response to the service, if appropriate to the service provided, including any changes in the participant's condition; and ( )

iv. Length of visit, including time in and time out, if appropriate to the service provided. Unless the participant is determined by the Service Coordinator to be unable to do so, the delivery will be verified by the participant as evidenced by their signature on the service record. ( )

v. A copy of the above information will be maintained in the participant's home unless authorized to be kept elsewhere by the Department. Failure to maintain such documentation will result in the recoupment of funds paid for undocumented services. ( )

b. The plan of service developed by the plan developer and the person-centered planning team must specify which services are required by the participant. The plan of service must contain all elements required by Subsection 704.01 of these rules and a copy of the most current plan of service must be maintained in the participant's

home and must be available to all service providers and the Department. ( )

c. In addition to the plan of service, all providers, with the exception of chore, non-medical transportation, and enrolled Medicaid vendors, must submit a provider status review six (6) months after the start date of the plan of service and annually to the plan monitor as described in Sections 507 through 520 of these rules. ( )

03. Provider Responsibility for Notification. It is the responsibility of the service provider to notify the service coordinator or plan developer when any significant changes in the participant's condition are noted during service delivery. Such notification will be documented in the service record. ( )

04. Records Maintenance. In order to provide continuity of services, when a participant changes service providers, plan developers, or service coordinators, all of the foregoing participant records will be delivered to and held by the Department until a replacement service provider, plan developer, or service coordinator is selected by the participant. When a participant leaves the waiver services program, the records will be retained by the Department as part of the participant's closed case record. Provider agencies will be responsible to retain their participant's records for five (5) years following the date of service. ( )

705. ADULT DD WAIVER SERVICES: PROVIDER QUALIFICATIONS AND DUTIES.
All providers of waiver services must have a valid provider agreement with the Department. Performance under this agreement will be monitored by the Department. ( )

01. Residential Habilitation -- Supported Living. When residential habilitation services are provided by an agency, the agency must be certified by the Department as a Residential Habilitation Agency under IDAPA 16.04.17, "Residential Habilitation Agencies," and must supervise the direct services provided. Individuals who provide residential habilitation services in the home of the participant (supported living) must be employed by a Residential Habilitation Agency. Providers of residential habilitation services must meet the following requirements: ( )

a. Direct service staff must meet the following minimum qualifications: ( )

i. Be at least eighteen (18) years of age; ( )

ii. Be a high school graduate, or have a GED, or demonstrate the ability to provide services according to a plan of service; ( )

iii. Have current CPR and First Aid certifications; ( )

iv. Be free from communicable disease; ( )

v. Each staff person assisting with participant medications has successfully completed the "Assistance with Medications" course available through the Idaho Professional Technical Education Program approved by the Idaho State Board of Nursing or other Department-approved training. ( )

vi. Residential habilitation service providers who provide direct care or services satisfactorily completed a criminal background check in accordance with Section 009 of these rules and IDAPA 16.05.06, "Criminal History and Background Checks." ( )

vii. Have appropriate certification or licensure if required to perform tasks that require certification or licensure. ( )

b. All skill training for agency direct service staff must be provided by a Qualified Intellectual Disabilities Professional (QIDP) who has demonstrated experience in writing skill training programs. ( )

c. Prior to delivering services to a participant, agency direct service staff must complete an orientation program. The orientation program must include the following subjects: ( )

i. Purpose and philosophy of services; ( )

ii. Service rules; ( )

iii. Policies and procedures; ( )

iv. Proper conduct in relating to waiver participants; ( )

v. Handling of confidential and emergency situations that involve the waiver participant; ( )

vi. Participant rights; ( )

vii. Methods of supervising participants; ( )

viii. Working with individuals with developmental disabilities; and ( )

ix. Training specific to the needs of the participant. ( )

d. Additional training requirements must be completed within six (6) months of employment with the residential habilitation agency and include at a minimum: ( )

i. Instructional techniques: Methodologies for training in a systematic and effective manner; ( )

ii. Managing behaviors: Techniques and strategies for teaching adaptive behaviors; ( )

iii. Feeding; ( )

iv. Communication; ( )

v. Mobility; ( )

vi. Activities of daily living; ( )

vii. Body mechanics and lifting techniques; ( )

viii. Housekeeping techniques; and ( )

ix. Maintenance of a clean, safe, and healthy environment. ( )

e. The provider agency will be responsible for providing on-going training specific to the needs of the participant as needed. ( )

f. Through the duration of the COVID-19 public health emergency, agency direct service staff may begin rendering services prior to completing the training requirements, provided that they complete the training requirements within thirty (30) days of first rendering services, advise the participant or legal guardian that the individual has not yet completed the applicable trainings, and comply with any other requirements specified by the Department in a COVID-19 information release posted on the Department's website at https://healthandwelfare.idaho.gov/Providers/Providers-Medicaid/InformationReleases/tabid/264/Default.aspx. ( )

02. Residential Habilitation -- Certified Family Home (CFH). ( )

a. An individual who provides direct residential habilitation services in their own home must be certified by the Department to operate a certified family home under IDAPA 16.03.19, "Certified Family Homes," and must receive residential habilitation program coordination services provided through the Department, or its contractor, for the residential habilitation services they provide. ( )

b. CFH providers providing residential habilitation services as a DD Waiver provider must meet the following minimum qualifications: ( )

i. Be at least eighteen (18) years of age; ( )

ii. Be a high school graduate, have a GED, or demonstrate the ability to provide services according to a plan of service; ( )

iii. Have current CPR and First Aid certifications; ( )

iv. Be free from communicable disease; ( )

v. Each CFH provider of residential habilitation services assisting with participant medications has successfully completed the "Assistance with Medications" course available through the Idaho Professional Technical Education Program approved by the Idaho State Board of Nursing, or other Department-approved training. ( )

vi. CFH providers of residential habilitation services who provide direct care and services have satisfactorily completed a criminal history check in accordance with Section 009 of these rules and IDAPA 16.05.06, "Criminal History and Background Checks;" and ( )

vii. Have appropriate certification or licensure if required to perform tasks that require certification or licensure. ( )

c. All skill training for CFH providers who are providing residential habilitation services must be provided through the Department or its contractor by qualified intellectual disabilities professional (QIDP) who has demonstrated experience in writing skill training programs. ( )

d. Prior to delivering residential habilitation services to a participant, the CFH provider must complete an orientation training in the following areas as provided by either the Department, or its contractor or both, and include the following areas: ( )

i. Purpose and philosophy of services; ( )

ii. Service rules; ( )

iii. Policies and procedures; ( )

iv. Proper conduct in relating to waiver participants; ( )

v. Handling of confidential and emergency situation that involve the waiver participant; ( )

vi. Participant rights; ( )

vii. Methods of supervising participants; ( )

viii. Working with individuals with developmental disabilities; and ( )

ix. Training specific to the needs of the participant. ( )

e. Additional training requirements for CFH providers providing residential habilitation waiver services must be completed by the CFH provider within six (6) months of certification date and include a minimum of the following: ( )

i. Instructional Techniques: Methodologies for training in a systematic and effective manner; ( )

ii. Managing behaviors: techniques and strategies for teaching adaptive behaviors; ( )

iii. Feeding; ( )

iv. Communication; ( )

v. Mobility; ( )

vi. Activities of daily living; ( )

vii. Body mechanics and lifting techniques; ( )

viii. Housekeeping techniques; and ( )

ix. Maintenance of a clean, safe, and healthy environment. ( )

f. The Department or its contractor will be responsible for providing on-going training to the CFH provider of residential habilitation specific to the needs of the participant as needed. ( )

g. Through the duration of the COVID-19 public health emergency, CFH providers may begin rendering services prior to completing the training requirements, provided that they complete the training requirements within thirty (30) days of first rendering services, advise the participant or legal guardian that the individual has not yet completed the applicable trainings, and comply with any other requirements specified by the Department in a COVID-19 information release posted on the Department's website at https://healthandwelfare.idaho.gov/Providers/Providers-Medicaid/InformationReleases/tabid/264/Default.aspx. ( )

03. Chore Services. Providers of chore services must meet the following minimum qualifications: ( )

a. Be skilled in the type of service to be provided; and ( )

b. Demonstrate the ability to provide services according to a plan of service. ( )

c. Chore service providers who provide direct care and services have satisfactorily completed a criminal history and background check in accordance with Section 009 of these rules and IDAPA 16.05.06, "Criminal History and Background Checks." ( )

04. Respite Care. Providers of respite care services must meet the following minimum qualifications: ( )

a. Have received care giving instructions in the needs of the person who will be provided the service; ( )

b. Demonstrate the ability to provide services according to a plan of service; ( )

c. Be free of communicable disease; and ( )

d. Respite care service providers who provide direct care and services have satisfactorily completed a criminal history and background check in accordance with Section 009 of these rules and IDAPA 16.05.06, "Criminal History and Background Checks." ( )

05. Supported Employment. Supported employment services must be provided by an agency that supervises the direct service and is accredited by the Commission on Accreditation of Rehabilitation Facilities or other comparable standards, or meets State requirements to be a State-approved provider. Supported employment service providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with Section 009 of these rules and IDAPA 16.05.06, "Criminal History and Background Checks." ( )

06. Non-Medical Transportation. Providers of non-medical transportation services must: ( )

a. Possess a valid driver's license; and ( )

b. Possess valid vehicle insurance. ( )

07. Environmental Accessibility Adaptations. All services must be provided in accordance with applicable state or local building codes and meet state or local building, plumbing, and electrical requirements for certification. ( )

08. Specialized Medical Equipment and Supplies. Providers of specialized medical equipment and supplies must be enrolled in the Medicaid program as participating medical vendor providers. Providers must ensure all items meet applicable standards of manufacture, design, and installation. Preference will be given to equipment and supplies that are the most cost-effective option to meet the participant's needs. ( )

09. Personal Emergency Response System. Personal emergency response system providers must demonstrate that the devices installed in a waiver participant's home meet Federal Communications Standards, or Underwriter's Laboratory standards, or equivalent standards. ( )

10. Home Delivered Meals. Providers of home-delivered meals must be a public agency or private business, and must exercise supervision to ensure that: ( )

a. Each meal meets one-third (1/3) of the Recommended Daily Allowance, as defined by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences; ( )

b. Meals are delivered in accordance with the service plan, in a sanitary manner, and at the correct temperature for the specific type of food; ( )

c. A Registered Dietitian documents the review and approval of menus, menu cycles, and any changes or substitutions; and ( )

d. The agency or business is inspected and licensed as a food establishment under IDAPA 16.02.19, "Idaho Food Code." ( )

11. Skilled Nursing. Skilled nursing service providers must be licensed in Idaho as a licensed registered nurse or licensed practical nurse in good standing, or must be practicing on a federal reservation and be licensed in another state. Skilled nursing providers who provide direct care and services must satisfactorily complete a criminal history and background check in accordance with Section 009 of these rules and IDAPA 16.05.06, "Criminal History and Background Checks." ( )

12. Behavior Consultation or Crisis Management. Behavior Consultation or Crisis Management Providers must meet the following: ( )

a. Work under the direct supervision of a licensed psychologist or Ph.D. in Special Education, with training and experience in treating severe behavior problems and training and experience in applied behavior analysis; and ( )

b. Have a Master's Degree in a behavioral science such as social work, psychology, psychosocial rehabilitation counseling, psychiatric nursing, special education or a closely related course of study; or ( )

c. Be a licensed pharmacist; or ( )

d. Be a Qualified Intellectual Disabilities Professional (QIDP). ( )

e. Emergency back-up providers must meet the minimum residential habilitation provider qualifications described under IDAPA 16.04.17, "Residential Habilitation Agencies." ( )

f. Behavior consultation or crisis management providers who provide direct care or services must satisfactorily complete a criminal history and background check in accordance with Section 009 of these rules and IDAPA 16.05.06, "Criminal History and Background Checks." ( )

13. Adult Day Health. Providers of adult day health must meet the following requirements: ( )

a. Services provided in a facility must be provided in a facility that meets the building and health standards identified in IDAPA 16.03.21, "Developmental Disabilities Agencies (DDA)"; ( )

b. Services provided in a home must be provided in a home that meets the standards of home certification identified in IDAPA 16.03.19, "Certified Family Homes"; ( )

c. Adult day health providers who provide direct care or services must satisfactorily complete a criminal history check in accordance with Section 009 of these rules and IDAPA 16.05.06, "Criminal History and Background Checks"; ( )

d. Providers of adult day health must notify the Department on behalf of the participant, if the adult day health is provided in a certified family home other than the participant's primary residence. The adult day health provider must provide care and supervision appropriate to the participant's needs as identified on the plan. ( )

e. Adult day health providers who provide direct care or services must be free from communicable disease. ( )

14. Service Supervision. The plan of service that includes all waiver services is monitored by the plan monitor or targeted service coordinator. ( )

15. Transition Services. Transition managers as described in Section 350.01 of these rules are responsible for administering transition services. ( )

706. ADULT DD WAIVER SERVICES: PROVIDER REIMBURSEMENT.

01. Fee for Service. Waiver service providers will be paid on a fee for service basis based on the type of service provided as established by the Department. ( )

02. Claim Forms. Provider claims for payment will be submitted on claim forms provided or approved by the Department. Billing instructions will be provided by the Department. ( )

03. Rates. The reimbursement rates 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 transportation. ( )

707. -- 719. (RESERVED)

SUB AREA: SERVICE COORDINATION SERVICES
(Sections 720-779)

720. SERVICE COORDINATION.
The Department will purchase service coordination for persons eligible for Enhanced Benefits who are unable, or have limited ability to gain access, coordinate or maintain services on their own or through other means. These rules are not applicable to behavioral health service coordination, also known as case management services, provided under the Idaho Behavioral Health Plan (IBHP) included in IDAPA 16.03.09, "Medicaid Basic Plan Benefits." ( )

721. SERVICE COORDINATION: DEFINITIONS.
The following definitions apply for Sections 721 through 736 of these rules. ( )

01. Agency. An agency is a business entity that provides management, supervision, and quality assurance for service coordination and includes at least two (2) individuals, one (1) supervisor and a minimum of one (1) service coordinator. ( )

02. Brokerage Model. Referral or arrangement for services identified in an assessment. This model does not include the provision of direct services. ( )

03. Conflict of Interest. A situation in which an agency or person directly or indirectly influences. or appears to influence the direction of a participant to other services for financial gain. ( )

04. Crisis. An unanticipated event, circumstance or life situation that places a participant at risk of at least one (1) of the following: ( )

a. Hospitalization; ( )

b. Loss of housing; ( )

c. Loss of employment or major source of income; ( )

d. Incarceration; or ( )

e. Physical harm to self or others, including family altercation or psychiatric relapse. ( )

05. Human Services Field. A particular area of academic study in health care, social services, education, behavioral science or counseling. ( )

06. Paraprofessional. An adult with a high school diploma or equivalency who has at least twelve (12) months supervised work experience with the population to whom they will be providing services. ( )

07. Person-Centered Planning. A planning process facilitated by the service coordinator that includes the participant and individuals significant to the participant, to collaborate and develop a plan based on the expressed needs and desires of the participant. For children, this planning process must involve the child's family. ( )

08. Practitioner of the Healing Arts. For purposes of this rule, a nurse practitioner, physician assistant or clinical nurse specialist. ( )

09. Service Coordination. Service coordination is a case management activity that assists individuals eligible for Medicaid in gaining and coordinating access to necessary care and services appropriate to the needs of the individual. Service coordination is a brokerage model of case management. ( )

10. Service Coordination Plan. The service coordination plan, also known in these rules as the "plan," includes two components: ( )

a. An assessment that identifies the participant's need for service coordination as described in Section 730 of these rules; and ( )

b. A plan that documents the supports and services required to meet the service coordination needs of the participant as described in Section 731 of these rules. ( )

11. Service Coordination Plan Development. An assessment and planning process performed by a service coordinator using person-centered planning principles that results in a written service coordination plan. The plan must accurately reflect the participant's need for assistance in accessing and coordinating supports and services. ( )

12. Service Coordinator. An individual, excluding a paraprofessional, who provides service coordination to a Medicaid eligible participant, is employed by or contracts with a service coordination agency, and

meets the training, experience, and other requirements in Section 729 of these rules. ( )

13. **Supports**. Formal and informal services and activities that are not paid for by the Department and that enable an individual to reside safely in the setting of their choice. ( )

722. SERVICE COORDINATION SERVICES: ELIGIBILITY.
Participants identified in Sections 723 through 726 of these rules, who do not receive hospice services or live in hospitals, nursing facilities, or intermediate care facilities for persons with intellectual disabilities, are eligible for service coordination. ( )

723. TARGETED SERVICE COORDINATION: ELIGIBILITY: INDIVIDUALS WITH A DEVELOPMENTAL DISABILITY.
An individual is eligible to receive targeted service coordination if they meet the following requirements in this rule. ( )

01. **Age**. An adult eighteen (18) years of age or older. ( )

02. **Diagnosis**. Is diagnosed with a developmental disability, defined in Section 66-402, Idaho Code and Section 500 through 506 of these rules, that: ( )

a. Is attributable to an impairment, such as an intellectual disability, cerebral palsy, epilepsy, autism or other condition found to be closely related to or similar to one (1) of these impairments that requires similar treatment or services, or is attributable to dyslexia resulting from such impairments; ( )

b. Results in substantial functional limitations in three (3) or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency; and ( )

c. Reflects the need for a combination and sequence of special, interdisciplinary or generic care, treatment or other services that are of lifelong or extended duration and individually planned and coordinated. ( )

03. **Need Assistance**. Requires and chooses assistance to access services and supports necessary to maintain their independence in the community. ( )

724. -- 725. (RESERVED)

726. SERVICE COORDINATION: ELIGIBILITY: INDIVIDUALS UP TO THE AGE OF TWENTY-ONE.
To be eligible for children's service coordination, a participant must meet the following requirements in Subsections 726.01 through 726.03. Eligibility is determined initially and annually by the Department based on information provided by the service coordination agency or the family. All information necessary to make the eligibility determination must be received by the Department twenty (20) business days prior to the anticipated start date of any service coordination services. The eligibility determination will be made by the Department prior to the initiation of initial and ongoing plan development and services. ( )

01. **Age**. From the age of thirty-seven (37) months through the month in which their twenty-first birthday occurs. ( )

02. **Diagnosis**. Must have special health care needs requiring medical and multidisciplinary rehabilitation services identified by a physician or other practitioner of the healing arts to prevent or minimize a disability. ( )

03. **Need Assistance**. Medicaid-reimbursed service coordination services are not available for participants whose needs can be met by other service coordination or case management resources, including paid and non-paid sources. The participant must have needs for service coordination for one (1) or more of the following problems: ( )

a. The condition has resulted in a level of functioning below normal age level in one (1) or more life areas such as school, child care setting, family, or community; ( )

b. The child is at risk of placement in a more restrictive environment or the child is returning from an out of home placement as a result of the condition; ( )

c. There is danger to the health or safety of the child or the parent is unable to meet the needs of the child; ( )

d. Further complications may occur as a result of the condition without provision of service coordination services; or ( )

e. The child requires multiple service providers and treatments. ( )

727. SERVICE COORDINATION: COVERAGE AND LIMITATIONS.
Service coordination consists of services provided to assist individuals in gaining access to needed services. Service coordination includes the following activities described in Subsections 727.01 through 727.10 of this rule. ( )

01. Plan Assessment and Periodic Reassessment. Activities that are required to determine the participant's needs by development of a plan assessment and periodic reassessment as described in Section 730 of these rules. These activities include: ( )

a. Taking a participant’s history; ( )

b. Identifying the participant’s needs and completing related documentation; and ( )

c. Gathering information from other sources such as family members, medical providers, social workers, and educators, to form a complete assessment of the participant. ( )

02. Development of the Plan. Development and revision of a specific plan, described in Section 731 of these rules that includes information collected through the assessment and specifies goals and actions needed by the participant. The plan must be updated at least annually (or extended through the duration of the declared COVID-19 public health emergency) and as needed to meet the needs of the participant. ( )

03. Referral and Related Activities. Activities that help link the participant with service providers that are capable of providing needed services to address identified needs and achieve goals specified in the service coordination plan. ( )

04. Monitoring and Follow-Up Activities. Monitoring and follow-up contacts that are necessary to ensure the plan is implemented and adequately addresses the participant's needs. These activities may be with the participant, family members, providers, or other entities or individuals and conducted as frequently as necessary. These activities must include at least one face-to-face contact with the participant at least every ninety (90) days (the face-to-face encounter may occur via synchronous interaction telehealth, as defined in Title 54, Chapter 57, Idaho Code), to determine whether the following conditions are met: ( )

a. Services are being provided according to the participant's plan; ( )

b. Services in the plan are adequate; and ( )

c. Whether there are changes in the needs or status of the participant, and if so, making necessary adjustments in the plan and service arrangements with providers. ( )

05. Crisis Assistance. Crisis assistance is service coordination used to assist a participant to access community resources in order to resolve a crisis. Crisis service coordination does not include crisis counseling, transportation to emergency service providers, or direct skill-building services. The need for all crisis assistance hours must meet the definition of crisis in Section 721 of these rules. ( )

a. Crisis Assistance for Children's Service Coordination. Crisis hours are not available until four and a half (4.5) hours of service coordination have already been provided in the month. Crisis hours for children's service coordination must be authorized by the Department. ( )

b. Crisis Assistance for Adults With a Developmental Disability. Crisis hours are not available until four and a half (4.5) hours of service coordination have already been provided in the month. Crisis assistance for adults with a developmental disability must be authorized by the Department and is based on community crisis supports as found in Section 646 through 648 of these rules. ( )

c. Authorization for crisis assistance hours may be requested retroactively as a result of a crisis, defined in Section 721 of these rules, when a participant's service coordination benefits have been exhausted and no other means of support is available to the participant. In retroactive authorizations, the service coordinator must submit a request for crisis services to the Department within seventy-two (72) hours of providing the service. ( )

06. Contacts for Assistance. Service coordination may include contacts with non-eligible individuals only when the contact is directly related to identifying the needs and supports to help the participant access services. ( )

07. Exclusions. Service coordination does not include activities that are: ( )

a. An integral component of another covered Medicaid service; ( )

b. Integral to the administration of foster care programs; ( )

c. Integral to the administration of another non-medical program for which a participant may be eligible. This exclusion does not apply to case management provided as part of the individualized education program or individualized family service plan required by the Individuals with Disabilities Education Act. ( )

08. Limitations on the Provision of Direct Services. Providers of service coordination services may only provide both service coordination and direct services to the same Medicaid participant when the participant is receiving children's service coordination. The service coordination provider must document that the participant has made a free choice of service coordinators and direct service providers. ( )

09. Limitations on Service Coordination. Service coordination is limited to four and a half (4.5) hours per month. ( )

10. Limitations on Service Coordination Plan Assessment and Plan Development. Reimbursement for the annual assessment and plan development cannot exceed six (6) hours per year. ( )

728. SERVICE COORDINATION: PROCEDURAL REQUIREMENTS.

01. Prior Authorization for Service Coordination Services. Services must be prior authorized by the Department according to the direction provided in the Medicaid Provider Handbook available at www.idmedicaid.com. ( )

02. Service Coordination Plan Development. ( )

a. A written plan, described in Section 731 of these rules, must be developed and implemented within sixty (60) days after the participant chooses a service coordinator. ( )

b. The plan must be updated at least annually (or extended through the duration of the declared COVID-19 public health emergency) and amended as necessary. ( )

c. The plan must address the service coordination needs of the participant as identified in the assessment described in Section 730 of these rules. ( )

d. The plan must be developed prior to ongoing service coordination being provided. ( )

03. Documentation of Service Coordination. Agencies must maintain records that contain documentation describing the services provided, review of the continued need for service coordination, and progress toward each service coordination goal. Documentation must be completed as required in Section 56-209(h), Idaho Code. All active records must be immediately available. Documentation must include all of the following: ( )

a. The name of the eligible participant. ( )

b. The name of the provider agency and the person providing the services. ( )

c. The date, time, duration, and place the service was provided. ( )

d. The nature, content, units of the service coordination received and whether goals specified in the plan have been achieved. ( )

e. Whether the participant declined any services in the plan. ( )

f. The need for and occurrences of coordination with any non-Medicaid case managers. ( )

g. The timeline for obtaining needed services. ( )

h. The timeline for re-evaluation of the plan. ( )

i. A copy of the assessment or prior authorization from the Department that documents eligibility for service coordination services, and a dated and signed plan. ( )

j. Agency records must contain documentation describing details of the service provided signed by the person who delivered the service. ( )

k. Documented review of participant's continued need for service coordination and progress toward each service coordination goal. A review must be completed at least every one hundred eighty (180) days after the plan development or update. Progress reviews must include the date of the review, and the signature of the service coordinator completing the review. ( )

l. Documentation of the participant's, family's, or legal guardian's satisfaction with service. ( )

m. A copy of the informed consent form signed by the participant, parent, or legal guardian that documents that the participant has been informed of the purposes of service coordination, their rights to refuse service coordination, and their right to choose their service coordinator and other service providers. ( )

n. A plan that is signed by the participant, parent, or legal guardian, and the service coordinator. The plan must reflect person-centered planning principles and document the participant’s inclusion in the development of the plan. The service coordinator must also document that a copy of the plan was given to the participant or their legal representative. The plan must be updated and authorized when required, but at least annually. Children’s service coordination plans cannot be effective before the date that the child’s parent or legal guardian has signed the plan. ( )

04. Documentation Completed by a Paraprofessional. Each entry completed by a paraprofessional must be reviewed by the participant’s service coordinator and include the date of review and the service coordinator’s signature on the documentation. ( )

05. Participant Freedom of Choice. A participant must have freedom of choice when selecting from the service coordinators available to them. The service coordinator cannot restrict the participant’s choice of other health care providers. ( )

06. Service Coordinator Contact and Availability. The frequency of contact, mode of contact, and

person or entity to be contacted must be identified in the plan and must meet the needs of the participant. The contacts must verify the participant's well being and whether services are being provided according to the written plan. At least every ninety (90) days, service coordinators must have face-to-face contact with each participant. The face-to-face encounter may occur via synchronous interaction telehealth, as defined in Title 54, Chapter 57, Idaho Code. ( )

a. When it is necessary for the children's service coordinator to conduct a face-to-face contact with a child participant without the parent or legal guardian present, the service coordinator must notify the parent or legal guardian prior to the face-to-face contact with the participant. Notification must be documented in the participant's file. ( )

b. Service coordinators do not have to be available on a twenty-four (24) hour basis, but must include an individualized objective on the plan describing what the participant, families, and providers should do in an emergency situation. The individualized objective must include how the service coordinator will coordinate needed services after an emergency situation. ( )

07. Service Coordinator Responsibility Related to Conflict of Interest. Service coordinators have a primary responsibility to the participant whom they serve, to respect and promote the right of the participant to self-determination, and preserve the participant's freedom to choose services and providers. In order to assure that participant rights are being addressed, service coordinators must: ( )

a. Be alert to and avoid conflicts of interest that interfere with the exercise of professional discretion and impartial judgment. ( )

b. Inform the participant parent, or legal guardian when a real or potential conflict of interest arises and take reasonable steps to resolve the issue in a manner that makes the participant's interests primary and protects the participant's interests to the greatest extent possible. ( )

08. Agency Responsibility Related to Conflict of Interest. To assure that participants are protected from restrictions to their self-determination rights because of conflict of interest, the agency must guard against conflict of interest, and inform all participants and guardians of the risk. Each agency must have a document in each participant's file that contains the following information: ( )

a. The definition of conflict of interest as defined in Section 721 of these rules; ( )

b. A signed statement by the agency representative verifying that the concept of conflict of interest was reviewed and explained to the participant parent, or legal guardian; and ( )

c. The participant's, parent's, or legal guardian's signature on the document. ( )

729. SERVICE COORDINATION: PROVIDER QUALIFICATIONS.
Service coordination services must be provided by an agency as defined in Section 721 of these rules. ( )

01. Provider Agreements. Service coordinators must be employees or contractors of an agency that has a valid provider agreement with the Department. ( )

02. Supervision. The agency must provide supervision to all service coordinators and paraprofessionals. The agency must clearly document: ( )

a. Each supervisor's ability to address concerns about the services provided by employees and contractors under their supervision, and ( )

b. That a paraprofessional is not a supervisor. ( )

03. Agency Supervisor Required Education and Experience. ( )

a. Master's Degree in a a human services field from a nationally accredited university or college, and

have twelve (12) months supervised work experience with the population being served; or ( )

b. Bachelor's degree in a human services field from a nationally accredited university or college, and have twenty-four (24) months supervised work experience with the population being served. ( )

c. Be a licensed registered nurse (RN) and have twenty-four (24) months supervised work experience with the population being served. ( )

04. Service Coordinator Education and Experience. ( )

a. Minimum of a Bachelor's degree in human services field from a nationally accredited university or college and have twelve (12) months supervised work experience with the population being served; or ( )

b. Be a licensed registered nurse (RN) and have twelve (12) months work experience with the population being served. ( )

c. When an individual meets the education or licensing requirements in Subsections 729.04.a. or 729.04.b. of this rule, but does not have the required supervised work experience, the individual must be supervised by a qualified service coordinator while gaining the required work experience. ( )

05. Paraprofessional Education and Experience. Under the supervision of a qualified service coordinator, a paraprofessional may be used to assist in the implementation of the plan. Paraprofessionals must have the following qualifications: ( )

a. Be at least eighteen (18) years of age and have a minimum of a high school diploma or equivalency; ( )

b. Be able to read and write at an appropriate level to process the required paperwork and forms involved in the provision of the service; and ( )

c. Have twelve (12) months supervised work experience with the population being served. ( )

06. Limitations on Services Delivered by Paraprofessionals. Paraprofessionals must not conduct assessments, evaluations, person-centered planning meetings, ninety (90) day face-to-face contacts described in Section 728.06 of these rules, one hundred eighty (180) day progress reviews, plan development, or plan changes. Paraprofessionals cannot be identified as the service coordinator on the plan and they cannot supervise service coordinators or other paraprofessionals. ( )

07. Criminal History Check Requirements. Service coordination agencies must verify that each service coordinator and paraprofessional they employ or with whom they contract has complied with Section 009 of these rules and IDAPA 16.05.06, “Criminal History and Background Checks.” ( )

08. Health, Safety and Fraud Reporting. Service coordinators are required to report any concerns about health and safety to the appropriate governing agency and to the Department. Service coordinators must also report fraud, including billing of services that were not provided, to the Department unit responsible for authorizing the service; and to the Surveillance and Utilization Review Unit (SUR) within the Department or its toll-free Medicaid fraud hotline. ( )

09. Individual Service Coordinator Case Loads. The total caseload of a service coordinator must assure quality service delivery and participant satisfaction. ( )

730. SERVICE COORDINATION: PLAN DEVELOPMENT -- ASSESSMENT.

01. Assessment Process. The service coordination assessment must be completed by a service coordinator as part of the person-centered planning process. The focus of the assessment is to identify the participant’s need for assistance in gaining and coordinating access to care and services. The participant must be included in the assessment process. The parent or legal guardian, when appropriate, and pertinent service providers as

identified by the participant must also be included during the assessment process. The assessment component is used to determine the prioritized needs and services of the participant and must be documented in the plan. When the participant is a child, the assessment must include identification of the family's needs to ensure the child's needs are met. ( )

02. Components of an Assessment. The components in the assessment of a participant's service coordination needs must document the following information; ( )

a. Basic needs; ( )

b. Medical needs; ( )

c. Health and safety needs; ( )

d. Therapy needs; ( )

e. Educational needs; ( )

f. Social and integration needs; ( )

g. Personal needs; ( )

h. Family needs and supports; ( )

i. Long range planning; ( )

j. Legal needs; and ( )

k. Financial needs. ( )

731. SERVICE COORDINATION: PLAN DEVELOPMENT -- WRITTEN PLAN.
The service coordination plan is developed using information collected through the assessment of the participant's service coordination needs. The plan must specify the goals and actions to address the service coordination needs of the participant identified in the assessment process. The plan must include goals developed using the person-centered planning process. ( )

01. Plan Implementation. The plan must identify activities required to respond to the assessed needs of the participant. ( )

02. Plan Content. Plans must include the following: ( )

a. A list of problems and needs identified during the assessment; ( )

b. Identification of each and any potential risk or substantiation that there are no potential risks. The plan must identify services and actions that will be implemented in case of a participant crisis situation. ( )

c. Concrete, measurable goals and objectives to be achieved by the participant; ( )

d. Reference to all services and contributions provided by the participant's supports including the actions, if any, taken by the service coordinator to develop the support system; ( )

e. Documentation of who has been involved in the service planning, including the participant's involvement; ( )

f. Schedules for service coordination monitoring, progress review, and reassessment; ( )

g. Documentation of unmet needs and service gaps including goals to address these needs or gaps;

( )

h. References to any formal services arranged including costs, specific providers, schedules of service initiation, frequency or anticipated dates of delivery; and ( )

i. Time frames for achievement of the goals and objectives. ( )

03. Adult Developmental Disability Service Coordination Plan. The plan for adults with developmental disabilities must comply with and be incorporated into the participant's developmental disability plan of service identified in Section 513 of these rules. ( )

732. -- 735. (RESERVED)

736. SERVICE COORDINATION: PROVIDER REIMBURSEMENT.

01. Duplication. Participants are only eligible for one (1) type of service coordination. If they qualify for more than one (1) type, the participant must choose one (1). Service coordination payment must not duplicate payment made to public or private sector entities under other program authorities for this same purpose. ( )

02. Payment for Service Coordination. Subject to the service limitations in Subsection 736.06 of this rule, only the following services are reimbursable: ( )

a. Service coordination plan development defined in Section 721 of these rules. ( )

b. Face-to-face contact required in Subsection 728.06 of these rules. ( )

c. Two-way communication between the service coordinator and the participant, participant's service providers, family members, primary care givers, legal guardian, or other interested persons. ( )

d. Face-to-face contact between the service coordinator and the participant's family members, legal representative, primary caregivers, providers, or other interested persons. ( )

e. Referral and related activities associated with obtaining needed services as identified in the service coordination plan. ( )

03. Service Coordination During Institutionalization. Service coordination is reimbursable on the day a participant is admitted to a medical institution if the service is provided prior to admission. Service coordination is reimbursable on the day of discharge from a medical institution if the service is provided after discharge. ( )

a. Service coordination for reintegration into the community, can only be provided by and reimbursed to a service coordination agency when the following applies: ( )

i. During the last fourteen (14) days of an inpatient stay that is less than one hundred eighty (180) days in duration; or ( )

ii. During the last sixty (60) days of an inpatient stay of one hundred eighty (180) days or more. ( )

b. Service coordination providers may not file claims for reimbursement until the participant is discharged and using community services; ( )

c. Service coordination must not duplicate activities provided as part of admission or discharge planning activities of the medical institution. ( )

04. Incarceration. Service coordination is not reimbursable when the participant is incarcerated. ( )

05. Services Delivered Prior to Assessment. Payment for on-going service coordination will not be made prior to the completion of the service coordination plan. ( )

06. Payment Limitations. Reimbursement is not allowed for missed appointments, attempted contacts, travel to provide the service, leaving messages, scheduling appointments with the Medicaid service coordinator, transporting participants, or documenting services. ( )

a. Service coordination providers are paid in unit increments of fifteen (15) minutes each. A service coordinator can only be reimbursed for the amount of time worked and must not bill for more than four (4) billing units per hour. The following table is an example of minutes to billing units. ( )

Services Provided Are More Than Minutes	Services Provided Are Less Than Minutes	Billing Units
8	23	1
22	38	2
37	53	3
52	68	4
67	83	5
82	98	6
97	113	7

( )

b. Direct delivery of medical, educational, psychiatric, social, early intervention, or other service to which a participant has been referred is not reimbursable as service coordination. ( )

c. Activities that are an integral component of another covered Medicaid service are not reimbursable as service coordination. ( )

d. Activities that are integral to the administration of foster care programs are not reimbursable as service coordination. ( )

e. Activities that are integral to the administration of another non-medical program are not reimbursable as service coordination. This exclusion does not apply to case management provided as part of the individualized education program or individualized family service plan required by the Individuals with Disabilities Education Act. ( )

07. Group Service Coordination. Payment is not allowed for service coordination provided to a group of participants. ( )

737. -- 779. (RESERVED)

SUB AREA: BREAST AND CERVICAL CANCER PROGRAM (Sections 780-799)

780. BREAST OR CERVICAL CANCER PROGRAM THROUGH THE WOMEN'S HEALTH CHECK. Women who are determined eligible for Medicaid through the Women's Health Check program are eligible for enhanced Medicaid benefits until it is determined that cancer treatment has ended. ( )

781. BREAST OR CERVICAL CANCER PROGRAM: DEFINITIONS.

01. Primary Treatment. The initial action of treating a patient medically or surgically for cancer using conventional treatment modalities. ( )

02. Adjuvant Therapy. Treatment that includes either radiation or systemic chemotherapy, or both, as part of the plan of care. ( )

03. End of Treatment. Cancer treatment ends: ( )

a. When the woman's plan of care reflects a status of surveillance, follow-up, or maintenance mode; or ( )

b. If the woman's treatment relies on an unproven procedure, as referred to in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," Section 390 in lieu of primary or adjuvant treatment. ( )

782. BREAST OR CERVICAL CANCER PROGRAM: ELIGIBILITY.
Women eligible for Medical Assistance, as provided for in IDAPA 16.03.05, "Eligibility for Aid to the Aged, Blind, and Disabled (AABD)," Section 802, will be covered while receiving either primary or adjuvant cancer treatment, or both. ( )

783. BREAST OR CERVICAL CANCER PROGRAM: PROCEDURAL REQUIREMENTS.
The Division of Medicaid, or its successor, is responsible for determining when a woman's treatment has ended. ( )

784. -- 999. (RESERVED)

APPENDIX A

IDAHO MEDICAID HANDICAPPING MALOCCLUSION INDEX

OVERBITE:	MEASUREMENT/POINTS:	SCORE:
Lower incisors: striking lingual of uppers at incisal	1/3 = 0	
Striking lingual of uppers at middle	1/3 = 1	
Striking lingual of uppers at gingival	1/3 = 2	
OPENBITE: (millimeters) *a,b		
Less than……	2 mm = 0	
	2-4 mm = 1	
	4+ mm = 2	
OVERJET: (millimeters) *a		
Upper…….	2-4 mm = 0	
Measure horizontally parallel to occlusal plane.	5-9 mm = 1	
	9+ mm = 2	
Lower……	0-1 mm = 0	
	2 mm = 1	
	3+ mm = 2	
POSTERIOR X-BITE: (teeth) *b		

OVERBITE:	MEASUREMENT/POINTS:	SCORE:
Number of teeth in x-bite:	0-2 = 0	
	3 = 1	
	4 = 2	
TOOTH DISPLACEMENT: (teeth) *c, d, e		
Number of teeth rotated 45 degrees or displaced 2mm from normal position in arch.	0-2 = 0 3-6 = 1 7+ = 2	
BUCCAL SEGMENT RELATION-SHIP:		
One side distal or mesial ½ cusp	= 0	
Both sides distal or mesial or one side full cusp	= 1	
Both sides full cusp distal or mesial	= 2	

TOTAL SCORE:_____

Scoring Definitions:

Impacted or blocked cuspids are scored 1 open bite and 1 over jet for two teeth. Score 2 for open bite and 2 for over jet for 4 blocked cuspids.

a) Cross bites are scored for the teeth in cross bite, not the teeth in the opposing arch.
b) Missing teeth count as 1, if the space is still present.
c) Do not score teeth that are not fully erupted.
d) Displaced teeth are based on where they are in their respective arch line, not their relationship with the opposing arch.

16.03.11 – INTERMEDIATE CARE FACILITIES FOR PEOPLE WITH INTELLECTUAL DISABILITIES (ICFS/IID)

000. LEGAL AUTHORITY.

The Board of Health and Welfare is authorized under Sections 39-1301 through 39-1314, Idaho Code, to adopt, amend, and enforce rules, regulations, and standards for licensure that promote safe and adequate treatment, and to protect the health and safety of individuals being cared for in intermediate care facilities for people with intellectual disabilities defined in Section 39-1301(c), Idaho Code. The Department is authorized under 42 CFR Part 483 to set conditions of participation for intermediate care facilities for individuals with intellectual disabilities (ICFs/IID). Under Sections 56-1002, 56-1003, 56-1004, 56-1004A, 56-1005, 56-1007, and 56-1009, Idaho Code, the Department and the Board of Health and Welfare have prescribed powers and duties to provide for the administration and enforcement of Department programs and rules. ( )

001. TITLE AND SCOPE.

01. Title. These rules are titled IDAPA 16.03.11, "Intermediate Care Facilities for People with Intellectual Disabilities (ICFs/IID)." ( )

02. Scope. These rules include the licensing standards and requirements for the administration of intermediate care facilities for the active treatment of individuals with intellectual disabilities and related conditions. This service delivery system provides care through small community-based facilities with the least restrictive alternatives including deinstitutionalization, normalization, and individual programming to enhance each individual's self-sufficiency for personal development and health needs. ( )

002. WRITTEN INTERPRETATIONS.

The Department may have written statements that pertain to the interpretation of this chapter, or to the documentation of compliance with these rules. ( )

003. (RESERVED)

004. INCORPORATION BY REFERENCE.

The following are incorporated by reference in this chapter of rules: ( )

01. Code of Federal Regulations (CFR). The Board has adopted by reference certain Codes of Federal Regulations (CFR), Standards and Certification, Part 483, in this chapter. 42 CFR Part 483 may be found online at: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-483/subpart-I. Modifications and additions to the "Conditions of Participation for Intermediate Care Facilities for Individuals with Intellectual Disabilities" are made in Subsections 004.02 through 004.13 of this rule. ( )

02. 42 CFR 483.400 - Basis and Purpose. No additions or modifications have been adopted for this subpart. ( )

03. 42 CFR 483.405 - Relationship to Other Health and Human Services (HHS) Regulations. No additions or modifications have been adopted for this subpart. ( )

04. 42 CFR 483.410 - Condition of Participation: Governing Body and Management. Additions and modifications for this subpart are found in Sections 100-199 of these rules. ( )

05. 42 CFR 483.420 - Condition of Participation: Client Protections. Additions and modifications for this subpart are found in Sections 200-299 of these rules. ( )

06. 42 CFR 483.430 - Condition of Participation: Facility Staffing. Additions and modifications for this subpart are found in Sections 300-399 of these rules. ( )

07. 42 CFR 483.440 - Condition of Participation: Active Treatment Services. No additions or modifications have been adopted for this subpart. ( )

08. 42 CFR 483.450 - Condition of Participation: Client Behavior and Facility Practices. Additions and modifications for this subpart are found in Sections 500-599 of these rules. ( )

09. 42 CFR 483.460 - Condition of Participation: Health Care Services. No additions or modifications have been adopted for this subpart. ( )

10. 42 CFR 483.470 - Condition of Participation: Physical Environment. Additions and modifications for this subpart are found in Sections 700-799 of these rules. ( )

11. 42 CFR 483.480 - Condition of Participation: Dietetic Services. Additions and modifications for this subpart are found in Sections 800-899 of these rules. ( )

12. 42 CFR 1001.1301 - Failure to Grant Immediate Access. No additions or modifications have been adopted for this subpart. ( )

13. 42 CFR 442.101 - Obtaining Certification. No additions or modifications have been adopted for this subpart. ( )

14. IDAPA 24.39.30, Rules of Building Safety. IDAPA 24.39.30, "Rules of Building Safety," as adopted by the Division of Building Safety, Building Code Advisory Board. The rules are available online at: https://adminrules.idaho.gov/rules/current/24/243930.pdf. The Building Safety rules adopt The International Building Code that may be obtained from the International Code Council, Western Regional Office, 5360 Workman Mill Road, Whittier, CA 90601-2298, phone: (888) 422-7233, and online at http://www.iccsafe.org. ( )

15. National Fire Protection Association (NFPA) Standard 101, The Life Safety Code, (edition 2000). The following document is incorporated by reference in these rules: National Fire Protection Association (NFPA) Standard 101, The Life Safety Code, (2000), published by the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169-7471. A copy is available for review at the Department's Division of Licensing and Certification located at 3232 Elder Street, Boise, Idaho 83705. The NFPA 101: Life Safety Code may be accessed online at: http://www.nfpa.org/codes-and-standards/document-information-pages?mode=code&code=101. ( )

005. (RESERVED)

006. CONFIDENTIALITY OF RECORDS AND PUBLIC RECORDS ACT COMPLIANCE AND REQUESTS.

01. Confidentiality of Records. Any disclosure of confidential information used or disclosed in the course of the Department's business is subject to the restrictions in state or federal law, and must comply with IDAPA 16.05.01, "Use and Disclosure of Department Records." ( )

02. Public Records Act. The Department will comply with Title 74, Chapter 1, Idaho Code, when requests for the examination and copying of public records are made. Unless otherwise exempted, all public records in the custody of the Department are subject to disclosure. ( )

03. Disclosure of an Individual's Identity. Under Section 39-1310, Idaho Code, information received by the Department through filed reports, inspections, or as required by law, will not be disclosed publicly in such a manner as to identify individuals except as necessary in a proceeding involving a question of licensure. ( )

04. Public Availability of Survey Reports. The Department will post on the Division of Licensing and Certification's website, survey reports and findings of complaint investigations relating to a facility at http://facilitystandards.idaho.gov. ( )

007. -- 008. (RESERVED)

009. CRIMINAL HISTORY AND BACKGROUND CHECK REQUIREMENTS.

01. Criminal History and Background Check. An intermediate care facility for people with intellectual disabilities (ICF/IID) must comply with the Department's criminal history and background check rules in IDAPA 16.05.06, "Criminal History and Background Checks." ( )

02. Individuals Subject to Criminal History Checks. Owners, administrators, employees, and contractors, hired or contracted with after October 1, 2007, who have direct access to individuals residing in an ICF/

IID must complete and receive a Department criminal history and background check clearance as provided in IDAPA 16.05.06, "Criminal History and Background Checks." ( )

010. DEFINITIONS AND ABBREVIATIONS -- A THROUGH K.
For the purposes of this chapter of rules, the following terms apply. ( )

01. Active Treatment. Aggressive, consistent implementation of a program of specialized and generic training, treatment, health, and related services directed toward the acquisition of skills necessary for the individual to function with as much self-determination and independence as possible. It includes the prevention or deceleration of regression or loss of current optimal functional status. ( )

02. Administrator. The person delegated the responsibility for management of a facility. ( )

03. Advocate. A person who assists the individual in exercising their rights within the facility and as a citizen of the United States. ( )

04. Alteration. Any change or modification to the building or property that does affect Life Safety Code compliance or a change in space usage or utilization of the facility, including additions, remodeling or systems modifications. ( )

05. Board. The Idaho State Board of Health and Welfare. ( )

06. Certification. Federal program approval (Medicare, Medicaid, etc.) of the facility to participate in the delivery of program care to eligible individuals under applicable federal requirements. ( )

07. Client. A term used in the Code of Federal Regulations (CFR) for an "individual" residing in an intermediate care facility for individuals with intellectual disabilities who requires active treatment. A "client" is synonymous with the terms "individual" and "resident" in this chapter. ( )

08. Department. The Idaho Department of Health and Welfare. ( )

09. Director. The Director of the Idaho Department of Health and Welfare, or their designee. ( )

10. Discharge. The permanent movement of an individual to another facility or setting that operates independently from the ICF/IID. ( )

11. Enclosure. Any barrier designed, constructed, or used to contain an individual within a designated area for the purposes of behavior modification, and does not meet the definition of a "time out" room as stated in 42 CFR 483.450(c)(1). ( )

12. Governmental Unit. The State of Idaho, any county, municipality, or other political subdivision, or any department, division, board, or other agency thereof. ( )

13. Individual. A term used in the Code of Federal Regulations (CFR) for an "individual" residing in an intermediate care facility for individuals with intellectual disabilities who requires active treatment. An "individual" is synonymous with the terms "client" and "resident" in this chapter. ( )

14. Individual Program Plan (IPP). A written plan developed by the interdisciplinary team for each individual in the ICF/IID. The IPP is based on a completed, thorough review of the individual's preferences, lifestyle, cultural background, strengths, needs, and capabilities in all major life areas essential to increasing independence and ensuring rights. Each individual's IPP addresses what an individual needs in order to function with as much independence as possible by stating: ( )

a. The desired outcomes the individual is trying to achieve; ( )

b. The specific steps and actions that will be taken to reach the desired outcomes; and ( )

c. Any additional adaptive equipment, assistive technology, services, and supports required to meet the individual's needs. ( )

15. Initial License. The first license issued to a facility. ( )

16. Interdisciplinary Team (IDT). Professionals, paraprofessionals, and non-professionals who possess the knowledge, skills, and expertise necessary to accurately identify the comprehensive array of the individual's needs and design a program which is responsive to those needs. The IDT must include the individual unless inability or unwillingness is documented, their parent, guardian, or representative unless documented to be inappropriate or unobtainable, a physician, a social worker, and other appropriate professional and non-professional staff, at least one (1) of whom is a Qualified Intellectual Disabilities Professional. ( )

17. Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID). An institution that meets federal conditions of participation and has as its primary purpose the provision of health or rehabilitation services to individuals with intellectual disabilities or related conditions receiving care and services under the Medicaid program, which is organized and operated to provide services to four (4) or more individuals, not related to the owner. ( )

011. DEFINITIONS AND ABBREVIATIONS -- L THROUGH Z.
For the purposes of this chapter of rules, the following terms apply. ( )

01. Legal Guardian. A court-appointed surrogate designated to advocate on behalf of the individual. The guardian's role is to encourage self-reliance and independence as well as make decisions on behalf of the individual. ( )

02. Licensee. Any person, firm, partnership, corporation, company, association, joint stock association, governmental unit, legal entity, legal successor thereof, or organization to whom a license is issued. ( )

03. National Fire Protection Association (NFPA). The National Fire Protection Association, from whom copies of applicable safety standards referenced herein are available at cost. Requests should be addressed to NFPA Publication Department, 1 Batterymarch Park, Quincy, Massachusetts 02169-7471 or www.NFPA.org. ( )

04. Noxious Stimuli. A startling, unpleasant, or painful action used in response to an individual's behavior that has a potentially aversive or harmful effect. ( )

05. On Duty. Personnel are considered "on duty" when working with, or available to meet an individual's needs. ( )

06. Outside Service. Any service provided at a location other than the premises for which the license was issued, pursuant to Section 39-1305, Idaho Code. Includes off-site treatment locations regardless of ownership or operating party, schools, vocational programs, and separately licensed Developmental Disabilities Agencies per Section 39-4605, Idaho Code. ( )

07. Owner. Any recognized legal entity, governmental unit, or person having legal ownership of an ICF/IID. ( )

08. Parent. A person who by birth, through adoption, or through fostering is considered legally responsible for a child under the age of eighteen (18), unless otherwise ordered by a court of competent jurisdiction. ( )

09. Participate. To provide input through whatever means necessary to ensure an individual's IPP is responsive to the individual's needs. ( )

10. Physician. An individual licensed to practice medicine and surgery by the Idaho State Board of Medicine or the Idaho State Board of Podiatry under Section 39-1301(h), Idaho Code. ( )

11. Provisional License. A license issued to a facility that conforms substantially with these rules, during which time the facility is to correct deficiencies, or to implement administrative or major structural changes. ( )

12. Qualified Intellectual Disabilities Professional (QIDP). An individual who has at least one (1) year of experience working directly with individuals with intellectual disabilities or developmental disabilities; and meets the requirements in 42 CFR 483.430 (a). ( )

13. Related to Owner. An individual who is related to an owner of an intermediate care facility by blood, marriage, adoption, fostering, or legal guardianship. ( )

14. Renovations, Minor. Changes or modifications to the building or property that do not affect the structural integrity of the building, the fire safety, the physical spaces within the building, or the functional operation for which the facility is licensed. ( )

15. Resident. A term used in the International Building Code for an "individual" residing in an intermediate care facility for individuals with intellectual disabilities who requires active treatment. A "resident" is synonymous with the terms "individual" and "client" in this chapter. ( )

16. Sufficient Staff. Sufficient numbers of staff to meet each individual's needs and to implement the active treatment program defined in each individual's IPP. ( )

17. Transfer. A transfer means any of the following: ( )

a. The temporary movement of an individual between facilities; ( )

b. The temporary movement from an ICF/IID to a psychiatric or medical hospital for medical reasons; ( )

c. The permanent movement of an individual between living units of the same facility; or ( )

d. The permanent movement of an entire facility to a new location, including individuals served, staff and records. ( )

18. Waiver. Provision by the Department to allow for an exception to rule on a case-by-case basis. ( )

012. -- 019. (RESERVED)

020. LICENSE REQUIRED.

An intermediate care facility for people with intellectual disabilities (ICF/IID) cannot be established, maintained, or operated within Idaho without obtaining a license from the Department as required in Sections 39-1301 through 39-1314, Idaho Code. An ICF/IID must be in compliance with Idaho statutes, federal regulations, and this chapter of rules in order to hold a license. ( )

021. ICF/IID LICENSURE REQUIREMENTS.

01. Facility Name. Each ICF/IID must use a distinctive name for the facility which is registered with the Secretary of State of Idaho. The facility cannot change its name without written notification to the Department at least thirty (30) days prior to the date the proposed name change is to be effective. ( )

02. Physical Location. Each ICF/IID must meet the requirements under Sections 67-6530 through 67-6532, Idaho Code, for local planning and zoning laws or ordinances. Facilities serving eight (8) or fewer individuals with intellectual disabilities are not required to secure conditional use permits, zoning variances, or zoning clearance. ( )

03. Size Limitations. The maximum size of an ICF/IID must be no more than fifteen (15) beds. An ICF/IID that has continuously operated under current ownership since July 1, 1980, or before, and continues to operate under that ownership, is exempt from this requirement. ( )

04. Compliance with Water and Sanitation Rules. Each ICF/IID must have a statement from the Public Health District indicating that the water supply and sewage disposal systems meet the Department requirements in Sections 700 through 799 of these rules. ( )

05. Approval of Facility Construction Plans. Each ICF/IID must obtain written Department approval prior to any proposed construction of a facility or alterations to an ICF/IID. Construction or alteration plans must be provided to the Department prior to licensing of the facility. ( )

022. INSPECTION OF FACILITY.

01. Representatives of the Department. The Department is authorized to enter an ICF/IID, or its buildings associated with its operation, at all reasonable times for the purpose of inspection. The Department may, at its discretion, utilize the services of any legally qualified person or organization, either public or private, to examine and inspect any ICF/IID for licensing requirements. ( )

02. Accessible With or Without Prior Notification. The Department or its representatives may enter a facility for the purpose of inspections with or without prior notification to the facility. ( )

03. Inspection of Records. For the purposes of these rules, the Department is authorized to inspect all records required by the Department to be maintained by the facility. ( )

04. Inspection of Outside Services. The Department is authorized to inspect any outside services that a licensed facility uses for its individuals. ( )

023. -- 024. (RESERVED)

025. INITIAL APPLICATION FOR LICENSURE.
Each person or entity planning to operate an ICF/IID must apply to the Department for an initial license. ( )

01. Form of Application. The applicant must complete an initial application form provided by the Department. The application and documents required in Subsection 025.02 of this rule must be submitted to the Department at least ninety (90) days prior to the planned opening date. ( )

02. Documents Required. In addition to the application form, the following documents must be submitted with the application prior to approval of a license: ( )

a. A certificate of occupancy from the local building and fire authority. ( )

b. Acceptable policies and procedures governing the facility, including a sample of an individual record, as required by the Department. ( )

c. If the facility is owned by a corporation, the names and addresses of all officers and stockholders having more than five percent (5%) ownership. ( )

026. CHANGE OF OWNERSHIP (CHOW).
A new owner must submit a new application for licensure, and receive the license from the Department before operating the facility. A "change in ownership" is a change in the person or legal organization that has final decision-making authority over the daily operation of an existing ICF/IID. ( )

01. CHOW of ICF/IID. An ICF/IID must apply for a change of ownership when: ( )

a. The form of legal organization of the facility changes, such as when a sole proprietorship becomes a partnership or corporation; ( )

b. Title of the ICF/IID is transferred from the current licensee to another party; ( )

c. The ICF/IID is leased to another party, or the facility's existing lease is terminated; ( )

d. An event occurs that terminates or dissolves a partnership or sole proprietorship; or ( )

e. The licensee is a corporation; and ( )

i. The corporation is dissolved; or ( )

ii. A new corporation is formed through consolidation or merger with one (1) or more other corporations, and the licensed corporation no longer exists. ( )

02. No CHOW. Ownership does not change when: ( )

a. The licensee contracts with another party to manage the facility and to act as the licensee's agent. The licensee must retain final decision-making authority over daily operating decisions; or ( )

b. When the licensee is a corporation, some or all of its corporate stock is transferred, and the corporation continues to exist. ( )

03. Application for Change of Ownership. An ICF/IID must apply to the Department for a change of ownership at least ninety (90) days prior to the proposed date of the change, using an initial licensing application form. ( )

027. -- 029. (RESERVED)

030. ISSUANCE OF LICENSE.
An ICF/IID license is issued when the Department finds that the applicant has demonstrated compliance with the requirements in Idaho statutes and these rules. ( )

01. License Issued Only to Named Applicant and Location. Each license is issued only for the premises and persons or governmental units named in the application, as required in Section 39-1305, Idaho Code. ( )

02. License Specifies Maximum Allowable Beds. Each license specifies the maximum allowable number of beds in each facility, which may be exceeded only on an emergency basis, for the minimum amount of time required to address the emergency. This emergency exception must be authorized by the Department. ( )

03. Initial License. When the Department determines that all required application information has been received and demonstrates compliance, a license is issued. The initial license expires at the end of the calendar year in which the license was issued. ( )

04. Provisional License. A provisional license issued to an ICF/IID is valid for a period not to exceed six (6) months from the date of issuance by the Department. A provisional license may be issued in order for the facility to: ( )

a. Implement administrative changes; ( )

b. Implement structural changes to a facility's premises; or ( )

c. Work on correcting deficiencies to bring the facility into compliance with statutory requirements and these rules. ( )

031. EXPIRATION AND RENEWAL OF LICENSE.
An ICF/IID license issued by the Department is valid until the end of the calendar year in which it is issued. The

license is renewed annually unless the license is revoked or suspended. ( )

032. -- 039. (RESERVED)

040. DISPLAY OF LICENSE.
Under Section 39-1305, Idaho Code, an ICF/IID must post its license in a conspicuous place on the premises visible to the general public. ( )

041. -- 049. (RESERVED)

050. DENIAL OR REVOCATION OF LICENSE.
Under Section 39-1306, Idaho Code, the Department may deny an application for an ICF/IID license or revoke an existing license. ( )

01. Notice to Deny or Revoke. The Department will send a written notice to the applicant or licensee by certified mail, registered mail, or personal delivery service, to deny or revoke a license or application. The notice will inform the applicant or licensee of the opportunity to request a hearing as provided in IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings." ( )

02. Major Deficiency. The Department may deny an application for a license or revoke an existing license if a major deficiency exists in the compliance of the ICF/IID with the provisions of Idaho Code, federal regulations, or of these rules. A major deficiency is: ( )

a. Any violation of ICF/IID requirements contained in Idaho Code, federal regulations, or these rules that would endanger the health, safety, or welfare of any individual; ( )

b. Any repeated violations of any requirements in Idaho Code, federal regulations, or these rules; or ( )

c. The accumulation of minor violations at the facility that, taken as a whole, would endanger the health, safety, or welfare of any individual. ( )

03. Prior Record Related to Licensure. The Department may deny an application for a license or revoke an existing license when the owner or administrator has: ( )

a. Had any health or personal care license denied or revoked; ( )

b. Been found to have operated any health or personal care facility without a license; or ( )

c. Been enjoined from operating any health or personal care facility in an action related to improper operation of a facility. ( )

04. Personnel Inadequacies. The Department may deny an application for a license or revoke an existing license when the owner or administrator lacks sufficient staff in number or qualification to properly care for the proposed or actual number and needs of individuals. ( )

05. Inadequate or False Disclosure. The Department may deny an application for a license or revoke an existing license when the owner or administrator has misrepresented, or failed to fully disclose, any facts or information or any items in any application or any other document requested by the Department, when such facts and information were required to have been disclosed. ( )

06. Prior Criminal Record. The Department may deny an application for a license or revoke an existing license when the owner or administrator has been convicted of any crime or infraction associated with the operation of a licensed health or personal care facility. ( )

051. -- 059. (RESERVED)

060. SUMMARY SUSPENSION OF LICENSE.
The Director may summarily suspend any ICF/IID license in the event of any emergency endangering the health, safety, or welfare of an individual in the facility. The Director will provide an opportunity for a contested case hearing under IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings." ( )

061. -- 069. (RESERVED)

070. RETURN OF SUSPENDED, REVOKED, OR RELINQUISHED LICENSE.
Each ICF/IID license is the property of the State of Idaho and must be returned to the Department immediately upon its suspension, revocation, or the voluntary closure of the facility. ( )

071. -- 079. (RESERVED)

080. WAIVER.
Under Section 39-1306, Idaho Code, a temporary or permanent waiver to these rules and minimum standards, either in whole or in part, may be granted by the Department to an ICF/IID on a case-by-case basis under the following conditions: ( )

01. Waiver for Good Cause. The Department finds good cause to grant a waiver and no individual's health, safety, or welfare is endangered by the waiver being granted. ( )

02. No Precedent. Precedent will not be set by granting the requested waiver, and such waiver will have no force or effect in any other proceeding. ( )

081. -- 099. (RESERVED)

100. GOVERNING BODY AND MANAGEMENT.
The requirements of Sections 100 through 199 of these rules are modifications and additions to the requirements in 42 CFR 483.410 - 483.410(e), Condition of Participation: Governing Body and Management incorporated in Section 004 of these rules. ( )

101. GOVERNING BODY DUTIES.

01. Unrelated to Owner. The governing body of each ICF/IID must ensure that individuals residing at the ICF/IID are unrelated to the owner. ( )

02. Appointment of Administrator. The governing body of each licensed ICF/IID must appoint an administrator. ( )

102. ADMINISTRATOR.

01. Administrator Requirements. Each ICF/IID must have an administrator who: ( )

a. Is at least twenty-one (21) years of age; ( )

b. Is responsible and accountable for implementation of the policies established by the governing body; ( )

c. Has a minimum three (3) years direct experience working in an ICF/IID setting; and ( )

d. Meets all other qualifications required by the facility's governing body. ( )

02. Administrator Duties. The administrator's responsibilities and duties are to: ( )

a. Implement and monitor written policies and procedures for each service of the ICF/IID and the operation of its physical plant. The administrator must see that these policies and procedures are adhered to and make them available to authorized representatives of the Department. ( )

b. Implement and monitor written policies and procedures for the recruitment and employment of sufficient staff and personnel in number and qualification to perform each service and for the operation of the ICF/IID. The administrator must see that the policies and procedures for administration of personnel requirements in Section 120 of these rules are adhered to and available to authorized representatives of the Department. ( )

c. Compile, complete, and submit all reports and records required by the Department. ( )

d. Notify the Department immediately of an anticipated or actual termination of any service vital to the continued safe operation of the ICF/IID or the health, safety, and welfare of its individuals and personnel. ( )

e. When not on duty, delegate the necessary authority to an administrator designee who is competent to handle the administrator's duties. Delegation of authority must occur according to the ICF/IID policies and procedures set by the facility's governing body. In the event of an emergency, the administrator designee must know how to contact the administrator. ( )

103. -- 109. (RESERVED)

110. FACILITY RECORDS.

01. Records Available Upon Request. Each ICF/IID must be able to print and provide paper copies of electronic records upon the request of the individual who is the subject of the requested records, the individual's legal guardian, payer, or the Department. ( )

02. Census Register. Each ICF/IID must maintain a census register that lists: ( )

a. The name of each individual residing in the facility; ( )

b. The individual's date of admission and discharge; and ( )

c. A daily census of each individual who is in the facility on any given day. ( )

111. -- 119. (RESERVED)

120. ADMINISTRATIVE REQUIREMENTS -- PERSONNEL.
Each ICF/IID must employ personnel sufficient in number and qualifications to meet, at a minimum, the quality of care mandated by law and these rules for all individuals' needs in the facility. ( )

01. Job Descriptions. Current job descriptions outlining the authority, responsibilities, and duties of all personnel in the facility, including the administrator, must be established and maintained as required by the governing body. A copy of an employee's particular job description must be provided to each employee. ( )

02. Policies and Procedures. The facility must ensure that explicit and uniform policies and procedures are established for each employment position concerning hours of work, overtime, and related personnel matters. A statement of these policies must be provided to each employee. ( )

03. Daily Work Schedules. Daily work schedules must be maintained that show the personnel on duty at any given time for the previous three (3) month period. These schedules must be kept up to date and identify the employee as follows: ( )

a. First and last names; ( )

b. Professional designations such as registered nurse (RN), licensed practical nurse, (LPN), QIDP; and ( )

c. Employment position in the facility. ( )

04. Organizational Chart. A current organizational chart that clearly indicates lines of authority within the facility's organizational structure must be available at the facility to be viewed by all employees, or kept in each employee's possession while on duty. ( )

05. Personnel Records. A separate personnel record must be maintained for each employee of the facility that contains the following information: ( )

a. The employee's name, current address, and telephone number; ( )

b. The employee's Social Security Number; ( )

c. The employee's educational background; ( )

d. The employee's work experience; ( )

e. The employee's other qualifications to provide ICF/IID care. If licensure is required to provide a service the employee was hired to provide, the facility must have written verification of the original license number and date the current license expires; ( )

f. The employee's criminal history and background check (CHC) clearance must be printed and on file, when a CHC is required; ( )

g. The employee's date of employment; ( )

h. The employee's date of termination including the reason for termination; ( )

i. The employee's position in the facility and a description of that position; and ( )

j. The employee's hours and work schedule, paydays, overtime, and related personnel matters. ( )

06. Health and Age Requirements. All personnel employed by an ICF/IID must meet and observe the following requirements: ( )

a. Each employee must be free of communicable disease and infected skin lesions while on duty; and ( )

b. At the time of employment, each employee must have a tuberculin skin test consistent with current tuberculosis control procedures. ( )

c. No employee who is less than eighteen (18) years of age can provide direct individual care in an ICF/IID. ( )

07. Training Requirements. Each ICF/IID must have and follow structured written training programs designed to train each employee in the responsibilities specified in the written job description, and to provide for quality of care and compliance with these rules. Signed evidence of personnel training, indicating dates, hours, and topic, must be retained at the facility. This training must include at a minimum: ( )

a. Initial orientation for new employees; and ( )

b. Continuing in-service training designed to, at a minimum, meet the quality of care mandated by law and these rules for individuals residing in the facility. ( )

121. -- 199. (RESERVED)

200. CLIENT PROTECTIONS.

The requirements of Sections 200 through 299 of these rules are modifications and additions to the requirements in 42 CFR 483.420 - 483.420(d)(4), Condition of Participation: Client Protections incorporated in Section 004 of these rules. ( )

201. INDIVIDUAL ADVOCATE.
An individual advocate is a person whose primary responsibility is to help ensure the individual's rights are not violated and to act in the best interest of the individual. ( )

202. APPOINTED ADVOCATE.
The administrator of an ICF/IID must appoint an advocate for an individual with input from the individual's IDT when the following exists: ( )

01. Parent or Legal Guardian Unable to Participate. The individual's parent or legal guardian is unable or unwilling to participate, or is unavailable after reasonable efforts to contact them for participation have been made. ( )

02. Individual Unable to Make Informed Decisions. An individual "lacks capacity to make informed decisions" as defined in Section 66-402(9), Idaho Code. The IDT must determine and document in the individual's record the specific impairment that has rendered the individual incapable of understanding their own rights. ( )

03. Requested by Individual, Parent, or Guardian. An advocate is requested by the individual, their parent, or their guardian. ( )

04. Advise Individual of Rights. The fact that an individual has been determined to be incompetent or incapable does not absolve the facility from advising the individual of their rights to the extent that the individual is able to understand them. ( )

05. Advocate Selection. The administrator must ensure that all individuals are represented only by persons who are not employed by the facility. The priority for selection of advocates will be in the following order: ( )

a. Parent(s); ( )

b. An interested family member; or ( )

c. Other interested parties. ( )

203. ADVOCATES' RIGHTS.
Each advocate has the following rights: ( )

01. Be Informed. To be informed of activities related to the individual that may be of interest to them or of significant changes in the individual's condition. ( )

02. Visitation Rights. To visit the individual and all parts of the facility that provide services to the individual at any reasonable hour and without prior notice, unless contraindicated by the individual's needs or such practice infringes upon the privacy and rights of others. ( )

03. Prompt Communications. To receive prompt replies to any communication sent to the facility regarding the individual. ( )

04. Written Interpretation of Evaluations. To be given within thirty (30) days of admission to the facility, a written interpretation of the evaluation that is conducted for the individual. The administrator of the facility must provide a written interpretation of any and all subsequent evaluations. ( )

05. Discharge Counseling. To be counseled as to the advantages and disadvantages of discharging the individual from the facility, including admission to another facility. ( )

06. Prompt Notification of Significant Events. To be notified promptly in the event of any unusual occurrence, including serious illness or accident, impending death, and/or death; and in the case of death, to be told of autopsy findings if an autopsy is performed. ( )

07. Access to Individual's Records. To be given access to all of the individual's records that pertain to their active treatment, subject to the requirements specified in IDAPA 16.05.01, "Use and Disclosure of Department Records." ( )

204. -- 299. (RESERVED)

300. FACILITY STAFFING.
The requirements of Sections 300 through 399 of these rules are modifications and additions to the requirements in 42 CFR 483.430 - 483.430(e)(4), Condition of Participation: Facility Staffing incorporated in Section 004 of these rules. ( )

301. INTERNS AND VOLUNTEERS.
Volunteers and interns must be under the direct supervision of facility staff during all times of direct contact with individuals. ( )

302. -- 399. (RESERVED)

400. ACTIVE TREATMENT SERVICES.
The requirements of Sections 400 through 499 of these rules are modifications and additions to the requirements in 42 CFR 483.440 - 483.440(f)(4), Condition of Participation: Active Treatment Services incorporated in Section 004 of these rules. ( )

401. -- 499. (RESERVED)

500. CLIENT BEHAVIOR AND FACILITY PRACTICES.
The requirements of Sections 500 through 599 of these rules are modifications and additions to the requirements in 42 CFR 483.450 - 483.450(e)(4)(iii), Condition of Participation: Client Behavior and Facility Practices incorporated in Section 004 of these rules. ( )

501. MANAGEMENT OF INAPPROPRIATE INDIVIDUAL BEHAVIOR.
The application of painful or noxious stimuli and the use of enclosures are prohibited. ( )

502. -- 599. (RESERVED)

600. HEALTH CARE SERVICES.
The requirements of Sections 600 through 699 of these rules are for modifications and additions to the requirements in 42 CFR 483.460 - 483.460(n)(2), Condition of Participation: Health Care Services incorporated in Section 004 of these rules. ( )

601. -- 699. (RESERVED)

700. PHYSICAL ENVIRONMENT.
The requirements of Sections 700 through 799 of these rules are modifications and additions to the requirements in 42 CFR 483.470 - 483.470(1)(4), Condition of Participation: Physical Environment, incorporated in Section 004 of these rules. Other documents incorporated in Section 004 of these rules related to an ICF/IID physical environment are the NFPA's Life Safety Code and IDAPA 24.39.30, "Rules of Building Safety." ( )

701. ENVIRONMENTAL SANITATION STANDARDS.
Each ICF/IID must ensure that its environment promotes the health, safety, independence, and learning of each individual in the facility. ( )

702. ENVIRONMENTAL STANDARDS -- WATER, SEWER, AND GARBAGE.

01. Water Supply. Each ICF/IID must have a water supply that is adequate, safe, and of a sanitary quality. The water supply must: ( )

a. Be from an approved public or municipal water supply; or ( )

b. Be from a private water supply that meets the standards approved by the Department, when an approved public or municipal water supply is not available. ( )

02. Private Water Supply. An ICF/IID using a private water supply must: ( )

a. Submit water samples to the local Public Health District Laboratory for bacteriological examination at least once every three (3) months; and ( )

b. Keep copies of the Public Health District laboratory reports on file at the facility and available to authorized representatives of the Department. ( )

03. Adequate Water Supply. Each ICF/IID must have a sufficient amount of water under adequate pressure to meet sanitary and fire sprinkler system requirements of the facility at all times, according to the requirements in IDAPA 07.02.06, "Rules Concerning Idaho State Plumbing Code," and the NFPA Life Safety Code incorporated in Section 004 of these rules. ( )

04. Sewage Disposal. Each ICF/IID must discharge all sewage and liquid wastes into a municipal sewage system where such a system is available. Where a municipal sewage system is not available, sewage and liquid wastes must be collected, treated, and disposed of in a manner approved by the Department. ( )

05. Garbage and Refuse Disposal. Each ICF/IID must provide garbage and refuse disposal at its facility that meets the following requirements: ( )

a. The premises and all buildings must be kept free from accumulation of weeds, trash, and rubbish; ( )

b. Materials not directly related to the maintenance and operation of the facility must not be stored on the premises; ( )

c. All containers used for storage of garbage and refuse must be constructed of durable, nonabsorbent material, and cannot leak. Containers must be provided with tight-fitting lids unless stored in a vermin-proof room or enclosure; ( )

d. Garbage containers must be maintained in a sanitary manner. Sufficient containers must be afforded to hold all garbage and refuse that accumulates between periods of removal from the facility; and ( )

e. Storage areas must be kept clean and sanitary. ( )

703. ENVIRONMENTAL STANDARDS -- CHEMICALS AND PESTICIDES.

01. Rodent and Pest Control. Each ICF/IID must be maintained free from insects, rodents, vermin, and other pests. ( )

a. Chemicals and pesticides must be selected on the basis of the pest involved and used only in the manner prescribed by the manufacturer that is registered with the Idaho Department of Agriculture; and ( )

b. Chemicals and pesticides used in the facility's pest control program must be used and stored to meet local, state, and federal requirements. ( )

02. Chemical Storage. All toxic chemicals must be properly labeled and stored according to the manufacturer's instructions. Toxic chemicals must not be stored in individual areas, with drugs, or in any area where

food is stored, prepared, or served. ( )

704. ENVIRONMENTAL STANDARDS -- LINENS AND LAUNDRY SERVICES.

01. Linens Provided. Each ICF/IID must have available at all times a quantity of linens sufficient for the proper care and comfort of its individuals. The linens must: ( )

a. Be of good quality, not thread-bare, torn, or badly stained; and ( )

b. Be handled, processed, and stored in an appropriate manner that prevents contamination. ( )

02. Laundry Facilities. Unless a laundry service is used as described in Subsection 704.03 of this rule, each ICF/IID must have adequate laundry facilities for the sanitary washing and drying of the linens and other washable goods laundered in the facility. An individual's personal laundry must be collected, sorted, washed, and dried in a sanitary manner, and cannot be washed with the general linens. The laundry area must: ( )

a. Be situated in an area separate and apart from where food is stored, prepared, or served; ( )

b. Be well-lighted and ventilated; ( )

c. Be adequate in size for the needs of the facility; ( )

d. Be maintained in a sanitary manner; and ( )

e. Be kept in good repair. ( )

03. Laundry Services. When an ICF/IID sends its linens and individuals' personal laundry out for laundry services, the facility must ensure that: ( )

a. Soiled linens and clothing are handled in a proper manner to prevent cross-contamination and material damage prior to sending out; ( )

b. Clean linens and clothing received from a laundry service are stored in a proper manner to prevent potential re-contamination or material damage; and ( )

c. Each individual's personal laundry is collected, transported, sorted, washed, and dried in a sanitary manner and is not washed with general linens. ( )

705. ENVIRONMENTAL STANDARDS -- HOUSEKEEPING SERVICES.
Each ICF/IID must have sufficient housekeeping and maintenance personnel and equipment to maintain the interior and exterior of the facility in a safe, clean, orderly, and attractive manner. ( )

01. Facility Interior. Floors, walls, ceilings, and other interior surfaces, equipment, and furnishings must be maintained in a clean and sanitary manner. ( )

02. Housekeeping Procedures. Each ICF/IID must have written procedures for cleaning surfaces and equipment that is explained to each person engaged in housekeeping duties. An individual in the facility who is engaged in facility housekeeping duties as part of their training program must be supervised by the facility's program personnel according to the individual's assessed needs. ( )

03. Requirements After Individual Discharged. After discharge of an individual the facility must ensure that the individual's room is thoroughly cleaned, including the bed, bedding, linens, and furnishings. ( )

04. Deodorizers. Deodorizers and other products must not be used to cover odors caused by poor housekeeping or unsanitary conditions. ( )

05. Housekeeping Equipment. All housekeeping equipment must be in good repair and maintained in a clean and sanitary manner. ( )

706. -- 709. (RESERVED)

710. PHYSICAL FACILITY STANDARDS -- EXISTING GENERAL REQUIREMENTS.
Each ICF/IID must meet the minimum standards related to physical construction and maintenance for all of its buildings used for ICF/IID services as required in Sections 711 through 712 of these rules. All buildings are subject to approval by the Department. ( )

711. PHYSICAL FACILITY STANDARDS -- EXISTING CONSTRUCTION.
Each ICF/IID must use buildings that are of such character and quality to be suitable for the services and usage provided in its buildings. Other requirements for existing buildings are: ( )

01. Good Repair. Each building used by the ICF/IID and its equipment must be in good repair. ( )

a. The walls and floors must be of such character as to permit frequent cleaning. ( )

b. Walls and ceilings in kitchens, bathrooms, and utility rooms must have smooth, cleanable surfaces. ( )

c. The building must be kept clean and sanitary, and every reasonable precaution taken to prevent the entrance of insects and rodents. ( )

02. Stairways. Each stairway in an ICF/IID must have sturdy handrails on both sides of the stairs, and all open stairwells protected with guardrails. Each stairway must have a nonskid tread covering the entire surface of the stair. ( )

03. Porches and Verandas. Each open porch and veranda must be protected by sturdy guardrails of a height measuring a minimum of forty-two (42) inches. ( )

04. Telephone. Each ICF/IID must have telephone access that provides a reliable means of communication to each individual in the facility for private conversations and to contact emergency services. ( )

05. Dining Areas. Each ICF/IID must provide one (1) or more attractively furnished, multi-purpose areas of an adequate size for individuals' dining, diversional, and social activities. Each area must be: ( )

a. Well-lighted; ( )

b. Ventilated; and ( )

c. Equipped with tables and chairs that have easily cleanable surfaces. ( )

06. Storage Areas. Each ICF/IID must provide general storage areas and medical storage areas. ( )

a. For each licensed bed in the facility there must be a minimum of ten (10) square feet of general storage area; ( )

b. In addition, each individual's bedroom must have suitable storage for personal clothing, possessions, and individual adaptive equipment; and ( )

c. The facility must provide safe and adequate storage space for medical supplies and an area appropriate for the preparation of medications. ( )

07. Lighting. Each ICF/IID must meet the following lighting requirements: ( )

a. In addition to natural lighting, artificial lighting is required to provide an average illumination of ten (10) foot-candles (107 lux) over the area of a room at thirty (30) inches (standard household lighting level) above the floor level. ( )

b. With the exception of emergency egress lighting, all artificial lighting must be controllable by switches. ( )

c. Task lighting and reading lights must be available to meet each individual's needs. ( )

08. Ventilation. Each ICF/IID must be ventilated and precautions taken to prevent offensive odors. ( )

09. Heating and Air Conditioning. Each ICF/IID must provide heating and air conditioning systems throughout each building that are capable of maintaining a temperature range between sixty-eight (68°F) degrees and eighty-one (81°F) degrees Fahrenheit in all weather conditions. An ICF/IID cannot use any of the following: oil space heaters, recessed gas wall heaters, or floor furnaces. ( )

10. Plumbing. Each ICF/IID must meet the following plumbing requirements: ( )

a. All plumbing fixtures must be clean and in good repair. ( )

b. Vacuum breakers must be installed where necessary to prevent backsiphonage. ( )

c. The temperature of hot water at plumbing fixtures used by individuals in the facility must be between one hundred (100°F) degrees and one hundred twenty (120°F) degrees Fahrenheit. ( )

712. PHYSICAL FACILITY STANDARDS -- INDIVIDUAL ACCOMMODATIONS FOR EXISTING CONSTRUCTION.

Each ICF/IID must provide accommodations for each individual that meet the following requirements: ( )

01. Multi-Bedroom. No more than two (2) individuals can be housed in any multi-bedroom. ( )

02. Windows. Each individual's room window area must be no less than one-eighth (1/8) of the floor area and able to open. ( )

a. Suitable window shades or drapes must be provided to control lighting in the room. ( )

b. Windows must be located to permit an individual to have a view through the windows from a sitting position, allow for natural light, and room ventilation. ( )

c. Windows must be constructed to prevent any drafts when closed. ( )

03. Location of Bedroom. Each individual's bedroom must be an approved room that is not located: ( )

a. In a way that its outside walls are below grade; ( )

b. In any attic story; ( )

c. In any trailer house; ( )

d. In any other room not approved; or ( )

e. In a way that it can only be reached by passing through another individual's room, a utility room, or any other similar rooms. ( )

04. Room Size. Each individual's room must have dimensions that allow for no less than three (3) feet between beds. ( )

05. Ceilings. Each individual's room must have a ceiling height of seven and one-half (7 1/2) feet or more. ( )

06. Bathrooms. Each ICF/IID must have toilet rooms and hand washing facilities that are constructed as follows: ( )

a. Toilet rooms and bathrooms for individuals and personnel must not open directly into any room in which food, drink, or utensils are handled or stored. Toilet rooms or bathrooms may open into great rooms containing kitchen and dining areas if the doors are equipped with self-closures and ventilation is activated automatically with lighting. ( )

b. Toilet rooms and bathrooms must be separated from all rooms by solid walls or partitions. Adequate provisions to insure an individual's privacy must be made. ( )

c. Toilet rooms and bathrooms must be constructed for ease of cleaning. ( )

d. When an individual in an ICF/IID requires the use of a wheelchair, there must be at least one (1) toilet room and one (1) bathing area large enough to accommodate wheelchairs. ( )

e. Inside bathrooms and toilet rooms with no exterior window, must have forced ventilation to the outside. ( )

f. Toilet rooms must be so arranged that it is not necessary for an individual to pass through another individual's room to reach the toilet facilities. ( )

g. When an ICF/IID serves an individual with physical impairments, handrails or grab-bars must be provided in the individual's toilet rooms and bathrooms, and located so as to be functionally adequate. ( )

07. Bath Linens. Each individual must be provided with an individual towel and washcloth. ( )

08. Beds. Each individual must be provided with their own bed that is thirty-six (36) inches wide or more, substantially constructed, and in good repair. Roll-away beds, cots, and folding beds cannot be used. Each individual's bed must be clean and: ( )

a. Have satisfactory springs in good repair; ( )

b. Have a comfortable mattress that is standard in size for the bed; and ( )

c. Each mattress must be maintained, and for individuals known to be incontinent, water repellent. ( )

09. Interior Design. The interior design of each ICF/IID must provide the functional arrangement of a home to encourage a personalized atmosphere for its individuals. ( )

10. Furnishings and Equipment. Each ICF/IID must have furniture and equipment that is maintained in a sanitary manner, kept in good repair, and is located to permit convenient use by its individuals. ( )

11. Corridors and Hallways. Each ICF/IID must ensure corridors and hallways are free of accessory equipment that projects into such areas or otherwise poses a hazard or impedes easy passage. ( )

713. -- 729. (RESERVED)

730. PHYSICAL FACILITY STANDARDS -- NEW CONSTRUCTION.

Each ICF/IID must comply with IDAPA 24.39.30, "Rules of Building Safety," incorporated in Section 004 of these rules, or with locally adopted code when more stringent. In addition to the construction and the physical facility standards for new construction, a facility must also comply with Sections 730 through 732 of these rules. Additions to existing facilities, conversions of an existing building to a facility, and portions of facilities undergoing remodeling or alterations other than repairs, must meet these required standards. ( )

731. PHYSICAL FACILITY STANDARDS -- NEW CONSTRUCTION REQUIREMENTS.

01. New Facility Life Safety Code Requirements. Each new ICF/IID must meet the provisions of the National Fire Protection Association (NFPA) Standard 101, The Life Safety Code, as incorporated in Section 004 of these rules, applicable to an ICF/IID, as specified below: ( )

a. Each new facility housing sixteen (16) individuals or less on the first floor only, must meet the requirements of Chapter 32, New Residential Board and Care Occupancies, Small Facilities, Impractical Evacuation Capabilities, specifically the sections found within 32.1, 32.2 and 32.7, and the applicable provisions of chapters 1 through 10. ( )

b. Each new facility housing individuals on other than the first floor must meet the requirements of NFPA 101, the Life Safety Code, Chapter 18, New Health Care Occupancies, Limited Care Facility. ( )

02. Plans, Specifications, and Inspections. Plans, specifications, and inspections of each new ICF/IID construction or any addition, alteration, conversion, or remodeling of an existing structure are governed by the following rules: ( )

a. Plans for new construction of an ICF/IID must be prepared by an architect licensed in the state of Idaho; ( )

b. Employment of an architect can be waived by the Department in connection with certain minor alterations. ( )

03. Approved by Department. Each ICF/IID must submit plans and specifications to the Department prior to beginning any work on the construction of new buildings, additions, or structural changes to existing facilities, or conversion of existing buildings to be used as an ICF/IID. The Department will review and approve plans and specifications to ensure compliance with the applicable construction standards, codes, rules, and regulations. ( )

04. Preliminary Plans. Preliminary plans must be submitted and include: ( )

a. The assignment of all spaces, size of areas and rooms, and indication in outline of the fixed and movable equipment and furniture; ( )

b. Drawings of each floor, attic, and basement; ( )

c. The total floor area and number of beds; ( )

d. Drawings of approaches or site plans, roads, parking areas, and sidewalks; ( )

e. An outline describing the general construction, including interior finishes, acoustical materials, heating, electrical, and ventilation systems; and ( )

f. Plans drawn to scale of sufficient size to clearly present the proposed design, but not less than a scale of one-eighth (1/8) inch to one (1) foot. ( )

05. Working Drawings. Each ICF/IID must develop working drawings in close cooperation with the Department and other appropriate agencies and receive written Department approval prior to beginning construction. The drawings and specifications must: ( )

a. Be well-prepared with accurate dimensions; ( )

b. Include all necessary explanatory notes, schedules, and legends; ( )

c. Be complete and adequate for contract purposes; and ( )

d. Be stamped with the architect's seal. ( )

06. Inspection. Each ICF/IID must be inspected and approved by the Department prior to occupancy. The Department must be notified at least six (6) weeks prior to completion of construction to schedule a final inspection. ( )

07. ICF/IID Regulations. Each ICF/IID being constructed must meet or exceed construction features that are applicable for all local, state, and national codes. In the event of a conflict in requirements between codes, the most restrictive will apply. ( )

08. Site Requirements. Each ICF/IID site location must: ( )

a. Be served by an all-weather road kept open to motor vehicles at all times of the year; ( )

b. Be accessible to physician, professional, and habilitation services, medical facilities, shopping centers, and population centers where employees may be recruited and retained; ( )

c. Be remote from railroads, factories, airports, and similar noise, odor, smoke, dust, or other nuisances; ( )

d. Be accessible to public utilities and services such as electrical power, telephone service, and fire protection; ( )

e. Have adequate off-street parking available; and ( )

f. Comply with homeowner association covenants, conditions, and restrictions. ( )

732. PHYSICAL FACILITY STANDARDS -- INDIVIDUAL ACCOMMODATIONS FOR NEW CONSTRUCTION.
Each ICF/IID must provide accommodations for each individual that meets the following requirements: ( )

01. Bedrooms. Each individual bedroom must be of sufficient size to allow for the following: ( )

a. Eighty (80) square feet or more of usable floor space per bed in a multiple-occupancy bedroom; and ( )

b. One hundred (100) square feet or more of usable floor space for a single occupancy bedroom. ( )

02. Multi-Bedrooms. No more than two (2) individuals can be housed in any multi-bedroom. ( )

03. Windows. Each individual's room window area must be no less than eight percent (8%) of the floor area and able to open. ( )

a. Suitable window shades or drapes must be provided to control lighting in the room. ( )

b. Windows must be located to permit an individual to have a view through the windows from a sitting position, allow for natural light, and room ventilation. ( )

c. Windows must be constructed to prevent any drafts when closed. ( )

04. Location of Bedroom. Each individual's bedroom must be an approved room that is not located: ( )

a. In a way that its outside walls are below grade; ( )

b. In any attic story; ( )

c. In any trailer house; ( )

d. In any other room not approved; or ( )

e. In a way that it can only be reached by passing through another individual's room, a utility room, or any other similar rooms. ( )

05. Bathrooms. Each ICF/IID must have one (1) toilet, one (1) tub or shower, and one (1) lavatory bowl for every four (4) licensed beds in the facility. Tubs, showers, and lavatory bowls must be connected to hot and cold running water. Toilet and bathing rooms must not be accessed through another individual's sleeping room. ( )

06. Living and Dining Areas. Each ICF/IID must provide a minimum of thirty (30) square feet per licensed bed for living, dining, and recreational activities. This area must be for the sole use of individuals, and under no circumstances can these rooms be used as bedrooms by an individual or personnel. A hall or entry is not acceptable as a living room or recreation room. ( )

07. Closets. Each individual must have closet space provided in their bedroom that is four (4) square feet or more per licensed bed. When a common closet is used for two (2) individuals, there must be a physical separation for the clothing of each individual. ( )

733. -- 739. (RESERVED)

740. FIRE AND LIFE SAFETY STANDARDS -- EXISTING FACILITY.
All buildings on the premises of an ICF/IID must meet all the requirements of local, state, and national codes concerning fire and life safety standards that are applicable to ICFs/IID. ( )

01. General Requirements. Each ICF/IID must meet the following general requirements for the fire and life safety standards: ( )

a. The facility must be structurally sound and maintained and equipped to ensure the safety of the individuals who reside there, employees, and the public. ( )

b. On the premises of each facility where natural or man-made hazards are present, suitable fences, guards, and railings must be provided to protect the individuals who reside there, employees, and the public. ( )

02. Existing Life Safety Code Requirements. Each ICF/IID must meet provisions of the National Fire Protection Association (NFPA) Standard 101, The Life Safety Code, incorporated in Section 004 of these rules, applicable to an ICF/IID, as specified below: ( )

a. Each existing facility housing sixteen (16) or fewer individuals on a single story must meet the requirements of Chapter 33, Existing Residential Board and Care Occupancies, Small Facilities, Impractical Evacuation Capabilities, specifically the sections found within 33.1, 33.2 and 33.7, and the applicable provisions of Chapters 1 through 10 of the NFPA Standard 101, The Life Safety Code. ( )

b. Existing fire sprinkler systems in a facility are permitted to continue in service until building footprint modifications are made, or a change of ownership, provided the lack of conformity with these standards

does not present a serious hazard to the occupants as determined by the authority having jurisdiction. ( )

c. Sprinkler systems for a facility must be connected to the building fire alarm system and be supervised. ( )

d. Sprinkler systems installed in a newly constructed or converted facility must be designed to the standards of NFPA 13, NFPA 13-R or NFPA 13-D. Multipurpose sprinkler and domestic piping systems are prohibited. ( )

03. Existing Licensed Facilities. Each existing ICF/IID housing seventeen (17) or more individuals, or any number of individuals residing in multiple story buildings, must meet the requirement of Chapter 19, Existing Health Care Occupancies, Limited Care Facilities, and the applicable provision of Chapters 1 through 10 of the NFPA Standard 101, The Life Safety Code, incorporated in Section 004 of these rules. ( )

04. Portable Fire Extinguishers. Each ICF/IID must have portable fire extinguishers installed throughout the facility in accordance with applicable provisions of NFPA Standard 10, "Portable Fire Extinguishers." ( )

05. Portable Comfort Space Heating Devices Prohibited. The use of portable comfort space heating devices of any kind is prohibited in an ICF/IID. ( )

06. Emergency Battery Operated Lighting. Each ICF/IID must provide emergency battery-operated lighting for at least the exit passageway lighting, hall lighting, and the fire alarm system, in accordance with NFPA 101, The Life Safety Code, Section 7.9, as incorporated in Section 004 of these rules. ( )

741. FIRE AND LIFE SAFETY STANDARDS -- EMERGENCY PLANS.

01. Emergency Plans for Protection and Evacuation of Individuals. In cooperation with the local fire authority, the administrator of each ICF/IID must develop a prearranged written plan for employee response for protection of the individuals who reside there and for orderly evacuation of these individuals in case of an emergency. These plans must include procedures to meet all potential emergencies and disasters relevant to the facility, such as fire, severe weather, and missing individuals. ( )

a. The written emergency plan for each facility must contain a diagram of the building showing emergency protection equipment, evacuation routes, and exits. This diagram must be conspicuously posted in a common area within the facility. An outline of emergency instructions must be posted with the diagram. ( )

b. The facility must communicate the written emergency plan to staff and train staff in the use of the written emergency plan. ( )

c. The facility must periodically review the written emergency plan and thoroughly test it to ensure rapid and efficient function of the plan. ( )

d. The facility must hold unannounced evacuation drills at least quarterly for each shift of personnel for a total of no less than twelve (12) per year. The evacuation drills must be irregularly scheduled throughout all shifts and under varied conditions. At least one (1) drill per shift must be held on a Sunday or holiday. The facility must actually evacuate individuals during at least one (1) drill each year on each shift. ( )

e. The facility must document evacuation drills, cite the problems investigated, and take the appropriate corrective action for the identified problems. ( )

02. Report of Fire. Each ICF/IID must submit to the Department a separate report of each fire incident that occurs within the facility within thirty (30) days of the occurrence. The facility must use the Department's reporting form, "Facility Fire Incident Report," available online at: http://facilitystandards.idaho.gov. The facility must provide all specific data concerning the fire including the date, origin, extent of damage, method of extinguishment, and injuries, if any, for each fire incident. A reportable fire incident is when a facility has an incident: ( )

a. That causes staff to activate the facility emergency plan in whole or in part; ( )

b. That causes an alarm throughout, causing staff or residents to activate the facility emergency plan, in whole, or in part; ( )

c. That causes a response by the fire department or emergency services to investigate an alarm or incident; ( )

d. That is unplanned in which residents are evacuated, prepared to evacuate, partially evacuated, or protected in place, due to smoke, fire, unknown gases/odors, or other emergency; or ( )

e. That results in an injury, burn, smoke inhalation, death, or other fire or emergency-related incident. ( )

03. Maintenance of Equipment. Each ICF/IID must establish routine test, check, and maintenance procedures for alarm systems, extinguishment systems, and all essential electrical systems. Each facility must meet the following requirements: ( )

a. The use of any defective equipment on the premises of any facility is prohibited. ( )

b. The administrator of the ICF/IID must have all newly acquired equipment and appliances inspected for safe condition and function prior to use by any individual residing there, employee, or visitor to the facility. ( )

c. The administrator of the ICF/IID must show written evidence of adequate preventive maintenance procedures for equipment directly related to the health and safety of the individuals who reside there. ( )

d. The facility must have the fire alarm system and smoke detection system serviced at least annually by an authorized servicing agency. Servicing must be in accordance with the applicable provision of NFPA Standard 72, The National Fire Alarm Code. ( )

e. The facility's automatic sprinkler systems, if installed, must be serviced at least annually by an authorized servicing agency. Servicing must be in accordance with the applicable provisions of NFPA Standard 25, "Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems." Facilities protected by an NFPA 13D sprinkler system must be serviced and tested annually by an authorized servicing agency to include a visual inspection of all heads, testing of all water flow and tamper devices at a minimum. ( )

f. The facility must have all portable fire extinguishers serviced annually in accordance with the applicable provisions of NFPA Standard 10, "Portable Fire Extinguishers." ( )

g. The facility must establish routine in-house test and check procedures covering alarm systems, extinguishment systems, and essential electrical systems. ( )

742. -- 749. (RESERVED)

750. VEHICLES.
Each ICF/IID that transports individuals must have a vehicle safety policy that meets the following: ( )

01. Vehicle Safety Policy Content. Each ICF/IID must develop, implement, monitor, and maintain a written vehicle safety policy for each vehicle owned, leased, or used that includes: ( )

a. The establishment of a preventative maintenance program for each vehicle; ( )

b. Vehicle inspections and other regular maintenance needed to ensure individuals' safety; and ( )

c. Inspection of wheelchair lifts, securing devices, and other devices necessary to ensure individuals' safety. ( )

02. Motor Vehicle Licensing Requirements. Each ICF/IID must meet and adhere to all laws, rules, and regulations, including licensing, registration, and insurance requirements applicable to drivers and vehicles for each vehicle type used. ( )

751. -- 799. (RESERVED)

800. DIETETIC SERVICES.
The requirements of Sections 800 through 899 of these rules are modifications and additions to the requirements of 42 CFR 483.480 - 483.480(d)(5), Condition of Participation: Dietetic Services incorporated in Section 004 of these rules. ( )

801. PURCHASING AND STORAGE OF FOOD.
Each ICF/IID must purchase and store food as follows: ( )

01. Food Source. Each ICF/IID must obtain all food and drink from an approved source identified in IDAPA 16.02.19, "Idaho Food Code." ( )

02. Record of Food Purchases. At a minimum, each ICF/IID must keep a record of food purchases that includes invoices for the preceding thirty-day (30) period. ( )

03. Food Supply. Each ICF/IID must maintain on its premises the following food supplies: ( )

a. Staple food items sufficient for a one-week (1) period; and ( )

b. Perishable food items sufficient for a two-day (2) period. ( )

04. Temperature Requirements. Each refrigerator and freezer must be equipped with a reliable, easily read thermometer to ensure the following guidelines are met: ( )

a. Refrigerators must be maintained at forty-one (41°F) degrees Fahrenheit or below; and ( )

b. Freezers must be maintained at ten (10°F) degrees Fahrenheit or below. ( )

802. -- 999. (RESERVED)

000. LEGAL AUTHORITY.
In accordance with Sections 56-202, 56-203, Sections 56-250 through 257, and Sections 56-260 through 56-266, Idaho Code, the Idaho Legislature has authorized the Department of Health and Welfare to adopt and enforce rules for the provision of consumer-directed services. ( )

001. TITLE AND SCOPE.

01. Title. These rules are titled IDAPA 16.03.13, "Consumer-Directed Services." ( )

02. Scope. Consumer-Directed Community Supports (CDCS) is a flexible program option for participants eligible for the Children's Home and Community Based Services (HCBS) State Plan Option, and Adult and Children's Developmental Disabilities (DD) waivers. CDCS is not a covered option for participants enrolled in the Children's Act Early Waiver. The CDCS option allows the eligible participant to: choose the type and frequency of supports they want, negotiate the rate of payment, and hire the person or agency they prefer to provide those supports. ( )

002. WRITTEN INTERPRETATIONS.
This agency may have written statements that pertain to the interpretations of the rules of this chapter. These documents are available for public inspection. ( )

003. -- 007. (RESERVED)

008. AUDIT, INVESTIGATION AND ENFORCEMENT.
In addition to any actions specified in these rules, the Department may audit, investigate and take enforcement action under the provisions of IDAPA 16.05.07, "Investigation and Enforcement of Fraud, Abuse, and Misconduct." ( )

009. CRIMINAL HISTORY AND BACKGROUND CHECK REQUIREMENTS.

01. Compliance With Department Criminal History Check. The fiscal employer agent must verify that each support broker and community support worker, whose criminal history check has not been waived by the participant, has complied with IDAPA 16.05.06, "Criminal History and Background Checks." When a participant chooses to waive the criminal history check requirement for a community support worker, the waiver must be completed in accordance with Section 150 of these rules. Except, through the duration of the declared COVID-19 public health emergency, if each support broker and community support worker, whose criminal history check has not been waived by the participant is unable to complete a criminal background check in accordance with the timeframes set forth in IDAPA 16.05.06, then provider may allow newly hired direct care staff to begin rendering services prior to completion of the criminal background check in accordance with the requirements specified by the Department in a COVID-19 information release posted on the Department's website at https://healthandwelfare.idaho.gov/Providers/Providers-Medicaid/InformationReleases/tabid/264/Default.aspx. ( )

02. Availability to Work or Provide Service. Participants, at their discretion, may review the completed application and allow the community support worker to provide services on a provisional basis if no disqualifying offenses listed in IDAPA 16.05.06, "Criminal History and Background Checks," are disclosed. ( )

03. Additional Criminal Convictions. Once criminal history clearances have been received, any additional criminal convictions must be immediately reported by the worker to the participant and by the participant to the Department. ( )

04. Notice of Pending Investigations or Charges. Once criminal history clearances have been received, any charges or investigations for abuse, neglect or exploitation of any vulnerable adult or child, criminal charges, or substantiated adult protection or child protection complaints, must be immediately reported by the worker to the participant and by the participant to the Department. ( )

05. Providers Subject to Criminal History Check Requirements. A community support worker, who has not had the requirement waived by the participant, and a support broker as defined in Section 010 of these rules. ( )

010. DEFINITIONS.

01. Circle of Supports. People who encourage and care about the participant and provide unpaid supports. ( )

02. Community Support Worker. An individual, agency, or vendor selected and paid by the participant to provide community support worker services. ( )

03. Community Support Worker Services. Community support worker services are those identified supports listed in Section 110 of these rules. ( )

04. Consumer-Directed Community Supports (CDCS). For the purposes of this chapter, consumer-directed supports include Self-Directed Community Supports (SDCS) and Family-Directed Community Supports (FDCS). ( )

05. Family-Directed Community Supports (FDCS). A program option for children eligible for the Children's Developmental Disabilities (DD) Waiver and the Children's Home and Community Based Services State Plan Option described in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." ( )

06. Financial Management Services (FMS). Services provided by a fiscal employer agent that include: ( )

a. Financial guidance and support to the participant by tracking individual expenditures and monitoring overall budgets; ( )

b. Performing payroll services; and ( )

c. Handling billing and employment related documentation responsibilities. ( )

07. Fiscal Employer Agent (FEA). An agency that provides financial management services to participants who have chosen the CDCS option. The fiscal employer agent (FEA) is selected by the participant. The duties of the FEA are defined under Section 3504 of the Internal Revenue Code (26 USC 3504). ( )

08. Goods. Tangible products or merchandise that are authorized on the support and spending plan. ( )

09. Guiding Principles for the CDCS Option. Consumer-Directed Community Supports is based upon the concept of self-determination and has the following guiding principles: ( )

a. Freedom for the participant to make choices and plan their own life; ( )

b. Authority for the participant to control resources allocated to them to acquire needed supports; ( )

c. Opportunity for the participant to choose their own supports; ( )

d. Responsibility for the participant to make choices and take responsibility for the result of those choices; and ( )

e. Shared responsibility between the participant and their community to help the participant become an involved and contributing member of that community. ( )

10. Home and Community Based Services (HCBS). HCBS are those long-term services and supports that assist eligible participants to remain in their home and community. ( )

11. Participant. A person eligible for and enrolled in the Consumer-Directed Services Programs. ( )

12. Readiness Review. A review conducted by the Department to ensure that each fiscal employer

agent is prepared to enter into and comply with the requirements of the provider agreement and this chapter of rules. ( )

13. Self-Directed Community Supports (SDCS). A program option for adults eligible for the Adult Developmental Disabilities (DD) Waiver described in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." ( )

14. Support and Spending Plan. A support and spending plan is a document that functions as a participant's plan of care when the participant is eligible for and has chosen a consumer-directed service option. This document identifies the goods or services, or both, selected by a participant, including those goods, services, and supports available outside of Medicaid-funded services that can help the participant meet desired goals, and the cost of each of the identified goods and services. The participant uses this document to manage their individualized budget. ( )

15. Supports. Services provided for a participant, or a person who provides a support service. A support service may be a paid service provided by a community support worker, or an unpaid service provided by a natural support, such as a family member, a friend, neighbor, or other volunteer. A person who provides a support service for pay is a paid support. A person who provides a volunteer support service is a natural support. ( )

16. Support Broker. An individual who advocates on behalf of the participant and who is hired by the participant to provide support broker Services. ( )

17. Support Broker Services. Services provided by a support broker to assist the participant with planning, negotiating, and budgeting. ( )

18. Traditional Adult DD Waiver Services. A program option for participants eligible for the Adult Developmental Disabilities (DD) Waiver consisting of the specific Medicaid Enhanced Plan Benefits described in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." ( )

19. Traditional Children's DD Waiver Services. A program option for children eligible for the Children's Developmental Disabilities (DD) Waiver consisting of the specific Medicaid Enhanced Plan Benefits described in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." ( )

20. Traditional Children's HCBS State Plan Option Services. A program option for children eligible for the Children's Home and Community-Based Services (HCBS) State Plan Option consisting of the specific Medicaid Enhanced Plan Benefits described in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." ( )

21. Waiver Services. A collective term that refers to services provided under a Medicaid Waiver program. ( )

011. -- 019. (RESERVED)

020. RESPONSIBILITY FOR DECISION-MAKING.
Under this chapter of rules, decisions are to be made as follows: ( )

01. Children. The parent or legal guardian is responsible for decisions made on behalf of a child participant. ( )

02. Adults. The participant, or legal guardian if one exists, is responsible for decisions made on behalf of an adult participant. ( )

021. -- 099. (RESERVED)

100. CONSUMER-DIRECTED COMMUNITY SUPPORTS (CDCS) OPTION.
The CDCS option requires the participant to have a support broker to assist the participant to make informed choices, participate in a person-centered planning process, and become skilled at managing their own supports. The participant must use a fiscal employer agent to provide Financial Management Services (FMS) for payroll and

reporting functions. ( )

101. ELIGIBILITY.

01. Determination of Medicaid and Home and Community Based Services - DD Requirements. In order to choose the CDCS option, the participant must first be determined Medicaid-eligible and determined to meet existing DD waiver programs or HCBS State Plan Option requirements as outlined in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." ( )

02. Participant Agreement Form. The participant, and their legal representative, if one exists, must agree in writing using a Department-approved form to the following: ( )

a. Accept the guiding principles for the CDCS option, as defined in Section 010 of these rules; ( )

b. Agree to meet the participant responsibilities outlined in Section 120 of these rules; ( )

c. Take responsibility for and accept potential risks, and any resulting consequences, for their support choices; and ( )

d. Acknowledge and follow the rules in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Sections 310 through 317. ( )

03. Legal Representative Agreement. The participant's legal representative, if one exists, must agree in writing to honor the choices of the participant as required by the guiding principles for the CDCS option. ( )

102. -- 109. (RESERVED)

110. PAID CONSUMER-DIRECTED COMMUNITY SUPPORTS.
The participant must purchase Financial Management Services (FMS) and support broker services to participate in the CDCS option, except for under the family-directed services option where the qualified parent or legal guardian may act as an unpaid support broker. The participant must purchase goods and community supports through the fiscal employer agent who is providing the FMS. ( )

01. Financial Management Services. The Department will enter into a provider agreement with a qualified fiscal employer agent, as defined in Section 010 of these rules, to provide financial management services to a participant who chooses the consumer-directed option. ( )

02. Support Broker. Support broker services are provided by a qualified support broker. ( )

03. Community Support Worker. The community support worker provides identified supports to the participant. If the identified support requires specific licensing or certification within the state of Idaho, the identified community support worker must obtain the applicable license or certification. Identified supports include activities that address the participant's preference for: ( )

a. Job support to help the participant secure and maintain employment or attain job advancement; ( )

b. Personal support to help the participant maintain health, safety, and basic quality of life; ( )

c. Relationship support to help the participant establish and maintain positive relationships with immediate family members, friends, spouse, or others in order to build a natural support network and community; ( )

d. Emotional support to help the participant learn and practice behaviors consistent with their goals and wishes while minimizing interfering behaviors; ( )

e. Learning support to help the participant learn new skills or improve existing skills that relate to their identified goals; ( )

f. Transportation support to help the participant accomplish their identified goals; ( )

g. Adaptive equipment identified in the participant's plan that meets a medical or accessibility need and promotes their increased independence; and ( )

h. Skilled nursing support identified in the participant's plan that is within the scope of the Nurse Practice Act and is provided by a licensed registered nurse (RN) or licensed practical nurse (LPN) under the supervision of an RN, licensed to practice in Idaho. ( )

111. UNPAID COMMUNITY SUPPORTS AND SERVICES.
The Department requires that participants and their support broker identify and prioritize the use of any goods, services and supports available through an unpaid volunteer support or service, or those goods, services, and supports that can be provided by a natural support such as a family member, a friend, a neighbor or other volunteer. ( )

112. -- 119. (RESERVED)

120. PARTICIPANT RESPONSIBILITIES.
With the assistance of the support broker and the legal representative, if one exists, the participant is responsible for the following: ( )

01. Guiding Principles. Accepting and honoring the guiding principles for the CDCS option found in Section 010 of these rules. ( )

02. Person-Centered Planning. Directing the person-centered planning process in order to identify and document paid and unpaid support and service needs, wants, and preferences. ( )

03. Rates. Negotiating payment rates for all paid community supports they want to purchase, ensuring rates negotiated for supports and services do not exceed the prevailing market rate, and that are cost-effective when comparing them to reasonable alternatives, and including the details in the employment agreements. ( )

04. Agreements. Completing and implementing agreements for the fiscal employer agent, the support broker and community support workers and submitting the agreements to the fiscal employer agent. These agreements must be submitted on Department-approved forms. ( )

05. Agreement Detail. Ensuring that employment agreements specifically identify the type of support being purchased, the rate negotiated for the support, and the frequency and duration of the scheduled support or service. The participant is responsible for ensuring that each employment agreement: clearly identifies the qualifications needed to provide the support or service; includes a statement signed by the hired worker that they possess the needed skills; and the signature of the participant that verifies the same. Additionally, each employment agreement will include statements that: the participant is the employer even though payment comes from a third party; employees are under the direction and control of the participant; services must be delivered consistent with the rules in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Sections 311 through 317; and no employer-related claims will be filed against the Department. ( )

06. Plan. Developing a comprehensive support and spending plan based on the information gathered during the person-centered planning. ( )

07. Time Sheets and Invoices. Reviewing and verifying that supports being billed were provided and indicating that they approve of the bill by signing the timesheet or invoice. ( )

08. Quality Assurance and Improvement. Providing feedback to the best of their ability regarding their satisfaction with the supports they receive and the performance of their workers. ( )

121. -- 129. (RESERVED)

130. FISCAL EMPLOYER AGENT REQUIREMENTS AND LIMITATIONS.

01. Requirements. The fiscal employer agent must meet the requirements outlined in its provider agreement with the Department, and Section 3504 of the Internal Revenue Code (26 USC 3504). ( )

02. Limitations. The fiscal employer agent must not: ( )

a. Provide any other direct services to the participant, to ensure there is no conflict of interest; or ( )

b. Employ the guardian, parent, spouse, payee or conservator of the participant or have direct control over the participant's choice. ( )

131. FISCAL EMPLOYER AGENT DUTIES AND RESPONSIBILITIES.
The fiscal employer agent performs Financial Management Services for each participant. Prior to providing Financial Management Services the participant and the fiscal employer agent must enter into a written agreement. Financial Management Services include: ( )

01. Payroll and Accounting. Providing payroll and accounting supports to participants that have chosen the Consumer-Directed Community Supports option; ( )

02. Financial Reporting. Performing financial reporting for employees of each participant. ( )

03. Information Packet. Preparing and distributing a packet of information, including Department-approved forms for agreements, for the participant hiring their own staff. ( )

04. Time Sheets and Invoices. Processing and paying time sheets for community support workers and support brokers, as authorized by the participant, according to the participant's Department-authorized support and spending plan. ( )

05. Taxes. Managing and processing payment of required state and federal employment taxes for the participant's community support worker and support broker. ( )

06. Payments for Goods and Services. Processing and paying invoices for goods and services, as authorized by the participant, according to the participant's support and spending plan. ( )

07. Spending Information. Providing each participant with reporting information that will assist the participant with managing the individualized budget. ( )

08. Quality Assurance and Improvement. Participating in Department quality assurance activities. ( )

132. -- 134. (RESERVED)

135. SUPPORT BROKER REQUIREMENTS AND LIMITATIONS.

01. Initial Application to Become a Support Broker. Individuals interested in becoming a support broker must complete the Department-approved application to document that they: ( )

a. Is eighteen (18) years of age or older; ( )

b. Has skills and knowledge typically gained by completing college courses or community classes or workshops that count toward a degree in the human services field; and ( )

c. Has at least two (2) years verifiable experience with the target population and knowledge of

services and resources in the developmental disabilities field. ( )

02. Application Exam. Applicants that meet the minimum requirements outlined in this section will receive training materials and resources to prepare for the application exam. Under Family-Directed Community Supports (FDCS), children's support brokers must attend the initial training. Applicants must earn a score of seventy percent (70%) or higher to pass. Applicants may take the exam up to three (3) times. After the third time, the applicant will not be allowed to retest for twelve (12) months from the date of the last exam. Applicants who pass the exam, and meet all other requirements outlined in these rules, will be eligible to enter into a provider agreement with the Department. Through the duration of the COVID-19 public health emergency, support brokers may begin rendering services prior to completing the training requirements, provided that they complete the training requirements within thirty (30) days of first rendering services, advise the participant or legal guardian that the individual has not yet completed the applicable trainings, and comply with any other requirements specified by the Department in a COVID-19 information release posted on the Department's website at https://healthandwelfare.idaho.gov/Providers/Providers-Medicaid/InformationReleases/tabid/264/Default.aspx. ( )

03. Required Ongoing Training. All support brokers must document a minimum of twelve (12) hours per year of ongoing, relevant training in the provision of support broker services. Up to six (6) hours of the required twelve (12) hours may be obtained through independent self-study. The remaining hours must consist of classroom training. ( )

04. Termination. The Department may terminate the provider agreement when the support broker: ( )

a. Is no longer able to pass a criminal history background check as outlined in Section 009 of these rules. ( )

b. Puts the health or safety of the participant at risk by failing to perform job duties as outlined in the employment agreement. ( )

c. Does not receive and document the required ongoing training. ( )

05. Limitations. The support broker must not: ( )

a. Provide or be employed by an agency that provides paid community supports under Section 150 of these rules to the same participant; and ( )

b. For Self-Directed Community Supports (SDCS), be the guardian, parent, spouse, payee, or conservator of the participant, or have direct control over the participant’s choices. Additionally, the support broker must not be in a position to both influence a participant's decision making and receive undue financial benefit from the participant’s decisions. ( )

136. SUPPORT BROKER DUTIES AND RESPONSIBILITIES.

01. Support Broker Initial Documentation. Prior to beginning employment for the participant, the support broker must complete the packet of information provided by the fiscal employer agent and submit it to the fiscal employer agent. This packet must include documentation of: ( )

a. Support broker application approval by the Department; ( )

b. A completed criminal history check, including clearance in accordance with Section 009 of these rules and IDAPA 16.05.06, “Criminal History and Background Checks”; and ( )

c. A completed employment agreement with the participant that identifies the specific tasks and services that are required of the support broker. The employment agreement must include the negotiated hourly rate for the support broker, and the type, frequency, and duration of services. The negotiated rate must not exceed the maximum hourly rate for support broker services established by the Department. ( )

02. Required Support Broker Duties. Support broker services may include only a few required tasks or may be provided as a comprehensive service package depending on the participant's needs and preferences. At a minimum, the support broker must: ( )

a. Assist in facilitating the person-centered planning process as directed by the participant and consistent with the rules in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Sections 313, 316, and 317; ( )

b. Develop a written support and spending plan with the participant that includes the paid and unpaid supports that the participant needs and wants, related risks identified with the participant's wants and preferences, and a comprehensive risk plan for each potential risk that includes at least three (3) backup plans should a support fail. This plan must be authorized by the Department; ( )

c. Assist the participant to monitor and review their budget; ( )

d. Submit documentation regarding the participant's satisfaction with identified supports as requested by the Department; ( )

e. Participate with Department quality assurance measures, as requested; ( )

f. Assist the participant to complete the annual re-determination process as needed, including updating the support and spending plan and submitting it to the Department for authorization; ( )

g. Assist the participant, as needed, to meet the participant responsibilities outlined in Section 120 of these rules and assist the participant, as needed, to protect their own health and safety; ( )

h. Complete the Department-approved criminal history check waiver form when a participant chooses to waive the criminal history check requirement for a community support worker. Completion of this form requires that the support broker provide education and counseling to the participant and their circle of support regarding the risks of waiving a criminal history check and assist with detailing the rationale for waiving the criminal history check and how health and safety will be protected; and ( )

i. Assist children enrolled in the Family-Directed Community Supports (FDCS) Option as they transition to adult DD services. ( )

j. Sign the written support and spending plan as required in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Section 317. ( )

03. Additional Support Broker Duties. In addition to the required support broker duties, each support broker must be able to provide the following services when requested by the participant: ( )

a. Assist the participant to develop and maintain a circle of support; ( )

b. Help the participant learn and implement the skills needed to recruit, hire, and monitor community supports; ( )

c. Assist the participant to negotiate rates for paid community support workers; ( )

d. Maintain documentation of supports provided by each community support worker and participant's satisfaction with these supports; ( )

e. Assist the participant to monitor community supports; ( )

f. Assist the participant to resolve employment-related problems; ( )

g. Assist the participant to identify and develop community resources to meet specific needs; and ( )

h. Assist the participant in distributing the support and spending plan to community support workers or vendors as described in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Section 317. ( )

04. Termination of Support Broker Services. If a support broker decides to end services with a participant, they must give the participant at least thirty (30) days' written notice prior to terminating services. The support broker must assist the participant to identify a new support broker and provide the participant and new support broker with a written service transition plan by the date of termination. The transition plan must include an updated support and spending plan that reflects current supports being received, details about the existing community support workers, and unmet needs. ( )

137. -- 139. (RESERVED)

140. COMMUNITY SUPPORT WORKER LIMITATIONS.
A paid community support worker must not be the spouse of the participant, and, for FDCS, must not be the parent or legal guardian of the participant, and must not have direct control over the participant's choices, must avoid any conflict of interest, and must not receive undue financial benefit from the participant's choices. ( )

01. Self-Directed Community Supports (SDCS). A legal guardian can be a paid community support worker but must not be paid from the individualized budget for the following: ( )

a. The legal guardian must not be paid to perform or to assist the participant in meeting the participant responsibilities outlined in Section 120 of these rules. ( )

b. The legal guardian must not be paid to fulfill any obligations they are legally responsible to fulfill as outlined in the guardianship or conservator order from the court. ( )

02. Family-Directed Community Supports (FDCS). A parent or legal guardian cannot be a paid community support worker. A paid community support worker: ( )

a. Must not supplant the role of the parent or legal guardian; ( )

b. Cannot be paid to fulfill any obligations that the parent or legal guardian is legally responsible to fulfill for their child. ( )

141. -- 149. (RESERVED)

150. PAID COMMUNITY SUPPORT WORKER DUTIES AND RESPONSIBILITIES.

01. Initial Documentation. Prior to providing goods or services to the participant, the community support worker must complete the packet of information provided by the fiscal employer agent and submit it to the fiscal employer agent. When the community support worker will be providing services, this packet must include documentation of: ( )

a. A completed criminal history check, including clearance in accordance with Section 009 of these rules and IDAPA 16.05.06, "Criminal History and Background Checks," or documentation that this requirement has been waived by the participant. This documentation must be provided on a Department-approved form and include the rationale for waiving the criminal history check and describe how health and safety will be ensured in lieu of a completed criminal history check. Individuals listed on a state or federal provider exclusion list must not provide paid supports; ( )

b. A completed employment agreement with the participant that specifically defines the type of support being purchased, the negotiated rate, and the frequency and duration of the support to be provided. If the community support worker is provided through an agency, the employment agreement must include the specific individual who will provide the support and the agency's responsibility for tax-related obligations; ( )

c. Current state licensure or certification if identified support requires certification or licensure; and

( )

d. A statement of qualifications to provide supports identified in the employment agreement. ( )

02. Employment Agreement. The community support worker must deliver supports as defined in the employment agreement. ( )

03. Documentation of Supports. The community support worker must track and document the time required to perform the identified supports and accurately report the time on the time sheets provided by the participant's fiscal employer agent or complete an invoice that reflects the type of support provided, the date the support was provided, and the negotiated rate for the support provided, for submission to the participant's fiscal employer agent. ( )

04. Time Sheets and Invoices. The community support worker must obtain the signature of the participant or their legal representative on each completed timesheet or invoice prior to submitting the document to the fiscal employer agent for payment. Time sheets or invoices that are not signed by the community support worker and the participant or their legal representative will not be paid. ( )

151. -- 159. (RESERVED)

160. SUPPORT AND SPENDING PLAN DEVELOPMENT.

01. Support and Spending Plan Requirements. The participant, with the help of their support broker, must develop a comprehensive support and spending plan based on the information gathered during the person-centered planning. The support and spending plan is not valid until authorized by the Department and must include the following: ( )

a. The participant's preferences and interests by identifying all the supports and services, both paid and non-paid, the participant wants and needs to live successfully in their community. ( )

b. Paid or non-paid consumer-directed community supports that focus on the participant's wants, needs, and goals in the following areas: ( )

i. Personal health and safety including quality of life preferences; ( )

ii. Securing and maintaining employment; ( )

iii. Establishing and maintaining relationships with family, friends and others to build the participant's circle of supports; ( )

iv. Learning and practicing ways to recognize and minimize interfering behaviors; and ( )

v. Learning new skills or improving existing ones to accomplish set goals. ( )

c. Support needs such as: ( )

i. Medical care and medicine; ( )

ii. Skilled care including therapies or nursing needs; ( )

iii. Community involvement; ( )

iv. Preferred living arrangements including possible roommate(s); and ( )

v. Response to emergencies including access to emergency assistance and care. This plan should reflect the wants, preferences, and needs of the whole person, regardless of payment source, if any. ( )

d. Risks or safety concerns in relation to the identified support needs on the participant's plan. The plan must specify the supports or services needed to address the risks for each issue listed, with at least three (3) backup plans for each identified risk to implement in case the need arises; ( )

e. Sources of payment for the listed supports and services, including the frequency, duration, and main task of the listed supports and services; ( )

f. The budgeted amounts planned in relation to the participant's needed supports. Community support worker employment agreements submitted to the fiscal employer agent must identify the negotiated rates agreed upon with each community support worker along with the specific support being purchased, the frequency and duration that the support will be provided, and the payment increment; that is, hourly or daily. The fiscal employer agent will compare and match the employment agreements to the appropriate support categories identified on the initial spending plan prior to processing time sheets or invoices for payment; and ( )

g. Additional HCBS person-centered plan requirements as defined in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Sections 313, 316, and 317. ( )

02. Support and Spending Plan Limitations. Support and spending plan limitations include: ( )

a. Traditional Medicaid waiver and traditional rehabilitative or habilitative services must not be purchased under the CDCS option. Because a participant cannot receive these traditional services and consumer-directed services at the same time, the participant, the support broker, and the Department must all work together to ensure that there is no interruption of required services when moving between traditional services and the CDCS option; ( )

b. Paid community supports must not be provided in a group setting with recipients of traditional Medicaid waiver, rehabilitative or habilitative services. This limitation does not preclude a participant who has selected the consumer-directed option from choosing to live with recipients of traditional Medicaid services; ( )

c. All paid community supports must fit into one (1) or more types of community supports described in Section 110 of these rules. The support and spending plan must not include supports or services that are illegal, that adversely affect the health and safety of the participant, that do harm, or that violate or infringe on the rights of others; ( )

d. Support and spending plans that exceed the approved budget amount will not be authorized; and ( )

e. Time sheets or invoices that are submitted to the fiscal employer agent for payment that exceed the authorized support and spending plan amount will not be paid by the fiscal employer agent. ( )

161. -- 169. (RESERVED)

170. PERSON-CENTERED PLANNING.

01. Direction of the Person-Centered Planning Process. The participant agrees to direct the person-centered planning process in order to identify and document their support and service needs, wants, and preferences. ( )

02. Participant Choice. The participant decides who they want to participate in the planning sessions in order to ensure the participant's choices are honored and promoted. ( )

03. Facilitation of Person-Centered Planning Meetings. The participant may facilitate their person-centered planning meetings, or these meetings may be facilitated by the chosen support broker. ( )

04. Focus of Person-Centered Planning. The person-centered planning should focus on identifying strengths, capacities, preferences, needs, and desired goals of the participant for all life areas. ( )

05. Timeframes of Person-Centered Planning. The person-centered planning should be completed as timely as possible in order to provide the necessary information required to develop the participant's support and spending plan. Time limitations are not currently mandated in order to allow for extensive, comprehensive planning and thoughtful support and spending plan development. ( )

06. HCBS Person-Centered Planning Requirements. The person-centered planning process must meet all HCBS requirements as defined in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Section 316. ( )

171. -- 179. (RESERVED)

180. CIRCLE OF SUPPORTS.
The circle of support is a means of natural supports for the participant and consists of people who encourage and care about the participant. Work or duties the circle of supports performs on behalf of the participant are not paid. ( )

01. Focus of the Circle of Support. The participant's circle of support should be built and operate with the primary goal of working in the interest of the participant. The group's role is to give and get support for the participant and to develop a plan of action, along with and on behalf of the participant, to help the participant accomplish their personal goals. ( )

02. Members of the Circle of Support. A circle of support may include family members, friends, neighbors, co-workers, and other community members. For the SDCS, when the participant's legal guardian is selected as a community support worker, the circle of support must include at least one (1) non-family member that is not the support broker. For the purposes of this chapter a family member is anyone related by blood or marriage to the participant or to the legal guardian. ( )

03. Selection and Duties of the Circle of Support. Members of the circle of support are selected by the participant and commit to work within the group to: ( )

a. Help promote and improve the life of the participant in accordance with the participant's choices and preferences; and ( )

b. Meet on a regular basis to assist the participant to accomplish their expressed goals. ( )

04. Natural Supports. A natural support may perform any duty of the support broker as long as the support broker still completes the required responsibilities listed in Subsection 136.02 of these rules. Additionally, any community support worker task may be performed by a qualified natural support person. Supports provided by a natural support person must be identified on the participant's support plan, but time worked does not need to be recorded or reported to the fiscal employer agent. ( )

181. -- 189. (RESERVED)

190. INDIVIDUALIZED BUDGET.
The Department sets an individualized budget for each participant according to an individualized measurement of the participant's functional abilities, behavioral limitations, medical needs, and other individual factors related to the participant's assessed needs. Using these specific participant factors, the budget-setting methodology will correlate a participant's characteristics with the participant's individualized budget amount, so participants with higher needs will be assigned a higher individualized budget amount. The participant must work within the identified budget and acknowledge that they understand the budget figure is a fixed amount. ( )

01. Budget Amount Notification. The Department notifies each participant of their set budget amount as part of the eligibility determination or annual redetermination process. The notification will include how the participant may appeal the set budget amount. ( )

02. Annual Re-Evaluation of Adult Individualized Budgets. Individualized budgets will be re-evaluated annually. At the request of the participant, the Department will also re-evaluate the set budget amount when there are documented changes in the participant's condition that results in a need for services that meet medical necessity criteria, and that is not reflected on the current inventory of individual needs. ( )

03. Annual Re-Evaluation of Children's Individualized Budgets. Individualized budgets will be re-evaluated annually. At the request of the participant, the Department will also re-evaluate the set budget amount when there are documented changes that may support placement in a different budget category as identified in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Section 527. ( )

191. -- 199. (RESERVED)

200. QUALITY ASSURANCE.
The Department will implement quality assurance processes to ensure: access to consumer-directed services, participant direction of plans and services, participant choice and direction of providers, safe and effective environments, and participant satisfaction with services and outcomes. ( )

01. Participant Experience Survey (PES). Each participant will have the opportunity to provide feedback to the Department about their satisfaction with consumer-directed services utilizing the PES. ( )

02. Participant Experience Outcomes. Participant experience information will be gathered at least annually in an interview by the Department, and will address the following participant outcomes: ( )

a. Access to care; ( )

b. Choice and control; ( )

c. Respect and dignity; ( )

d. Community integration; and ( )

e. Inclusion. ( )

03. Fiscal Employer Agent Quality Assurance Activities. The fiscal employer agent must participate in quality assurance activities identified by the Department such as readiness reviews, periodic audits, maintaining a list of criminal history check waivers, and timely reporting of accounting and satisfaction data. ( )

04. Community Support Workers and Support Brokers Quality Assurance Activities. Community support workers and support brokers must participate and comply with quality assurance activities identified by the Department including performance evaluations, satisfaction surveys, quarterly review of services provided by a legal guardian, if applicable, and spot audits of time sheets and billing records. ( )

05. Participant Choice of Paid Community Support Worker. Paid community support workers must be selected by the participant, or their chosen representative, and meet the qualifications identified in Section 150 of this rule. ( )

06. Complaint Reporting and Tracking Process. The Department will maintain a complaint reporting and tracking process to ensure participants, workers, and other supports have the opportunity to readily report instances of abuse, neglect, exploitation, or other complaints regarding the HCBS program. ( )

07. Quality Oversight Committee. A Quality Oversight Committee consisting of participants, family members, community providers, and Department designees will review information and data collected from the quality assurance processes to formulate recommendations for program improvement. ( )

08. Quarterly Quality Assurance Reviews. On a quarterly basis, the Department will perform an enhanced review of services for those participants who have waived the criminal history check requirement for a

community support worker or who have their legal guardian providing paid services. These reviews will assess ongoing participant health and safety and compliance with the approved support and spending plan. ( )

09. Home and Community Based Service Specific Reviews. The Department will implement quality assurance and improvement activities to ensure compliance with the rules in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Sections 310 through 317. ( )

201. -- 209. (RESERVED)

210. CONTINUATION OF THE CONSUMER-DIRECTED COMMUNITY SUPPORTS (CDCS) OPTION.
The following requirements must be met or the Department may require the participant to discontinue the CDCS option: ( )

01. Required Supports. The participant is willing to work with a support broker and a fiscal employer agent. ( )

a. The participant can only change FEA services by providing a written request to their current FEA provider at least sixty (60) days in advance, and this change must occur at the end of a fiscal quarter. The request must include the name of the new FEA chosen by the participant and provide the specific date the change will occur. ( )

b. When a participant provides a written request to their current FEA provider to change to a different FEA provider, the current FEA provider must notify the participant of the specific date that the last payroll run will occur at the end of the fiscal quarter. ( )

02. Support and Spending Plan. The participant's support and spending plan is being followed. ( )

03. Risk and Safety Back-Up Plans. Back-up plans to manage risks and safety are being followed. ( )

04. Health and Safety Choices. The participant's choices do not directly endanger their health, welfare and safety or endanger or harm others. ( )

211. -- 299. (RESERVED)

FISCAL EMPLOYER AGENT DUTIES AND RESPONSIBILITIES (Sections 300-314)

300. FISCAL EMPLOYER AGENT DUTIES AND RESPONSIBILITIES: DEFINITIONS.
For purposes of Sections 300 through 314, the following definitions apply: ( )

01. Employee. A community support worker employed by a participant receiving services under the CDCS option. ( )

02. Employer. A participant receiving services under the CDCS option. ( )

03. Provider. The term "provider" specifically refers to the fiscal employer agent providing financial management services to individuals participating in consumer-direction. ( )

04. SFTP. Secure File Transfer Protocol. A secure means of transferring data that allows certain Department staff to access information regarding consumer-direction participants. ( )

05. Vendor. Provides goods and services rendered by agencies and independent contractors in accord with a participant's support and spending plan. ( )

06. Medicaid Billing Report. A report generated every payroll period by the provider; it provides a list and count of unduplicated participants and payroll expenditures by service code, based on the date of service time frame specified by the user. ( )

301. FISCAL EMPLOYER AGENT DUTIES AND RESPONSIBILITIES: CONSUMER-DIRECTED COMMUNITY SUPPORTS.

01. Federal Tax ID Requirement. The fiscal employer agent must obtain a separate Federal Employer Identification Number (FEIN) specifically to file tax forms and to make tax payments on behalf of program participants under Section 3504 of the Internal Revenue Code (26 USC 3504). In addition, the provider must: ( )

a. Maintain copies of the participant's FEIN, IRS FEIN notification letter, and Form SS-4 Request for FEIN in the participant's file. ( )

b. Retire participant's FEIN when the participant is no longer an employer under consumer-directed community supports (CDCS). ( )

02. Requirement to Report Irregular Activities or Practices. The provider must report to the Department any facts regarding irregular activities or practices that may conflict with federal or state rules and regulations; ( )

03. Procedures Restricting FMS to Adult and Children's DD Waiver and Children's HCBS State Plan Option Participants. The provider must not act as a fiscal employer agent and provide fiscal management services to a DD waiver or Children's HCBS State Plan Option participant for whom it also provides any other services funded by the Department. ( )

04. Policies and Procedures. The provider must maintain a current manual containing comprehensive policies and procedures. The provider must submit the manual and any updates to the Department for approval. ( )

05. Key Contact Person. The provider must provide a key contact person and at least (2) two other people for backup who are responsible for answering calls and responding to e-mails from Department staff and ensure these individuals respond to the Department within one (1) business day. ( )

06. Face-to-Face Transitional Participant Enrollment. The provider must conduct face-to-face transitional participant enrollment sessions in group settings or with individual participants in their homes or other designated locations. The provider must work with the regional Department staff to coordinate and conduct enrollment sessions. The face-to-face encounter may occur via synchronous interaction telehealth, as defined in Title 54, Chapter 57, Idaho Code. ( )

07. SFTP Site. The provider must provide an SFTP site for the Department to access. The site must have the capability of allowing participants and their employees to access individual specific information such as time cards and account statements. The site must be user name and password protected. The provider must have the site accessible to the Department upon commencement of the readiness review. ( )

08. Required IRS Forms. The provider must prepare, submit, and revoke the following IRS forms in accordance with IRS requirements and must maintain relevant documentation in each participant's file including: ( )

a. IRS Form 2678; ( )

b. IRS Approval Letter; ( )

c. IRS Form 2678 revocation process; ( )

d. Initial IRS Form 2848; and ( )

e. Renewal IRS Form 2848. ( )

09. Requirement to Obtain Power of Attorney. The provider must obtain an Idaho State Tax Commission Power of Attorney (Form TC00110) from each participant it represents and maintain the relevant documentation in each participant's file. ( )

10. Requirement to Revoke Power of Attorney. The provider must revoke the Idaho State Tax Commission Power of Attorney (Form TC00110) when the provider no longer represents the participant and maintain the relevant documentation in the participant's file. ( )

11. Home and Community Based Person-Centered Service Plan Requirements. The provider must sign the written support and spending plan as required in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," Section 317. ( )

302. FISCAL EMPLOYER AGENT DUTIES AND RESPONSIBILITIES: CUSTOMER SERVICE.

01. Customer Service System. The provider must provide a customer service system to respond to all inquiries from participants, employees, agencies, and vendors. The provider must: ( )

a. Provide staff with customer service training with an emphasis on consumer-direction. ( )

b. Ensure staff are trained and have the skills to assist participants with enrollment and to help them understand their account statements. ( )

c. Ensure that fiscal employer agent personnel are available during regular business hours, 8 a.m. to 5 p.m. Mountain Time, Monday through Friday, excluding state holidays. ( )

d. Provide translation and interpreter services (i.e., American Sign Language and services for persons with limited English proficiency). ( )

e. Provide prompt and consistent response to verbal and written communication. Specifically: ( )

i. All voice mail messages must be responded to within one (1) business day; and ( )

ii. All written and electronic correspondence must be responded to within five (5) business days. ( )

f. Maintain a toll-free phone line where callers speak to a live person during business hours and are provided the option to leave voice mail at any time, all day, every day. ( )

g. Maintain a toll-free fax line that is available all day, every day, exclusively for participants and their employees. ( )

02. Complaint Resolution and Tracking System. The provider is responsible for receiving, responding to, and tracking all complaints from any source under this agreement. A complaint is defined as a verbal or written expression of dissatisfaction about fiscal employer agent services. The provider must: ( )

a. Respond to all written and electronic correspondence within five (5) days. ( )

b. Respond to verbal complaints within one (1) business day. ( )

c. Maintain an electronic tracking system and log of complaints and resolutions. The electronic log of complaints and resolutions must be accessible for Department review through the SFTP site. ( )

d. Log and track complaints received from the Department pertaining to fiscal employer agent

services. ( )

e. Compile a summary report and analyze complaints received on a quarterly basis to determine the quality of services to participants and to identify any corrective action necessary. ( )

f. Post the complaint to the SFTP site within twenty-four (24) hours any day a complaint is received Monday through Friday. Saturday and Sunday complaints must be posted to the SFTP site by close of business the following Monday. Failure to comply will result in a fifty dollar ($50) penalty payable to Medicaid within ninety (90) days of incident. ( )

303. FISCAL EMPLOYER AGENT DUTIES AND RESPONSIBILITIES: PERSONAL AND CONFIDENTIAL INFORMATION.

The provider must implement and enforce policies and procedures regarding documents that are mailed, faxed, or e-mailed to and from the provider to ensure documents are tracked and that confidential information is not compromised, is stored appropriately and not lost, and is traceable for historical research purposes. ( )

304. FISCAL EMPLOYER AGENT DUTIES AND RESPONSIBILITIES: ENROLLMENT PROCESS.

01. Submission of Participant Enrollment and Employee Packets for Department Approval. The provider must submit the following for participant enrollment and employee packets to the Department for approval. ( )

a. The participant enrollment packet must include: ( )

i. Fiscal employer agent authorization form; ( )

ii. Employer Appointment of Agent - IRS Form; ( )

iii. Tax Information Form; and ( )

iv. Employer information. The employer information must include: ( )

(1) Instructions for completing forms; ( )

(2) Payroll schedule, including deadlines for submission of time cards; ( )

(3) Sample employment agreements; ( )

(4) Sample Request for Vendor Payment form; ( )

(5) Sample independent provider agreement; and ( )

(6) Other sample employment agreements as needed. ( )

b. The employee enrollment packet must contain: ( )

i. Employee Information Form; ( )

ii. I-9 Employment Eligibility Form; ( )

iii. W-4 Employee Withholding Allowance Certificate; ( )

iv. Pay selection agreement; ( )

v. Direct deposit authorization (optional); ( )

vi. Sample time sheets and instructions for completion; and ( )

vii. IRS Form W-5. ( )

02. Distribution of Participant Enrollment and Employee Packets to Participant after Department Approval. The provider must distribute Department-approved participant enrollment packets and employment packets to the participant within two (2) business days after the participant requests the packets. ( )

a. To enroll a participant, the provider must: ( )

i. Enroll the participant within two (2) business days of receipt of completed paperwork; and ( )

ii. Log and maintain an electronic record of all enrollment paperwork, which includes participant support and spending plan cost and authorization sheets. ( )

b. To enroll an employee, the provider must: ( )

i. Enroll the employee within two (2) business days of receipt of completed paperwork; and ( )

ii. Log and maintain an electronic record of all the employee's paperwork that includes the employment agreements. ( )

305. FISCAL EMPLOYER AGENT DUTIES AND RESPONSIBILITIES: PAYMENT PROCESS.

01. Process Payroll. The provider must process payroll, including time sheets and taxes, in accordance with the participant's support and spending plan. The payroll process must include: ( )

a. Payment of employer and withholding taxes to State Tax Commission and Internal Revenue Service. ( )

b. Payment of invoices to vendors. ( )

c. Management of participant budget funds as per authorized support and spending plan. ( )

d. Garnishment of wages as per court orders. ( )

e. Preparation of year-end federal and state tax forms. ( )

f. Payment of worker's compensation insurance premiums. ( )

02. Requirement to Track and Log Time Sheet Billing Errors. The provider must track and log time sheet billing errors or time sheets that cannot be paid due to late arrival, missing, or erroneous information. The provider must notify the employee and participant within one (1) business day of when errors are identified on the time sheets. ( )

03. Requirement to Track and Log Improperly Cashed or Improperly Issued Checks. The provider must track and log occurrences of improperly cashed or improperly issued checks and stop payment on checks when necessary. The provider must reissue lost, stolen, or improperly issued checks at no expense to the participant or the Department within fourteen (14) calendar days of when the error occurred. ( )

04. Process Employee Payments. The provider must verify employees' documentation and process employees' payments via check, direct deposit, or pay cards as per preference of employees. The employee payment process includes: ( )

a. Receipt of time cards from employees via mail, fax, or website by specified due dates. ( )

b. Review time cards for accuracy and verify that timecards contain the following information: ( )

i. Employer name and ID number. ( )

ii. Employee name and ID number. ( )

iii. Hours of work. ( )

iv. Code for service. ( )

c. Match codes to employment agreement to verify rate of pay. ( )

d. Verify that rate of pay multiplied by the hours worked per each pay period is equal to the gross pay. ( )

e. Calculate all taxes and other withholding. ( )

f. Pay employees every two (2) weeks or semi-monthly. ( )

g. Contact participant and representative if there are problems with timecards or other documents in order to resolve issues prior to pay-date, if possible. ( )

h. Maintain an electronic complaint log of payroll issues and resolutions. ( )

i. The provider must verify there is money remaining in each participant's budget and specific service category prior to issuing a check. ( )

05. Process Vendor Payments. When participants submit requests for payment to vendors, the provider must: ( )

a. Review, and maintain on file, the vendor payment request with attached voided vendor receipt submitted by the participant. ( )

b. Ensure item or payment is authorized on the participant's support and spending plan. ( )

c. Issue a check made out to the vendor and mail to participant for distribution. Vendor payments are made on the same schedule as payroll. ( )

06. Process Independent Contractor or Outside Agency Payments. When the participant hires an independent contractor or outside agency, in accordance with the support and spending plan, the provider must: ( )

a. Obtain a W-9 from the contractor or agency. ( )

b. Review, and maintain on file, the independent contractor or agency agreement submitted by the participant. ( )

c. Review, and maintain on file, the independent contractor or agency invoice for services submitted by the participant. ( )

d. Ensure service or payment is authorized on the support and spending plan. ( )

e. Issue payment directly to the independent contractor or agency. ( )

07. End-of-Year Processing. For purposes of end-of-year processing, the provider must maintain

relevant documentation and must: ( )

a. Refund over-collected Federal Insurance Contributions Act tax (FICA) to applicable employees, or to state government; ( )

b. Prepare, file, and distribute IRS Form W-2 for each employee; ( )

c. Prepare and file IRS Form W-3 for each participant represented; ( )

d. Prepare and file State Form 957 for state income taxes for each employer; ( )

e. Report and pay any Unclaimed Property per Idaho State Tax Commission rules; and ( )

f. Report and pay all state and federal unemployment insurance premiums. ( )

08. Transition to New FEA. The following items must be addressed if a participant transitions to a new FEA provider. For the purposes of a smooth transition between FEA providers, the two providers must work closely with one another to transfer the participant from the services one is no longer providing to the services the other is providing. The following items must be transferred: ( )

a. Participant's Federal Employer Identification Number (FEIN). ( )

b. Mailing address for FEIN. ( )

c. IRS Form 2678 Agent/Payer Authorization. ( )

d. Depositing taxes and filing report. This includes Federal and State tax withholdings and Federal Unemployment Tax Act tax (FUTA). ( )

e. Participant's FUTA Liability Status. ( )

f. FICA Exemption Status of Participant Employees. ( )

g. FUTA Exemption Status of Participant Employees. ( )

h. Unemployment Insurance (U/I). ( )

i. Unemployment Insurance Experience Rate and Taxable Wage Base. ( )

j. Unemployment Insurance Taxable Wage Base. ( )

k. State Unemployment Insurance Liability Status of the Participant. ( )

l. State Unemployment Insurance Liability Status of Exempt Employees. ( )

m. Unemployment Insurance Filing and Depositing. ( )

n. State Income Tax - Account Number. ( )

o. State Income Tax - Agent Authorization. ( )

p. State Income Tax - Filing and Depositing. ( )

q. Budget Authorization - authorized services. ( )

r. Budget Authorization - spent and remaining. ( )

s. Budget Authorization - authorized providers. ( )

t. Budget Authorization - authorized provider rates. ( )

u. Participant's Demographic information. ( )

v. Participant's Representative demographic information. ( )

w. Participant's Employee and provider demographic information. ( )

x. Participant's Employee tax and other information. ( )

y. Participant's Independent contract and other information. ( )

z. Participant's Employee New Hire Reporting. ( )

aa. Participant's Employee Liens and Garnishments. ( )

306. FISCAL EMPLOYER AGENT DUTIES AND RESPONSIBILITIES: ANNUAL PARTICIPANT SURVEY.

01. Requirement to Conduct Annual Participant Satisfaction Survey. Starting October 1 of each calendar year, each provider who has been providing services for at least six (6) months must conduct an annual participant satisfaction survey. ( )

a. Three (3) weeks prior to the survey launch, the provider must present the questions to the Department staff for approval. ( )

b. Once the questions are approved by the Department, the provider can send out the survey. ( )

c. The provider must survey its participants who receive services under consumer-directed services, such as participants with disabilities, family members of participants, and participants whose primary language is other than English. ( )

d. The provider must provide options for participants to respond to the surveys, other than by mail, for those participants who may not be able to respond by that method. ( )

02. Requirement to Provide Results of Annual Participant Satisfaction Survey. The provider must provide the results of the surveys to the Department in a comprehensive report, along with the completed surveys, by the 15th of December of each calendar year. ( )

307. FISCAL EMPLOYER AGENT DUTIES AND RESPONSIBILITIES: QUALITY ASSURANCE.

01. Required Elements of Quality Insurance Process. The provider must provide a quality assurance process that includes: ( )

a. Implementation of a quality management plan; ( )

b. Preparation of a quarterly, quality management analysis report; ( )

c. Distribution, collection, and analysis of an annual participant satisfaction survey; and ( )

d. A review of the monthly complaint summary and resolutions, monitoring of standards, and implementation of program improvements as needed. ( )

02. Requirement for Formal Quality Assurance Review. Every two (2) years, the provider must

participate in a formal quality assurance review conducted in collaboration with the Department. ( )

308. FISCAL EMPLOYER AGENT DUTIES AND RESPONSIBILITIES: DISASTER RECOVERY PLAN.

01. Disaster Recovery Plan. The provider must develop and maintain a Disaster Recovery Plan for electronic and hard copy files that includes restoring software and data files, and hardware backup if management information systems are disabled or servers are inoperative. The results of the Disaster Recovery Plan must ensure the continuation of payroll and invoice payment systems. The provider must submit the Disaster Recovery Plan for Department approval during the readiness review. ( )

02. Requirement to Report a Disaster. The provider must report to the Department if management information systems are disabled or servers are inoperative within twenty-four (24) hours of the event. ( )

309. FISCAL EMPLOYER AGENT DUTIES AND RESPONSIBILITIES: TRANSITION PLAN.

01. Transition Plan Objectives. The provider must provide a transition plan to the Department within ninety (90) days after successful completion of the readiness review. The objectives of the transition plan are to minimize the disruption of services and provide an orderly and controlled transition of the provider's responsibilities to a successor at the conclusion of the agreement period or for any other reason the provider cannot complete responsibilities described in this chapter of rules. ( )

02. Transition Plan Requirements. The transition plan must: ( )

a. Be updated at least ninety (90) days prior to termination of the provider agreement. ( )

b. Include tasks, and subtasks for transition, a schedule for transition, operational resource requirements, and training to be provided. ( )

c. Provide for transfer of data, documentation, files, and other records relevant to the agreement in an electronic format accepted by the Department. ( )

d. Provide for the transfer of any current, Idaho-specific policy and procedure manuals, brochures, pamphlets, and all other written materials developed in support of agreement activity to the Department. ( )

310. FISCAL EMPLOYER AGENT DUTIES AND RESPONSIBILITIES: PERFORMANCE METRICS.

01. Readiness Review. The provider must complete a readiness review conducted by the Department with the provider prior to providing fiscal employer agent services. ( )

a. Required Level of Expectation: The provider must complete one hundred percent (100%) of the readiness review. ( )

b. Method of Monitoring: The Department will access SFTP site for review of provider documents and conduct an onsite review. ( )

02. Compliance with Tax Regulations and Labor Laws. The provider must ensure each participant's compliance with regulations for both federal taxes and state taxes, as well as all applicable labor laws. ( )

03. Fiscal Support and Financial Consultation. ( )

a. The provider must provide each participant with fiscal support and financial consultation. ( )

b. Required Level of Expectation: The provider must respond to ninety-five percent (95%) of participant calls within two (2) business days and to e-mails within five (5) days. ( )

04. Federal and State Forms Submitted. The provider must ensure each participant's compliance with regulations for both federal taxes and state taxes, including preparation and submission of all federal and state forms for each participant and their employees. ( )

05. Mandatory Reporting, Withholding, and Payment. The provider must perform all mandatory reporting, withholding, and payment actions according to the compliance requirements of the state and federal agencies. ( )

06. Payroll Checks. The provider must issue payroll checks within the two (2) week or semi-monthly payroll cycle, after receipt of completed, approved time sheets. ( )

07. Adherence to Support and Spending Plan. The provider must distribute payments to each participant employee in accordance with participant's support and spending plan. ( )

08. Record Activities. The provider must record all activities in an individual file for each participant and their employees. ( )

09. Records in Participant File. The provider must maintain complete records in each participant's file. ( )

10. Manage Phone, Fax, and E-Mail for Fiscal and Financial Questions. ( )

a. The provider must manage toll-free telephone line, fax, and e-mail related to participant fiscal and financial questions. ( )

b. Required Level of Expectation: The provider must respond to ninety-five percent (95%) of participant queries within two (2) business days. ( )

11. Tracking of Complaints and Complaint Resolution. ( )

a. The provider must maintain a register of complaints from participants, participant employees, and others, with corrective action implemented by the provider within one (1) day of the complaint. ( )

b. Required Level of Expectation: The provider must respond to ninety-five percent (95%) of complaints within one (1) business day. ( )

12. Web Access to Electronic Time Sheet Entry. The provider must maintain web access to electronic time sheet entry for participants. ( )

13. Participant Enrollment Packets and Employment Packets. The provider must prepare and distribute participant enrollment packets and employment packets to each participant. ( )

14. Payroll Spending Summaries. The provider must provide each participant with payroll spending summaries and information about how to read the payroll spending summary each time payroll is executed. ( )

15. Quarterly Reconciliation. Each fiscal quarter after initiating service, the provider must reconcile its Medicaid Billing Report to a zero dollar ($0) balance with the Medicaid Bureau of Financial Operations. The provider has ninety (90) days to comply with reconciling each participant's spending plan balance to a zero dollar ($0) balance with Medicaid's reimbursements. ( )

a. Required Level of Expectation: The provider must have one hundred percent (100%) compliance with the required quarterly reconciliation of the Medicaid Billing Report. ( )

b. Strategy for Correcting Noncompliance: The provider must notify the Department immediately if an issue is identified that may result in the provider not reconciling the Medicaid Billing Report. The Department will notify the provider when a performance issue is identified. The Department may require the provider to submit a

written corrective action plan for Department approval within two (2) business days after notification. If the provider fails to reconcile within ninety (90) days after the end of each quarter, the provider will be penalized fifty dollars ($50) each week until the provider has reconciled with Medicaid to a zero dollar ($0) balance. ( )

16. Cash Management Plan. Each provider's cash management plan must equal one point five (1.5) times the monthly payroll cycle amount. The cash management plan can be forms of liquid cash and lines of credit. For example, in the case that the a provider's current payroll minimum has averaged one hundred thousand dollars ($100,000) per payroll cycle, the provider would be required to have one hundred fifty thousand dollars ($150,000) in a cash management plan. The Department must be listed on the notification list if any lines of credit are decreased in the amount accessible or terminated. The expectation is to provide a seamless payroll cycle to the participant, without loss of pay to their employees. ( )

311. FISCAL EMPLOYER AGENT DUTIES AND RESPONSIBILITIES: REPORTS.

01. Account Summary Statements. This report provides an overview of each participant account and includes the services accessed and the remaining dollar amount in the budget. In addition to the provider providing this report each month, a participant may request this report for a specified timeframe. Each month, the provider must mail a hard copy of the report to each participant and also make the report available on a secure website for those who prefer to access the information electronically. The provider must generate the report after every payroll and post it on a secure SFTP site for the Department to access. This SFTP site must have a user name and password protection. ( )

a. Report Format: The provider must provide the account summary statement in Microsoft Excel. ( )

b. Report Due Date: The provider must post the account summary statement by the 10th day of each month. ( )

02. Medicaid Billing Report. This report provides a detailed breakdown of community support worker services rendered by service date per employee, per employer. Each line on this report must provide, at a minimum, the following information: employee name, employee ID number, hours worked, period start, period end, pay rate, service date, check number, check date, participant's name, participant's date of birth, participant's ID number, service code, taxes, and billing amount. This report collects information based on the timeframe specified by the user. The provider must generate the report after every payroll and post it on a secure SFTP site for the Department to access. This SFTP site must have a user name and password protection. ( )

a. Report Format: The provider must provide the Medicaid Billing Report in Microsoft Excel. ( )

b. Report Due Date: The provider must post the Medicaid Billing Report by the 10th day of each month. ( )

03. Demographic Report. This report provides general client demographics in the region and the employee count per participant for each participant in the database. The provider must generate the report after every payroll and post it on a secure SFTP site for the Department to access. This SFTP site must have a user name and password protection. ( )

a. Report Format: The provider must provide the demographic report in Microsoft Excel. ( )

b. Report Due Date: The provider must post the demographic report by the 10th day of each month. ( )

04. Criminal History Check Report. This report provides a breakdown, by participant, of which employees the participant waived the background check, which employees passed or failed the background check, the criminal history reference number, and the date the background check was submitted. This report does not include support brokers. The provider must generate the report after every payroll and post it on a secure SFTP site for the Department to access. This SFTP site must have a user name and password protection. ( )

a. Report Format: The provider must provide the criminal history report in Microsoft Word, Microsoft Excel, or PDF. ( )

b. Report Due Date: The provider must post the criminal history report by the 10th day of each month. ( )

05. Medicaid Billing Report. This report provides a list and count of the unduplicated participants and expenditures by services code based on the time frame specified by the user. The provider must generate the report after every payroll and post it on a SFTP site. Additionally, the provider must provide a quarterly Medicaid Billing Report that can been reconciled quarterly and work with the Department to reconcile the annual report. ( )

a. Report Format: The provider must provide the Medicaid Billing Report in Microsoft Excel. ( )

b. Report Due Date: The provider must post the Medicaid Billing Report by 10th day of each month. ( )

06. Complaint and Resolution Summary Report. The provider must analyze complaints received on a quarterly basis to determine the quality of services to participants and identify any corrective actions and program improvements needed and implemented. The provider must post the report on a secure SFTP site for Department review. ( )

a. Report Format: The provider must provide the complaint and resolution summary report in Microsoft Word, Microsoft Excel, or PDF. ( )

b. Report Due Date: The provider must post the complaint and resolution summary report by the 10th day of the month following the end of each annual quarter. ( )

07. Customer Satisfaction Survey Report. The provider must provide a comprehensive report summarizing the results of the customer satisfaction survey completed by each participant. ( )

a. Report Format: The provider must provide the customer satisfaction survey report in Microsoft Word, Microsoft Excel, or PDF. ( )

b. Report Due Date: The provider must post the customer satisfaction survey report by December 1 of each year. ( )

08. Quarterly Financial Statements. The provider must provide the Department a quarterly balance sheet and income statement that shows the provider's quarterly financial status and cash management plan cash reserve. ( )

a. Report Format: The provider must provide the quarterly balance sheet and income statement in Microsoft Word, Microsoft Excel, or PDF. ( )

b. Report Due Date: The provider must provide the quarterly balance sheet and income statement on the 25th day of the month following the end of each annual quarter. ( )

312. FISCAL EMPLOYER AGENT DUTIES AND RESPONSIBILITIES: PAYMENT REQUIREMENTS.

01. Requirement to Accept a Per Member Per Month (PMPM) Payment. The Department will pay, and the provider must accept a per member per month (PMPM) payment that covers a comprehensive set of fiscal employer agent services. The Department will set allowable reimbursement rates for PMPM based on a methodology approved by CMS in the DD HCBS Waiver. The provider can only bill the PMPM rate for the months services are actually provided for participants, The provider must provide transition, training, and closeout services during the active agreement, at no additional cost to the Department. ( )

02. PMPM Payment Process Requirements. The payment (PMPM) must include all administrative costs, travel, transition, training, and closeout services. The Department will not pay for participants who do not have a support and spending plan. For the purposes of PMPM payment, one (1) month must include all payroll batch dates within that specific calendar month. ( )

03. Requirement to Complete a Readiness Review. The provider must complete a readiness review prior to billing for services. ( )

313. TERMINATION OF FISCAL EMPLOYER AGENT PROVIDER AGREEMENTS.

01. Termination of the Provider Agreement. The following must occur in the event of termination of the provider agreement: ( )

a. The provider must ensure continuation of services to participants for the period in which a Per Member per Month (PMPM) payment has been made, and submit the information, reports and records, including the Medicaid Billing Report (reconciliation) as specified in Section 310 of these rules. ( )

b. The provider must provide to the Department a written notice ninety (90) days in advance and the change notification must occur at the end of the next calendar quarter. ( )

02. Termination of Service to Participant. In the event of termination of the provider agreement, the provider must provide to the participant a written notice ninety (90) days in advance. The change notification must occur at the end of the next calendar quarter. ( )

314. REMEDIES TO NONPERFORMANCE OF A FISCAL EMPLOYER AGENT SERVICE PROVIDER.

01. Remedial Action. If any of the services do not comply with the performance metrics under Section 310 of these rules, the Department will consult with the provider and may, at its sole discretion, require any of the following remedial actions, taking into account the scope and severity of the noncompliance, compliance history, the number of noncompliances, the integrity of the program, and the potential risk to participants. ( )

a. Require the provider to take corrective action to ensure that performance meets the performance metrics under Section 310 of these rules; ( )

b. Reduce payment to reflect the reduced value of services received; ( )

c. Require the provider to subcontract all or part of the service at no additional cost to the Department; or ( )

d. Terminate the provider agreement with notice. ( )

02. Direct Monetary Action. If any of the performance metrics under Section 310 of these rules are not met, the Department will enforce a fifty dollar ($50) a week penalty for each performance metric not met. The penalty will be captured prior to any payment from the Department to the provider. ( )

315. -- 999. (RESERVED)

000. LEGAL AUTHORITY.
The Idaho legislature has delegated to the Board of Health and Welfare the power to promulgate rules governing hospitals, pursuant to Section 39-1307, Idaho Code. ( )

001. TITLE AND PURPOSE.

01. Title. These rules are titled Idaho Department of Health and Welfare Rules, IDAPA 16.03.14, "Hospitals." ( )

02. Purpose. The purpose of the rules is to provide for the development, establishment and enforcement of standards for the care and treatment of individuals in hospitals and for the construction, maintenance and operation of hospitals that, in the light of advancing knowledge, will promote safe and adequate treatment of such individuals in hospitals. ( )

002. WRITTEN INTERPRETATIONS.
The Department may have written statements that pertain to the interpretation of this chapter, or to the documentation of compliance with these rules. ( )

003. -- 009. (RESERVED)

010. DEFINITIONS AND ABBREVIATIONS – A THROUGH M.
For the purposes of this chapter, the following terms and definitions apply. ( )

01. Anesthesiologist. A physician who meets the requirements for certification by the American Board of Anesthesiology or the American Osteopathic Board of Anesthesiology. ( )

02. Anesthetist. A person who is: ( )

a. A dentist who has successfully completed a three (3) year residency in anesthesiology approved by the American Medical Association. ( )

b. A physician whose competence in the practice of anesthesiology is approved by the medical staff, of the hospital in which he works. ( )

c. A licensed registered nurse who meets the requirements for certification (CRNA) by the Council on Certification of the American Association of Nurse Anesthetists. ( )

03. Approved Drugs and Biologicals. Only such drugs and biologicals as are: ( )

a. Included (or approved for inclusion) in the United States Pharmacopoeia, National Formulary, or United States Homoeopathic Pharmacopoeia. ( )

b. Approved by the pharmacy and therapeutics committee (or equivalent) of the hospital that approves such drugs and biologicals for use in the hospital. ( )

c. Those drugs approved by the State Title XIX Agency. ( )

04. Board. The Idaho State Board of Health and Welfare. ( )

05. Chief Executive Officer or Administrator. The person appointed by the governing body to act in its behalf in the overall management of the hospital. ( )

06. Clinical Privileges. Permission to render patient care, granted by the hospital governing body on recommendation of the medical staff, within well defined limits based upon the applicant's professional license, experience, competence, and judgment. ( )

07. Dentist. A person currently licensed by the state of Idaho to practice dentistry. ( )

08. Department. The Department of Health and Welfare of the state of Idaho. ( )

09. Dietetic Service Supervisor. A person who: ( )

a. Is a licensed dietitian; or ( )

b. Is a graduate of a dietetic technician or dietetic assistant educational program class or correspondence school accredited by the Academy of Nutrition and Dietetics, formerly the American Dietetic Association; or ( )

c. Is a graduate of a state-approved education program that provides ninety (90) or more hours of classroom instruction in food service management and has at least three (3) months supervisory experience in a health care institution with consultation from a dietitian; or ( )

d. Has training and experience in food service management in a military program equivalent in content to the requirements in Subsections 010.09.b. or 010.09.c. of this rule; or ( )

e. Has training and experience in food service management equivalent to requirements in Subsections 010.09.b. or 010.09.c. of this rule; or ( )

10. Dietitian. A person who meets the requirements of Title 54, Chapter 35, Idaho Code, and is licensed by the Board of Medicine as a licensed dietitian (LD). ( )

11. Director of Nursing Service. A licensed registered nurse who is licensed by the state of Idaho, and has been so designated by the facility. ( )

12. Director of Psychiatric Nursing Service. A licensed registered nurse licensed by the state of Idaho who has training and experience in psychiatric nursing and has been so designated by the facility. ( )

13. Drug Administration. An act in which a single dose of a prescribed drug or biological is given to a patient by an authorized person in accordance with laws and regulations governing such acts. The complete act of administration entails the removal of an individual dose from a previously dispensed, properly labeled container (including a unit dose container), verifying the drug and dosage with the practitioner’s orders, administering dose to the proper patient, and immediately recording the time and amount given. ( )

14. Governmental Unit. The state, any county, municipality, or other subdivision, department, division, board, or agency thereof. ( )

15, Grievance. A grievance is a formal or informal, written or verbal complaint that is made to the hospital by a patient, or the patient's representative, regarding the patient's care, alleged abuse or neglect, or issues related to the hospital's compliance with Idaho state licensure rules. ( )

16. Hospital. A facility that: ( )

a. Is primarily engaged in providing, by or under the daily supervision of physicians; ( )

i. Concentrated medical and nursing care on a twenty-four (24) hour basis to inpatients experiencing acute illness; or ( )

ii. Diagnostic and therapeutic services for medical diagnosis and treatment, psychiatric diagnosis and treatment, and care of injured, disabled, or sick persons; or ( )

iii. Rehabilitation services for injured, disabled, or sick persons; or ( )

iv. Obstetrical care. ( )

b. Provides for care of two (2) or more individuals for twenty-four (24) or more consecutive hours. ( )

c. Is staffed to provide professional nursing care on a twenty-four (24) hour basis. ( )

d. Any hospital licensed under the provisions of these rules must be deemed a "facility" as defined at and for the purposes of Section 66-317(7), Idaho Code. ( )

17. Hospital Licensing Act. The law referred to in Sections 39-1301 through 39-13l4, Idaho Code, as amended. ( )

18. Hospital for the Treatment of Alcohol and Drug Abuse. A facility for the diagnosis, care, and treatment of patients suffering from chronic alcoholism. ( )

19. Infectious Wastes. Infectious wastes are defined as set out in Subsections 010.19.a. through 010.19.f. of this rule. Infectious wastes must be handled within specific rules as prescribed in Section 550 of these rules. Except as otherwise provided in these rules, infectious wastes must be handled and disposed of in accordance with the most current guidelines and recommendations of the Centers for Disease Control. ( )

a. Cultures and stocks of infectious agents and associated biologicals including: ( )

i. Specimens from medical and pathology laboratories. ( )

ii. Wastes from production of biologicals (by-products from the production of vaccines, reagents in the laboratory, etc.). ( )

iii. Cultures and stocks from clinical, research and industrial laboratories, such as disposable culture dishes and devices used to transfer, inoculate and mix cultures. ( )

b. Human blood and blood products (fluid form) and their containers, and liquid body wastes (fluid form) and their containers. ( )

c. Pathologic waste including tissue, organs, body parts, autopsy and biopsy materials, unless such waste has been treated with formaldehyde or other preservative agents. ( )

d. "Sharps" including needles, syringes, scalpel blades, pipettes, lancets or glass tubes that could be broken during handling. ( )

e. Animal carcasses that have been exposed to pathogens, their bedding and other waste from such animals. ( )

f. Items contaminated with blood or body fluids from patients known to be infected with diseases transmitted by body fluid contact. ( )

20. Licensed Independent Practitioner (L.I.P.). A person who is: ( )

a. A licensed physician or physician assistant under Section 54-1803, Idaho Code; or ( )

b. A licensed advance practice registered nurse under Section 54-1402, Idaho Code. ( )

21. Licensed Practical Nurse (L.P.N.). A person currently licensed by the Idaho State Board of Nursing to practice as a licensed practical nurse. ( )

22. Licensee. The person or entity to whom a license is issued. ( )

23. Licensing Agency. The Idaho Department of Health and Welfare. ( )

24. Maternity Hospital. A facility, the primary purpose of which is to provide services and facilities for obstetrical care. ( )

24. Medical Record Practitioner (Qualified Consultant). A person who: ( )

a. Meets the requirements for certification as a registered record administrator (RRA) or as an accredited record technician (ART) by the American Medical Record Association; or ( )

b. Is a graduate of a school of medical record science that is accredited jointly by the Council on Medical Education of the American Medical Association and the American Medical Record Association. ( )

25. Medical Staff Members. Those licensed physicians, dentists, podiatrists and other professionals granted the privilege to practice in the hospital by the governing authority of a hospital. ( )

011. DEFINITIONS AND ABBREVIATIONS – N THROUGH Z.
For the purposes of this chapter, the following terms and definitions apply. ( )

01. New Construction or New Hospitals. Includes the following: ( )

a. New buildings to be used as hospitals; and ( )

b. Additions to existing hospitals; and ( )

c. Conversion of existing buildings or portions thereof for use as a hospital; and ( )

d. Remodeling, alteration, addition or upgrading of a hospital or hospital building system that affects the structural integrity of the building, that changes functional operation, that affects fire safety or that adds beds, departments or services over those for which the hospital is currently licensed. ( )

02. Nuclear Medicine Physician. A physician who: ( )

a. Meets the requirements for certification by the American Board of Nuclear Medicine or the American Osteopathic Board of Nuclear Medicine; or ( )

b. Meets the requirement for certification by the American Board of Radiology, the American Board of Pathology, or the American Board of Internal Medicine, and whose competence in the practice of nuclear medicine is approved by the medical staff. ( )

03. Nursing Graduate. A new graduate practicing on a temporary license must be provided direct supervision by a licensed registered nurse and may not assume charge responsibilities according to the rules of the Idaho State Board of Nursing. ( )

04. Nurse Practitioner. A licensed registered nurse having specialized skill, knowledge and experience authorized, by rules and regulations jointly promulgated by the Idaho State Board of Medicine and the Idaho Board of Nursing and implemented by the Idaho Board of Nursing, to perform designated acts of medical diagnosis, prescription of medical, therapeutic and corrective measures and delivery of medications. ( )

05. Nursing Unit. A separate and distinct service area constructed, equipped, and staffed to function independently of other nursing units and having its own related service facilities. ( )

06. Occupational Therapist. A person who is licensed by the Idaho State Board of Medicine to practice occupational therapy. ( )

07. Occupational Therapist Assistant. A person who: ( )

a. Is a graduate of an occupational therapy assistant educational program accredited by the American Occupational Therapy Association; or ( )

b. Meets the requirements for certification (COTA) by the American Occupational Therapy Association under its requirements in effect on the effective date of these rules. ( )

08. Operating Room Technician. A person who: ( )

a. Has successfully completed a one (1) year education program for operating room technicians accredited by the Committee on Allied Health Education and Accreditation of the American Medical Association in cooperation with the Joint Review Committee on Education for the Operating Room Technician, or meets the requirements for certification (CST) by the Association of Surgical Technologists; or ( )

b. Is licensed as a practical (vocational) nurse in the state of Idaho and meets the training requirements of the Idaho State Board of Nursing. ( )

09. Patient. Any individual admitted to a hospital for diagnosis, treatment, and/or care. ( )

10. Person. Any individual, firm, partnership, corporation, company, association, or joint stock association, and the legal successor thereof. ( )

11. Pharmacist. A person who is licensed by the state of Idaho and has training or experience in the specialized functions of institutional pharmacy, such as residences in hospital pharmacy, seminars in institutional pharmacy, and other related training programs. ( )

12. Physiatrist. A physician licensed by the Idaho State Board of Medicine and who meets the requirements for certification by the American Board of Physical Medicine and Rehabilitation. ( )

13. Physical Therapist. A person who meets all requirements of Title 54, Chapter 22, Idaho Code, holds an active license, and engages in the practice of physical therapy in Idaho. ( )

14. Physical Therapist Assistant. A person who meets the requirements of Title 54, Chapter 22, Idaho Code, holds an active license, and who performs physical therapy procedures and related tasks that have been selected and delegated only by a supervising physical therapist. ( )

15. Physician. A person currently licensed under the Idaho Medical Practice Act to practice medicine and surgery in the state of Idaho. ( )

16. Physician's Assistant. A person employed by a physician who: ( )

a. Is a graduate of an approved program; and ( )

b. Is qualified by general education, training, experience and personal character; and ( )

c. Has been authorized by the Hospital Board to render patient services under the direction of a supervising physician who is not required to be physically present on the premises when the physician's assistant is rendering patient services, unless so required by the Hospital Board. ( )

17. Podiatrist. A person who is licensed by the state of Idaho and is a doctor of podiatric medicine (D.P.M.) or doctor of podiatry (D.P.). ( )

18. Provisional License. A license issued to a hospital that is in substantial compliance with the regulations but that is temporarily unable to meet all of the requirements. A provisional license can be issued for a specified period of time, not to exceed six (6) months, while corrections are being completed. ( )

19. Psychiatric Hospital. A facility for the diagnosis and treatment of persons with mental illness. ( )

20. Psychiatric Nurse. A licensed registered nurse, licensed by the state of Idaho and qualified by training or experience in psychiatric nursing. ( )

21. Psychiatric Unit. A specialized unit within a general hospital for the diagnosis and treatment of the mentally ill. ( )

22. Psychiatrist. A physician who meets the requirements for certification in psychiatry by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry. ( )

23. Radiologic Service Director. A person who: ( )

a. Is a radiologist; or ( )

b. Is a radiotherapist; or ( )

c. In a geographic area where the services of a radiologist or radiotherapist are not available, is a physician who meets the requirements for certification in a medical specialty in which he has become qualified by experience and training in the use of radiographs, and whose competence in the practice of radiology is approved by the medical staff. ( )

24. Radiologic Technologist (Diagnostic). A person who meets at least one (1) of the following criteria: ( )

a. Is a graduate of a two (2) year education program for radiologic technologists accredited by the Council on Medical Education of the American Medical Association in cooperation with the Joint Review Committee on Education in Radiologic Technology; or ( )

b. Meets the requirements for registration by the American Registry of Radiologic Technologists or by the American Registry of Clinical Radiography Technologists, and has one (1) year of experience as a radiologic technologist within the last three (3) years; or ( )

c. Has successfully completed an educational program in radiologic technology in a military service, and has one (1) year of experience in radiologic technology within the last three (3) years; or ( )

d. Has two (2) years of pertinent radiologic equipment experience within the last five (5) years, and has achieved a satisfactory grade on a proficiency examination in radiologic technology approved by the Secretary of Health and Human Services, except that such determination of proficiency will not apply with respect to persons initially licensed by a state or seeking initial qualification as a radiologic technologist after December 21, 1977. ( )

25. Radiologist. A physician who meets the requirements for certification by the American Board of Radiology or the American Osteopathic Board of Radiology. ( )

26. Radiotherapist. A physician who: ( )

a. Meets the requirements for certification as a radiotherapist by the American Board of Radiology; or ( )

b. Meets the requirements for certification as a radiologist by the American Board of Radiology or the American Osteopathic Board of Radiology, and whose competence in the practice of radiation therapy is approved by the medical staff of the hospital in which he practices. ( )

27. Registered Nurse (R.N.). A person licensed by the Idaho State Board of Nursing to practice professional nursing, also known as a licensed registered nurse. ( )

28. Rehabilitation Hospital. A facility operated for the primary purpose of assisting with the rehabilitation of disabled persons through an integrated program of medical, psychological, social, and vocational evaluation and services under competent professional supervision. ( )

29. Respiratory Therapist. A person who meets the requirements for registration by the American Registry of Respiratory Technicians (ARRT). ( )

30. Respiratory Therapy Technician. A person who meets the requirements for certification as a Certified Respiratory Therapy Technician (CRTT) by the National Board for Respiratory Therapy. ( )

31. Restraints. A restraint is (1) any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely; or (2) a drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition. ( )

a. A restraint does not include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm. ( )

b. Side rails: Side rails are considered a restraint when they restrict the patient's freedom to exit the bed. Side rails may not be considered a restraint when they protect the patient. Examples include raising the side rails when a patient is: on a stretcher, recovering from anesthesia, sedated, experiencing involuntary movement, or on certain types of therapeutic beds. ( )

c. Physically escorting a patient from one area to another against the patient's will is a restraint. ( )

d. Physically holding a patient to administer a medication against the patient's will is a restraint. ( )

e. Placing a patient in a chair or recliner that prevents him or her from getting out of the chair safely and easily, is a restraint. ( )

f. Age or developmentally appropriate protective safety interventions (such as stroller safety belts, swing safety belts, high chair lap belts, and raised crib rails) that a safety-conscious child care provider outside a health care setting would utilize to protect an infant, toddler, or preschool-aged child would not be considered restraint or seclusion for the purposes of this rule. The use of these safety interventions needs to be addressed in the hospital's policies or procedures. ( )

32. Seclusion. Seclusion is the involuntary confinement of a patient in a room or area, such as an activity center, from which the patient is physically prevented from leaving. Physically prevented from leaving includes threats by staff, if the patient attempts to leave, including the threat of restraint or seclusion. Confinement on a locked unit or ward does not constitute seclusion. ( )

33. Skilled Nursing Facility. A facility whose design and function must provide area, space and equipment to meet the health needs of two (2) or more individuals who, at a minimum, require inpatient care and services for twenty-four (24) or more consecutive hours for unstable chronic health problems requiring daily professional nursing supervision and licensed nursing care on a twenty-four (24) hour basis, restorative, rehabilitative care, and assistance in meeting daily living needs. Medical supervision is necessary on a regular, but not daily basis. ( )

34. Social Worker. An individual who is licensed by the state of Idaho to practice social work. ( )

35. Special Hospital. A facility that provides primarily one (1) type of care. The specialized hospital must meet the applicable regulations for general hospitals. All medical and related health services in these facilities must be prescribed by or must be under the general direction of persons licensed to practice medicine in Idaho. ( )

36. Speech Pathologist or Audiologist. A person who: ( )

a. Meets the current requirements for a certificate of clinical competence in the appropriate area

(speech pathology or audiology) granted by the American Speech and Hearing Association; or ( )

b. Meets the educational requirements for certification, and is in the process of accumulating the supervised clinical experience required for certification. ( )

37. Substantial Compliance. Substantial compliance means a facility is in substantial compliance with these rules when there are no deficiencies that would endanger the health, safety or welfare of residents. ( )

38. Supervision. Authoritative procedural guidance by a qualified person for the accomplishment of a function within his sphere of competence, with initial direction and periodic inspection of the actual act of accomplishing the function. Unless otherwise stated in the rules, the supervisor must be on the premises to perform supervisory duties. ( )

39. Temporary License. A license issued for a period not to exceed six (6) months and issued initially upon application when the Department determines that all application information is acceptable. A temporary license allows the Department time to evaluate the Facility's on-going capability to provide services and to meet these rules. ( )

40. Tuberculosis Hospital. A facility for the diagnosis and treatment of patients with tuberculosis or other pulmonary disease. ( )

41. Video Monitoring. Close observation of a person for the purpose of protecting them and/or gathering information. The observation is made from a distance by means of electronic equipment, such as closed-circuit television cameras. ( )

42. Video and/or Audio Recording. Saving video and audio information on an electronic medium that can be viewed and/or listened to at a later time. ( )

43. Waiver or Variance. Waiver or variance means a waiver or variance to these rules and minimum standards in whole or in part that may be granted under the following conditions: ( )

a. Good cause is shown for such waiver and the health, welfare or safety of patients/residents will not be endangered by granting such a waiver; ( )

b. Precedent is not set by granting of such waiver. The waiver may be renewed annually if sufficient written justification is presented to the licensing agency. ( )

012. -- 099. (RESERVED)

100. LICENSURE.

Pursuant to Section 39-1303, Idaho Code, no person or governmental unit, acting separately or jointly with any other person or governmental unit shall establish, conduct or maintain a hospital in this state without a license issued pursuant to Sections 39-1301 through 39-1314, Idaho Code. ( )

01. Application for License. Pursuant to Section 39-1304, Idaho Code, an application for a license shall be made to the licensing agency upon forms provided it and shall contain such information as the licensing agency reasonably requires, that shall include affirmative evidence of ability to comply with such reasonable standards, rules and regulations as are lawfully prescribed herein, and to include evidence of a request for a determination of review ability if a program providing prospective review for hospitals is in effect. ( )

02. Issuance and Renewal of License. Pursuant to Section 39-1305, Idaho Code, upon receipt of an application for license, the licensing agency shall issue a license if the applicant and hospital facilities meet the requirements established in these rules. ( )

a. A license, unless suspended or revoked, shall be renewable annually upon filing by the licensee and approval by the licensing agency of an annual report upon such uniform dates and containing such information in

such form as the licensing agency prescribes. ( )

b. Each license will be issued only for the premises and persons or governmental units named in the application and shall not be transferable or assignable except with the written approval of the licensing agency. ( )

03. Posting of License. Licenses must be framed and posted in a conspicuous place on the licensed premises. ( )

101. -- 104. (RESERVED)

105. DENIAL OR REVOCATION OF LICENSE.
Pursuant to Section 39-1306, Idaho Code, relating to hearings and review, after notice and opportunity for hearing to the applicant or licensee, the licensing agency is authorized to deny, or revoke a license in any case in which it finds that conditions exist that endanger the health or safety of any patient. ( )

106. -- 109. (RESERVED)

110. COMPLIANCE DEADLINE.
Pursuant to Section 39-1308, Idaho Code, any hospital that is in operation at the time of implementation of any applicable regulations will be given a reasonable time under the particular circumstances, not to exceed one (1) year from the date of implementation, within which to comply with the applicable rules and regulations. ( )

111. -- 119. (RESERVED)

120. INSPECTIONS AND CONSULTATIONS.

01. Inspections. Pursuant to Section 39-1309, Idaho Code, the licensing agency will make or cause to be made such inspections and investigations as it deems necessary. Any licensee or applicant desiring to alter, add to or remodel its existing facility, or to construct new facilities or convert an existing structure to hospital use, is referred to Subsection 002.26 and Section 600, for construction standards and review procedures that must occur prior to commencing such structural changes. ( )

02. Consultations. Consultations may be provided at the option of the licensing agency. ( )

121. -- 129. (RESERVED)

130. CONFIDENTIALITY.
Pursuant to Section 39-1310, Idaho Code, information received by the licensing agency through filed reports, inspections, or as otherwise authorized under this law, will not be disclosed publicly in such a manner as to identify individuals except in a proceeding involving the question of licensure. ( )

131. -- 139. (RESERVED)

140. PENALTIES.

01. Penalty for Operating Hospital Without License. Any person establishing, conducting, managing, or operating a hospital, as defined, without a license shall be guilty of a misdemeanor punishable by imprisonment in a county jail for a period of time not exceeding six (6) months, or by a fine not exceeding three hundred dollars ($300), or by both, and each day of continuing violations shall constitute a separate offense. ( )

02. Injunction to Prevent Operation Without License. Notwithstanding the existence or pursuit of any other remedy, the licensing agency may in the manner provided by law maintain an action in the name of the state for injunction or other process against any person or governmental unit to restrain or prevent the establishment, conduct, management or operation of a hospital as defined, without a license. ( )

141. -- 149. (RESERVED)

150. LICENSING PROVISIONS.

01. General License Requirements. ( )

a. Before any person can directly or indirectly operate a hospital, he must make application and receive a valid license for the operation of the hospital. No patient will be admitted until a valid license is issued. ( )

b. Applicants for license and licensees must conform to the rules and minimum standards for hospitals in Idaho. ( )

c. Facilities making an initial application for a license shall be issued a temporary license when the licensing agency determines that all application information is acceptable and that the facility is at least in substantial compliance with these rules and standards. The temporary license provides the Department time to determine the facility's on-going capability to provide services and to meet these rules. A temporary license may not be issued for a period that exceeds six (6) months. ( )

d. If a hospital that is required to be licensed under these rules does not normally provide a particular service or department, the section or sections of these regulations relating to such service or department will not be applicable. ( )

e. The licensing agency can upon written application submitted by the hospital allow the substitution of procedures, equipment, or facilities for those specified in these rules, when such procedure, equipment, or facility has been demonstrated to be at least equivalent to those prescribed. Such substitution shall be in writing and placed on file with the licensing agency and the hospital. The foregoing provision shall not apply to new construction. ( )

f. No facility can create the impression it is a hospital, unless it does in fact meet the legal definition of a hospital and is so licensed by the Board. ( )

g. A provisional license may be issued to a hospital that is in substantial compliance with the rules but is temporarily unable to meet all requirements. ( )

02. Application for License. ( )

a. All persons contemplating the operation of a hospital must apply to the licensing agency for a license on a form provided by the licensing agency. The application shall be submitted to the licensing agency at least three (3) months prior to the opening date. In addition to the application form the proposed hospital shall include evidence of a request for determination of reviewability if a program providing prospective review of hospitals is in effect. ( )

b. When a hospital is leased by the owner to a second party for the operation of the facility, a copy of the lease agreement showing clearly in its context the responsibilities of both parties shall be filed with the application for a license. ( )

03. Issuance of License. ( )

a. Every hospital shall be designated by a distinctive name in applying for a license and the name shall not be changed without first notifying the licensing agency in writing. ( )

b. Each license shall specify the maximum allowable number of permanent beds in a facility whether set up for use or not, exclusive of labor and recovery beds, that number shall not be exceeded. ( )

04. Expiration and Renewal of License. ( )

a. Each license for the operation of a hospital will expire one (1) year from the date issued unless otherwise dated, revoked or suspended prior to that date. ( )

b. Each application for renewal of a license shall be submitted prior to expiration of the license on a form prescribed by the licensing agency. ( )

c. A report shall be submitted annually on a form prescribed by the licensing agency giving such information as contained within said form. A report for the preceding year shall be on file with the licensing agency prior to renewal of a license. ( )

05. License Certificate. Each license certificate in the licensee's possession must be destroyed immediately upon suspension or revocation of the license or if the operation of the hospital is discontinued by voluntary action. ( )

06. Change of Ownership or Operator. ( )

a. When a change of ownership, lessee or management firm for any hospital is contemplated, the owner shall notify the licensing agency at least thirty (30) days prior to the proposed date of transfer. ( )

b. A new application for licensure shall be submitted where there is a change of ownership or operator. ( )

151. -- 199. (RESERVED)

200. GOVERNING BODY AND ADMINISTRATION.
There shall be an organized governing body, or equivalent, that has ultimate authority and responsibility for the operation of the hospital. ( )

01. Bylaws. The governing body shall adopt bylaws in accordance with Idaho Code, community responsibility, and identify the purposes of the hospital and that specify at least the following: ( )

a. Membership of Governing Body, that consists of: ( )

i. Basis of selecting members, term of office, and duties; and ( )

ii. Designation of officers, terms of office, and duties. ( )

b. Meetings: ( )

i. Specify frequency of meetings; ( )

ii. Meet at regular intervals, and there is an attendance requirement; ( )

iii. Minutes of all governing body meetings shall be maintained. ( )

c. Committees: ( )

i. The governing body officers shall appoint committees as appropriate for the size and scope of activities in the hospitals; ( )

ii. Minutes of all committee meetings shall be maintained, and reflect all pertinent business. ( )

d. Medical Staff Appointments and Reappointments: ( )

i. A formal written procedure shall be established for appointment to the medical staff; ( )

ii. Medical staff appointments shall include an application for privileges, signature of applicant to abide by hospital bylaws, rules, and regulations, and delineation of privileges as recommended by the medical staff. The same procedure shall apply to nonphysician practitioners who are granted clinical privileges; ( )

iii. The procedure for appointment and reappointment to the medical staff shall involve the administrator, medical staff, and the governing body. Reappointments shall be made at least biannually; ( )

iv. The governing body bylaws shall approve medical staff authority to evaluate the professional competence of applicants, appointments and reappointments, curtailment of privileges, and delineation of privileges; ( )

v. Applicants for appointment, reappointment or applicants denied to the medical staff privileges shall be notified in writing; ( )

vi. There shall be a formal appeal and hearing mechanism adopted by the governing body for medical staff applicants who are denied privileges, or whose privileges are reduced. ( )

e. The bylaws shall provide a mechanism for adoption, and approval of the organization bylaws, rules and regulations of the medical staff. ( )

f. The bylaws shall specify an appropriate and regular means of communication with the medical staff. ( )

g. The bylaws shall specify departments to be established through the medical staff, if appropriate. ( )

h. The bylaws shall specify that every patient be under the care of a physician licensed by the Idaho State Board of Medicine. ( )

i. The bylaws shall specify that a physician be on duty or on call at all times. ( )

j. The bylaws shall specify to whom responsibility for operations, maintenance, and hospital practices can be delegated and how accountability is established. ( )

k. The governing body shall appoint a chief executive officer or administrator, and shall designate in writing who will be responsible for the operation of the hospital in the absence of the administrator. ( )

l. Bylaws shall be dated and signed by the current governing body. ( )

m. Patients being treated by nonphysician practitioners shall be under the general care of a physician. ( )

02. Administration. The governing body, through the administrator, shall provide appropriate physical facilities and personnel required to meet the needs of the patients and the community. ( )

03. Chief Executive Officer or Administrator. The governing body through the chief executive officer shall establish the following policies, procedures or plans: ( )

a. The hospital shall adopt a written personnel policy concerning qualification, responsibility, and condition of employment for each category of personnel. The policy and/or procedures shall contain the following elements: ( )

i. Documentation of orientation of all employees to policies, procedures and objectives of the hospital. ( )

ii. Job descriptions for all categories of personnel. ( )

iii. Documentation of continuing education (inservice) for all patient care personnel. ( )

b. There shall be a personnel record for each employee that shall contain at least the following: ( )

i. Current licensure and/or certification status. ( )

ii. The results of a Tuberculin Skin Test that shall be determined either by history of a prior positive, or by the application of a skin test prior to or within thirty (30) days of employment. If the skin test is positive, either by history or by current test, a chest X-ray shall be taken, or a report of the result of a chest X-ray taken within three (3) months preceding employment, shall be accepted. The Tuberculin Skin Test status shall be known and recorded and a chest X-ray alone is not a substitute. No subsequent annual chest X-ray or skin test is required for routine surveillance. ( )

c. There shall be regularly scheduled departmental and interdepartmental meetings, appropriate to the needs of the hospital, and documentation of such meetings shall be available. ( )

d. The chief executive officer shall serve as liaison between the governing body, medical staff and the nursing staff, and all other departments of the hospital. ( )

e. Written policies and procedures shall be reviewed as needed. ( )

04. Discharge Planning. Administration shall provide a procedure to screen each patient for discharge planning needs. If discharge planning is necessary, a qualified person shall be designated responsible for such planning. The hospital shall have a transfer agreement with a Medicare and/or Medicaid skilled nursing home. If there is a common governing board for a hospital and a skilled nursing home, a policy statement concerning transfers will be sufficient. ( )

05. Institutional Planning. The governing body through the chief executive officer shall provide for institutional planning by means of a committee composed of members of the governing body, administration, and medical staff. The plan shall include at least these elements: ( )

a. Annual budgeting; and ( )

b. A protocol for coordinating the hospital services with other health care facilities and community resources. ( )

06. Disclosure of Ownership. The governing body and administration of hospitals required to be licensed under these rules shall fully disclose to the licensing agency the names and addresses of all persons owning or controlling five percent (5%) interest in the hospital. ( )

07. Compliance with Laws and Regulations. The governing body through the chief executive officer will be responsible for meeting all applicable laws and regulations pertaining to hospitals, and acting promptly upon reports and reviews of regulatory and inspecting agencies. ( )

08. Use of Outside Resources. If a hospital does not employ a required professional person to render a specific service, there shall be a written agreement for such service to meet the requirements of these rules. The agreement shall specify the following: ( )

a. Responsibilities of both parties, with the hospital retaining responsibility for services rendered. ( )

b. All services to be performed by outside resources including reports, frequency of visits, and services rendered. ( )

09. Substantial Change in Services. Any hospital proposing to offer a new service or a new department under these rules or proposing to implement a substantial change in an existing service or department

shall provide to the licensing agency evidence of a request for a determination of reviewability if a program providing prospective review of hospitals is in effect. ( )

10. Quality Assurance. Through administration and medical staff, the governing body shall ensure that there is an effective, hospital-wide quality assurance program to evaluate the provision of care. The hospital must take and document appropriate remedial action to address deficiencies found through the program. The hospital must document the outcome of the remedial action. ( )

201. -- 219. (RESERVED)

220. PATIENT RIGHTS.
A hospital must protect and promote each patient's rights. Patient rights are provided for and described in Sections 220 through 234 of these rules. ( )

01. Informed in Advance of Patient Care. A hospital must inform each patient, or when appropriate, the patient's representative or caregiver, of the patient's rights in advance of furnishing or discontinuing patient care whenever possible. ( )

02. Identify Who Is Responsible for Medical Decisions. The hospital must identify who is responsible for making medical decisions and representing the patient if the patient is unable to make those decisions. ( )

03. Specify Procedures to Inform Patient of Patient Rights. ( )

a. The hospital must specify a procedure to inform patients, their representative, or caregiver of their rights before providing care. ( )

b. In an emergency, rights may be provided after emergent care is provided. ( )

c. The procedure must include a method to document that patients were informed of their rights or the reasons they were not informed before care was provided. ( )

04. Informed in Format Understandable to Patient/Patient's Representative. The patient and/or the patient's representative has the right to be informed of the patient's rights in a language or format that the patient and/or legal representative understands. ( )

05. Make Informed Decisions. The patient or patient's representative has the right to make informed decisions regarding patient's care. ( )

06. Informed and Involved in Care Plan.The patient has the right to be informed of health status, be involved in care planning and treatment, and to request or refuse treatment. This right must not be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate. ( )

a. The hospital must obtain written consent for general treatment at the hospital. If the hospital is not able to obtain this consent, the reasons must be documented. ( )

b. The hospital must obtain an informed written consent from each patient or the patient's representative for the provision of specific medical and/or surgical care, except in medical emergencies. The consent must include an explanation of risks, benefits, and alternatives for high-risk procedures, sedation, and other procedures or services as defined by the governing body. ( )

07. Formulate Advance Directives. The patient has the right to formulate advance directives and to have hospital staff and practitioners who provide care in the hospital comply with these directives. The hospital must document whether the patient has an advance directive. If the patient has an advance directive, the hospital must document what it includes. If the patient does not have an advance directive, the hospital must offer the patient assistance to create one and document the patient's response. ( )

08. Privacy. The patient has the right to meet privately with an attorney, a physician, a licensed independent practitioner, a representative of the state protection and advocacy group, and adult/child protection agency. ( )

09. Personal Privacy. The patient has the right to personal privacy, including the right to privacy during all personal care, including hygiene activities such as bathing, dressing, and toileting. This right includes the right to treatment with dignity during personal care. ( )

a. A patient's right to privacy may be limited in situations when a treatment team determines a person must be continuously observed to ensure his or her safety. A decision to continuously observe a patient, either in person or by video and audio monitoring, must be based on an individualized assessment of the patient's needs and it must be part of the patient's individualized plan of care. ( )

b. When patients are video monitored, the hospital must turn the camera off or utilize an electronic privacy option during personal care and activities of daily living where the patient may be exposed, such as bathing, dressing, and toileting. Monitoring during these times must be done by staff members in person. Video and audio monitoring and recording must also be turned off during meetings with the patient and an attorney, a physician, a licensed independent practitioner, a representative of the state protection and advocacy group, and adult/child protection agency. ( )

c. When the hospital utilizes the continuous observation of patients, and/or video recording of patients, it must develop policies and procedures to direct staff in these activities. ( )

d. The hospital must obtain the patient's or patient's legal representative's written consent for video or audio recording except in common areas. ( )

e. Video or audio recordings of a patient for any reason must be included as part of the patient's medical record except in common areas. ( )

f. Monitors used for observing patients must not be visible or audible to unauthorized persons. ( )

10. Video Monitoring of Common Areas. Closed circuit television may be used to monitor common areas when signs are clearly posted that video monitoring or video recording is occurring. Patient consent is not required for common areas. Video recordings of common areas are not part of the patient's medical record. ( )

11. Safe Setting. The patient has the right to receive care in a safe setting. ( )

12. Free From Abuse, Neglect, and Harassment. The patient has the right to be free from all forms of abuse, neglect, and harassment. If hospital staff become aware of potential abuse or neglect of a patient, the hospital must protect the patient from future harm and report the suspicions to the appropriate legal entity. ( )

13. Confidentiality. The patient has the right to the confidentiality of his or her clinical records. ( )

14. Access to Patient's Own Records. The patient has the right to access information contained in his or her clinical records within three business days. The patient may request clinical record information as a paper copy or in an electronic format. ( )

a. The hospital may not charge the patient a rate for copies that is higher than that of the local library. ( )

b. When the patient requests the information electronically, the hospital must provide it on a currently popular media storage device. The information must be provided in a coherent format. ( )

15. State Agency Contact Information. The hospital must provide patients with contact information

for the Idaho state survey agency, including the agency's physical and mailing addresses and telephone number. ( )

221. -- 224. (RESERVED)

225. PATIENT GRIEVANCES.
The hospital must establish a clearly explained process for the prompt resolution of patient grievances. ( )

01. Grievance by Patient or Patient's Representative. A patient's grievance is a formal or informal, written or verbal complaint that is made to the hospital by a patient, or the patient's representative, regarding the patient's care, alleged abuse or neglect, or issues related to the hospital's compliance with Idaho state licensure rules. When a complaint is resolved at the time of the complaint by staff present, it is not considered a grievance and does not require investigation. ( )

02. Grievance Process. The grievance process must include: ( )

a. The hospital must inform each patient how to submit a grievance. Grievances may be submitted to any professional staff member. ( )

b. Grievances must be investigated. The grievance process must specify time frames for review of the grievance and the provision of a response. ( )

c. The hospital must document the steps taken to investigate the grievance and the results of the grievance process. ( )

03. Written Notice of Decision. The hospital must provide the patient with written notice of its decision that contains: ( )

a. The name of the hospital contact person; ( )

b. The steps taken to investigate the grievance; and ( )

c. The results of the grievance process. ( )

226. -- 228. (RESERVED)

229. LAW ENFORCEMENT RESTRAINTS.
The use of law enforcement restraint devices are not considered safe, appropriate health care restraint interventions for use by hospital staff to restrain patients. ( )

01. Law Enforcement Use of Restraint Devices. The use of handcuffs, manacles, shackles, other chain-type restraint devices, or other restrictive devices applied by non-hospital employed or contracted law enforcement officials for custody, detention, and public safety reasons are not governed by these rules. ( )

02. Law Enforcement Maintains Custody and Direct Supervision. When a law enforcement officer applies handcuffs, manacles, shackles, other chain-type restraint devices to a patient, the law enforcement officer must maintain custody and direct supervision of the prisoner who is the hospital's patient. ( )

a. The law enforcement officer is responsible for the use, application, and monitoring of these restrictive restraint devices in accordance with state law. ( )

b. The hospital is responsible for an appropriate patient assessment and the provision of safe, appropriate care to its patient who is in the custody of a law enforcement officer. ( )

230. RESTRAINT AND SECLUSION.
The hospital must establish a clearly explained process for restraint and/or seclusion. The hospital must follow its restraint and seclusion policies. ( )

01. Patient's Right to be Free From Restraint and Seclusion. All patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. ( )

02. Use of Restraint or Seclusion. Restraint and/or seclusion may only be imposed to ensure the physical safety of the patient, a staff member, or others. Restraint and/or seclusion must be discontinued at the earliest possible time, when the patient no longer presents an immediate risk of harm to self or others. ( )

03. Policy and Procedures. Restraint and seclusion policies and procedures must include: ( )

a. Definitions for restraint and seclusion as defined in these rules. ( )

b. Specification of: ( )

i. Which personnel may assess patients to determine the need for restraint and/or seclusion; ( )

ii. Which personnel may perform formal face-to-face evaluations for episodes of restraint and/or seclusion; and ( )

iii. Which personnel may evaluate patients for the need to continue restraint and/or seclusion. ( )

c. How patients will be assessed for the need for restraint and/or seclusion, including the types of restraint to be used and time frames for reassessment. ( )

d. How patients will be monitored while in restraints and/or seclusion to ensure their well-being. ( )

e. A requirement that restraint and/or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the patient, staff members, or others from harm. ( )

f. A requirement that the type or technique of restraint used must be the least restrictive intervention that will be effective to protect the patient, staff members, or others from harm. ( )

g. How services will be provided to patients while in restraint and/or seclusion, including time frames for general assessments, taking vital signs, offering fluids and nourishment, toileting/elimination, systematic release of restrained limbs to provide range of motion and exercise of those limbs, and other care as needed. ( )

h. A requirement that specifies when restraint or seclusion is applied, the patient's plan of care is changed to direct staff on how to care for the patient while in restraint or seclusion and how to prevent further episodes. ( )

i. The training requirements for staff who participate in the use of restraints and/or seclusion, including training requirements for persons who may order restraints and for persons who perform face-to-face examinations. Policies must address initial and ongoing training requirements. ( )

j. A requirement that restraint or seclusion must be discontinued when the patient no longer presents an immediate risk of harm to themselves or others. ( )

k. Documentation requirements for staff caring for patients in restraint and/or seclusion, including the documentation of assessments and behaviors following episodes of restraint or seclusion. ( )

04. Investigation of Injuries. A procedure for the hospital to investigate injuries that occur during the application or use of restraint or seclusion. The investigation procedure must include recommendations for the prevention of future injuries from restraint or seclusion. ( )

231. RESTRAINT AND SECLUSION ORDERS.
The use of restraint or seclusion must be in accordance with the order of a physician or other licensed independent practitioner, who has been granted privileges by the governing body to order restraint and seclusion. ( )

01. Orders. Orders for the use of restraint or seclusion must never be written as a standing order or on an as needed basis (PRN). ( )

02. Attending Physician.The attending physician must be consulted as soon as practical if the attending physician did not order the restraint or seclusion. ( )

03. Time Limits on Orders. Each order for restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others may only be renewed according to the following limits up to a total of twenty-four (24) hours: ( )

a. Four (4) hours for adults eighteen (18) years of age or older; ( )

b. Two (2) hours for children and adolescents nine (9) to seventeen (17) years of age; or ( )

c. One (1) hour for children under nine (9) years of age. ( )

d. The original restraint or seclusion order may only be renewed within the required time limits for up to a total of twenty-four (24) hours. After the original order expires, a physician or other licensed independent practitioner must see and assess the patient before issuing a new order. ( )

e. Seclusion may only be ordered for the management of violent or self-destructive behavior. ( )

f. Each order for restraint used to ensure the physical safety of a non-violent or non-self-destructive patient may be renewed as allowed by hospital policies. ( )

g. Restraint or seclusion must be discontinued at the earliest possible time when the patient no longer presents an immediate risk of harm to self or others. The risk of harm must be assessed by a physician or licensed independent practitioner, or a registered nurse prior to releasing the patient. ( )

232. RESTRAINT AND SECLUSION IMPLEMENTATION AND MONITORING.
The use of restraint or seclusion must be implemented in accordance with safe and appropriate restraint and seclusion techniques as determined by hospital policy. ( )

01. Written System. The hospital must adopt a written system for the use of restraints and seclusion, including techniques to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require the use of a restraint or seclusion. ( )

02. Observation of Patients Who Are Not Violent or Self-Destructive. Patients who are restrained but who are not violent or self-destructive, must be observed at intervals not greater than fifteen (15) minutes. ( )

03. Management of Violent or Self-Destructive Behavior. Patients who are restrained or secluded for violent or self-destructive behaviors must be continuously observed by trained staff assigned to observe the patient. Staff must observe the patient either directly or using both video and audio equipment. Staff observing the patient must be physically close enough to protect the patient in an emergency. ( )

04. Face-to-Face by Physician or Other Licensed Independent Practitioner. Patients who are restrained or secluded for the management of violent or self-destructive behavior, must be seen face-to-face within one (1) hour after the initiation of the intervention by a physician or other licensed independent practitioner or by a registered nurse who has been trained to conduct face-to-face examinations. The face-to-face examination must evaluate: ( )

a. The patient's immediate situation; ( )

b. The patient's reaction to the intervention; ( )

c. The patient's medical and behavioral condition; and ( )

d. The need to continue or terminate the restraint or seclusion. ( )

e. When the face-to-face evaluation is conducted by a trained registered nurse, the trained registered nurse must consult the attending physician or other licensed independent practitioner who is responsible for the care of the patient, as soon as possible after the completion of the one (1) hour face-to-face evaluation. ( )

233. RESTRAINT AND SECLUSION DOCUMENTATION.
The clinical record for each patient that is restrained or secluded must contain comprehensive documentation of the episode. ( )

01. Patient's Behavior. A description of the patient's behavior that led to the use of restraint or seclusion. ( )

02. Interventions Used Prior to Restraint or Seclusion. Alternatives or other less restrictive interventions attempted prior to the use of restraint or seclusion. ( )

03. Type of Intervention. The type of interventions used, including the date and time the interventions were initiated. ( )

04. Assessments. Initial and ongoing assessments of the need for restraint or seclusion by medical and nursing staff. ( )

05. Patient's Response. The patient's response to the use of restraint or seclusion, including ongoing behaviors. ( )

06. Monitoring Activities. Monitoring activities by staff. ( )

07. Restraint and Seclusion Log. Each hospital must maintain a log of restraint and/or seclusion use that must include: ( )

a. The name of the patient; ( )

b. The type of restraints and/or seclusion used; ( )

c. The date and time restraints and/or seclusion were applied and discontinued; and ( )

d. Any injury or adverse consequence to the patient incurred during the restraint and/or seclusion. ( )

234. RESTRAINT AND SECLUSION TRAINING.
All staff involved with the ordering, application, and monitoring of restraints and seclusion must be trained. ( )

01. Training Requirements. Training must include an overview of the hospital's system for the use of restraints and seclusion, including techniques to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require the use of a restraint or seclusion. Training must also include: ( )

a. De-escalation techniques; ( )

b. Use of least restrictive interventions; ( )

c. The safe application of restraints; ( )

d. Monitoring patients in restraint or seclusion; and ( )

e. Providing care for a patient in restraint or seclusion. ( )

02. Training Related to Job Responsibilities. All hospital staff members who participate in restraint or seclusion must be trained in relation to their job responsibilities. ( )

03. Hospital's Policy Training. Physicians and licensed independent practitioners, who order restraints and seclusion and monitor those patients, must be trained in the hospital's policies for ordering restraints and seclusion and assessing patients who are restrained or secluded. ( )

04. Ongoing Training. Staff must receive ongoing restraint and/or seclusion training in accordance with hospital policies. ( )

235. -- 249. (RESERVED)

250. MEDICAL STAFF.
The hospital must 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. ( )

01. Medical Staff Qualifications and Privileges. All medical staff members must be qualified legally and professionally for the privileges that they are granted. ( )

a. Privileges must be granted only on the basis of individual training, competence, and experience. ( )

b. The medical staff, with governing body approval, must develop and implement a written procedure for determining qualifications for medical staff appointment, and for determining privileges. ( )

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

02. Authority to Admit Patients. A hospital may grant to physicians, physician assistants, and advanced practice nurses the privilege to admit patients, provided that admitting privileges be granted only if the privileges are: ( )

a. Recommended by the medical staff at the hospital; ( )

b. Approved by the governing body of the hospital; and ( )

c. Within the scope of practice conferred by the license of the physician, physician assistant, or advanced practice nurse. ( )

d. A hospital must specify in its bylaws the process by which its governing body and medical staff oversee those practitioners granted admitting privileges. Such oversight must include credentialing and competency review. ( )

03. Medical Staff Appointments and Reappointments. Medical staff appointments and reappointments must be made by the governing body upon the recommendation of the active medical staff, or a committee of the active staff. ( )

a. Appointments to the medical staff must include a written delineation of all privileges including

surgical procedures, and governing body approval must be documented. ( )

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

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

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

04. Required Hospital Functions. Each hospital must have a mechanism in place to perform the following functions: ( )

a. Coordinate all activities of the medical staff; ( )

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

c. Establish procedures to prevent and control infections in the hospital; ( )

d. Develop and monitor standards of medical records contents; ( )

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

f. Review clinical work of the medical staff. ( )

05. Documentary Evidence of Medical Staff Activities. The medical staff or any committees of the staff must meet as often as necessary, but at least twice annually, to assure implementation of the required functions in Subsection 250.04 of this rule. Minutes of all meetings of the medical staff or any committees of the staff must be maintained. ( )

06. Medical Staff Bylaws, Rules, and Regulations. These must specify at least the following: ( )

a. A description of the medical staff organization that includes: ( )

i. Officers and their duties; ( )

ii. Staff committees and their responsibilities; ( )

iii. Frequency of staff and committee meetings; and ( )

iv. Agenda for all meetings and the type of records to be kept. ( )

b. A statement of the necessary qualifications for appointment to the staff, and the duties and privileges of each category of medical staff. ( )

c. A procedure for appointment, granting and withdrawal of privileges. ( )

d. A mechanism for hearings and appeals of decisions regarding medical staff membership and privileges. ( )

e. A statement regarding attendance at staff meetings. ( )

f. A statement of qualifications and a procedure for delineation of clinical privileges for all categories

of nonphysician practitioners. ( )

g. A requirement for keeping accurate and complete medical records. ( )

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. ( )

i. A statement requiring a medical history and physical examination be performed no more than seven (7) days before or within forty-eight (48) hours after admission. The findings from this history and physical examination, including a provisional diagnosis, must be included in the medical record prior to surgery, except in emergencies. ( )

j. A requirement that consultation is necessary with unusual cases, except in emergencies. Unusual cases must be defined by the hospital medical staff. ( )

07. Review of Policies and Procedures. The medical staff must review and approve all policies and procedures directly related to medical care. ( )

08. Dentists and Podiatrists. If dentists and podiatrists are appointed to the medical staff, the bylaws must specifically refer to services performed by such professionals, and must specify at least the following: ( )

a. Patients admitted for dental or podiatry service must be under the general care of a physician member of the active staff. ( )

b. All medical staff requirements and procedure for privileges must be followed for dentists and podiatrists. ( )

09. Dating of Bylaws. Bylaws must be dated and signed by the current officers of the medical staff or the committee of the whole. ( )

10. Medical Orders. Written, verbal and telephone orders from persons authorized to give medical orders under Idaho law must be accepted by those health care practitioners empowered to do so under Idaho law and written hospital policies and procedures. Verbal and telephone orders must 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) must be promptly signed or otherwise authenticated by the prescribing practitioner in a timely manner in accordance with the hospital's policy. ( )

251. -- 309. (RESERVED)

310. NURSING SERVICE.

There shall be an organized nursing department with a plan that delineates authority, responsibility and duties of each category of nursing personnel, and a functional structure for cooperative planning and cooperation. An organizational chart shall be in the nursing service office and in all policy manuals. Job descriptions shall be available and in use that delineate responsibilities, functions or duties, and qualifications for each category of nursing positions. ( )

01. Director of Nursing Services. The nursing service shall be under the overall direction of a qualified licensed registered nurse with education and experience commensurate with size and complexity of the hospital whose duties are as follows: ( )

a. To organize, coordinate, and evaluate nursing service functions and staff; and ( )

b. To be responsible for development and implementation of policies and procedures as they relate to care of patients; and ( )

c. To select, promote, and terminate nursing staff; and ( )

d. To establish a procedure to insure staff licenses are valid and current. ( )

02. Records. Nurses shall maintain records that document patient status, progress and care given using descriptive measurable data. This documentation shall include but not be limited to: ( )

a. Admission note; and ( )

b. Vital signs; and ( )

c. Medication record; and ( )

d. Rationale for and results of PRN drug administration; and ( )

e. Patient teaching; and ( )

f. Adverse drug or blood reaction; and ( )

g. Discharge note. ( )

03. Patient Care Plans. Individual patient care plans shall be developed, implemented and kept current for each inpatient. Each patient care plan shall include but is not limited to: ( )

a. Nursing care treatments required by the patient; and ( )

b. Medical treatment ordered for the patient; and ( )

c. A plan devised to include both short-term and long-term goals; and ( )

d. Patient and family teaching plan both for hospital stay and discharge; and ( )

e. A description of socio-psychological needs of the patient and a plan to meet those needs. ( )

04. Nursing Department Meetings. The nursing service department or appropriate committee shall meet monthly to review and evaluate the activities and programs of the nursing service and related departments. All meetings shall be documented to include: ( )

a. Subject matter; and ( )

b. Who and how presented; and ( )

c. A record of attendance. ( )

05. New Employee Orientation. An orientation shall be given to all new employees of the nursing service. ( )

06. Inservice/Continuing Education. An ongoing educational program shall be developed, implemented and evaluated for nursing service. ( )

07. Policies and Procedures. Written policies supported by written procedures shall be available for all nursing staff that includes all areas for delivery of nursing services and shall be consistent with generally accepted nursing practice. The following shall be included with all other policies and procedures for nursing services: ( )

a. There shall be a written procedure for reporting and processing incidents/accidents to patients; and ( )

b. There shall be a written procedure for reporting and processing medication errors. ( )

08. Staffing. The following rules apply to the nursing staff: ( )

a. There shall be adequate nursing personnel to plan, administer, and evaluate individual bedside nursing care; and ( )

b. A licensed registered nurse shall be on duty on the premises twenty-four (24) hours a day. ( )

09. Monthly Staffing Patterns. Monthly staffing patterns indicating daily staff, staff titles, and patient census shall be kept. ( )

10. Staff Assignments. Licensed registered nurses shall make assignments for nursing care. ( )

a. In the absence of the Director of Nursing Services, an RN shall be designated to assume the director's duties. ( )

b. There shall be a licensed registered nurse on duty at all times. ( )

c. There shall be twenty-four (24) hour licensed registered nurse coverage in critical care areas in accordance with Subsection 420.02.d. Exception: small hospitals may have an available licensed registered nurse on call to the critical care unit, when there are no patients in the critical care unit. ( )

d. No person will be assigned nursing duties (aides and orderlies included) who has been on duty in the facility during the preceding twelve (12) hours, except in an emergency. ( )

e. There shall be sufficient numbers of nursing personnel in all categories to ensure quality of patient care. ( )

f. Personnel who have a communicable disease, infectious wound or other transmittable conditions and who provide care or services to patients shall be required to implement protective infection control techniques approved by administration; or be required not to work until the infectious stage is corrected; or be reassigned to a work area where contact with others is not expected and likelihood of transmission of infection is absent; or seek other remedy to avoid spreading the employees infection. ( )

g. A licensed registered nurse shall make assignments of nursing care to nursing assistants. ( )

h. Private duty nurses shall be currently licensed in Idaho and shall comply with all hospital rules and regulations, and be under the general direction of the appropriate DNS. ( )

i. Private duty nurses shall not be assigned to critical care areas unless properly oriented and fully trained to the policies and procedures of the hospital. ( )

311. -- 319. (RESERVED)

320. DIETARY SERVICE.
Dietetic services shall be organized and function in a manner to meet the nutritional needs of all patients admitted to the hospital. ( )

01. Dietary Supervision. The dietary service in each hospital shall be under the supervision of a person who by education or specialized training and experience is knowledgeable in food service management. ( )

a. This person shall be responsible for management of the food service, and represent the department in interdepartmental meetings. ( )

b. The nutritional aspects of patient care shall be supervised by a qualified dietitian. ( )

c. The dietitian shall correlate and integrate the dietary aspects of patient care with the patient, patient's chart and the patient's care plan. ( )

d. When the dietitian serves as a consultant only, she shall train and instruct the food service supervisor and/or nurses to take diet histories, instruct patients, and transmit dietary information to the charts. ( )

02. Dietary Personnel. There shall be a sufficient number of supervisors and personnel employed, and their hours shall be scheduled to meet the dietary needs of the patients. ( )

03. Inservice Training. Inservice training shall be provided for all dietary employees as appropriate to their level of responsibility. ( )

04. General Menu. The general menu shall meet the nutrition needs of patients in accordance with the current recommended dietary allowances of the Food and Nutrition Board, National Research Council, and shall be planned at least one (1) week in advance, approved by the dietitian, and posted in the kitchen. ( )

05. Records of Menus. Records of menus "as served" shall be kept on file for at least thirty (30) days. ( )

06. Modified Diets. All diets, including general diets, shall be ordered by the attending physician. ( )

a. The nursing service shall transmit the diet order to the dietary department on a written form that includes at least the patient's name, age, physician and room number. Additional information pertinent to the dietary department shall be included. ( )

b. A diet manual for all modified diets, approved jointly by the dietitian and the medical staff, shall be available to all staff. ( )

c. Modified diets shall be planned in writing, conform with the principles of the diet manual, approved by the dietitian, and served as planned. ( )

07. Food Preparation and Service. ( )

a. The dietary department shall have adequate space, equipment and utensils for the preparation, storage and serving of food and drink to the patient. ( )

b. Foods shall be stored, prepared and served following procedures that shall ensure the retention of their nutritive value. ( )

08. Dietary Policies and Procedures. ( )

a. Written policies and procedures shall be developed for all areas of the dietary Department. They shall be reviewed at least once a year, revised if necessary, and dated at time of review. ( )

b. Policies and procedures that involve another department shall be developed in cooperation with that department's personnel. Copies shall be available in each department involved. These policies and procedures shall include, but are not limited to: ( )

i. Serving of trays; and ( )

ii. Serving of nourishments; and ( )

iii. Procedures for hold or late trays; and ( )

iv. Exchange of information when patient is not eating or is not accepting a diet. ( )

09. Dietary Sanitation. Sanitary standards for hospitals shall be those found in Idaho Department of Health and Welfare Rules, IDAPA 16.02.19, "Idaho Food Code." ( )

10. Meetings. Departmental staff meetings shall be held at regular intervals. ( )

321. -- 329. (RESERVED)

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. ( )

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. ( )

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. ( )

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. ( )

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

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. ( )

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. ( )

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. ( )

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. ( )

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. ( )

b. A pharmacist shall be available on premises or on call at all times. ( )

03. Scope of Services. 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. ( )

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. ( )

a. Policies and procedures shall be reviewed revised and amended as necessary, and dated to indicate the time of last review. ( )

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. ( )

c. Policies and procedures shall include, but are not limited to the following: ( )

i. There shall be a drug recall procedure that can be readily implemented; and ( )

ii. All medications not specifically prescribed as to time or number of doses shall be controlled by automatic stop orders or other methods; and ( )

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 signed or otherwise authenticated in a timely manner by the prescriber in accordance with the hospital's policy. The person accepting the verbal or telephone orders shall meet the procedures set forth in Subsection 250.09; and ( )

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 ( )

v. Self-administration of medications by patients shall not be permitted unless specifically ordered by the physician; and ( )

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 ( )

vii. Acts of drug compounding, packaging, labeling, and dispensing, shall be restricted to the pharmacist or to his designee under supervision; and ( )

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 ( )

ix. Discontinued drugs, outdated drugs, or containers with worn, illegible, or missing labels shall be returned to the pharmacy for proper disposition; and ( )

x. Only approved drugs and biologicals shall be used. (See definition.) A list or formulary of approved drugs shall be maintained in the hospital. ( )

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. ( )

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. ( )

b. There shall be special storage areas throughout the hospital for photosensitive and thermolabile

products, and for controlled substances requiring special security. ( )

c. Up-to-date pharmaceutical reference materials shall be provided to furnish the medical and nursing staffs with current information concerning drugs. ( )

06. Safe Handling of Drugs. In addition to the rules listed below, written policies and procedures that 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. ( )

a. The pharmacist shall review the prescriber's original order or a direct copy thereof; and ( )

b. The pharmacist shall develop a procedure for the safe mixture of parenteral products; and ( )

c. All medications shall be administered by trained personnel in accordance with accepted professional practices and any laws and regulations governing such acts; and ( )

d. Each dose of medication administered shall be properly recorded as soon as administered in the patient's medication record that is a separate and distinct part of the patient's medical record; and ( )

e. Drug reactions and medication errors shall be reported to the attending physician and pharmacist in accordance with hospital policy. ( )

07. Inservice/Continuing Education. The pharmacist shall provide inservice/continuing education for medical and nursing staff at least once quarterly. ( )

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. ( )

09. Unit Dose Drug Distribution. Unit dose procedures, if employed, shall be practiced in accordance with accepted standards of labeling, quality control, and accountability. ( )

331. -- 339. (RESERVED)

340. RADIOLOGY SERVICE.
The hospital shall provide diagnostic radiological service, equipment, and facilities according to the size of the hospital and the scope of services rendered. ( )

01. Radiological Requests. Radiological services shall be performed only on the request of a person legally authorized to diagnose, treat and prescribe. ( )

02. Radiation Control and Safety. All hospitals shall comply with Idaho Department of Health and Welfare Rules, IDAPA 16.02.27, "Idaho Radiation Control Rules." ( )

03. Personnel. There shall be sufficient qualified personnel to meet the needs of services being offered. Minimum requirements are as follows: ( )

a. A physician eligible or certified by the American Board of Radiology shall have overall direction for the service. In small hospitals this requirement can be accomplished by a consulting physician who meets the definition found in Subsection 002.51 and is a member of the medical staff. ( )

b. There shall be sufficient radiologic technologists to meet the needs of the patients and services offered, and not less than one (1) available or on call at all times. If a hospital is unable to employ sufficient radiologic technologists to meet its needs, that hospital may use other hospital personnel who have documented, on-the-job training in radiologic technology and who are certified as being able to perform safely the duties assigned within the radiology services by the persons with overall direction of the radiology service under Subsection

340.03.a. Such certification shall be documented and updated annually. ( )

c. The physician director of the department or service, or the medical staff shall determine if radiologic technologists are qualified by education and experience. Such determination shall be documented. ( )

d. An ongoing educational program shall be developed, implemented and evaluated for personnel in radiology service. ( )

e. An orientation shall be given to all new employees of the radiology department. ( )

04. Records and Reports. All radiology reports (readings) shall be signed and filed with the inpatient's medical record. ( )

a. Requests for services shall be in writing and contain a statement of the reason for the request; and ( )

b. Reports of examinations shall be written and signed by the appropriate physician; and ( )

c. Reports and films (or reproductions) shall be preserved pursuant to Section 39-1394, Idaho Code. ( )

05. Policies and Procedures. There shall be written policies concerning the use of radiology services together with supporting procedures to include at least the following: ( )

a. Safety precautions against electrical, mechanical, and fire hazards; and ( )

b. Infection control procedure for patients, personnel, and procedures for decontamination of equipment; and ( )

c. Written authority and procedure for all nonphysicians who administer diagnostic agents parenterally; and ( )

d. There shall be written procedures for proper collimation, shielding and monitoring to minimize exposure to ionizing radiation to both patients and personnel. ( )

341. -- 349. (RESERVED)

350. LABORATORY SERVICE.
The hospital shall maintain a clinical laboratory with the necessary space, personnel and equipment to meet the needs of the services offered. Contractual services shall also meet the requirements of Subsection 200.08. ( )

01. Laboratory Services. Basic laboratory service necessary for routine tests shall be maintained in the hospital. Clinical laboratory tests shall be performed, or arranged for, and shall include the following: ( )

a. Chemistry; and ( )

b. Microbiology; and ( )

c. Hematology; and ( )

d. Serology; and ( )

e. Clinical microscopy; and ( )

f. Immunohematology; and ( )

g. Urinalysis. ( )

02. Availability. Clinical laboratory services needed to meet medical needs shall be available at all times. Where services are provided outside the hospital, the conditions, procedures, and availability of work done must be written and available. ( )

03. Clinical Laboratories. All hospital laboratories and other clinical laboratories shall comply with Idaho Department of Health and Welfare Rules, IDAPA 16.02.06, "Quality Assurance for Idaho Clinical Laboratories." ( )

04. Personnel. The clinical laboratory shall be under the overall direction of a physician. If that physician is not a pathologist on a full-time or part-time basis, then a Board Certified Pathologist shall be available for consultation to assure performance by the staff. ( )

a. There shall be sufficient technologists to meet the needs of the patients and medical staff. ( )

b. The laboratory medical director shall be responsible for the qualifications and performance of the laboratory staff. ( )

05. Education Programs. An ongoing educational program shall be developed, implemented and evaluated for laboratory personnel. Documentation of all orientation and education programs for each employee shall be maintained at the facility. ( )

06. Routine Examinations. Any routine examinations that are required on all admissions shall be determined by the medical staff and there shall be a written policy regarding such tests. ( )

07. Orders and Reports. Orders for tests shall be made only by those practitioners legally authorized to diagnose, treat and prescribe. The signed reports of all tests shall be made a part of the patient's medical record. ( )

08. Tissues and Reports. A specimen of all tissue surgically removed will be sent 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. All tissue reports shall be signed by the examining pathologist, contain findings and a diagnosis, and shall be on file. ( )

09. Blood and Blood Products. Facilities for procurement, proper storage, and transfusion of blood and products shall be readily available. The blood program shall include at least the following: ( )

a. A means of acquiring blood for emergencies; and ( )

b. Written agreement on blood supply by outside resource; and ( )

c. A written procedure for prompt typing and crossmatching, and transfusion reaction investigation; and ( )

d. Blood storage shall be in a refrigerator with a recording thermometer and audible and visual alarms for temperature variance. There shall also be a mercury thermometer inside, and temperatures recorded daily; and ( )

e. Records shall be kept of receipt and disposition of all blood; and ( )

f. Samples of each unit of blood shall be kept seven (7) days in the event of a reaction; and ( )

g. The medical staff or an appropriate committee shall review all transfusions, all reactions, and is responsible for establishing policies and procedures for the blood service. ( )

10. Policies and Procedures. These shall be written and approved by the medical director, the medical staff (or appropriate committee) and the administration. Procedures shall cover at least the following: ( )

a. A complete description of each test; and ( )

b. Ordering of tests; and ( )

c. Procedures for collection, storage, and preservation of all specimens; and ( )

d. Procedures for patient and test identification, storage and preservation of specimens; and ( )

e. There shall be written safety procedures for all potentially hazardous tests, specimens, cultures, or materials, including the disposal of such hazardous items, materials or equipment. ( )

351. -- 359. (RESERVED)

360. MEDICAL RECORDS SERVICE.
The hospital shall maintain medical records that are documented accurately and timely, and that are readily accessible and retrievable. ( )

01. Facilities. The hospital shall provide a medical record room, equipment, and facilities for the retention of medical records. Provision shall be made for the safe storage of medical records. ( )

02. Policies and Procedures. There shall be written policies and procedures for the operation of the medical records service. ( )

03. Maintenance of Records. A medical record shall be maintained for every person who is evaluated or treated as an inpatient, outpatient, emergency patient or a home care patient. ( )

04. Access to Records. Only authorized personnel shall have access to the record. ( )

05. Release of Medical Information. No release of medical information shall be made without written consent of the patient or by official court order except to legally authorized entities such as third party payors, peer review organizations, licensing agency, etc. ( )

06. Removal of Medical Records. Medical records shall only be removed from the hospital in accordance with written hospital procedures. ( )

07. Retention. Records shall be retained to conform with Section 39-1394, Idaho Code. ( )

08. Personnel. The medical records service shall be under the overall direction of a Registered Health Information Administrator or a Registered Health Information Technician. If the person in charge of records is not so trained, the facility shall retain an R.H. I.A. or R.H.I.T. on a regular consulting basis. ( )

09. Identification and Filing. A system of identifying and filing to ensure prompt retrieval of patient's records shall be maintained as follows: ( )

a. Any system shall bear at least the name, address, birthdate, medical record number, dates of admission and discharge; and ( )

b. Each record shall be maintained so that both in and outpatient records for treatment are readily retrievable. ( )

10. Centralizing and Completion of Records and Reports. All (clinical) information pertinent to the patient's stay shall be centralized in the record as follows: ( )

a. All reports shall be filed with the record. Copies of reports are acceptable; and ( )

b. All reports and records shall be completed and filed within thirty (30) days following discharge. ( )

11. Indexing of Records. Records shall be indexed as follows: ( )

a. According to disease, operation, and physician; and ( )

b. Any recognized system can be used. As additional indices become appropriate (due to medical advance), their use shall be adopted; and ( )

c. The card index or other record for disease or operation shall list all essential data; and ( )

d. Records of diagnoses and operations shall be expressed in terminology that describes the morbid condition by site, etiology, or method of procedure; and ( )

e. Indexing shall be current within six (6) months following discharge of the patient. ( )

12. Record Content. The medical records shall contain sufficient information to justify the diagnosis, warrant the treatment and end results. The medical record shall also be legible, shall be written with ink or typed, and shall contain the following information: ( )

a. Admission date; and ( )

b. Identification data and consent forms; and ( )

c. History, including chief complaint, present illness, inventory of systems, past history, family history, social history and record of results of physical examination and provisional diagnosis that was completed no more than seven (7) days before or within forty-eight (48) hours after admission; and ( )

d. Diagnostic, therapeutic and standing orders; and ( )

e. Records of observations, that shall include the following: ( )

i. Consultation written and signed by consultant that includes his findings; and ( )

ii. Progress notes written by the attending physician; and ( )

iii. Progress notes written by the nursing personnel; and ( )

iv. Progress notes written by allied health personnel. ( )

f. Reports of special examinations including but not limited to: ( )

i. Clinical and pathological laboratory findings; and ( )

ii. X-ray interpretations; and ( )

iii. E.K.G. interpretations. ( )

g. Conclusions that include the following: ( )

i. Final diagnosis; and ( )

ii. Condition on discharge; and ( )

iii. Clinical resume and discharge summary; and ( )

iv. Autopsy findings when applicable. ( )

h. Informed consent forms. ( )

i. Anatomical donation request record (for those patients who are at or near the time of death) containing: ( )

i. Name and affiliation of requestor; and ( )

ii. Name and relationship of requestee; and ( )

iii. Response to request; and ( )

iv. Reason why donation not requested, when applicable. ( )

13. Signature on Records. Signatures on medical records shall be noted as follows: ( )

a. Every physician shall sign and date the entries that that physician makes or directs to be made. ( )

b. A single signature on the face sheet record does not authenticate the entire record. ( )

c. Any person writing in a medical record shall sign his name to enable positive identification by name and title. ( )

d. If initials are used, an identifying signature shall appear on each page. ( )

e. Rubber stamp signatures can be used only by the person whose signature the stamp represents. A signed statement to this effect shall be placed on file with the hospital administrator. ( )

14. Administrative Records. The following hospital records shall be maintained: ( )

a. Daily census register; and ( )

b. Record of admissions and discharges; and ( )

c. Register of live births and still births; and ( )

d. Death register; and ( )

e. Register of surgical procedures; and ( )

f. Register of outpatients; and ( )

g. Emergency room admissions; and ( )

h. Narcotic and barbiturate record; and ( )

i. Annual report. Each year the hospital shall file with the licensing agency an Application for License and Annual Report form furnished by the agency; and ( )

j. Vital statistics. Hospitals licensed under these rules shall comply with the provisions of Idaho Department of Health and Welfare Rules, IDAPA 16.02.08, "Vital Statistics Rules." ( )

15. Availability of Records. The entire medical record of any person who is a patient, or who has been

a patient in any hospital in Idaho, shall be available to the state licensing agency or authorized representatives of the agency, during the survey process or a complaint investigation. ( )

16. Standing Orders. There shall be an annual review and approval of standing orders, and a current signed and dated copy of approved orders shall be available. This review shall be done by the medical staff or appropriate staff committee and there shall be evidence of the review, signed and dated by the designated authority. ( )

361. -- 369. (RESERVED)

370. EMERGENCY SERVICE.
All hospitals who provide emergency medical care in a specific area of the facility shall have an organized plan for emergency care based upon current community needs and the capability of the hospital. ( )

01. Policies and Procedures. The emergency room of every hospital shall have written policies and procedures. These shall be in conformance with state and local laws. The procedures shall be approved by the hospital administration, medical staff, and nursing service. The policies shall be approved by the governing body. The policies and procedures shall include but are not limited to, the following: ( )

a. Policies and procedures for handling accident victims, rape victims, contagious disease, persons suspected of criminal acts, abused children or adults, emotionally disturbed persons, persons under the influence of drugs and/or alcohol, persons contaminated by radioactive materials, and patients dead on arrival; and ( )

b. Medical responsibility shall be delineated regarding emergency care (including levels of care relating to clinical privileges and specialty areas) and shall specify a method to insure staff coverage; and ( )

c. Procedures that can/cannot be performed in the emergency room; and ( )

d. Policies and supporting procedures for referral and/or transfer to another facility; and ( )

e. Policies regarding instructions to be given patients requiring follow-up services; and ( )

f. Policies and supporting procedures for storage of equipment, medication, and supplies; and ( )

g. Policy and supporting procedures for care of emergency equipment; and ( )

h. Instructions for procurement of drugs, equipment, and supplies; and ( )

i. Policy and supporting procedures involving toxicology; and ( )

j. Policy and supporting procedures devised for notification of patient's physician and transmission of reports; and ( )

k. Policy involving instructions relative to disclosure of patient information; and ( )

l. A policy for integration of the emergency room into a disaster plan. ( )

02. Staffing. There shall be adequate medical and nursing personnel to care for patients arriving at the emergency room. Minimum personnel and qualifications of such personnel shall be as follows: ( )

a. A physician in the hospital or on call twenty-four (24) hours a day and available to see emergency patients as needed. ( )

b. A qualified licensed registered nurse shall be on duty in the facility and available to the emergency room at all times. ( )

03. Staff Roster. A written roster shall be available with the names of all physicians on call and where they can be located if there is no physician on duty. ( )

04. Records. Medical records shall be kept on every patient who presents himself for treatment in the emergency room of the hospital. ( )

a. The record shall contain at least the following: ( )

i. Patient identification; and ( )

ii. Time of arrival; and ( )

iii. Description of illness or injury; and ( )

iv. Clinical, laboratory and x-ray findings as appropriate; and ( )

v. Diagnosis, physician orders, medication, and treatment given; and ( )

vi. Condition of patient on discharge or transfer; and ( )

vii. Final disposition and time of day; and ( )

viii. Instructions for follow-up care; and ( )

ix. Signature of attending physician and nurse for all treatments and medications provided. ( )

b. Emergency room records shall be filed with inpatient records when appropriate. ( )

05. Retention, Filing, and Indexing Records. The retention, indexing and filing of emergency room records shall be the responsibilities of the medical records service. ( )

06. Emergency Room Register. There shall be an emergency room register containing name of patient, age, physician, and diagnosis. ( )

07. Equipment and Supplies. ( )

a. Parenterals, drugs, instruments, equipment, and supplies shall be readily available to the emergency room for use. ( )

b. Emergency drugs shall be available based upon a formulary designed by medical staff and pharmacy staff. ( )

08. Minor Elective Surgical Procedures. A record shall be maintained for all patients seen in the emergency room for minor elective surgical procedures. The record shall contain the following: ( )

a. Short medical history and record of physical; and ( )

b. Reports of diagnostic tests; and ( )

c. Tissue report; and ( )

d. Description of procedure performed; and ( )

e. Discharge instructions for patient. ( )

371. -- 373. (RESERVED)

374. FREESTANDING EMERGENCY DEPARTMENT (FSED) - DEFINITION.
A freestanding emergency department (FSED) means a facility that provides emergency services twenty-four (24) hours per day, seven (7) days per week on an outpatient basis, is physically separate from a hospital, and meets the staffing and service requirements of Section 376 of these rules. A FSED is located within thirty-five (35) miles of the hospital that owns or controls it. An FSED is owned by a hospital with a dedicated emergency department that also meets the staffing and service requirements found in Section 376 of these rules. ( )

375. FREESTANDING EMERGENCY DEPARTMENT (FSED): STANDARDS.

01. Capability of Receiving Ground Ambulance Patients. An FSED must be capable of receiving patients transported via ground ambulance within the protocols established by a licensed Emergency Medical Services (EMS) Agency Medical Director. Provisions must be made to communicate any reduction or increase in the capability of the FSED to receive specific levels of patients to the local EMS director. ( )

02. Transfer to Inpatient Hospital. An FSED must transfer each patient requiring inpatient hospital services as soon as a bed is available. ( )

03. Extension of the Main Hospital. An FSED as an extension of the main hospital must comply with all applicable rules of IDAPA 16.03.14, "Hospitals," and Section 39-1307, Idaho Code ( )

04. Availability of Resources and Staffing for Main Hospital and FSED. Resources and staff available at the main hospital are likewise available to individuals seeking care at the FSED within the capability of the hospital. ( )

05. Prohibited Transfers. Transferring a patient to a different provider type for surgery, with the intent of returning the patient to the FSED or main hospital for recovery, is prohibited. ( )

06. Written Transfer Agreements. The hospital that owns and operates the FSED must have written transfer agreements with one (1) or more hospitals that provide the basis for effective working arrangements in which inpatient hospital care or other hospital departments are promptly available to patients when needed. ( )

07. FSED Accreditation. Each hospital granted deemed status by the Centers for Medicare/Medicaid Services as a result of accreditation must ensure the FSED is included under the same accreditation. ( )

376. FREESTANDING EMERGENCY DEPARTMENT (FSED): STAFFING AND SERVICES.
The FSED must be integrated into the main hospital. This integration must be defined in the hospital's policies and procedures, and practices. Additional requirements are as follows: ( )

01. Staffing. An FSED must be staffed twenty-four (24) hours per day, seven (7) days per week with: ( )

a. A board certified physician, or board eligible emergency department physician, approved by the governing board as described under Section 200, "Governing Body and Administration," and the medical staff as described under Section 250, "Medical Staff," of these rules; ( )

b. A qualified licensed registered nurse certified in Advanced Cardiac Life Support and Pediatric Advanced Life Support; and ( )

c. Additional medical, nursing, and other personnel necessary to meet the needs of patients. ( )

02. An FSED Must Provide or Arrange for: ( )

a. At least one (1) ambulance licensed to the Critical Care Transport level by the EMS Bureau in accordance with: Title 56, Chapter 10, Idaho Code; IDAPA 16.02.02, "Idaho Emergency Medical Services Physician Commission"; and IDAPA 16.01.03, "Emergency Medical Services (EMS) - Agency Licensing Requirements." If the ambulance service is not provided directly by the FSED or main hospital, a contract must be in place including a provision that requires a maximum response time of thirty (30) minutes to the FSED. ( )

b. A communications system that is fully integrated with the main hospital and that is capable of two (2) way radio communications with local EMS agencies in accordance with IDAPA 16.01.03, "Emergency Medical Services (EMS) - Agency Licensing Requirements." ( )

03. Nursing Service. Nursing service at the FSED is a nursing unit as described under Subsection 002.31 of these rules. ( )

04. Dietary Service. The FSED must provide dietary services consistent with the needs of each patient. ( )

05. Laboratory Service. Basic laboratory service necessary for routine tests, as described under Subsection 350.01 of these rules, must be maintained at the FSED; and ( )

a. The FSED must be able to perform emergency (stat) laboratory tests on-site necessary to meet the needs of patients served. ( )

b. Laboratory services must be available twenty-four (24) hours per day, seven (7) days per week; and ( )

c. Facilities for the procurement, proper storage, and transfusion of blood and blood products must be readily available at the FSED. ( )

06. Radiology Service. The FSED must maintain and provide radiology services sufficient to perform and interpret the radiological examinations necessary for the diagnosis and treatment of patients twenty-four (24) hours per day, seven (7) days per week. ( )

07. Pharmacy Service. Pharmacy services must be available at the FSED as follows: ( )

a. The FSED must provide a pharmacy or drug and medicine service for the care and treatment of patients, consistent with the size and scope of the FSED; and ( )

b. A pharmacist must be available on the premises, or on call, at all times. ( )

377. NOTIFICATION REQUIREMENTS TO LICENSED EMERGENCY MEDICAL SERVICES (EMS) AGENCIES.

01. Required Notifications to Licensed EMS Agencies. ( )

a. On an annual basis, the FSED must send written notice containing the information described in Section 377.01.c of this rule, to all area EMS services and EMS services' medical directors, licensed by the Department's EMS Bureau, that transport to the facility, ( )

b. Within three (3) business days of any change in capability, the FSED must send written notice containing the information described in Section 377.01.c of this rule, to all area EMS services and EMS services' medical directors, licensed by the Department's EMS Bureau, that may transport to the facility. ( )

c. The written notice must include the following information: ( )

i. A list of capabilities that are not available at the FSED but are available at the main hospital emergency department; ( )

ii. A description of the preferred and alternate means by which an ambulance service must make a notification to the FSED that it intends to transport to the FSED. ( )

d. The EMS Bureau will identify and provide, upon request from the FSED, the names and mailing addresses of all EMS services and medical directors that must receive notification. ( )

02. Emergency Medical Services Physical Requirements. ( )

a. Ambulance bays must be located close to the emergency suite and the designated treatment rooms holding patients requiring transfer to a hospital for treatment after stabilization. ( )

b. If the FSED exists greater than thirty (30) road miles from the main hospital it must include a helicopter landing area inspected and approved for EMS helicopter landing by the Federal Aviation Administration (FAA). ( )

c. Where appropriate, features such as garages, landing pads, approaches, lighting, and fencing required to meet state and local codes, rules, and statutes that govern the placement, safety features, and elements required to accommodate helicopter(s) and ambulance(s), must be provided on the campus of the freestanding emergency department. ( )

378. FREESTANDING EMERGENCY DEPARTMENT (FSED): PLANT, EQUIPMENT AND PHYSICAL ENVIRONMENT.

01. Building Construction Standards. General requirements for construction of an FSED are as follows: ( )

a. All new construction of an FSED must comply with any and all state and local building, fire, electrical, plumbing, zoning, heating, or other applicable codes adopted by the jurisdiction in which the FSED is located and that are in effect when construction is begun. Where a conflict in code requirements occurs, both requirements must be met, or at the discretion of the licensing agency, the most restrictive will apply. ( )

b. The FSED must be structurally sound and must be maintained and equipped to assure the safety of patients, employees, and the public. ( )

c. On the premise of an FSED where natural or man-made hazards are present, suitable fences, guards, and railings must be provided to protect patients, employees, and the public. ( )

d. Minimum construction standards must be in accordance with the following standards incorporated by reference: ( )

i. The 2006 Edition of National Fire Protection Association (NFPA) 101, the Life Safety Code, Chapter 18, New Health Care Occupancies, and the applicable provisions of chapters 1 through 11, as published by the NFPA. The NFPA documents referenced in these regulations are available from the National Fire Protection Association, 11 Tracy Drive, Avon, MA 02322-9908; 1-800-344-3555; and online at http://www.nfpa.org; and ( )

ii. The 2006 Edition of the American Institute of Architects (AIA) Guidelines for Design and Construction of Health Care Facilities applicable to a Freestanding Emergency Department and General Hospital. The AIA documents referenced in these regulations are available from the American Institute of Architects, 1735 New York Avenue N.W., Washington, D.C. 20006; 1-800-242-3837; and online at http://www.aia.org. ( )

e. The FSED must provide a Type 1 Essential Electrical System (generator and transfer switch) in accordance with NFPA 99, 2005 Edition. ( )

f. The FSED must provide a Level 1 Medical Gas and Vacuum System (piped gas system) in accordance with NFPA 99, 2005 Edition. ( )

02. Plans, Specifications, and Inspections. Plans, specifications, and inspections of any new facility construction or any addition, conversion, or remodeling of an existing structure are governed by the following: ( )

a. Plans for new construction, additions, conversions, and remodels must be prepared by or executed

under the supervision of an architect or engineer licensed in the state of Idaho. This requirement may be waived by the Department in connection with minor alterations provided the alterations comply with all construction requirements. ( )

b. Prior to commencing work pertaining to construction of a new building, any addition or structural changes to existing facilities, or conversion of existing buildings to be used as an FSED, plans and specifications must be submitted to, and approved by, the Department. ( )

c. Preliminary plans must be submitted and must include at least the following: ( )

i. A functional program description as defined in 2006 Edition of AIA Guidelines for Design and Construction of Health Care Facilities; ( )

ii. The assignment of all spaces, size of areas and rooms, and indicate in dashed outline the fixed equipment; ( )

iii. Drawings of each floor including, but not limited to, the basement, approach or site plan, roads, parking areas, and sidewalks; ( )

iv. The total floor area and number of beds; ( )

v. Outline specifications describing the general construction, including interior finishes, acoustical materials, and HVAC; ( )

vi. The plans must be drawn to scale of sufficient size to clearly present the proposed design, but not less than a scale of one-eighth (1/8) inch to one (1) foot; ( )

vii. Before commencement of construction, working drawings must be developed in close cooperation and with approval of the Department and other appropriate agencies; ( )

viii. The drawings and specifications must be well prepared and of accurate dimensions and must include all necessary explanatory notes, schedules, and legends. They must be stamped with the architect's or engineer's seal; and ( )

ix. The drawings must be complete and adequate for contract purposes. ( )

d. Prior to occupancy, the construction must be inspected and approved by the Department. The Department must be notified at least four (4) weeks prior to completion in order to schedule a timely final inspection. ( )

e. Buildings used as a FSED must meet all the requirements of local, state, and national codes concerning fire and life safety that are applicable to hospitals. ( )

03. Electrical Safety. ( )

a. A preventative maintenance program must ensure an electrically safe environment within the FSED. Written policies and procedures must be established and implemented to ensure compliance with NFPA 99 Health Care Facilities, 2005 Edition. ( )

b. Specific restrictions on the use of extension cords and adapters are: extension cords must be used in emergency situations only, be of the grounded type, and have wire gauge compatible to the piece of equipment being used; and ( )

c. Prohibition of the use of personal electrical equipment by patients and employees. Specific items may be allowed if the hospital adopts formal policies for defining and inspecting them. ( )

04. Smoking. Because smoking has been acknowledged to be a fire hazard, a continuous effort must be

made to reduce its presence in all health care facilities. Written policy governing smoking must be conspicuously posted and made known to all freestanding emergency department personnel, patients, and the public. The policy must include provisions for compliance with Title 39, Chapter 55, Idaho Code "Clean Indoor Air" and Section 18.7 of NFPA 101, 2006 Edition. ( )

05. Emergency Plans for Protection and Evacuation of Patients. ( )

a. The FSED must develop a prearranged written plan for employee response for protection of patients and for orderly evacuation and relocation of occupants in case of an emergency in accordance with Section 18.7 of the Life Safety Code, 2006 Edition. ( )

b. Fire drills must be planned by key personnel and conducted on an unannounced basis. Fire drills must be held as required by Section 18.7 of the Life Safety Code, 2006 Edition. ( )

06. Report of Fire. A separate report on each fire incident occurring within the FSED must be submitted to the Department within thirty (30) days of the occurrence. The reporting form, "Facility Fire Incident Report" is provided by the Department to secure specific data concerning date, origin, extent of damage, method of extinguishment, and injuries, if any. ( )

09. Maintenance of Equipment. The FSED must establish routine test, check, and maintenance procedures for alarm systems, extinguishment systems, and all essential electrical systems. Frequency of testing, checks, and maintenance must be in accordance with applicable National Fire Protection Association Standards referenced in Chapter 2 of the 2006 "Life Safety Code" or as adopted by the Idaho State Fire Marshal. ( )

10. Disaster Plans. ( )

a. The FSED must have written plans for the care of casualties from both external and internal disasters. ( )

b. The plans must be developed with the assistance of the local emergency planning committee and all appropriate community resources. ( )

c. The plan must be reviewed and revised at least annually. ( )

d. The plan must be a part of the overall community emergency response plan. ( )

e. As part of the disaster and mass casualty program, a plan for the emergency supply of water must be available. This plan must include at least written contracts with any outside firms, a listing of procedures to be followed, the amounts of water needed by different departments, the means of dispensing water within the facility, and procedures for sanitizing in the case of contamination. Plans utilizing existing piping are recommended. ( )

11. External Disaster Plan. ( )

a. The hospital and FSED must conduct a hazard vulnerability analysis and develop a plan for external disasters for the geographic area served and within the capability of each physical location. ( )

b. The plan must consider the performance of structural and critical non-structural building systems and the likelihood of loss of externally supplied power, gas, water, sanitary sewer, and communications under local or regional disaster situations. ( )

c. The plan must contain the following elements: ( )

i. Storage or a functional contingency plan to obtain; food, sterile supplies, pharmacy supplies, linen, and water for sanitation, sufficient for four (4) days; ( )

ii. A procedure for notifying and assigning personnel; ( )

iii. Unified medical command; ( )

iv. Space and procedure for decontamination and triage; ( )

v. Procedure for casualty transfer to an appropriate facility; ( )

vi. Agreement with other agencies for communications. ( )

d. The External Disaster Plan for the FSED may be an annex or appendix to the Hospital Plan, copies of which must be maintained onsite at the FSED. ( )

12. Internal Disaster Plans. ( )

a. The hospital and FSED must conduct a hazard vulnerability analysis and develop a plan for internal disasters for the building and personnel assigned to function in each physical location. The plan must consider the performance of the facility in dealing with an internal emergency such as the loss of building systems, supplied power, gas, vacuum, domestic water, blocked sanitary sewer, and loss of building communications. The plan must contain the following elements: ( )

i. Those listed in Subsections 378.11. a. through 378.11.d., of these rules; ( )

ii. Back up communications; ( )

iii. Building security and lockdown; ( )

iv. Internal traffic and crowd control; ( )

v. Loss of, or isolation of, other related departments; and ( )

vi. Evacuation or relocation security. ( )

b. Drills. The plans must be exercised annually at the FSED. ( )

c. The Internal Disaster Plan for the FSED may be an annex or appendix to the Hospital Plan, copies of which must be maintained on site at the freestanding emergency department. ( )

13. Preventative Maintenance. The FSED must be equipped and maintained to protect the health and safety of the patient, personnel, and visitors. The FSED must have a written preventive maintenance program to include at least the following elements: ( )

a. Designation of person responsible for maintaining the facility; ( )

b. Written preventive maintenance procedures and appropriate inspection intervals in accordance with NFPA 99 and additional mandatory references listed in NFPA 101, 2006 Edition must be made for at least the following: ( )

i. Heating systems; ( )

ii. Air conditioning and mechanical systems; ( )

iii. Electrical systems; ( )

iv. Vacuum systems and gas systems; ( )

v. All air filters in heating, air conditioning and ventilating systems; and ( )

vi. Equipment related directly and indirectly to patient care, and any other equipment deemed essential

under the emergency plan. ( )

c. Maintenance and testing of Essential Electrical System, Vacuum, and Gas Systems must be in accordance with National Fire Protection Association 99; Health Care Facilities, 2005 Edition. ( )

14. Safety. The FSED and hospital must have a safety committee and must be responsible for at least the following: ( )

a. There must be comprehensive written safety procedures for all areas of the FSED that must include the safe use of equipment and handling of patients; ( )

b. Safety orientation of new employees; and ( )

c. Establishment of an incident or accident system for all patients, personnel, and visitors, that includes: ( )

i. Reporting procedure; ( )

ii. Investigation of incidents or accident; ( )

iii. Documentation of investigation and disposition; and ( )

iv. Evaluation of incidents or accidents and implementation of mitigation efforts. ( )

379. (RESERVED)

380. SURGICAL SERVICE.
A hospital that provides surgical service shall have equipment, facilities and personnel according to the needs of the type of patients served. ( )

01. Location of Surgical Department. The surgical department shall be segregated from the remainder of the hospital so as to prevent traffic through the area to any other part of the hospital. ( )

02. Physical Facilities. The facilities of each surgical department shall have the following: ( )

a. Scrub sinks with goose neck spout and knee, elbow or foot action water control; and ( )

b. Operating rooms, that shall have floors, walls and ceilings with easily cleanable surfaces; and ( )

c. A housekeeping closet shall be provided for the sole use of the surgical department; and ( )

d. A utility room for the cleaning of contaminated equipment and supplies; and ( )

e. Separate space for the storage of sterile and non-sterile supplies. ( )

03. Policies and Procedures. Written policies and procedures concerning surgical service shall be approved by the medical staff, appropriate nursing staff and the administration. They shall include, but not be limited to, the following: ( )

a. Specific delineation of surgical privileges shall be made for each physician or practitioner performing surgery. Privileges for each physician shall be available to the operating room supervisor; and ( )

b. A policy and procedure for all persons admitted for surgery, and shall include the following: ( )

i. Verification of patient identity; and ( )

ii. Site and side of body to be operated upon; and ( )

c. Written procedures for infection control including aseptic techniques for patients and personnel during preoperative, operative and postoperative periods in the surgery suite; and ( )

d. When appropriate, a procedure for accountability of all instruments, sponges, needles used in surgery; and ( )

e. A procedure for the safe handling and transportation of patients. ( )

04. Records. Prior to surgery patient records shall contain the following: ( )

a. A properly executed informed consent; and ( )

b. Medical history and record of physical examination performed and recorded no more than seven (7) days before or within forty-eight (48) hours after admission; and ( )

c. Appropriate screening tests, based on patient needs, completed and recorded prior to surgery. ( )

d. Record requirements may be modified in emergency surgery cases to the extent necessary under the circumstances. ( )

05. Records Following Surgery. Patient records following surgery shall contain the following: ( )

a. Operative report of techniques and findings shall be recorded directly after surgery; and ( )

b. All tissues and foreign bodies shall be sent to a pathologist in accordance with Subsection 350.08; and ( )

c. Sponge and needle count, if appropriate. ( )

06. Operating Room Registry. Operating room registry shall contain the following: ( )

a. Name, age, sex, and hospital admitting number of patient; and ( )

b. Date and time of surgery; and ( )

c. Preoperative and postoperative diagnosis; and ( )

d. Names of surgeons, assistants, anesthetists, scrub and circulating assistants; and ( )

e. Surgical procedure performed; and ( )

f. Complications, if any, during surgery. ( )

07. Surgical Staff. The surgical staff of a hospital shall consist of the following personnel: ( )

a. A licensed registered nurse with experience in operating room techniques who acts as supervisor; and ( )

b. Sufficient numbers of personnel to assure there is a licensed registered nurse serving as circulating nurse for each separate operating room where surgery is being performed; and ( )

c. A surgical team of one (1) or more physicians and licensed registered nurses on call at all times; and ( )

d. A physician of the active medical staff shall provide overall direction for the surgical service. ( )

08. Staff Training and Education. There shall be evidence of continuing education and training for the staff. ( )

09. Surgical Service Supplies and Equipment. ( )

a. Parenterals, drugs, instruments, equipment and supplies necessary for the scope of services provided shall be readily available to the surgical suite; and ( )

b. Emergency IV fluids and medications as approved by the pharmacy and therapeutics committee shall be available; and ( )

c. There shall be a written procedure for the use, care, and maintenance of all supplies, instruments and equipment, and responsibility for such maintenances. ( )

381. -- 389. (RESERVED)

390. ANESTHESIA SERVICES.
These services shall be available when the hospital provides surgery or obstetrical services with C-section capacity and shall be integrated with other services of the hospital and shall include at least the following: ( )

01. Policies and Procedures. Policies and procedures shall be approved by the medical staff and the administration of the hospital. These written policies and procedures shall include at least the following: ( )

a. Designation of persons permitted to give anesthesia, types of anesthetics, preanesthesia, and post anesthesia responsibilities; and ( )

b. Preanesthesia physical evaluation of a patient by an anesthetist, with the recording of pertinent information prior to surgery together with the history and physical and preoperative diagnosis of a physician; and ( )

c. Review of patient condition immediately prior to induction; and ( )

d. Safety of the patient during anesthetic period; and ( )

e. Record of events during induction, maintenance, and emergence from anesthesia including: ( )

i. Amount and duration of agents; and ( )

ii. Drugs and IV fluids; and ( )

iii. Blood and blood products. ( )

f. Record of post-anesthetic visits and any complications shall be made within three (3) to forty-eight (48) hours following recovery; and ( )

g. There shall be a written infection control procedure including aseptic techniques, and disinfection or sterilizing methods. ( )

02. Anesthesia Service Staff. Anesthesia service shall be under the overall direction of a physician. The medical staff or appropriate committee shall approve all persons granted anesthesia privileges. ( )

a. All general anesthetics shall be given by a physician or certified nurse anesthetist; and ( )

b. Responsibility shall be assigned for the development of procedures concerning patient safety, including a record of equipment inspection and maintenance. The procedures shall be approved by the physician director of the anesthesia service. ( )

03. Anesthesia Equipment and Supplies. There shall be at least the following immediately available: ( )

a. Cardiac monitor; and ( )

b. Defibrillator; and ( )

c. Positive pressure breathing apparatus; and ( )

d. Crash cart or equivalent with appropriate cardiopulmonary resuscitation equipment. ( )

391. RESPIRATORY CARE SERVICES.
These services shall be under the supervision of a physician, organized and integrated with other services of the hospital. ( )

01. Policies and Procedures. Respiratory care policies and procedures shall include the following: ( )

a. Responsibility of the service to the medical staff; and ( )

b. Clear protocol as to who can perform specific procedures; and ( )

c. A written procedure for each type of therapeutic or diagnostic procedure; and ( )

d. A written procedure for the care of all equipment; and ( )

e. Written procedures for the cleaning, disinfection, or sterilizing of all equipment that is not disposable; and ( )

f. Written procedures for infection control; and ( )

g. A procedure for the control of all water used for respiratory therapy where applicable. ( )

02. Records. All treatments involving respiratory care shall be recorded in the patient record by the person rendering the service, and shall include the following: ( )

a. Type of therapy; and ( )

b. Date and time of treatments; and ( )

c. Practitioners order recapitulation; and ( )

d. Any adverse reactions to treatments; and ( )

e. Records of periodic physician evaluations. ( )

03. Staff. All treatments shall be given by a respiratory therapist, a respiratory therapy technician or a licensed nurse. If a hospital is unable to employ sufficient respiratory therapists, respiratory therapy technicians or licensed nurse personnel to meet its needs, that hospital may use other hospital personnel who have documented on-the-job training in respiratory therapy and who are certified as being able to perform safely the duties assigned within the respiratory care service by the person with overall direction of the respiratory care service under Section 391. Such certification shall be documented and updated annually. ( )

392. -- 399. (RESERVED)

400. MATERNITY AND NEWBORN SERVICE.
If a hospital offers maternity and newborn service, care shall be provided during pregnancy, labor, delivery, postpartum and neonatal periods with appropriate staff, space and equipment. ( )

01. Area Requirements. If the hospital offers maternity and newborn service, it shall be located in such a manner as to minimize traffic to and from other patient care areas. ( )

02. Delivery/Birthing Room Facilities. The delivery/birthing room shall be located in such a manner as to prevent traffic to and from other areas, and meet the following: ( )

a. At least one (1) delivery room shall be provided; and ( )

b. Scrub-up facilities shall be provided for the delivery room. Each sink shall have a soap dispenser, elbow, knee, or foot action water control, and gooseneck spout. Disposable brushes or brushes capable of withstanding sterilization shall be provided; and ( )

c. A separate space shall be provided for the cleanup of non-sterile and contaminated material; and ( )

d. Walls, ceilings and floors shall be of a waterproof, washable surface; and ( )

e. Space shall be available for the storage of sterile and non-sterile supplies; and ( )

f. A janitor's closet shall be provided within or adjacent to the delivery suite and be used only for the delivery suite; and ( )

g. There shall be provided a source of oxygen with a mechanism for controlling the concentration of oxygen and with a suitable device for administering oxygen to both infants and adults; and ( )

h. There shall be provided a safe and suitable type of suction device for both infants and adults; and ( )

i. A properly heated bassinet shall be provided; and ( )

j. Functional obstetrical equipment and supplies shall be provided to assure safe and aseptic treatment of mothers and infants; and ( )

k. There shall be immediately available all cardiopulmonary resuscitation equipment for both adults and infants; and ( )

l. The delivery and birthing rooms shall not be used for purposes other than obstetrical care, except in a disaster or life threatening emergency. ( )

03. Alternate Birthing Services. If the facility so desires, it may establish birthing services as an alternate to traditional delivery services that meet currently accepted professional practices and the following is provided: ( )

a. Patients requesting use of alternate birthing services shall meet pre-established criteria as developed and approved by the medical staff and be identified as low risk maternity patients prior to admission. ( )

b. Birthing facilities shall be as follows: ( )

i. The alternate birthing service shall be so located as to have ready accessibility to emergency

services, including surgical and/or traditional delivery facilities; and ( )

ii. The birthing area shall be of sufficient size to adequately provide for staff, equipment, supplies, support personnel and emergency procedures during labor, delivery and the immediate postpartum period; and ( )

iii. There shall be immediately available oxygen, suction, linen, instruments, supplies, medications and equipment to meet the needs of both mother and infant. ( )

04. Rooming-In. Rooming-in care of newborn infants is permissible provided the following requirements are met: ( )

a. The room shall have a lavatory equipped with hot and cold running water, soap, soap dispenser, approved disposable towel, and waste receptacle; and ( )

b. Mother and infant shall have individual equipment and supplies; and ( )

c. Individual self-closing containers shall be provided for the infant's soiled linen. ( )

05. Nursery Facilities. The newborn nursery in each hospital shall meet the following requirements: ( )

a. An existing nursery shall provide a minimum of twelve (12) square feet per bassinet. A nursery established by new construction or a new hospital (see Subsection 002.26) shall provide a minimum of twenty-four (24) square feet per bassinet or as required under Section 600, whichever is more restrictive; and ( )

b. Bassinets shall be spaced at least twenty-four (24) inches apart; and ( )

c. Each bassinet shall be mounted on a single stand and be removable to facilitate cleaning; and ( )

d. Each bassinet shall be fully equipped to give individualized routine care to babies. A common bathing table or dressing table shall not be used; and ( )

e. Handwashing facilities shall be provided and equipped with soap, soap dispenser, disposable towel, and waste receptacle; and ( )

f. Each nursery shall have at least one (1) mechanical unit approved by Underwriters' Laboratories, Inc., capable of providing a temperature, humidity, and oxygen controlled environment; and ( )

g. Space and facilities for the care of premature infants shall be provided; and ( )

h. Scales and examining tables shall be provided and be protected to prevent cross infection; and ( )

i. Sufficient separation between well infants and infants that are suspected of harboring some infectious disease to avoid transmission of the disease causing organisms. ( )

06. Patient Accommodations. Maternity patient accommodations shall meet the following requirements: ( )

a. Postpartum nursing facilities shall meet the requirements of nursing units outlined in these rules; and ( )

b. Isolation capability shall be available at all times for an obstetrical or newborn patient showing any evidence of infection that requires isolation; and ( )

c. At least one (1) labor/birthing room shall be provided in the facility for examinations and preparation of patients for delivery unless alternative services are utilized as described in Subsection 400.03. ( )

07. Practices and Procedures. Practices and Procedures for the nursery and delivery room shall be as follows: ( )

a. All health care personnel in the delivery/birthing room or alternative birthing area during a delivery shall observe appropriate sterile or aseptic techniques as the case requires, including established dress requirements; and ( )

b. All persons entering the newborn nursery shall dress in such a manner to protect the newborn from cross contamination; and ( )

c. A safe means of identifying both the infant and mother shall be employed before the infant is removed from the delivery room or alternate birthing area. This shall be of a type that cannot be removed during routine care of the infant; and ( )

d. Infants found to have an infectious condition (skin lesions, inflammation of the eye, diarrhea, or other evidence of infection or born of a mother with an identified infectious condition) shall be transferred promptly to an isolation area outside the general nursery. Those infants whose eyes have not received prophylactic treatment, due to the religious opposition of parents or for any other reason, shall be cared for during their stay in the hospital in accordance with Subsection 400.05.i. ( )

08. Obstetrical Records. All obstetrical records shall include, in addition to the requirements for medical records, the following: ( )

a. Report of antenatal blood serology, and RH factor determination; and ( )

b. Past obstetrical history of patient's previous pregnancies, prior to onset of labor whenever possible; and ( )

c. Obstetrical assessment report describing conditions of mother and fetus on admission; and ( )

d. If fetal monitoring is used, all fetal monitoring records; and ( )

e. Complete description of progress of labor including reasons for induction and operative procedures, if any, signed by the attending physician; and ( )

f. Records of anesthesia, analgesia, and medications given in the course of labor and delivery; and ( )

g. Signed report of obstetrical consultant when such service has been obtained; and ( )

h. Names of assistants present during delivery; and ( )

i. Progress notes including descriptions of involution of uterus, type of lochia, condition of breasts and nipples; and ( )

j. Report of condition of infant following delivery. ( )

09. Newborn Records. Records of newborn infants shall include, in addition to the requirements for medical records set forth in Section 2-1360, the following information: ( )

a. Date and hour of birth, birth weight and length, period of gestation, sex; and ( )

b. Parents' names and address; and ( )

c. Type of identification placed on infant in delivery room; and ( )

d. Description of complications of pregnancy or delivery including premature rupture of membranes, condition at birth including color, quality of cry, method and duration of resuscitation; and ( )

e. Record of instillation into each eye at delivery of prophylactic remedy; and ( )

f. Report of initial physical examination, including any abnormalities, signed by the attending physician; and ( )

g. Record of metabolic screening blood tests; and ( )

h. Progress notes including: temperature, weight and feeding charts; number, consistency, and color of stools; condition of eyes and umbilical cord; condition and color of skin; motor behavior; and condition upon discharge. ( )

10. Policies and Procedures. Written policies and procedures involving maternity and newborn service shall be reviewed and revised at least once yearly. They shall be approved by the medical staff, nursing department, and hospital administration. Policies shall govern personnel, patients, and visitors to be admitted to the obstetrical area. Policies and procedures shall include at least the following: ( )

a. A policy for infection control supported by specific procedures, including all appropriate aseptic techniques, housekeeping procedures and isolation procedures. These policies and procedures shall be approved by the infection control committee; and ( )

b. Policies and supporting procedures for transporting or admitting infants born outside the hospital and/or born outside the obstetrical unit. These procedures shall be approved by the infection control committee; and ( )

c. Written policies and supporting procedures shall govern nursing care of the patient during labor, delivery, and postpartum; and ( )

d. Written policies and supporting procedures shall govern nursing care of the newborn infant; and ( )

e. Written policies and supporting procedures to govern "rooming-in" services; and ( )

f. A procedure for identification of the infant upon delivery and discharge; and ( )

g. An admission policy indicating types of high risk mothers or infants admitted; and ( )

h. A policy and procedure for consultation with and/or transfer to a newborn intensive care unit for high risk infants; and ( )

i. A policy and supporting procedure for the care and maintenance of all movable and fixed equipment, including electrical and mechanical equipment; and ( )

j. Additional policies and procedures for the alternate birthing service that shall include at least the following: ( )

i. Definition of the low-risk maternity patient; and ( )

ii. Written screening process for evaluating maternity patients; and ( )

iii. Written criteria that, if met, would necessitate the transfer of a laboring mother to traditional labor

and delivery setting. ( )

11. Staffing. The maternity and newborn service shall be staffed as follows: ( )

a. The service shall be under the supervision of a licensed registered nurse on a twenty-four (24) hour basis; and ( )

b. A licensed registered nurse shall be in attendance during labor and delivery. ( )

12. Capability. The hospital shall have the capability for operative delivery including cesarean section. ( )

13. Waiver of Capability. A hospital offering maternity and newborn services without C-section capability upon the effective date of these rules may apply in writing to the licensing agency for waiver of the requirement of Subsection 400.12. Waiver will not be granted without a showing by the hospital that: ( )

a. There is an existing hospital policy that requires its medical staff in advance of admission to inform their patients of the percentage of C-section deliveries in the United States, the likelihood that a C-section will be required in the instant case, the risks of delivery in a hospital without C-section capability and the location of the nearest hospital with C-section capability; and ( )

b. The hospital has adopted for use a form of informed consent to be signed by the patient in advance of admission. Such form shall make on its face a detailed showing that the items in Subsection 400.13.a. have been presented to the patient; and ( )

c. There is an existing hospital policy for emergency transport with a physician in attendance to a C-section capable hospital in the event of an unforeseen emergency; and ( )

d. The hospital has in place a medical record system to document the informed consent of each patient admitted to the maternity and newborn service. ( )

401. -- 409. (RESERVED)

410. CENTRAL SERVICE.
The hospital shall provide an area for the cleaning, disinfection, packaging, sterilization, storing and distribution of medical/surgical patient care supplies. ( )

01. Service Areas. The service shall be separated into the following areas: ( )

a. Receiving and cleaning of contaminated supplies; and ( )

b. Assembly area (packaging); and ( )

c. Sterilization area; and ( )

d. Sterile and nonsterile storage area. ( )

02. Equipment and Supplies. Autoclaves, sterilizers, and other equipment shall be available to meet the needs of the hospital. ( )

03. Policies and Procedures. Policies and procedures established for processing and reprocessing of all instruments and supplies shall be approved by the infection control committee and must include the following: ( )

a. Method of cleaning all equipment; and ( )

b. A listing of contents of package and material to be used for all items autoclaved or sterilized; and

( )

c. Procedure for operation of autoclaves and sterilizers; and ( )

d. Policy regarding shelf life of all types of packages; and ( )

e. Policy regarding expiration dates of packages; and ( )

f. Procedure for conducting daily check of thermometers, and recordings; and ( )

g. Determination of temperature, time, pressures, and humidity for autoclaves and sterilizers; and ( )

h. Procedure for recall and disposal or reprocessing; and ( )

i. Policy regarding maximum size and weight of packs; and ( )

j. Procedure for biological (spore) check of gas sterilizers, each load; and ( )

k. Procedure for biological (spore) check of autoclave at least monthly; and ( )

l. Policy establishing aeration periods for various kinds of materials that are gas sterilized; and ( )

m. Procedure for cleaning and disinfection of all items that are not sterilized; and ( )

n. Procedure for cleaning and sanitizing equipment and surfaces (housekeeping); and ( )

o. Policy establishing that all water issued for respiratory therapy shall be sterile; and ( )

p. Written infection control procedure; and ( )

q. Procedure for the control of water used for respiratory therapy if that service is not responsible. ( )

04. Inservice/Continuing Education. Documentation of all orientation and educational programs for each employee shall be present at the facility. ( )

411. -- 419. (RESERVED)

420. CRITICAL CARE UNITS.
If appropriate for the hospital, these units may be established for patients requiring extraordinary care. ( )

01. Policies and Procedures. If the hospital has critical care units then written policies and procedures shall be developed and implemented by the medical staff, appropriate nursing staff, and administration. The physician or committee responsible for the overall medical direction of the unit, shall also participate in the development of the written policies and procedures and approve them. Policies and procedures shall include at least the following: ( )

a. A policy statement regarding the responsibility of the units to the medical staff including the working relationship between the unit director and the patient's physician; and ( )

b. Admission criteria, priorities, discharge and transfer policies and procedures; and ( )

c. Staffing requirements including training and experience; and ( )

d. Emergency procedures; and ( )

e. Infection control procedure including isolation procedures; and ( )

f. Policies and procedures including standing orders for medical emergencies when a physician is not present. These shall include the procedure for the use of drugs and equipment, and specify who can do the procedure. ( )

02. Critical Care Staff. The staff of a hospital critical care unit shall be composed of the following: ( )

a. A physician shall have overall medical direction and responsibility for the unit. The physician, with concurrence from the medical staff and administration, shall provide direction for: ( )

i. Implementation of policies and procedures involving critical care service; and ( )

ii. Determination of qualifications of all other personnel serving the unit; and ( )

iii. Development of a system to assure physician coverage; and ( )

iv. Criteria for admission and discharge; and ( )

v. Assuring continuing education for medical and nursing staff. ( )

b. There shall be sufficient licensed registered nurses with training and experience in critical care on duty on a twenty-four (24) hour basis for nursing care and nursing management. ( )

c. Licensed registered nurses who work in the unit must have training or experience in that type of nursing care. ( )

d. If there is only one (1) patient in the critical care unit there shall be one (1) licensed registered nurse who shall be available to observe the patient. If there are two (2) or more patients in the unit, a licensed registered nurse shall be present in the unit at all times. ( )

03. Equipment and Supplies. There shall be sufficient equipment and supplies to meet the needs of the patients treated; and ( )

a. There shall be a call signal at each bed to a continuously staffed station; and ( )

b. There shall be an alarm system or other method of calling assistance for special teams. ( )

04. Area Requirements. Critical care unit requirements are as follows: ( )

a. There shall not be more than twelve (12) patient beds in each unit. ( )

b. Each bed area shall be one hundred thirty-two (132) square feet. ( )

c. There shall be a minimum of eight (8) feet between beds with at least four (4) feet at the foot and sides of the bed. ( )

05. Maintenance Program. There shall be a regularly scheduled preventive maintenance program with emphasis on electrical safety, and there shall be written evidence of such a program (refer to Subsection 510.03, Electrical Safety). ( )

421. -- 429. (RESERVED)

430. NUCLEAR MEDICINE SERVICES.
If appropriate for the hospital the use of internal radionuclides for diagnosis and treatment of patients may be

established. ( )

01. Nuclear Medicine Staffing. If the hospital has nuclear medical service, medical care shall be under the overall direction of a qualified nuclear medicine physician. The physician shall provide direction for: ( )

a. Determination of qualifications of all other personnel in the service; and ( )

b. Organizational structure and personnel needed; and ( )

c. Establishing a procedure for assuring physician coverage; and ( )

d. Continuing education for all staff. ( )

02. Policies and Procedures. Written policies and procedures, approved by the physician director in consultation with other appropriate professionals and administration, shall be developed and implemented. Policies and procedures shall include but shall not be limited to: ( )

a. Policies and procedures for the preparation, use, storage, disposition, and labeling of all radioactive materials; and ( )

b. Quality control procedures to ensure proper identity, strength, and purity of all radiopharmaceutical agents; and ( )

c. Procedures for the testing, use, calibration, and preventive maintenance of all equipment; and ( )

d. A policy stating the responsibility of the nuclear medicine staff to the medical staff. ( )

03. Facilities. Nuclear medicine services shall be provided in an area that is appropriately equipped for the scope of services, and is safe for both patients and personnel. ( )

04. Radiation Control. The nuclear medicine service shall comply with Sections 39-3001 through 39-3019, Idaho Code. ( )

05. Records. Signed and dated requests, reports, and records of diagnostic and therapeutic procedures shall be incorporated into the patient's medical record, and copies shall be kept on file in the nuclear medicine department. Records shall contain at least the following: ( )

a. Patient identification; and ( )

b. Reason for diagnostic or treatment request; and ( )

c. A record of all radiopharmaceuticals that shall include: ( )

i. Date; and ( )

ii. Identity; and ( )

iii. Supplies and lot number; and ( )

iv. Amounts administered. ( )

d. All records of equipment or monitor testing, repair, and calibration. ( )

06. Nuclear Medicine Reviews. The medical staff or a committee of the staff shall review nuclear medicine services as needed, but not less than annually. ( )

431. -- 439. (RESERVED)

440. REHABILITATION SERVICES FOR HOSPITALS.
If this service is offered the ill or injured patient shall be rehabilitated to the highest level of self-sufficiency possible. ( )

01. Rehabilitation Service. If the hospital offers rehabilitation services, they shall be provided in accordance with orders of practitioners who are authorized by the medical staff to order the services and shall be given by qualified therapists and shall include at least the following services for inpatients and outpatients: ( )

a. Physical therapy; and ( )

b. Occupational therapy; and ( )

c. Speech pathology and audiology. ( )

02. Rehabilitation Service Staff. Rehabilitation service shall be under the overall medical direction of a physician with qualified therapists and qualified nursing staff. ( )

03. Facilities. The hospital shall provide adequate space, supplies, and equipment to provide for patient care and safety. ( )

04. Organization. Each service or program offered shall have a written organizational plan. ( )

05. Policies and Procedures. Policies and procedures shall be developed by the physician director, nursing service, administration, and other personnel representing each service offered. ( )

06. Services and Records. There shall be a written plan of treatment and record for each inpatient or outpatient that includes at least the following information relating to rehabilitation potential: ( )

a. Type, amount, frequency, and duration of treatments and response; and ( )

b. Contraindications; and ( )

c. Discharge planning; and ( )

d. Patient progress by all personnel involved in care. ( )

07. Other Requirements. In addition to special rehabilitation requirements, the hospital shall conform to all other applicable sections of these hospital rules. ( )

441. -- 449. (RESERVED)

450. SOCIAL SERVICES.
If the hospital offers this service, the patient and his family shall be assisted to understand and cope with social problems that affect health. ( )

01. Provision of Social Services. If the hospital provides these services, it can be provided by the following methods: ( )

a. An organized service within the hospital under the overall direction of a social worker; or ( )

b. A social worker employed part time; or ( )

c. Consultation from a social worker from an outside resource. ( )

02. Organization and Staffing. An organizational plan of services shall be developed by those providing the service, medical staff, and administration. ( )

03. Policies and Procedures. Policies and procedures shall be developed to include the following: ( )

a. Services offered; and ( )

b. Identification of relationship with other hospital and community services; and ( )

c. Definition of other support personnel for patient care; and ( )

d. Procedure for discharge planning; and ( )

e. Procedure for referral and consultation. ( )

04. Records. Pertinent social data shall be incorporated into the patient's medical record. ( )

451. -- 459. (RESERVED)

460. OUTPATIENT SERVICE.
If the hospital has such service it shall meet the nonemergency health needs of patients who remain in the hospital less than twenty-four (24) hours. ( )

01. Staffing. When a hospital maintains a formally organized clinic service distinct from the emergency service, the outpatient service shall be under the overall medical direction of a physician whose authority and responsibilities are defined in writing and approved by the governing body. There shall be adequate personnel to meet the needs of the patients, and a licensed registered nurse shall be on duty at all times. All practitioners shall be members of the active medical staff. ( )

02. Outpatient Surgery. If outpatient surgery is performed, the requirements found in Section 380 shall be met. ( )

03. Policies and Procedures. There shall be written policies and procedures for at least the following: ( )

a. Services offered, including types of surgeries performed; and ( )

b. Procedure for evaluation, treatment and referral of patients; and ( )

c. Responsibility and accountability to other hospital services or departments, and to the medical staff and administration. ( )

04. Medical Record. A medical record shall be maintained for every patient utilizing out patient services. The record shall contain all applicable requirements of Section 360. ( )

461. -- 469. (RESERVED)

470. PSYCHIATRIC SERVICE.
If the hospital offers psychiatric service it must be organized, staffed and equipped to provide inpatient and outpatient treatment to the mentally ill. ( )

01. Staffing. If the hospital offers psychiatric service, it must be directed and evaluated by a psychiatrist and staffed by adequate numbers of qualified personnel to meet patient needs. ( )

a. A licensed registered nurse qualified by training or experience in psychiatric nursing must

supervise the nursing care rendered in the psychiatric service. ( )

b. Psychiatric service staff must collaborate with medical, nursing, and other professional personnel in patient care planning, and provide consultation to staff of other services regarding the psychiatric problems of patients. ( )

02. Patient Treatment Plan. Patient's records must reflect that an individualized plan of treatment is developed for each patient that is specific and appropriate to individual problems and takes into consideration strengths as well as disabilities. The plan must designate the persons responsible for each component of care and must be reviewed, evaluated, and updated at regularly scheduled intervals by all professional personnel involved in the patient's care. ( )

03. Policies and Procedures. Policies and procedures governing the service must be developed by appropriate representatives of each discipline and in collaboration with other appropriate services. ( )

04. Examination to Assess Mental Status. All examinations to assess the patient's mental status must be recorded, signed and dated as soon as possible after admission and must include a description of the patient's physical and emotional state and intellectual functions. There must be an initial patient history and report of the patient's mental status within twenty-four (24) hours after admission that may be based on the results of prior examinations by the reporting physician. ( )

05. Records. Adequate and comprehensive records must be retained for assessment, evaluation and treatment purposes. Admitting and subsequent psychiatric diagnoses must be recorded in currently accepted terminology; and ( )

a. The patient's psychiatric history and social evaluation must provide information regarding the patient's background, the onset and development of the illness, including factors and precipitating circumstances that led to the patient's admission, and data useful for patient care and discharge planning; and ( )

b. A properly executed consent form must be obtained and incorporated into the record in any case of treatment approach that carries significant risks, and shows that the patient, his family, or other legally responsible person is informed of available alternative approaches; ( )

c. Documentation must show that the patient, his family, or other legally responsible person is informed of the treatment to be given; and ( )

d. Documentation must show that planning for continued care and treatment in the community are coordinated with the patient's family and others in his social environment. ( )

06. Special Medical Record Requirements for Psychiatric Hospitals or Services. In addition to meeting all the requirements contained in Section 360 of these rules, patient medical records maintained by a psychiatric hospital or service unit must clearly reflect the types and intensity of treatment provided to patients in the hospital. The records must contain the following: ( )

a. Information essential for identifying the patient's problems, for developing treatment objectives, and other information necessary for psychiatric evaluation and diagnosis; ( )

b. A record of the treatment received by the patient, including records of all treatment related to short-term and long-term goals, including discharge planning; ( )

c. The medical record must provide information regarding the management of the patient's condition and of changes in treatment and patient status. Progress notes must reflect that care provided in accordance with the treatment plan is recorded at least weekly for the first two (2) months after admission and at least monthly thereafter; and ( )

d. Every safeguard must be employed to preserve confidentiality of the patient-therapist relationship and to prevent revelation of information that would be harmful or embarrassing to the patient, his family, or others.

( )

07. Discharge Planning. Consideration for continued care and services in the community after discharge, placement alternatives, and utilization of community resources must be initiated on admission and carried out to ensure that each patient has a documented plan for continuing care that meets his individual needs. Provision must be made for exchange of appropriate information with outside resources. ( )

08. Physician Services. A board certified or board eligible psychiatrist must provide the overall direction of the service including monitoring and evaluating the quality and appropriateness of psychiatric services rendered. Physicians must be available at all times to provide medical and surgical diagnosis and treatment services. ( )

09. Nursing Service. The nursing service must be under the overall direction of a psychiatric nurse qualified by training or experience in psychiatric nursing, who monitors and evaluates nursing care provided. ( )

a. A licensed registered nurse must be on duty twenty-four (24) hours a day, seven (7) days a week to provide direct patient care, and to assign and supervise nursing care activities performed by other nursing personnel. ( )

b. There must be adequate numbers of qualified licensed registered nurses, licensed practical (vocational) nurses, psychiatric technicians, and other supportive nursing personnel to carry out the nursing aspects of the individual treatment plan for each patient and capable of maintaining progress notes on all patients. ( )

10. Psychological Services. The director of the psychological services must be a clinical psychologist who continually monitors and evaluates the quality and appropriateness of psychological services rendered (in accordance with standards of practice, service objectives, and established policies and procedures). ( )

11. Social Services. The director of social services must be a social worker who monitors and evaluates the quality and appropriateness of social services (in accordance with service objectives, standards of practice, and established policies and procedures). ( )

12. Therapeutic Activities. The hospital must provide a therapeutic activities program appropriate to meet the needs and interests of patients that is directed toward rehabilitation to and maintenance of optimal levels of physical and psychosocial functioning, and toward attaining a life style appropriate for each patient. ( )

a. If occupational therapy services are offered, they must be under the supervision of an occupational therapist. ( )

b. Adequate numbers of qualified therapists, supportive personnel, and consultants must be available to provide comprehensive therapeutic activities in conjunction with each patient's treatment plan. ( )

c. Therapeutic recreational activities must be under the supervision of a designated member of the staff who has demonstrated competence in therapeutic recreational activities programs. ( )

d. The supportive staff of the occupational therapy and therapeutic recreational activities services must be provided formal orientation and inservice training to enable them to carry out assigned functions. ( )

e. If volunteers are utilized in the therapeutic activities program, they must be provided appropriate orientation, training, and supervision by qualified professional staff. ( )

13. Physical Therapy Service. If physical therapy services are offered, the director of the service must be a physical therapist who monitors the quality and appropriateness of services rendered. ( )

14. Psychiatric Unit Space. After the effective date of these rules, any psychiatric unit not free standing must be separated and able to be secured form the general hospital with which it is associated. Each psychiatric service unit, free standing or not, must include the following: ( )

a. Consultation room or rooms; ( )

b. Facilities for examination and a treatment room for medical procedures; ( )

c. At least one (1) observation room for acutely disturbed patients, with facilities for visual observation; ( )

d. Facilities for dining; and ( )

e. Indoor and outdoor facilities for therapeutic activities. ( )

15. Construction of Psychiatric Hospitals. New construction, alterations, or modifications must not be made until plans and specifications have been approved by the licensing agency. ( )

471. -- 499. (RESERVED)

500. PHYSICAL ENVIRONMENT AND SANITATION.
The provisions contained in Sections 510 through 550 specify physical environment and sanitation standards for hospitals. ( )

501. -- 509. (RESERVED)

510. FIRE AND LIFE SAFETY STANDARDS.
Buildings on the premises used as a hospital shall meet all the requirements of local, state, and national codes concerning fire and life safety that are applicable to hospitals. ( )

01. General Requirements. General requirements for the fire and life safety standards for a hospital are that: ( )

a. The hospital shall be structurally sound and shall be maintained and equipped to assure the safety of patients, employees, and the public. ( )

b. On the premises of all hospitals where natural or man-made hazards are present, suitable fences, guards, and railings shall be provided to protect patients, employees, and the public. ( )

02. Life Safety Code Requirements. The hospital shall meet such provisions of the "Life Safety Code," 1985 Edition, of the National Fire Protection Association as are applicable to Health Care Occupancies that is incorporated by reference. ( )

a. Any hospital in compliance with either the 1967 Edition of the "Life Safety Code" or the 1981 Edition of the "Life Safety Code" prior to the effective date of these rules is considered to be in compliance with this section so long as the hospital continues to remain in compliance with that Edition of the "Life Safety Code." Life Safety Codes are available in the licensing agency of the Department. ( )

b. Remodelings, additions, and/or upgrading of building systems in existing hospitals shall meet the minimum standards set forth in the 1985 Edition of the "Life Safety Code" for new construction. ( )

c. In the event of a conflict between the applicable edition of the Life Safety Code and applicable state or local building, fire, electrical, plumbing, zoning, heating, sanitation or other applicable codes, the most restrictive shall govern. ( )

03. Electrical Safety. A continued effort shall be made to provide an electrically safe environment within the hospital. Written policies and procedures shall be established for, but not limited to, the following: ( )

a. Methods and frequency of testing, verification of performance, and use specifications for all

hospital electrical patient care equipment. All new equipment shall be tested prior to use and in no case shall the retesting interval exceed one (1) year; and ( )

b. Periodic evaluation of the electrical distribution system and all nonpatient care equipment. Inspection and testing of nonclinical equipment shall be performed at regular intervals to be determined by the chief maintenance engineer; and ( )

c. Specific restrictions on the use of extension cords and adapters. Extension cords shall be used in emergency situations only, be of the grounded type and have wire gauge compatible to the piece of equipment being used; and ( )

d. Prohibition of the use of personal electrical equipment by patients and employees. Specific items may be allowed if the hospital adopts formal policies for defining and inspecting them. ( )

04. Smoking. Because smoking has been acknowledged to be a fire hazard, a continuous effort shall be made to reduce its presence in the hospital. Written regulations governing smoking shall be conspicuously posted and made known to all hospital personnel, patients, and the public. These regulations shall include provisions for compliance with the "Idaho Clean Indoor Air Act" and at least the following provisions: ( )

a. Smoking shall be prohibited in any area of the hospital where flammable liquids, gases or oxygen is in use or stored. These areas shall be posted with appropriate signage; and ( )

b. Patients shall not be permitted to smoke in bed unless a responsible person is in attendance; and ( )

c. Unsupervised smoking by patients classified as not mentally or physically responsible shall be prohibited. This shall also include patients so affected by medications; and ( )

d. Smoking shall be prohibited in areas where combustible materials and supplies are stored; and ( )

e. Designated areas shall be provided for employee and visitor smoking. This requirement need not be complied with in any hospital that has established, by policy, that smoking is prohibited within the hospital. ( )

05. Emergency Plans for Protection and Evacuation of Patients. The hospital shall develop a prearranged written plan for employee response for protection of patients and for orderly evacuation of residents in case of an emergency. ( )

a. A diagram of the building noting the locations of exits, extinguishers, and fire alarm pull stations along with written emergency instructions shall be available within each department of the hospital. ( )

b. Emergency plans shall be thoroughly tested and used as necessary to assure rapid and efficient function. ( )

c. Fire drills shall be planned by key personnel and conducted on an unannounced basis. Fire drills shall be held as required by the "Life Safety Code." ( )

06. Report of Fire. A separate report on each fire incident occurring within the hospital shall be submitted to the Department within thirty (30) days of the occurrence. The reporting form, "Facility Fire Incident Report," shall be issued by the Department to secure specific data concerning date, origin, extent of damage, method of extinguishment, and injuries, if any. ( )

07. Maintenance of Equipment. The hospital shall establish routine test, check, and maintenance procedures for alarm systems, extinguishment systems, and all essential electrical systems. Frequency of testing, checks, and maintenance shall be in accordance with applicable National Fire Protection Association Standards referenced in Appendix B of the 1985 "Life Safety Code" or as adopted by the Idaho State Fire Marshal. ( )

511. -- 519. (RESERVED)

520. DISASTER PLANS.
The hospital shall have written plans for the care of casualties from both external and internal disasters. The plans shall be developed with the assistance of all appropriate community resources. The plan shall be reviewed and/or revised at least annually. ( )

01. External Disaster Plan. The hospital shall develop a plan for external disasters for the area served and within the capability of the facility. The plan shall contain the following elements: ( )

a. Availability of basic utilities, including food, water, and essential medical supplies; and ( )

b. A procedure for notifying and assigning personnel; and ( )

c. Unified medical command; and ( )

d. Space and procedure for triage; and ( )

e. Procedure for casualty transfer to appropriate facility; and ( )

f. Agreement with other agencies for communications; and ( )

02. Drills. The plan shall be rehearsed annually. ( )

521. -- 529. (RESERVED)

530. MAINTENANCE AND SAFETY.
The hospital shall be equipped and maintained to protect the health and safety of the patient, personnel, and visitors. ( )

01. Maintenance. The hospital shall have a written preventive maintenance program to include at least the following elements: ( )

a. Designation of person responsible for maintaining the hospital; and ( )

b. Written preventive maintenance procedure and appropriate inspection interval shall be made for at least the following: ( )

i. Heating systems; and ( )

ii. Air conditioning/mechanical systems; and ( )

iii. Electrical systems; and ( )

iv. Vacuum systems and gas systems; and ( )

v. All air filters in heating, air conditioning and ventilating systems; and ( )

vi. Equipment related directly and indirectly to patient care, and any other equipment. ( )

02. Safety. The hospital shall have a safety committee and shall be responsible for at least the following: ( )

a. There shall be comprehensive written safety procedures for all areas of the hospital that shall include the safe use of equipment and handling of patients; and ( )

b. Safety orientation of new employees; and ( )

c. Establishment of an incident/accident system for all patients, personnel and visitors, to include: ( )

i. Reporting procedure; and ( )

ii. Investigation of incidents; and ( )

iii. Documentation of investigation and disposition. ( )

531. GENERAL PATIENT ACCOMMODATIONS.
Hospitals licensed prior to the effective date of these rules shall provide for the comfort and safety of all patients as follows: ( )

01. General Requirements. The hospital shall comply with the following minimums: ( )

a. Minimum floor area exclusive of toilet rooms, closets, lockers, wardrobes, alcoves, and/or vestibules shall be one hundred (100) square feet in single-bed rooms and eighty (80) square feet per bed in multi-bed rooms. ( )

b. A minimum distance of three (3) feet shall be provided between beds in multi-bed rooms. ( )

c. Adequate storage space shall be provided for clothing, toilet articles, and other personal belongings of each patient. ( )

d. Cubicle curtains or drapes shall be provided in multi-bed rooms for patient privacy. ( )

e. A staff calling system shall be provided at each patient bed and in each patient toilet, bath, and/or tub room. All calls shall register at the staff station and must activate a visual signal in the corridor at the patient room door. ( )

f. Tubs (or showers), toilets, and lavatories shall be provided at the rate of one (1) each for every ten (10) licensed beds. ( )

532. -- 539. (RESERVED)

540. INFECTION CONTROL.
The hospital shall develop a plan for the prevention and control of infection with special emphasis on hospital acquired infection. ( )

01. Infection Control Committee. The hospital shall establish an infection control committee composed of representatives of the medical staff, administration, nursing service, pharmacy services and laboratory. Other appropriate department heads shall be members as needed. ( )

02. Infection Control Program. The program shall include at least the following elements: ( )

a. Definition of nosocomial infection, as opposed to community acquired infections; and ( )

b. A procedure for hospital surveillance of and for nosocomial infections; and ( )

c. A procedure for reporting and evaluating nosocomial infections. The procedure must enable the hospital to establish the following on at least a quarterly basis: ( )

i. Level or rate of nosocomial infections; and ( )

ii. Site of infection; and ( )

iii. Microorganism involved. ( )

03. Infection Control and Prevention Procedures. There shall be a written infection control procedure that shall include aseptic techniques, cleaning, sanitizing, and disinfection of all instruments, equipment and surfaces, for all departments and services of the hospital where patient care is rendered. ( )

04. Infection Control Committee Responsibilities. The infection control committee shall be responsible for at least the following: ( )

a. Designate one (1) person to act as the surveillance officer; and ( )

b. Evaluating antibiotic susceptibility/resistance trends; and ( )

c. Review of all infection control procedures for all departments, including housekeeping and laundry procedures, at least annually; and ( )

d. Development of procedures for defining and controlling hazardous and infectious wastes; and ( )

e. Continuing education for all appropriate personnel. ( )

541. -- 549. (RESERVED)

550. ENVIRONMENTAL SANITATION.
The hospital shall be responsible for the prevention of disease and the maintenance of sanitary conditions. ( )

01. Water Supply. The water supply of a hospital shall meet the following requirements: ( )

a. An approved public or municipal water supply shall be used whenever available; and ( )

b. In areas where an approved public or municipal water supply is not available, a private water supply shall be provided, and it shall meet the standards approved by the Department; and ( )

c. Public or private water supplies shall meet the Idaho Department of Environmental Quality Rules, IDAPA 58.01.08, "Idaho Rules for Public Drinking Water Systems"; and ( )

d. If water is from a private supply, water samples shall be submitted to an approved laboratory for bacteriological examination at least quarterly. Copies of the laboratory reports shall be kept on file in the facility; and ( )

e. There shall be a sufficient amount of water under adequate pressure to meet the sanitary requirements of the facility at all times. ( )

02. Sewage Disposal. All sewage and liquid wastes shall be discharged into a municipal sewerage system where such a system is available. Where a municipal sewerage system is not available, sewage and liquid wastes shall be collected, treated, and disposed of in a manner approved by the Department. ( )

03. Garbage and Refuse Disposal. All garbage from the hospital shall be disposed of as follows: ( )

a. All garbage and refuse shall be collected, stored, and disposed of in a manner that shall not permit the transmission of communicable disease, create a nuisance or fire hazard, or provide a breeding place for insects or rodents; and ( )

b. When municipal garbage collection and disposal services are not available, garbage shall be disposed of by garbage grinders, incineration, burial sanitary fill, or other methods approved by the Department. ( )

04. Garbage Containers. Hospital garbage containers shall meet the following requirements: ( )

a. All containers used for storage of garbage and refuse shall be constructed of durable nonabsorbent material and shall not leak or absorb liquids. Containers shall be provided with tight-fitting lids unless stored in vermin-proof rooms or enclosures; and ( )

b. Garbage containers outside the facility shall be stored at least twelve (12) inches above the ground, if not stored in a dumpster. ( )

c. Garbage containers shall be maintained in a sanitary manner. ( )

05. Insect and Rodent Control. Every hospital shall have a pest control program in effect at all times. ( )

a. This program shall effectively prevent insects, rodents and other pests from entrance to, or infestation of, the facility. ( )

b. Chemicals (pesticides) used in the control program shall be selected, used, and stored, in the following manner: ( )

i. The chemical shall be selected on the basis of the pest involved and used only in the manner described by the manufacturer, who shall be registered with the Idaho Department of Agriculture; and ( )

ii. All toxic chemicals shall be properly labeled and stored under lock and key; and ( )

iii. No toxic chemicals shall be stored in patient areas, with drugs, or in any area where food is stored, prepared, or served; and ( )

iv. The storage and use of pesticides shall be in accordance with local, state, or federal directives. ( )

06. Storage, Transportation, Treatment and Disposal of Infectious Waste. ( )

a. For purposes of this section, the following definitions shall apply: ( )

i. Storage shall mean the containment of infectious waste in such a manner as not to constitute treatment of such waste. ( )

ii. Transport shall mean the movement of infectious waste from the point of generation to any intermediate point and finally to the point of treatment and such waste must be transported by haulers knowledgeable in handling of infectious waste. ( )

iii. Treatment shall mean any method, technique or process used to change the character or composition of any infectious waste so as to render such waste noninfectious. Effective treatment may include, but is not limited to, one (1) of the following methods: ( )

(1) Incineration in an incineration facility approved and permitted in accordance with the current requirements of the Idaho Air Quality Bureau. Incinerators shall be capable of providing proper temperatures and residence time to ensure destruction of all pathogenic organisms. ( )

(2) Sterilization by heating in a steam sterilizer utilizing saturated steam within a pressure vessel (known as a steam sterilizer, autoclave or retort) at time lengths and temperatures sufficient to kill infectious agents

within the waste. Operating procedures shall include, but are not limited to, standards for temperature settings, residence times, recording or operational procedures and results, and periodic testing by treatment indicators. ( )

(3) Discharge of liquid or semi-solid waste into a sanitary sewer that provides secondary treatment of waste. ( )

(4) One (1) of several less commonly used methods such as chemical disinfection, thermal inactivation, gas/vapor sterilization or irradiation. Efficacy of the method shall be demonstrated by the development of a biological testing program, e.g., spore strips. Monitoring shall be conducted on a periodic basis using appropriate indicators. ( )

iv. Disposal shall mean the final placement of treated waste in a properly permitted landfill. ( )

b. Storage and transport of infectious waste. The following shall apply: ( )

i. Containment of infectious waste shall be in a manner and location that affords protection from animals, rain and wind; does not provide a breeding place or a food source for insects and rodents; and minimizes exposure to the waste by the public. Enclosures used for containment of infectious waste shall be secured so as to deny access by unauthorized persons and shall be marked with prominent warning signs. ( )

ii. Infectious waste, except for sharps, shall be contained in disposable containers/bags that are impervious to moisture and have a strength sufficient to preclude ripping, tearing or busting under normal conditions of use. The bags shall be securely tied so as to prevent leakage or expulsion of solid or liquid waste during storage, handling or transport. The containment system shall have a tight-fitting cover and be kept clean and in good repair. ( )

iii. Sharps shall be disposed of in impervious, rigid, puncture-resistant containers immediately after use. Needles shall not be bent, clipped or broken by hand. ( )

iv. All bags used for containment of infectious waste shall be clearly identified by label or color, or both. Rigid containers of discarded sharps shall be labeled in the same way or placed in the disposable bags used for other infectious waste. ( )

v. Reusable containers for infectious waste shall be thoroughly washed and decontaminated each time they are emptied by an approved method for decontamination as described in Subsection 550.06.b.v.(1), unless the surfaces of the containers have been protected from contamination by disposable liners, bags or other devices removed with the waste except for that waste outlined in Subsection 550.06.b.ii. ( )

(1) Approved methods of decontamination include, but are not limited to, agitation to remove visible soil combined with exposure to hot water of at least one hundred eighty (180) degrees Fahrenheit for a minimum of fifteen (15) seconds; or exposure to a chemical sanitizer by rinsing with or immersion in one (1) of the following for a minimum of three (3) minutes: hypochlorite solution (five hundred (500) ppm available chlorine), phenolic solution (five hundred (500) ppm active agent), iodophor solution (one hundred (100) ppm available iodine), or quaternary ammonium solution (four hundred (400) ppm active agent). ( )

(2) Reusable pails, drums, dumpsters or bins used for containment of infectious waste shall not be used for containment of waste to be disposed of as noninfectious waste or for other purposes except after being decontaminated by procedures as described in Subsection 550.06. ( )

vi. Trash chutes shall not be used to transfer infectious waste between locations where the waste is contained. ( )

vii. Storage of infectious waste shall not exceed seven (7) days unless stored at a temperature below thirty-two (32) degrees Fahrenheit, but no longer than ninety (90) days. ( )

c. Treatment and disposal of infectious waste. Except as otherwise provided in these rules, infectious

waste shall be treated prior to disposal using a process defined in Subsection 550.06. ( )

d. Alternate Methods. Where on-site treatment of infectious waste is demonstrated to be economically or technically unfeasible, by petition to the licensing agency, alternate methods of on-site or off-site treatment or disposal may be used with the approval of the licensing agency. ( )

07. Plumbing. The hospital plumbing system shall be free from cross-connections and interconnections between a safe water supply and one that is subject to contamination. ( )

08. Heating and Ventilation. The heating and ventilation system in a hospital shall meet the following: ( )

a. The systems shall be so designed and maintained as to provide sufficient capacity for the demands of the hospital; and ( )

b. Patient's rooms shall be so ventilated by natural or mechanical means to assure a fresh air supply. ( )

09. Housekeeping. Each hospital shall establish an organized housekeeping service with sufficient personnel to maintain and provide a pleasant, safe, and sanitary environment. ( )

a. The service shall be under the supervision of a person competent in environmental sanitation and management; and ( )

b. There shall be specific written procedures for appropriate cleaning of all service areas in the hospital, giving special emphasis to procedures applying to infection control; and ( )

c. All mop heads shall be removable and changed daily; and ( )

d. Suitable equipment and supplies shall be provided for cleaning of all surfaces. Such equipment shall be maintained in a safe, sanitary condition; and ( )

e. Selection of germicides shall be under the supervision of the infection committee; and ( )

f. Solutions, cleaning compounds, and hazardous substances shall be labeled properly and stored in safe places; and ( )

g. Dry dusting and sweeping are prohibited; and ( )

h. Surgeries, nurseries, delivery rooms, dietary, and laundry shall have separate housekeeping equipment; and ( )

i. There shall be evidence of orientation training for all new employees and continuing education for all employees. ( )

10. Laundry. Where laundry facilities are provided within the hospital, the following shall apply: ( )

a. There shall be space provided for the processing of laundry. Isolation linens shall be processed separately. All linens and garments used for newborn infants shall be processed separately from other hospital laundry; and ( )

b. Space separate from the laundry processing area shall be provided for the storing and mending of clean linen; and ( )

c. Handwashing facilities with hot and cold running water, soap, soap dispenser, disposable towels, and waste receptacles shall be provided for laundry personnel; and ( )

d. Carts, bags, hampers, or other devices for the transporting and handling of soiled laundry shall not be used to distribute clean linen; and ( )

e. All soiled laundry or clean linens shall be covered during transportation throughout the hospital; and ( )

f. Isolation linen shall be bagged and identified separately; and ( )

g. Provisions shall be made for mechanical ventilation in the laundry area. Special care shall be taken to prevent the recirculation of air from these areas through the heating and/or air conditioning system of the hospital; and ( )

h. Soiled linen carts shall be constructed of impervious material and cleaned after each use; and ( )

i. There shall be evidence of continuing education related to infection control. ( )

551. -- 599. (RESERVED)

600. NEW CONSTRUCTION AND NEW HOSPITAL STANDARDS.
The standards set forth in this section together with the standards set out in the Section 510 (entitled Fire and Life Safety Standards), shall apply to all new construction or new hospitals begun after the effective date of these rules (see Subsection 002.26). These standards are intended to specify the minimum essential facilities that shall be included in a hospital. ( )

01. Additions, Conversions, Remodelings, Etc. Additions to existing hospitals, conversions of existing buildings or portions thereof for use as a hospital, and portions of a hospital undergoing remodeling, alteration, addition or upgrading of a hospital or hospital building system that affects the structural integrity of the building, that changes functional operation, that affects fire safety or that adds beds, departments or services over those for which the hospital is currently licensed (herein simply "remodeling or remodels") shall be required to meet these standards. ( )

02. General Requirements of Constructions. General requirements for construction of a hospital are that: ( )

a. All new construction or new hospitals (see Subsection 002.26) shall comply with any and all state and local building, fire, electrical, plumbing, zoning, heating, or other applicable codes adopted by the jurisdiction in which the hospital is located and that are in effect when construction is begun. Where a conflict in code requirements occurs, the most restrictive shall govern. ( )

b. Minimum construction standards shall be in accordance with the DHHS Publication No. (HRS-M-HF)84-1, "Construction and Equipment of Hospitals and Medical Facilities" as are applicable to a hospital and is incorporated herein by reference, available in the licensing agency of the Department. ( )

03. Plans, Specifications, and Inspections. Plans, specifications, and inspections of any new facility construction or any addition, conversion, or remodeling of an existing structure shall be governed by the following: ( )

a. Plans for new construction, additions, conversions, and/or remodels shall be prepared by or executed under the supervision of an architect or engineer licensed in the state of Idaho. This requirement can be waived by the Department in connection with minor alterations provided the alterations comply with all construction requirements. ( )

b. Prior to commencing work pertaining to construction of a new building, any addition or structural changes to existing facilities, or conversion of existing buildings to be used as a hospital, plans and specifications shall be submitted to, and approved by, the Department. ( )

c. Preliminary plans shall be submitted and shall include at least the following: ( )

i. The assignment of all spaces, size of areas and rooms, and indicate in out line the fixed equipment; and ( )

ii. Drawings of each floor including, but not limited to, the basement, approach or site plan, roads, parking areas, and sidewalks; and ( )

iii. The total floor area and number of beds; and ( )

iv. Outline specifications describing the general construction, including interior finishes, acoustical materials, and HVAC; and ( )

v. The plans shall be drawn to scale of sufficient size to clearly present the proposed design, but not less than a scale of one-eighth (1/8) inch to one (1) foot. ( )

d. Before commencement of construction, working drawings shall be developed in close cooperation and with approval of the Department and other appropriate agencies, and: ( )

i. The drawings and specifications shall be well prepared and of accurate dimensions and shall include all necessary explanatory notes, schedules, and legends. They shall be stamped with the architect's or engineer's seal; and ( )

ii. The drawings shall be complete and adequate for contract purposes. ( )

e. Prior to occupancy, the construction shall be inspected and approved by the Department. The Department shall be notified at least two (2) weeks prior to completion in order to schedule a final inspection. ( )

601. -- 999. (RESERVED)

16.03.17 – MEDICARE/MEDICAID COORDINATED PLAN BENEFITS

000. LEGAL AUTHORITY.
The Department is authorized to promulgate these rules under Sections 56-202(b), 56-251(2)(c), and 56-255(4), Idaho Code, the Medicare Prescription Drug Improvement and Modernization Act of 2003, P.L. 108-173, Section 231, and Section 1937 of the Social Security Act. ( )

001. TITLE AND SCOPE.

01. Title. These rules are titled IDAPA 16.03.17, "Medicare/Medicaid Coordinated Plan Benefits." ( )

02. Scope. These rules cover the Medicaid benefit plan option that coordinates and integrates health plan benefits for individuals who are eligible for and enrolled in both Medicare and Medicaid. This package of benefits is referred to as the Medicare/Medicaid Coordinated Plan (MMCP). These rules cover eligibility, participant responsibility, general provider requirements, and the range of services covered under the MMCP. ( )

002. WRITTEN INTERPRETATIONS.
This agency may have written statements that pertain to the interpretations of the rules of this chapter. ( )

003. -- 007. (RESERVED)

008. AUDIT, INVESTIGATION AND ENFORCEMENT.
In addition to any actions specified in these rules, the Department may audit, investigate, and take enforcement action under the provisions of IDAPA 16.05.07, "The Investigation and Enforcement of Fraud, Abuse, and Misconduct." ( )

009. (RESERVED)

010. DEFINITIONS.
For the purposes of this chapter of rules, the following definitions are used: ( )

01. Capitated Payment. The amount paid to a Medicare Advantage Organization for Medicare/Medicaid Coordinated Plan services as expressed in a per member per month amount. ( )

02. Department. The Idaho Department of Health and Welfare or a person authorized to act on behalf of the Department. ( )

03. Dual-Eligible. Individuals who meet all the eligibility requirements under Section 100 of these rules. ( )

04. Evidence of Coverage. The Medicare Advantage Plan contract the MAO has with the participant. This document explains the covered services, including services included in Medicare Parts A, B, and D. It also defines the Medicare Advantage Plan obligations, and explains the participant's rights and responsibilities. ( )

05. Medicare. Medicare is a federal health insurance program for people age sixty-five (65) or older, people under age sixty-five (65) with certain disabilities, and people of all ages with End-Stage Renal Disease. It has three (3) types of coverage: Part A Hospital Insurance, Part B Medical Insurance, and Prescription Drug Coverage. It is administered under Title XVIII of the Social Security Act. ( )

06. Medicare Advantage Organizations (MAOs). Insurance companies approved by the Centers for Medicare/Medicaid Services to offer Medicare Advantage Plans in accordance with Title XVIII, Part C, of the Social Security Act and 42 CFR, Part 422, which include those services available under Medicare Parts A, B, and D, and who are Medicaid providers authorized to enroll participants in the Medicare/Medicaid Coordinated Plan. ( )

07. Medicare Advantage Plan. A health plan approved by Medicare but offered by a private company that contracts with Medicare to provide Medicare Part A, Part B, and Part D benefits. The Medicare Advantage Plan under this chapter is a special integrated plan offered by participating MAOs that includes a benefit package in its "Evidence of Coverage" approved by CMS. ( )

08. Medicare/Medicaid Coordinated Plan (MMCP). Medical assistance in which Medicaid purchases services from an MAO and provides other Medicaid-only services covered under the Medicaid Basic Plan or the Medicaid Enhanced Plan in accordance with these rules. ( )

09. Medicaid. Idaho's Medical Assistance program administered under Title XIX of the Social Security Act. ( )

10. Medicaid Basic Plan. The medical assistance benefits included under IDAPA 16.03.09, "Medicaid Basic Plan Benefits." ( )

11. Medicaid Enhanced Plan. The medical assistance benefits included under IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." ( )

12. Medical Assistance. Payments made by Medicaid. ( )

011. -- 099. (RESERVED)

GENERAL PARTICIPANT PROVISIONS
(Sections 100-199)

100. MEDICARE/MEDICAID COORDINATED PLAN (MMCP): PARTICIPANT ELIGIBILITY.
To be eligible to select the MMCP, the participant must meet the following criteria. ( )

01. Medicare Eligibility. The participant must be eligible for and enrolled in both Medicare Part A and Medicare Part B, and not have Medicare eligibility due to End-Stage Renal Disease (ESRD). ( )

02. Medicaid Eligibility. The participant must be eligible for medical assistance under IDAPA 16.03.05, "Eligibility for Aid to the Aged, Blind, and Disabled (AABD)." The individual's Medicaid eligibility must not be based solely on the requirements found under IDAPA 16.03.05, "Eligibility for Aid to the Aged, Blind, and Disabled (AABD)," Section 802, "Women Diagnosed With Breast or Cervical Cancer." ( )

03. Age. The participant must be age twenty-one (21) or older. ( )

101. MEDICARE/MEDICAID COORDINATED PLAN (MMCP): PARTICIPANT ENROLLMENT.
To receive services under the MMCP, the participant must select and enroll with an MAO. ( )

102. MEDICARE/MEDICAID COORDINATED PLAN (MMCP): PARTICIPANT RESPONSIBILITIES.
Participants who select the MMCP must comply with the following requirements: ( )

01. Selecting the Medicare/Medicaid Coordinated Plan. The participant must contact a participating MAO and request to sign up for the MMCP. Participation in the MMCP begins the month following the month the participant signs an application for the Medicare Advantage Plan that includes MAO-covered services in its "Evidence of Coverage." ( )

02. Compliance with Medicare Advantage Organization Requirements. The participant must comply with all of the requirements of the participating MAO, including the requirement to pay for services provided by out-of-network providers. Out-of-network providers are those who do not have a contract with the MAO with which the participant is enrolled. ( )

03. Notification to the Provider. ( )

a. The participant must present their Medicare Advantage card when seeking any of the services listed in the MAO's "Evidence of Coverage." ( )

b. The participant must present their Medicaid card when seeking any of the Medicaid-covered services in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," or IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." ( )

04. Termination of the Medicare/Medicaid Coordinated Plan. The participant can terminate their MMCP at any time. Coverage will continue until the end of the month in which the termination date falls. The

participant will subsequently be automatically reenrolled in the Medicaid benefit plan, either Basic or Enhanced, in which they were initially enrolled. ( )

103. -- 199. (RESERVED)

MAO CONTRACT REQUIREMENT
(Sections 200-299)

200. CONTRACT WITH MEDICAID.
Any MAO seeking to offer MMCP services must have a contract with the State Medicaid agency. An MAO retains responsibility under the contract for providing benefits, or arranging for benefits to be provided, for individuals entitled to receive medical assistance under Title XIX. ( )

201. -- 299. (RESERVED)

COVERED SERVICES
(Sections 300-301)

300. MEDICARE/MEDICAID COORDINATED PLAN (MMCP): COVERAGE AND LIMITATIONS.
Medicare Advantage Plans and Medicaid are subject to applicable federal managed care requirements that provide participant protections regarding acceptable marketing activities, information regarding cost sharing, quality assurance, grievance systems, and participant rights. ( )

01. MMCP-Covered Services. The MMCP-covered services include the following: ( )

a. MAO-Covered Services. Services covered by the MAO as listed in its "Evidence of Coverage." The MAO may limit or expand the scope of services as defined in the "Evidence of Coverage." MAO-covered services, including Medicare Parts A, B, and D benefits, are detailed in the MMCP contract. ( )

b. Medicaid-Only Services. Services listed under IDAPA 16.03.09, "Medicaid Basic Plan Benefits," or IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," provided by Medicaid providers that are not MAOs. Medicaid may cover additional services that are not included in the MAO's "Evidence of Coverage." ( )

02. Services Excluded from the MMCP. Services not included in the MAO "Evidence of Coverage" or listed under the IDAPA 16.03.09, "Medicaid Basic Plan Benefits," or IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," are not covered under the MMCP. ( )

03. Premiums and Cost-Sharing. The participant will not pay for any premiums or cost-sharing when covered under the MMCP, except as provided under Subsection 102.02 of these rules. ( )

301. MEDICARE/MEDICAID COORDINATED PLAN BENEFITS: PROVIDER REIMBURSEMENT.
Each provider must apply for and be approved as a Medicaid provider under the MMCP before it can be reimbursed. ( )

01. Medicaid-Only Service Providers. Medicaid-only service providers are reimbursed according to the reimbursement methodology in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," related to the Medicaid-only service. Medicaid-only service providers are also subject to the General Provider Provisions under IDAPA 16.03.09, "Medicaid Basic Plan Benefits." ( )

02. Medicare Advantage Organizations. Each MAO will be paid a monthly per member per month (PMPM) rate that is defined in the MAO contract. The MAO is responsible for submitting a monthly invoice to the Department in the Department-specified electronic format. This invoice must include the name of the Medicaid participant, the Medicaid ID number, and the time frame of coverage. The PMPM rate paid to the MAO includes the participant's Medicare premium, any cost-sharing required by the MAO, and the services listed in its "Evidence of Coverage. ( )

302. -- 999. (RESERVED)

000. LEGAL AUTHORITY.
Section 39-4605, Idaho Code, authorizes the Idaho Board of Health and Welfare to adopt rules and standards of certification for Developmental Disabilities Agencies to promote the health and safety of participants. ( )

001. SCOPE.
These rules govern: ( )

01. Certification. The granting, denial, or revocation of certification is based on whether agencies are adequate for the health, safety, and the care, treatment, maintenance, training, and support of participants under these rules. ( )

02. Application. Any person, corporation, or association may *apply* to the Department for approval and certification of the applicant's DDA. *( )*

002. -- 008. (RESERVED)

009. CRIMINAL HISTORY AND BACKGROUND CHECK REQUIREMENTS.

01. Verification of Compliance. The agency must verify that all employees, subcontractors, agents of the agency, and volunteers delivering DDA services have complied with IDAPA 16.05.06, "Criminal History and Background Checks." ( )

02. Reporting Criminal Convictions, Pending Investigations, or Pending Charges. Once an employee, subcontractor, agent of the agency, or volunteer delivering DDA services has received a criminal history clearance, any additional criminal convictions, pending investigations, or pending charges must be reported to the Department as listed in IDAPA 16.05.06, "Criminal History and Background Checks," Subsections 210.01 and 02 by the close of the next business day when the agency learns of the convictions, investigations, or changes. ( )

010. DEFINITIONS -- A THROUGH Z.
For the purposes of this chapter of rules, the following terms apply. ( )

01. ADA. The "Americans with Disabilities Act Accessibility Guidelines," under 28 CFR Part 36, Appendix A. ( )

02. Center-Based Services. Services provided in a location under control of the agency through ownership or lease agreement that meets requirements under Section 400 of these rules. ( )

03. Communicable Disease. A disease that may be transmitted from one (1) person or animal to another person either by direct contact or through an intermediate host, vector, inanimate object, or other means that may result in infection, illness, disability, or death. ( )

04. Deficiency. A determination of non-compliance with a specific rule or part of rule. ( )

05. Department. The Idaho Department of Health and Welfare. ( )

06. Developmental Disability. A developmental disability, defined in Section 66-402, Idaho Code. ( )

07. Developmental Disability Agency (DDA). A business entity, also known as "agency," that meets the definition of a developmental disabilities facility provided in Section 39-4604(3), Idaho Code, that is certified by the Department to provide services to individuals with developmental disabilities under these rules. ( )

08. Health Care Professional. An individual licensed to provide health care within their respective discipline and scope of practice. ( )

09. Implementation Plan. A plan that details how goals from the plan of service will be accomplished. ( )

10. Natural Setting. The environment where an activity or behavior naturally occurs that is typical for peers of the participant's age, such as the home and community, where the participant lives or participates in

activities, and in the service environment indicated. ( )

11. **Participant**. An individual receiving services through a DDA. ( )

12. **Plan of Service**. An initial annual plan, or addendum that identifies all services, supports, or both, if applicable. ( )

13. **Repeat Deficiency**. A violation or deficiency found on a resurvey or revisit to a DDA that was also found during the previous survey or visit. ( )

14. **Survey**. A review conducted by the Department to determine compliance with statutes and rules. ( )

011. -- 074. (RESERVED)

SERVICES PROVIDED BY DEVELOPMENTAL DISABILITIES AGENCIES
Sections 075-099

075. DDA SERVICES.
A DDA provides services that include evaluation, diagnostics, skill development, intervention, and support services that are provided in the community, home, or center to individuals eligible to receive services. ( )

076. -- 099. (RESERVED)

CERTIFICATION REQUIREMENTS FOR DEVELOPMENTAL DISABILITIES AGENCIES
Sections 100-299

100. TYPES OF CERTIFICATES ISSUED.
The Department issues certificates in effect for a period no longer than three (3) years. The types of certificates issued are as follows: ( )

01. **Initial Certificate**. When the Department determines application requirements have been met, an initial certificate is issued for a period of up to six (6) months from the initiation of services. The Department will survey the agency prior to the certificate expiration date to ensure substantial compliance with these rules. When the agency is determined to be in substantial compliance, a one (1) year certificate will be granted. ( )

02. **One-Year Certificate**. A one (1) year certificate is issued by the Department when it determines the agency is in substantial compliance with these rules, following an initial or provisional certificate, or when there may be areas of deficient practice that would impact the agency's ability to provide adequate care. An agency is prohibited from receiving consecutive one (1) year certificates. ( )

03. **Three-Year Certificate**. A three (3) year certificate is issued by the Department when it determines the agency requesting certification is in substantial compliance with these rules. ( )

04. **Provisional Certificate**. When an agency is found to be out of substantial compliance with these rules but does not have deficiencies that jeopardize the health or safety of participants, a provisional certificate may be issued by the Department for up to a six (6) month period. ( )

a. A provisional certificate is issued contingent upon the correction of deficiencies under a plan developed by the agency and approved by the Department. ( )

b. Before the end of the provisional certification period, the Department will determine whether areas of concern have been corrected and whether the agency is in substantial compliance with these rules. ( )

c. If the Department determines the agency is in compliance, a one (1) year certificate will be issued. If the agency is determined to be out of compliance, the certificate will be revoked. ( )

101. APPLICATION FOR INITIAL CERTIFICATION.

01. Certification Required. Before any agency can operate and provide services as a DDA, it must apply for, obtain, and maintain DDA certification from the Department. ( )

02. Department Review Not Guaranteed. The Department may choose not to consider the application of any operator, administrator, or owner of an agency whose license or certification has been revoked until five (5) years have lapsed from the date of revocation. ( )

03. Open Application. An applicant may *apply* up to three (3) times within a three hundred sixty-five (365) day period starting on the date of the first submission. If the application is incomplete upon a third submission, the application will be denied. The applicant may not resubmit an application for six (6) months from the date of the denial notice. *( )*

04. Content of Application for Certification. Application for certification must be submitted to the Department on the Department-approved form with the following information and supporting documents at least sixty (60) days prior to the planned opening: ( )

a. An application form that contains name, address, and telephone number of the agency, type of services to be provided, the geographic service area of the agencies, and the anticipated date for the initiation of services; ( )

b. An accurate and complete statement of all business names of the agency as filed with the Secretary of State, whether it is an assumed business name, partnership, corporation, limited liability company, or other entity that identifies each owner and the management structure of the agency; ( )

c. A statement that the agency will comply with these rules and all other applicable local, state, and federal requirements, including an assurance that the agency complies with pertinent state and federal requirements governing equal opportunity and nondiscrimination; ( )

d. A copy of the proposed organizational chart or plan for staffing of the agency; ( )

e. Written policies and procedures addressing qualifications to meet service delivery requirements including resumes, job descriptions, verification of criminal history clearance, and copies of state licenses and certificates, when applicable; ( )

f. Written policies and procedures for the development and implementation of personnel training to meet the requirements of Section 302 of these rules; ( )

g. Personnel and participant illness policy, communicable disease policy, and other health-related policies and procedures; ( )

h. Written transportation safety policies and procedures required in Section 402 of these rules; ( )

i. Written participant grievance policies and procedures to meet requirements in Section 406 of these rules; ( )

j. Written medication policies and procedures to address medication standards to meet requirements in Section 405 of these rules; ( )

k. Written policies and procedures that address the development of positive behavior supports to meet requirements in Section 510 of these rules; ( )

l. Written policies and procedures for reporting incidents to the adult protection, child protection authority, or both, and to the Department to meet requirements in Section 404 of these rules; ( )

m. A written code of ethics policy reflecting nationally recognized professional standards of practice. The policy must articulate basic values, ethical principles and standards for confidentiality, conflict of interest, exploitation, and inappropriate boundaries in an agency's relationship with participants, relatives, or with other agencies; ( )

n. Complete administrator and supervisor records as required in Subsection 301.04 of these rules; ( )

o. Sample of the following documents: ( )

i. Complete participant record as required in Subsection 301.05 of these rules; ( )

ii. Program billing; ( )

iii. Quality assurance program developed to meet requirements in Section 500 of these rules; ( )

iv. All documents referenced in the application. ( )

p. Any other information requested by the Department for determining the agency's compliance of these rules or the agency's ability to provide the services for which certification is requested; ( )

q. *Written termination policies and procedures under Section 407 of these rules.* *( )*

r. When center-based services are to be provided, the agency must *include the following and meet requirements under* Section 400 of these rules: *( )*

i. Address and telephone number for each service location; *( )*

i*i*. *S*upporting documentation requirements including the ADA checklist, local fire safety inspection, and local building and zoning compliance; *( )*

ii*i*. Written policies and procedures covering the protection of all individuals in the event of fire and other emergencies to include emergency evacuation procedures; and ( )

i*v*. A site review completed by the Department prior to the initiation of center-based services verifying compliance with these rules. ( )

102. -- 109. (RESERVED)

110. DEPARTMENT'S WRITTEN DECISION REGARDING APPLICATION FOR CERTIFICATION.
The Department will provide to the agency, within thirty (30) days of the date the completed application packet is received, a written decision regarding certification. An application is considered completed when all required documents are received and *comply* with these rules. *( )*

111. DENIAL OF AN APPLICATION.
The Department may deny any application. ( )

01. Causes for Denial. Causes for denial of an application may include: ( )

a. The application does not meet rule requirements in Subsection 101.04 of these rules; ( )

b. The applicant, owner, operator, or provider has: ( )

i. Willfully misrepresented or omitted information on the application or other documents pertinent to obtaining a certificate; ( )

ii. Been denied or has had revoked any license or certificate for a DDA, facility, certified family

home, or residential habilitation agency; or ( )

iii. Been convicted of operating an unlicensed or uncertified DDA, facility, certified family home, or residential habilitation agency; ( )

iv. A court order that mandates the applicant must not operate a DDA, facility, certified family home, or residential habilitation agency; ( )

v. An action, either current or in process, against a certificate held by the applicant either in Idaho or any other state or jurisdiction. ( )

02. Before Denial is Final. The Department will advise the individual or provider in writing of the denial and their right and method to appeal. Contested case hearings, including denial and revocation, must be conducted under IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings." ( )

112. -- 114. (RESERVED)

115. CHANGES THAT REQUIRE REPORTING.

01. Notification To The Department. ( )

a. When a change of a certified agency's ownership, administrator, geographic service area, or address is contemplated, the owner or designee must notify the Division of Licensing and Certification in writing through the Department-approved process. ( )

02. Center-Based Services. When an agency plans to provide center-based services in a new physical location, on a temporary or permanent basis, the Department will conduct a site review within thirty (30) days after the agency has relocated. Included with the notification required under this rule, the agency must provide: ( )

a. Evidence of review and approval by the local fire and building authorities, including issuance of occupancy permit; ( )

b. A checklist that verifies compliance with the ADA requirements and Subsection 400.01 of these rules.; and ( )

c. Written policies and procedures covering the protection of all individuals in the event of fire and other emergencies to include emergency evacuation procedures. ( )

03. Updated Certificate Necessary. To continue operation after any such anticipated change, the DDA must receive an updated certificate from the Department that reflects the change(s). An agency that fails to notify the Department of such changes is operating without a certificate. ( )

04. New Ownership. For new ownership, the new owner must submit a new application to the Division of Licensing and Certification through the approved process at least sixty (60) days prior to the proposed date of change under Section 101 of these rules. ( )

116. CERTIFICATE NOT TRANSFERABLE.
The certificate is issued only to the agency named in the application, for the period specified, and for the location indicated in the application, and to the owners or operators as expressed on the application submitted to the Department. The certificate may not be transferred or assigned to any other person or entity. The certificate is nontransferable from one (1) location to another. ( )

117. RESTRICTION ON CERTIFICATION.
A business entity established by a parent for the sole purpose of providing DDA services to their own child cannot be certified as a DDA. ( )

118. AVAILABILITY OF CERTIFICATE.

The certificate must be posted in a conspicuous location in the DDA where it may be seen readily by the participants and members of the public. ( )

119. AGENCIES APPROVED THROUGH NATIONAL ACCREDITATION.
Agencies approved by national accrediting bodies must maintain Department certification requirements in the following: ( )

01. The Current Accreditation Verification or Report. ( )

02. Criminal History Background Check Requirements. See Section 009 of these rules; ( )

03. Personnel Records. See Subsection 301.04 of these rules; ( )

04. General Training Requirements. See Section 302 of these rules; and ( )

05. Facility Standards for Agencies Providing Center-Based Services. See Section 400 of these rules. ( )

120. RENEWAL AND EXPIRATION OF THE CERTIFICATE.

01. Renewal Request. An agency must request renewal of its certificate no less than ninety (90) days before the expiration date of the certificate, to ensure there is no lapse in certification. ( )

02. Expiration Without Timely Request for Renewal. Expiration of a certificate without a timely request for renewal automatically rescinds the agency's certificate to deliver services under these rules. If an agency's certificate is rescinded, a new application for certification must be submitted to deliver services under these rules. ( )

121. -- 299. (RESERVED)

GENERAL AGENCY QUALIFICATIONS AND REQUIREMENTS
Sections 300-399

300. GENERAL STAFFING REQUIREMENTS FOR AGENCIES.
Each DDA is accountable for all operations, policy, procedures, and service elements of the agency. ( )

01. Agency Administrator Qualifications. The agency administrator must have two (2) years of supervisory experience with the population served in an administrative role. An administrator may designate a qualified individual to perform administrative functions on their behalf. ( )

02. Agency Administrator Duties. An agency administrator is accountable for the overall operations of the agency, including ensuring compliance with these rules, overseeing and managing personnel, developing and implementing written policies and procedures, and overseeing the agency's quality assurance program. ( )

03. Supervisor Qualifications. The agency must have documentation that ensures personnel acting in a supervisory capacity meets qualifications as required by the payer source for the service provided. The agency administrator and supervisor can be the same individual if the agency can meet requirements of each duty. ( )

04. Supervisor Duties. ( )

a. Complete or obtain participant assessments and plans according to the authorized plan of service. ( )

b. *P*rovide personnel initial direction, procedural guidance, and *monthly* supervision of work performed to ensure programs are implemented as written and demonstrate the necessary skills to provide the services. *( )*

05. Direct Service Provider (DSP) Qualifications. A person qualified to provide services must meet the qualifications prescribed for the type of services to be rendered and training requirements of Section 302 of these rules. ( )

06. DSP Duties. Perform tasks as assigned under the direction of a supervisor. Tasks may not be assigned that require specific certification or licensure. ( )

07. Parent or Legal Guardian of Participant. A DDA may not hire the parent or legal guardian of a participant to provide services to the parent's or legal guardian's child. ( )

08. Volunteer Workers in a DDA. If volunteers are utilized, the agency must establish written policies and procedures governing the screening, training, and utilization of volunteer workers. If a volunteer is working directly with participants, they must meet the qualifications, training, and record requirements of a DSP. ( )

301. AGENCY RECORD REQUIREMENTS.

01. Accessibility of Agency Records. The agency records required under these rules must be accessible to the Department during normal operations of the agency for the purpose of inspection and copying, with or without prior notification, under Section 39-4605(4), Idaho Code. ( )

02. General Record Requirements. Each agency certified under these rules must maintain accurate, current, and complete administrative, personnel, and participant records for at least five (5) years. ( )

03. Administrative Records. Records must include: ( )

a. An organizational chart; ( )

b. Legal authority identified in organizational bylaws or other documentation of legal authority of ownership; and ( )

c. Fiscal records verifying service delivery prior to request for payment. ( )

04. Personnel Records. Records must include: ( )

a. Name, current address, and phone number of the employee; ( )

b. Documentation supporting qualifications to carry out assigned duties; ( )

c. Verification of satisfactory completion of criminal history checks under IDAPA 16.05.06, "Criminal History and Background Checks." ( )

d. Date of Employment; ( )

e. Documentation of training under Section 302 of these rules; ( )

f. Evidence of current age-appropriate CPR and first aid certifications; ( )

g. Current assistance with medications certification, if applicable; ( )

h. Other current certifications, as applicable; ( )

i. Obtain and maintain documentation of licenses and certifications for drivers and vehicles under public transportation laws, regulations, and ordinances that apply to the agency to conduct business and to operate the types of vehicles used to transport participants; ( )

j. Continuously maintain liability insurance that covers all passengers and meets the minimum liability insurance requirements under Idaho law. The agency will ensure that liability insurance coverage is carried to

cover circumstances when an employee transports participants in their personal vehicle; and ( )

k. Date and reason for termination, if applicable. ( )

05. Participant Records Requirements. Each agency must have an organized participant records system to provide past and current information and to safeguard participant confidentiality under these rules that contain the following: ( )

a. Clear documentation of the date, time, duration, and type of service with credentialed signature and corresponding initials of the individual providing the service, for each service provided. ( )

b. Profile sheet containing the *following* information*:* *( )*

i. *C*urrent living arrangement; *( )*

ii. *Complete address and contact information for the participant, guardian (if applicable), emergency contacts, and physician;* *( )*

iii. *Current medications and allergies; and* *( )*

iv. *Special dietary or medical needs.* *( )*

c. Notification of rights, access to grievance procedures, and the names, addresses, and telephone numbers of protection and advocacy services; ( )

d. Authorized plan of service for the participant; ( )

e. Assessments from a health care professional, if relevant or needed for service provision due to medical or behavioral condition; ( )

f. An evaluation to be completed by a qualified supervisor or obtained by the agency, if applicable; ( )

g. Implementation plans, as applicable; ( )

h. Written documentation that identifies the participant's progress toward goals defined on their plan of service; and ( )

i. Incident reports under Section 404 of these rules. ( )

302. GENERAL TRAINING REQUIREMENTS.
Each DDA must ensure that all training of staff is completed as follows: ( )

01. Documentation. Documentation of training retained and available for review by the Department to include the following: ( )

a. Direct service staff receiving the training; ( )

b. Individual conducting the training; ( )

c. Name of the participant, if applicable; ( )

d. Description of the content trained; and ( )

e. Date and duration of the training ( )

02. Initial and Annual Training. Prior to working with participants and annually thereafter, direct

service providers are to complete: ( )

a. Safety training to include location based structural and environmental risks, and natural disasters; ( )

b. Abuse, neglect, and exploitation training covering definitions and reporting requirements; ( )

c. Agency adopted ethical standards; ( )

d. Participant's rights, advocacy resources, and confidentiality; and ( )

e. For center-based services, fire training to include policies and procedures, fire drills, and emergency evacuation plans. ( )

03. Participant-Sufficient Training. ( )

a. Prior to working alone with participants, DSPs will receive basic introductory review of participant information to provide services and supports, to include the following: ( )

i. Participant's profile sheet; ( )

ii. Correct and appropriate use of assistive technology used by participants; and ( )

iii. Special, medical, or health requirements. ( )

b. Supervisor will provide or ensure training provided by a designee on the following, as applicable: ( )

i. Instructional techniques including correct and consistent implementation of the participant's implementation plan or plan of service; ( )

ii. Managing behaviors including techniques and strategies for teaching adaptive behaviors; and ( )

iii. Accurate record keeping and data collection procedures; ( )

04. Certification Training. ( )

a. Prior to working alone with participants, personnel receive age-appropriate certification in CPR and first aid, and maintain current certification thereafter; and ( )

b. Personnel assisting with participant medications successfully complete the assistance with medications training course available through an Idaho college or university; ( )

c. Personnel that implement physical restraints receive and maintain certification in a nationally recognized physical intervention strategy. ( )

05. Ongoing Training. The supervisor provides and ensures ongoing training of DSPs when there are changes that impact services or supports including: ( )

a. Participant’s plan of service and corresponding implementation plans, as applicable; and ( )

b. Participant’s physical, medical, and behavioral status. ( )

303. -- 399. (RESERVED)

FACILITY, SAFETY, AND HEALTH STANDARDS
Sections 400-499

400. FACILITY STANDARDS FOR AGENCIES PROVIDING CENTER-BASED SERVICES.
When an agency is providing center-based services they must meet the following: ( )

01. Accessibility. Agencies designated under these rules must be responsive to the needs of individuals receiving services and accessible to individuals with disabilities as defined in Section 504 of the federal Rehabilitation Act, the ADA, and the uniform federal accessibility standard. The DDA must submit a completed checklist to the Department with the application for certification to verify compliance with the ADA requirements. ( )

02. Environment. The facilities of the agency must be designed and equipped to meet the needs of each participant including factors such as sufficient space, equipment, lighting, and noise control. ( )

03. Fire and Safety Standards. Center-based locations must: ( )

a. Meet all local and state codes concerning fire and life safety that are applicable to a DDA through annual inspection by the local fire authority or Idaho State Fire Marshal's office as required by local, city, or county ordinances, documented with inspection results and corrective actions taken on violations cited; ( )

b. Provide suitable fences, guards, or railings to protect participants on the premises where natural or man-made hazards are present; ( )

c. Remove the accumulation of weeds, trash, and rubbish; ( )

d. Limit and use of portable heating devices that have heating elements to not more than two hundred twelve degrees Fahrenheit (212°F), certified by Underwriters Laboratories, and approved by the local fire or building authority; ( )

e. Properly label and store all hazardous or toxic substances under lock and key; ( )

f. Maintain water temperatures in areas accessed by participants at one hundred twenty degrees Fahrenheit (120°F) or below; and ( )

g. Have a telephone available on the premises with emergency numbers near the telephone for use in the event of an emergency. ( )

04. Evacuation Plans. Evacuation plans must be posted throughout the center and indicate point of orientation, location of all fire extinguishers, location of all fire exits, and designated meeting area outside of the building. ( )

05. Fire Drills. The DDA must conduct and document quarterly fire drills. and meet the following: ( )

a. At least two (2) times each year these fire drills will include complete evacuation of the building; and ( )

b. A brief summary of each fire drill conducted, written, and maintained on file indicating the date, time, and duration the drill occurred, participants and personnel participating, problems encountered, and corrective action(s) taken. ( )

06. Food Safety and Storage. ( )

a. When the agency provides food service for participants and meets the definition of a “food establishment,” in Section 39-1602, Idaho Code, the agency must comply with IDAPA 16.02.19, “Idaho Food Code.” Compliance is verified through inspection by the local District Health Department. ( )

b. Refrigerators and freezers used to store participant foods will be maintained at or below forty-one degrees Fahrenheit (41°F), and ten degrees Fahrenheit (10°F) respectively, and in good repair. ( )

c. When medicines requiring refrigeration are stored in a food refrigerator, medicines must be stored in a package and kept inside a covered, leak-proof container that is clearly identified as a container for the storage of medicines. ( )

07. Housekeeping and Maintenance Services. The agency must meet the following: ( )

a. Maintain the interior and exterior of the center be maintained in a clean, safe, and orderly manner and kept in good repair; ( )

b. Not use deodorizers to cover odors caused by poor housekeeping or unsanitary conditions; ( )

c. Ensure the agency is free from infestations of insects, rodents, and other pests; and ( )

d. Maintain the temperature and humidity of the agency within a normal comfort range by heating, air conditioning, or other means. ( )

401. SETTING REQUIREMENTS.
The service setting must meet the needs of the participant as follows: ( )

01. Accessibility. Be accessible, safe, and appropriate. ( )

02. Environment. Be assessed to meet the needs of each participant including factors such as sufficient space, equipment, lighting, and noise control. ( )

03. Promote Inclusion. Promote the participant's inclusion in the natural setting. ( )

402. TRANSPORTATION POLICY.
Each agency must develop and implement transportation policies that include the following: ( )

01. Preventative Maintenance Program. Establish a preventive maintenance program for each agency-owned or leased vehicle, including vehicle inspections and other regular maintenance to ensure participant safety. ( )

02. Adequate Staffing. Ensure adequate staffing for participants who require additional supervision during transportation for the safety of all vehicle occupants. ( )

03. Licenses, Certifications, and Insurance for Drivers and Vehicles. Ensure adequate insurance coverage to protect the individuals utilizing agency transportation. This may include commercial vehicle insurance and employee vehicle insurance coverage. Obtain and maintain licenses, certifications, and insurance for drivers and vehicles required by public transportation laws, regulations, and ordinances. ( )

04. Laws, Rules, and Regulations. Adhere to all laws, rules, and regulations applicable to drivers and types of vehicles used. ( )

403. HEALTH POLICY.
Each DDA must develop and implement policies and procedures that: ( )

01. Ensure Personnel are Disease-Free. Describe how the agency will ensure that personnel are free from communicable disease; ( )

02. Protect Participants. Describe how the agency will protect participants from exposure to individuals exhibiting symptoms of illness. ( )

03. Medication Standards. Implement medication requirements under Section 405 of these rules. ( )

04. Address Needs of Participants. Address any special medical or health care needs of participants as relevant to service delivery. ( )

404. AGENCY REPORTING POLICY.
Each agency must develop and implement written policies and procedures outlining how the agency will document reporting and other communications for the following requirements: ( )

01. Incident Reports. Document all participant incidents that occur during service delivery and affect the ability to participate in services. Each report will document that the participant's legal guardian has been notified within twenty-four (24) hours. A documented review by the agency of all incident reports will be completed at least annually with written recommendations and retained by the agency for five (5) years. ( )

02. Reporting Requirements. Any agency employee, contractor, or volunteer will report all suspected incidents and allegations of mistreatment, abuse, neglect, or exploitation to the administrator, adult or child protection authorities, or law enforcement under Sections 39-5303 and 16-1605, Idaho Code. The agency will protect the participant from the possibility of abuse during services while the investigation is in progress. The administrator will ensure the events and the agency response to the events are documented in the participant record. ( )

03. Reporting Incidents to the Department. Through a Department-approved process, the agency administrator or designee must notify the Division of Licensing and Certification by the close of the next business day of any significant incidents that occur to the participant during service hours including: ( )

a. Death; ( )

b. Hospitalization; ( )

c. Participant’s arrest or incarceration; or ( )

d. When staff actions result in a report to protective or legal authorities. ( )

405. MEDICATION POLICY.
Each agency must develop and implement written medication policies and procedures that outline in detail how the agency will ensure appropriate handling and safeguarding of medications. If the agency chooses to assist participants with medications, the agency must also develop and implement specific policies and procedures to ensure assistance is safe and delivered by qualified, fully-trained personnel. ( )

01. Handling of Participant's Medication. The agency must: ( )

a. Maintain that medication is in the original pharmacy-dispensed container, original over-the-counter container, or placed in a unit container (by a licensed nurse) appropriately labeled with the name of the medication, dosage, time to be taken, route of administration, and any special instructions. Each medication will be packaged separately, unless in a Mediset, blister pack, or similar system. ( )

b. Maintain evidence of the written or verbal order for the medication from the health care professional in the participant's record. Medisets filled and labeled by a pharmacist or licensed nurse can serve as written evidence of the order. An original prescription bottle labeled by a pharmacist describing the order and instructions for use can also serve as written evidence of an order from the health care professional. ( )

c. Be responsible to safeguard the participant's medications while the participant is at the agency or in the community. ( )

d. Not retain medications that are no longer used by the participant for longer than thirty (30) calendar days. ( )

02. Self-Administration of Medication. Written approval is required when the participant is responsible for administering their own medication without assistance, stating the participant's health care professional has evaluated the participant's ability to self-administer medication, and has found that the participant: ( )

a. Understands the purpose of the medication; ( )

b. Knows the appropriate dosage and times to take the medication; ( )

c. Understands expected effects, adverse reactions or side effects, and action to take in an emergency; and ( )

d. Is capable of taking the medication without assistance. ( )

03. Assistance with Medication. An agency may assist participants with medications; however, only a health care professional may administer medications. Prior to unlicensed agency personnel assisting participants with medication, the following conditions must be in place: ( )

a. Personnel assisting with participant medications successfully complete the assistance with medications training course available through an Idaho college or university; ( )

b. The participant's health condition is stable; ( )

c. The participant's health status does not require nursing assessment before receiving the medication or nursing assessment of the therapeutic or side effects after the medication is taken; ( )

d. The medication is in the original pharmacy-dispensed container with proper label and directions, in an original over-the-counter container, or the medication has been placed in a unit container by a licensed nurse. Proper measuring devices will be available for liquid medication that is poured from a pharmacy-dispensed container; ( )

e. Written and oral instructions from a physician, practitioner of the healing arts, health care professional, pharmacist, or nurse concerning the reason(s) for the medication, the dosage, expected effects, adverse reactions, side effects, and action to take in an emergency have been reviewed. ( )

f. Written instructions are in place that outline required documentation of assistance including the following: ( )

i. Name of the participant; ( )

ii. Name and dosage of the medication given; ( )

iii. Time and date the medication was given; ( )

iv. Initials of individual assisting with medication that can be verified with matching signature; ( )

v. Documentation of medication errors to include any dose not taken, incorrect medication taken, overdose occurrence, or side effects observed; ( )

vi. Health care professional contacted to determine the level of threat to the individual's health and determine the treatment required, if any; and ( )

vii. Documentation of corrective action taken and results. ( )

g. Procedures for disposal or destruction of medications must be documented and consistent with procedures outlined in the assistance with medication training course. ( )

406. GRIEVANCE POLICY.
Each DDA must develop and implement written grievance policies and procedures that outline in detail the agency's grievance policy. The policy must include how the agency will ensure participant and guardian are aware of the process, how to file a grievance, and receive a response from the agency in fourteen (14) days or less. ( )

407. TERMINATION PROCEDURES.
The agency must develop and implement termination policies and procedures ensuring thirty (30) day written notice and grievance procedures are provided to the participant and the guardian, if applicable. The participant is entitled to appeal the termination utilizing the agency's grievance process regardless of the reason for termination. Thirty (30) days is not required if: ( )

***01. Written Termination Agreement**. Both parties agree in writing to the termination conditions.* ( )

***02. Emergency Termination of Services**. Emergency conditions warranting termination of services include:* ( )

***a.** A change in the participant's condition resulting in an increased level of care beyond the scope of the agency's ability to provide care for the participant.* ( )

***b.** Significant behavior concerns including physical aggression by the participant that puts the health and safety of the agency's staff or other participants in jeopardy and behavior management techniques have failed to reduce the risk to staff or others.* ( )

40*8*. -- 499. (RESERVED)

QUALITY ASSURANCE, PARTICIPANT RIGHTS, REQUIRED POLICIES, ETC.
Sections 500-599

500. REQUIREMENTS FOR AN AGENCY'S QUALITY ASSURANCE PROGRAM.
Each agency must develop and implement a quality assurance program that identifies any corrections needed, a time frame for those corrections, and ensures the following: ( )

01. Measurable Outcomes. Produces high quality services that maintain interests, needs, and current standards of practice consistent with individual choices. This includes: ( )

a. Review of participant records, for content and effectiveness of programs; and ( )

b. A method for gathering and assessing participant satisfaction; ( )

02. Available Personnel and Resources. Sufficient personnel and material resources are available to meet the needs of each individual served to include a review of: ( )

a. Personnel records for content. ( )

b. Supervision and training data to ensure there are personnel who have the skills necessary to provide the service. ( )

c. Work scheduled to assure coverage. ( )

03. Health and Safety Supports. The overall agency practices are within rule and support participant health and safety to include a review of: ( )

a. Code of ethics, identification of violations, and implementation of an internal plan of correction; ( )

b. Policy and procedure manual to specify date and content of revisions made; ( )

c. Center-based facilities, if applicable, to ensure compliance with these rules. ( )

501. -- 504. (RESERVED)

505. PARTICIPANT RIGHTS.
Each agency must ensure the rights provided under Section 66-412, Idaho Code, as well as the additional rights listed below for each participant receiving DDA services. ( )

01. Participant Rights Provided Under Idaho Code. Provide the following rights for participants: ( )

a. Humane care and treatment; ( )

b. Not be put in isolation; ( )

c. Be free of restraints, unless necessary for the safety of that individual or for the safety of others; ( )

d. Be free of mental and physical abuse; ( )

e. Voice grievances and recommend changes in policies or services being offered; ( )

f. Practice their own religion; ( )

g. Wear their own clothing and retain and use personal possessions; ( )

h. Be informed of their medical and habilitative condition, of services available at the agency, and the charges for the services; ( )

i. Reasonable access to all records concerning themselves; ( )

j. Refuse services; ( )

k. Exercise all civil and all other rights established by law, unless limited by prior court order; ( )

l. Privacy and confidentiality; ( )

m. Receive a response from the agency to any request made within fourteen (14) business days;( )

n. Receive services that enhance the participant's social image, personal competencies, and whenever possible, promote inclusion in the community; ( )

o. Refuse to perform services for the agency. If the participant is hired to perform services for the agency the wage paid must be consistent with state and federal law; and ( )

p. Review the results of the most recent survey conducted by the Department and the accompanying plan of correction. ( )

02. Method of Informing Participants of Their Rights. Each agency must ensure and document that each participant receiving services is informed of their rights in the following manner: ( )

a. Upon initiation of services, provide each participant and their parent or guardian, where applicable, with a packet of information that outlines rights, access to grievance procedures, and the names, addresses, and telephone numbers of protection and advocacy services. This packet must be written in easily understood terms. ( )

b. When providing center-based services, prominently post a list of the rights contained in this chapter. ( )

c. Provide each participant and their parent or guardian, where applicable, with a verbal explanation of their rights in a manner that will best promote individual understanding of these rights. ( )

506. -- 509. (RESERVED)

510. POLICIES AND PROCEDURES REGARDING DEVELOPMENT OF RESTRICTIVE INTERVENTIONS.
Each agency must develop and implement written policies and procedures that address restrictive interventions to include the following: ( )

01. Protected Rights. Ensure the safety, welfare, and human and civil rights of participants are adequately protected. ( )

02. Appropriate Use of Interventions. Ensure interventions used to manage participants' maladaptive behavior are never used: ( )

a. For disciplinary purposes; ( )

b. For the convenience of personnel; ( )

c. As a substitute for a needed training program; or ( )

d. By untrained or unqualified personnel. ( )

03. Use of Restraint on Participants. No restraints, other than physical restraint in an emergency, must be used on participants prior to the use of positive behavior interventions. The following requirements apply to the use of physical restraint on participants by qualified personnel. ( )

a. Physical restraint may be used in an isolated emergency to prevent injury to the participant or others and must be documented and reviewed by the DSP and the supervisor. Documentation must include a debrief with the participant, guardian, and DSP involved focusing on strategies to avoid the occurrence of future physical restraints. ( )

b. Physical restraint may be used in a non-emergency setting when a written behavior program is developed by a supervisor, the participant, and their guardian, if applicable, and approved by a health care professional. Informed consent is required by the participant and parent or legal guardian. ( )

04. Written Informed Consent. If the program contains restrictive or aversive components, an individual working within the scope of their license or certification must also review and approve, in writing, the plan prior to implementation. The participant, parent or legal guardian, if applicable, must also consent prior to implementation. When programs implemented by the agency are developed by another service provider, the agency must obtain a copy of these reviews and approvals. ( )

511. -- 599. (RESERVED)

RULE ENFORCEMENT PROCESS AND REMEDIES
SECTIONS 600-699

600. ENFORCEMENT PROCESS.
The Department may impose a remedy when it determines an agency has not met the requirements in these rules. ( )

01. Determination of Remedy. In determining which remedy to impose, the Department will consider the agency's compliance history, change of ownership, the number of deficiencies, the scope and severity of the

deficiencies, and the potential risk to participants. Subject to these considerations, any one or combination of the following remedies, is subject under these rules for notice and appeal: ( )

a. Require the agency to submit a plan of correction approved in writing by the Department; ( )

b. Issue a provisional certificate with a specific date for correcting deficient practices; ( )

c. Ban enrollment of all participants with specified diagnoses; ( )

d. Ban any new enrollment of participants; ( )

e. Summarily suspend the certificate and transfer participants; or ( )

f. Revoke the agency's certificate. ( )

02. Immediate Jeopardy. If the Department finds an agency's deficiency immediately jeopardizes the health or safety of its participants, the Department may summarily suspend the agency's certificate. ( )

03. Repeat Deficiency. If the Department finds a repeat deficiency in an agency, it may impose any of the remedies listed in Subsection 600.01 of this rule, The Department may monitor the agency on an as-needed basis, until the agency has demonstrated to the Department's satisfaction that it is in compliance with these rules. If so, then certification will be granted. If not, the certificate will be denied or revoked. ( )

04. Failure to Comply. The Department may impose one (1) or more of the remedies specified in Subsection 600.01 of this rule if: ( )

a. The agency has not complied with any requirement in these rules within three (3) months after the date it was notified of its failure to comply with such requirement; or ( )

b. The agency has failed to correct the deficiencies stated in the agency's accepted plan of correction and as verified by the Department, via resurveys. ( )

601. REVOCATION OF CERTIFICATE.

01. Revocation of the Agency's Certificate. The Department may revoke a agency's certificate when persuaded by the preponderance of the evidence that the agency is not in substantial compliance with the requirements in these rules. The certificate is the property of the state and must be returned to the state if it is revoked or suspended. ( )

02. Causes for Revocation of the Certificate. The Department may revoke any agency's certificate for any of the following causes: ( )

a. The certificate holder has willfully misrepresented or omitted information on the application for certification or other documents pertinent to obtaining a certificate; ( )

b. Conditions exist in the agency that endanger the health or safety of any participant; ( )

c. Any act adversely affecting the welfare of participants is being permitted, performed, or aided and abetted by the person(s) supervising the provision of services in the agency. Such acts include neglect, physical abuse, mental abuse, emotional abuse, violation of civil rights, or exploitation; ( )

d. The provider has demonstrated or exhibited a lack of sound judgment that jeopardizes the health, safety, or well-being of participants; ( )

e. The agency has failed to comply with any of the conditions of a provisional certificate; ( )

f. The agency has one (1) or more major deficiencies. A major deficiency is a deficiency that

endangers the health, safety, or welfare of any participant; ( )

g. An accumulation of minor deficiencies that, when considered as a whole, indicate the agency is not in substantial compliance with these rules; ( )

h. Repeat deficiencies by the agency of any requirement of these rules or of the Idaho Code; ( )

i. The agency lacks adequate personnel, as required by these rules or as directed by the Department, to properly care for the number and type of participants served at the agency; ( )

j. The agency is not in substantial compliance with the provisions for services required in these rules or with the participants' rights under Section 505 of these rules; ( )

k. The certificate holder refuses to allow the Department or protection and advocacy agencies full access to the agency environment, agency records, or the participants. ( )

602. NOTICE OF ENFORCEMENT REMEDY.
The Department will notify the following of the imposition of any enforcement remedy on a agency: ( )

01. Notice to Agency. The Department will notify the agency in writing, transmitted in a manner that will reasonably ensure timely receipt. ( )

02. Notice to Public. The Department will notify the public by sending the agency printed notices to post. The agency must post all the notices on the premises of the agency in plain sight in public areas where they will readily be seen by participants and their representatives, including exits and common areas and with the notices remaining in place until all enforcement remedies have been officially removed by the Department. ( )

603. -- 999. (RESERVED)

000. LEGAL AUTHORITY.
In accordance with Section 31-3503C, Idaho Code, the Idaho Legislature has authorized the Department of Health and Welfare to adopt and enforce rules governing requests for Medicaid eligibility determination for persons who may be medically indigent. ( )

001. TITLE AND SCOPE.

01. Title. These rules are titled IDAPA 16.03.24, "The Medically Indigent Program." ( )

02. Scope. ( )

a. The Idaho Legislature has declared that the County Medically Indigent Program and the Catastrophic Health Care Cost Program are payers of last resort. These programs are only a partial solution to the health care costs of Idaho's medically indigent citizens. Therefore, hospitals, providers, applicants, and third-party applicants seeking financial assistance under the County Medically Indigent Program and the Catastrophic Health Care Cost Program are subject to the limitations and requirements in this chapter of rules. ( )

b. In accordance with Section 31-3503E(7), Idaho Code, the denial of Medicaid eligibility is not a determination of medical indigency under the County Medically Indigent Program or the Catastrophic Health Care Cost Program. Title 31, Chapter 35, Idaho Code, provides that under the County Medically Indigent Program and the Catastrophic Health Care Cost Program eligibility for financial assistance will be determined by the respective counties and the Board. The respective counties and the Board may, limit or prioritize eligibility for financial assistance based upon such factors as availability of funding, degree of financial need, degree of clinical need, or other factors. ( )

c. In accordance with Title 31, Chapter 35, Idaho Code, these rules provide for and establish policies, procedures, requirements, and appeal processes applicable to requests for Medicaid eligibility determination for persons who may be medically indigent. This chapter is not intended to, and does not establish an entitlement for or to receive financial assistance under Title 31, Chapter 35, Idaho Code. ( )

d. Individuals who may be eligible for Medicaid must comply with requirements in Title XIX and Title XXI of the Social Security Act, and the following Department rules: ( )

i. IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children." ( )

ii. IDAPA 16.03.05, "Eligibility for the Aged, Blind, and Disabled (AABD)." ( )

iii. IDAPA 16.03.06, "Refugee Medical Assistance." ( )

002. -- 005. (RESERVED)

006. CONFIDENTIALITY OF RECORDS AND PUBLIC RECORDS.

01. Confidential Records. The use or disclosure of records or information covered by these rules must comply with IDAPA 16.05.01, "Use and Disclosure of Department Records." ( )

02. Public Records. The Department will comply with Title 74, Chapter 1, Idaho Code, when requests for the examination and copying of public records are made. Unless otherwise exempted, all public records in the custody of the Department are subject to disclosure. ( )

03. Authorization for Disclosure. An application for financial assistance and request for Medicaid eligibility determination constitutes authorization for hospitals, providers, the Board, the Department, and the respective counties of the State of Idaho to copy, transmit, share, and exchange information pertaining to an applicant's health and finances for the purpose of determining Medicaid eligibility or medical indigency. ( )

007. -- 009. (RESERVED)

010. DEFINITIONS.
For the purposes of this chapter of rules, the following terms apply. ( )

01. Application. An application for financial assistance under Section 31-3504, Idaho Code, and the uniform form used for the initial review and the Department's Medicaid eligibility determination under Section 31-

3503E, Idaho Code. An application under Title 31, Chapter 35, Idaho Code, for financial assistance is not an application for Medicaid. ( )

02. **Clerk**. The clerk of the respective counties or their designee. ( )

03. **Counties**. The respective counties described in Title 31, Chapter 1, Idaho Code. ( )

04. **Department**. The Idaho Department of Health and Welfare. ( )

05. **HIPAA**. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) under 42 USC Section 12204, and federal regulations at 45 CFR Parts 160, 162, and 164. ( )

06. **Hospital**. A facility as defined in IDAPA 16.03.14, "Hospitals." ( )

07. **Medicaid**. The federally funded program for medical care (Title XIX, Social Security Act) also known as Idaho's Healthcare Assistance Program. ( )

08. **Obligated Person**. The person or persons who are legally responsible for an applicant. ( )

09. **Third-Party Applicant**. A person other than an obligated person who completes, signs, and files an application on behalf of a patient. ( )

011. -- 109. **(RESERVED)**

110. REQUESTS FOR MEDICAID ELIGIBILITY DETERMINATION.
Requests for Medicaid eligibility determination for persons who may be medically indigent may only be accessed by a hospital or a county through a request for Medicaid eligibility determination addressed to the Department. By signing a request for Medicaid eligibility determination, each hospital or county requesting a Medicaid eligibility determination agrees to comply with these rules. ( )

01. **Form of Request**. Each hospital or county requesting a Medicaid eligibility determination under these rules must apply to the Department on a form provided by the Department and must provide all information required by the Department. ( )

02. **Filing Request**. Each request for Medicaid eligibility determination submitted to the Department under these rules must be signed by an authorized representative of the hospital or the county. ( )

03. **Application for Financial Assistance Required**. A completed and signed application for financial assistance under Title 31, Chapter 35, Idaho Code, must be submitted and transmitted to the Department along with the request for Medicaid eligibility determination. ( )

04. **Other Information as Requested**. Each hospital or county requesting a Medicaid eligibility determination by the Department under these rules must provide all other information that may be requested by the Department for the proper administration and enforcement of the provisions of these rules. ( )

05. **Cooperation of Applicant, Third-Party Applicant, and Obligated Person**. Each applicant, third-party applicant, and obligated person must cooperate with the Department and provide documentation necessary to complete the Department's determination of Medicaid eligibility. ( )

111. -- 129. **(RESERVED)**

130. ELIGIBILITY DETERMINATION.
Each request for Medicaid eligibility determination submitted to the Department under this chapter of rules will be processed by the Department in accordance with the following rules: ( )

01. **Medicaid**. IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children." ( )

02. **AABD**. IDAPA 16.03.05, "Eligibility for the Aged, Blind and Disabled (AABD)." ( )

03. **Refugee**. IDAPA 16.03.06, "Refugee Medical Assistance." ( )

04. **Time Limits on Determinations**. The Department will process each request for Medicaid eligibility determination within forty-five (45) days of receiving the request, unless prevented by events beyond the Department's control. ( )

131. -- 139. (RESERVED)

140. NOTICE OF DECISION ON ELIGIBILITY FOR MEDICAID.

01. **Denial on Request Submitted by a Hospital**. If the Department determines that an applicant is not eligible for Medicaid, the Department will promptly notify the applicant and the hospital of its determination. The Department will transmit a copy of its determination and a copy of the application to the respective county clerk. The clerk will treat the copy of the Department's determination and the copy of the application as an application for financial assistance under Title 31, Chapter 35, Idaho Code. Denial of Medicaid eligibility is not a determination of medical indigency or eligibility for financial assistance under the county Medically Indigent Program or the Catastrophic Health Care Cost Program. ( )

02. **Denial on Request Submitted by a County**. If the Department determines that an applicant is not eligible for Medicaid, the Department will promptly notify the applicant and the respective county clerk of its determination. Denial of Medicaid eligibility is not a determination of medical indigency or eligibility for financial assistance under the County Medically Indigent Program or the Catastrophic Health Care Cost Program. ( )

03. **Approval of Medicaid Eligibility**. If the Department determines that an applicant is eligible for Medicaid, the Department will act on the request and application as an application for Medicaid and notify the applicant, according to provisions in IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children," and IDAPA 16.03.05, "Eligibility for Aid to the Aged, Blind, and Disabled (AABD). ( )

141. -- 149. (RESERVED)

150. ADDITIONAL DUTIES AND RESPONSIBILITIES OF HOSPITALS AND COUNTIES.

01. **Additional Duties and Responsibilities**. Each hospital or respective county submitting an application and request for Medicaid eligibility determination under these rules must: ( )

a. Cooperate with the Department, the Board, and the respective counties of the state and contractors retained by the Board or the respective County Commissioners. ( )

b. Assist applicants in completing an application form and request for Medicaid eligibility determination. ( )

02. **Comply with Confidentiality Laws and Rules**. Each hospital or respective county must comply with IDAPA 16.05.01, "Use and Disclosure of Department Records," and all applicable state and federal laws, rules, and regulations pertaining to the confidentiality of, and the disclosure of, information and records. ( )

03. **Comply with HIPPA**. Each hospital must comply with the Health Insurance Portability and Accountability Act (HIPAA). ( )

151. -- 999. (RESERVED)

16.03.25 – IDAHO MEDICAID PROMOTING INTEROPERABILITY (PI) PROGRAM

000. LEGAL AUTHORITY.

01. Rulemaking Authority. Under Sections 56-202, 56-203, and 56-1054, Idaho Code, the Department has the authority to adopt rules regarding the Idaho Medicaid Promoting Interoperability (PI) Program. This program was formerly known as the "Idaho Medicaid Electronic Health Record (EHR) Incentive Program." ( )

02. General Administrative Authority. The American Reinvestment and Recovery Act of 2009 (ARRA), Section 4201, and 42 CFR Part 495, provide the basic authority for administration of this federal program. ( )

001. TITLE AND SCOPE.

01. Title. These rules are titled IDAPA 16.03.25, "Idaho Medicaid Promoting Interoperability (PI) Program." ( )

02. Scope. These rules: ( )

a. Establish the Medicaid Electronic Health Record (EHR) Incentive Program for Idaho covered under 42 CFR Part 495. ( )

b. Provide the Medicaid EHR Incentive Program criteria for participation of qualified eligible professionals and hospitals that adopt, implement, or upgrade to become meaningful users of certified electronic health record systems in accordance with the American Recovery and Reinvestment Act of 2009 (ARRA), Section 4201. ( )

c. Provide for the audit of providers receiving incentive payments. ( )

002. WRITTEN INTERPRETATIONS.

This agency may have written statements that pertain to the interpretations of the rules of this chapter. These documents are available for public inspection. ( )

003. -- 009. (RESERVED)

010. DEFINITIONS AND ABBREVIATIONS.

For the purposes of this chapter of rules the following terms apply: ( )

01. Acute Care Hospital. A health care facility, including a critical access hospital, with a CMS Certification Number that ends in 0001-0879 or 1300-1399. An acute care hospital: ( )

a. Must have ten percent (10%) Medicaid patient discharges; ( )

b. Is a primary health care facility where the average length of patient stay is twenty-five (25) days or fewer. ( )

02. Adopt, Implement, or Upgrade (AIU). ( )

a. Acquire, purchase, or secure access to certified EHR technology; ( )

b. Install or commence utilization of certified EHR technology capable of meeting meaningful use requirements; or ( )

c. Expand the available functionality of certified EHR technology capable of meeting meaningful use requirements at the practice site, including staffing, maintenance, and training, or upgrade from existing EHR technology to certified EHR technology. ( )

03. Attestation. Signature as a witness by each professional or hospital who applies to the PI Program signifying the information they have provided is true and genuine and affirms that they meet the incentive payment eligibility criteria. ( )

04. Border States. The border states for Idaho are: Washington, Oregon, Nevada, Utah, Wyoming, and

Montana. ( )

05. Certified EHR Technology. As defined in 42 CFR Section 495.4 and 45 CFR Section 170.102, in accordance with the Office of the National Coordinator for Health Information Technology EHR certification criteria. ( )

06. Children's Hospital. As referenced in 42 CFR Section 495.302, a separately certified hospital, either freestanding or hospital-within-hospital, that has a CMS Certification Number that ends in 3300–3399 and predominantly treats individuals under twenty-one (21) years of age. ( )

07. CMS. Centers for Medicare and Medicaid Services. ( )

08. Critical Access Hospital (CAH). A small, generally geographically remote facility that provides outpatient and inpatient hospital services to people in rural areas. The designation was established by law, for special payments under the Medicare program. A critical access hospital: ( )

a. Is located in a rural area and provides 24-hour emergency services; ( )

b. Has an average length-of-stay for its patients of ninety-six (96) hours or less; ( )

c. Is located more than thirty-five (35) miles (or more than fifteen (15) miles in areas with mountainous terrain) from the nearest hospital or is designated by the State as a "necessary provider"; and ( )

d. Has no more than twenty-five (25) beds. ( )

09. CY. Calendar Year. ( )

10. Dentist. A person who meets all the applicable requirements to practice as a licensed dentist under IDAPA 24.31.01, "Rules of the Idaho State Board of Dentistry." ( )

11. Department. The Idaho Department of Health and Welfare. ( )

12. EHR. Electronic Health Record. ( )

13. Eligible Hospital. An acute care hospital with at least ten percent (10%) Medicaid patient volume or a children's hospital. ( )

14. Eligible Professional. A physician, dentist, nurse practitioner (including a nurse-midwife nurse practitioner), or a physician assistant practicing in a Federally Qualified Health Center (FQHC) or a Rural Health Clinic (RHC) that is led by a physician assistant and meets patient volume requirements described in 42 CFR Section 495.306. ( )

15. Eligible Provider. Eligible hospital or eligible professional. ( )

16. Eligible Provider, Hospital-Based. In accordance with 42 CFR Section 495.4, an eligible provider who furnishes ninety (90) percent or more of their covered professional services in a hospital setting in the CY preceding the payment year. A setting is considered a hospital setting if it is a site of service that would be identified by the codes used in the HIPAA standard transactions as an inpatient hospital, or emergency room setting. ( )

17. Encounter. ( )

a. For an eligible hospital either may apply: ( )

i. Services rendered to an individual per inpatient discharge; or ( )

ii. Services rendered to an individual in an emergency department on any one (1) day; ( )

b. For an eligible professional, services rendered to an individual on any one (1) day. ( )

18. Enrolled Provider. A hospital or health care practitioner who is actively registered with the PI Program. ( )

19. Federal Fiscal Year (FFY). The federal fiscal year is from October 1 to September 30. ( )

20. Federally Qualified Health Center (FQHC). A federal designation for a medical entity that meets the requirements of 42 U.S.C. Section 1395x(aa)(4). The FQHC may be located in either a rural or urban area designated as a shortage area or in an area that has a medically underserved population. ( )

21. Hospital-Based. An eligibility criterion that excludes an eligible professional from participating in the PI Program when an eligible professional furnishes 90 percent (90%) or more of the eligible professional's Medicaid covered services in a hospital emergency room (place of service code 23), or inpatient hospital (place of service code 21) in the CY preceding the payment year. ( )

22. Meaningful EHR User. An eligible provider that, for an EHR reporting period for a payment year, demonstrates meaningful use of certified EHR technology by meeting the applicable objectives and associated measures in 42 CFR Part 495. ( )

23. Nurse Practitioner (NP). A licensed registered nurse (RN) who meets all the applicable requirements to practice as nurse practitioner under Title 54, Chapter 14, Idaho Code, and IDAPA 24.34.01, "Rules of the Idaho Board of Nursing," and as defined in 42 CFR Section 440.166. ( )

24. Payment Year. ( )

a. The CY for an eligible professional; or ( )

b. The FFY for an eligible hospital. ( )

25. 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, and who performs services as defined in 42 CFR Section 440.50. ( )

26. Physician Assistant. A person who meets all the applicable requirements to practice as licensed physician assistant under Title 54, Chapter 18, Idaho Code, and IDAPA 24.33.02, "Rules for the Licensure of Physician Assistants," and who performs services as defined in 42 CFR Section 440.60. ( )

011. -- 099. (RESERVED)

ELIGIBILITY DETERMINATION
(Sections 100-399)

100. PROMOTING INTEROPERABILITY (PI) PROGRAM ELIGIBILITY.

01. Providers and Hospitals Eligible to Participate in the PI Program. The Department administers the federal PI Program that pays incentive payments to eligible providers and eligible hospitals that adopt, implement, upgrade, and meaningfully use certified EHR technology in accordance with the provisions of 42 CFR Part 495. Providers and hospitals eligible to participate in the PI Program are identified in 42 CFR Section 495.304. ( )

02. Department Reviewing and Auditing of PI Program Participants. As authorized by 42 CFR Part 495, the Department reviews and may audit all professionals and hospitals participating in the PI Program. The Department reviews all practice, documentation, and data related to the EHR technology to determine whether professionals and hospitals participating in the PI Program are eligible and complying with the state and federal rules and regulations. The Department uses a defined audit strategy for auditing the PI Program. PI Program participants must meet the following requirements: ( )

a. Patient volume thresholds and calculations, as outlined in 42 CFR Sections 495.304 and 495.306. ( )

b. Eligibility criteria and payment limitations, as outlined in 42 CFR Sections 495.10, 495.304, 495.306, 495.308, and 495.310. ( )

c. Attestations and compliance demonstrations including, at a minimum: ( )

i. Attestations that certified EHR technology has been adopted, implemented, or upgraded; and ( )

ii. Demonstrations of meaningful use, as outlined in 42 CFR Sections 495.20, 495.22, 495.24, 495.6, and 495.8. ( )

d. The payment process and incentive payment amounts, as outlined in 42 CFR Sections 495.310, 495.312, 495.314, and 495.316. ( )

e. Additional issues regarding PI Program eligibility, participation, documentation, and compliance as outlined in 42 CFR Part 495. ( )

101. -- 199. (RESERVED)

200. EHR: FEDERALLY INITIATED PROGRAM.

01. Voluntary Federal Program. The PI Program is a federal program, using federal funding, and is voluntary for providers. The Department has no obligation to pay incentive payments to the provider once federal funding is exhausted. ( )

02. Idaho Sanctions/Outstanding Debt. ( )

a. To be eligible for incentive payments, providers must be free of both state and federal level sanctions and exclusions as provided in Section 56-209h, Idaho Code, IDAPA 16.05.07, and 42 CFR Part 455. Providers who are on either the Idaho Medicaid Provider Exclusion List or on the federal List of Excluded Individuals/Entities (http://exclusions.oig.hhs.gov/) are not eligible to participate in the PI Program. ( )

b. The Department will reference the Idaho State Sanctions and the Outstanding Debt-Termination Exclusion Lists. Federal level checks with the Office of the Inspector General (OIG) will be conducted through the Idaho Incentive Management System (IIMS) and CMS interface. ( )

c. Detection for improper payment will be conducted both at the state program level and at the federal level, as referenced in 42 CFR Sections 495.368(a)(1)(i) & (ii). ( )

201. -- 299. (RESERVED)

300. PI: ADDITIONAL PROVIDER QUALIFICATIONS.

01. Out-of-State Professionals and Hospitals. Incentive payments will be made only to Idaho Medicaid providers (professionals with an Idaho Medicaid Provider Agreement), unless they predominantly practice in an RHC or FQHC that is an Idaho Medicaid provider. ( )

02. Patient Volume Calculation. Encounters for out-of-state Medicaid members (Border States only) may be included in the patient volume calculation only if needed to meet patient volume threshold. Out-of-state encounters must then be included in the numerator and the denominator of the patient volume calculation. ( )

03. Eligible Professionals (EP) Licensure. The Department will consider a provisional license the same as licenses. ( )

301. -- 399. (RESERVED)

400. STATE OPTIONS ELECTIONS UNDER THE PI PROGRAM.
In addition to the federal provisions in the ARRA, Section 4201, the PI Program is governed by federal regulations at 42 CFR Part 495. In compliance with the requirements of federal law, the Department establishes the following State options under the PI Program: ( )

01. Calculating Patient Volume. For purposes of calculating patient volume as required by 42 CFR Section 495.306, the Department has elected eligible professionals and eligible hospitals to use 42 CFR Section 495.306(c). ( )

02. Patient Volume Methodology. For eligible professionals who use a group proxy patient volume methodology outlined in 42 CFR Section 495.306(h), the EP must see at least one (1) Medicaid or medically underserved patient before he may apply for a Medicaid incentive payment. ( )

03. Hospital Fiscal Year. The twelve (12) month period defined by a hospital for financial reporting purposes that will be used to comply with 42 CFR Section 495.310(g)(1)(i)(B). ( )

04. Determination of Hospital-Based. In accordance with 42 CFR Section 495.4, in order to distinguish "hospital-based eligible professional" from "eligible professional (EP)" during the program year, the Department reviews the quantity and place of services rendered for the CY preceding the program year to which the payment will apply. ( )

401. -- 999. (RESERVED)

000. LEGAL AUTHORITY.
This program is authorized by the Low-Income Home Energy Assistance Act of 1981, 42 U.S.C Sections 8621 to 8629, and by provisions of Section 56-202 Idaho Code. ( )

001. TITLE, SCOPE, AND LIMITATIONS.

01. **Title**. These rules are titled IDAPA 16.04.14, "Low-Income Home Energy Assistance Program," and may also be known as LIHEAP. ( )

02. **Scope**. The intent of the program is to provide assistance to eligible low income households particularly those with the lowest incomes, that pay the highest proportion of their income for home energy, primarily in meeting their immediate home energy needs. ( )

03. **Program Limitation**. This federally funded program does not entitle any household to a certain amount or form of assistance. An eligible participant household will receive one (1) benefit payment from the standard program funding each program year. ( )

002. – 009. (RESERVED)

010. DEFINITIONS.
For purposes of this chapter of rules, the following terms apply. ( )

01. **Crisis Assistance**. Energy assistance provided to an eligible participant household to reduce or eliminate an energy related health threatening situation to the household. ( )

02. **Department**. The Department of Health and Welfare or its designee. ( )

03. **Federal Poverty Guidelines (FPG)**. The federal poverty guidelines issued annually by the U. S. Department of Health and Human Services (HHS). ( )

04. **Fraud**. A deliberate attempt to conceal or misrepresent pertinent information which could affect eligibility or grant amounts. ( )

05. **Head of Participant Household**. The person designated by the household members to receive energy assistance benefit on behalf of the household and in whose favor the energy assistance warrant is written. ( )

06. **Income**. The gross amount of moneys received by the participant household from all sources. ( )

07. **Participant**. An individual or group of individuals who has applied for the Low-Income Home Energy Assistance Program from the state of Idaho. ( )

08. **Participant Household**. A participant household is one (1) of the following: ( )

a. An individual who lives alone; or ( )

b. A group of individuals who are living together as one (1) economic unit where residential energy is customarily purchased in common or they make undesignated payments for energy in the form of rent. ( )

09. **Primary Fuel**. The type of fuel declared by the participant household to be the major source of their home heating. ( )

10. **Undocumented Resident**. Individuals who enter the United States illegally and who have not obtained legal resident status. ( )

11. **Vendor**. A utility company or other provider of fuel utilized for home heating. ( )

011. -- 099. (RESERVED)

100. PARTICIPANT CASE RECORD.

The participant case record is the documentary basis justifying the expenditure of LIHEAP funds. All material pertinent to a participant household will be retained for a permanent record. Each eligibility determination must be supported by information in the permanent record showing that each eligibility requirement is met, or that one (1) or more eligibility requirements are not met. ( )

101. ELIGIBLE ACTIVITIES.
Funds made available through the LIHEAP grant will be used as follows: ( )

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. ( )

02. Governor Declared Emergency or Disaster. A portion of the LIHEAP grant funds may be used 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. ( )

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. ( )

102. PARTICIPANT RIGHTS.
The Department must inform participants of the following rights during the application and eligibility determination process: ( )

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. ( )

02. Right to a Hearing. Rules governing hearing rights are contained in Idaho Department of Health and Welfare Rules, IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings." ( )

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. ( )

103. PARTICIPANT RESPONSIBILITIES.
Each participant applying for LIHEAP benefits must, to the extent permitted by their physical and mental condition, provide all necessary and reasonable verification to establish eligibility, and must otherwise cooperate in the eligibility determination process. ( )

104. RELATIONSHIP TO OTHER PROGRAMS.
LIHEAP benefits paid to eligible participant households must not be counted as income or resources for any purpose under any federal or state law, including any law relating to taxation, public assistance, or welfare programs. ( )

105. -- 149. (RESERVED)

150. ELIGIBILITY REQUIREMENTS AND COLLATERAL CONTACTS.
All participant households assisted through LIHEAP must provide proof of both financial eligibility requirements and non-financial eligibility requirements. ( )

01. Failing to Meet the Financial and Non-Financial Eligibility. Participant households failing to meet the financial and non-financial eligibility requirements will be denied LIHEAP assistance. ( )

02. Participant's Signature. A participant's signature on the application is their consent for the Department to contact collateral sources for verification of the eligibility requirement(s). ( )

151. INCOME ELIGIBILITY REQUIREMENTS.

01. Households Receiving SSI or Food Stamps. Households in which one (1) or more individuals are receiving one (1) of the following are eligible for LIHEAP: ( )

a. Supplemental Security Income (SSI) under Title XVI of the Social Security Act; or ( )

b. Food Stamps under the Food Stamp Act of 1977, under 7 USC 2011 through 2027. ( )

02. Income Not Counted. Income listed in Subsections 151.02.a. through 151.02.t. is not counted in determining LIHEAP eligibility or benefit level. All other income is counted in determining LIHEAP eligibility and benefit level. ( )

a. Benefit payments from Medicare Insurance. ( )

b. Private loans made to the participant or the household. ( )

c. Assets withdrawn from a personal bank account. ( )

d. Sale of real property, if the funds are reinvested within three (3) calendar months. ( )

e. Income tax refunds. ( )

f. Infrequent, irregular or unpredictable income from gifts or lottery winnings of less than thirty dollars ($30) during the three (3) month period before application for LIHEAP. ( )

g. Wages or allowances for attendant care when the attendant resides in the household of the disabled member. ( )

h. Interest income of thirty dollars ($30) or less received during the three (3) month period before application for LIHEAP. ( )

i. Legal fees or settlements from Workman's Compensation paid in a lump sum. ( )

j. Monies received 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. ( )

k. Monies from VA-GI Bill for Education. ( )

l. Department of Health and Welfare Adoption subsidies. ( )

m. Compensation provided volunteers in the Older American Act or Foster Grandparent Program, including Green Thumb and Vista volunteers, Title V Senior Employment Program. ( )

n. Third party payments made by a non-household member on behalf of the household. Third party payments include child care, energy assistance funds, shelter, food and clothing assistance. ( )

o. Value of food stamps or donated food to household. ( )

p. Utility allowance. ( )

q. TAFI lump sum payments. ( )

r. Tribal crop or land payments. ( )

s. AmeriCorps stipend. ( )

t. Child support income. ( )

152. NONFINANCIAL ELIGIBILITY REQUIREMENTS.

01. Residence. When the application is completed, the household must reside in the state of Idaho. LIHEAP benefits are not transferable to an out-of-state residence. ( )

02. Living Situations. The household must reside in housing where they are responsible for home energy costs and incur the costs either directly or as an undesignated portion of their rent. ( )

03. Native Americans. Native American households whose tribe has entered into a separate agreement with the federal funding agency and the Department to receive LIHEAP grant funds, are not entitled to benefits under this program unless: ( )

a. Tribal funds are not available. ( )

b. Funds are depleted and an emergency exists. ( )

04. Resident Status. As part of the application process, participants must sign a declaration, under penalty of perjury, attesting to the residency or citizenship status of all household members. At least one (1) household member must be a citizen or legal resident of the United States. ( )

153. -- 200. (RESERVED)

201. APPLICATION PROCESS.
A participant must be provided a prompt opportunity to complete an application for assistance. Application forms must contain a statement which clearly explains participant's civil and criminal liability for the truthfulness of the information included on the forms; and their right to a hearing according to Idaho Department of Health and Welfare Rules, IDAPA 16.05.03, "Contested Cases Proceedings and Declaratory Rulings." ( )

01. Date of Application. The participant application process begins the date the completed and signed application and all supporting forms are received by the Department. ( )

02. Participant Representation. A participant household may be assisted by a person or persons of their choice and, when accompanied by such persons, may be represented by them. ( )

03. Signature. The application must be signed by the participant designated as the head of household, or their designee. Electronic signatures are acceptable. ( )

a. Applications signed by a designee must have a letter of authorization or power of attorney from the participant included in the file. ( )

b. Employees of the Department must not be designated to sign the application. ( )

04. Signature by Mark. A signature by mark requires two (2) witnesses. The signatures and addresses of the witnesses must appear on the application, followed by the word "witness." ( )

05. Assistance with Application. When completing the application forms or obtaining required documentation, the Department will assist limited or non-English speaking applicants by providing interpreter services. ( )

202. APPLICATION TIME LIMITS AND DISPOSAL ACTIONS.
Unless circumstances beyond the control of the Department prohibit it, each application is to be acted upon within thirty (30) days from the date the application is completed and signed by the participant. An application for LIHEAP assistance must be disposed of by one (1) of the following three (3) methods: ( )

01. Approval. A determination the participant household is eligible for LIHEAP benefits. ( )

02. Denial. A determination the participant household is ineligible for LIHEAP benefits or that eligibility could not be determined due to lack of necessary information or verification. ( )

03. Withdrawal. The participant household voluntarily requests that no further consideration be given to their application or the participant becomes deceased. ( )

203. NOTIFICATION OF DECISION.
Each participant household must be notified, in writing, of the decision made with regard to their LIHEAP application for assistance. ( )

01. Approvals. At the time the application is completed, the participant household will receive a copy of their preliminary approval notification. The Department issuance of the benefit payment or denial notice will be the participant household's formal eligibility notification. ( )

02. Denials or Withdrawals. The LIHEAP Notice of Denial will be provided to participant households denied assistance and include the reason for the denial and an explanation of the participant household's right to appeal the eligibility decision. ( )

204. -- 299. (RESERVED)

300. CONDITION OF PAYMENT ENDORSEMENT.
When an eligible participant household receives a LIHEAP benefit payment directly, they must endorse it and take it to their designated energy supplier. Two-party payments will have the name of the energy supplier imprinted on the face of the warrant. When an eligible participant and their energy supplier endorse the LIHEAP benefit payment, they certify that to the best of their knowledge, the funds are being used to provide home energy for the eligible participant household. ( )

301. VENDOR AGREEMENTS.
All participating energy suppliers must enter into a vendor agreement with the Department to provide home energy assistance to eligible participant households. ( )

302. OVERPAYMENTS.
Payments issued on behalf of a participant household that is not eligible must be repaid to the Department. ( )

303. RECOUPMENT OF OVERPAYMENT.

01. Recoupment of Overpayment. The Department may recoup or recover the amount issued on behalf of a LIHEAP participant. Interest will accrue on overpayments at the statutory rate set under Section 28-22-104, Idaho Code, from the date of the final determination of the amount owed for services. Recoupment of an overpayment based on Department error may be collected from a vendor or participant when the overpayment is one hundred dollars ($100), or more. Interest will not accrue on overpayments made due to Department error. An overpayment due to vendor or participant error, intentional program violations (IPV), or fraud must be recovered in full. ( )

02. Repayment Requirement. A vendor or participant must repay any overpayment, but may negotiate a repayment schedule with the Department. Failure to comply with the negotiated repayment agreement will result in revocation of that agreement and may result in the revocation of the vendor agreement. ( )

304. -- 309. (RESERVED)

310. INTENTIONAL PROGRAM VIOLATIONS (IPV).
An IPV is an intentionally false or misleading action or statement. An IPV is established when a vendor or participant admits the IPV in writing and waives the right to an administrative hearing, or when determined by an administrative hearing, a court decision, or through deferred adjudication. Deferred adjudication exists when the court defers a

determination of guilt because the accused vendor or participant meets the terms of a court order or an agreement with the prosecutor. The following are IPVs: ( )

01. False Statement. Made to the Department by an individual or vendor orally or in writing, to participate in LIHEAP. ( )

02. Misleading Statement. Made to the Department by an individual or vendor orally or in writing, to participate in LIHEAP. ( )

03. Misrepresentation of Fact. Made to the Department by an individual or vendor orally or in writing, to participate in LIHEAP. ( )

04. Concealed Fact. Concealed or withheld from the Department by an individual or vendor to participate in LIHEAP. ( )

05. Non-Compliance with Rules and Regulations. ( )

06. Violation of Vendor Agreement. ( )

07. Failure to Repay. ( )

311. PENALTIES FOR AN IPV.
When the Department determines an IPV was committed, the participant or vendor who committed the IPV loses eligibility to participate in LIHEAP. If an individual in a LIHEAP household has committed an IPV, the entire household is ineligible for LIHEAP. If a vendor has committed an IPV, the vendor is ineligible to receive payments. The period of ineligibility for each offense, for both a participant or a vendor, is as follows: ( )

01. First Offense. Twelve (12) months, for the first IPV or fraud offense, or the length of time specified by the court. ( )

02. Second Offense. Twenty-four (24) months for the second IPV or fraud offense, or the length of time specified by the court. ( )

03. Third Offense. Permanent ineligibility for the third or subsequent IPV or fraud offense, or the length of time specified by the court. ( )

312. -- 319. (RESERVED)

320. DENIAL OF PAYMENT.
The Department may deny payment to the vendor or participant for the following reasons: ( )

01. Services Not Provided. Any or all claims for vendor services the Department determines were not provided. ( )

02. Contrary to Rules or Provider Agreement. Vendor services provided contrary to these rules or the vendor agreement. ( )

03. Failure to Provide Immediate Access to Records. The vendor does not allow immediate access by the Department to LIHEAP records. ( )

04. Willful Misrepresentation or Concealment of Facts. The vendor or participant willfully misrepresents or conceals facts relating to LIHEAP. ( )

321. -- 349. (RESERVED)

350. TERMINATION OF VENDOR STATUS.
Under Section 56-209h, Idaho Code, the Department may terminate the vendor agreement of, or otherwise deny

vendor status for up to five (5) years from when the Department's action becomes final to any individual or entity providing LIHEAP. The following are bases for the Department to terminate vendor status: ( )

01. Knowing Submission of an Incorrect Claim. ( )

02. Submission of a Fraudulent Claim. ( )

03. False Statements. Knowingly making a false statement or representation of material facts in any document required to be maintained or submitted to the Department. ( )

04. Failure to Provide Immediate Access to Required Documentation Upon the Department's Written Request. ( )

05. Non-Compliance With Rules and Regulations. ( )

06. Violation of Material Term or Condition of the Vendor Agreement. ( )

07. Failure to Repay. Failure by a managing employee or one with an ownership or control interest in any entity to repay overpayments or claims previously found to have been obtained contrary to statute, rule, regulation, or vendor agreement. ( )

08. Fraudulent or Abusive Conduct in Connection with the Delivery of LIHEAP-Funded Services. Being found, or being a managing employee in any entity who is found, to have engaged in fraudulent or abusive conduct. ( )

351. REFUSAL TO ENTER INTO AN AGREEMENT.
The Department may refuse to enter into a vendor agreement for the following reasons: ( )

01. Convicted of a Felony. The vendor has been convicted of a felony relating to their involvement in a public assistance program. ( )

02. Failed to Repay. The vendor has failed to repay the Department monies which had been previously determined to have been owed to the Department. ( )

03. Investigation Pending. The vendor has a pending investigation for program fraud or abuse. ( )

04. Terminated Vendor Agreement. The vendor was the managing employee, officer, or owner of an entity whose vendor agreement was terminated under Section 350 of these rules. ( )

05. Excluded Individuals. The vendor has a current exclusion from participation in federal programs by the Office of Inspector General List of Excluded Individuals and Entities. ( )

352. VENDOR OR PARTICIPANT NOTIFICATION.
When the Department determines any actions defined in Sections 303 through 351 of these rules are appropriate, it will send written notice of the decision to the vendor or participant. The notice will state the basis for the action, the length of the action, the effect of the action on the participant or the vendor's ability to provide services under state and federal programs, and appeal rights. ( )

353. -- 994. (RESERVED)

995. PROVISIONS CONTINGENT UPON FEDERAL FUNDING.
The provisions in Sections 000 through 999 inclusive, are contingent upon availability and receipt of funds appropriated through federal legislation. When federal funds are not available to the state of Idaho, these provisions or any part therein are considered dormant; there may be no advance notice of termination or reduction of benefits. If additional funds are available, a supplemental payment may be made, in an equitable manner, to each eligible household at the discretion of the Director. ( )

996. -- 999. (RESERVED)

000. LEGAL AUTHORITY.
The Idaho Board of Health and Welfare is authorized under the Developmental Disabilities Services and Facilities Act, Sections 39-4601 et seq., Idaho Code, and under Section 56-1003, Idaho Code, to adopt and enforce rules, standards, and certification criteria for Residential Habilitation Agencies and provide for the delivery of appropriate services of habilitation and rehabilitation to the eligible population. ( )

001. TITLE AND SCOPE.

01. Title. These rules are titled IDAPA 16.04.17, "Residential Habilitation Agencies." ( )

02. Scope. These rules govern: ( )

a. The certification of residential habilitation agencies; and ( )

b. Establish standards and minimum requirements for agencies that provide residential habilitation services. The provisions are intended to regulate agencies so that services to participants will optimize participant opportunities for independence and self-determination while assuring adequate supports, services, participant satisfaction, and health and safety. Residential habilitation agencies will provide individualized services and supports encouraging participant choice, providing the greatest degree of independence possible, enhancing the quality of life, and maintaining community integration and participation. Services provided by such agencies are intended to be person-centered and participant-driven, and based on a person-centered plan to meet each participant's needs for self-sufficiency, medical care, and personal development with goals that safely encourage each participant to become a productive member of the community in which they live. Access to these services must be authorized in accordance to the procedures of the paying entity. ( )

002. -- 008. (RESERVED)

009. CRIMINAL HISTORY AND BACKGROUND CHECK REQUIREMENTS.

01. Verification of Compliance. The agency must verify that all employees and subcontractors delivering residential habilitation agency services have complied with IDAPA 16.05.06, "Criminal History and Background Checks." ( )

02. Requirement to Report Additional Criminal Convictions, Pending Investigations, or Pending Charges. Once an employee or subcontractor delivering residential habilitation agency services has received a criminal history clearance, any additional criminal convictions, pending investigations, or pending charges must be reported to the Department or its designee by the close of the next business day when the agency learns of the convictions, investigations, or charges. ( )

010. DEFINITIONS -- A THROUGH N.
For the purposes of these rules the following terms are used as defined below: ( )

01. Abuse. The non-accidental act of sexual, physical, verbal, or mental mistreatment, or injury of a resident through the action or inaction of another individual. ( )

02. Administrator. The individual who has primary responsibility for the direction and control of an agency. ( )

03. Advocate. An authorized or designated representative of a program or organization operating under federal or state mandate to represent the interests of a person with developmental disabilities. A participant may act as their own advocate. ( )

04. Agency. Any business entity that directly provides residential habilitation services. ( )

05. Board. The Idaho Board of Health and Welfare. ( )

06. Certificate. A permit to operate a residential habilitation agency. ( )

07. Complaint. A formal expression of dissatisfaction, discontent, or unhappiness by or on behalf of a participant concerning the services provided by the agency. This expression can be oral, in writing, or by alternative means of communication. ( )

08. Complaint Investigation. An investigation of an agency to determine the validity of allegations of non-compliance with applicable state rules. ( )

09. Deficiency. A determination of non-compliance with a specific rule, or part of a rule. ( )

10. Department. The Idaho Department of Health and Welfare, or a person authorized to act on behalf of the Department. ( )

11. Direct Service Staff. Any individual employed by the agency that provides direct services and supports to the participant. ( )

12. Director. Director of the Idaho Department of Health and Welfare, or their designee. ( )

13. Exploitation. An action that may include, but is not limited to, the unjust or improper use of a vulnerable participant's financial power of attorney, funds, property, or resources by another person for profit or advantage. ( )

14. Functional Assessment. An evaluation of the participant's strengths, needs, and interests that guides the development of program plans or plan of care. ( )

15. Governing Authority. The designated person or persons (i.e., board) who assume full responsibility for the conduct and operations of the residential habilitation services agency. ( )

16. Guardian. A legally-appointed person who has decision-making responsibility for the care or property of another, under Section 15-5-301, et seq., Idaho Code, or Section 66-404, Idaho Code. ( )

17. Habilitation services. Service aimed at assisting the individual to acquire, retain, or improve their ability to reside as independently as possible in the community or maintain family unity. Habilitation services include training in one (1) or more of the following areas: self-direction, money management, daily living skills, socialization, mobility, and behavior-shaping and management. ( )

18. Immediate Jeopardy. A situation in which the provider's non-compliance with one (1) or more requirements in this chapter of rules has caused, or is likely to cause, serious injury, harm, impairment, or death to a participant. ( )

19. Inadequate Care. The failure to provide the services required to meet the terms of the plan of service. ( )

011. DEFINITIONS -- M THROUGH Z.

For the purposes of these rules the following terms are used as defined below: ( )

01. Measurable Objective. A statement that specifically describes the skill to be acquired or the service or support to be provided, includes quantifiable criteria for determining progress towards and attainment of the service, support or skill, and identifies a projected date of attainment. ( )

02. Medication. Any substance or drug used to treat a disease, condition, or symptoms that may be taken orally, injected, or used externally, and is available through prescription or over-the-counter. ( )

03. Neglect. The failure to provide food, clothing, shelter, or medical care reasonably necessary to sustain the life and health of a vulnerable adult. ( )

04. Owner. Any person or entity, having legal ownership of the agency as an operating business, regardless of who owns the real property. ( )

05. Participant. An adult who is receiving residential habilitation services. ( )

06. Physical Restraint. Any manual method that restricts the free movement of, normal functioning of, or normal access to, a portion or portions of an individual's body. Excluded are physical guidance and prompting techniques of brief duration utilized to assist a participant with completing a desired action for himself. ( )

07. Physician. Any person licensed as required by Title 54, Chapter 18, Idaho Code. ( )

08. Plan of Service. An initial or annual plan that identifies all services and supports based on a planning process. Plans are authorized annually. ( )

09. Program Plan. The participant's plan that details how the participant's individualized goals will be addressed. ( )

10. Progress Note. A written notation, recording participant response to program objective, date, time, duration, and type of service signed and dated by the staff that provided services. ( )

11. PRN (Pro Re Nata) Medication. A medication that is given "as needed" or "as the circumstances warrant" to treat a symptom of a medical or psychiatric condition that has a periodic, episodic, or breakthrough presentation. ( )

12. Provisional Certificate. A certificate issued by the Department to a residential habilitation agency with deficiencies that do not adversely affect the health or safety of participants. A provisional certificate is issued contingent upon the correction of deficiencies in accordance with an agreed-upon plan. A provisional certificate is issued for a specific period of time, up to, but not to exceed, six (6) months. ( )

13. Quarterly. For the purpose of these rules, quarterly is defined as every three (3) months. ( )

14. Residential Habilitation. Services consisting of an integrated array of individually tailored services and supports furnished to an eligible participant that are designed to assist them to reside successfully in their own home, with their family, or alternate family home. Residential habilitation includes habilitation services, personal care services, and skill training. Individuals who provide residential habilitation services must be employed by a residential habilitation agency. ( )

15. Residential Habilitation Professional. An individual who has at least one (1) year of experience working directly with individuals with intellectual disabilities or developmental disabilities, and meets the requirements in 42 CFR 483.430 (a). ( )

16. Self-Neglect. The failure of a vulnerable adult to provide food, clothing, shelter, or medical care reasonably necessary to sustain the life and health for himself. ( )

17. Services. Paid services authorized on the plan of service that enable the individual to reside safely and effectively in their own home. ( )

18. Skill Training. To train direct service staff to teach the participant how to perform activities with greater independence and to carry out or reinforce habilitation training. Services are focused on training and are not designed to provide substitute task performance. Skills training is provided to encourage and accelerate development in independent daily living skills, self-direction, money management, socialization, mobility, and other therapeutic programs. ( )

19. Substantial Compliance. An agency is in substantial compliance with these rules when none of the following issues have been cited against the agency: ( )

a. Abuse; ( )

b. Neglect; ( )

c. Exploitation; ( )

d. Inadequate care; ( )

e. A situation in which the agency has operated more than thirty (30) days without an administrator or a residential habilitation professional; or ( )

f. Surveyors denied access to records, participants, or agency premises. ( )

20. Supervision. Initial and ongoing oversight of service and support elements by the residential habilitation professional or designee. The designee will report directly to the residential habilitation professional. ( )

21. Survey. A review conducted by a surveyor to determine an agency's compliance with statutes and rules. ( )

22. Surveyor. A person authorized by the Department to conduct surveys or complaint investigations to determine compliance with statutes and rules. ( )

012. -- 099. (RESERVED)

100. TYPES OF CERTIFICATES ISSUED.
The Department issues certificates that are in effect for a period of no longer than three (3) years. The types of certificates issued are as follow: ( )

01. Initial Certificate. When the Department determines that all application requirements have been met, an initial certificate is issued for a period of up to six (6) months from the initiation of services. The Department will survey the agency prior to the certificate expiration date to ensure the agency's ongoing capability to provide services and is in substantial compliance with these rules. When the agency is determined to be in substantial compliance, a one (1) year certificate will be granted. ( )

02. One-Year Certificate. A one (1) year certificate is issued by the Department when it determines the agency is in substantial compliance with these rules, following an initial or provisional certificate, or when there may be areas of deficient practice which would impact the agency's ability to provide adequate care. An agency is prohibited from receiving consecutive one (1) year certificates. ( )

03. Three-Year Certificate. A three (3) year certificate is issued by the Department when it determines the agency requesting certification is in substantial compliance with these rules. ( )

04. Provisional Certificate. When an agency is found to be out of substantial compliance with these rules, but does not have deficiencies that jeopardize the health or safety of participants, a provisional certificate may be issued by the Department for up to a six (6) month period. A provisional certificate is issued contingent upon the correction of deficiencies in accordance to a plan developed by the agency and approved by the Department. Before the end of the provisional certification period, the Department will determine whether areas of concern have been corrected and whether the agency is in substantial compliance with these rules. If the Department determines the agency is in compliance, a one (1) year certificate will be issued. If the agency is determined to be out of compliance, the certificate will be revoked. ( )

101. CERTIFICATION – GENERAL REQUIREMENTS FOR AGENCIES.

01. Certificate Required. ( )

a. No agency may provide services within this state until the Department has approved the application for certification and issued the agency a certificate. No agency may provide services within this state without a current certificate. ( )

b. The Department is not required to consider the application of any operator, administrator, or owner of an agency whose license or certification has been revoked until five (5) years have lapsed from the date of revocation. ( )

02. Application. An application for a certificate must be made to the Department on forms provided by the Department at: https://healthandwelfare.idaho.gov/providers/developmental-disabilities-and-residential-habilitation-agencies/residential-habilitation. The application must contain the following to be considered complete: ( )

a. Application form that contains the name, address, and telephone number of the agency, type of services to be provided, the geographic service area of the agencies, and the anticipated date for the initiation of services; ( )

b. An accurate and complete statement of all business names of the agency as filed with the Secretary of State, whether an assumed business name, partnership, corporation, limited liability company, or other entity, that identifies each owner of the agency, and the management structure of the agency; ( )

c. A statement that the agency will comply with these rules and all other applicable local, state, and federal requirements, including an assurance that the agency complies with pertinent state and federal requirements governing equal opportunity and nondiscrimination; ( )

d. A copy of the proposed organizational chart or plan for staffing of the agency; ( )

e. Staff qualifications including resumes, job descriptions, verification of satisfactory completion of criminal history checks in accordance with IDAPA 16.05.06, "Criminal History and Background Checks," and copies of state licenses and certificates for staff, when applicable; ( )

f. Written policies and procedures for the development and implementation of staff training to meet the requirements of Section 204 of these rules. ( )

g. Staff and participant illness policy, communicable disease policy, and other health-related policies and procedures required in Section 300 of these rules; ( )

h. Written policies and procedures that address special medical or health care needs of participants required in Section 300 of these rules; ( )

i. Written transportation safety policies and procedures required in Section 300 of these rules; ( )

j. Written participant grievance policies and procedures to meet requirements in Section 300 of these rules; ( )

k. Written medication policies and procedures to address medication standards and requirements to meet requirements in Section 302 of these rules; ( )

l. Written policies and procedures that address the development of participants' social skills and the management of participants' maladaptive behavior to meet requirements in Section 303 of these rules; ( )

m. Written termination policies and procedures in accordance with Section 400 of these rules; ( )

n. Written policies and procedures for reporting incidents to the adult protection authority and to the Department to meet requirements in Section 404 of these rules; ( )

o. Written description of the program records system including a completed sample of a program plan, and a monitoring record; ( )

p. Written description of the fiscal record system including a sample of program billing; ( )

q. Written description of the agency's quality assurance program developed to meet requirements in

Section 405 of these rules; ( )

r. Any other policies, procedures, or requirements as outlined in these rules; and ( )

s. All referenced forms. ( )

03. Completed Applications. Applications must be complete. Incomplete applications will not be considered and will be returned to the applicant. An applicant may submit an application up to three (3) times within a three hundred sixty-five (365) day period starting on the date of the first submission. If the application is incomplete upon a third submission, the application will be denied. The applicant may not resubmit an application for six (6) months from the date of the denial notice. ( )

04. Conformity. Applicants for certification and certified residential habilitation agencies must conform to all applicable rules of the Department. ( )

05. Inspection of Residential Habilitation Records. The agency and all records required under these rules must be accessible at any reasonable time to authorized representatives of the Department for the purpose of inspection with or without prior notice. Refusal to allow such access may result in revocation of the agency's certificate. ( )

102. DENIAL OF AN APPLICATION.
The Department may deny any application. ( )

01. Causes for Denial. Causes for denial of an application may include: ( )

a. The application does not meet all rule requirements; or ( )

b. The agency does not meet requirements for certification to the extent that it hinders its ability to provide quality services that comply with the rules for residential habilitation agencies; or ( )

c. The application is incomplete; or ( )

d. The applicant, owner, operator, or provider has willfully misrepresented or omitted information on the application or other documents pertinent to obtaining a certificate; ( )

e. The applicant, owner, operator, or provider has been denied or has had revoked any license or certificate for a health facility, residential assisted living facility, certified family home, or residential habilitation agency; or ( )

f. The applicant, owner, operator, or provider has been convicted of operating a health facility, residential assisted living facility, certified family home, or residential habilitation agency without a license or certificate; or ( )

g. A court has ordered that the applicant, owner, operator, or provider must not operate a health facility, residential assisted living facility, certified family home, or residential habilitation agency. ( )

h. The Department will not review an application of an applicant who has an action, either current or in process, against a certificate held by the applicant either in Idaho or any other state or jurisdiction. ( )

02. Before Denial is Final. Before denial is final, the Department will advise the individual or provider in writing of the denial and their right and method to appeal. Contested case hearings, including denial and revocation, must be conducted under IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings." ( )

103. RENEWAL AND EXPIRATION OF CERTIFICATE.
An agency must request, through a Department-approved process, renewal of its certificate no less than ninety (90) days before the expiration date of the certificate, to ensure there is no lapse in certification. ( )

01. Renewal of Certificate. A certificate may be renewed by the Department when it determines the agency requesting recertification is in substantial compliance with the provisions of this chapter of rules. A certificate issued on the basis of substantial compliance is contingent upon the correction of deficiencies in accordance with a plan developed by the agency and approved by the Department. ( )

02. Expiration of Certificate Without Timely Request for Renewal. Expiration of a certificate without a timely request for renewal automatically rescinds the agency's certification to deliver services under these rules. ( )

03. Availability of Certificate. The certificate must be available upon request by the Department, a participant, their guardian, and members of the public. ( )

104. CERTIFICATE NOT TRANSFERABLE.
The certificate is issued only to the agency named in the application, only for the period specified, only for the location indicated in the application, and only to the owners or operators as expressed on the application submitted to the Department. The certificate may not be transferred or assigned to any other person or entity. The certificate is nontransferable from one (1) location to another. ( )

105. RETURN OF CERTIFICATE.
The certificate is the property of the state and must be returned to the state if it is revoked or suspended or voluntarily closed. ( )

106. CHANGE OF OWNERSHIP, ADMINISTRATOR, OR LOCATION.

01. Notification to Department. When a change of ownership, or locations is contemplated, the agency must be recertified and implement the same procedure as an agency that has never been certified. When a change of a certified agency's ownership, administrator, or address is contemplated, the owner or designee must notify the Division of Licensing and Certification in writing through the Department-approved process. ( )

02. New Application Required. In the instance of a change of ownership or lessee the new owner must submit a new application to the Department at least sixty (60) days prior to the proposed date of change. The new application must be submitted to the Division of Licensing and Certification through the Department-approved process and must contain the required information under Section 101.02 of these rules. ( )

107. -- 199. (RESERVED)

200. AGENCY GOVERNING AUTHORITY.
Each agency must be organized and administered under one governing (1) authority. The governing authority may be a named individual or a number of individuals that will assume full legal responsibility for the overall conduct of the agency. ( )

01. Structure. The agency must document an organizational chart that identifies the individuals acting as its governing authority, the administrator, the residential habilitation professional, and all other agency employees with administrative responsibilities. This organizational chart must be provided at the time of the application, updated at least annually or upon significant change to the agency's organizational structure, and available to the Department upon request. ( )

02. Responsibilities. The governing authority must assume responsibility for: ( )

a. Adopting appropriate organizational bylaws and policies and procedures; ( )

b. Appointing an administrator qualified to carry out the agency's overall responsibilities in relation to written policies and procedures and applicable state and federal laws. The administrator must participate in deliberation of policy decisions concerning all services; ( )

c. Ensuring the agency administrator fulfills the duties and obligations outlined in Section 201 of these rules. Any failure on part of the Administrator is the ultimate responsibility of the agency and its governing

body. ( )

d. Conducting and documenting that it performed an annual review of the agency for compliance with these rules; ( )

e. Developing and implementing written administrative policies and procedures that comply with applicable state and federal rules; and ( )

f. Developing and implementing policies and procedures under these rules. These are to be reviewed at least annually and revised as necessary. ( )

201. AGENCY ADMINISTRATOR.
An administrator for an agency is accountable for the overall operations of the agency including ensuring compliance with these rules, overseeing and managing staff, and administering the agency's policies and procedures, and quality assurance program. ( )

01. Administrator Qualifications. Each agency must employ a designated administrator who: ( )

a. Is at least twenty-one (21) years of age; ( )

b. Has satisfactorily completed a criminal history check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks"; and ( )

c. Has a minimum of three (3) years of experience in service delivery with the population served with at least one (1) year having been in an administrative role. ( )

02. Absences. The administrator must designate, in writing, a qualified employee to perform the functions of the administrator to act in their absence. This document must be available upon request. ( )

03. Responsibilities. The administrator must: ( )

a. Document and review the overall program and general participant needs on at least a quarterly basis, or more often as necessary, to plan and implement appropriate strategies for meeting those needs; ( )

b. Make all records available to the Department for review or audit; ( )

c. Implement all policies addressing safety measures for the protection of participants and staff as mandated by state and federal rules; ( )

d. Ensure agency personnel, including those providing services, practice within the scope of their certificate or license; ( )

e. Conduct satisfaction surveys at least annually with each participant or guardian, as applicable. ( )

f. Assure training, support services, and equipment for agency staff are provided to carry out assigned responsibilities; ( )

g. Schedule coverage to assure compliance with the Plan of Service and Program Plans. Work schedules reflecting the daily adjustments of employees must be maintained to show the personnel on duty for the scheduled shift. The agency must specify provisions and procedures to assure back-up coverage for those work schedules; and ( )

h. Coordinate with other service providers to assure continuity of the delivery of residential habilitation services in the plan of service. ( )

202. QUALIFICATIONS AND RESPONSIBILITIES OF A RESIDENTIAL HABILITATION PROFESSIONAL.

01. Education and Experience. To be qualified as a residential habilitation professional, a person must: ( )

a. Have at least one (1) year of experience professionally supervised with the population served; and ( )

b. Meet the qualifications of a Qualified Intellectual Disabilities Professional (QIDP) as described in 42 CFR 483.430(a). ( )

c. Experience writing and implementing behavior and skill training program plans; or ( )

i. Provide documentation the employee received such training from an experienced residential habilitation professional; and ( )

ii. Demonstrate the ability to write and implement behavior and skill training program plans. ( )

02. Criminal History and Background Check. A residential habilitation professional must have satisfactorily completed a criminal history check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." ( )

03. First Aid and CPR Certification. A residential habilitation professional must be certified in first aid and Cardio-Pulmonary Resuscitation (CPR) appropriate for the age of participants they serve prior to providing direct service to participants and maintain current certification thereafter. ( )

04. Responsibilities of a Residential Habilitation Professional. A residential habilitation professional must be employed by the agency on a continuous and regularly scheduled basis. A residential habilitation professional must perform the following: ( )

a. Provide all skill training to agency direct service staff necessary to fulfill each participant's plan of service; ( )

b. Complete or obtain an age appropriate functional assessment for participants served within thirty (30) days of initiation of the service; ( )

c. Develop participant program plans according to the current authorized plan of service for each participant; and ( )

d. Supervise habilitation services of the agency at least quarterly or more often as necessary to include: ( )

i. The review of direct services performed by direct service staff to ensure that staff are implementing the programs as written and demonstrate the necessary skills to correctly provide the services; and ( )

ii. Monitoring participant progress and documenting changes when necessary to ensure revisions are made for progress, regression, or inability to maintain independence. ( )

05. Direct Service Qualifications. If a residential habilitation professional is providing any type of direct service, they must meet the qualifications of direct service staff as defined in Section 203 of these rules. ( )

203. DIRECT SERVICE STAFF.
Each direct service staff person for an agency must meet all of the following minimum qualifications: ( )

01. **Age**. Be at least eighteen (18) years of age. ( )

02. **Education**. Be a high school graduate, or have a GED or demonstrate the ability to provide services according to a plan of service. ( )

03. **First Aid and CPR Certification**. Be certified in first aid and Cardio-Pulmonary Resuscitation (CPR) appropriate for the age of participants they serve prior to providing direct care or services to participants and maintain current certification thereafter. ( )

04. **Health**. Have signed a statement maintained by the agency that they are free from communicable disease, understands universal precautions, and follows agency policies and procedures regarding communicable disease. ( )

05. **"Assistance with Medications" Course**. Each staff person assisting with participant medications must successfully have completed and follow the "Assistance with Medications" course available through the Idaho Division of Career-Technical Education, or other Department-approved training. A copy of the certificate or other verification of successful completion must be maintained by the agency in the employee record. ( )

06. **Criminal History Check**. Have satisfactorily completed a criminal history check in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." ( )

204. DIRECT SERVICE STAFF TRAINING.
Each agency must ensure that all staff who provide direct services have completed training in accordance with these rules. ( )

01. **Training Documentation**. ( )

a. Training documentation must include the following: ( )

i. Direct service staff receiving the training; ( )

ii. Individual conducting the training; ( )

iii. Name of the participant; ( )

iv. Description of the content trained; and ( )

v. Date and duration of the training. ( )

b. Documentation of training must be available for review by the Department, and retained in each employee's record. ( )

02. **Orientation Training**. Orientation training must be completed prior to working with participants. The orientation training must include: ( )

a. Policies and procedures; ( )

b. Proper conduct in working with participants; ( )

c. Handling of confidential and emergency situations that involve the participant; ( )

d. Participant rights to include personal, civil, and human rights; ( )

e. Body mechanics and lifting techniques; ( )

f. Maintenance of a clean, safe, and healthy environment; and ( )

g. Skills training specific to the needs of each participant served must be provided by a residential habilitation professional and include the following: ( )

i. Instructional techniques including correct and consistent implementation of the participant's program plan or plan of care; and ( )

ii. Managing behaviors including techniques and strategies for teaching adaptive behaviors. ( )

03. Ongoing Training. The residential habilitation professional must provide and document ongoing training of direct service staff when changes are made to the participant's plan of service and corresponding program plans. Additionally, the agency will be responsible for providing on-going training to direct service staff when there are changes to the participant's physical, medical, and behavioral status. ( )

205. -- 299. (RESERVED)

300. AGENCY POLICIES AND PROCEDURES.
A policy and procedure manual must be developed by the agency to effectively implement its objectives. It must be approved by the governing authority. The manual must, at a minimum, include policies and procedures reflecting the following: ( )

01. Scope of Services and Area Served. The agency must define the scope of services offered and the geographic area served by the agency. ( )

02. Acceptance Standards. The agency must develop and implement written policies and procedures that specify the agency will only accept and retain participants for whom the agency is adequately equipped to provide appropriate services according to the participant's plan of care. The agency will not accept or retain participants when the agency does not have the personnel appropriate in number and with appropriate knowledge and skill to provide the services needed by each participant according to each participant's plan of care. ( )

03. Participant Records. Each agency must develop and implement written policies and procedures that describe the content, maintenance, and storage of participant records. Each agency must maintain accurate, current, and complete participant records. These records must be maintained for at least five (5) years following the participant's termination of services, or to the extent required by other federal or state requirements. Each agency must have a participant records system to include past and current information and to safeguard participant confidentiality under these rules. ( )

04. Required Services. Each agency must develop and implement written policies and procedures that describe how the agency will assess and provide residential habilitation services. Residential habilitation services consist of an integrated array of individually tailored services and supports. These services and supports are designed to assist the participants to reside in their own homes. Residential habilitation includes habilitation services aimed at assisting the individual to acquire, retain, or improve their ability to reside as independently as possible in the community or maintain family unity, and include training in one (1) or more of the following areas: ( )

a. Self-direction, including the identification of and response to dangerous or threatening situations, making decisions and choices affecting the individual's life, and initiating changes in living arrangements or life activities; ( )

b. Money management, including training or assistance in handling personal finances, making purchases, and meeting personal financial obligations; ( )

c. Daily living skills, including training in accomplishing routine housekeeping tasks, meal preparation, dressing, personal hygiene, self-administration of medications, and other areas of daily living including proper use of adaptive and assistive devices, appliances, home safety, first aid, and emergency procedures; ( )

d. Socialization, including training or assistance in participation in general community activities and establishing relationships with peers with an emphasis on connecting the participant to their community. ( )

i. Socialization training associated with participation in community activities includes assisting the participant to identify activities of interest, working out arrangements to participate in such activities, and identifying specific training activities necessary to assist the participant to continue to participate in such activities on an on-going basis. ( )

ii. Socialization training does not include participation in non-therapeutic activities that are merely diversional or recreational in nature; ( )

e. Mobility, including training or assistance aimed at enhancing movement within the person's living arrangement, mastering the use of adaptive aids and equipment, accessing and using public transportation, independent travel, or movement within the community; ( )

f. Behavior shaping and management includes training and assistance in appropriate expressions of emotions or desires, assertiveness, acquisition of socially appropriate behaviors; or extension of therapeutic services, which consist of reinforcing physical, occupational, speech and other therapeutic programs. ( )

g. Personal Assistance Services necessary to assist the individual in daily living activities, household tasks, and such other routine activities as the participant or the participant's primary caregiver(s) are unable to accomplish on their own behalf. ( )

h. Skills training conducted by direct service staff to teach the participant how to perform activities with greater independence and to carry out or reinforce habilitation training. Services are focused on training and are not designed to provide substitute task performance. Skills training is provided to encourage and accelerate development in independent daily living skills, self-direction, money management, socialization, mobility, and other therapeutic programs. ( )

05. Participant Safety. Each residential habilitation agency must develop and implement a policy and procedure for assessing each individual participant's safety. The assessment must include environmental and structural risks to the participant served and how those risks will be reduced or eliminated. ( )

06. Disaster/Emergency Care. Each agency must develop and implement emergency planning and care policies and procedures that include situational and environmental emergencies. The policy and procedure must include an emergency preparedness plan to follow in the event of an emergency. ( )

07. Administrative Records. Each agency must maintain all administrative records, including all written policies and procedures, for at least five (5) years or to the extent necessary to meet any other federal or state requirements. Administrative records must include, at a minimum: ( )

a. Administrative structure must include an organizational chart; ( )

b. Legal authority must be identified in organizational bylaws and other documentation of legal authority of ownership; ( )

c. Fiscal records must verify service delivery prior to request for payment. ( )

08. Personnel. Each agency must develop and implement written personnel policies and procedures. The agency is responsible for the recruitment, hiring, training, supervision, scheduling, and payroll for its employees. Written personnel policies that describe the employee's rights, responsibilities, and agency's expectations must be on file and provided to employees. The record must contain documentation supporting staff qualifications. A record for each employee must be maintained from date of hire for not less than five (5) year(s) after the employee is no longer employed by the agency or as necessary to meet other requirements. ( )

09. Participant Rights. Each agency must develop and implement written policies that include a clear definition of personal, civil, and human rights. Upon initiation of services, the agency must provide each participant and guardian, if applicable, with written and verbal information outlining participant rights. This information must be in easily understood terms. The policy and procedure must include the following rights: ( )

a. Humane care and treatment; ( )

b. Not be put in isolation; ( )

c. Be free of restraints, unless necessary for the safety of that person or for the safety of others; ( )

d. Be free of mental and physical abuse; ( )

e. Voice grievances and recommend changes in policies or services being offered; ( )

f. Have the opportunity to participate in social, religious, and community activities of their choice; ( )

g. Wear their own clothing and retain and use personal possessions; ( )

h. Be informed of their habilitative condition, services available at the agency; ( )

i. Reasonable access to all records concerning himself; ( )

j. Choose or refuse services; ( )

k. Exercise all civil rights, unless limited by prior court order; ( )

l. Privacy and confidentiality; ( )

m. Receive courteous treatment; ( )

n. Receive a response from the agency to any request made within (14) business days; ( )

o. Receive services that enhance the participant's personal competencies and, whenever possible, promote inclusion in the community; ( )

p. Refuse to perform services for the agency. If the participant is hired to perform services for the agency, the wage paid must be consistent with state and federal law; ( )

q. Review the results of the most recent survey conducted by the Department and the accompanying plan of correction; ( )

r. All other rights established by law; ( )

s. Be protected from harm; ( )

t. Choose one's roommate; ( )

u. Reside in the environment or setting that is least restrictive of personal liberties in which appropriate treatment can be provided; ( )

v. Communicate by sealed mail, telephone, or otherwise with persons inside or outside of their residence, to have access to reasonable amounts of letter writing material and postage and to have access to private areas to make telephone calls and receive visitors; ( )

w. Receive visitors at all reasonable times and to associate freely with persons of their own choice; ( )

x. Keep and be allowed to spend a reasonable sum of their own money for personal expenses and small purchases, and have access to individual storage space for their own use; and ( )

y. Unless limited to prior court order, exercise all civil rights, including the right to dispose of property, execute instruments, make purchases, enter into contractual arrangements, and vote. ( )

10. Health. Each agency must develop and implement written policies and procedures that: ( )

a. Define how the agency will train each direct service staff on procedures to follow for communicable diseases or infected skin lesions; ( )

b. Describe how the agency will protect participants from exposure to individuals exhibiting symptoms of illness; ( )

c. Address any special medical or health care needs specific to each participant; and ( )

d. Implement medication standards and requirements in accordance to Section 302 of these rules. ( )

11. Transportation. Each agency must develop and implement transportation policies that include the following: ( )

a. Preventative Maintenance Program. Establish a preventive maintenance program, including vehicle inspections and other regular maintenance, for all agency-owned vehicles used to transport participants to ensure participant safety. ( )

b. Transportation Safety Policy. Develop and implement a written transportation safety policy. The policy must include procedures for ensuring adequate staffing of participants who require additional supervision during transportation to ensure safety of all vehicle occupants. ( )

c. Licenses and Certifications for Drivers and Vehicles. Obtain and maintain licenses and certifications for drivers and vehicles required by public transportation laws, regulations, and ordinances that apply to the agency to conduct business and to operate the types of vehicles used to transport participants. Agencies must maintain documentation of appropriate licensure for all employees who operate vehicles. ( )

d. Applicable Laws, Rules, and Regulations. Adhere to all laws, rules, and regulations applicable to drivers and vehicles of the type used. ( )

e. Liability Insurance. Continuously maintain liability insurance that covers all passengers and meets the minimum liability insurance requirements under Idaho law. If an agency employee transports participants in the employee's personal vehicle, the agency must ensure that adequate liability insurance coverage is carried to cover those circumstances. ( )

12. Quality Assurance. Each agency must develop and implement policies and procedures that describe the Purpose of the Quality Assurance Program that, at minimum, address the components of Section 405 of these rules. ( )

13. Grievance. Each agency must develop and implement policies and procedures that describe the agencies methodology for accepting and responding to grievances presented by participants or their guardians. ( )

301. PERSONNEL RECORDS.

The record for each employee must contain at least the following: ( )

01. Name, Current Address, and Phone Number of the Employee; ( )

02. Social Security Number; ( )

03. Education and Experience; ( )

04. Other Qualifications. If licensed in Idaho, the original license number and the date the current registration expires, or if certificated, a copy of the certificate; ( )

05. Date of Employment; ( )

06. Job Description. Documentation that the employee signed and received a copy of their job description stating that the requirements of their position have been explained to them; ( )

07. Date of Termination of Employment and Reason for Termination, If Applicable; ( )

08. Documentation of the Employee's Initial Orientation and Required Training; ( )

09. Evidence of Current Age-Appropriate CPR and First Aid Certifications; ( )

10. Current Assistance With Medications Certification, If Applicable; and ( )

11. Criminal History Check. Verification of satisfactory completion of criminal history checks in accordance with IDAPA 16.05.06, "Criminal History and Background Checks." ( )

302. AGENCY MEDICATION STANDARDS AND REQUIREMENTS.
The agency must develop and implement written policy and procedures describing the program's system for handling participant medications. ( )

01. Medication Policy. Each agency must develop written medication policies and procedures that outline in detail how the agency will ensure appropriate handling and safeguarding of medications. An agency that chooses to assist participants with medications to include PRN medications must also develop specific policies and procedures to ensure this assistance is safe and is delivered by qualified, fully-trained staff. Documentation of training must be maintained in the staff personnel record. ( )

02. Handling of Participant's Medication. ( )

a. The medication must be in the original pharmacy-dispensed container, or in an original over-the-counter container, or placed in a unit container by a licensed nurse and be appropriately labeled with the name of the medication, dosage, time to be taken, route of administration, and any special instructions. Each medication must be packaged separately, unless in a Mediset, blister pack, or similar system. ( )

b. Evidence of the written order for the medication from the physician or other practitioner of the healing arts must be maintained in the participant's record. Medisets, blister pack, or similar system filled and labeled by a pharmacist or licensed nurse can serve as written evidence of the order. An original prescription bottle labeled by a pharmacist describing the order and instructions for use can also serve as written evidence of an order from the physician or other practitioner of the healing arts. ( )

c. The agency is responsible to safeguard the participant's medications when assuming the responsibility for assisting with medications. ( )

d. Medications that are expired or no longer used by the participant must not be retained by the agency or agency staff for longer than thirty (30) calendar days. ( )

03. Self-Administration of Medication. When the participant is responsible for administering their own medication without assistance, a written approval stating that the participant is capable of self-administration must be obtained from the participant's primary physician or other practitioner of the healing arts. The participant's record must also include documentation that a physician or other practitioner of the healing arts, or a licensed nurse has evaluated the participant's ability to self-administer medication and has found that the participant: ( )

a. Understands the purpose of the medication; ( )

b. Knows the appropriate dosage and times to take the medication; ( )

c. Understands expected effects, adverse reactions or side effects, and action to take in an emergency; and ( )

d. Is able to take the medication without assistance. ( )

04. Assistance with Medication. An agency may choose to assist participants with medications; however, only a licensed nurse or other licensed health professional may administer medications. Prior to unlicensed agency staff assisting participants with medication, the following conditions must be in place: ( )

a. Each staff person assisting with participant medications must successfully complete and follow the "Assistance with Medications" course available through the Idaho Division of Career-Technical Education, or other Department-approved training; ( )

b. The participant's health condition is stable; ( )

c. The participant's health status does not require nursing assessment, as outlined in IDAPA 24.34.01, "Rules for the Idaho Board of Nursing," before receiving the medication or nursing assessment of the therapeutic or side effects after the medication is taken; ( )

d. The medication is in the original pharmacy-dispensed container with proper label and directions, or in an original over-the-counter container, or the medication has been placed in a unit container by a licensed nurse. Proper measuring devices must be available for liquid medication that is poured from a pharmacy-dispensed container; ( )

e. Written and oral instructions from a licensed physician or other practitioner of the healing arts, pharmacist, or nurse concerning the reason(s) for the medication, the dosage, expected effects, adverse reactions or side effects, and action to take in an emergency have been reviewed by the staff person; ( )

f. Written instructions are in place that outline required documentation of assistance and who to call if any doses are not taken, overdoses occur, or actual or potential side effects are observed; ( )

g. Procedures for disposal or destruction of medications must be documented and consistent with procedures outlined in the "Assistance with Medications" course or local medication destruction programs. ( )

05. Administration of Medications. Only a licensed nurse or another licensed health professional working within the scope of their license may administer medications. Administration of medications must comply with IDAPA 24.34.01, "Rules of the Idaho Board of Nursing." ( )

303. AGENCY POLICIES AND PROCEDURES REGARDING DEVELOPMENT OF SOCIAL SKILLS AND MANAGEMENT OF MALADAPTIVE BEHAVIOR.

Each agency must develop and implement written policies and procedures that address the development of participants' social skills and management of maladaptive behavior. These policies and procedures must include statements that address: ( )

01. Adaptive and Maladaptive Behavior. The agency must address possible underlying causes or function of a behavior and identify what the participant may be attempting to communicate by the behavior. ( )

02. Behavior Intervention. Positive behavior interventions must be used prior to and in conjunction with, the implementation of any restrictive intervention. Interventions must address the following: ( )

a. Social Skills Development. Focus on developing or increasing participants' social skills. ( )

b. Prevention Strategies. Ensure and document the use of positive approaches to increase social skills

and decrease maladaptive behavior while using least restrictive alternatives and consistent, proactive responses to behaviors. ( )

c. Behavior replacement. Ensure that programs to assist participants with managing maladaptive behavior include teaching of alternative adaptive skills to replace the maladaptive behavior. ( )

d. Protected Rights. Ensure the safety, welfare, and human and civil rights of participants are adequately protected. ( )

e. Objectives and Programs. Ensure that objectives and intervention techniques are developed or obtained and implemented to address self-injurious behavior, aggressive behavior, inappropriate sexual behavior, and any other behaviors that significantly interfere with participants' independence or ability to participate in the community. Ensure that reinforcement selection is individualized and appropriate to the task and not contraindicated for medical reasons. ( )

f. Participant Involvement. Ensure programs developed by the agency involve the participants, to the best of their ability, in developing the plan to increase social skills and to manage maladaptive behavior. ( )

g. Written Informed Consent. Ensure programs developed by an agency to assist participants with managing maladaptive behaviors are conducted only with the written informed consent of the participant, or legal guardian, where applicable. When programs used by the agency are developed by another service provider the agency must obtain a copy of the informed consent. ( )

h. Review and Approval. Programs developed by an agency to manage maladaptive behavior are implemented after the review and written approval of the residential habilitation professional. If the program contains restrictive or aversive components, an individual working within the scope of their license or certification must also review and approve, in writing, the program prior to implementation. When programs implemented by the agency are developed by another service provider, the agency must obtain a copy of these reviews and approvals. ( )

03. Appropriate Use of Interventions. Employees of the agency must not use physical, verbal, sexual, or psychological abuse, or punishment. For the purposes of these rules, punishment is any procedure in which an adverse consequence is presented that is designed to produce a decrease in the rate, intensity, duration, or probability of the occurrence of a behavior; or, the administration of any noxious or unpleasant stimulus or deprivation of a participant's rights or freedom for the purpose of reducing the rate, intensity, duration, or probability of a particular behavior. Employees of the agency must not withhold food or hydration that contributes to a nutritionally adequate diet. The agency must ensure that interventions used to manage participants' maladaptive behavior are never used: ( )

a. For disciplinary purposes; ( )

b. For the convenience of staff; ( )

c. As a substitute for a needed training program; or ( )

d. By untrained or unqualified staff. ( )

04. Use of Restraint on Participants. No restraints, other than physical restraint in an emergency, must be used on participants prior to the use of positive behavior interventions. The following requirements apply to the use of physical restraint on participants: ( )

a. Physical restraint. ( )

i. Physical restraint may be used in an isolated emergency to prevent injury to the participant or others and must be documented and reviewed in the participant's record by the direct service staff and the residential habilitation professional. Documentation must include a debrief with the participant and staff involved focusing on strategies to avoid the occurrence of future physical restraints. ( )

ii. Physical restraint may be used in a non-emergency setting when a written behavior change plan is developed by the participant and their guardian, if applicable, their team, and a qualified residential habilitation professional. Informed participant consent is required. ( )

304. -- 399. (RESERVED)

400. AGENCY PARTICIPANT RECORD REQUIREMENTS.
Each agency certified under these rules must maintain accurate, current, and complete participant and administrative records. Each participant record must clearly document the date, time, duration, and type of service, and include the signature of the individual providing the service, for each service provided. Each participant record must contain the following information: ( )

01. Profile Sheet. Each participant record must include a profile sheet containing the following: ( )

a. Name, current address, and current phone number of the participant; ( )

b. Medicaid ID number; ( )

c. Gender and marital status; ( )

d. Date of birth; ( )

e. Names, addresses, and current phone numbers of legal guardian if applicable, family, advocates, friends, and persons to be contacted in case of an emergency; ( )

f. Names, addresses, and current phone number of physician, pharmacy, dentist, and other health care providers as applicable; ( )

g. A list, or an attached list, of current medications, diet, and all other treatments prescribed for the participant; and ( )

h. Current diagnoses or reference to a current history and physical. ( )

02. Authorized Plan of Service. The agency must obtain a current authorized plan of service from the paying entity. ( )

03. Participant Rights. Each agency must document upon initiation of services, that each participant and their guardian, where applicable, have been informed of their rights, access to grievance procedures, and the names, addresses, and telephone numbers of protection and advocacy services. This information must be provided in easily understood terms both verbally and in writing. ( )

04. History and Physical. Results of a most current history and physical. ( )

05. Functional Assessment. An age-appropriate functional assessment must be completed or obtained by the agency within thirty (30) days of the initiation of service. The functional assessment must be used for the development of program plans and include: ( )

a. An assessment reflecting the person's functional abilities in the following areas: self-direction, money management, daily living skills, socialization, mobility, behavior shaping, and other therapeutic programs; and ( )

b. The results and summary signed with credentials and dated by the qualified residential habilitation professional. ( )

06. Psychological or Psychiatric Assessment. When a participant has had a psychological or psychiatric assessment for the purpose of treatment, the results of the assessment must be maintained in the

participant's record and used when developing program objectives. ( )

07. Program Plan. Each participant must have a program plan that includes goals and objectives specific to their authorized residential habilitation program. Program plans that include participant's name, baseline statement, measurable objectives, start date, written instructions to staff, service environments, and target date. ( )

08. Record of Significant Incidents, Accidents, Illnesses, and Treatments. ( )

09. Daily Medication Log, When Applicable. ( )

10. Daily Record of the Date, Time, Duration, and Type of Service Provided. ( )

11. Service Delivery and Progress Notes. Documentation of service delivery and progress notes that correspond with the program plans when services are delivered to the participant. ( )

12. Status Review. Residential habilitation agencies must review each participant's progress to ensure revisions are made for progress, regression, or inability to maintain independence. The review of progress must be documented on a status review document. The status review document identifies the participant's progress toward goals defined in the plan of service. ( )

13. Termination Procedures. The agency must develop and implement termination policies and procedures that address how the agency will ensure safety of the participant and community to the extent possible in the event that emergency conditions exist or the participant no longer in need of or desires services. ( )

a. Emergency conditions warranting termination of services include: ( )

i. A change in the participant's condition resulting in an increased level of care beyond the scope of the agency's ability to provide care for the participant. ( )

ii. Significant behavior concerns including physical aggression by the participant that puts the health and safety of the agency's staff or other participants in jeopardy and behavior management techniques have failed to reduce the risk to staff or others. ( )

b. In the instance where the participant is no longer in need of or desires services, the agency must ensure that the procedures include written notice of no less than thirty (30) days for termination, include a transition plan, and a copy of the agency's grievance process. For the purposes of this chapter, a transition plan is an interim plan developed by the agency defining activities to assist the participant to transition out of residential habilitation services from that agency. ( )

c. Services may be terminated prior to thirty (30) days if both parties agree in writing to the termination conditions. The agency may not terminate services when to do so would pose a threat of endangerment to the participant or others. The participant is entitled to appeal the termination utilizing the agency's grievance process regardless of the reason for termination. ( )

d. The agency must notify the participant and their guardian, if applicable, no less than thirty (30) days prior to a change of ownership to ensure informed choice in the services they receive. ( )

401. -- 402. (RESERVED)

403. PARTICIPANT FINANCES.

01. Written Policy and Procedure. Each agency must develop and implement a written policy and procedure that describes the management of participant funds. In order for an agency to manage participant's funds, they must have written designation as a payee by either Social Security Administration or the participant's guardian or conservator if they are not a recipient of Social Security funds. ( )

02. Participant's Personal Finance Records. When the agency, or its employees or contractors, are designated as the payee on behalf of the participants, the agency must establish and maintain an accounting system that assures a full and complete accounting of participants' personal funds entrusted to the agency, its employees, or contractors on behalf of participants. Records of financial transactions must be sufficient to allow a thorough audit of the participant's funds. An agency that manages participant funds must: ( )

a. Not commingle of participant funds with agency funds. Borrowing between participant accounts is prohibited; ( )

b. Document any financial transactions. A separate transaction record is to be maintained for each participant, including receipts for each expenditure paid for using the participant funds, except for purchases made with participant's personal funds; ( )

c. Restore funds to the participant if the agency cannot produce proper accounting records of participant's funds or property; and ( )

d. Provide access to the participant's funds to the participant or their legal guardian or conservator. ( )

e. Document dispersion of participant personal spending money. Documentation is to include the date and amount of the money given to the participant. The participant must acknowledge in writing receipt of the spending money at the time it is dispersed. ( )

404. AGENCY REPORTING AND COMMUNICATION REQUIREMENTS.
Each agency must develop and implement written policies and procedures outlining how the agency will document reporting and other communications for the following: ( )

01. Reciprocal Communication. Communication with the legal guardian and other authorized individuals; and ( )

02. Reporting Requirements. Any agency employee or contractor must report all incidents and allegations of mistreatment, abuse, neglect, injuries of unknown origin, or exploitation to the administrator and to adult protection and law enforcement officials, as required by law under Section 39-5303, Idaho Code. ( )

a. The agency administrator must investigate and document in the participant's records their investigation of all alleged violations. The agency must protect the participant from the possibility of abuse while the investigation is in progress. The administrator must ensure the events and the agency response to the events are documented in the participant record. ( )

b. If the agency administrator verifies the alleged violation, appropriate corrective action must be taken and reported to law enforcement, the Department, and adult protection as required by law under Section 39-5303, Idaho Code. ( )

03. Participant's Condition. The agency administrator must notify the participant's legal guardian within twenty-four (24) hours, if one exists, of any significant incidents, or changes in participant's condition including serious illness, accident, death, or abuse. ( )

04. Notification to Department of a Participant's Condition. Through a Department-approved process, the agency administrator must notify the Department by the close of the next business day of any significant incidents including: death, hospitalization, or if the participant is arrested or incarcerated. The Department will investigate or cause to be investigated any such incident that indicates there was a violation of the rules or statute. ( )

405. AGENCY QUALITY ASSURANCE PROGRAM.
Each agency must develop and implement a quality assurance program. ( )

01. What the Quality Assurance Program Verifies. The quality assurance program is an ongoing,

proactive, internal review of the agency designed to verify: ( )

a. Services are provided in accordance with these rules; ( )

b. Sufficient staff are available to meet the needs of each person served; ( )

c. Skill training activities are conducted as written in the program plans. ( )

d. The rights of a person with disabilities are protected and each person is provided opportunities and training to make informed choices. ( )

02. Quality Assurance Program Components. Each agency's written quality assurance program must include: ( )

a. Goals and procedures to be implemented to achieve the purpose of the quality assurance program; ( )

b. Person, discipline, or department responsible for each goal; ( )

c. A system to ensure the correction of problems identified within a specified period of time; ( )

d. A method for assessing participant satisfaction at least annually including minimum criteria for participant response and alternate methods to gather information if minimum criteria is not met; ( )

e. An annual review of agency's policy and procedure manual signed and dated by the administrator that specifies content of revisions made; and ( )

f. An annual review of participant and employee records for complete and current content to meet rules. ( )

406. COMPLAINTS AND INVESTIGATIONS.

01. Filing a Complaint. Any person who believes that the agency has failed to meet any provision of the rules or statute may file a complaint with the Division of Licensing and Certification. All complaints must have a basis in rule or statutory requirements. In the event that it does not, the complainant will be referred to the appropriate entity or agency. ( )

02. Investigation Survey. The Division of Licensing and Certification will investigate, or cause to be investigated the following: ( )

a. Any complaint alleging a violation of the rules or statute; and ( )

b. Any reportable incident which indicates there was a violation of the rules or statute. ( )

03. Disclosure of Complaint Information. The Division of Licensing and Certification will not disclose the name or identifying characteristics of a complainant unless: ( )

a. The complainant consents in writing to the disclosure; ( )

b. The investigation results in a judicial proceeding and disclosure is ordered by the court; or ( )

c. The disclosure is essential to prosecution of a violation. The complainant is given the opportunity to withdraw the complaint before disclosure. ( )

04. Method of Investigation. The nature of the complaint will determine the method used to

investigate the complaint. ( )

05. Statement of Deficiencies. If violations of these rules are identified, depending on the severity, the Department may send the agency a statement of deficiencies. ( )

06. Public Disclosure. Information received by the Division of Licensing and Certification through filed reports, inspection, or as otherwise authorized under the law, must not be disclosed publicly in such a manner as to identify individual residents except in a proceeding involving a question of certification. ( )

07. List of Deficiencies. A current list of deficiencies including plans of correction will be available to the public upon request in accordance with IDAPA 16.05.01, "Use and Disclosure of Department Records." ( )

08. Notification to Complainant. The Division of Licensing and Certification will inform the complainant of the results of the investigation survey when the complainant has provided a name and address. ( )

407. -- 499. (RESERVED)

500. ENFORCEMENT PROCESS.
The Department may impose a remedy or remedies when it determines an agency is not in compliance with these rules. ( )

01. Determination of Remedy. In determining which remedy or remedies to impose, the Department will consider the agency's compliance history, change of ownership, the number of deficiencies, the scope and severity of the deficiencies, and the potential risk to participants. Subject to these considerations, the Department may impose any of the remedies in Subsection 500.02 of this rule, independently or in conjunction with others, subject to the provisions of these rules for notice and appeal. ( )

02. Enforcement Remedies. If the Department determines that an agency is out of compliance with these rules, it may impose any of the following remedies according to Section 500.01 of this rule. ( )

a. Require the agency to submit a plan of correction that must be approved in writing by the Department; ( )

b. Issue a provisional certificate with a specific date for correcting deficient practices; ( )

c. Ban enrollment of all participants with specified diagnoses; ( )

d. Ban any new enrollment of participants; ( )

e. Revoke the agency's certificate; or ( )

f. Summarily suspend the certificate and transfer participants. ( )

03. Immediate Jeopardy. If the Department finds an agency's deficiency or deficiencies immediately jeopardize the health or safety of its participants, the Department may summarily suspend the agency's certificate. ( )

04. No Immediate Jeopardy. If the Department finds that the agency's deficiency or deficiencies do not immediately jeopardize participant health or safety, the Department may impose one (1) or more of the remedies specified in Subsections 500.02.a. through 500.02.e. of this rule. ( )

05. Repeat Deficiencies. If the Department finds a repeat deficiency in an agency, it may impose any of the remedies listed in Subsection 500.02 of this rule as warranted. The Department may monitor the agency on an "as needed" basis, until the agency has demonstrated to the Department's satisfaction that it is in compliance with requirements governing residential habilitation agencies and that it is likely to remain in compliance. ( )

06. Failure to Comply. The Department may impose one (1) or more of the remedies specified in Subsection 500.02 of this rule if: ( )

a. The agency has not complied with any requirement in these rules within three (3) months after the date it was notified of its failure to comply with such requirement; or ( )

b. The agency has failed to correct the deficiencies stated in the agency's accepted plan of correction and as verified by the Department, via resurveys. ( )

501. REVOCATION OF CERTIFICATE.

01. Revocation of the Agency's Certificate. The Department may revoke an agency's certificate when persuaded by the preponderance of the evidence that the agency is not in substantial compliance with the requirements in this chapter of rules. ( )

02. Causes for Revocation of the Certificate. The Department may revoke any agency's certificate for any of the following causes: ( )

a. The certificate holder has willfully misrepresented or omitted information on the application for certification or other documents pertinent to obtaining a certificate; ( )

b. Conditions exist in the agency that endanger the health or safety of any participant; ( )

c. Any act adversely affecting the welfare of participants is being permitted, performed, or aided and abetted by the person or persons supervising the provision of services in the agency. Such acts include neglect, physical abuse, mental abuse, emotional abuse, violation of civil rights, or exploitation; ( )

d. The provider has demonstrated or exhibited a lack of sound judgment that jeopardizes the health, safety, or well-being of participants; ( )

e. The agency has failed to comply with any of the conditions of a provisional certificate; ( )

f. The agency has one (1) or more major deficiencies. A major deficiency is a deficiency that endangers the health, safety, or welfare of any participant; ( )

g. An accumulation of minor deficiencies that, when considered as a whole, indicate the agency is not in substantial compliance with these rules; ( )

h. Repeat deficiencies by the agency of any requirement of these rules or of the Idaho Code; ( )

i. The agency lacks adequate personnel, as required by these rules or as directed by the Department, to properly care for the number and type of participants served at the agency; ( )

j. The agency is not in substantial compliance with the provisions for services required in these rules or with the participants' rights under Subsection 300.09 of these rules; or ( )

k. The certificate holder refuses to allow the Department or protection and advocacy agencies full access to the agency environment, agency records, or the participants. ( )

502. NOTICE OF ENFORCEMENT REMEDY.
The Department will notify the following of the imposition of any enforcement remedy on an agency: ( )

01. Notice to the Agency. The Department will notify the agency in writing, transmitted in a manner that will reasonably ensure timely receipt. ( )

02. Notice to Public. The Department will notify the public by sending the agency printed notices to post. The agency must post all the notices on their premises in plain sight in public areas where they will readily be seen by participants and their representatives, including exits and common areas. The notices must remain in place until all enforcement remedies have been officially removed by the Department. ( )

03. Notice to the Professional Licensing Boards. The Department will notify professional licensing boards, as appropriate. ( )

503. -- 509. (RESERVED)

510. EMERGENCY POWERS OF THE DIRECTOR.
In the event of an emergency endangering the life or safety of a participant receiving services from an agency, the Director may summarily suspend or revoke any residential habilitation certificate. As soon thereafter as practicable, the Director must provide an opportunity for a hearing. ( )

511. INJUNCTION TO PREVENT OPERATION WITHOUT CERTIFICATE.
Notwithstanding the existence or pursuit of any other remedy, the Department may in the manner provided by law, maintain an action in the name of the state for injunction or other process against any person or governmental unit to restrain or prevent the establishment, conduct, management, or operation of an agency without a certificate required under this chapter. For the purposes of these rules, a governmental unit is the state, or any county, municipality, or other political subdivision, or any department, division, board, or other agency thereof. ( )

512. -- 599. (RESERVED)

600. WAIVERS.
Waivers to these rules may be granted by the Department as needed provided that granting the waiver does not endanger the health or safety or rights of any participant. The decision to grant a waiver is not precedent or given any force or effect of law in any other proceeding. Any waiver granted by the Department may be renewed annually if sufficient written justification is presented to the Department. Waivers granted by the Department must be given in writing and signed by the Department's Licensing and Certification program manager. ( )

601. -- 999. (RESERVED)

16.05.01 – USE AND DISCLOSURE OF DEPARTMENT RECORDS

000. LEGAL AUTHORITY.
The Idaho Department of Health and Welfare and the Board of Health and Welfare have authority to promulgate rules governing the use and disclosure of Department records, according to Sections 39-242, 56-221, 56-222, 56- 1003, and 56-1004, Idaho Code. ( )

001. TITLE AND SCOPE.

01. Title. These rules are titled IDAPA 16.05.01, "Use and Disclosure of Department Records." ( )

02. Scope. These rules govern the use and disclosure of information maintained by the Department, in compliance with applicable state and federal laws, and federal regulations. ( )

a. These rules apply to all Department employees, contractors, providers of services, and other individuals or entities who request or use that information. ( )

b. These rules apply to all use and disclosure information, regardless of the form in which it is retained or disclosed. ( )

c. All individuals and entities must comply with any standards in state or federal law or regulation that contain additional requirements, or are more restrictive than the requirements of these rules. ( )

002. -- 006. (RESERVED)

007. DISTRICT COURT APPEALS, COMPLAINTS AND REQUESTS FOR RECONSIDERATION.
The confidentiality of health information is defined in part by the Health Insurance Portability and Accountability Act (HIPAA), Sections 262 and 264 of Public Law 104-191, 42 USC 1320d, 110 Statutes at Large 2033-4, and 45 CFR Sections 160 and 164. ( )

01. Appeals to District Court. Anyone who is aggrieved by a denial of disclosure or amendment of a public record may file an appeal in the appropriate district court in compliance with the Idaho Public Records Act, Title 74, Chapter 1, Idaho Code. ( )

02. Complaints to Privacy Officer. Individuals who are dissatisfied with a Department decision regarding confidential information may file a written complaint with the Department's Privacy Officer. Complaints must be submitted to the Department's Privacy Officer at the mailing address for the Department's business office. The Privacy Officer determines if a complaint is valid and makes a recommendation for its resolution to the Department within twenty-eight (28) days after the complaint is received. ( )

a. Secretary of Health and Human Services (HHS). Complaints that involve the use and disclosure of health information may also be submitted to the Secretary of Health and Human Services at the following address: The U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, DC 20201. ( )

b. Time for filing complaints. Complaints must be filed within one hundred eighty (180) days from the date of the alleged violation. ( )

03. Request for Reconsideration to Access Health Information. The individual or legal representative may submit a written request for reconsideration to the Privacy Officer if access to health information is denied. ( )

a. The request for reconsideration must be postmarked no later than twenty-eight (28) days after notice of the denial was mailed. ( )

b. The reconsideration will be conducted by another licensed health care professional who did not participate in the original decision. ( )

c. The Department will notify the individual of the outcome of the review within twenty-eight (28) days after the request is received. ( )

008. -- 009. (RESERVED)

010. DEFINITIONS.

01. Authorization. A time-limited written consent for the disclosure of confidential information to a specific individual or entity outside the Department, and outside of normal business processes for providing Department services. ( )

02. Confidential Information. Information that may only be used or disclosed as provided by state or federal law, federal regulation, or state rule. ( )

03. Consent. Permission to use or disclose confidential information. Consent may be inferred from the circumstances. ( )

04. Department. The Idaho Department of Health and Welfare. ( )

05. Guardian ad Litem. The person appointed by the court, according to law, to protect the interest of a minor or an incompetent in a case before the court. ( )

06. Health Information. Identifying information about the past, present or future: ( )

a. Physical or mental health or condition of an individual; ( )

b. Provision of health care to an individual; or ( )

c. Payment for health care for an individual. ( )

07. Identifying Information. The name, address, social security number, or other information by which an individual could be identified. Information may also be identifying without a name, based on the context or circumstances of a disclosure. ( )

08. Informal Representative. A person who is not a legal representative, but who is a relative, friend, or other person permitted to communicate with the Department on behalf of an individual. The individual or legal representative may give such permission verbally, in writing, or through their conduct. ( )

09. Legal Representative. The parent of a minor, a guardian, conservator, attorney, or an individual who has an appropriate power of attorney. ( )

10. Minimally Necessary. The information that is essential to provide benefits or services, and to perform normal business processes of the Department. ( )

11. Need-to-Know. Confidential information that is necessary to provide benefits or services, and to perform normal business processes of the Department. ( )

12. Psychotherapy Notes. Notes recorded in any format by a mental health professional that documents or analyzes the content of individual or group counseling sessions, and that are separated from the rest of the individual's medical record. The term "psychotherapy notes" excludes: ( )

a. Medication prescription and monitoring; ( )

b. Counseling session start and stop times; ( )

c. Types and frequencies of treatment furnished; ( )

d. Results of clinical tests; and ( )

e. Any summary of diagnosis, functional status, the treatment plan, symptoms, prognosis and progress to date. ( )

011. DEFINITIONS FOR VITAL STATISTICS.
The definitions provided in Subsection 011 of these rules apply to Vital Statistics and to the disclosure provisions of Section 39-270, Idaho Code. ( )

01. Authorized Representative. An attorney, physician, funeral director, a legally designated agent, or an entity whose purpose for obtaining a vital record is to pay direct benefits to a person with a direct and tangible interest defined in Subsection 011.03 of this rule. ( )

02. Certificate. A certificate of birth, death, stillbirth, miscarriage, marriage, or divorce, filed pursuant to law, excluding information contained in the statistical section of any record. ( )

03. Individuals with a Direct and Tangible Interest. Individuals who have a direct and tangible interest in a vital record are: ( )

a. The registrant and that person's spouse, children, parents, grandparents, grandchildren, siblings, or guardian; ( )

b. Any other person who demonstrates that the record is needed for the determination or protection of that person's property right; ( )

c. An authorized representative of any of these individuals; ( )

d. The surviving next-of-kin if a deceased registrant has no other surviving family member listed in this subsection; ( )

e. The Idaho Attorney General, and state and federal prosecuting attorneys, if such attorney submits an affidavit affirming that the record is necessary in the furtherance of the attorney's official law enforcement duties, is not reasonably available from another source, and that reasonable steps will be taken to preserve the confidentiality of the record; ( )

f. Any person, upon the order of an Idaho court of competent jurisdiction, where the court finds that disclosure of the record is necessary in the interests of justice; and ( )

g. Any person with the right to control the disposition of remains of a deceased person or to determine provisions not clearly covered in a prearranged funeral plan as authorized in Section 54-1142(1) Idaho Code, in accordance with Section 39-270(b), Idaho Code. ( )

04. Parent. Does not include a biological parent whose parental rights have been terminated. ( )

05. Public Health. The science and art of: ( )

a. Preventing disease, prolonging life, or promoting health and efficiency through organized community effort for the sanitation of the environment; ( )

b. The control of communicable infections; ( )

c. The education of the individual in personal hygiene; ( )

d. The organization of medical and nursing services for the early diagnosis and preventive treatment of disease; and ( )

e. The development of the social machinery to ensure everyone a standard of living adequate for the maintenance of health, so organizing these benefits as to enable every citizen to realize their birthright of health and longevity. ( )

06. Putative Father. The biological father of a child as identified by himself, the natural mother, an adoption agency, or a court. ( )

07. Registrar. The state Registrar as defined in Section 39-241(18), Idaho Code. The mailing and street address for the state Registrar is Bureau of Vital Records and Health Statistics, 450 W. State St., 1st Floor, PO Box 83720, Boise, Idaho 83720-0036. ( )

08. Research. Organized scientific inquiry or examination of data in order to discover and interpret facts. ( )

09. Statistical Purposes. The collection, analysis, interpretation and presentation of masses of non-identifying numerical information. ( )

012. -- 049. (RESERVED)

GENERAL CONSENT AND DISCLOSURE REQUIREMENTS
(Sections 050-199)

050. CONSENT TO GATHER, USE AND DISCLOSE INFORMATION.
When individuals, legal representatives or informal representatives sign an application, they consent for the Department to gather, use and disclose information as needed for an individual to receive Department benefits or services. If none of these individuals provides a consent on an application, service may be denied. An informal representative may only consent to the disclosure of confidential information when permitted by these rules. ( )

051. AUTHORIZATION FOR THE USE AND DISCLOSURE OF CONFIDENTIAL INFORMATION.
An authorization for the use and disclosure of confidential information must be in writing, and identify the individual who is the subject of the record. ( )

01. Content of Authorization. An authorization must be dated and signed by the individual or legal representative, and: ( )

a. Identify the specific information involved; ( )

b. State the duration of the authorization, defined by a specific date or the description of an event; ( )

c. Identify the recipient of the information; and ( )

d. State the purpose for the authorization, or state that it is, "At the request of the individual," or similar wording. ( )

02. Defective Authorization. An authorization must not be acted upon if the authorization has expired or has been revoked, or if any essential information is omitted or is false. ( )

03. Authorization for the Use and Disclosure of Health Information. An authorization for the use and disclosure of health information must contain the content listed in Subsection 051.01 and the statements required by 45 CFR 164.508(c)(2). ( )

04. Psychotherapy Notes. Psychotherapy notes that are separate from the rest of an individual's record may not be used or disclosed without an authorization except to the originator of the notes for treatment or to defend the Department in a legal action brought by the individual. ( )

05. Revocation of an Authorization. An individual or legal representative may revoke an authorization at any time by submitting a written request at any Department office. ( )

06. Effect on Benefits and Services. An individual's refusal to provide an authorization does not

affect the receipt of benefits or services the individual would otherwise receive. ( )

07. Copy of Authorization. The Department will provide a copy of the signed authorization to the individual or legal representative. ( )

052. -- 074. (RESERVED)

075. USE AND DISCLOSURE OF CONFIDENTIAL INFORMATION.
Without a consent or an authorization, no one may use or disclose health or other confidential information except as provided in Section 100 of this chapter. With a consent or an authorization, confidential information will be used or disclosed only on a need-to-know basis and to the extent minimally necessary for the conduct of the Department's business and the provision of benefits or services, subject to law and the exceptions listed in these rules. Recipients of information must protect against unauthorized disclosure or use of the information for purposes that are not specified in a consent or an authorization. Access to an individual's own records is governed by Section 125 of this chapter. Specific consent and disclosure requirements are identified in Sections 200 through 283 of these rules. ( )

01. Identity. Any individual who requests to review, copy, restrict or amend confidential information, or to sign an authorization, must provide verification of identity, and where appropriate, present proof that the individual is a legal representative of the subject of the record. Except for verifications or requests for certified copies of vital records, requests submitted by mail must be notarized if necessary to identify the individual's signature. ( )

02. Order of Court or Hearing Officer. If information is subpoenaed in a civil, criminal or administrative action, the Department will provide such information as would be disclosed with a public records request, without an order from the court or hearing officer. Alternatively, the Department may submit the record with a request for a review solely by the judge or hearing officer, and an order appropriately limiting its use by the parties. If Department staff have reason to believe that release of a record through a public records request may be detrimental to any individual, the Department may seek a protective order. ( )

03. Referent. Unless the individual is a witness in litigation, identifying information must not be disclosed about an individual who reported concerns relating to any Department responsibility, including: ( )

a. Fraud; ( )

b. Abuse, neglect or abandonment of a child; ( )

c. Abuse, neglect or abandonment of a vulnerable adult; ( )

d. Concerns about the mental health of another; and ( )

e. Certified family homes, unless the complainant consents to disclosure in writing or disclosure is required in any administrative or judicial proceeding, in compliance with Section 74-105(16), Idaho Code. ( )

04. Collateral Contact. Identifying information must not be disclosed about individuals who are not the subject of the record and who provide information to the Department in the ordinary course of business. ( )

05. Alternative Communication. The Department, contractors and providers must comply with an individual's request that confidential information be communicated by alternative means of delivery unless it is administratively difficult to do so or the request is unreasonable. If approved, all information from a Department program will use the same alternative means of delivery after the request is received and recorded. ( )

06. Restriction on Disclosure of Health Information. ( )

a. An individual may request in writing that use or disclosure of health information be restricted. The Department will respond in writing, and may deny the request if: ( )

i. Disclosure is required; ( )

ii. Necessary for the safety of the individual or others; ( )

iii. Necessary for the provision of services, benefits or payment; or ( )

iv. The restriction is unreasonable. ( )

b. The uses and disclosures of confidential information are subject to a restriction after it is received and recorded by the Department. Department employees, contractors, and the individual may request the Department to terminate the restriction. The Department will notify the individual of its response to a request to terminate a restriction. ( )

07. Discovery. Records will be provided only in response to valid discovery in any federal or state criminal, civil or administrative proceeding, as required by the Public Records Act, Section 74-115(3), Idaho Code. ( )

076. -- 099. (RESERVED)

100. EXCEPTIONS TO REQUIREMENT FOR AUTHORIZATION.
Confidential information will be released without an authorization to individuals and entities in compliance with a court order, or if they are legally authorized to receive it. The following are exceptions to the requirement for an authorization: ( )

01. Advocates and Guardians. Federally-recognized protection and advocacy agencies or duly appointed guardians ad litem have access to an individual's file as necessary to perform their legal functions. Guardians ad litem have access to records as provided in Section 16-1634, Idaho Code, except for: ( )

a. Drug abuse and sickle cell anemia records maintained by the Veteran's Administration (VA), as required by 38 USC Section 7332; ( )

b. Claims under laws administered by the VA as required by 38 USC Section 3301; and ( )

c. Drug abuse prevention programs that receive federal assistance, as required by 42 USC Section 290ee - 3. ( )

02. Licensure. In compliance with Section 74-106(9), Idaho Code, records will be released if they are part of an inquiry into an individual's or organization's fitness to be granted or retain a license, certificate, permit, privilege, commission or position. These records will otherwise be provided in redacted form as required by law or rule. ( )

03. Fugitives and Missing Persons. ( )

a. A state or local law enforcement officer may receive the current address of any cash assistance recipient who is a fugitive felon, in compliance with Section 56-221, Idaho Code. ( )

b. The following health information may be disclosed to a law enforcement officer for the purpose of identifying or locating a suspect, fugitive, material witness or missing person: ( )

i. Name and address; ( )

ii. Date and place of birth; ( )

iii. Social security number; ( )

iv. Blood type and rh factor; ( )

v. Type of injury; ( )

vi. Date and time of treatment or death, if applicable; and ( )

vii. Distinguishing physical characteristics. ( )

c. DNA, dental records, or typing, samples or analysis of body fluids or tissue must not be disclosed. ( )

04. Duty to Warn or Report. Confidential information may be released without an authorization if necessary under a legal duty to warn or to report. ( )

05. Department Business, Monitoring and Legal Functions. Department employees and contractors may use and disclose records as necessary to perform normal business functions, including health treatment, audit and quality improvement, investigation of fraud and abuse, establishment of overpayments and recoupment, public health, or other functions authorized by law. Information will be made available to state and federal auditors and compliance monitors. Confidential information will be provided to counsel as needed to evaluate, prepare for and represent the Department in legal actions. ( )

06. Emergencies. Confidential information may be disclosed to qualified medical personnel to the extent necessary to respond to a medical emergency that requires immediate attention. ( )

07. Multidisciplinary Staffing. Confidential information may be disclosed to employees of the Department, law enforcement, and other appropriate individuals to participate in a multidisciplinary team evaluation of child protection cases under Section 16-1617, Idaho Code, or interdisciplinary Department staffing of services for an individual. All individuals who participate in such staffing must not redisclose the information and must comply with any other pertinent statute, rule or regulation. ( )

08. Collaborative Staffing. Confidential information may be disclosed in staffing by the Department and other individuals or entities if all participants are involved with the same or similar populations and have an equal obligation or promise to maintain confidentiality. Disclosure of information in inter-agency staffing must be necessary to coordinate benefits or services, or to improve administration and management of the services. Confidential information may be disclosed only on a need-to-know basis and to the extent minimally necessary for the conduct of the staffing. All individuals who participate in such staffing must not redisclose the information except in compliance with any other pertinent statute, rule or regulation. ( )

09. Elected State Official. As provided by Section 16-1629(6), Idaho Code, any duly elected state official carrying out their official functions may have access to child protection records of the Department, and must not redisclose the information. ( )

10. Child Protection Agency. A legally mandated child protection agency may provide information necessary to investigate a report of known or suspected child abuse or neglect, or to treat a child and family who are the subjects of the record. ( )

11. Legally Authorized Agency. An agency will be provided appropriate information if the agency is legally responsible for or authorized to care for, treat or supervise a child who is the subject of the record. ( )

12. Informal Representatives. Informal representatives may be permitted to receive and deliver information on behalf of an individual, and may be given health information if the informal representative is directly involved with the individual's care. Confidential information may be withheld in whole or part if professional staff determines that disclosure is not in the best interest of the individual, based on the circumstances and their professional judgment. The Department will not disclose information that is prohibited from being disclosed by these rules or any other legal requirement. ( )

13. Law Enforcement. Any federal, state, or local law enforcement agency, or any agent of such agency, may be permitted access to information as needed in order to carry out its responsibilities under law to protect children from abuse, neglect, or abandonment. ( )

101. ABUSE, NEGLECT, OR DOMESTIC VIOLENCE.
Health information may be disclosed to a law enforcement officer if the victim of abuse, neglect, or domestic violence agrees to the disclosure. ( )

01. Incapacity of Victim. If the victim is unable to agree because of incapacity, health information will be disclosed if the officer states: ( )

a. That the information is not intended to be used against the victim; and ( )

b. That immediate enforcement activity would be materially and adversely affected by waiting for the victim's agreement. ( )

02. Judgment of Professional Staff. The victim must be promptly informed that a report to law enforcement has been or will be made unless in the judgment of professional staff: ( )

a. Informing the victim would place them at risk of serious harm; or ( )

b. The probable perpetrator of the abuse, neglect or domestic violence would be the recipient of the report, and disclosure would not be in the victim's best interest. ( )

102. VICTIM OF OTHER CRIME.
Health information may be disclosed in response to a law enforcement official's request about a victim or suspected victim of a crime other than those listed in Section 101 of these rules, if the individual agrees to the disclosure. ( )

01. Incapacity of Victim or Emergency Circumstance. If the individual is unable to agree because of incapacity or emergency circumstance, health information will be disclosed if the official states that the information is needed to determine whether a violation of law has occurred, and that it is not intended to be used against the individual. ( )

02. Best Interest of the Individual. The officer must also represent that immediate enforcement activity would be materially and adversely affected by waiting for the individual's agreement. Professional staff must agree that disclosure is in the best interest of the individual. ( )

103. SERIOUS THREAT TO HEALTH OR SAFETY.
Subject to the restrictions in this rule, health information may be used or disclosed if necessary to prevent or lessen a serious and imminent threat to the health and safety of a person or the public. Disclosure must be based on actual knowledge or credible information from a person with apparent knowledge or authority. Disclosure will be made only to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat. ( )

01. Apprehension by Law Enforcement. Health information may be disclosed as necessary to law enforcement to identify or apprehend an individual. Disclosure is limited to an admission that an individual participated in a violent crime if it is reasonable to believe that serious physical harm has been caused to the victim. ( )

02. Escape From Law Enforcement. Health information may be disclosed as necessary for law enforcement to identify or apprehend an individual where it appears from all the circumstances that the individual has escaped from a correctional institution or lawful custody. ( )

03. Prohibition on Disclosure. Disclosure of an admission of participation in a violent crime is prohibited if the information is learned in the course of treatment to affect the individual's tendency to commit the criminal conduct, or through a request by the individual to initiate such treatment. ( )

104. REPORTING OF CRIME ON PREMISES.
Health information may be disclosed to a law enforcement official if the information constitutes evidence of criminal conduct that occurred on the Department's premises. ( )

105. REPORTING CRIME IN EMERGENCIES.
If a Department employee is providing emergency health care off the Department's premises, health information may be disclosed if necessary to alert law enforcement to a crime; the location of the crime or victim; and the identity, description and location of the perpetrator. If the crime involves abuse, neglect or domestic violence, the requirements of Section 101 of this chapter apply. ( )

106. -- 124. (RESERVED)

125. ACCESS TO AN INDIVIDUAL'S OWN RECORD.
An individual who is at least fourteen (14) years old, or a legal representative, may review and obtain a copy of Department records that pertain to the individual, subject to the exceptions listed in Subsections 125.01 through 125.04 of these rules. Requests must be in writing, identifying the individual whose record is sought, and the record or information requested. The principles of disclosing only minimally necessary information on a need-to-know basis do not apply to a request for an individual's own records. The following information must not be disclosed:
( )

01. Children's Mental Health. Records of a child's mental health services must not be disclosed to the child when a physician or other mental health professional has noted that disclosure would be damaging to the child, unless access is ordered by a court according to Section 16-2428, Idaho Code. ( )

02. Legal Action. No disclosure will be made to an individual of information compiled in an ongoing investigation, that is exempt from disclosure, or that relates to adoption. Information compiled in reasonable anticipation of litigation that is not otherwise discoverable must not be disclosed. Information compiled for use in a civil, criminal, or administrative proceeding to which the individual is a party must not be disclosed except in compliance with valid discovery. ( )

03. Clinical Laboratories. There will be no disclosure of information maintained by a clinical laboratory except as authorized by the provider who ordered the test or study, in compliance with 42 USC 263a.
( )

04. Confidential Information. Health and other confidential information will not be disclosed to the individual if a licensed professional in an appropriate discipline determines that disclosure is likely to endanger the life or physical safety of the individual or another person. Disclosure to a legal representative will be denied if there is a professional determination that access by the representative is likely to cause substantial harm to the subject of the record or another person. ( )

126. -- 149. (RESERVED)

150. AMENDMENT OF RECORD.
Unless otherwise provided by law, individuals may request in writing to amend the content of a record created by the Department. The Department will respond in writing within ten (10) days, granting or denying the amendment. A record created by a third party will not be amended by the Department. ( )

01. Amendment of Health Information. Once an amendment regarding health information is approved and recorded, the Department will provide the amended health information when the record is disclosed in the future. If an amendment of health information is denied, the individual may provide a written response, which the Department may rebut in writing to the individual. Upon request, documentation of all the records involved in the denial will be provided whenever that information is disclosed in the future. ( )

02. Updating Identifying Information. Name and address changes, and similar updates of information in Department files will be made without using the amendment process. ( )

151. -- 174. (RESERVED)

175. REPORT OF DISCLOSURES OF HEALTH INFORMATION.

01. Documented Disclosures. The following disclosures of identifying health information for a purpose other than providing health treatment, payment or operations will be documented: ( )

a. Required by law; ( )

b. Public health activities; ( )

c. Related to victims of abuse, neglect or domestic violence; ( )

d. Health care oversight; ( )

e. Judicial and administrative proceedings; ( )

f. Correctional institutions or custodial law enforcement situations; ( )

g. Coroners, medical examiners, and funeral directors; ( )

h. Organ or tissue donations; ( )

i. Research; ( )

j. To avert a serious threat of health and safety; and ( )

k. Specialized government functions such as national security or intelligence. ( )

02. Documentation of Disclosure. Documentation will identify when the disclosure occurred, to whom, what information was disclosed and for what purpose. ( )

03. Maintenance of Documentation. The Department maintains documentation of these disclosures of health information for six (6) years. ( )

04. Request for Report of Disclosures. An individual or legal representative may receive one (1) free report of disclosures per calendar year for six (6) years beginning April 14, 2003. Additional requests for a report of disclosures are processed as public record requests, and may be subject to fees. ( )

05. Pending Investigation. The Department must suspend reporting of a disclosure of health information at the request of any federal, state or local entity that is conducting an investigation related to the oversight of health care, illegal discrimination, licensing, certification or accreditation. If the request is verbal, the suspension will terminate after thirty (30) days unless the request is renewed in writing. ( )

176. -- 189. (RESERVED)

190. RECORDS OF DECEDENTS.
Records of decedents are confidential for as long as the Department maintains the records, except as needed by: ( )

01. Law Enforcement. If there is suspicion that the death was the result of criminal conduct. ( )

02. Coroners and Medical Examiners. Information may be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law. ( )

03. Funeral Directors. Confidential information may be given to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent. If necessary to carry out their duties, confidential information may be disclosed to funeral directors prior to and in reasonable anticipation of the individual's death. ( )

04. Personal Representatives. While records are maintained, the same confidentiality requirements apply to the personal representative of the estate or other legal representative of the deceased individual. Information may be disclosed to such representatives only to the extent necessary to perform their legal function, ( )

05. Family Members and Others. The Department may disclose health information to a family member, other relative, a close personal friend of the deceased individual, or any other person identified by the deceased individual. Information provided must be directly related to such person's involvement with the individual's care or payment for health care prior to the individual's death, unless doing so is inconsistent with any prior expressed preference of the individual that is known to the Department. ( )

191. DATA FOR RESEARCH OR OTHER PURPOSES.
Records that contain non-identifying information may be disclosed for Department-approved research or other purposes without a written authorization. ( )

192. -- 199. (RESERVED)

SPECIFIC CONSENT AND DISCLOSURE REQUIREMENTS
(Sections 200-283)

200. ABORTION FOR MINORS.
Consent for an abortion for a minor is governed by Section 18-609A, Idaho Code. ( )

201. ABUSE, NEGLECT OR DOMESTIC VIOLENCE.
Abuse, abandonment or neglect of a minor is required to be reported in compliance with Section 16-1605, Idaho Code. Abuse, neglect or exploitation of adults is governed by Section 39-5303, Idaho Code. An exception to the physician/patient privilege for domestic violence is contained in Section 9-203, Idaho Code. ( )

202. ADOPTION.
Disclosure of adoption records is governed by the provisions of Sections 74-105(6), 16-1501, 39-258, 39-259A, and 39-7501 through 39-7905, Idaho Code. Consent to adoption by children who are more than twelve (12) years old, by parents and by others, is governed by Section 16-1504, Idaho Code. ( )

203. -- 209. (RESERVED)

210. CHILD PROTECTION.
Unless allowed by these rules or other provision of law, the Department will disclose information from child protection records in its possession upon a court order obtained in compliance with Subsection 075.02 of these rules. Disclosure of Department records under the Child Protective Act is governed by Section 16-1629(6), Idaho Code. Court records of Child Protective Act proceedings are governed by Section 16-1626, Idaho Code. Pertinent federal laws and regulations include 42 USC 5106a. Information regarding child fatalities or near fatalities may be made public. ( )

01. Child Fatalities. In accordance with 42 USC 5106a(b)(2)(B)(x), the Department will disclose non-identifying summary information to the Statewide Child Fatality Review Team, established by the Governor's Task Force on Children at Risk, regarding child fatalities that were determined to be the result of abuse, neglect, or abandonment. ( )

02. Public Disclosure. The Department has the discretion to disclose child-specific information under this rule when the disclosure is not in conflict with the child's best interests and one (1) or more of the following applies: ( )

a. Identifying information related to child-specific abuse, neglect, or abandonment has been previously published or broadcast through the media; ( )

b. All or part of the child-specific information has been publicly disclosed in a judicial proceeding; or ( )

c. The disclosure of information clarifies actions taken by the Department on a specific case. ( )

211. CHILDREN'S MENTAL HEALTH.
Consent to voluntary treatment for a minor with serious emotional disturbance, emergency and involuntary treatment are governed by the Children's Mental Health Services Act, Title 16, Chapter 24, Idaho Code. Section 16-2428, Idaho Code, describes requirements for confidentiality. ( )

212. -- 219. (RESERVED)

220. HARD TO PLACE CHILDREN.
The Department disseminates information to prospective adoptive families and families who wish to be appointed legal guardians of a child in the state's custody, as to the availability of hard-to-place children, adoption and guardianship procedures, and the existence of financial aid to adoptive families and guardians of hard-to-place children, in compliance with Section 56-804, Idaho Code. ( )

221. HOSPITAL RECORDS.
Records of hospitalization in a state facility are governed by Sections 39-1392b, 39-1392e and 39-1394, Idaho Code. ( )

222. HUMAN RESOURCES.
Disclosure of employee information is governed by Section 74-106(1), Idaho Code. ( )

223. INFANT/TODDLER PROGRAM.
Consent to early intervention services and confidentiality of records that relate to the Infant/Toddler program are governed by the Individuals with Disabilities Education Act (IDEA), 20 USC 1414(a)(1)(C) and (c)(3), and 20 USC 1415(b)(3); the Family Educational Rights and Privacy Act (FERPA), 20 USC 1232g; and 34 CFR 303.400, 34 CFR 303.500 and 34 CFR part 99. ( )

224. -- 229. (RESERVED)

230. MEDICAL CARE.
Consent to apply for services or treatment is governed by Title 39, Chapter 45, Idaho Code, for hospital, medical, dental or surgical care, treatment or procedure. ( )

231. -- 239. (RESERVED)

240. MENTAL ILLNESS.
Records of assessment, treatment, and commitment or hospitalization of individuals with mental illness are governed by Sections 66-318, 66-348, 66-355, 66-329(9), and 66-337, Idaho Code. ( )

241. MINOR'S CONSENT REGARDING INFECTIOUS, CONTAGIOUS OR COMMUNICABLE DISEASE.
Section 39-3801, Idaho Code, governs consent to treatment for infectious, contagious or communicable disease by a minor who is at least fourteen (14) years of age. ( )

242. SPECIFIC REQUIREMENTS - PROTECTION AND ADVOCACY AGENCIES.
A protection and advocacy system for individuals who have a developmental disability is created by 42 USC 15042 et seq.; for individuals with mental illness, by 42 USC 10801. Advocacy for adult protection is governed by Sections 39-5307 and 39-5308, Idaho Code. ( )

243. -- 249. (RESERVED)

250. SUBSTANCE ABUSE.
Consent to treatment and confidentiality of alcohol and drug abuse patient records are governed by 42 CFR 2.12 through 2.67, and Sections 37-2743, 37-3102, 39-307, and 39-308, Idaho Code. ( )

01. Drug Abuse. A medical practitioner will not disclose identifying information, treatment or request for treatment, to any law enforcement officer or agency or in any proceeding, in compliance with Sections 37-2743 and 37-3102, Idaho Code. ( )

02. Age Sixteen and Over. Information regarding substance abuse treatment of an individual who is at least age sixteen (16) years old will not be disclosed to a parent or guardian unless authorized by the individual, in compliance with Section 37-3102, Idaho Code, and 42 CFR 2.14. Individuals who are at least sixteen (16) years old may consent to substance abuse treatment. ( )

251. -- 259. (RESERVED)

260. TERMINATION OF PARENTAL RIGHTS.
Disclosure of information regarding the termination of parental rights is governed by Section 16-2013, Idaho Code. ( )

261. -- 269. (RESERVED)

270. VENEREAL DISEASES.
Disclosures of health information pertaining to the control of venereal diseases, including Human Immunodeficiency Virus (HIV), is governed by Title 39, Chapter 6, Idaho Code. ( )

271. -- 279. (RESERVED)

280. VITAL STATISTICS -- VERIFICATION OF DATA.

01. Verifications. The Registrar will confirm or deny the presence and accuracy of data already known to a governmental agency that requests information from a vital record. Such verifications may be conducted by telephone for Idaho state agencies. Other requests for verification require a signed application on forms provided or approved by the Registrar, and a copy of the front and back of signed photo identification or such other information as the Registrar requests. Verifications may also be conducted via Department automated systems approved by the Registrar. ( )

02. Administrative Fact of Death Verifications. Upon agreement in writing to such conditions as the Registrar may impose, the Registrar may compare Idaho state agency administrative data to Idaho death data and return an indication of death, also known as fact of death verification, for administrative purposes only. ( )

03. Verifications to Protect a Person's Property Right. The State Registrar may approve electronic fact of death verification by entities seeking to determine or protect a person's property right. ( )

281. VITAL STATISTICS: DISCLOSURE FOR RESEARCH, PUBLIC HEALTH OR STATISTICAL PURPOSES.
Upon agreement in writing to such conditions as the Registrar may impose, the Registrar may permit the use of data from vital statistics records for research, public health or statistical purposes. The Registrar may deny a request for access to identifying information if the Registrar determines that the benefits would be outweighed by the possible adverse consequences to those individuals whose records would be used. ( )

282. VITAL STATISTICS: REGISTRY OF PUTATIVE FATHERS.
Except by Idaho court order or in accordance with the provisions of Section 16-1513, Idaho Code, information acquired by the confidential registry of putative fathers will not be disclosed. ( )

283. VITAL STATISTICS: PROCEDURES FOR REQUESTING INFORMATION.
Individuals who request access to, information from, or copies of vital records must present a signed application on forms provided or approved by the Registrar, and a copy of the front and back of signed photo identification or such other information as the Registrar requests. Minors who are less than fourteen (14) years old may receive certified copies of vital records that pertain to them if they present the required information. ( )

01. Expedited Copy. An expedited certified copy of a vital record may be issued using Department automated systems. ( )

02. Certified Copy. When a certified copy is issued, it is certified as a true copy or abstract of the original vital record by the officer who has custody of the record. The certified copy will include the date issued, the Registrar's signature or an authorized facsimile thereof, and the seal of the issuing office. Full or short form certified copies of vital records may be made by mechanical, electronic or other reproduction processes. ( )

284. WOMEN, INFANTS AND CHILDREN (WIC) PROGRAM.
WIC information may be used and disclosed only for the purpose of establishing the eligibility of WIC applicants and participants for health and welfare programs. ( )

285. -- 999. (RESERVED)

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 under Sections 16-107, 56-133, 56-135, 56-202, 56-204A, 56-216, 56-1003, 56-1004, and 56-1005, Idaho Code. ( )

001. TITLE AND SCOPE.

01. Title. These rules are titled IDAPA 16.05.03, "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. ( )

002. ACCESS TO RECORDS OF INDIVIDUALS WITH DEVELOPMENTAL OR MENTAL DISABILITIES.
The state Protection and Advocacy System established under 42 USC 15041, et seq., and 42 USC 10801 et seq., 29 USC 794e, et seq., and 42 USC 300d as designated by the Governor has access to records of individuals who are clients of the system maintained by any program or institution of the Department if the individual has authorized or is unable to authorize the system to have such access, or does not have a legal guardian, conservator or other legal representative. ( )

003. ADMINISTRATIVE APPEALS.
All contested cases are 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. -- 009. (RESERVED)

010. DEFINITIONS AND ABBREVIATIONS.
For the purposes of this chapter, the following definitions and abbreviations apply. ( )

01. Administrative Review. An informal review by a Division Administrator or designee, to determine whether a Department decision is correct. ( )

02. Appellant. A person or entity who files an appeal of Department action or inaction. ( )

03. Board. The Idaho Board of Health and Welfare. ( )

04. Complainant. A person or individual who has a grievance regarding Youth Empowerment Services (YES). ( )

05. Cost Report. A fiscal year report of provider costs required by the Medicare program and any supplemental schedules required by the Department. ( )

06. Cost Settlement. Final determinations of payment, based on cost reports, to a Medicaid-enrolled provider. ( )

07. Department. The Idaho Department of Health and Welfare. ( )

08. Director. The Director of the Department of Health and Welfare. ( )

09. Hearing Officer. The person designated to preside over a particular hearing and any related proceedings. ( )

10. IPV. Intentional program violation. ( )

11. Intervenor. Any person, other than an appellant or the Department, who requests to be admitted as

a party in an appeal. ( )

12. Managed Care Entity (MCE). An entity contracted by Medicaid to administer Medicaid services, which may be a Prepaid Ambulatory Health Plan (PAHP), Prepaid Inpatient Health Plan (PIHP), or other Managed Care Organization (MCO) as defined in 42 CFR 438.2. As used in these rules, the term does not include service brokers or entities providing non-emergency medical transportation (NEMT) services. ( )

13. Party. An appellant, the Department and an intervenor, if intervention is permitted. ( )

14. Youth Empowerment Services (YES) Program Participant. A YES program participant, is an Idaho resident with a Serious Emotional Disturbance who: ( )

a. Is under the age of eighteen (18); ( )

b. Has a mental health condition described in the current Diagnostic and Statistical Manual of Mental Disorders (DSM) and diagnosable by a qualified professional operating within the scope of their practice as defined by Idaho state law; and ( )

c. Has a substantial functional impairment that is measured by and documented through the use of a standardized instrument conducted or supervised by a qualified clinician. ( )

d. A substance use disorder or development disorder alone does not constitute an eligible diagnosis, although one (1) or more of these conditions may coexist with an eligible mental health diagnosis. ( )

011. -- 039. (RESERVED)

040. PETITION FOR ADOPTION OF RULES.
Under 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 must 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 will initiate rulemaking proceedings or deny the petition in writing within twenty-eight (28) days. ( )

041. -- 049. (RESERVED)

050. PETITION FOR DECLARATORY RULING.
Under 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 must identify that it is a request for a declaratory ruling under this section of rule; 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 must 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 must 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 will 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 will advise the individual or provider in writing of the right and method to appeal and the right to be represented. ( )

101. FILING OF APPEALS.

01. Appeals. Appeals must be filed in writing and state the appellant's name, address, and phone number, and the remedy requested, unless otherwise provided in these rules. Appeals should be accompanied by a copy of the decision notice that is the subject of the appeal and state the reason for disagreement with the Department's action. ( )

02. Time Limits for Filing Appeal. Unless otherwise provided by statute or these rules, individuals who are aggrieved by a Department decision have twenty-eight (28) days from the date the decision is mailed to file an appeal. An appeal is filed when it is received by the Department or postmarked within the time limits provided in the decision notice, or in these rules. ( )

102. NOTICE OF HEARING.
All parties in an appeal will 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 will 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 must identify how and when documents for the hearing will be provided to all parties. ( )

103. PREHEARING CONFERENCE.

01. Prehearing Conference. The hearing officer may, upon written or other sufficient notice to all interested parties, hold a prehearing conference. The purpose of the prehearing conference is to: ( )

a. Formulate or simplify the issues; ( )

b. Obtain admissions or stipulations of fact and documents; ( )

c. Identify whether there is any additional information that had not been presented to the Department with good cause; ( )

d. Arrange for exchange of proposed exhibits or prepared expert testimony; ( )

e. Limit the number of witnesses; ( )

f. Determine the procedure at the hearing; and ( )

g. Determine any other matters that may expedite the orderly conduct and disposition of the proceeding. ( )

02. Exception to Prehearing Conference. The prehearing conference cannot be mandatory for any Division of Welfare or Division of Medicaid benefit programs. The following apply: ( )

a. Participation in the prehearing conference is optional for individuals seeking to appeal for any benefit through the Division of Welfare or Division of Medicaid; and ( )

b. A default order may not be entered for cases in which an individual does not participate in the prehearing conference involving benefits through the Division of Welfare, or Division of Medicaid. ( )

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, or for lack of jurisdiction. The hearing officer must dismiss an appeal that is not filed within the time limits set forth in these rules. ( )

106. DEFAULT.
Unless otherwise provided by statute or rule, if a party fails to appear at a scheduled hearing or at any stage of a contested case, the hearing officer must enter a proposed default order against that party. The default order must be set aside if, within fourteen (14) days of the date of mailing, that party submits a written explanation for not appearing, which the hearing officer finds substantial and reasonable. ( )

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 is not to be construed as 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. CONSOLIDATED HEARING.
When there are multiple appeals or a group appeal involving the same change in law, rules, or policy, the hearing officer will hold a consolidated hearing. ( )

109. -- 119. (RESERVED)

120. DISCOVERY.
Except for hearings involving Section 56-1005(5), Idaho Code, prehearing discovery is limited to obtaining the names of witnesses and copies of documents the opposing party intends to offer as exhibits. The hearing officer may order production of this information if a party refuses to comply after receiving a written request. The hearing officer will issue such other orders as are needed for the orderly conduct of the proceeding. Nothing in Section 120 limits 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 must be filed with the hearing officer. Such documents will be provided to every party at the time they are filed with the hearing officer, in person, by first class mail, or as otherwise ordered by the hearing officer. 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 will 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. RESERVED.

125. INTERPRETERS.
If necessary, an interpreter will 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. The hearing officer can order that individuals be identified by initials or an alias if necessary to protect their privacy. At the discretion of the hearing officer, 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 will 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 will remand the case to the Department for consideration. No hearing officer has the jurisdiction or authority to invalidate any federal or state statute, rule, regulation, or court order. The hearing officer must defer to the Department's interpretation of statutes, rules, regulations or policy unless the hearing officer finds the interpretation to be contrary to statute or an abuse of discretion. The hearing officer will not 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 under Sections 39-5705 and 39-5708, Idaho Code. In a child support matter, the Department must first establish that arrearages are sufficient for child support enforcement action. 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, asset seizure, or other enforcement actions 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.
Under Section 67-5251, Idaho Code, the hearing is informal and technical rules of evidence do not apply, except that irrelevant, immaterial, incompetent, unduly repetitious evidence, evidence excludable on constitutional or statutory grounds, or evidence protected by legal privilege is excluded. Hearsay evidence will 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 is 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 will 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 will 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.
The hearing officer will take judicial notice, on its own motion or on the motion of any party, of the following admissible, valid and enforceable materials: Rules of the Department and other state agencies; Federal regulations; State plans of the Department; The Constitutions and statutes of the United States and Idaho; Public records; and Such other materials that a court of law must judicially notice. ( )

137. HEARING RECORD.
The hearing officer must arrange for a record to be made of a hearing. The hearing must 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 must 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 must 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 must be issued by the hearing officer not later than thirty (30) days after the case is submitted for decision. The order must 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 will not be accepted. ( )

139. -- 149. (RESERVED)

150. REVIEW OF PRELIMINARY ORDERS BY DEPARTMENT.
Unless otherwise provided in these rules, 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 must identify all legal and factual bases of disagreement with the preliminary order. The Director or designee must allow for briefing by the parties and determines whether oral argument will be allowed. The Director or designee determines whether a transcript of the hearing is needed and if so, one will be provided by the party who requests review of the preliminary order. The Director or designee must exercise all of the decision-making power they would have had if they had presided over the hearing. ( )

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 fourteen (14) days from the date the preliminary order was mailed. The request must identify all legal and factual bases of disagreement with the preliminary order. The Administrative Procedures Section will establish a schedule for the submission of briefs and if allowed, oral argument. The Board chair or designee will determine whether a transcript of the hearing is needed and, if so, one will be provided by the party who requests review of the preliminary order. Board members will exercise all of the decision-making power they would have had if they had presided over the hearing. ( )

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 informs the parties of the procedure and time limits for filing appeals with the district court. Motions for reconsideration of a final order will not be accepted. ( )

153. SERVICE OF PRELIMINARY AND FINAL ORDERS.
Orders will be deemed to have been served when copies are mailed to all parties of record or their attorneys.
( )

154. MAINTENANCE OF ORDERS.
All final orders of the Board or the Director will 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 will 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 of this chapter provide special requirements of various Department divisions or programs that supersede the general provisions of these rules to the extent that they are different. ( )

200. DIVISION OF WELFARE: APPEALS.
The provisions of Sections 200 through 299 of these rules govern the conduct of individual benefit hearings to determine eligibility for benefits or services in the Division of Welfare and its programs. ( )

01. Division of Welfare Programs. The following programs are covered under the following chapter of rules: ( )

a. IDAPA 16.03.01, "Eligibility for Health Care Assistance for Families and Children"; ( )

b. IDAPA 16.03.03, "Child Support Services"; ( )

c. IDAPA 16.03.04, "Idaho Food Stamp Program"; ( )

d. IDAPA 16.03.05, "Eligibility for Aid to the Aged, Blind, and Disabled (AABD)"; ( )

e. IDAPA 16.03.08, "Temporary Assistance for Families in Idaho (TAFI) Program"; ( )

f. IDAPA 16.04.14, "Low-Income Home Energy Assistance Program"; ( )

g. IDAPA 16.06.12, "Idaho Child Care Program (ICCP)." ( )

02. Methods for Filing Appeals. Requests for appeals may be made with the Division of Welfare using any one (1) of the following listed in this subsection: ( )

a. Via the Department's internet website: ( )

b. By telephone; ( )

c. Via mail; ( )

d. In person; and ( )

e. Other commonly available electronic means. ( )

201. DIVISION OF WELFARE: TIME FOR FILING APPEAL.
A decision issued by the Department in a Division of Welfare benefit program will 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 has 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. DIVISION OF WELFARE: 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 will be held unless the appellant withdraws the appeal, or the Department withdraws the action contested by the appellant. ( )

203. DIVISION OF WELFARE: WITHDRAWAL OF AN APPEAL.
An appellant or representative may withdraw an appeal upon request to the hearing officer using any one (1) of the methods listed in Section 200 of these rules. ( )

204. DIVISION OF WELFARE: TIME LIMITS FOR COMPLETING HEARINGS.
The Department must conduct the hearing relating to an individual's benefits and take action within ninety (90) days from the date the hearing request is received, unless as provided in Subsections 204.01 through 204.03 of this rule. ( )

01. Community Spouse Resources Allowance. When the hearing request concerns the computed amount of the Community Spouse Resource Allowance, the hearing will be held within thirty (30) days from the date the hearing request is received. ( )

02. Food Stamps. When the hearing relates to Food Stamps, the hearing, the decision of the hearing, and the notice regarding the outcome of the hearing will be completed within sixty (60) days from the date the hearing request is received. ( )

03. Expedited Hearings. The Department will expedite hearing requests from appellants for the following reasons: ( )

a. Migrant farm workers who are planning to move before the hearing decision would normally be reached; or ( )

b. Individuals requesting an expedited fair hearing will be provided a hearing as required according to 42 CFR 431.224. ( )

205. DIVISION OF WELFARE: APPEAL OF AUTOMATIC ADJUSTMENTS.
An appeal will 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. (RESERVED)

207. DIVISION OF WELFARE: POSTPONEMENT OF FOOD STAMP HEARINGS.
An appellant may request, and be granted a postponement of a hearing, not to exceed thirty (30) days. The time limit for the Department's response will be extended for as many days as the hearing is postponed. ( )

208. -- 249. (RESERVED)

250. DIVISION OF WELFARE: FOOD STAMPS DISQUALIFICATION HEARINGS.
A disqualification hearing will be scheduled when the Department has evidence that an individual has allegedly committed one (1) or more acts of intentional program violations (IPV). ( )

251. DIVISION OF WELFARE: COMBINING DISQUALIFICATION HEARING AND BENEFIT HEARING.
The hearing officer must consolidate a hearing regarding benefits or overpayment and a disqualification hearing if the issues are the same or related. The appellant must be notified that the hearings will be combined. ( )

252. DIVISION OF WELFARE: RIGHT NOT TO TESTIFY.
The hearing officer must advise the appellant that they may refuse to answer questions during a disqualification hearing. ( )

253. DIVISION OF WELFARE: FAILURE TO APPEAR.
If an appellant or representative fails to appear at a disqualification hearing or cannot be located, the hearing will be conducted in their absence. The Department must present proof that advance notice of the hearing was mailed to the appellant's last known address. The hearing officer must 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 will be void and a new hearing will be conducted. The previous hearing officer may conduct the new hearing. ( )

254. DIVISION OF WELFARE: STANDARD FOR DETERMINING INTENTIONAL PROGRAM VIOLATIONS.
The determination that an intentional program violation has been committed must be established by clear and convincing evidence that the appellant committed or intended to commit an IPV. ( )

255. -- 297. (RESERVED)

298. DIVISION OF WELFARE: CHILD SUPPORT SERVICES.
In a child support enforcement proceeding, an individual or a representative may request a hearing after being served notice of license suspension or notice of an asset withholding order from the Financial Institution Data Match (FIDM) process. ( )

01. Time Limits for Requesting a Hearing. ( )

a. License Suspension. The licensee has twenty-one (21) days from the date of service of the notice either by personal service or certified mail, to request a hearing by filing with the Department to contest the suspension of license or licenses. A timely request for a hearing stays the suspension of the license or licenses through the issuance of the order by the Department. The Department will notify the licensing authority if the suspension is vacated or stayed. ( )

b. Financial Institution Data Match (FIDM). The obligor or co-owner has fourteen (14) days from the date of mailing the notice of asset withholding order to request a hearing in writing to contest the asset being withheld. Upon receiving a timely request for hearing, the Department will notify the financial institution that it must continue to hold the asset until an order is issued and the Department provides instructions for the disposition of the asset. If the obligor or co-owner does not file a timely request for hearing, the Department will notify the financial institution to promptly surrender the amount of the asset that has been frozen to the Department. ( )

02. Time Limits for Completing Hearings. The Department will hold an administrative hearing within thirty (30) days from the day the Department receives the request for hearing to contest asset withholding from the FIDM process. ( )

03. Default. ( )

a. Licensing Authority. If the licensee fails to make a timely request for a hearing or fails to appear at the hearing without good cause, the Department will issue an order of Default suspending the license or licenses. On receipt of the final order from the Department, the licensing authority will suspend the license effective the date the order became final, without additional review or hearing. ( )

b. Financial Institution. If the obligor or co-owner of the asset fails to appear at the hearing without good cause, the Department will issue an order of Default upholding the asset withholding order. On receipt of the final order from the Department, the financial institution will promptly surrender the amount of the asset that has been frozen to the Department. ( )

04. Time for Filing an Appeal. An order of suspension or asset withholding order issued by a hearing officer of the Department will be final and conclusive between the parties unless a petition for review is filed within twenty-eight (28) days with the district court. ( )

299. (RESERVED)

300. DIVISION OF MEDICAID: ADMINISTRATIVE REVIEWS FOR PROVIDERS AND FACILITIES.

01. Written Request. An action relating to audited cost reports or Medicaid cost settlement calculations required by administrative rule is final and effective unless the provider or facility requests in writing an administrative review within thirty (30) days after the notice is mailed. The request must: ( )

a. Be signed by the licensed administrator of the facility or by the provider; ( )

b. Identify the challenged decision; ( )

c. State specifically the grounds for its contention that the decision was erroneous; and ( )

d. Include copies of any documentation on which the facility or provider intends to rely to support its position. ( )

02. Review Conference. The parties must clarify and attempt to resolve the issues at the review conference, which must be held within thirty (30) days after the request for the administrative review is received. The thirty (30) day requirement may be extended when both parties agree in writing to a specified later date. If the Department determines that additional documentation is needed to resolve the issues, a second session of the conference may be scheduled within thirty (30) days of the initial conference. This second session date may be extended when both parties agree in writing to a specified later date. ( )

03. Department Decision. The Department will provide a written decision to the facility or provider. ( )

301. DIVISION OF MEDICAID: SCOPE OF APPEAL HEARING.
If the Department's decision after the administrative review is appealed, only issues and documentation that were presented in the administrative review will be admissible in the appeal hearing. ( )

302. DIVISION OF MEDICAID: APPEALS PROCESS FOR MEDICAID PARTICIPANTS.

01. Medicaid Participant Appeals. Medicaid participants whose appeals are not related to services delivered through a Managed Care Entity (MCE), as defined in Section 010 of these rules, must use the appeals process provided in Sections 101 through 199 of these rules. ( )

02 Medicaid Participant Appeals Related to Services Delivered Through Managed Care Entity. ( )

a, Participants whose appeals are related to services delivered through a managed care entity must utilize the complaint, grievance, and appeal process required by the Department and the managed care contractor. ( )

b. Participants whose appeals are related to services delivered through a Managed Care Entity (MCE) must follow the appeals process in 42 CFR 438.402 through 42 CFR 438.408. ( )

03. Expedited Fair Hearings for Medicaid Participants. The Department will provide a process for expedited fair hearings for Medicaid participants in accordance with 42 CFR Part 438 or 431, as applicable. ( )

303. -- 399. (RESERVED)

400. DIVISION OF HEALTH: LABORATORIES.
A notice of grounds for denial, suspension, revocation or renewal becomes 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 will be held not more than twenty-eight (28) days from receipt of the appeal. The applicant or responsible person will 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. DIVISION OF HEALTH: REPORTABLE DISEASES.
An order for isolation or quarantine is a final agency action as set forth in Section 56-1003(7), Idaho Code. Other orders or restrictions as specified in IDAPA 16.02.10, "Idaho Reportable Diseases," 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 will be reviewed by the Board. The order or restriction remains effective unless rescinded by the Board. ( )

402. DIVISION OF HEALTH: FOOD ESTABLISHMENTS.
Appeal procedures will be as provided under IDAPA 16.02.19, "Idaho Food Code," Section 861. ( )

403. -- 499. (RESERVED)

500. DIVISION OF FAMILY AND COMMUNITY SERVICES: CHILD PROTECTION CENTRAL REGISTRY ADMINISTRATIVE REVIEW.
A substantiated incident of child abuse, neglect, or abandonment will automatically become effective and be placed on the Child Protection Central Registry unless the individual identified in the notification files a request for an administrative review within twenty-eight (28) days from the date on the notification. The request for an administrative review must be mailed to the Family and Community Services (FACS) Division Administrator.
( )

01. Content of Request. The request for an administrative review must identify the notification being protested and explain the reasons for disagreement. Additional information may be provided for the Administrator's consideration. ( )

02. Administrative Review. The FACS Division Administrator will consider all available information and determine whether the incident was erroneously determined to be "substantiated." The Administrator will furnish a written decision to the individual. ( )

501. DIVISION OF FAMILY AND COMMUNITY SERVICES: INTENSIVE BEHAVIORAL INTERVENTION (IBI) ADMINISTRATIVE REVIEW.

01. Request for Administrative Review. An action relating to certification, billing, or reimbursement is final and effective unless the provider requests in writing an administrative review within twenty-eight (28) days after the notice is mailed. The request must be signed by the provider, identify the challenged decision, and state specifically the grounds for its contention that the decision was erroneous. The parties must clarify and attempt to resolve the issues at the review conference, which must be held within twenty-eight (28) days after the request for the administrative review. If the Department determines that additional documentation is needed to resolve the issues, a second session of the conference may be scheduled. The Department will provide a written decision to the facility or provider. ( )

02. Scope of Appeal Hearing. If the Department's decision after the administrative review is appealed, only issues and documentation that were presented in the administrative review will be admissible in the appeal hearing. ( )

502. DIVISION OF FAMILY AND COMMUNITY SERVICES: INFANT TODDLER PROGRAM - INDIVIDUAL CHILD COMPLAINTS.

01. Individual Child Complaints. Parents or providers may request a hearing if they disagree with decisions regarding the identification, evaluation, or placement of a child, or, with the provision of appropriate early intervention services. A request must be filed with the Department's Administrative Procedures Section within

twenty-eight (28) days from the date the decision is issued. The request for a hearing must identify: ( )

a. The child's name, home address, and the early intervention program serving the child; ( )

b. A statement identifying the facts and the reason for disagreement with the decision; ( )

c. The name of the provider who is serving the child; ( )

d. A proposed resolution; and ( )

e. A dated signature of the person who is submitting the request. ( )

02. Mediation. The Department must offer mediation services at Department expense, which must be held within thirty (30) days after the request for a hearing. A qualified and impartial mediator who is trained in effective mediation techniques will meet at a location convenient to both parties to help them find a solution to the complaint in an informal, non-adversarial atmosphere. ( )

a. The parties must sign a confidentiality agreement before these discussions. Information discussed in the mediation cannot be used in any subsequent proceeding. ( )

b. If there is a resolution, both parties must sign a mediation agreement, which is enforceable in state or federal court. ( )

03. Due Process Hearings. The hearing must be held and a written decision mailed within thirty (30) days from the receipt of the request for a hearing, whether or not mediation occurs. The hearing officer may bar any party from introducing a relevant evaluation or recommendation that has not been disclosed at least five (5) calendar days before the hearing, unless the other party consents. ( )

a. Current Services. Appropriate early intervention services that are being provided at the time of the decision will continue unless the parties agree otherwise. ( )

b. Initial Application. If the decision involves an application for initial services, any services that are not in dispute must be provided. ( )

503. DIVISION OF FAMILY AND COMMUNITY SERVICES: INFANT TODDLER PROGRAM - ADMINISTRATIVE COMPLAINTS.

01. Filing of Complaint. An individual or organization, including those from another State, may file a written, signed complaint against any public or private service provider, alleging a violation of the Part C program and regulations at 34 CFR Part 303. The complaint must identify what requirement has been violated and the facts upon which the complaint is based. Complaints can include an allegation that a provider failed to implement the decision after a hearing. The complaint must be filed with the Department's Administrative Procedures Section within one (1) year of the alleged violation, except in the following circumstances: ( )

a. If there is a continuing violation for that child or other children; or ( )

b. If the complaint requests reimbursement or corrective action for a violation that occurred not more than three (3) years prior to the date the complaint is received by the public agency. ( )

02. Investigation and Decision. Upon receipt, the Department has sixty (60) days, unless exceptional circumstances exist, to: ( )

a. Investigate the complaint, including conducting an independent, on-site investigation if necessary; ( )

b. Receive additional information about the complaint; ( )

c. Make an independent determination whether a violation occurred; ( )

d. Issue a written decision with findings, conclusions, and an explanation for the decision. ( )

03. Resolution. If the Department concludes that appropriate services were or are not being provided, the decision must address remedial action including, if appropriate, the award of monetary reimbursement or corrective action appropriate to the needs of the child and family, technical assistance, and negotiation. The Department must also address appropriate future services for all infants and toddlers with disabilities and their families. ( )

04. Extent of Review. No issue that is being addressed in an active hearing process can be dealt with in an administrative complaint until the conclusion of the hearing. Any issue that is not part of the hearing must be resolved within the sixty (60) day review time. Issues that have already been decided in the hearing are final and binding on the complainant. ( )

504. -- 599. (RESERVED)

600. DIVISION OF LICENSING AND CERTIFICATION: REQUEST FOR ADMINISTRATIVE REVIEW.

01. Written Request. An action relating to licensure or certification is 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 must: ( )

a. Be signed by the licensed administrator of the facility, or by the provider; ( )

b. Identify the challenged decision; and ( )

c. State specifically the grounds for its contention that the decision was erroneous. ( )

02. Review Conference. An administrative review conference must be held within twenty-eight (28) days of receipt of the request for the administrative review. The twenty-eight (28) day requirement may be extended when both parties agree in writing to a specified later date. The parties must clarify and attempt to resolve the issues during the administrative review conference. If the Department determines additional documentation is needed to resolve the issues, a second session of the review conference may be scheduled. ( )

03. Department Decision. The Department will provide a written decision to the facility or provider within thirty (30) days of the conclusion of the administrative review conference. ( )

601. -- 699. (RESERVED)

700. DIVISION OF BEHAVIORAL HEALTH: REQUEST FOR ADMINISTRATIVE REVIEW.

01. Written Request. An action relating to program approval is 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 must: ( )

a. Be signed by the program administrator of the facility; ( )

b. Identify the challenged decision; and ( )

c. State specifically the grounds for its contention that the decision was erroneous. ( )

02. Review Conference. The parties must clarify and attempt to resolve the issues at the review conference, which must be held within twenty-eight (28) days after the request for the administrative review. The twenty-eight (28) day requirement may be extended when both parties agree in writing to a specified later date. If the Department determines that additional documentation is needed to resolve the issues, a second session of the

conference may be scheduled. ( )

03. Department Decision. The Department will provide a written decision to the facility or provider within thirty (30) days of the conclusion of the administrative review conference. ( )

701. -- 749. (RESERVED)

750. DIVISION OF BEHAVIORAL HEALTH: YOUTH EMPOWERMENT SERVICES (YES).
Contested case proceedings for non-Medicaid Youth Empowerment Services (YES) are governed by the general provisions of this chapter, unless otherwise specified in Section 751 of these rules. ( )

751. DIVISION OF BEHAVIORAL HEALTH: YOUTH EMPOWERMENT SERVICES (YES) GRIEVANCE PROCESS.

01. Grievance. Individuals, family members, or legal guardians may choose to submit a written request to participate in this grievance process regarding non-Medicaid matters related to YES services. A grievance is a statement of dissatisfaction about any matter other than an adverse benefit determination. ( )

02. Grievance Content. A grievance must include: ( )

a. The full name, mailing address, phone numbers, and e-mail contact for the individual who is the complainant using YES services; ( )

b. The full name, mailing address, phone numbers, and e-mail contact of the person submitting the grievance on behalf of the complainant; ( )

c. A detailed explanation of the decision or non-Medicaid matter related to YES services that is being contested from the perspective of the complainant; and ( )

d. Any steps that have already been taken to resolve the issue. ( )

03. Department Response to Grievance. The Department will respond to the complainant within sixty (60) days of receipt of the grievance on its findings. The grievance process may include gathering additional information from involved parties and may run concurrent to the fair hearing process. ( )

a. The Department will address concerns related to dissatisfaction with a process or a provider at the lowest or most appropriate organizational level possible. ( )

b. The Department will document the filing of the grievance and the outcome in its response to the complainant. ( )

04. Expedited Hearings. When the Division of Behavioral Health determines that an expedited fair hearing is needed using the same standards described in Section 302 of these rules, the Department will provide an expedited fair hearing for non-Medicaid eligible YES individuals in compliance with time limits for an agency found in 42 CFR 431 for YES inpatient services, or the time limits for a PAHP found in 42 CFR 438, for outpatient YES services. ( )

752. -- 999. (RESERVED)

16.05.04 – GRANT FUNDING FOR THE IDAHO COUNCIL ON DOMESTIC VIOLENCE AND VICTIM ASSISTANCE

000. LEGAL AUTHORITY.
Under Section 39-5209, Idaho Code, the Idaho Council on Domestic Violence and Victim Assistance (ICDVVA) is authorized to promulgate, adopt, and amend rules to implement the provisions of the Domestic Violence Project Grants Act, as contained in Title 39, Chapter 52, Idaho Code. ( )

001. TITLE AND SCOPE.

01. Title. The title of these rules is IDAPA 16.05.04, "Grant Funding for the Idaho Council on Domestic Violence and Victim Assistance." ( )

02. Scope. These rules define the application process, eligibility determination, and other requirements for the grants administered by the (ICDVVA). ( )

03. Relationship to the Department of Health and Welfare. The (ICDVVA) is attached to the Department of Health and Welfare for fiscal and administrative purposes, and any grant awards, disbursement of funds, and other procedural matters must be in compliance with Department requirements. Programmatically, the Council is independent of the Department. ( )

002. -- 005. (RESERVED)

006. CONFIDENTIALITY OF RECORDS AND PUBLIC RECORDS ACT REQUESTS.

01. Confidentiality of Records. Any information about an individual covered by these rules and contained in the Department's records must comply with IDAPA 16.05.01, "Use and Disclosure of Department Records." ( )

02. Public Records Act. The Department will comply with Title, 74, Chapter 1, Idaho Code, when requests for the examination and copying of public records are made. Unless otherwise exempted, all public records in the custody of the Department are subject to disclosure. ( )

007. -- 009. (RESERVED)

010. DEFINITIONS.
For the purpose of these rules, the following definitions apply: ( )

01. Conflict of Interest. No member of the Council may vote on any matter before the Council in which they have any substantial ownership, or fiduciary, contractual, consultative, creditor, or directly competitive relationship, and any such relationship be made publicly known. ( )

a. Appearance. In the use of grantor agency project funds, officials or employees of state or local units of government and nongovernmental grantees/subgrantees must avoid any action that might result in, or create the appearance of: ( )

i. Using his official position for private gain; ( )

ii. Giving preferential treatment to any person; ( )

iii. Losing complete independence or impartiality; ( )

iv. Making an official decision outside official channels; or ( )

v. Adversely affecting the confidence of the public in the integrity of government or the program. ( )

b. Fiduciary. Exercising a position of trust on behalf of an organization or entity, including any trustee, member of the Board of Directors, officer, legal counsel, or any other person with a legal obligation to act in the best interest of such an organization or entity. ( )

02. Contract. The grant contract between the program and the Council that results from a Council grant award. ( )

03. Council. The Idaho Council on Domestic Violence and Victim Assistance (ICDVVA) as outlined in Section 39-5201, et seq., Idaho Code. ( )

04. Department. The Idaho Department of Health and Welfare. ( )

05. Domestic Violence. Crimes of violence committed by a current or former spouse or intimate partner of the victim, by a person with whom the victim shares a child in common, by a person who is cohabitating with or has cohabitated with the victim as a spouse or intimate partner, by a person similarly situated to a spouse of the victim under the domestic or family violence laws of the state of Idaho, or a family or household member. This definition also includes criminal or non-criminal acts constituting intimidation, control, coercion and coercive control, emotional and psychological abuse and behavior, expressive and psychological aggression, financial abuse, harassment, tormenting behavior, distributing or alarming behavior, and additional acts. This definition applies to individuals and relationships as set forth in 45 CFR 1370.2. ( )

06. Victim. A person who suffers direct or threatened physical, sexual, emotional, psychological, or financial harm as a result of an act by someone else, which is a crime. ( )

011. -- 014. (RESERVED)

015. GRANTS.

01. Family Violence Grant. Money awarded to a program under the Family Violence Prevention and Services Act, Title III of the Child Abuse Amendments of 1984 P.L. 98-457,42 U.S.C. 10401, and any applicable rules and regulations. ( )

02. State Domestic Violence Grant. Money awarded to a program under Sections 39-5201 through 39-5213, Idaho Code (domestic violence project grants), and any applicable rules and regulations. ( )

03. VOCA Grant. Money awarded to a program under Victims of Crime Act of 1984, P.L. 98-473, Title II, Chapter XIV, 42 U.S.C. 10601, et seq. and any applicable rules and regulations. ( )

04. Regions. The seven (7) regions of the Department of Health and Welfare are as follows: ( )

a. REGION I -- Benewah County, Bonner County, Boundary County, Kootenai County, Shoshone County. ( )

b. REGION II -- Clearwater County, Idaho County, Latah County, Lewis County, Nez Perce County. ( )

c. REGION III -- Adams County, Canyon County, Gem County, Owyhee County, Payette County, Washington County. ( )

d. REGION IV -- Ada County, Boise County, Elmore County, Valley County. ( )

e. REGION V -- Blaine County, Camas County, Cassia County, Gooding County, Jerome County, Lincoln County, Minidoka County, Twin Falls County. ( )

f. REGION VI -- Bannock County, Bear Lake County, Bingham County, Caribou County, Franklin County, Oneida County, Power County. ( )

g. REGION VII -- Bonneville County, Butte County, Clark County, Custer County, Fremont County, Jefferson County, Lemhi County, Madison County, Teton County. ( )

05. Grant Applications. Applications for grant funding that are obtained from the Council. These will have eligibility, legal, and paperwork requirements for the grants administered by the Council. ( )

016. COUNCIL DUTIES.

01. Membership. Under Section 39-5204, Idaho Code, consist of seven (7) members appointed by the Governor of Idaho. At least one (1) member must reside in one (1) of the seven (7) Department of Health and Welfare regions. Members must be representative of persons who have been victims of domestic violence, care providers, law enforcement officials, medical and mental health personnel, counselors, and interested and concerned members of the general public. ( )

02. Purpose. Be the advisory body for programs and services affecting victims of crime. For budgetary purposes and for administrative support purposes, the Council is assigned by the Governor to the Department. ( )

03. Grants Awards Process. Award available state and federal grant money to eligible victims' services programs within the state of Idaho. The current available grants are: ( )

a. State domestic violence; ( )

b. Federal family violence; ( )

c. Federal VOCA; and ( )

d. State offender intervention program grants. ( )

04. Other Grants. The Council may establish other state or federal grants authorized under Executive Orders and under Section 39-5208(2), Idaho Code. ( )

017. ELIGIBILITY.

01. State Domestic Violence Grants. To be eligible for a state domestic violence grant, a program must comply with the applicable requirements of Title 39, Chapter 52, Idaho Code, as specified in Appendix A, these rules, and any additional requirements in the grant applications, or from the Council. ( )

02. Federal Family Violence Grant. To be eligible for a federal family violence grant, a program must comply with all the applicable sections of the Family Violence and Services Act, other federal rules and regulations, and any additional requirements in the grant applications or from the Council. ( )

03. Federal VOCA Grant. To be eligible for a federal VOCA grant, a program must comply with all the applicable sections of the Victims of Crime Act, any other federal rules and regulations that apply, these rules and any additional requirements listed in the grant applications, or from the Council. ( )

04. Tribes. All federally acknowledged tribes in the state of Idaho are eligible for ICDVVA funding. ( )

05. Application Process. The application process for grants, including time frames for both submission and disposition of applications and the form and contents of applications for annual or supplemental funding, is described in Section 018 of these rules. ( )

018. TIME FRAMES.

01. Grant Applications for Annual Grants from the Council. ( )

a. No less than once a year, the Department will publish a "Grant Applications" (GA) at least two (2) times (once a week for two (2) consecutive weeks, on the same day of the week) in a major daily newspaper in each service area. The GA will specify the deadline for submission of proposals. In no event will the deadline be less than sixty (60) days from the date of first publication of the GA. ( )

b. A copy of each GA will also be sent to current grantees and to persons and organizations who have

requested timely notification. Requests for advance notification of the solicitation of grant proposals should be directed to the Executive Director of the Idaho Council on Domestic Violence and Victim Assistance, P.O. Box. 83720, Boise, Idaho 83720 - 0036, or info@icdv.idaho.gov. ( )

c. Applications for annual grants must be postmarked, hand-delivered, e-mailed, or electronically delivered as specified in the ICDVVA application RFP, no later than the date designated in the "Grant Applications." ( )

02. Proposals or Supplemental Grants. Applications for supplemental grants may be submitted for consideration at any time during the effective period of a grant. ( )

019. DISPOSITION OF APPLICATIONS.
The Council will deny or grant funding as specified below, and all applicants will be notified in writing as to the disposition of their application. ( )

01. Applications. The Council will deny or grant funding for an annual application within ninety (90) days of the GA deadline. ( )

02. Supplemental Applications. Allocation of supplemental funding is made based upon the availability of funds. ( )

03. Late Applications. An application for annual funding received after the deadline specified in any GA will be acted upon at a regularly-scheduled meeting of the Council, following consideration of all timely initial and renewal applications for the service area. ( )

020. EVALUATION OF APPLICATIONS.
Applications from each region are be evaluated according to the following criteria: ( )

01. Threshold Factors. Before an application is evaluated and ranked, an affirmative determination must be made that: ( )

a. The applicant meets eligibility requirements as specified in Section 017 of these rules; and ( )

b. The applicant has the administrative capacity, or has adequately described how provisions for that capacity will be made if not present at the time of application, to administer a grant including having, contracting for, or obtaining staff and expertise to: ( )

i. Provide proper management and maintain the proper records; ( )

ii. Assure fiscal control and efficient disbursement of grant funds; ( )

iii. Fulfill grant requirements, including meeting reporting requirements; and ( )

iv. Provide the proposed services. ( )

02. Conflict of Interest. Under the following circumstances, a Council member must declare a conflict of interest in writing to the Executive Director and subsequently refrain from evaluating or ranking, or casting a vote to award a grant to an applicant who: ( )

a. Serves on a board of directors or advisory board with the Council member, or a member of the Council member's immediate family; ( )

b. Has been, or would be, directly involved in the project as an advisory board member, a consultant, collaborator, or trainer whose expenses would be paid from the subgrant, etc.; ( )

c. Is from the same institution or organization as the Council member, or was employed by that organization within the past year; ( )

d. Has collaborated recently on work related to the current application or other proposal; ( )

e. May consider the Council member for a position at the applicant's organization or institution; ( )

f. Has an organization in which the Council member has served in an official or unofficial capacity within the past year; ( )

g. Has an organization in which the Council member has employees, or closely affiliated officials, who serve as board members or in other official capacities for the applicant; ( )

h. Has a family relationship with the Council member; ( )

i. Is known to be close friends or open antagonists with the Council member; or ( )

j. Is currently directly involved in a closely associated project with the Council member. ( )

03. Evaluation Criteria. The Council uses the following criteria to evaluate applications: ( )

a. Assessment of existing victim services in the community and demonstrated need for proposed services in the area. ( )

b. Scope of services or number of eligible activities to be provided. ( )

c. Estimated number of clients to be served and expansion potential, if any. ( )

d. Knowledge and use of other available funding sources or fund-raising activities. ( )

e. Involvement and coordination with community resources including identification of sources of victim access. ( )

f. Recruitment efforts for volunteers to meet the specific needs of the program and the community. ( )

g. Performance record of past activities, if any, including: ( )

i. Creative use of volunteers; ( )

ii. Training of volunteers; ( )

iii. Fund-raising activities; ( )

iv. Administrative performance; ( )

v. Degree of incorporation of self-help activities into program; and ( )

vi. Education service to community. ( )

h. Cooperation with other area domestic violence and victim assistance programs to insure services to all areas and victims without duplicating services. ( )

021. ON-SITE EVALUATIONS.

01. Initial Evaluation. Prior to the awarding of an initial grant, the Department is authorized to

conduct an on-site evaluation of the program to ensure that the program is in substantial compliance with these rules and to determine the capability of the program to provide the services for which funding is requested. The program must provide for review of any and all client records, program records, financial statements, and other documents needed by the Council to make its determination, including any information that may have changed since the time the application was submitted. ( )

02. Follow-Up Evaluations. In addition to any initial on-site evaluation, the Council is authorized, upon reasonable notice to the program, to conduct such on-site evaluations of the program: ( )

a. To determine continued compliance with these rules and other applicable requirements; or ( )

b. To determine the continued capability of the program to provide the services for which funding has been granted. ( )

022. DOMESTIC VIOLENCE GRANT DISTRIBUTION.
Domestic violence project grants will be awarded in the following manner: ( )

01. Distribution of Domestic Violence Grants to Regions. On an annual basis, following determination by the Council of the total funds available for domestic violence grant awards for the following fiscal year, the Council shall establish and announce the base level of funding available for each region. ( )

a. In accordance with Section 39-5212, Idaho Code, not less than fifty-one percent (51%) of available grant funds will be allocated to programs within the seven (7) regions in the proportion that marriage licenses are filed in each region, based on statistics compiled by the state registrar of Vital Statistics. ( )

b. The allocation of the remaining percentage of available grant funds shall be established and announced annually in varying percentages based on consideration of the following and in the order of priority shown below: ( )

i. Identification of critical needs and evidence of relative distribution of victim population within the state. ( )

ii. Calculation of a population/area factor, using current U.S. census data and employing the following formula: ( )

(1) Multiply the population of a region by two (2) and divide the product by the total state population; and ( )

(2) Divide the square miles for a region by the total square miles for the state and add the resulting figure to the figure determined by calculating the amount as set out in Subsection 022.01.b.i.(1). ( )

(3) Divide the sum by three (3), yielding a percentage figure which represents the population/area factor for the region. ( )

iii. Identification of programs with statewide applicability. ( )

c. In the event that proposals received from eligible applicants within a given region are insufficient and/or inadequate or that grants awarded are not accepted or grant agreements finalized on a timely basis, or a grant is terminated prior to the completion date, the Council shall solicit qualified new or supplemental proposals from the region and will hold the funds available for the region for a period of six (6) months. ( )

d. Any domestic violence grant funds not obligated or expended during any award period will be apportioned by the Council at its discretion. ( )

02. Distribution of Domestic Violence Grants Within the Regions. ( )

a. Programs shall be selected through a comparative application process; and ( )

b. Applicants shall be compared only with other applicants from the same region; and ( )

c. The Council is not obligated to select or approve any proposal received. ( )

03. Timing and Duration of Grant Awards. Grant awards under the domestic violence grants project shall be made for a period not to exceed one (1) year unless revoked. Actual funds shall be distributed in accordance with the schedule of payments established for each grant. ( )

023. VICTIM ASSISTANCE GRANT DISTRIBUTION.
Victim assistance grants will be awarded in the following manner: ( )

01. Distribution of Victim Assistance Grants to Priority Categories and Regions. On an annual basis, following the Council's receipt of an award letter from the U.S. Justice Department announcing the amount available for victim assistance grants for the following fiscal year, the Council shall establish and announce the base level of funding available for the priority categories and for each region. Determination of the actual percentage and amount of funds to be allocated for the priority and other categories for the regions, and for statewide projects will be based on data available to the Council. ( )

a. Allocations for Priority and Other Categories. The Council shall allocate the federal crime victim assistance funds awarded to Idaho to programs by complying with regulations of the Victims of Crime Act of 1989, P.L. 98-473, Title II, Chapter XIV, 42 U.S.C. 10601, et seq. ( )

b. Allocations for Service Areas. ( )

i. The Council shall allocate the victim assistance funds by region based on a population/area factor, as outlined in Subsection 022.01.b.ii. ( )

ii. At its discretion, the Council may reserve a portion of the victim assistance grant funds for programs with statewide applicability. ( )

c. Any victim assistance grant funds not obligated or expended during any award period shall be apportioned by the Council at its discretion, within the established federal limits governing use of the funds. ( )

02. Distribution of Victim Assistance Grants Within Priority Categories and Regions. Grants shall be awarded through comparison and consideration of applications within a region according to the category of victim services being proposed. The Council is not obligated to select or approve any proposal received. ( )

03. Timing and Duration of Grant Awards. Grant awards made under the victim assistance grants project shall be made for a period not to exceed one (1) year unless revoked. Actual funds shall be distributed in accordance with the schedule of payments established for each grant. ( )

024. FAMILY VIOLENCE GRANT DISTRIBUTION.
Family violence grants shall be awarded on an annual basis, following receipt of an award letter from the United States Department of Health and Human Services, announcing the amount available for family violence grants for the following fiscal year. The Council shall establish and announce the funding available for each region based upon the following allocation. ( )

01. Allocation. If all seven (7) regions have qualified and eligible applicants, the amount available shall be divided by seven (7). If not all regions have qualified and eligible applicants, the amount available shall be divided by the number of regions that have qualified and eligible applicants. The Council is not obliged to accept or approve any proposal received. ( )

02. Timing and Duration of Grant Awards. Grant awards made under the family violence grant project will be made for a period not to exceed one (1) year, unless revoked by the Council. Actual funds shall be

distributed in accordance with the payment scheduled for each grant. ( )

025. -- 030. (RESERVED)

031. AWARDING OF GRANTS.
Notification of grant awards shall be accomplished through preparation and issuance of a contract specifying, at a minimum, the eligible activities for which the grant is to be awarded, including the beginning and termination dates of the grant; the amount of the grant award; the schedule of payments; and any terms and conditions additional to these rules which are agreed to by the parties. ( )

01. Acceptance of Grant Award by Grantee. Acceptance of the grant award is to be accomplished by returning two (2) copies of the contract bearing the original, signature of the duly authorized representative of the grantee. The copies of the signed contract are to be returned to the Council within fifteen (15) days of the date of the letter transmitting the agreement to the grantee. ( )

02. Approval or Grant Agreement. The agreement will be deemed approved and the grant effective upon the effective date specified in the agreement when signed by the authorized official for the Council. If more than sixty (60) days have elapsed between the stated effective date and the date the agreement is signed for the Council: ( )

a. There will be no penalty or reduction of funding if the delay was attributable to the Council. ( )

b. The program may face a reduction in funding and renegotiation of the agreement if the delay was attributable to the program. ( )

032. DENIAL, SUSPENSION, OR TERMINATION OF GRANT.

01. Compliance Issues. A grant may be suspended pending investigation to determine compliance with these rules. An application for a grant may be denied or a grant terminated if the program is not in compliance with these rules. ( )

02. Disincorporation. In the event a legal entity which is the recipient of a grant disincorporates, the Council must be informed in writing within twenty (20) days and the grant terminated. Grant funds for all but the portion of the fiscal year during which services required under the grant were performed must be recovered by the Council. Reallocation of remaining grant funds will be in accordance with applicable law. ( )

03. Internal Take-Over. If the governing board of one (1) of an agency's programs takes over the agency, with the program's board actually becoming the new board of the agency, the Council must be notified in writing within twenty (20) days. The grant may continue in effect without interruption. ( )

033. APPEAL OF GRANT AWARD DECISION.
No later than fifteen (15) days from the date of written notification from the Council to a program announcing denial of its grant application or suspension or termination of its grant, a program may file a written request for reconsideration of the Council's decision. All requests for reconsideration must be addressed and submitted to the executive director of the Council. ( )

01. Contents of Request for Reconsideration. Any request for reconsideration must contain all pertinent facts supporting the program's request for the Council to reconsider its grant award decision. ( )

02. Disposition of Request for Reconsideration. Upon notification of a timely request for reconsideration, the chairperson of the Council will appoint a panel composed of three (3) Council members to review the contents of the request and all pertinent data upon which the Council based its original decision. ( )

03. Disposition of Funds for Service Area Pending Reconsideration. While a timely and valid request for reconsideration received from a program is pending, fifty percent (50%) of the funds allocated to the

service area in which the program is located will be held. ( )

04. Issuance of Decision. Following consideration of all data pertinent to the issue, the appointed panel will prepare a written report of its deliberations and issue a dated decision concerning the recommended resolution of the dispute. Copies of the report and the decision will be transmitted to the full Council and to the program submitting the request. ( )

05. Appeal of the Council's Decision. If the program is unsatisfied by the decision of the Council, a written appeal setting out the basis for the appeal may be filed. It must be received by the executive director of the Council no later than fifteen (15) days from the date of the Council's written decision. ( )

06. Hearing on Appeal. Upon notification of receipt of a timely appeal, the chairperson of the Council will appoint a hearing officer to convene a hearing in accordance with the Idaho Administrative Procedure Act, Sections 67-5201, et seq., Idaho Code. ( )

034. PAYMENT PROCEDURES.
Procedures for payment will be set out in the contract issued by the Council. ( )

035. STATE AND FEDERAL DOMESTIC VIOLENCE GRANT -- RECORD KEEPING REQUIREMENTS.
Each program receiving a grant(s) from the Department must maintain accurate, current and complete client, administrative and fiscal records, including accurate records of the receipt, obligation and disbursement of funds. Records must be accessible to authorized state officials during normal operating hours for purposes of inspection and/or audit, with or without prior notification, pursuant to Section 39-108, Idaho Code. The fiscal and program record requirements required for each grant are in the contract. ( )

036. AUDITS.
Projects selected for funding by the Council will be subject to audit. Pursuant to the U.S. Office of Management and Budget (OMB) Circular A-128, "Audits of State and Local Governments," grantees have the responsibility to provide for an audit of their activities. These audits shall be made annually. Grantees as well as their contractors or other organizations under cooperative agreements or purchase of service contracts are to arrange for examination in the form of independent audits in conformance with OMB Circular A-128. ( )

01. Audit Requirement. These audits shall be made by an independent auditor in accordance with generally accepted governmental auditing standards governing financial and compliance audits. The required audits are to be performed on an organization-wide basis. The audit reports must include: ( )

a. The auditor's report on financial statements of the recipients organization and a schedule of financial assistance showing the total expenditures for each assistance program; ( )

b. The auditor's report on compliance containing: ( )

i. A statement of positive assurance with respect to those items tested for compliance, including compliance with law and regulations pertaining to financial reports and claims for advances and reimbursements; ( )

ii. A negative assurance of those items not tested and a summary of all instances of noncompliance; and ( )

iii. The auditor's report on the study and evaluation of internal control systems, which must identify accounting controls, and those controls designed to provide reasonable assurance that federal programs are being managed in compliance with applicable laws and regulations. It must also identify the controls that were not evaluated, and the material weaknesses identified as a result of that identification. ( )

02. Audit Objectives. Grants and other agreements are awarded subject to conditions of fiscal, program and general administration to which the recipient expressly agrees. Accordingly, the audit objective is to renew the recipient's administration of grant funds and required non-federal contributions for the purpose of

determining whether the recipient has: ( )

a. Financial statements of the government, department, agency, or establishment that present fairly its financial position and the results of financial operations in accordance with generally accepted accounting principles; ( )

b. The organization has internal accounting and other control systems to provide reasonable assurance that it is managing federal financial assistance programs in compliance with applicable laws and regulations; and ( )

c. The organization has complied with laws and regulations that may have material effect on its financial statements and on each federal assistance program. ( )

037. -- 999. (RESERVED)

000. LEGAL AUTHORITY.
Sections 56-202(b), 56-203(1), 56-203(2), 56-209, 56-209h, 56-227, 56-227A through D, 56-1001, and 56-1003, Idaho Code, authorize the Director to adopt rules regarding fraud, abuse, and misconduct of public assistance programs. ( )

001. SCOPE.
These rules protect the integrity of the public assistance programs by identifying instances of fraud, abuse, and other misconduct by providers and their employees, participants, and by providing that appropriate action is taken to correct the problem. Nothing contained within this chapter will limit the Department from taking any other action authorized by law, including seeking damages under Section 56-227B, Idaho Code. ( )

002. WRITTEN INTERPRETATIONS.
This agency 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. The document is available for public inspection and copying at cost in the main office of this agency. ( )

003. ADMINISTRATIVE APPEALS.
Appeals and proceedings for any Department actions are governed by IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings." An appeal does not stay the action of the Department. ( )

004. -- 009. (RESERVED)

010. DEFINITIONS.
For purposes of this chapter of rules, the following terms apply. ( )

01. Abuse or Abusive. Provider practices that are inconsistent with sound fiscal, business, child care, or medical practices, and result in an unnecessary cost to a public assistance program, in reimbursement for services that are not medically necessary, or that fail to meet professionally recognized standards for health care, or in physical harm, pain, or mental anguish to a medical assistance recipient. ( )

02. Access to Documentation and Records. To review and copy records at the time a written request is made during normal business hours. Documentation includes all materials as described in Section 101 of these rules. ( )

03. Claim. Any request or demand for payment, or document submitted to initiate payment, for items or services provided under a public assistance program, whether under a contract or otherwise. ( )

04. Conviction. An individual or entity is considered to have been convicted of a criminal offense: ( )

a. When a judgment of conviction has been entered against the individual or entity by a federal, state, or local court, regardless of whether there is an appeal pending or whether the judgment of conviction or other record relating to criminal conduct has been expunged; ( )

b. When there has been a finding of guilt against the individual or entity by a federal, state, or local court; ( )

c. When a plea of guilty or nolo contendere by the individual or entity has been accepted by a federal, state, or local court; or ( )

d. When the individual or entity has entered into participation in a first offender, deferred adjudication, or other arrangement or program where judgment of conviction has been withheld. ( )

05. Department. The Idaho Department of Health and Welfare, its authorized agent or designee. ( )

06. Director. The Director of the Idaho Department of Health and Welfare or the Director's designee. ( )

07. Exclusion. A specific person or provider will be precluded from directly or indirectly providing services and receiving reimbursement under Medicaid. ( )

08. Fraud or Fraudulent. An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. ( )

09. Knowingly, Known, or with Knowledge. A person, with respect to information or an action, who: ( )

a. Has actual knowledge of the information or an action; ( )

b. Acts in deliberate ignorance of the truth or falsity of the information or the correctness or incorrectness of the action; or ( )

c. Acts in reckless disregard of the truth or falsity of the information or the correctness or incorrectness of the action. ( )

10. Managing Employee. A general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency. ( )

11. Medicaid. Idaho's Medical Assistance Program. ( )

12. Medical Assistance. Payments for part or all of the cost of services funded by Titles XIX or XXI of the federal Social Security Act, as amended. ( )

13. Misconduct. Wrongful, improper, or unlawful conduct related to public assistance rules and programs, including violations of rules, statutes, provider agreements and terms, provider handbooks, and any instructions contained in provider information releases or other program notices. ( )

14. Participant. An individual or recipient who is eligible and enrolled in any public assistance program. ( )

15. Person. An individual, trust or estate, partnership, corporation, professional association or corporation, or other entity, public or private. ( )

16. Program. Any public assistance program, including the Medicaid program and Idaho's State Plan, or any parts thereof. ( )

17. Provider. An individual, organization, agency, or other entity providing items or services under a public assistance program. ( )

18. Provider Agreement. A written agreement between the Department and a provider or group of providers of supplies or services. This agreement contains any terms or conditions deemed appropriate by the Department. ( )

19. Public Assistance Program. Assistance for which provision is made in any federal or state law existing, or hereafter enacted, by the state of Idaho or the congress of the United States by which payments are made from the federal government to the state in aid, or in respect to payment by the state for welfare purposes to any category of needy person, and any other program of assistance for which provision for federal or state funds for aid may from time to time be made. ( )

20. Recoup and Recoupment. The collection of funds for the purpose of recovering overpayments made to providers for items or services the Department has determined should not have been paid. The recoupment may occur through the collection of future claims paid or other means. ( )

21. Sanction. Any abatement or corrective action taken by the Department which is appealable under Section 003 of these rules. ( )

22. **State Plan**. The contract between the state and federal government under 42 U.S.C. Section 1396a(a). ( )

011. -- 019. (RESERVED)

020. DEPARTMENT ACTIONS.
When an instance of fraud, abuse, or other misconduct is identified, the Department will take action to correct the problem as provided in this rule. Such corrective action may include: denial of payment, recoupment, payment suspension, provider agreement suspension, termination of provider agreement, imposition of civil monetary penalties, exclusion, participant lock-in, referral for prosecution, or referral to state licensing boards. ( )

021. - 099. (RESERVED)

100. INVESTIGATION AND AUDITS.
Investigation and audits of provider fraud, abuse, or misconduct conducted by the Department's Bureau of Compliance or its successor are governed under these rules. ( )

01. **Investigation Methods**. Under Sections 56-209h(2) and 56-227(5), Idaho Code, the Department will investigate and identify potential instances of fraud, abuse, or other misconduct by any person related to or involved in public assistance programs administered by the Department. Methods may include: ( )

a. Review of computerized reports; ( )

b. Referrals to or from other agencies, health care providers, or persons; ( )

c. Conducting audits, interviews, and pre-payment and post-payment reviews; ( )

d. Probability sampling and extrapolation; and ( )

e. Issuing subpoenas to compel testimony or the production of records. ( )

02. **Probability Sampling**. Probability sampling will be done in conformance with generally accepted statistical standards and procedures. "Probability sampling" means the standard statistical methodology in which a sample is selected based on the theory of probability, a mathematical theory used to study the occurrence of random events. ( )

03. **Extrapolation**. Whenever the results of a probability sample are used to extrapolate the amount to be recovered, the demand for recovery will be accompanied by a clear description of the universe from which the sample was drawn, the sample size and method used to select the sample, the formulas and calculation procedures used to determine the amount to be recovered, and the confidence level used to calculate the precision of the extrapolated overpayment. "Extrapolation" means the methodology whereby an unknown value can be estimated by projecting the results of a probability sample to the universe from which the sample was drawn with a calculated margin of error. ( )

101. DOCUMENTATION OF SERVICES AND ACCESS TO RECORDS.

01. **Documentation of Services**. Providers must generate documentation at the time of service sufficient to support each claim or service, and as required by rule, statute, or contract. Documentation must: ( )

a. Be legible and consistent with professionally recognized standards; and ( )

b. Be retained for a period of five (5) years from the date the item or service was provided. ( )

02. **List Of Records**. Documentation to support claims for services may include medical records, treatment plans, medical necessity justification, assessments, appointment sheets, patient accounts, financial records or other records regardless of its form or media. ( )

03. Immediate Access To Records. Providers must grant to the Department, the U.S. Department of Health and Human Services and its agents, immediate access to records for review and copying during normal business hours. These records are listed in Subsection 101.02 of this rule. ( )

04. Copying Records. The Department may copy any record listed in Subsection 101.02 of this rule. ( )

a. They may request in writing to have copies of records supplied by the provider. ( )

b. The requested copies must be furnished within twenty (20) working days after the date of the written request, unless an extension of time is granted by the Department for good cause. ( )

c. Failure to timely provide requested copies will be a refusal to provide access to records. ( )

05. Removal of Records From Provider's Premises. The Department may remove from the provider's premises copies of any records listed in Subsection 101.02 of this rule. ( )

102. -- 199. (RESERVED)

200. DENIAL OF PAYMENT.
The following are reasons the Department may deny payment. ( )

01. Billed Services Not Provided or Not Medically Necessary. The Department may deny payment for any and all claims it determines are for items or services: ( )

a. Not provided or not found by the Department to be medically necessary. ( )

b. Not documented to be provided or medically necessary. ( )

c. Not provided under professionally recognized standards of health care. ( )

d. Provided as a result of a prohibited physician referral under 42 CFR Part 411, Subpart J. ( )

02. Contrary to Rules or Provider Agreement. The Department may deny payment when services billed are contrary to Department rules or the provider agreement. ( )

03. Failure to Provide Immediate Access to Records. The Department may deny payment when the provider does not allow immediate access to records as listed in Section 101 of these rules. ( )

201. -- 204. (RESERVED)

205. RECOUPMENT.
The Department may recoup the amount paid for items or services listed in Section 200 of these rules. If recoupment is impracticable, the Department may pursue any available legal remedies it may have. Interest will accrue on overpayments at the statutory rate set forth in Section 28-22-104, Idaho Code, from the date of the final determination of the amount owed for items or services until the date of recovery. ( )

206. -- 209. (RESERVED)

210. SUSPENSION OF PAYMENTS PENDING INVESTIGATION.
The Department may suspend public-assistance payments in whole or part in a suspected case of fraud or abuse pending investigation and conclusion of legal proceedings related to the provider's alleged fraud or abuse. When payments have been suspended under this rule, the Department will provide for a hearing within thirty (30) days of receipt of any timely filed notice of appeal. ( )

01. Basis for Suspension of Payments. When the Department through reliable evidence suspects fraud or abuse, or when a provider fails to provide immediate access to records, public-assistance payments may be

withheld or suspended. ( )

02. Notice of Suspension of Payments. The Department may withhold public-assistance payments without first notifying the provider of its intention to do so when the Department is suspending payments of a Medicaid provider. The Department will send written notice within five (5) days of taking such action under 42 CFR 455.23(b). All other public assistance providers will be notified prior to the suspension of payments. ( )

03. Duration of Suspension of Payments. The withholding of payment actions under this rule will be temporary and will not continue after: ( )

a. The Department or the prosecuting authorities determine there is insufficient evidence of fraud or willful misrepresentation by the provider; or ( )

b. Legal proceedings related to the provider's alleged fraud or abuse are completed. ( )

211. -- 219. (RESERVED)

220. PROVIDER AGREEMENT SUSPENSION.
In the event the Department identifies a suspected case of fraud or abuse, it may summarily suspend the provider agreement when necessary to prevent or avoid immediate danger to the public health or safety. This provider agreement suspension temporarily bars the provider from participation in the medical assistance program, pending investigation and Department action. The Department will notify the provider of the suspension. The suspension is effective immediately upon written, electronic, or oral notification. When a provider agreement is suspended under this rule, the Department will provide for a hearing within thirty (30) days of receipt of any timely filed notice of appeal ( )

221. -- 229. (RESERVED)

230. TERMINATION OF PROVIDER STATUS.
Under Section 56-209h, Idaho Code, the Department may terminate the provider agreement or otherwise deny provider status for a period of up to five (5) years from the date the Department's action becomes final. ( )

231. -- 234. (RESERVED)

235. CIVIL MONETARY PENALTIES.
Under Section 56-209h, Idaho Code, the Department may assess civil monetary penalties against a provider, any officer, director, owner, and managing employee for conduct identified in Idaho Code 56-209h(6)(a) through (i). ( )

236. CIVIL MONETARY PENALTY PERCENTAGES.
The Department will determine the percentage of each penalty by the type of conduct, the frequency, and knowledge of the conduct. When more than one (1) type of conduct described in Idaho Code 56-209h(6)(a) through (i) is found per line item, the penalty percentage will be based on the most significant conduct. ( )

01. Conduct Resulting in No Overpayment. The Department determines civil monetary penalties to be assessed for the following types of conduct violations that did not result in an overpayment. ( )

a. Participant Fees. The provider collected or attempted to collect fees from participants that the provider was not entitled to collect. Violations for this type of conduct will result in a ten percent (10%) penalty. ( )

b. Minor Rule Violations. Services were provided and properly paid but violated rule, policy, or provider agreement. Minor rule violations will result in a ten percent (10%) penalty. Minor rule violations may include: ( )

i. Incorrect date spanning; ( )

ii. Failure to list required provider credentials; or ( )

iii. Failure to obtain required client signatures. ( )

c. Significant Rule Violations. Services were provided but violated rule, policy, or provider agreement. Significant rule violations will result in a fifteen percent (15%) penalty. Significant rule violations may include: ( )

i. Incomplete physician referrals; or ( )

ii. Failure to maintain documentation once valid Healthy Connections referral is obtained. ( )

02. Conduct Resulting in Overpayment. The Department determines the civil monetary penalties to be assessed for the following types of conduct violations resulting in overpayment. Civil monetary penalties will not be assessed when a provider self-reports an overpayment and the Department receives the report prior to the initiation of a Department audit. ( )

a. Significant Rule Violations. Services were provided but violated rule, policy, or provider agreement. Significant rule violations will result in a fifteen percent (15%) penalty. Significant rule violations may include: ( )

i. Billing more services than allowed; ( )

ii. Billing non-physician services as physician services; ( )

iii. Billing incorrect codes (such as Physician's Current Procedural Terminology (CPT), diagnosis, revenue, etc.) or modifiers; or ( )

iv. Inadequate documentation to support services billed. ( )

b. Significant Rule Violations Related to Participant Care. Services were provided but violated rule, policy, or provider agreement related to participant care. Significant rule violations related to participant care will result in a twenty percent (20%) penalty. Significant rule violations may include: ( )

i. Failure to obtain required Healthy Connections referrals or failure to list required core elements, such as the start and end dates on the referral; ( )

ii. No required physician or practitioner signatures; ( )

iii. No orders or inadequate orders, assessments, plans or evaluations prior to delivery of service or items; ( )

iv. Services or items provided by unqualified staff; ( )

v. Services or items provided by excluded individual; or ( )

vi. Services or items not covered by program. ( )

c. Significant Rule Violations for No Service or Refusal of Immediate Access to Documentation. Services were not provided, were not documented, or refusal to provide immediate access to documentation upon written request as required in Section 56-209h(6)(e), Idaho Code, of these rules. Violations will result in a twenty-five percent (25%) penalty. Significant rule violations may include: ( )

i. Billing and receiving payment multiple times for the same service or item; ( )

ii. No documentation; ( )

iii. Cloned documentation; ( )

iv. Service not provided; ( )

v. More units billed than provided; ( )

vi. Billing laboratory services provided by independent laboratory, unless an exception applies, such as an independent laboratory that can bill for a reference laboratory; or ( )

vii. Missing required pre-authorization. ( )

03. Penalty Enhancements. ( )

a. Error Rates. The Department determines which error rate applies by comparing the number of violations to the number of similar line items audited, or to all audited line items. Penalty percentages identified in Subsections 236.01 and 236.02 of this rule may be increased by: ( )

i. Five percent (5%) when the error percentage of audited services is greater than twenty-five percent (25%); and ( )

ii. Ten percent (10%) when the error percentage of audited services is greater than thirty-five percent (35%). ( )

b. Fraudulently or Knowingly. When the Department determines the conduct was committed fraudulently or knowingly as defined in Section 010 of these rules, the penalty percentages may be increased by fifteen percent (15%). ( )

237. CIVIL MONETARY PENALTIES FOR CRIMINAL HISTORY BACKGROUND CHECK VIOLATIONS.
Under Section 56-209h(8)(b), Idaho Code, the Department may assess civil monetary penalties against a provider, any officer, director, owner, or managing employee for failing to perform required background checks or failing to meet required time lines for completion of background checks as required by rule. ( )

238. -- 239. (RESERVED)

240. MANDATORY EXCLUSIONS FROM THE MEDICAID PROGRAM.
The Department will exclude from the Medicaid program any provider, entity, or person that: ( )

01. Conviction of a Criminal Offense. Has been convicted of a criminal offense related to the delivery of an item or service under a federal or any state health care program, including the performance of management or administrative services relating to the delivery of items or services under any such program. ( )

02. Conviction of a Criminal Offense Related to Patient Neglect or Abuse. Has been convicted, under federal or state law, of a criminal offense related to the neglect or abuse of a patient, in connection with the delivery of a health care item or service, including any offense that the Department concludes entailed, or resulted in, neglect or abuse of patients. The conviction need not relate to a patient who is a program beneficiary. ( )

03. Other Exclusions. Is identified by the Centers for Medicare and Medicaid Services (CMS) as having been excluded by another state, the Office of Inspector General or any person CMS directs the Department to exclude. ( )

241. -- 244. (RESERVED)

245. TERMS OF MANDATORY EXCLUSIONS FROM THE MEDICAID PROGRAM.
Mandatory exclusions from the Medicaid program imposed under Section 240 of these rules, will be for not less than ten (10) years. The exclusion may exceed ten (10) years if aggravating factors are present. In the case of any mandatory exclusion of any person, if the individual has been convicted on two (2) or more previous occasions of one

(1) or more offenses for which an exclusion may be effected under this rule, the period of exclusion will be permanent. ( )

246. -- 249. (RESERVED)

250. PERMISSIVE EXCLUSIONS FROM THE MEDICAID PROGRAM.
The Department may exclude any person or entity from the Medicaid program for a period of not less than one (1) year: ( )

01. Endangerment of Health or Safety of a Patient. Where there has been a finding by a governmental agency against such person or entity of endangering the health or safety of a patient, or of patient abuse, neglect, or exploitation. ( )

02. Failure to Disclose or Make Available Records. That has failed or refused to disclose, make available, or provide immediate access to the Department, or any licensing board, any records maintained by the provider or required of the provider to be maintained, which the Department deems relevant to determining the appropriateness of payment. ( )

03. Other Exclusions. For any reason for which the Secretary of Health and Human Services, or their designee, could exclude an individual or entity. ( )

251. -- 259. (RESERVED)

260. AGGRAVATING FACTORS.
For purposes of lengthening the period of mandatory exclusions and permissive exclusions from the Medicaid program, the following factors may be considered. This is not intended to be an exhaustive list of factors which may be considered: ( )

01. Financial Loss. The acts resulted in financial loss to the program of one thousand five hundred dollars ($1,500) or more. The entire amount of financial loss to such program will be considered, including any amounts resulting from similar acts not adjudicated, regardless of whether full or partial restitution has been made to the program. ( )

02. Time Acts Were Committed. The acts were committed over a period of one (1) year or more. ( )

03. Adverse Impact. The acts had a significant adverse physical, mental, or financial impact on one (1) or more program participants or other individuals. ( )

04. Length of Sentence. The length of any sentence imposed by the court related to the same act. ( )

05. Prior Record. The excluded person has a prior criminal, civil, or administrative sanction record. ( )

261. REINSTATEMENT AFTER EXCLUSION FROM MEDICAID PROGRAM.
An individual or entity who has been excluded from the Medicaid Program is not automatically reinstated at the end of the exclusion period. An individual or entity excluded by the Department must submit a written application for reinstatement to the Department. An applicant excluded by the Department must receive written notice of reinstatement from the Department before reinstatement is complete. ( )

01. Conditions for Reinstatement. To be reinstated, the applicant must meet the following criteria: ( )

a. Not be currently excluded from the Medicaid program by the federal government or by any state Medicaid agency; ( )

b. Not have a currently terminated Medicaid provider number by any state Medicaid agency; ( )

c. Has all debts to the Department paid in full; ( )

d. Not be the subject of any civil, criminal, or state licensing authority investigation; ( )

e. Has not been convicted of any crime during the exclusion period; ( )

f. Has all the required, valid licensure and credentials necessary to provide services; ( )

g. Has met and continues to meet all terms and conditions of any court-ordered probation; ( )

h. Did not work in any capacity as an employee or contractor for any individual or entity receiving Medicaid funds during the applicant's exclusion period; and ( )

i. Did not submit claims or cause claims to be submitted for Medicaid reimbursement for services or supplies provided, ordered, or prescribed by an excluded individual or entity during the applicant's exclusion period. ( )

02. Applying for Reinstatement. An individual or entity may not begin the process of reinstatement earlier than one hundred twenty (120) days before the end of the exclusion period specified in the exclusion notice. The Department will not consider a premature application. An applicant that appears on the federal or any state exclusion list may apply for reinstatement, but consideration of the application will not start until after the excluding agency has reinstated the individual or entity. ( )

03. Request for Reinstatement. An excluded individual or entity must request an application form in writing from the Department and specifically request reinstatement. The request for reinstatement must include: ( )

a. The applicant's name, address, and phone number; and ( )

b. Copies of any required license, credentials, and provider number, if they exist. ( )

04. Complete Application for Reinstatement. The applicant must complete the reinstatement application form and return the fully executed and notarized form to the Department. ( )

05. Department Decision. The Department will issue a written decision to grant or deny a request for reinstatement. ( )

06. Reinstatement Denied. When an application for reinstatement is denied, the applicant is ineligible to reapply for one (1) year from the date the decision of denial becomes final. ( )

262. -- 264. (RESERVED)

265. REFUSAL TO ENTER INTO AN AGREEMENT.
The Department may refuse to enter into a provider agreement for the reasons described in this rule. ( )

01. Convicted of a Felony. The provider has been convicted of a felony under federal or state law. ( )

02. Committed an Offense or Act Not in Best Interest of Medicaid Participants. The provider has committed an offense or act which the Department determines is inconsistent with the best interests of Medicaid participants. ( )

03. Failed to Repay. The provider has failed to repay the Department monies which had been previously determined to have been owed to the Department. ( )

04. Investigation Pending. The provider has a pending investigation for program fraud or abuse. ( )

05. Terminated Provider Agreement. The provider was the managing employee, officer, or owner of an entity whose provider agreement was terminated under Section 230 of these rules. ( )

266. -- 269. (RESERVED)

270. MISCELLANEOUS CORRECTIVE ACTIONS.
The Department may take lesser action to investigate, monitor and correct suspected instances of fraud, abuse, over utilization, and other misconduct as provided in this rule. ( )

01. Issuance of a Warning. Issuance of a warning letter describing the nature of suspected violations, and requesting an explanation of the problem and a warning that additional action may be taken if the action is not justified or discontinued. ( )

02. Review. Prepayment review of all or selected claims submitted by the provider with notice that claims failing to meet written guidelines will be denied. ( )

03. Referral. Referral to state licensing boards for review of quality of care and professional and ethical conduct. ( )

271. -- 274. (RESERVED)

275. DISCLOSURE OF CERTAIN PERSONS.
Prior to entering into or renewing a provider agreement, or at any time upon written request by the Department, a provider must disclose to the Department the identity of any person described under 42 CFR 1001.1001. The Department may refuse to enter into or renew an agreement with any provider associated with any person so described. The Department may also refuse to enter into, or terminate, a provider agreement if it determines that the provider did not fully and accurately make any disclosure required under these rules. ( )

276. -- 279. (RESERVED)

280. PROVIDER NOTIFICATION.
When the Department determines actions defined in Sections 200 through 250 of these rules are appropriate, it will send written notice of the decision to the provider or person. The notice will state the basis for, and the length and effect of the action on that person's ability to provide services under state and federal programs, and the person's appeal rights. ( )

281. -- 284. (RESERVED)

285. NOTICE TO STATE LICENSING AUTHORITIES.
The Department will promptly notify all appropriate licensing authorities having responsibility for licensing or certification of a Department action, and the facts and circumstances of that action. The Department may request certain action be taken and that it be informed of actions taken. ( )

286. -- 289. (RESERVED)

290. PUBLIC NOTICE.
The Department will give notice of the action taken and the effective date to the public, appropriate beneficiaries, and may give notice as appropriate to related providers, the Quality Improvement Organization (QIO), institutional providers, professional organizations, contractors, other health insurance payors, and other agencies or Departmental divisions. ( )

291. -- 299. (RESERVED)

300. DEPARTMENT OF HEALTH AND HUMAN SERVICES.
The Department will notify the Office of Inspector General within fifteen (15) days after a final action in which a person has been excluded, convicted of a criminal offense related to participation in the delivery of health care items or services under the Medicaid program, or reinstated from a prior exclusion. ( )

301. -- 999. (RESERVED)

000. LEGAL AUTHORITY.
The legal authority for promulgation of these rules is in accordance with the following provisions: ( )

01. Federal Authority. Federal authority for promulgation of rules governing activities involving alleged medical neglect of disabled infants in health care settings is provided in 42 USC 5101 et seq., the federal "Child Abuse Prevention and Treatment Act." ( )

02. State Authority. State authority is provided in: ( )

a. Section 56-202(b), Idaho Code, which requires the Director to promulgate, adopt, and enforce such rules, regulations, and methods of administration as may be necessary and proper to carry out the provisions of the Public Assistance Law, Section 56-201 et seq., Idaho Code, including services for children in accordance with Section 56-204A, Idaho Code, except where such authority is granted to the Board; and ( )

b. Section 16-1623, Idaho Code, which empowers the Department to do all things reasonably necessary to carry out the purpose of the "Child Protective Act." ( )

001. TITLE, SCOPE, AND PURPOSE.

01. Title. These rules are titled IDAPA 16.06.05, "Alleged Medical Neglect of Disabled Infants." ( )

02. Scope. These rules are established to ensure protection of, and attention to, the needs of infants in health care facilities throughout the state who have been continuously hospitalized since birth, who were born extremely prematurely, or who have a long-term disability. ( )

03. Purpose. The purpose of these rules is to ensure coordinated response to reports of alleged medical neglect of infants who are in health care facilities throughout the state and who have been continuously hospitalized since birth, who were born extremely prematurely, or who have a long-term disability. ( )

002. -- 009. (RESERVED)

010. DEFINITIONS.
The following terms are used in this chapter as defined below: ( )

01. Central Office. The state-level administrative office of the Department of Health and Welfare located in Boise, Idaho. ( )

02. Department. The Idaho Department of Health and Welfare. ( )

03. Director. The Director of the Idaho Department of Health and Welfare or their designee. ( )

04. Family and Children's Services (FACS). Those programs and services directed to families and children, administered by the Department of Health and Welfare. ( )

05. Field Office. A Department of Health and Welfare service delivery site. ( )

06. Infant. An infant less than one (1) year of age or older than one (1) year of age but less than two (2) years of age who has been continuously hospitalized since birth, who was born extremely prematurely, or who has a long-term disability. ( )

07. Infant -- Extremely Premature. An infant born before the twenty-seventh week or weighing less than one thousand (1,000) grams or having a crown-heel length that is less than forty-seven (47) centimeters or with occipito-frontal diameter less than eleven and one-half (11.5) centimeters. ( )

08. Reasonable Medical Judgment. A medical judgment that would be made by a reasonably prudent physician, knowledgeable about the case and the treatment possibilities with respect to the medical conditions involved. Such a judgment may not take into account the future extent of the infant's disability or social or economic factors related to the infant or family. ( )

09. Regional Office. An Idaho Department of Health and Welfare office located in one (1) of seven (7) areas of the state that comprises a geographically defined service area for the administration and delivery of the Department's services. ( )

10. Withholding of Medically Indicated Treatment. ( )

a. The failure to respond to the infant's life-threatening conditions by providing treatment, including appropriate nutrition, hydration and medication which, in the treating physician's reasonable medical judgment, will most likely be effective in ameliorating or correcting all such conditions. ( )

b. The term does not include the failure to provide treatment, other than appropriate nutrition, hydration, or medication, to an infant when, in the treating physician's reasonable medical judgment, any of the following circumstances apply: ( )

i. The infant is chronically and irreversibly comatose; or ( )

ii. The provision of such treatment would merely prolong dying, would not be effective in ameliorating or correcting all of the infant's life-threatening conditions, or would otherwise be futile in terms of the survival of the infant; or ( )

iii. The provision of such treatment would be virtually futile in terms of the survival of the infant, and the treatment itself under such circumstances would be inhumane. ( )

011. -- 014. (RESERVED)

015. COMMUNICATION WITH HEALTH CARE FACILITIES.

01. Annual Check of Health Care Facilities. Regional FACS managers or their designees will make an annual check by October 1st each year of health care facilities in their regions to obtain: ( )

a. The name, address, and telephone number of the health care facility designated contact person; or ( )

b. If no individual is appointed the designated contact person, the name, address, and telephone number of the health care facility or hospital administrator. ( )

02. List of Contact Persons to Be Maintained. Regional FACS managers or their designees will maintain a complete list of the health care facility contact persons or administrators for their regions. ( )

a. Copies of the list will be distributed to all field offices within the regions within fourteen (14) working days of October 1st each year. ( )

b. At the same time, copies will be sent to the Department: ( )

i. Chief of the Bureau of Family Services; ( )

ii. Chief of the Bureau of Maternal and Child Health; and ( )

iii. Chief of the Bureau of Developmental Disabilities. ( )

03. Information to Be Provided to Facilities. Within fourteen (14) working days of October 1st each year, regional FACS managers or their designees will provide each health care facility, hospital contact person, or administrator in their regions a list that includes: ( )

a. The names and telephone numbers of the regional director and the Regional FACS manager; ( )

b. The addresses and telephone numbers of Department field offices in their regions; and ( )

c. The twenty-four (24) hour child abuse and neglect reporting "hot-line" numbers. ( )

04. Notification of Changes. ( )

a. The health care facility, hospital contact person, or administrator must notify the Regional FACS manager of any changes in the names and telephone numbers of the health care facility designated contact person or hospital administrator within five (5) working days of the change. ( )

b. The Regional FACS manager will notify the health care facility, hospital contact persons, and administrators in the region of any changes in the Department personnel, addresses, or telephone numbers identified above within five (5) working days of the change. ( )

016. -- 019. (RESERVED)

020. INVESTIGATIONS OF ALLEGED MEDICAL NEGLECT OR WITHHOLDING OF MEDICALLY INDICATED TREATMENT FROM DISABLED INFANTS WITH LIFE-THREATENING CONDITIONS.

01. Reports of Suspected Medical Neglect. The Department must receive notification from health care facility and hospital contact persons and administrators, and from any other individual reporting in accordance with provisions of the Child Protective Act, Section 16-1601 et seq., Idaho Code, of cases of suspected medical neglect, including instances of withholding of medically indicated treatment from disabled infants with life-threatening conditions. ( )

a. Reports of suspected medical neglect must be received during regular office hours at any office of the Department. ( )

b. After regular business hours, weekends, or holidays, reports must be received through the twenty-four (24) hour child abuse and neglect reporting "hot-line" numbers in the local telephone directories. ( )

02. Investigation. ( )

a. The Department will begin an investigation of a report of suspected withholding of medically indicated treatment in accordance with the provisions of the current FACS policy "Referral Response Priority Guide." When appropriate, the investigation will include an on-site investigation of such reports. ( )

b. The investigation must be conducted under the authority granted under Sections 16-1619, 16-1623 and 16-1625, Idaho Code. ( )

c. The family services worker for the Department must obtain: ( )

i. The name and address of the health care facility or hospital; ( )

ii. The administrator's name and address; ( )

iii. The infant's name and date of birth; ( )

iv. The name, address, and telephone number of the infant's parents; ( )

v. The attending physician's name; ( )

vi. The health care facility or hospital contact person's name if the report came from someone other than the health care facility or hospital; ( )

vii. The infant's medical condition, prognosis, and any indication that treatment, including nutrition, hydration, or medication, is being withheld; ( )

viii. The participation of any treatment review committee in the infant's case; and ( )

ix. The extent of counseling provided to the parents. ( )

03. Unsubstantiated Reports. Should the report be unsubstantiated because the infant is not at the health care facility or hospital, or because the pediatric consultant for the Department's Bureau of Maternal and Child Health or designee, or the regional or central office committee deems the report to be unsubstantiated because there is no withholding of medically indicated treatment as defined in Section 010 of these rules, written documentation will be made of: ( )

a. The investigative steps taken by the Department to determine the validity of the report; and ( )

b. The Department's disposition of the report. ( )

04. Verification. If the medically disabled infant is a patient at the health care facility or hospital: ( )

a. The Department will verify with the health care facility, hospital contact person, hospital administrator, attending physician, or the infant's parents the information obtained through the investigation in accordance with Subsection 020.02.c. of this rule. ( )

b. The family services worker will interview the infant's parents to assess their understanding of the infant's condition, treatment, and prognosis with and without treatment. ( )

c. The family services worker will also interview the attending physician to obtain information about the infant's condition, treatment, and prognosis with and without treatment. ( )

d. The family services worker will also obtain a copy of the infant's medical treatment record from the health care facility or hospital, as a function of the investigation process under Section 16-1625, Idaho Code. ( )

05. Findings. ( )

a. Family services workers will notify their immediate supervisor or the Regional FACS manager, within four (4) hours of receipt of a report, indicating if a disabled infant does reside within a health care facility or hospital and the circumstances of the case. ( )

b. The regional director, the Regional FACS manager, or the family services worker will report all complaints and information gathered to the pediatric consultant, the Department's Bureau of Maternal and Child Health, or designee. ( )

c. The initial determination that withholding of medically indicated treatment as defined in Section 010 of these rules is occurring or is being prescribed by the infant's physician will be made, with or without an independent medical evaluation, by the pediatric consultant, the Department's Bureau of Maternal and Child Health, or designee. ( )

021. REVIEW OF ALLEGED MEDICAL NEGLECT OR WITHHOLDING OF MEDICALLY INDICATED TREATMENT FROM DISABLED INFANTS WITH LIFE-THREATENING CONDITIONS.

01. Regional Committee Review. A regional committee must consist of the Department's regional director, the Regional FACS manager or family services worker, and the pediatric consultant, the Department's Bureau of Maternal and Child Health, or designee. ( )

a. The pediatric consultant or designee must immediately inform the regional committee of the determination made in accordance with Subsection 020.05.c. of these rules. ( )

b. If the pediatric consultant or designee determined that indicated medical treatment is being withheld, the regional committee must attempt to resolve the matter informally, if possible, in an expeditious manner. ( )

c. The regional committee must ensure that the parents of the infant are fully informed of: ( )

i. The existence and function of any infant care review committee, chaplain services, or other counseling services within the health care facility or hospital; and ( )

ii. The existence, function, and opportunity to consult with parent support groups or other organizations that include parents of children with disabilities. ( )

d. If resolution is possible and the infant receives necessary treatment, the matter will not be referred for any further legal action. ( )

i. The Department's regional director will verbally notify the administrator of the Division of FACS or the chief of the Bureau of Family Services, the health care facility or hospital contact person or administrator, the attending physician, the individual who reported the concern, and the parents of the infant that no legal action will be taken by the Department. ( )

ii. The Department's regional director will provide written confirmation that no legal action will be taken by the Department within five (5) working days to the health care facility or hospital contact person or administrator. ( )

e. If informal resolution is not possible, the regional director will notify the administrator of the Division of FACS or the chief of the Bureau of Family Services of the concern within four (4) hours of the receipt of the report. ( )

02. Central Office Committee Review. The administrator of the Division of FACS will convene a central office committee within twenty-four (24) hours of the receipt of notice from the regional committee. ( )

a. The central office committee will consist of the Department's chief of the Bureau of Family Services, the pediatric consultant for the Bureau of Maternal and Child Health, the chief of the Bureau of Developmental Disabilities, a deputy attorney general or their designees; and other individuals deemed appropriate. ( )

i. The regional director, the Regional FACS manager and the family services worker will be available, by telephone, to provide investigation information. ( )

ii. The county prosecuting attorney should be requested to participate, when appropriate. ( )

b. The committee will make appropriate contacts, which may include the attending physician, the health care facility or hospital contact person or administrator, the parents of the infant, and other persons deemed appropriate to gather information and work toward resolution of the matter. ( )

c. Efforts will be made to resolve the matter on an informal basis. If informal resolution is not possible: ( )

i. The county prosecuting attorney or deputy attorney general will determine, within four (4) hours of the committee meeting, the need for legal intervention. Such intervention might include obtaining temporary legal custody of the infant until such time as the court can determine the appropriate disposition of the matter under Sections 16-1614 and 16-1616, Idaho Code. ( )

ii. Failure to provide treatment including appropriate nutrition, hydration, or medication that is determined by the committee to be necessary to maintain the infant's life will be considered grounds to initiate legal proceedings. ( )

022. CONTINUING CONSULTATION AND INVESTIGATION.

01. Further Consultation and Investigation. At any time during the decision-making or resolution process, as deemed appropriate and as time and agency resources permit, the pediatric consultant or designee, the regional committee, or the central office committee may seek additional information or technical assistance from the physician, health care facility or hospital contact person or administrator, any treatment review committee, the parents of the infant, or other persons or agencies. ( )

a. If any independent medical examination is necessary, the family services worker will seek voluntary compliance for such an examination. ( )

b. If consent to an independent medical examination is not expeditiously provided, the family services worker will contact the county prosecuting attorney or a deputy attorney general to initiate legal proceedings to obtain an order under the "Child Protective Act," or other applicable law mandating such examination. ( )

02. Decision-Making Landmarks. At each stage of the decision-making and resolution process, the pediatric consultant or designee, the regional committee, and the central office committee will consider the following elements of the case: ( )

a. The extent of the counseling offered and received by the parents of the infant; ( )

b. The knowledge and experience of the attending physician in the diagnosis and treatment of the infant's life-threatening conditions; ( )

c. The existence within the health care facility or hospital of an infant care review committee, or like agent, and its participation in the infant's case; ( )

d. Any independent medical consultation or examination; ( )

e. Conformity with current Department of Health and Human Services guidelines regarding "Services and Treatment for Disabled Infants"; and ( )

f. The consistency of the medical treatment provided with the information available through the computer-based neonatal information clearing house maintained by the Department of Health and Human Services. ( )

023. RESPONSIBILITIES OF THE DEPARTMENT RELEVANT TO INFANTS WITH LIFE-THREATENING CONDITIONS.

01. Report to the Court. The family services worker must prepare and submit a written report of investigation that may be ordered by the court on the matter under Section 16-1609, Idaho Code. The report must include copies of the medical information obtained regarding the matter. ( )

02. Case Staffing. If legal custody of the infant is granted to the Department, the family services worker, the Regional FACS manager, the regional director, the pediatric consultant for the Bureau of Maternal and Child Health, the chief of the Bureau of Family Services, the chief of the Bureau of Developmental Disabilities, the administrator of the Division of FACS, a deputy attorney general, the parents of the infant, and other individuals deemed appropriate will: ( )

a. Staff the case in person or through telephone conference call; and ( )

b. Develop a service plan within ten (10) days of adjudication. The staffing may be conducted by telephone. ( )

024. -- 999. (RESERVED)

000. LEGAL AUTHORITY.
Under Section 56-202, Idaho Code, the Director of the Department of Health and Welfare is authorized to promulgate, adopt, and enforce rules for the administration of public assistance programs. ( )

001. TITLE AND SCOPE.

01. Title. These rules are titled IDAPA 16.06.12, "Idaho Child Care Program (ICCP)." ( )

02. Scope. These rules provide the requirements for determining participant and provider eligibility for the Idaho Child Care Program (ICCP) and issuing child care benefit payments. ( )

002. -- 007. (RESERVED)

008. AUDIT, INVESTIGATION AND ENFORCEMENT.
In addition to any actions specified in these rules, the Department may audit, investigate and take enforcement action under the provisions of IDAPA 16.05.07, "Investigation and Enforcement of Fraud, Abuse or Misconduct." ( )

009. CRIMINAL HISTORY AND BACKGROUND CHECK REQUIREMENTS.

01. Compliance with Department Criminal History and Background Check. Criminal history and background checks are required for ICCP providers. Providers who are required to have a criminal history check must comply with IDAPA 16.05.06, "Criminal History and Background Checks." ( )

02. ICCP Provider is Approved. The ICCP provider must have completed a criminal history and background check, and received a clearance, prior to becoming an ICCP provider. ( )

03. Availability to Work or Provide Service. ( )

a. Those individuals licensed or certified by the Department are not available to provide services or receive licensure or certification until the criminal history and background check is completed and a clearance issued by the Department. ( )

b. Individuals living in the home who have direct contact with children are allowed contact after the criminal history application and self-disclosure is completed as provided in Section 56-1004A, Idaho Code, except when they have disclosed a disqualifying crime listed in IDAPA 16.05.06, "Criminal History and Background Checks." ( )

04. Applicants, Providers, and Other Individuals Subject to Criminal History Check Requirements. The following applicants, providers, and other individuals listed below must submit evidence to the Department that the following individuals have successfully completed and received a Department criminal history and background check clearance: ( )

a. All child care centers group, family, relative, and in-home providers including owners, operators, and staff, who have direct contact with children; ( )

b. All individuals thirteen (13) years of age or older who have direct contact with children; and ( )

c. All individuals thirteen (13) years of age or older who are regularly on the premises. ( )

05. Renewal of Criminal History and Background Check Requirement. Applicants, providers, employees, volunteers, and individuals thirteen (13) years of age or older who have direct contact with or provide care to children eligible for ICCP benefits must comply with these requirements and receive a clearance as provided in IDAPA 16.05.06, "Criminal History and Background Checks," every five (5) years. ( )

06. Criminal History and Background Check at Any Time. The Department can require a criminal history and background check at any time on any individual providing child care to an ICCP eligible child. ( )

07. Additional Criminal Convictions. Once an individual has received a criminal history clearance, any additional criminal convictions must be reported by the child care provider to the Department when the provider

learns of the conviction. ( )

010. DEFINITIONS AND ABBREVIATIONS -- A THROUGH L.
The following definitions and abbreviations apply to this chapter: ( )

01. AABD. Aid to the Aged, Blind, and Disabled. ( )

02. Abuse or Abusive. Provider practices that are inconsistent with sound fiscal, business, or child care practices and result in an unnecessary cost to the Idaho Child Care Program, in reimbursement that is not necessary, or that fail to meet professional recognized standards for child care, or result in physical harm, pain, or mental anguish to children. ( )

03. Child. Any person under age eighteen (18) who is under the care of a parent, relative, or someone acting in loco parentis. ( )

04. Child Care. Care, control, supervision, or maintenance of a child provided for compensation by an individual, other than a parent, for less than twenty-four (24) hours in a day. ( )

05. Claim. Any request or demand for payment, or document submitted to initiate payment, for items or services provided under the Idaho Child Care Program. ( )

06. Department. The Idaho Department of Health and Welfare or its designee. ( )

07. Earned Income. Income received by a person as wages, tips, or self-employment income before deductions for taxes or any other purposes. ( )

08. Employment. A job paying wages or salary at federal or state minimum wage, whichever is applicable, including work paid by commission or in-kind compensation. Full or part-time participation in a VISTA or AmeriCorps program is also employment. ( )

09. Foster Care. The twenty-four (24) hour substitute care of children in the legal custody of the state of Idaho provided in a state licensed foster home by persons who may or may not be related to a child. Foster care is provided in lieu of parental care and is arranged through a private or public agency. ( )

10. Foster Child. A child in the legal custody of the state of Idaho placed for twenty-four (24) hour substitute care by a private or public agency. ( )

11. Foster Home. The private home of an individual or family licensed under the state of Idaho and providing twenty-four (24) hour substitute care to six (6) or fewer children. ( )

12. Fraud or Fraudulent. An intentional deception or misrepresentation made by a person with knowledge that the deception could result in some unauthorized benefit to himself or some other person. ( )

13. Good Cause. The conduct of a reasonably prudent person in the same or similar circumstances, unless otherwise defined in these rules. ( )

14. In Loco Parentis. Acting “in loco parentis” means a person who acts in place of a parent, assuming care and custody of a child by legal guardianship. ( )

15. Intentional Program Violation (IPV). An intentional false or misleading action, omission, or statement made in order to qualify as a provider or recipient in the Idaho Child Care program or to receive program benefits or reimbursement. ( )

16. Job Training and Education Program. A program designed to provide job training or education. Programs may include high school, junior college, community college, college or university, general equivalency diploma (GED), technical school, and vocational programs. To qualify as a Job Training and Education Program, the program must prepare the trainee for employment. ( )

17. **Infant/Toddler**. A child less than forty-eight (48) months of age. ( )

18. **Incapacitated Parent**. A parent who is determined by a licensed practitioner of the healing arts to be unfit, incapable, or significantly limited in their ability to provide adequate care for their child or ward. ( )

19. **Knowingly, Known, or With Knowledge**. With respect to information or an action about which a person has actual knowledge of the information or action; acts in deliberate ignorance of the truth or falsity of the information or the correctness or incorrectness of the action; or acts in reckless disregard of the truth or falsity of the information or the correctness or incorrectness of the action. ( )

20. **Legal Guardian**. A court-appointed individual who acts as the primary caretaker of a child or minor. ( )

21. **Licensed Practitioner of the Healing Arts**. A licensed physician, physician assistant, nurse practitioner, or clinical nurse specialist. ( )

011. DEFINITIONS AND ABBREVIATIONS -- M THROUGH Z.
The following definitions and abbreviations apply to this chapter of rules: ( )

01. **Managing Employee**. A general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an organization or entity. ( )

02. **Minor Parent**. A parent under the age of eighteen (18). ( )

03. **Non-Recurring Lump Sum Income**. Income received by a family in a single payment, not expected to be available to the family again. ( )

04. **Parent**. A person responsible for a child because of birth, adoption, marriage, legal guardianship, foster care; or a person acting in loco parentis. ( )

05. **Preventive Services**. Services needed to reduce or eliminate the need for protective intervention. Preventive services permit families to participate in activities designed to reduce or eliminate the need for out-of-home placement of a child by the Department. ( )

06. **Prospective Income**. Income a family expects to receive within a given time. This can be earned or unearned income. ( )

07. **Provider**. An individual, organization, agency, or other entity providing child care. ( )

08. **Relative Provider**. Grandparent, great-grandparent, aunt, uncle, or adult sibling by blood or current marriage who provides child care. ( )

09. **SSI**. Supplemental Security Income. ( )

10. **Special Needs**. Any child with physical, mental, emotional, behavioral disabilities, or developmental delays identified on an Individual Education Plan (IEP) or an Individualized Family Service Plan (IFSP). ( )

11. **State Median Income (SMI)**. State Median Income Estimates in the Code of Federal Regulations are available on the U.S. Government Publishing Office website at https://www.gpo.gov/fdsys. ( )

12. **TAFI**. Temporary Assistance for Families in Idaho. ( )

13. **Unearned Income**. Unearned income includes retirement, interest child support, and any income received from a source other than employment or self-employment. ( )

012. -- 049. (RESERVED)

APPLICATION REQUIREMENTS
(Sections 050-069)

050. ICCP APPLICATION FOR BENEFITS.
A family applying for child care benefits must submit a completed and signed application to the Department. ( )

01. Application Received. The Department will date stamp the application on the day the application is received. The applicant has thirty (30) days from the date the application is received by the Department to complete the application process by providing all required verifications. ( )

02. New Application Required. A new application is required if all requested verification is not provided within thirty (30) days from the date the application was received by the Department. The time limit can be extended by the Department for events beyond the Department's control. ( )

03. Notification. The Department will act on applications for child care benefits within thirty (30) days of receipt. The applicant will be notified in writing of the approval or denial of the application and of the applicant's right to appeal. ( )

051. SIGNATURES.
An individual who is applying for benefits, receiving benefits, or providing additional information as required by this chapter, may do so with the depiction of the individual's name either handwritten, electronic, or recorded telephonically. Such signature serves as intention to execute or adopt the sound, symbol, or process for the purpose of signing the related record. ( )

052. -- 069. (RESERVED)

FINANCIAL CRITERIA FOR ICCP ELIGIBILITY
(Sections 070-099)

070. INCOME LIMITS.
To be eligible for child care assistance, a family's countable income must meet the following guidelines using the published Federal Poverty Guidelines (FPG) available on the U.S. Health and Human Services website at http://aspe.hhs.gov/poverty. ( )

01. Income at Application. At the time of application, a family's income cannot exceed one hundred thirty percent (130%) of the Federal Poverty Guidelines (FPG) for a family of the same size. ( )

02. Income During Eligibility Period. During the eligibility period, when a family's countable income exceeds eighty-five percent (85%) of the State Median Income (SMI) for a family of the same size, the family becomes ineligible for child care assistance. ( )

03. Income at Time of Redetermination. At the time of redetermination, if a family's income exceeds one hundred thirty percent (130%) of the Federal Poverty Guidelines (FPG) for a family of the same size, the family may be eligible to receive a graduated phase out of child care assistance. ( )

071. COUNTABLE INCOME.
All gross earned and unearned income is counted in determining eligibility and the child care benefit amount, unless specifically excluded under Section 072 of these rules. ( )

072. EXCLUDED INCOME.
The following sources of income are not counted as family income. ( )

01. Earned Income of a Dependent Child. Income earned by a dependent child under age eighteen (18) is not counted, unless the child is a parent who is seeking or receiving child care benefits. ( )

02. Income Received for Person Not Residing With the Family. Income received on behalf of a person who is not living in the home. ( )

03. Educational Funds. All educational funds including grants, scholarships, an AmeriCorps Education Award, and federal and state work-study income. ( )

04. Assistance. Assistance to meet a specific need from other organizations and agencies. ( )

05. Lump Sum Income. Non-recurring lump sum income is excluded. ( )

06. Loans. A loan is money received that is to be repaid. ( )

07. TAFI and AABD Benefits. ( )

08. Foster Care Payments. ( )

09. AmeriCorps/VISTA Volunteers. Living allowances, wages and stipends paid to AmeriCorps or VISTA volunteers under 42 U.C.S. 5044, P.L. 93-113, Title IV, Section 404(g) are excluded as income. ( )

10. Income Tax Refunds and Earned Income Tax Credits. Income tax refunds and earned income tax credits are excluded as income. ( )

11. Travel Reimbursements. Reimbursements from employers for work-related travel. ( )

12. Tribal Income. Income received from a tribe for any purpose other than direct wages. ( )

13. Foster Parents' Income. Income of licensed foster parents is excluded when determining eligibility for a foster child. Income is counted when determining eligibility for the foster parent's own child(ren). ( )

14. Adoption Assistance. Adoption assistance payments are excluded from income. ( )

15. Temporary Census Income. All wages paid by the Census Bureau for temporary employment related to U.S. Census activities are excluded for a time period not to exceed six (6) months during the regularly scheduled ten-year U.S. Census. ( )

16. Office of Refugee Resettlement Assistance. ( )

17. Workforce Investment Act (WIA) Benefits or Workforce Innovation and Opportunity Act (WIOA) Benefits. ( )

073. INCOME DEDUCTIONS.

Court-ordered child support payments made by a parent who receives child care benefits are deducted from income when determining eligibility. The actual amount paid and the amount of the legal obligation for child support must be verified. ( )

074. AVERAGING SELF-EMPLOYMENT INCOME.

01. Annual Self-Employment Income. When self-employment income is considered annual support by the household, the Department averages the self-employment income over a twelve-month (12) period, even if: ( )

a. The income is received over a shorter period of time than twelve (12) months; and ( )

b. The household receives income from other sources in addition to self-employment. ( )

02. Seasonal Self-Employment Income. A seasonally self-employed individual receives income from self-employment during part of the year. When self-employment income is considered seasonal, the Department averages self-employment income for only the part of the year the income is intended to cover. ( )

075. CALCULATION OF SELF-EMPLOYMENT INCOME.
The Department calculates self-employment income by adding monthly income to capital gains and subtracting a deduction for expenses as determined in Subsection 075.03 of this rule. ( )

01. How Monthly Income is Determined. If no income fluctuations are expected, the average monthly income amount is projected for the certification period. If past income does not reflect expected future income, a proportionate adjustment is made to the expected monthly income. ( )

02. Capital Gains Income. Capital gains include profit from the sale or transfer of capital assets used in self-employment. The Department calculates capital gains using the federal income tax method. If the household expects to receive any capital gains income from self-employment assets during the certification period, this amount is added to the monthly income as determined in Subsection 075.01 of this rule to determine the gross monthly income. ( )

03. Self-Employment Expense Deduction. The Department uses the standard self-employment deduction in Subsection 075.03.a. of this rule, unless the applicant claims that their actual allowable expenses exceed the standard deduction and provides proof of the expenses described in Subsection 075.03.b. of this rule. ( )

a. The self-employment standard deduction is determined by subtracting fifty percent (50%) of the gross monthly self-employment income as determined in Subsections 075.01 and 075.02 of this rule; or ( )

b. The self-employment actual expense deduction is determined by subtracting the actual allowable expenses from the gross monthly self-employment income. The following items are not allowable expenses and may not be subtracted from the gross monthly self-employment income: ( )

i. Net losses from previous tax years; ( )

ii. Federal, state, and local income taxes; ( )

iii. Money set aside for retirement; ( )

iv. Work-related personal expenses such as transportation to and from work; and ( )

v. Depreciation. ( )

076. PROJECTING MONTHLY INCOME.
Income is projected for each month. Past income may be used to project future income. Changes expected during the certification period will be considered. Criteria for projecting monthly income is listed below: ( )

01. Income Already Received. Count income already received by the household during the month. If the actual amount of income from any pay period is known, use the actual pay period amounts to determine the total month's income. Convert the actual income to a monthly amount if a full month's income has been received or is expected to be received. If no changes are expected, use the known actual pay period amounts for the past thirty (30) days to project future income. ( )

02. Anticipated Income. Count income the household and the Department believe the household will get during the remainder of the certification period. If the income has not changed and no changes are anticipated, use the income received in the past thirty (30) days as one indicator of anticipated income. If changes in income have occurred or are anticipated, past income cannot be used as an indicator of anticipated income. If income changes and income received in the past thirty (30) days does not reflect anticipated income, the Department can use the household income received over a longer period to anticipate income. If income changes seasonally, the Department can use the household income from the last season, comparable to the certification period, to anticipate income.

( )

a. Full Month's Income. If income will be received for all regular pay dates in the month, it is considered a full month of income. ( )

b. If income will not be received for all regular pay dates in the month, it is not considered a full month of income and it is not converted. ( )

c. Income Paid on Salary. Income received on salary, rather than an hourly wage, is counted at the expected monthly salary rate. ( )

d. Income Paid at Hourly Rate. Compute anticipated income paid on an hourly basis by multiplying the hourly pay by the expected number of hours the client will work in the pay period. Convert the pay period amount to a monthly amount. ( )

e. 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 monthly amount. ( )

077. CONVERTING INCOME TO A MONTHLY AMOUNT.
If a full month's income is expected, but is received on other than a monthly basis, convert the income to a monthly amount using one of the formulas below: ( )

01. Weekly Amount. Multiply weekly amounts by four point three (4.3). ( )

02. Bi-Weekly Amount. Multiply bi-weekly amounts by two point one five (2.15). ( )

03. Semi-Monthly Amount. Multiply semi-monthly amounts by two (2). ( )

04. Monthly Amount. Use the exact monthly income if it is expected for each month of the certification period. ( )

078. ASSET CAP.
A family must not be in possession of assets exceeding one million dollars ($1,000,000). ( )

079. -- 099. (RESERVED)

NON-FINANCIAL CRITERIA
(Sections 100-199)

100. (RESERVED)

101. PARENTAL CHOICE OF CHILD CARE PROVIDER.
Eligible parents may choose among the following types of child care providers available under ICCP: ( )

01. Child Care Center. A child care center cares for thirteen (13) or more children. ( )

02. Group Child Care. Group child care is for seven (7) to twelve (12) children. ( )

03. Family Child Care. Family child care is for six (6) or fewer children. ( )

04. Relative Child Care. Relative child care is for six (6) or fewer related children. ( )

05. In-Home Child Care. In-home child care is provided by a relative or non-relative in the home of the child. Eligibility for in-home child care is determined in accordance with Section 400 of these rules. ( )

102. RESIDENCY.

The family must live in the state of Idaho, and have no immediate intention of leaving. ( )

103. COOPERATION IN ESTABLISHMENT OF PATERNITY AND OBTAINING SUPPORT.
A natural or adoptive parent, or other individual who lives with and exercises parental control over a minor child who has an absent parent, must cooperate in establishing paternity for the child and obtaining child support. ( )

01. Providing All Information. "Cooperation" includes providing all information to identify and locate the non-custodial parent, unless good cause for non-cooperation exists. ( )

02. Established Case for Custodial Parent. After Child Support Services (CCS) has established a case for a custodial parent, all child support payments must be sent directly to CSS. If the custodial parent receives child support directly from the non-custodial parent, the custodial parent must forward the payment to CSS for receipting. ( )

03. Failure to Cooperate. ( )

a. Failure to cooperate includes failure to complete the non-custodial or alleged parent information or filiation affidavit as requested, failure to sign the limited power of attorney, or evidence of failure to cooperate provided by Child Support Services (CSS). ( )

b. When a parent or individual fails to cooperate in establishing paternity and obtaining support, the family is not eligible to participate in the Idaho Child Care Program. ( )

04. Exemptions From Cooperation Requirement. The parent or individual will not be required to provide information about the non-custodial or alleged parent or otherwise cooperate in establishing paternity or obtaining support if good cause for not cooperating exists. Good cause for failure to cooperate must be provided. ( )

a. Good cause for failure to cooperate in obtaining support is: ( )

i. Proof the child was conceived as a result of incest or forcible rape; ( )

ii. Proof the non-custodial parent may inflict physical or emotional harm to the children, the custodial parent or individual exercising parental control. This must be supported by medical evidence, police reports, or as a last resort, an affidavit from a knowledgeable source; and ( )

iii. Substantial and credible proof is provided indicating the custodial parent cannot provide the minimum information regarding the non-custodial parent. ( )

b. A parent or individual claiming good cause for failure to cooperate must submit a notarized statement to the Department identifying the child for whom the exemption is claimed. The statement must list the reasons for the good cause claim. ( )

c. The cooperation requirement will be waived if good cause exists. No further action will be taken to establish paternity or obtain support. If good cause does not exist the parent will be notified that they are not eligible to receive Idaho Child Care program benefits, until child support cooperation as been obtained. ( )

104. FAMILY COMPOSITION.
A family is a group of individuals living in a common residence, whose combined income is considered in determining eligibility and the child care benefit amount. No individual may be considered a member of more than one (1) family in the same month. The following individuals are included in determining the family composition: ( )

01. Married Parents. Married parents living together in a common residence, includes biological, adoptive, step-parent, guardian, and foster parent. ( )

02. Unmarried Parents. Unmarried parents who live in the same home and who have a child in

common living with them. ( )

03. Dependents. Individuals who are dependents of a parent, guardian, or caretaker relative and living in the home at the primary residence. ( )

04. Minor Parent. A minor parent and child are considered a separate family when they apply for child care benefits, even if they live with other relatives. ( )

05. Individual Acting In Loco Parentis. An individual acting in loco parentis who is eligible to apply for child care benefits, and the child's natural or adoptive parents are not living in the home. ( )

06. Citizenship or Alien Status Requirement. Family members who are not citizens or living lawfully in the United States will not be counted in the family size. The income of those non-counted family members will be counted when determining the household's income according to Sections 070 through 099 of these rules. ( )

105. ELIGIBLE CHILD.
A family can only receive child care benefits for eligible children. A child is eligible for child care benefits under the following conditions: ( )

01. Immunizations Requirements. A child must be immunized in accordance with IDAPA 16.02.11, "Immunization Requirements for Licensed Daycare Facility Attendees." Child care benefits can continue during a reasonable period necessary for the child to be immunized. Parents must provide evidence that the child has been immunized unless the child is attending school. ( )

02. Citizenship or Alien Status Requirement. A child must be one (1) of the following: ( )

a. A citizen; ( )

b. Living lawfully in the United States. ( )

03. Child's Age Requirement. A child must be under thirteen (13) years of age to be eligible for child care benefits, unless they meet one (1) or more of the following criteria: ( )

a. A child is eligible for child care benefits until the month of their nineteenth birthday if they are physically or mentally incapable of self-care, as verified by a licensed mental health professional or licensed practitioner of the healing arts. ( )

b. A child may be eligible for child care benefits until the month of their nineteenth birthday if a court order, probation order, child protection, or mental health case plan requires constant supervision. ( )

04. Child Custody. A child may move from one (1) parent's home to the other parent's home on a regular basis. The child may be a member of either household, but not both households. If the parents cannot agree on the child's household for the child care benefit, the child is included in the household with primary custody. Primary custody is determined by where the child is expected to spend fifty-one percent (51%) or more of the nights during a benefit period. When only one (1) parent applies for ICCP benefits, the child may be included in that parent's household even though they do not have primary physical custody of the child. ( )

106. INCAPACITATED PARENT.
An incapacitated parent, unable to adequately care for the children in a two (2) parent family, is not required to have any qualifying activities as listed under Section 200 of these rules, as long as the other parent is participating in qualifying activities. A single parent family in which the parent is incapacitated is not eligible for ICCP. A parent with a disability does not automatically qualify as an incapacitated parent. ( )

107. -- 199. (RESERVED)

QUALIFYING ACTIVITIES
(Sections 200-299)

200. QUALIFYING ACTIVITIES FOR CHILD CARE BENEFITS.

To be eligible for child care benefits, each parent included in the household must need child care because they are engaged in one (1) of the qualifying activities listed in Subsections 200.01 through 200.05 of this rule. ( )

01. Employment. The parent is currently employed. ( )

02. Self-Employment. The parent is currently self-employed in a business that is a sole proprietorship. A sole proprietorship is a business owned by one (1) person. Restrictions apply for self-employment as follows: ( )

a. For the first twelve (12) months of self-employment benefits, actual activity hours are used. ( )

b. At month thirteen (13), the number of activity hours will be limited. To calculate the activity hours, the net monthly self-employment income is divided by the current federal minimum wage. The qualifying activity hours are the lesser of the calculated activity hours or actual activity hours. ( )

03. Training or Education. The parent is attending an accredited education or training program. The following restrictions apply to training or education activities: ( )

a. On-line classes cannot be counted as a qualifying activity for child care. ( )

b. Persons who are attending post-baccalaureate classes with no other qualifying activity, do not qualify for child care benefits. ( )

c. More than forty-eight (48) months of post-secondary education has been used as a qualifying activity. ( )

04. Preventive Services. The parent is receiving preventive services as defined in Section 011 of these rules. The Department will verify the continued need for preventive services at least every three (3) months. ( )

05. Personal Responsibility Contract (PRC) or Other Negotiated Agreement. The parent is completing Personal Responsibility Contract (PRC) or other self-sufficiency activities negotiated between the Department and the parent. ( )

201. PROJECTING QUALIFYING ACTIVITY HOURS.

01. Activity Hours. Activity hours are projected for each month to determine if payment is made on a full-time or part-time basis. Past activity hours may be used to project future activity hours if the employer and number of hours worked are the same and are expected to remain the same throughout the certification period. Hours for each qualifying activity must be projected individually and converted to a monthly amount. ( )

01. Weekly Hours. Multiply weekly amounts by four point three (4.3). ( )

02. Bi-weekly Hours. Multiplying bi-weekly amounts by two point one five (2.15). ( )

03. Semi-Monthly Hours. Multiplying semi-monthly amounts by two (2). ( )

04. Monthly Hours. Use the exact monthly hours if it is expected for each month of the certification period. ( )

202. CESSATION OF QUALIFYING ACTIVITIES.

An eligible family who loses or ceases its qualifying activity, may continue to receive assistance for up to three (3) months to engage in a job search and resume work, or resume attendance at a job training or educational program.

( )

203. -- 399. (RESERVED)

400. REQUIREMENTS FOR IN-HOME CARE UNDER ICCP.
Parents must contact the Department to request approval of in-home child care. Only parents who have qualified activities outside their home will be considered for in-home care approval. The Department limits the approval of all in-home child care under ICCP to the following circumstances: ( )

01. Three or More Children in the Home. There are three (3) or more ICCP eligible children in the home who are not in school at any time during the day and require child care. ( )

02. Fewer Than Three Children in the Home. If there are fewer than three (3) children in the home who are eligible for ICCP and require child care, in-home care will be approved by the Department only when one (1) of the following special circumstances are met: ( )

a. Parents' qualifying activity occurs during times when out-of-home care is not available. If child care is needed during any period when out-of home care is not available, in-home care will be approved for the entire time care is needed. A family is not expected to change between out-of-home and in-home care. ( )

b. The family lives in an area where out-of-home care is not available. ( )

c. A child has a verified illness or disability that would place the child or other children in an out-of-home facility at risk. ( )

401. IN-HOME CARE HEALTH AND SAFETY REQUIREMENTS.
Annually each in-home care provider is responsible to ensure that health and safety requirements are met for children being cared for in the children's own home, as defined in Section 802 of these rules. ( )

402. -- 499. (RESERVED)

PAYMENT INFORMATION
(Sections 500-599)

500. ALLOWABLE CHILD CARE COSTS.
Care provided to an eligible child by an eligible child care provider is payable subject to the following conditions: ( )

01. Payment for Employment, Training, Education, or Preventive Service Hours. Child care must be reasonably related to the hours of the parent's qualifying activities. ( )

02. One-Time Registration Fees. One-time fees for registering a child in a child care facility are payable above the local market rate, if the fee is charged to all who enroll in the facility. Reimbursement can not exceed two hundred fifty dollars ($250) and must be usual and customary rates charged to all families. Registration fees are separate from local market rates. ( )

501. NON-ALLOWABLE CHILD CARE COSTS.
Care provided to an eligible child is not payable under the following conditions: ( )

01. Family Member or Guardian Providing Child Care. A parent, step-parent, or guardian will not be paid for providing child care to their own child or ward. ( )

02. Provider Living at Same Address as Child. ICCP will not pay for in-home child care if the provider lives at the same address as the child. ( )

03. School Tuition, Academic Credit, or Tutoring. ICCP payments will not be made for school tuition, academic credit, or tutoring for school age children; this includes: ( )

a. Any services provided to such students during the regular school day, including kindergarten; ( )

b. Any services for which such students receive academic credit toward graduation; or ( )

c. Any instructional services which supplant or duplicate the academic program of any public or private school. ( )

502. AMOUNT OF PAYMENT.
Child care payments will be based on Subsections 502.01 through 502.04 of this rule. ( )

01. Payment Rate. Payment will be based on the lower of the provider's usual and customary rates or the Local Market Rate (LMR). ( )

a. The local market rates for child care are the maximum monthly amounts that ICCP will pay for any given category of child care in a geographic area designated by the Department. The local market rates for child care are established based on a comprehensive survey of child care providers. Using information gathered in the survey, including the age of child, the type of child care, and the designated area where the provider does business, a local market rate is specified for each category of child care. The rate survey is conducted triennially. ( )

b. Payment rates will be determined by the location of the child care facility. ( )

c. If the child care facility is not in Idaho, the local market rate will be the rate where the family lives. ( )

02. Usual and Customary Rates. Rates charged by the child care provider must not exceed the usual and customary rates charged for child care to persons not entitled to receive benefits under ICCP. ( )

03. In-Home Care. Parents are responsible to pay persons providing care in the child's home the minimum wage, as required by the Fair Labor Standards Act (29 U.S.C. 206a) and other applicable state and federal requirements. ( )

04. Payments. Payments will be issued directly to eligible providers. ( )

503. COPAYMENTS.
Eligible families, except TAFI families participating in non-employment TAFI activities and guardians of foster children, must pay part of their child care costs. Providers are responsible for ensuring families pay the determined child care costs and must not waive these costs. ( )

01. Poverty Rates. Poverty rates will be one hundred thirty percent (130%) of the Federal Poverty Guidelines (FPG) available on the U.S. Health and Human Services website at http://aspe.hhs.gov/poverty. The monthly rate will be calculated by dividing the yearly rate by twelve (12). ( )

02. Calculating Family Payment. Family income and activity for the month of the child care will determine the family share of child care costs. The payment made by the Department will be the allowable local market rate or billed costs, whichever is lower, less the co-payment. ( )

504. STUDENT CO-PAYMENT REQUIREMENTS.

01. Post-Secondary Student. ( )

a. A post-secondary student who works less than ten (10) hours per week will be required to pay a co-payment. ( )

b. A post-secondary student who works ten (10) hours or more per week will have a co-payment based on family income. ( )

02. High School or GED Student. A student who is in high school, or who is taking GED courses will have a co-payment based on family income. ( )

505. INTERIM CHILD CARE PAYMENT.
If child care arrangements would otherwise be lost, child care may be paid when a child temporarily stops attending child care for no longer than (1) calendar month and plans to return. ( )

506. -- 599. (RESERVED)

CHANGE REPORTING REQUIREMENTS FOR THOSE RECEIVING CHILD CARE BENEFITS (Sections 600 - 699)

600. CHANGE REPORTING REQUIREMENTS.
A family who receives child care benefits must report the following permanent changes by the tenth day of the month following the month in which the change occurred. ( )

01. Change in Permanent Address. ( )

02. Change in Household Composition. ( )

03. Change in Income. When the household's total gross income for family of the same size exceeds any of the following: ( )

a. One hundred and thirty percent (130%) of the Federal Poverty Guidelines (FPG); ( )

b. Eighty-five percent (85%) of the State Median Income (SMI); or ( )

c. The graduated phase-out income limit as defined in the Idaho Child Care State Plan. ( )

04. Change in Child Care Provider. ( )

601. (RESERVED)

602. REDETERMINATION OF ELIGIBILITY FOR CHILD CARE BENEFITS.

01. Redetermination. The Department will redetermine eligibility for child care benefits at least every twelve (12) months. ( )

02. Graduated Phase Out. At the time of redetermination, if a household's income exceeds one hundred thirty percent (130%) of the Federal Poverty Guidelines (FPG) for a family of the same size eligible children may receive a graduated phase out benefit. Graduated phase out benefits are limited to twelve (12) months following the completion of a redetermination as defined in the Idaho Child Care State Plan. ( )

603. -- 699. (RESERVED)

PAYMENT ADJUSTMENTS AND PENALTIES (Sections 700-704)

700. UNDERPAYMENT OF CHILD CARE BENEFITS.
When the Department has underpaid a family's child care benefits, a supplemental payment will be made. ( )

701. RECOUPMENT OF OVERPAYMENTS.
The Department may recoup or recover the amount paid for child care services from a provider or a parent. Interest will accrue on these overpayments at the statutory rate set under Section 28-22-104, Idaho Code, from the date of the final determination of the amount owed for services. Interest will not accrue on overpayments made due to

Department error. An overpayment due to family, agency, or provider error, IPV or fraud must be recovered in full. A parent or provider may negotiate a repayment schedule with the Department. ( )

702. INTENTIONAL PROGRAM VIOLATIONS (IPV).
An IPV is an intentionally false or misleading action or statement as identified below in Subsections 702.01 through 702.08 of this rule. An IPV is established when a family member or the child care provider admits the IPV in writing and waives the right to an administrative hearing, or when determined by an administrative hearing, a court decision, or through deferred adjudication. Deferred adjudication exists when the court defers a determination of guilt because the accused family member or child care provider meets the terms of a court order or an agreement with the prosecutor. ( )

01. False Statement. An individual makes a false statement to the Department, either orally or in writing, in order to participate in the Idaho Child Care Program. ( )

02. Misleading Statement. An individual makes a misleading statement to the Department, either orally or in writing, to participate in the Idaho Child Care Program. ( )

03. Misrepresentation of Fact. An individual misrepresents one (1) or more facts to the Department, either orally or in writing, to participate in the Idaho Child Care Program. ( )

04. Concealing Fact. An individual conceals or withholds one (1) or more facts to participate in the Idaho Child Care Program. ( )

05. Non-Compliance With Rules and Regulations. An individual fails repeatedly or substantially to comply with this chapter of rules. ( )

06. Violation of Provider Agreement. An individual knowingly violates any term of their provider agreement. ( )

07. Failure to Meet Qualifications. A provider fails to meet the qualifications specifically required by this chapter of rules or by any applicable licensing board. ( )

703. PENALTIES FOR AN IPV.
When the Department determines an IPV was committed, the party who committed the IPV loses eligibility for ICCP. If an individual has committed an IPV, the entire family is ineligible for child care benefits. If a child care provider has committed an IPV, the provider is ineligible to receive payments. The period of ineligibility for each offense, for both participants and providers, is as follows: ( )

01. First Offense. Twelve (12) months, for the first IPV or fraud offense, or the length of time specified by the court. ( )

02. Second Offense. Twenty-four (24) months for the second IPV or fraud offense, or the length of time specified by the court. ( )

03. Third Offense. Permanent ineligibility for the third or subsequent IPV or fraud offense, or the length of time specified by the court. ( )

704. DENIAL OF PAYMENT.
The Department may deny payment for the reasons described in Subsections 704.01 through 704.05 of this rule. ( )

01. Services Not Provided. Any or all claims for child care services it determines were not provided. ( )

02. Services Not Documented. Child care services not documented by the provider as required in Subsection 810.01 of these rules. ( )

03. Contrary to Rules or Provider Agreement. Child care services provided contrary to these rules or the provider agreement. ( )

04. Failure to Provide Immediate Access to Records. The Department may deny payment when the provider does not allow immediate access to records as provided in Subsection 810.02 of these rules. ( )

05. Paying for Attendance. Payment will be denied if an eligible provider pays directly or indirectly, overtly or covertly, for a child to attend the provider's child care facility. ( )

705. FUNDING RESTRICTIONS.
If a funding shortfall is projected, the Department may reduce child care benefits to ensure that ICCP operates within its financial resources. ( )

706. -- 749. (RESERVED)

ENFORCEMENT REMEDIES
(Sections 750-799)

750. TERMINATION OF PROVIDER STATUS.
Under Section 56-209h, Idaho Code, the Department may terminate the provider agreement of, or otherwise deny provider status for a period up to five (5) years from the date the Department's action becomes final to any individual or entity providing ICCP. ( )

01. Submits an Incorrect Claim. Submits a claim with knowledge that the claim is incorrect. ( )

02. Fraudulent Claim. Submits a fraudulent claim. ( )

03. Knowingly Makes a False Statement. Knowingly makes a false statement or representation of material facts in any document required to be maintained or submitted to the Department. ( )

04. Immediate Access to Documentation. Fails to provide, upon written request by the Department, immediate access to documentation required to be maintained. ( )

05. Non-Compliance With Rules and Regulations. Fails repeatedly or substantially to comply with the rules and regulations governing Idaho child care payments. ( )

06. Violation of Material Term or Condition. Knowingly violates any material term or condition of the provider agreement. ( )

07. Failure to Repay. Has failed to repay, or was a managing employee or had an ownership or control interest in any entity that has failed to repay, any overpayments or claims previously found to have been obtained contrary to statute, rule, regulation, or provider agreement. ( )

08. Fraudulent or Abusive Conduct. Has been found, or was a managing employee in any entity which has been found, to have engaged in fraudulent conduct or abusive conduct. ( )

09. Failure to Meet Qualifications. Fails to meet the qualifications specifically required by rule or by any applicable licensing entity. ( )

751. REFUSAL TO ENTER INTO AN AGREEMENT.
The Department may refuse to enter into a provider agreement for the reasons described in Subsections 751.01 through 751.06 of this rule. ( )

01. Convicted of a Felony. The provider has been convicted of a felony or is under investigation for the commission of a felony. ( )

02. Committed an Offense or Act Not in Best Interest of Child Care Participants. The provider has committed an offense or act which the Department determines is inconsistent with the best interests of ICCP participants. ( )

03. Failed to Repay. The provider has failed to repay the Department monies which had been previously determined to have been owed to the Department. ( )

04. Investigation Pending. The provider has a pending investigation for program fraud or abuse. ( )

05. Terminated Provider Agreement. The provider was the managing employee, officer, owner, or spouse, partner, or relative of an owner of an entity, whose provider agreement was terminated under Section 750 of these rules. ( )

06. Excluded Individuals. The provider has a current exclusion from participation in federal programs by the Office of Inspector General List of Excluded Individuals and Entities. ( )

752. PROVIDER NOTIFICATION.
When the Department determines actions defined in Sections 701 through 705, 750, and 751 of these rules are appropriate, it will send written notice of the decision to the provider or person. The notice will state the basis for the action, the length of the action, the effect of the action on that person's ability to provide services under state and federal programs, and the person's appeal rights. ( )

753. NOTICE TO STATE LICENSING AUTHORITIES.
The Department will promptly notify all appropriate licensing authorities having responsibility for licensing of a Department action, and the facts and circumstances of that action. The Department may request certain actions be taken and that the Department be informed of actions taken. ( )

754. -- 799. (RESERVED)

PROVIDER ELIGIBILITY
(Sections 800-808)

800. CHILD CARE PROVIDER LICENSING.
All providers of child care who receive a Department subsidy must be licensed or must comply with: applicable State Daycare licensing requirements in Title 39, Chapter 11, Idaho Code; these rules; local licensing ordinances; or tribal ordinances. If both state requirements and ordinances apply to a provider, the provider must comply with the stricter requirement. A provider operating outside Idaho must comply with the licensing laws of their state or locality. ( )

801. HEALTH AND SAFETY TRAINING.
All child care providers must complete a series of health and safety trainings during an orientation period of not more than ninety (90) days, in addition to ongoing annual training that address each of the following topics: ( )

01. Infectious Diseases. The prevention and control of infectious diseases (including immunization). ( )

02. Sudden Infant Death Syndrome. The prevention of sudden infant death syndrome and use of safe sleeping practices. ( )

03. Medication. The administration of medication, consistent with standards for parental consent. ( )

04. Allergic Reactions. The prevention of and response to emergencies due to food and allergic reactions. ( )

05. Environmental Safety. Building and physical premises safety, including identification of and protection from hazards, bodies of water, and vehicular traffic. ( )

06. Child Abuse Prevention. Prevention of shaken baby syndrome**,** abusive head trauma, child maltreatment, and recognition and reporting of child abuse and neglect. ( )

07. Emergency Preparedness. Emergency preparedness and response planning for emergencies resulting from a natural disaster, or a man-caused event. ( )

08. Hazardous Substances. Proper handling, storage, and disposal of medicines, cleaning supplies, and other hazardous substances, including biocontaminants. ( )

09. Transportation. Appropriate precautions in transporting children, including the use of child safety restraints and seat belts. ( )

10. Child Development. Address major domains such as cognitive, social, emotional, physical development, and approaches to learning. ( )

802. HEALTH AND SAFETY REQUIREMENTS.
All providers must comply with the health and safety requirements listed in Subsections 802.01 through 802.13 of this rule. All providers must agree to an annual, unannounced health and safety inspection, with the exception of in-home child care described in Section 401 of these rules. Compliance with these standards does not exempt a provider from complying with stricter health and safety standards under state law, tribal law, local ordinance, or other applicable law. ( )

01. Age of Provider. All child care providers providing services must be eighteen (18) years old or older. Persons sixteen (16) or seventeen (17) years old may provide child care if they have direct, on-site supervision from a licensed child care provider who is at least eighteen (18) years old. ( )

02. Sanitary Food Preparation. Food for use in child care facilities must be prepared and served in a sanitary manner. Utensils and food preparation surfaces must be cleaned and sanitized before using to prevent contamination. ( )

03. Food Storage. All food served in child care facilities must be stored to protect it from potential contamination. ( )

04. Hazardous Substances. Medicines, cleaning supplies, and other hazardous substances must be handled safely and stored out of the reach of children. Biocontaminants must be disposed of appropriately. ( )

05. Emergency Communication. A telephone or some type of emergency communication system is required. ( )

06. Smoke Detectors, Fire Extinguishers, and Exits. A properly installed and operational smoke detector must be on the premises where child care occurs. Adequate fire extinguishers and fire exits must be available on the premises. ( )

07. Hand Washing. Each provider must wash his hands with soap and water at regular intervals, including before feeding, after diapering or assisting children with toileting, after nose wiping, and after administering first aid. ( )

08. CPR/First Aid. All providers must have current certification in pediatric rescue breathing (CPR) and pediatric first aid treatment from a certified instructor. ( )

09. Health of Provider. Each provider must certify that he does not have a communicable disease or any physical or psychological condition that might pose a threat to the safety of a child in his care. ( )

10. Child Abuse. Providers must report suspected child abuse to the appropriate authority. ( )

11. Transportation. Providers who transport children as part of their child care operations must operate safely and legally, using child safety restraints and seat belts as required by state and local statutes. ( )

12. Disaster and Emergency Planning. Providers must have documented policies and procedures planning for emergencies resulting from a natural disaster, or man-caused event that include: ( )

a. Evacuation, relocation, shelter-in-place, and lock-down procedures, and procedures for communication and reunification with families, continuity of operations, and accommodation of infants and toddlers, children with disabilities, and children with chronic medical conditions. ( )

b. Procedures for staff and volunteer emergency preparedness training and practice drills. ( )

c. Guidelines for the continuation of child care services in the period following the emergency or disaster. ( )

13. Environmental Safety. Building and physical premises must be safe, including identification of and protection from hazards that can cause bodily injury including electrical hazards, bodies of water, and vehicular traffic. ( )

14. Safe Sleep. Providers must place newborn infants to twelve (12) months in a safe sleep environment. Safe sleep practices include, alone, on their backs, and in a Consumer Product Safety Commission (CPSC) certified crib. ( )

803. CHILD CARE PROVIDER TRAINING REQUIREMENTS.
Each child care provider must receive and ensure that each staff member who provides child care receives and completes twelve (12) hours of ongoing training every twelve (12) months after the staff member's date of hire. ( )

01. Training Contents. Training must be related to continuing education in child development, teaching and curriculum, health and safety, and business practices. Pediatric rescue breathing (CPR) and pediatric first aid treatment training will not count towards the required twelve (12) hours of annual training. ( )

02. Documented Training. It is the responsibility of the child care provider to ensure that each staff member who provides child care has completed twelve (12) hours of training each year. The training must be documented in the staff member's record. ( )

03. Staff Training Records. Each child care provider is responsible for maintaining documentation of staff's training and must produce this documentation when the provider agreement is renewed annually. ( )

804. CHILD CARE PROVIDER AGREEMENT.

01. Compliance. All providers must sign and comply with a provider agreement. ( )

02. Provide Direct Care. Except for Child Care Centers described in Subsection 101.01 of these rules, the individual who signs the provider agreement must provide the majority of direct care to the children in that child care facility. ( )

805. CRIMINAL HISTORY AND BACKGROUND CHECK REQUIREMENT.
Applicants, providers, employees, volunteers, and all other individuals age thirteen (13) or older who have direct contact with or provide care to children eligible for ICCP benefits must comply with the requirements and receive clearance as provided in IDAPA 16.05.06, “Criminal History and Background Checks,” every five (5) years. ( )

806. PURVIEW OF CHILD PROTECTIVE ACT OR JUVENILE JUSTICE REFORM ACT.
Providers must certify that they are not, through stipulation or adjudication, under the purview of the Child Protective Act, Section 16-1600, Idaho Code, or the Juvenile Corrections Act, Section 20-501 through 20-547, Idaho Code. Any

person who has a substantiated child protection complaint cannot be a provider. ( )

807. PARENT OR CARETAKER ACCESS TO CHILD CARE PREMISES.
Providers serving families who receive a child care subsidy must allow parents or caretakers unlimited access to their children and to persons giving care, except that access to children will not be required if prohibited by court order. ( )

808. REPORTING REQUIREMENTS FOR PROVIDERS.
A child care provider must report any of the following changes within ten (10) days: ( )

01. Change in Provider Charges. The provider changes any rate for child care services. ( )

02. Child Stops Attending Care. A child covered under ICCP stops attending child care, or is taken to another child care provider. ( )

03. Change of Provider Address. The provider changes the location where child care is provided. ( )

04. Change in Who Lives in Home. An individual who provides child care in their home must report when any other person moves into the home. ( )

05. Intent Not to Renew License. The provider intends not to renew their license, or other required certifications. ( )

06. Death or Serious Injury. Providers must report when a child sustains a serious injury or dies while at the location of, or as a result of participating in child care. ( )

809. CONSUMER EDUCATION INFORMATION.
The Department will make public by electronic means, in an easily accessible format: ( )

01. Monitoring and Inspection Reports. The results of all child care monitoring and inspection reports. ( )

02. Substantiated Complaints. Substantiated complaints about failure to comply with child care laws, rules, and policies, that include information on the date of such an inspection, and where applicable, information on corrective action taken. ( )

03. Death and Serious Injury. The total number of deaths, serious injuries, and instances of substantiated child abuse that occurred in child care settings each year. ( )

810. DOCUMENTATION OF SERVICES AND ACCESS TO RECORDS.

01. Documentation of Services. Providers must generate documentation at the time of service sufficient to support the reimbursement for child care services. Documentation must be legible and retained for a period of three (3) years from the date the child care was provided. Documentation to support child care services includes: ( )

a. Records of attendance, including signatures of a parent or guardian; ( )

b. Immunization records, conditional admittance form, or exemption form according to IDAPA 16.02.11, "Immunization Requirements for Licensed Daycare Facility Attendees." ( )

c. Billing records and receipts; ( )

d. Policies regarding sign-in procedures, and others as applicable; and ( )

e. Sign-in records, electronic or manual, or the Child and Adult Food Care Program records.

( )

02. Immediate Access to Records. Providers must grant to the Department and its agents, immediate access to records for review and copying during normal business hours. These records are defined in Subsection 810.01 of this rule. ( )

03. Copying Records. The Department and its authorized agents may copy any record as defined in Subsection 810.01 of this rule. The Department may request in writing to have copies of records supplied by the provider. The requested copies must be furnished within twenty (20) working days after the date of the written request, unless an extension of time is granted by the Department for good cause. Failure to timely provide requested copies will be a refusal to provide access to records. ( )

04. Removal of Records From Provider's Premises.The Department and its authorized agents may remove from the provider's premises copies of any records defined in Subsection 810.01 of this rule. ( )

811. -- 999. (RESERVED)

000. LEGAL AUTHORITY.
Sections 56-201, and 56-202(b), Idaho Code, authorize the Department to adopt and enforce rules for administration of public assistance programs. ( )

001. SCOPE.
These rules establish statewide provisions of emergency assistance to families with children eligible to receive assistance through Title IV-A funds to meet the family's emergency conditions. ( )

002. -- 009. (RESERVED)

010. DEFINITIONS.

01. Adult Relatives. Any non-parent individual over the age of eighteen (18) years, who is related to the eligible child in any of the following ways: ( )

a. Brother, sister, aunt, uncle, nephew, niece, first cousin or first cousin once removed, or one (1) of these relationships including parents prefixed by “grand” or “great,” or: ( )

b. One (1) of the following relationships by half-blood: a step-parent, step-sibling, or the spouse of a relative by marriage, even if the marriage has ended. ( )

02. Authorization Assessment. A standardized assessment conducted by the Department within the first thirty (30) days following the date of application for emergency assistance. ( )

03. Child. An individual less than eighteen (18) years of age. ( )

04. Department. The Idaho Department of Health and Welfare, or its designee. ( )

05. Destitution. A state of being in extreme need from lacking possessions or resources. ( )

06. Emergency Assistance. Funding through Title IV-A for social services, emergency payments, and placement payments authorized by the Department and designed to meet short-term, non-recurrent emergency needs of families with children. ( )

07. Federal Poverty Guideline. Poverty guidelines issued each year in the Federal Register by the Department of Health and Human Services used to determine financial eligibility for certain state and federal programs. These guidelines may be accessed at the Internet website at http://aspe.hhs.gov/poverty. ( )

08. Respite Care. Time-limited care provided to children. Respite care is utilized in circumstances that require short-term, temporary placement of a child from the home of their usual caregiver to that of another licensed or agency-approved family. In general, the duration of a respite placement is from one (1) to fourteen (14) days. ( )

09. Service Period. The thirty (30) day authorization assessment period and up to ninety (90) days following the assessment period. ( )

011. -- 099. (RESERVED)

100. EMERGENCY CONDITION.
A family is assessed for an emergency condition when the Department receives a report, referral, or service request indicating an emergency condition exists, which includes a child who has unmet short-term basic needs affecting the child's health, safety, or well-being that place the child at risk of destitution. ( )

101. -- 149. (RESERVED)

150. APPLICATION FOR SERVICES.
An application must be completed and signed by one (1) of the following individuals on behalf of the eligible child for emergency assistance to be given: ( )

01. A Parent or Parents. ( )

02. An Adult Relative. An adult relative may sign on behalf of the child, when the child is residing with them and they are responsible for the child's care. ( )

151. -- 159. (RESERVED)

160. ELIGIBILITY REQUIREMENTS.
The following requirements of this rule must be met before a family is eligible for emergency assistance. ( )

01. Child. There must be a child in the household for the family to be eligible. ( )

02. Citizenship. To be eligible for emergency assistance, an individual must meet the citizenship requirements in IDAPA 16.03.08, "Temporary Assistance for Families in Idaho (TAFI),". ( )

03. Income Guidelines. The family is determined as needy when the household income is below two hundred percent (200%) of the current Federal Poverty Guideline, or is unable to meet the emergency condition because of circumstances beyond their control, and insufficient resources are immediately available to meet the child's basic needs and which threatens the child's safety, stability, or well-being. ( )

04. Residence. The child must have lived with one (1) or both parents or an adult relative, within six (6) months prior to the month of application for emergency assistance. A child may move from one (1) household to another and be eligible to receive emergency assistance in either household. ( )

05. Work Program Compliance. An individual who is required to participate in a work program must not have refused, without good cause, to accept employment or training for employment. ( )

161. -- 199. (RESERVED)

200. ASSESSMENT AND AUTHORIZATION FOR EMERGENCY ASSISTANCE.

01. Authority to Assess Needs for Emergency Assistance. Contractors may conduct assessments and make referrals for authorization. ( )

02. Authorization Of Emergency Assistance. Emergency assistance payments and services may only be authorized by the Department. ( )

03. Authorization and Assessment Period. The thirty (30) day authorization and assessment period begins the date the applicant signs the application. Services may be provided during this authorization and assessment period. ( )

04. Service Period. A service period may continue for a maximum of ninety (90) days following the assessment period. ( )

05. Total Number of Days for Emergency Assistance. The total number of days a family may receive emergency assistance is one hundred twenty (120) consecutive days in a twelve (12) month period from the date the application is signed. ( )

06. Assessment Content. The Department will describe in the assessment the following: ( )

a. The emergency condition; ( )

b. The family's issues that caused the emergency condition; and ( )

c. A family service plan. ( )

07. Family Service Plan Content. The Department must both develop a family service plan that has been signed by the applicant and include a description of the following: ( )

a. The types of services and the reason the services are needed; ( )

b. The specific period each service will be covered; ( )

c. Who is providing the service; ( )

d. A list of resources and contacts made on behalf of the family; and ( )

e. How the needs of the family will be met in the future. ( )

201. -- 209. (RESERVED)

210. DURATION FOR EMERGENCY ASSISTANCE.
Emergency assistance may be provided to a family one (1) time during a twelve (12) month period counted from the date the application is signed, unless the original application was denied or withdrawn. The emergency assistance can not exceed a total of one hundred and twenty (120) consecutive days and if: ( )

01. More than one (1) emergency condition occurs within the thirty (30) day authorization assessment period, all emergency conditions are considered to be the same emergency and additional funds may be authorized to cover additional services needed. ( )

02. A second emergency condition occurs after the thirty (30) day authorization assessment period, it is considered a separate emergency condition and emergency assistance cannot be used to provide services or payment of additional funds. ( )

211. -- 299. (RESERVED)

300. EMERGENCY ASSISTANCE PAYMENTS.
Emergency assistance payments are short-term benefits for specific emergency conditions that are provided to assist a family with an eligible child. These payments are not intended to meet ongoing and recurrent needs that will extend beyond the one hundred twenty (120) day service period. ( )

01. Emergency Payments. Emergency payments will be made to purchase goods and services relating to the emergency condition. ( )

02. Non-Allowable Payments. Emergency assistance funds may not be used to pay for the following: ( )

a. Medical services reimbursable by Medicaid regardless of whether the individual is receiving or eligible for Medicaid. ( )

b. Services provided to meet a family's ongoing basic needs including housing, food, clothing, transportation, and household goods that extend beyond the one hundred twenty (120) days. ( )

c. Services available through other community resources. ( )

d. Child care that is not considered respite care. ( )

e. Medical or automobile insurance. ( )

f. Down payment or purchases of vehicles or real property. ( )

03. Funding Restrictions. The Department may take action to reduce emergency assistance payments when available funding is insufficient. ( )

301. -- 999. (RESERVED)

000. LEGAL AUTHORITY.
Sections 56-1003, 56-1004, 56-1004A, 56-1007, and 56-1009, Idaho Code, authorize the Director to promulgate, recommend, and enforce rules promoting substance use disorders services. Sections 39-305, 39-306, and 39-311, Idaho Code, authorize the Idaho Board of Health and Welfare to adopt rules and to establish standards for treatment facilities. ( )

001. SCOPE.
This chapter sets standards for providing substance use disorders services administered under the Department's Division of Behavioral Health. ( )

002. (RESERVED)

003. ADMINISTRATIVE APPEALS.

01. Appeal of Denial Based on Eligibility Requirements. Administrative appeals from a denial of substance use disorder services based on eligibility requirements are governed by the provisions of IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings." ( )

02. Appeal of Decision Based on Clinical Judgment. Decisions involving ASAM clinical judgment, including the category of services, the particular provider of services, or the duration of services, are reserved to the Department, and are not subject to appeal, administratively or otherwise, under Maresh v. State, 132 Idaho 221, 970 P.2d 14 (Idaho 1999). ( )

03. Appeal by a Substance Use Disorder Services Provider or Program. Administrative appeals from a decision that a substance use disorder services provider or program is out of compliance with these rules are governed by the provisions of IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings." An appeal does not stay Department action. ( )

004. INCORPORATION BY REFERENCE.
The following are incorporated by reference in this chapter of rules: ( )

01. ASAM. American Society of Addiction Medicine (ASAM) Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions, Third Edition, 2013. A copy of this manual is available by mail at the American Society of Addiction Medicine, 4601 North Park Ave., Suite 101, Chevy Chase, MD 20815; by telephone and fax, (301) 656-3920 and (301) 656-3815 (fax); or on the internet at http://www.asam.org. ( )

02. DSM-5. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, (DSM-5) Washington, DC, American Psychiatric Association, 2000. Copies of the manual are available from the American Psychiatric Association, 1000 Wilson Boulevard, Suite 1825, Arlington VA 22209-3901. ( )

03. *Federal* Guidelines for Opioid Treatment Programs (OTP). Substance Abuse and Mental Health Services Administration. *HHS Publication No. (SMA) PEP15-FEDGUIDEOTP, March 2015. Center for Substance Abuse Treatment, Division of Pharmacologic Therapies for the Substance Abuse and Mental Health Services Administration, 1 Choke Cherry Road, Rockville, MD 20857. This manual is available* on the internet at https://store.samhsa.gov/product/Federal-Guidelines-for-Opioid-Treatment-Programs/PEP15-FEDGUIDEOTP.
( )

005. -- 008. (RESERVED)

009. CRIMINAL HISTORY AND BACKGROUND CHECK REQUIREMENTS.

01. Criminal History and Background Check. All employees, volunteers, interns, and contractors of substance use disorder treatment and recovery support services must comply with the provisions of IDAPA 16.05.06, "Criminal History and Background Checks. ( )

02. Availability to Work or Provide Service. An individual listed in Subsection 009.01 of this rule is available to work on a provisional basis at the discretion of the employer or agency once the individual has submitted their completed criminal history and background check application, it has been reviewed by the employer or agency, and no disqualifying crimes or relevant records are disclosed on the application. An individual must be fingerprinted within twenty-one (21) days of submitting their criminal history and background check. ( )

a. An individual is allowed to work or have access to participants only under supervision until the criminal history and background check is completed. ( )

b. An individual, who does not receive a criminal history and background check clearance or have a Behavioral Health waiver granted under the provisions in Subsection 009.03 of this rule, must not provide direct care or services, or serve in a position that requires regular contact with participants. ( )

03. Waiver of Criminal History and Background Check Denial.

a. A certified or uncertified individual who is seeking to provide Peer Support Specialist, Family Support Partner, or Recovery Coach services that receives an unconditional denial or a denial after an exemption review by the Department's Criminal History Unit, may apply for a Behavioral Health waiver. ( )

b. An individual is allowed to work or have access to participants only under supervision until the waiver request is processed. ( )

010. DEFINITIONS - A THROUGH F.
For the purposes of these rules, the following terms apply: ( )

01. Adolescent. A youth twelve (12) through seventeen (17) years of age. ( )

02. Adult. An individual eighteen (18) years or older. ( )

03. ASAM. Refers to the manual of the patient placement criteria for the treatment of substance-related disorders, published by the American Society of Addiction Medicine, incorporated by reference in Section 004 of these rules. ( )

04. ASAM Level of Care Certification.Verifies a treatment program's capacity to deliver services consistent with the Level III standards of care described in the ASAM criteria. ( )

05. Clinical Assessment. The gathering of historical and current clinical information through a clinical interview and from other available resources to identify an individual's strengths, weaknesses, problems, needs, and determine priorities so that a service plan can be developed. ( )

06. Clinical Judgment. Refers to observations and perceptions based upon education, experience, and clinical assessment. This may include psychometric, behavioral, and clinical interview assessments that are structured, integrated, and then used to reach decisions, individually or collectively, about an individual's functional, mental, and behavioral attributes and substance use disorders service needs. ( )

07. Department. The Idaho Department of Health and Welfare or its designee. ( )

08. Eligibility Screening. The collection and review of information directly related to the individual's substance use and level of functioning, which the Department uses to determine whether an individual is eligible for adult or adolescent substance use disorder services available through the Department's Division of Behavioral Health. ( )

09. Federal Poverty Guidelines. Guidelines issued annually by the Federal Department of Health and Human Services establishing the poverty income limits. The federal poverty guidelines for the current year may be found at: http://aspe.hhs.gov/poverty/. ( )

011. DEFINITIONS - G THROUGH Z.
For the purposes of these rules, the following terms apply: ( )

01. Idaho Board of Alcohol/Drug Counselor Certification, Inc. (IBADCC). A board affiliated with the International Certification Reciprocity Consortium/Alcohol and Other Drug Abuse (ICRC). The IBADCC is the certifying entity that oversees credentialing of Idaho Student of Addiction Studies (ISAS), and Certified Alcohol/ Drug Counselors (CADC) in the state of Idaho. ( )

02. Individualized Service Plan. A written action plan based on an eligibility screening and clinical assessment, that identifies the individual's clinical needs, the strategy for providing services to meet those needs, treatment goals and objectives and the criteria for terminating the specified interventions. ( )

03. Intensive Outpatient Services. Educational classes and individual or group counseling consisting of regularly scheduled sessions within a structured program, for a minimum of nine (9) hours of treatment per week for adults and six (6) hours of treatment per week for adolescents. ( )

04. Medication-Assisted Treatment (MAT). The use of medications, approved by the Food and Drug Administration (FDA), in combination with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of substance use disorders. ( )

05. Network Treatment Provider. Any provider, group of providers, or entity that has a network provider agreement with the Department's Division of Behavioral Health contractor to provide behavioral health services. ( )

06. Opioid Treatment Program (OTP). A program that provides MAT for persons diagnosed with opioid use disorder (OUD). OTPs provide all FDA approved MAT medications. In addition, participants receiving MAT medications must also receive counseling and other behavioral therapies to provide participants with a whole-person approach. ( )

07. Outpatient Services. Educational classes and individual or group counseling consisting of regularly scheduled sessions within a structured program for up to eight (8) hours of treatment per week for adults and five (5) hours of treatment per week for adolescents. ( )

08. Priority Population. Priority populations consist of individuals who receive services ahead of other persons. Priority populations are determined yearly by the Department and align with federally mandated priorities. ( )

09. Recovery Support Services. Non-clinical services designed to initiate, support, and enhance recovery. These services may include: safe and sober housing, transportation, child care, life skills education, drug testing, recovery coaching, and case management. ( )

10. Residential Treatment Services. A planned and structured regimen of treatment provided in a 24-hour residential setting. Residential programs serve individuals who, because of function limitations need safe and stable living environments and 24-hour care. ( )

11. Substance-Related Disorders. Clinical presentations due to substance use that may or may not demonstrate sufficient signs or symptoms to substantiate a diagnosis of a substance use disorder. ( )

12. Substance Use Disorder. A disorder evidenced by a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using a substance despite significant substance-related problems. According to the DSM-5, diagnosis of a substance use disorder is based on a pathological pattern of behaviors related to use of the substance. ( )

012. -- 099. (RESERVED)

PARTICIPANT ELIGIBILITY
(Sections 100-199)

100. ACCESSING SUBSTANCE USE DISORDERS SERVICES.
Individuals may access substance use disorders services administered by the Department's Division of Behavioral Health through an eligibility screening. ( )

101. ELIGIBILITY SCREENING AND CLINICAL ASSESSMENT.

01. Eligibility Screening. The eligibility screening must be directly related to the individual's substance-related disorder and level of functioning, and will include: ( )

a. Questions about the individual's substance use and history; and ( )

b. Questions about the individual's income and living situation. ( )

02. Clinical Assessment. Once an individual is found eligible for substance use disorders services, the individual will be authorized to receive a clinical assessment from a treatment provider in the Division of Behavioral Health's substance use disorder services network to determine ASAM level of care. ( )

102. ELIGIBILITY DETERMINATION.

01. Determination of Eligibility for Substance Use Disorders Services. The Department may limit or prioritize adult and adolescent substance use disorder services, impose income limits, define eligibility criteria, and establish the number of persons eligible based upon such factors as court-ordered services, availability of funding, the degree of financial need, the degree of clinical need, or other factors. ( )

02. Eligibility Requirements. To be eligible for substance use disorders services the individual must: ( )

a. Be an adult or adolescent with family income at or below federal poverty guidelines established by the Division; ( )

b. Be a resident of the state of Idaho; ( )

c. Be a member of a priority population; ( )

d. Meet diagnostic criteria for a substance-related disorder as described in the DSM-5; and ( )

e. Meet specifications in each of the ASAM dimensions required for the recommended level of care. ( )

103. NOTICE OF CHANGES IN ELIGIBILITY FOR SUBSTANCE USE DISORDERS SERVICES. The Department may, upon ten (10) days' written notice, reduce, limit, suspend, or terminate eligibility for substance use disorders services. ( )

104. NOTICE OF DECISION ON ELIGIBILITY AND RIGHT TO APPEAL.

01. Notification of Eligibility Determination. Within two (2) business days of receiving a completed screening, the Department will notify the individual or the individual's designated representative of its eligibility determination. When the individual is not eligible for services through the Department, the individual or the individual's designated representative will be notified in writing. ( )

02. Notice of Right to Appeal. When the individual is not eligible for services through the Department, the Department will notify the individual or the applicant's individual's designated representative. The written notice will include: ( )

a. A statement of the decision and the concise reasons for it; ( )

b. The process and timeline for pursuing an appeal of the decision under IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings"; and; ( )

c. The right to be represented on appeal. ( )

105. -- 119. (RESERVED)

120. FINANCIAL RESPONSIBILITY FOR SUBSTANCE USE DISORDERS SERVICES.
An individual receiving substance use disorders services through the Department is responsible for paying for the services received. The financial responsibility for each service is based on the individual's ability to pay as determined in IDAPA 16.07.01, "Behavioral Health Sliding Fee Schedules." ( )

121. -- 149. (RESERVED)

150. SELECTION OF SERVICE PROVIDERS.
A participant who is eligible for substance use disorders services administered by the Department's Division of Behavioral Health can choose a service provider that is in the contracted substance use disorder provider network. Treatment services must be within the recommended level of care according to ASAM based on the individual's needs identified in the assessment and resulting individualized service plan. ( )

151. -- 199. (RESERVED)

SUBSTANCE USE DISORDER SERVICES
(Sections 200-600)

200. QUALIFIED SUBSTANCE USE DISORDERS PROFESSIONAL PERSONNEL REQUIRED.
Each behavioral health program providing substance use disorders services must employ the number and variety of staff needed to provide the services and treatments offered by the program as a multidisciplinary team. The program must employ at least one (1) qualified substance use disorders professional for each behavioral health program location. A qualified substance use disorders professional includes individuals with the following qualifications: ( )

01. Idaho Board of Alcohol/Drug Counselor Certification - Certified Advanced or Certified Alcohol/Drug Counselor. ( )

02. Northwest Indian Alcohol/Drug Specialist Certification - Counselor II or Counselor III. ( )

03. National Board for Certified Counselors (NBCC) - Master Addictions Counselor (MAC). ( )

04. Clinical Social Worker (LCSW) or Masters Social Worker (LMSW). Licensed under Title 54, Chapter 32, Idaho Code; ( )

05. Marriage and Family Therapist or Associate Marriage and Family Therapist. Licensed under Title 54, Chapter 34, Idaho Code; ( )

06. Nurse Practitioner. Licensed under Title 54, Chapter 14, Idaho Code; ( )

07. Clinical Nurse Specialist. Licensed under Title 54, Chapter 14, Idaho Code; ( )

08. Physician Assistant. Licensed under Title 54, Chapter 18, Idaho Code; ( )

09. Professional Counselor (LPC) or Clinical Professional Counselor (LCPC). Licensed under Title 54, Chapter 34, Idaho Code; ( )

10. Psychologist or Psychologist Extender. Licensed under Title 54, Chapter 23, Idaho Code; ( )

11. Physician. Licensed under Title 54, Chapter 18, Idaho Code; and; ( )

12. Registered Nurse (RN). Licensed under Title 54, Chapter 14, Idaho Code. ( )

13. Pharmacist. Licensed under Title 54, Chapter 17, Idaho Code. ( )

201. -- 209. (RESERVED)

210. QUALIFIED SUBSTANCE USE DISORDERS PROFESSIONAL TRAINEE.
Each qualified substance use disorders professional trainee practicing in the provision of substance use disorders services must meet the following requirements. ( )

01. Work Qualifications for Qualified Substance Use Disorders Professional Trainee. A qualified substance use disorders professional trainee must meet one (1) of the following qualifications to begin work: ( )

a. Substance Use Disorder Associate certification; ( )

b. Formal documentation as a Northwest Indian Alcohol/Drug Specialist Counselor I; or ( )

c. Formal documentation of current enrollment in a program for qualifications in Section 200 of these rules. ( )

02. Continue as Qualified Substance Use Disorders Professional Trainee. An individual who has completed a program listed in Section 200 of these rules and is awaiting licensure can continue as a qualified substance use disorders professional trainee at the same agency for a period of six (6) months from the date of program completion. ( )

211. -- 299. (RESERVED)

300. SERVICES FOR ADOLESCENTS.
Behavioral health programs providing substance use disorders treatment to adolescents must comply with the following requirements: ( )

01. Separate Services From Adults. Each program providing adolescent program services must provide the services separate from adult program services. The program must ensure the separation of adolescent participants from adult participants except as specified in Subsections 300.03 and 300.04 of this rule. ( )

02. Residential Care as an Alternative to Parental Care. Any program that provides care, control, supervision, or maintenance of adolescents for twenty-four (24) hours per day as an alternative to parental care must meet the following criteria: ( )

a. Be licensed under the "Child Care Licensing Act," Title 39, Chapter 12, Idaho Code; or ( )

b. Be certified by the Department of Juvenile Corrections. ( )

03. Continued Care of an Eighteen-Year-Old. An adolescent who turns the age of eighteen (18), and is receiving outpatient or intensive outpatient treatment in a state-approved behavioral health program, may remain in the program under continued care described in this rule. The individual may remain in the program for: ( )

a. Up to ninety (90) days after their eighteenth birthday; or ( )

b. Until the close of the current school year for an individual attending school. ( )

04. Documentation Requirements for Continued Care. Prior to accepting an individual into continued care, the program must assure and document the following; ( )

a. A signed voluntary agreement to remain in the program or a copy of a court order authorizing continued placement after the individual's eighteenth birthday; ( )

b. Clinical staffing for appropriateness of continued care with clinical documentation; ( )

c. Verification the individual in continued care was in the care of the program prior to their eighteenth birthday; and ( )

d. Verification that the individual needs to remain in continued care to complete treatment, education, or other similar needs. ( )

05. Licensed Hospital Facilities. Facilities licensed as hospitals under Title 39, Chapter 13, Idaho Code, are exempt from the requirements in this rule. ( )

301. -- 349. (RESERVED)

350. RECOVERY SUPPORT SERVICES.
Recovery Support Services are administered through contract. Recovery Support Services are non-clinical services that support recovery from a substance use disorder and are based on an individual participant's needs. Recovery Support Services may include: ( )

01. Case Management. ( )

02. Alcohol and Drug Screening. ( )

03. Child Care. ( )

04. Transportation. ( )

05. Life Skills. ( )

06. Recovery Residence-Staffed Safe and Sober Housing for Adults. ( )

07. Recovery Residence-Enhanced Staffed Safe and Sober Housing for Adults. ( )

08. Recovery Coaching. ( )

351. -- 394. (RESERVED)

395. RESIDENTIAL TREATMENT SERVICES.

01. Residential Treatment Services. Residential Treatment Services are administered under the Department through a contractor and must be nationally accredited by the Joint Commission, the Council on Accreditation (COA), or Commission on Accreditation of Rehabilitation Facilities (CARF) and have an ASAM Level of Care certification. ( )

02. Licensed for Adolescent Residential Treatment. Each adolescent residential treatment program must be licensed as a Children's Residential Care Facility under IDAPA 16.06.02, "Child Care Licensing." ( )

396. -- 409. (RESERVED)

410. OUTPATIENT TREATMENT SERVICES.
Outpatient substance use disorder treatment services are contained in the Medicaid Idaho Behavioral Health Plan (IBHP) and delivered under contract. ( )

01. Treatment Services. Services are delivered according to ASAM criteria and Level of Care Placement guidelines. Services include: ( )

a. Assessments; ( )

b. Service planning and placement; ( )

c. Group therapy; and ( )

02. Treatment Providers. Outpatient treatment services are delivered by network providers enrolled with the Medicaid IBHP contractor. ( )

411. -- 414. (RESERVED)

415. MEDICATION-ASSISTED TREATMENT.

01. Medication-Assisted Treatment Services. A behavioral health program providing medication assisted treatment for substance use disorders must make counseling and behavioral therapies available in combination with MAT services. ( )

02. Opioid Treatment Program. OTP must meet all requirements established under 42 CFR, Section 8.12, Federal Opioid Treatment Standards. ( )

QUALITY ASSURANCE AND INSPECTIONS (Sections 416-419)

416. INSPECTIONS.
As the State substance abuse authority, the Department will periodically inspect substance use disorder services providers or programs as provided in Section 39-305, Idaho Code, to determine compliance with these rules and Title 39, Chapter 3, Idaho Code. ( )

01. Department Inspection. The Department may inspect a substance use services provider or program at any reasonable time during regular business hours. Inspections may be made without prior notice to the substance use services provider or program. ( )

02. Program Compliance with Inspection. The program or provider must, in compliance with federal and state confidentiality requirements, provide for review of participant treatment records, behavioral health records, logbooks, staffing charts, time reports, claims data, administrative documents, complaints, grievances, and any other requested documents or data required by the Department. ( )

03. Department Protection of Participants. The Department will take steps to protect individuals receiving substance use disorder services during its inspections. ( )

417. INVESTIGATIONS AND FINDINGS.
The Department may conduct inspections as provided in Section 416 of these rules, to investigate complaints, incidents, accidents, allegations of abuse, neglect, or exploitation. If the Department chooses to investigate, the investigation and a report of the Department's findings must be completed within thirty (30) calendar days of the date the Department learned of the complaint, incident, accident, or allegation. The Department may take any of the following actions: ( )

01. Corrective Action Plan. Require the substance use disorders services provider, program, or the Department contractor administering the provider network to engage in a corrective action plan as determined and monitored by the Department or the contractor administering the provider network; or ( )

02. Program Improvement Plan. Require the substance use disorder services provider, program, or the Department contractor administering the provider network to develop a program improvement plan to be implemented and monitored over time. ( )

418. NOTICES FOLLOWING INVESTIGATION.
Within thirty (30) calendar days of the date the Department learned of the complaint, incident, accident, or allegation, the Department must issue a notice to the provider, program, or the contractor administering the provider network. The notice must include: ( )

01. Statement of Department Findings. A statement of the Department's findings about whether the program, provider, or contractor is in compliance with these rules or has engaged in abuse, neglect, or exploitation; or whether an incident or accident occurred; ( )

02. Department Plan Requirement. Whether the Department will require a corrective action plan or program improvement plan; ( )

03. Department Notifications. Whether the Department will be notifying the program or provider's accrediting entity or licensing authority, if applicable; and ( )

04. Appealing the Decision. The process and timeline for appealing the decision under IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings." ( )

419. NOTIFICATION TO ACCREDITING OR LICENSING AUTHORITY.
When the Department issues a notice requiring corrective action or a program improvement plan, the Department: ( )

01. Notification of Accrediting Entity. May notify the program or provider's accrediting entity, if any, of the Department decision; and ( )

02. Notification of Licensing Authority. Must notify the licensing authority of any program or provider that must be licensed, of the Department decision. ( )

420. -- 999. (RESERVED)

16.07.19 – CERTIFICATION OF PEER SUPPORT SPECIALISTS AND FAMILY SUPPORT PARTNERS

000. LEGAL AUTHORITY.
Under Title 39, Chapter 31, Idaho Code, the Idaho Legislature has delegated to the Department of Health and Welfare as the state behavioral health authority the establishment, maintenance, and oversight of the state of Idaho's behavioral health services. Section 39-3140, Idaho Code, authorizes the Department to promulgate and enforce rules to carry out the purposes and intent of the Regional Behavioral Health Services Act. Under Sections 56-1003, 56-1004, Idaho Code, the Director of the Department is authorized to adopt and enforce rules to supervise and administer mental health programs. ( )

001. TITLE AND SCOPE.

01. Title. These rules are titled IDAPA 16.07.19, "Certification of Peer Support Specialists and Family Support Partners." ( )

02. Scope. These rules establish the minimum qualifications and requirements for certification of peer support specialists and family support partners in Idaho including enforcement actions. ( )

002. -- 009. (RESERVED)

010. DEFINITIONS.
For the purposes of these rules, the following terms apply. ( )

01. Behavioral Health Program. A behavioral health program refers to an organization offering mental health or substance use disorders treatment services that includes the organization's facilities, management, staffing patterns, treatment, and related activities. ( )

02. Certificate. A certificate issued by the Department to an individual who is a behavioral health peer support specialist or a family support partner who the Department deems to be in compliance with these rules. ( )

03. Department. The Idaho Department of Health and Welfare, or its designee. ( )

04. Director. The Director of the Department of Health and Welfare, or designee. ( )

05. Family Support Partner. An individual who has lived experience raising a child who has a behavioral health disorder diagnosis, mental illness, or mental illness with a co-occurring substance use disorder, has specialized training related to such care, and who has successfully navigated the various systems of care. ( )

06. Family Support Partner Services. Family-to-family services are non-clinical support services provided by family support partners who have participated in mental health services, and who have received training in how to share their experiences with others facing similar challenges. ( )

07. Lived Experience. Life experiences of an individual who has received behavioral health services or has raised a child who is living with a behavioral health diagnosis, mental illness, or mental illness with a co-occurring substance use disorder, and has at least one (1) year of lived experience navigating the behavioral health systems. ( )

08. Peer Support Services. Non-clinical services are provided by peer support specialists who are on their own recovery journey, and who have received training in supporting others who are actively involved in their own recovery process. ( )

09. Peer Support Specialist. An individual in recovery from mental illness or mental illness with a co-occurring substance use disorder who uses lived experience and specialized training to assist other individuals in recovery. ( )

011. -- 099. (RESERVED)

100. APPLICATION FOR CERTIFICATION.
An applicant for any certification by the Department must furnish the following information prior to any certification being issued. ( )

01. Completed Application. Each applicant must complete and sign an application for certification on

forms approved by the Department. ( )

02. Verification of Education, Training, and Experience. Each applicant must provide verification to the Department of the following: ( )

a. A copy of their high school diploma, GED certificate, or a Bachelor's degree in a human services field; ( )

b. Documentation of successful completion of training required for the certification being sought according to the requirements in Sections 200 and 300 of these rules; and ( )

c. A summary of work or volunteer experience, including documentation of supervised hours. ( )

03. Code of Ethics Acknowledgment. Each applicant must submit a signed and dated Code of Ethics Acknowledgment. ( )

101. -- 109. (RESERVED)

110. TYPES OF CERTIFICATION.

01. Peer Support Specialist. ( )

02. Family Support Partner. ( )

111. DURATION OF CERTIFICATION.

01. Six-Month Certification. A six (6) month certification applies to an applicant that has completed the requirements in Sections 200 and 300 of these rules for initial certification, but may be lacking work or volunteer experience and supervised hours. ( )

02. Full Certification. A full certification applies to an applicant that has completed all requirements in Sections 200 and 300 of these rules for certification, including work or volunteer experience and supervised hours. Full certification is valid for one (1) year. ( )

112. RENEWAL OF CERTIFICATION.

01. Submit Renewal Application. Each certified peer support specialist or certified family support partner who is seeking certification renewal must submit a completed renewal application prior to expiration of current certificate. ( )

02. Continuing Education. Each certified peer support specialist or certified family support partner must provide documentation of a minimum of ten (10) hours of continuing education as follows: ( )

a. Continuing education obtained in competency areas listed in training requirements germane to the type of certification being renewed; and ( )

b. At least one (1) hour of continuing education for each renewal period must be in ethics. ( )

03. Code of Ethics Acknowledgment. Each certified peer support specialist or certified family support partner must submit a signed and dated Code of Ethics Acknowledgment. ( )

113. -- 119. (RESERVED)

120. RECIPROCITY.
An applicant for a peer support specialist or a family support partner certificate must be a holder of a current and active license or certificate at the level for which certification is sought, and be in good standing in the profession, and

with the other state who is the authorizing regulatory entity for licensure or certification. ( )

01. Completed Application. Each applicant must complete and sign an application for reciprocity on forms approved by the Department. ( )

02. Provide Verification of Education, Training, and Experience. Each applicant seeking reciprocity must provide the Department with the following: ( )

a. Education experience summary; ( )

b. Continuing education/training hours received since certification; ( )

c. Statement of personal experience; and ( )

d. Work or volunteer experience summary form with documentation of supervised hours. ( )

03. Code of Ethics Acknowledgment. Each applicant seeking reciprocity must submit a signed and dated Code of Ethics Acknowledgment. ( )

04. Documentation From Other State. Documentation of licensure or certification must be received from the other state's issuing regulatory agency. The other state's licensing or certification requirements must be substantially equivalent to, or higher than, those required in this chapter of rules. ( )

121. -- 149. (RESERVED)

150. INACTIVE STATUS.
A certified peer specialist or certified family support partner, in good standing, may request an inactive status due to an inability to meet recertification requirements related to a decline in physical, mental health, or extenuating circumstances. ( )

01. Request for Inactive Status. An individual who is certified must submit a request in writing to the Department asking for inactive status. ( )

02. Inactive Certification Status. The Department may grant inactive status to a certified individual for up to one (1) year. ( )

03. Reactivation of Certification. When the individual desires to reactivate status, a new application and documentation of fulfillment of continuing education requirements for the previous twelve (12) months must be submitted to the Department. ( )

151. -- 199. (RESERVED)

200. PEER SUPPORT SPECIALIST -- CERTIFICATION QUALIFICATIONS AND REQUIREMENTS.
Each applicant must be at least eighteen (18) years of age and meet the minimum qualifications and requirements listed below to be certified as a Peer Support Specialist in Idaho. ( )

01. Educational Requirements. Each applicant for a peer support specialist certification must have a high school diploma or GED certificate. ( )

02. Training Requirements. Each applicant must complete forty (40) hours of training that includes the following Peer Support Specialist competency areas: ( )

a. Motivation and empowerment; ( )

b. The stages of recovery and the role peers play within it; ( )

c. The state behavioral health system and the role peers play within it; ( )

d. Advocacy for recovery programs and for the peers they serve; ( )

e. The practice of recovery values: authenticity, self-determination, diversity, and inclusion; ( )

f. How to tell your recovery story and use your story to help others; ( )

g. Ethics; ( )

h. The awareness of risk factors in participants' behaviors and the ability to access appropriate services; ( )

i. The use of interpersonal and professional communication skills; ( )

j. Stages of change; ( )

k. Work place dynamics and processes; ( )

l. The Certified Peer Support Specialist's roles and duties on the job; ( )

m. Relationship building; ( )

n. Family dynamics; ( )

o. The effects of trauma and use of a trauma informed approach; ( )

p. Wellness and natural supports; ( )

q. Boundaries and self-care; ( )

r. Cultural sensitivity; ( )

s. Recovery plans; and ( )

t. Local, state, and national resources. ( )

03. Work or Volunteer Experience Requirements. Each applicant must obtain supervised experience providing peer support services. A six-month (6) certification may be granted according to Section 111 of these rules to an applicant who lacks the required experience. ( )

a. An applicant who holds a bachelor's degree in a human services field must document one hundred (100) hours of peer support specialist experience. ( )

b. An applicant who does not hold a bachelor's degree in a human support services field must document two hundred (200) hours of peer support specialist experience. ( )

c. An applicant must document at a minimum twenty (20) hours of supervised peer support services work or volunteer experience. ( )

04. Supervision Requirements. A six-month (6) certification may be granted according to Section 111 of these rules to an applicant who lacks the required work or volunteer supervision hours required in Subsection 200.03 of this rule. ( )

05. Person Self-Identified with Lived Experience. Each applicant must identify as an individual with lived experience in recovery from mental illness or mental illness with a co-occurring substance use disorder. ( )

201. -- 249. (RESERVED)

250. PEER SUPPORT SPECIALISTS -- CODE OF ETHICS AND PROFESSIONAL CONDUCT.

01. Peer Support. Peer Support is a helping relationship between mental health clients and Certified Peer Support Specialists. The primary responsibility of Certified Peer Support Specialists is to help those they serve achieve self-directed recovery. They believe that every individual has strengths and the ability to learn and grow. ( )

02. Certified Peer Support Specialists. Certified peer support specialists are committed to providing and advocating for effective recovery-based services for the people they serve in order for these individuals to meet their own needs, desires, and goals. ( )

03. Certified Peer Support Specialist Professional Conduct. A certified peer support specialist must: ( )

a. Seek to role-model recovery; ( )

b. Respect the rights and dignity of those they serve; ( )

c. Respect the privacy and confidentiality of those they serve; ( )

d. Openly share their personal recovery stories with colleagues and those they serve; ( )

e. Maintain high standards of personal conduct and conduct themselves in a manner that fosters their own recovery; ( )

f. Never intimidate, threaten, or harass those they serve; never use undue influence, physical force, or verbal abuse with those they serve; and never make unwarranted promises of benefits to those they serve; ( )

g. Not practice, condone, facilitate, or collaborate with any form of discrimination on the basis of ethnicity, race, gender, sexual orientation, age, religion, national origin, marital status, political belief, or mental or physical disability; ( )

h. Never engage in sexual/intimate activities with colleagues or those they serve; ( )

i. Not accept gifts of significant value from those they serve; ( )

j. Not enter into dual relationships or commitments that conflict with the interests of those they serve; ( )

k. Not abuse substances under any circumstances while they are employed as a Certified Peer Support Specialist; ( )

l. Work to equalize the power differentials that may occur in the peer support/client relationship; ( )

m. Ensure that all information and documentation provided is true and accurate to the best of their knowledge; ( )

n. Keep current with emerging knowledge relevant to recovery, and openly share this knowledge with their colleagues and those they serve; ( )

o. Remain aware of their skills and limitations, and do not provide services or represent themselves as expert in areas for which they do not have sufficient knowledge or expertise; and ( )

p. Not hold a clinical role nor offer primary treatment for mental health issues, prescribe medicine, act as a legal representative or provide legal advice, participate in the determination of competence, or provide counseling, therapy, social work, drug testing, or diagnosis of symptoms and disorders. ( )

04. Ethics Training. A certified peer support specialist must complete ethics training at least once per year, and maintain personal documentation of completed ethics training. ( )

05. Comply with Code of Ethics. A certified peer support specialist must understand and comply with these rules and Idaho's Certified Peer Support Specialists Code of Ethics and Professional Conduct. ( )

251. -- 299. (RESERVED)

300. FAMILY SUPPORT PARTNER -- CERTIFICATION QUALIFICATIONS AND REQUIREMENTS.
Each applicant must be at least eighteen (18) years of age and meet the minimum qualifications and requirements listed below to be certified as a family support partner in Idaho. ( )

01. Educational Requirements. Each applicant for a family support partner certification must have, at a minimum, a high school diploma or GED certificate. ( )

02. Training Requirements. Each applicant must complete a minimum of forty (40) hours of training that includes, at a minimum, the following Family Support Partner competency areas: ( )

a. Overview of mental illness and substance use disorders and their effects on the brain; ( )

b. Advocacy skills used in multiple systems (children's behavioral health system, education and special education system, child welfare system, and juvenile court system); ( )

c. Ethics; ( )

d. The awareness of risk factors in participants' behaviors and the ability to access appropriate services; ( )

e. The use of interpersonal and professional communication skills; ( )

f. Stages of change; ( )

g. Motivation and empowerment; ( )

h. Parenting special needs children and family dynamics; ( )

i. The recovery process; ( )

j. The effects of trauma and use of a trauma-informed approach; ( )

k. Wellness and natural supports; ( )

l. Family-centered planning; ( )

m. Boundaries and self-care; ( )

n. Cultural sensitivity; ( )

o. The children's mental health system; ( )

p. How to tell your story and use your story to help others; ( )

q. The child and family team and how to be a team player; ( )

r. Work place dynamics and process; ( )

s. The Certified Family Support Partner's role and duties on the job; ( )

t. Relationship building; ( )

u. Recovery plans; and ( )

v. Local, state, and national resources. ( )

03. Work or Volunteer Experience Requirements. Each applicant must obtain supervised experience providing family support services. A six (6) month certification may be granted according to Section 111 of these rules to an applicant who lacks required experience. ( )

a. An applicant that holds a bachelor's degree in a human services field must document one hundred (100) hours of family support partner experience. ( )

b. An applicant that does not hold a bachelor's degree in a human support services field must document two hundred (200) hours of family support partner experience. ( )

c. An applicant must document at a minimum twenty (20) hours of supervised family support services work or volunteer experience. ( )

04. Supervision Requirements. A six (6) month certification may be granted according to Section 111 of these rules to an applicant who lacks the required work or volunteer supervision hours required in Subsection 300.03 of this rule. ( )

05. Person Self-Identified with Lived Experience. Each applicant must identify as an individual with lived experience as a parent or adult caregiver who is raising a child or has raised a child who lives with a mental illness or mental illness with a co-occurring substance use disorder. ( )

301. -- 349. (RESERVED)

350. FAMILY SUPPORT PARTNERS -- CODE OF ETHICS AND PROFESSIONAL CONDUCT.

01. Family Support Principles. These family support principles are intended to serve as a guide for certified family support partners and those who are working toward full certification in their everyday professional conduct that includes various roles, relationships, and levels of responsibilities within their jobs. ( )

02. Certified Family Support Partner Integrity. In order to maintain high standards of competency and integrity, a certified family support partner must: ( )

a. Apply the principles of resiliency, wellness and recovery, or both, family-driven approach, youth-guided or youth-driven approach, consumer-driven approach, and peer-to-peer mutual-learning principles in every day interactions with family members; ( )

b. Promote the family member's ethical decision-making and personal responsibility consistent with that family member's culture, values, and beliefs; ( )

c. Promote the family members' voices and the articulation of their values in planning and evaluating children's behavioral health related issues; ( )

d. Teach, mentor, coach, and support family members to articulate goals that reflect each family member's current needs and strengths; ( )

e. Demonstrate respect for the cultural-based values of the family members engaged in peer support;

( )

f. Communicate information in ways that are both developmentally and culturally appropriate; ( )

g. Empower family members to be fully informed in preparing to make decisions and understand the implications of these decisions; ( )

h. Maintain high standards of professional competence and integrity; ( )

i. Abstain from discriminating against or refusing services to anyone on the basis of race, ethnicity, gender, gender identity, religion/spirituality, culture, national origin, age, sexual orientation, marital status, language preference, socioeconomic status, or disability; ( )

j. Only assist family members whose concerns are within one's competency as determined by one's education, training, experience, and on-going supervision or consultation; ( )

k. Abstain from establishing or maintaining a relationship for the sole purpose of financial remuneration to self or the agency with which one is associated; and ( )

l. Terminate a relationship when it becomes reasonably clear that the peer relationship is no longer the desire of the family member. ( )

03. Certified Family Support Partner Safety. In order to maintain the safety of all family members involved with family support services, a certified family support partner must: ( )

a. Comply with all laws and regulations applicable to the jurisdiction in which the peer support services are provided, including confidentiality; ( )

b. Maintain confidentiality in personal and professional communication and ensure that family members have authorized the use or release of any and all information about themselves or family members for whom they have legal authority, including verbal statements, writings, or re-release of documents; ( )

c. Respect the privacy of partner agencies and not distribute internal or draft documents or share private, internal conversations; ( )

d. When complying with laws and regulations involving mandatory reporting of harm, abuse, or neglect, make every effort to involve the family members in the planning for services and ensure that no further harm is done to family members as the result of the reporting; ( )

e. Discuss and explain to family members the rights, roles, expectations, benefits, and limitations of the peer support process; ( )

f. Avoid ambiguity in the relationship with family members and ensure clarity of the certified family support partner's role at all times; ( )

g. Maintain a positive relationship with family members, refraining from premature or unannounced ceasing of the relationship until a reasonable alternative arrangement is made for continuation of similar peer support services; ( )

h. Abstain from engaging in intimate, emotional, or physical relationships with family members engaged in a peer support relationship; ( )

i. Neither offer nor accept gifts, other than token gifts, related to the professional service of peer support, including personal barter services, payment for referrals, or other remunerations; and ( )

j. Abstain from engaging in personal financial transactions with family members engaged in a peer

support relationship. ( )

04. Certified Family Support Partner Professional Responsibility. Through educational activities, supervision and personal commitment, a certified family support partner must: ( )

a. Stay informed and up-to-date with regard to the research, policy, and developments in the field of parent/peer support and children's emotional, developmental, behavioral (including substance use), or mental health which relates to one's own practice area and children's general health and wellbeing; ( )

b. Engage in helping relationships that include skills-building, not exceeding one's scope of practice, experience, training, education, or competence; ( )

c. Perform or hold oneself out as competent to perform only peer services not beyond one's education, training, experience, or competence; ( )

d. Seek appropriate professional supervision/consultation or assistance for one's personal problems or conflicts that may impair or affect work/volunteer performance or judgment; ( )

e. File a complaint with the certification body for Family Support Partners when one has reason to believe that another family support partner is, or has been, engaged in conduct that violates the law or these rules. Making a complaint to the certification body for Family Support Partners is an additional requirement, not a substitute for, or alternative to, any duty of filing reports required by statute or regulation; ( )

f. Refrain from distorting, misusing, or misrepresenting one's experience, knowledge, skills, or research findings; ( )

g. Refrain from financially or professionally exploiting a colleague or representing a colleague's work, associated with the provision of peer support or the profession of peer support, as one's own; ( )

h. In the role of a supervisor/consultant, be responsible for maintaining the quality of one's own supervisory/consultation skills and obtaining supervision/consultation for work as a supervisor/consultant; ( )

i. In the role of a researcher, be aware of and comply with federal and state laws and regulations, agency regulations, and professional standards governing the conduct of research, including ensuring the participants' complete informed consent for participating or declining to participate in a study; and ( )

j. In the role as a volunteer, member, or employee of an organization, give credit to persons for published or unpublished original ideas, take reasonable precautions to ensure that one's employer or affiliate organization promotes and advertises materials accurately and factually. ( )

05. Ethics Training. A certified family support partner must complete ethics training at least once per year, and maintain personal documentation of completed ethics training. ( )

06. Comply with Code of Ethics. A certified family support partner must understand and comply with these rules and Idaho's Certified Family Support Partners Code of Ethics. ( )

351. -- 399. (RESERVED)

400. SUPERVISOR FOR PEER SUPPORT SPECIALIST OR FAMILY SUPPORT PARTNER -- QUALIFICATIONS AND REQUIREMENTS.
An individual must meet the following requirements to provide supervision to a peer support specialist or family support partner. ( )

01. Bachelor's Degree or Higher. In order to supervise a peer support specialist or family support partner, an individual must hold a bachelor's degree or higher in a human services field. ( )

02. Supervisory Position. An individual must be in a supervisory position and work in that capacity

within the agency. ( )

401. -- 499. (RESERVED)

500. COMPLAINTS.
A complaint is an informal process to address the concerns of an individual. Any individual may file a written complaint or concern with the Department regarding a certified peer support specialist, certified family support partner, or a behavioral health program. ( )

01. Complaint Content. A complaint must include: ( )

a. The full name, mailing address, phone number, and email contact for the person reporting the complaint; ( )

b. A description of the nature of the complaint, including the desired outcome. ( )

02. Department Response to Complaint. The Department will respond to the complaint within thirty (30) days of receipt of the complaint. This process may include gathering additional information from involved parties, including the complainant. ( )

501. -- 509. (RESERVED)

510. GRIEVANCES.
A grievance is a type of complaint about the certification decision that has been made following application to the Department. When an applicant is denied certification, questions the results of the application review process, or is subject to an action that they deem unjustified, the applicant may submit a written grievance to the Department. ( )

01. Grievance Content. The grievance must include: ( )

a. The full name, mailing address, phone number, and email contact for the person reporting the grievance; and ( )

b. A detailed explanation of the decision that is being contested, from the perspective of the complainant, including any steps already taken to resolve the issue. ( )

02. Department Response to Grievance. The Department will respond within sixty (60) days of receipt of the grievance. This process may include gathering additional information from involved parties. ( )

511. -- 519. (RESERVED)

520. DENIAL, REVOCATION, OR SUSPENSION OF CERTIFICATION.
The Department may deny, suspend, or revoke an individual's application, certification, or recertification as a peer support specialist or family support partner for noncompliance with these rules. ( )

521. -- 524. (RESERVED)

525. IMMEDIATE DENIAL, REVOCATION, OR SUSPENSION.
The Department may deny, revoke, or suspend a certification or recertification, without prior notice, when conditions exist that endanger the health and safety of any participant. ( )

526. -- 529. (RESERVED)

530. REASONS FOR DENIAL, REVOCATION, OR SUSPENSION.
An individual may have a certification denied, revoked, or suspended for any one (1) of the reasons listed below. ( )

01. Failure to Comply. Failure to comply with these rules and the code of ethics described in Sections 250 and 350 of these rules. ( )

02. Failure to Provide Information. Failure to provide information requested by the Department. ( )

03. Failure to Perform. Inadequate knowledge or performance that is demonstrated by repeated substandard peer or quality assurance reviews. ( )

04. Misrepresentation of Information Provided. Misrepresentation by the applicant in an application, or in documents required by the Department for certification. ( )

05. Conflict of Interest. Conflict of interest in which a certified individual exploits their position as a Certified Peer Support Specialist or a Certified Family Support Partner for personal benefit. ( )

06. Negligent Performance or Fraud. A criminal, civil, or administrative determination that a certified individual has committed fraud or gross negligence in their capacity as a Certified Peer Support Specialist or Certified Family Support Partner. ( )

07. Failure to Correct. Failure to correct within thirty (30) days of written notice, any unacceptable conduct, practice, or condition as determined by the Department. ( )

531. -- 534. (RESERVED)

535. APPEAL OF DEPARTMENT DECISION.
An applicant or certificate holder may appeal a Department decision to deny, suspend, or revoke a certification according to IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings." ( )

536. -- 539. (RESERVED)

540. REAPPLICATION FOR CERTIFICATION.
Following a denial, suspension, or revocation of certification or recertification, the same applicant may not reapply for certification for a period of six (6) months after the effective date of the action. ( )

541. -- 999. (RESERVED)

16.07.25 – PREVENTION OF MINORS' ACCESS TO TOBACCO PRODUCTS

000. LEGAL AUTHORITY.
Under Section 39-5704, Idaho Code, the Department of Health and Welfare is authorized to promulgate rules in compliance with Title 39, Chapter 57 for the prevention of minors' access to tobacco products. ( )

001. TITLE AND SCOPE.

01. Title. These rules are titled IDAPA 16.07.25, "Prevention of Minors' Access to Tobacco Products." ( )

02. Scope. This rule implements provisions of Section 39-5701 et seq., Idaho Code. The Code defines the following: ( )

a. Possession, distribution, or use of tobacco products by a minor; ( )

b. Permit process for tobacco product retailers; ( )

c. Sale or distribution of tobacco products to a minor; ( )

d. Vendor-assisted sales; ( )

e. Opened packages and samples; ( )

f. Civil and criminal penalties for sales violations; and ( )

g. Conduct of enforcement actions. ( )

002. -- 009. (RESERVED)

010. DEFINITIONS.
The terms used in this rule are defined as follows: ( )

01. Business. Any company, partnership, firm, sole proprietorship, association, corporation, organization, or other legal entity, or a representative of the foregoing entities that sells or distributes tobacco products. Wholesalers' or manufacturers' representatives in the course of their employment are not included in the scope of these rules. ( )

02. Delivery Sale. The distribution of tobacco products to a consumer in a state where either: ( )

a. The individual submits the order for a purchase of tobacco products by a telephone call or other voice transmission method; data transfer via computer networks, including the internet and other online services; or by use of a facsimile machine transmission or use of the mails; or ( )

b. When tobacco products are delivered by use of the mails or a delivery service. ( )

03. Delivery Service. Any person who is engaged in the commercial delivery of letters, packages, or other containers. This includes permittees who take an order for tobacco products and then deliver the tobacco products without using a third party delivery service. ( )

04. Department. The Department of Health and Welfare (DHW) or its duly authorized representative. ( )

05. Direct Sale. Any face to face, or in person sale, of a tobacco product by a permittee, or their employee, to an individual. ( )

06. Distribute. To give, deliver, sell, offer to give, offer to deliver, offer to sell, or cause any person to do the same or hire any person to do the same. ( )

07. Effective Training. Training must include, at a minimum, the provisions of the law regarding minors' access to tobacco products as indicated on the suggested Employee Training form that is included with the permit provided by the Department and found in Appendix A of these rules. Such training will be presumed effective

for purposes of civil penalty actions in the first, second, and third violations within a two (2) year period. ( )

08. Evidence of Effective Training. Documentation provided by a permittee in response to a violation of this chapter clearly identifying that the permittee had a training program meeting the definition for effective training in place at the time of the violation and had on file a form signed by the employee prior to the violation stating understanding of the tobacco laws dealing with minors and the unlawful purchase of tobacco. ( )

09. Location. The street address and building in which the tobacco products are sold. ( )

10. Minor. A person under eighteen (18) years of age. ( )

11. Permit. A permit issued by the Department for the sale or distribution of tobacco products. ( )

12. Permit Endorsement. An endorsement identifies a sale or delivery method used by a permittee to sell tobacco products. There are three (3) types of endorsements that may be included on a permit. The three (3) endorsement types are: ( )

a. Delivery Sales; ( )

b. Delivery Service; and ( )

c. Direct Sales. ( )

13. Permittee. The holder of a valid permit for the sale or distribution of tobacco products. ( )

14. Photographic Identification. In all cases the identification must bear a photograph and a date of birth. Verification is not required by these rules if the buyer is known to the seller to be age eighteen (18) or older. Types of identification include: ( )

a. State, district, territorial, possession, provincial, national, or other equivalent government driver's license; or ( )

b. State identification card or military identification card; or ( )

c. A valid passport. ( )

15. Purchaser. An individual who seeks to buy or who buys a tobacco product. ( )

16. Random Unannounced Inspection. An inspection of business by a law enforcement agency or by the Department, with or without the assistance of a minor, to monitor compliance of this chapter. ( )

a. Random. At any time, without a schedule or frequency. ( )

b. Unannounced. Without previous notification. ( )

17. Retail Sales Minor-Exempt Permit. A permit that is issued to retail locations whose revenues from the sale of alcoholic beverages for on-site consumption are at least fifty-five percent (55%) of total revenues, or whose products and services are primarily obscene, pornographic, profane, or sexually oriented. A permittee issued this type of permit is exempt from minor-assisted inspections where minors are not allowed on the premises and such prohibition is clearly posted at all entrances. ( )

18. Seller. The person who physically sells or distributes tobacco products. ( )

19. Tobacco Product. Any substance that contains tobacco including: ( )

a. Cigarettes; ( )

b. Cigars; ( )

c. Pipes; ( )

d. Snuff; ( )

e. Smoking Tobacco; ( )

f. Tobacco Paper; and ( )

g. Smokeless Tobacco. ( )

20. Vending Machine. Any mechanical, electronic, or other similar device which, upon the insertion of tokens, money, or any other form of payment, dispenses tobacco products. ( )

21. Vendor Assisted Sales. Any sale or distribution in which the customer has no access to the product except through the assistance of the seller. The seller must physically dispense the tobacco product to the purchaser. ( )

22. Violation. An action contrary to Title 39, Chapter 57, Idaho Code, or IDAPA 16.07.25, "Prevention of Minors' Access to Tobacco Products." ( )

23. Without a Permit. A business that has failed to obtain a permit or a business whose permit is suspended or revoked. ( )

011. -- 019. (RESERVED)

020. APPLICATION FOR PERMIT.
All businesses that sell or distribute tobacco products to the public must obtain a permit issued annually by the Department of Health and Welfare. ( )

01. Where to Obtain an Application for Permit. A hard-copy application can be obtained, at no cost to the applicant, from the Department of Health and Welfare, Division of Behavioral Health, PO Box 83720, Boise, Idaho 83720-0036. A permit may also be obtained, at no cost to the applicant, via the internet at http://www.tobaccopermits.com/Idaho. ( )

02. Permits. A separate permit must be obtained for each business location. The permit is non-transferable to another person, business, or location. The applicant must request endorsements for each method of sale or delivery it uses. If a place of business sells or distributes tobacco by more than one (1) method, it must have an endorsement for each type. ( )

a. Issuance of a Permit. A permit may be issued when a new tobacco retail outlet has been established, when a currently permitted business is sold to new owners, or when a currently permitted business is moved to a different physical location. Permits may be issued to tobacco retailers established in a permanent location. Permits may not be issued for a retailer doing business in a temporary location. ( )

b. Closure of a Permit. A permit may be closed when the permittee closes the business, no longer sells tobacco products, moves to a different physical location, or sells the business to a new owner. ( )

c. Revocation of a Permit. A permit may be revoked by the Department of Health and Welfare when: ( )

i. It is determined a new permit was fraudulently obtained to avoid penalties accrued on an existing permit; or ( )

ii. The holder of a permit, suspended as established in Section 39-5708(5), has failed to provide an

effective training plan to the Department. ( )

d. Temporary Permit. Temporary permits are not allowed under 39-5704, Idaho Code. ( )

e. Expiration of a Permit. All permits expire annually at midnight on December 31 of each calendar year. ( )

03. Renewal of Permit. All permits must be renewed annually and are valid for twelve (12) calendar months. ( )

a. The Department will mail notices of renewal for permits no later than ninety (90) days prior to the expiration date on the permit. ( )

b. An application for renewal must be submitted annually for each business location through written application or online services, where available. ( )

c. A business with multiple locations may submit a single written application to renew the permit at each site, so long as the application is accompanied by a list of business permit numbers, locations, and addresses. ( )

d. A permit will not be renewed for any location until any past due fines for violations are paid in full. Fines are considered past due when not paid within ten (10) days of the citation date, or within ten (10) days after notification that the fine is upheld upon appeal, whichever is later. Violation fines under appeal are not considered past due. ( )

04. Application for Exemption. Businesses seeking exemption from vendor assisted sales must submit information to the Department to establish compliance with the following criteria: ( )

a. Tobacco products comprise at least seventy-five percent (75%) of total merchandise as determined by sales reported to the Idaho State Tax Commission; ( )

b. Minors are not allowed in exempt businesses and there is a sign on all entrances prohibiting minors; and ( )

c. There must be a separate entrance to the outside air or to a common area not under shared ownership by the exempt business. ( )

021. PERMITTEE RESPONSIBILITIES.
The permittee is responsible for the following: ( )

01. Possession of Permit. Each business location must have a permit. ( )

02. Visibility. The permit must be available upon request at each site. ( )

03. Display of Sign. Each business may display, at each business site, a sign that states: "State Law Prohibits the Sale of Tobacco Products to Persons Under the Age of Eighteen (18) Years. Proof of Age Required. Anyone Who Sells or Distributes Tobacco to a Minor is Subject to Strict Fines and Penalties. Minors are Subject to Fines and Penalties." ( )

04. Effective Training. Each permittee is responsible to train employees as to the requirements of Title 39, Chapter 57, Idaho Code, and these rules. ( )

a. Unless the permittee has its own training program as described in Subsection 021.04.b. of this rule, the employer must, at a minimum, read to the seller or prospective seller who may be responsible for sale or distribution of tobacco products, or assure the seller or prospective seller has read the information contained on the Employee Training form found in Appendix A of these rules and have them initial each statement, and sign and date the form indicating an understanding of the provisions of the law governing minors' access to tobacco products.

( )

b. Permittee may have their own training program, but it must contain all of the elements listed in the Employee Training form found in Appendix A of these rules. The seller or prospective seller who may be responsible for sale or distribution of tobacco products must affirm in writing their acknowledgment of such training. ( )

05. Permit Requirements. All permittees are required to be familiar with and comply with the requirements of Title 39, Chapter 57, Idaho Code as that act pertains to the permittee's sales of tobacco products. ( )

022. DELIVERY SALE ADDITIONAL REQUIREMENTS.
In addition to the requirements of Title 39, Chapter 57, Idaho Code, all permittees holding a Delivery Sale Endorsement, who mail or ship tobacco products must: ( )

01. Shipping Package Requirements. Imprint in clearly legible, black ink letters, that are no less than one (1) inch tall, the words "TOBACCO PRODUCT, MUST BE 18 YEARS OF AGE TO ACCEPT" on the exterior top and bottom of the shipping package. ( )

02. Delivery Requirements. Require that tobacco products only be delivered in a face-to-face delivery to the address on the original shipping label. The individual receiving the delivery must be verified to be at least eighteen (18) years of age and have the same address as on the original shipping label. ( )

023. -- 050. (RESERVED)

051. CIVIL PENALTIES FOR VIOLATION OF PERMIT.

01. Violations by the Seller. ( )

a. The seller will receive a one hundred dollar ($100) fine for each violation. ( )

b. Each violation will be recorded with the Department and may be accessed by potential employers upon the written consent of the seller as a portion of the training permit documentation. ( )

02. Violations by the Permittee. ( )

a. First violation. The permittee will be notified in writing of the violation and penalties to be levied for further violations. No fine will be imposed. ( )

b. Second violation in a two (2) year period. ( )

i. The permittee will be fined two hundred dollars ($200). ( )

ii. If the permittee provides evidence of effective training, provided to the seller prior to the second violation, within ten (10) business days from the date of violation, the Department will waive the fine. ( )

iii. The permittee will be notified in writing of the penalties to be levied for further violations. ( )

c. Third violation in a two (2) year period. ( )

i. The permittee will be fined two hundred dollars ($200). ( )

ii. The permit will be suspended for up to seven (7) days beginning upon a date set by the Department following the third violation. Evidence of effective employee training will be a mitigating factor in determining the length of the permit suspension. ( )

iii. The permittee must remove all tobacco products from public sight for the duration of the revocation

of the permit. ( )

iv. If the violation is by an employee, at the same location, who was involved in any previous citation for violation, the permittee will be fined four hundred dollars ($400). ( )

d. Fourth or subsequent violation in a two (2) year period. ( )

i. The permittee will be fined four hundred dollars ($400). ( )

ii. The permit will be revoked until such time as the permittee demonstrates an effective training program to the Department, but in no case will the revocation be less than thirty (30) days. ( )

iii. The permittee must remove all tobacco products from public sight for the duration of the revocation of the permit. ( )

03. Payment of Fines. All fine payments must be received by the Department within ten (10) days of the date of the citation. Fine payments should be mailed to, Tobacco Project Office, 450 West State Street, 3rd Floor, Boise, ID 83720-0036. ( )

052. CRIMINAL PENALTIES.

01. Selling or Distributing Without a Permit. Criminal penalties apply to any business or individual(s) who sells or distributes tobacco products to the public without a permit. ( )

02. Department Notified of Violation. If the Department is notified of a violation of Section 39-5709 et seq., Idaho Code, the Department will contact the appropriate law enforcement authority. ( )

053. -- 100. (RESERVED)

101. INSPECTIONS.

01. Random and Unannounced Inspections. The total number of random and unannounced inspections under Section 101 of this rule will be determined by: ( )

a. The number of permittees on the last day of each calendar year multiplied by the percentage of violations for the preceding year multiplied by a factor of ten (10). A calculation checklist is provided under Appendix B; ( )

b. In no instance will the total number of inspections be less than the number of permittees, or exceed twice the number of permittees. ( )

c. The Department and the Idaho State Police must conduct at least one (1) unannounced inspection per year at every known business location identified as a retailer of tobacco products to the public. All additional inspections required to meet the total number specified under Section 101 of this rule must be conducted in a random manner. ( )

02. Who Will Inspect. Inspections will be conducted for all minor-exempt permit locations by an adult enforcement officer. For all other permit locations, inspections will be conducted by an adult enforcement officer accompanied by a minor. ( )

03. Law Enforcement Agency Inspections. ( )

a. In addition to the inspections set forth in Subsection 101.01 of this rule, any law enforcement agency may conduct inspections consistent with agency policy and procedure with or without a minor at any business location, at any time, where tobacco products are sold or distributed to the public. ( )

b. Law enforcement agencies conducting inspections under Subsection 101.03.a. of this rule will

report the results from their inspections to the Department. All citations will become part of the permittee's permanent record. ( )

04. Complaint Investigation. ( )

a. The Department must refer all written complaints concerning the sale of tobacco products to minors to the appropriate agency, as determined by the Department, for investigation. ( )

b. Inspections conducted as part of the investigation of a written complaint are not included in the overall number of inspections identified under Subsections 101.01 and 101.03 of this rule. Citations issued during the investigation of a written complaint must be added to the permittee's permanent record. ( )

05. Issuance of Citation or Report. For inspections conducted under Subsection 101.01 of this rule, a representative of the business will be provided with a report, within two (2) business days, after the inspection. The date the Department provides notification of the citation must be used for determination of timely payment of fines and all other administrative actions including requests for waivers and request for appeals. ( )

102. -- 999. (RESERVED)

APPENDIX A
EMPLOYEE TRAINING FORM

The following may be used for training of employees to assure that they are aware of the current law regarding youth access to tobacco products in the state of Idaho. This would constitute "minimum" training required by the employer as indicated in Section 39-5701 et seq., Idaho Code.

Have the employee initial each section and sign at the bottom.

_____ I understand the state law prohibits the sale of ANY tobacco products to persons under 18 years of age and that verification of age is required for any sale of tobacco products.

_____ I understand that I am to ask for photo identification from any persons whom I do not personally know to be at least 18 years of age and verify their age before a sale of tobacco products.

_____ I understand that sales to anyone under the age of 18 can result in a personal fine to me of $100 for the first offense.

_____ I understand that "tobacco products" includes any substance that contains tobacco including, but not limited to, cigarettes, cigars, pipes, snuff, smoking tobacco, tobacco papers, or smokeless tobacco. (Section 39-5702 (13), Idaho Code)

_____ I understand that this store may be inspected at any time for compliance with the state law regarding "youth access to tobacco products."

_____ I understand that all sales must be "vendor assisted" unless the store in which I work has 75% of the total merchandise available for sale as tobacco products. This store is _____ is not _____ exempted from the vendor assisted requirement. (check one)

_____ I understand that cigarettes **must** be sold only in their original sealed package from the manufacturer. (Section 39-5707, Idaho Code)

_____ I have been given a copy of Section 39-5701 et seq., Idaho Code, and IDAPA 16.07.25, "Prevention of Minor's Access to Tobacco Products."

I have read and agree to these statements and have had all my questions answered regarding my responsibilities as a

seller of tobacco products in the state of Idaho.

By signing this agreement, I consent to having a current or potential employer contact the Department of Health and Welfare to determine if I have received citations for violation Title 39, Chapter 57, Idaho Code.

_____ _____
Printed Name of Employee Employee's Signature

_____ _____
Witnessed Date

( )

APPENDIX B
RANDOM AND UNANNOUNCED INSPECTION CHECKLIST

Inspection Year _____

1. Overall Violation Rate for Prior Year (20__) (Percentage)_____x__._____

2. Number of Permittees as of December 31, 20____:_____

3. Multiply the Overall Violation Rate for Prior Year by the Number of Permittees: _____

4. Multiply the results of Step 3 by 10: _____

5. The Result of Step 4 is the Total of Random and Unannounced Inspections:_____

( )

000. LEGAL AUTHORITY.
The Idaho Legislature has delegated to the Department of Health and Welfare, as the state mental health authority, the responsibility to ensure that mental health services are available throughout the state of Idaho to individuals who need such care and who meet certain eligibility criteria under the Regional Mental Health Services Act, Title 39, Chapter 31, Idaho Code. Under Section 39-3140, Idaho Code, the Department is authorized to promulgate rules to carry out the purposes and intent of the Regional Mental Health Services Act. Under Sections 56-1003(3)(c), 56-1004, 56-1004A, 56-1007, and 56-1009, Idaho Code, the Director is authorized to adopt rules to supervise and administer a mental health program. ( )

001. TITLE AND SCOPE.

01. Title. These rules are titled IDAPA 16.07.33, "Adult Mental Health Services." ( )

02. Scope. This chapter defines the scope of services, eligibility criteria, application requirements, individualized treatment plan requirements, and appeal process for the provision of adult mental health services administered under the Department's Division of Behavioral Health. ( )

002. (RESERVED)

003. ADMINISTRATIVE APPEALS.

01. Appeal of Denial Based on Eligibility Criteria. Administrative appeals from a denial of mental health services based on the eligibility criteria under Section 102 of these rules are governed by the provisions of IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings." ( )

02. Appeal of Decision Based on Clinical Judgment. All decisions involving clinical judgment, including the category of services, the particular provider of services, or the duration of services, are reserved to Department, and are not subject to appeal, administratively or otherwise, in accordance with *Maresh v. State,* 132 Idaho 221, 970 P.2d 14 (Idaho 1999). ( )

004. INCORPORATION BY REFERENCE.
American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, (DSM-5) Washington, DC, American Psychiatric Association, 2013, is hereby incorporated by reference under this chapter of rules. Copies of the manual are available from the American Psychiatric Association, 1000 Wilson Boulevard, Suite 1825, Arlington, Va. 22209-3901. A copy of the manual is also available for public review at the Department of Health and Welfare, 450 West State Street, Boise, Idaho, 83702. ( )

005. -- 008. (RESERVED)

009. CRIMINAL HISTORY AND BACKGROUND CHECK REQUIREMENTS.

01. Compliance With Department Criminal History and Background Check. All owners, operators, employees, transfers, reinstated former employees, student interns, contractors, and volunteers, who provide direct care or services, or whose position requires regular contact with clients, must comply with the provisions in IDAPA 16.05.06, "Criminal History and Background Checks." ( )

02. Availability to Work or Provide Service. An individual listed in Subsection 009.01 of these rules is available to work on a provisional basis at the discretion of the employer or agency once the individual has submitted their criminal history and background check application, it has been signed and notarized, reviewed by the employer or agency, and no disqualifying crimes or relevant records are disclosed on the application. An individual must be fingerprinted within twenty-one (21) days of submitting their criminal history and background check application. ( )

a. An individual is allowed to work or have access to clients only under supervision until the criminal history and background check is completed. ( )

b. An individual, who does not receive a criminal history and background check clearance or a waiver granted under the provisions in this chapter, may not provide direct care or services, or serve in a position that requires regular contact with clients accessing adult mental health services through the Department. ( )

03. Waiver of Criminal History and Background Check Denial. A certified or uncertified

individual who is seeking to provide Peer Support Specialist, Family Support Partner, or Recovery Coach services that receives an unconditional denial or a denial after an exemption review by the Department's Criminal History Unit, may apply for a Behavioral Health waiver. ( )

010. DEFINITIONS - A THROUGH F.
For the purposes of these rules, the following terms are used as defined below: ( )

01. Adult. An individual eighteen (18) years of age or older. ( )

02. Adult Mental Health Services. Adult mental health services are listed in Section 301 of these rules. These services are provided in response to the mental health needs of adults eligible for services required in Title 39, Chapter 31, Idaho Code, the Regional Behavioral Health Service Act, and under Section 102 of these rules. ( )

03. Applicant. An adult individual who is seeking mental health services through the Department who has completed, or had completed on their behalf, an application for mental health services. ( )

04. Assessment. The gathering of historical and current clinical information through a clinical interview and from other available resources to identify a client's mental health issues, strengths, and service needs. ( )

05. Assertive Community Services. Comprehensive, intensive, and long-term rehabilitative services provided to clients who suffer from serious and persistent mental illness (SPMI) who have not benefited from traditional outpatient programs. ( )

06. Behavioral Health. An integrated system for evaluation and treatment of mental health and substance use disorders. ( )

07. Behavioral Health Center. State-operated community-based centers located in each of the seven (7) geographical regions of Idaho that provide or arrange for adult mental health services listed under Section 301 of these rules. ( )

08. Case Management. A change-oriented service provided to clients that assures and coordinates the provision of an assessment, treatment planning, treatment and other services, protection, advocacy, review and reassessment, documentation, and timely closure of a case. ( )

09. Client. A person receiving mental health services through the Department. The term "client" is synonymous with the following terms: patient, participant, resident, consumer, or recipient of treatment or services. ( )

10. Clinical Judgment. Refers to observations and perceptions based upon education, experience, and clinical assessment. This may include psychometric, behavioral, and clinical interview assessments that are structured, integrated, and then used to reach decisions, individually or collectively, about an individual's functional, mental, and behavioral attributes and mental health service needs. ( )

11. Clinical Necessity. Adult mental health services are deemed clinically necessary when the Department, in the exercise of clinical judgment, recommends services to an applicant for the purpose of evaluating, diagnosing, or treating a mental illness and that are: ( )

a. Clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for treating the applicant's mental illness; and ( )

b. Not primarily for the convenience of the applicant or service provider, not more costly than an alternative service or sequence of services, and at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the applicant's mental illness. ( )

12. Clinical Team. A proposed client's clinical team may include: qualified clinicians, behavioral

health professionals, professionals other than behavioral health professionals, behavioral health technicians, and any other individual deemed appropriate and necessary to ensure that the treatment is comprehensive and meets the needs of the proposed client. ( )

13. Crisis Intervention Services. A set of planned activities designed to reduce the risk of life-threatening harm to self or another person. Crisis intervention services include evaluation, assessment, intervention, stabilization, and follow-up planning. ( )

14. Department. The Idaho Department of Health and Welfare or its designee. The Department is designated as the State Mental Health Authority under Section 39-3124, Idaho Code. ( )

15. Federal Poverty Guidelines. Guidelines issued annually by the Federal Department of Health and Human Services establishing the poverty income limits. The federal poverty guidelines for the current year may be found at: http://aspe.hhs.gov/poverty/. ( )

16. Functional Impairment. Difficulties that substantially impair or limit role functioning with an individual's basic daily living skills, or functioning in social, family, vocational, or educational contexts including psychiatric, health, medical, financial, and community or legal area, or both. ( )

011. DEFINITIONS - G THROUGH Z.
For the purposes of these rules, the following terms are used as defined below: ( )

01. Good Cause. A valid and sufficient reason for not complying with the time frame set for submitting a written request for a waiver by an individual who does not receive a criminal history and background check clearance. ( )

02. Gravely Disabled. An adult who, as a result of mental illness, is in danger of serious physical harm due to the person's inability to provide for any of their basic needs for nourishment, essential medical care, shelter, or safety. ( )

03. Individualized Treatment Plan. A written action plan based on an intake eligibility assessment, that identifies the applicant's clinical needs, the strategy for providing services to meet those needs, treatment goals and objectives, and the criteria for terminating the specified interventions. ( )

04. Medication Management. The in-depth management of medications for psychiatric disorders for relief of a client’s signs and symptoms of mental illness, provided by a physician or mid-level practitioner. ( )

05. Mental Health Crisis. A mental health crisis occurs when a sudden loss of an adult individual’s ability to use effective problem-solving and coping skills leads to an imminent risk of harm to self or others, or decompensation to the point of the individual’s inability to protect himself or herself. ( )

06. Outpatient Services. Mental health services provided to a client who is not admitted to a psychiatric hospital or in a residential care setting. ( )

07. Psychiatric Services. Medically necessary outpatient and inpatient services provided to treat and manage psychiatric disorders. ( )

08. Rehabilitative and Community-Based Services. Skill-building services that foster rehabilitation and recovery provided to client recovering from a mental illness. ( )

09. Residential Care. A setting for the treatment of mental health that provides twenty-four (24) hours per day, seven (7) days a week, living accommodations for clients. ( )

10. Serious Mental Illness (SMI). Means any of the following psychiatric illnesses as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual of Mental Disorders, (DSM-5), incorporated in Section 004 of these rules: ( )

a. Schizophrenia spectrum and other psychotic disorders; ( )

b. Bipolar disorders (mixed, manic and depressive); ( )

c. Major depressive disorders (single episode or recurrent); ( )

d. Obsessive-compulsive disorders. ( )

11. Serious and Persistent Mental Illness (SPMI). A primary diagnosis under DSM-5 of Schizophrenia, Schizoaffective Disorder, Bipolar I Disorder, Bipolar II Disorder, Major Depressive Disorder Recurrent Severe, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified (NOS) for a maximum of one hundred twenty (120) days without a conclusive diagnosis. The psychiatric disorder must be of sufficient severity to cause a substantial disturbance in role performance or coping skills in at least two (2) of the following functional areas in the last six (6) months: ( )

a. Vocational or educational, or both. ( )

b. Financial. ( )

c. Social relationships or support, or both. ( )

d. Family. ( )

e. Basic daily living skills. ( )

f. Housing. ( )

g. Community or legal, or both. ( )

h. Health or medical, or both. ( )

12. Sliding Fee Scale. A scale used to determine an individual's financial obligation for services based on Federal Poverty Guidelines and found in IDAPA 16.07.01, "Behavioral Health Sliding Fee Schedules." ( )

13. Substantial Material Change in Circumstances. A substantial and material change in circumstances which renders the Department's decision denying mental health services arbitrary and capricious. ( )

012. -- 099. (RESERVED)

100. ACCESSING ADULT MENTAL HEALTH SERVICES.

Adult mental health services may be accessed either through an application for services, or through a court order for services. ( )

101. ELIGIBILITY SCREENING AND MENTAL HEALTH ASSESSMENT.

01. Eligibility Screening. A screening for eligibility for adult mental health services through the Department is based on the eligibility criteria under Section 102 of these rules. If an applicant meets the eligibility criteria, they may be eligible for adult mental health services through the Department. If an applicant does not meet the eligibility criteria, they may be referred to other appropriate services. All applicants are required to complete an Application for Mental Health Services. If an applicant refuses to complete the Application for Mental Health Services, the Department reserves the right to discontinue the screening process for eligibility. The eligibility screening must be directly related to the applicant's mental illness and level of functioning and will include: ( )

a. Application for Mental Health Services; ( )

b. Notice of Privacy Practice; and ( )

c. Authorization for Disclosure. ( )

02. Mental Health Assessment. Once a signed application or court order has been received for adult mental health services, the Department will schedule and conduct a mental health assessment. Each mental health assessment will be completed by a Department clinician and will be documented using the Department's Idaho Standard Mental Health Assessment Report. ( )

102. ELIGIBILITY DETERMINATION.

01. The Department Determines Eligibility for Mental Health Services. The total number of adults who are eligible for mental health services through the Department will be established by the Department. The Department may, in its sole discretion, limit or prioritize mental health services, define eligibility criteria, or establish the number of persons eligible based upon such factors as court-ordered services, availability of funding, the degree of financial need, the degree of clinical need, or other factors. ( )

02. Eligibility Requirements. To be eligible for mental health services through a voluntary application to the Department, the applicant must: ( )

a. Be an adult; and ( )

b. Be a resident of the state of Idaho; and ( )

c. Have a primary diagnosis of SMI or SPMI; or ( )

d. Be determined eligible under the waiver provisions in Section 400 of these rules. ( )

03. Court-Ordered Assessment, Treatment, and Services. The court may order the Department to provide assessment, treatment, and services according to Sections 18-212, 19-2524, and 66-329, Idaho Code. ( )

04. Ineligible Conditions. An applicant who has epilepsy, an intellectual disability, dementia, a developmental disability, physical disability, or who is aged or impaired by chronic alcoholism or drug abuse, is not eligible for mental health services, unless, in addition to such condition, they have a primary diagnosis of SMI or SPMI or is determined eligible under the waiver provisions in Section 400 of these rules. ( )

103. NOTICE OF CHANGES IN ELIGIBILITY FOR MENTAL HEALTH SERVICES.
The Department may, upon ten (10) days' written notice, reduce, limit, suspend, or terminate eligibility for mental health services. ( )

104. CRISIS INTERVENTION SERVICES.
Crisis intervention services are available twenty-four (24) hours per day, seven (7) days per week to adults experiencing a mental health crisis as defined under Section 011 of these rules. Crisis intervention services include evaluation, assessment, intervention, stabilization, and follow-up planning. ( )

01. Determination of the Need for Crisis Intervention Services. The Department will assess an adult experiencing a mental health crisis to determine whether services are needed to alleviate the crisis. ( )

02. Identification of the Crisis Intervention Services Needed. If crisis intervention services are clinically necessary, as determined by the Department, the Department will: ( )

a. Identify the services needed to stabilize the crisis; ( )

b. Arrange for the provision of the crisis intervention services; and ( )

c. Document in the individual's record the crisis services that are to be provided to the individual. ( )

03. Immediate Intervention. If the Department determines that a mental health crisis exists necessitating immediate intervention, crisis services will be arranged immediately. ( )

105. NOTICE OF DECISION ON ELIGIBILITY.

01. Notification of Eligibility Determination. Within fourteen (14) calendar days of receiving a signed application, the Department will notify the applicant or the applicant's designated representative in writing of its eligibility determination. The written notice will include: ( )

a. The applicant's name and identifying information; ( )

b. A statement of the decision; ( )

c. A concise statement of the reasons for the decision; and ( )

d. The process for pursuing an administrative appeal regarding eligibility determinations. ( )

02. Right to Accept or Reject Mental Health Services. If the Department determines that an applicant is eligible for mental health services through the Department, an individual has the right to accept or reject mental health services offered by the Department, unless imposed by law or court order. ( )

03. Reapplication for Mental Health Services. If the Department determines that an applicant is not eligible for mental health services through the Department, the applicant may reapply after six (6) months or at any time upon a showing of a substantial material change in circumstances. ( )

106. -- 119. (RESERVED)

120. CLIENT'S RIGHTS AND RESPONSIBILITIES.
Each individual client receiving adult mental health services through the Department must be notified of their rights and responsibilities prior to the delivery of adult mental health services. ( )

01. Client to Be Informed of Rights and Responsibilities. The Department must inform each client of their rights and responsibilities. Each client must be given a written statement of client rights and responsibilities, which includes who the client may contact with questions, concerns, or complaints regarding services provided. ( )

02. Content of Client's Rights. The Department must assure and protect the fundamental human, civil, constitutional, and statutory rights of each client. The written client rights statement must, at a minimum, address the following: ( )

a. The right to impartial access to treatment and services, regardless of race, creed, color, religion, gender, national origin, age, or disability; ( )

b. The right to a humane treatment environment that ensures protection from harm, provides privacy to as great a degree as possible with regard to personal needs and promotes respect and dignity for each individual; ( )

c. The right to communication in a language and format understandable to the individual client; ( )

d. The right to be free from mental, physical, sexual, and verbal abuse, as well as neglect and exploitation; ( )

e. The right to receive services within the least restrictive environment possible; ( )

f. The right to an individualized treatment plan, based on assessment of current needs; ( )

g. The right to actively participate in planning for treatment and recovery support services; ( )

h. The right to have access to information contained in one's record, unless access to particular identified items of information is specifically restricted for that individual client for clear treatment reasons in the client's treatment plan; ( )

i. The right to confidentiality of records and the right to be informed of the conditions under which information can be disclosed without the individual client's consent; ( )

j. The right to refuse to take medication unless a court of law has determined the client lacks capacity to make decisions about medications and is an imminent danger to self or others; ( )

k. The right to be free from restraint or seclusion unless there is imminent risk of physical harm to self or others; ( )

l. The right to refuse to participate in any research project without compromising access to program services; ( )

m. The right to exercise rights without reprisal in any form, including the ability to continue services with uncompromised access; ( )

n. The right to have the opportunity to consult with independent specialists or legal counsel, at one's own expense; ( )

o. The right to be informed in advance of the reason(s) for discontinuance of any service provision, and to be involved in planning for the consequences of that event; ( )

p. The right to receive an explanation of the reasons for denial of service. ( )

121. -- 199. (RESERVED)

200. INDIVIDUALIZED TREATMENT PLAN.
The Department will prepare an individualized treatment plan for every client that addresses the mental health effects on the major life areas and is based on an assessment of the client's mental health needs. ( )

01. Individualized Treatment Plan. Overall responsibility for development and implementation of the plan will be assigned to a qualified clinician. A detailed individualized treatment plan will be developed within thirty (30) calendar days from the date of the Department's eligibility determination or date of any court order for services. ( )

02. Individualized Treatment Plan Requirements. The individualized treatment plan must include the following: ( )

a. The services deemed necessary to meet the client's mental health needs; ( )

b. A prioritized list of problems and needs; ( )

c. Referrals for needed services not provided by the program; ( )

d. Goals that are based on the client's unique strengths, preferences, and needs; ( )

e. Specific objectives that relate to the goals written in simple, measurable, attainable, realistic terms with expected achievement dates; ( )

f. Interventions that describe the kinds of services, frequency of services, activities, supports, and resources the client needs to achieve short-term changes described in the objectives; ( )

g. Goals and objectives that are individualized and reflect the choices of the client; ( )

h. Documentation of who participated in the development of the individualized treatment plan; ( )

i. The client or legal guardian must sign the treatment plan indicating their agreement with service needs identified and their participation in its development. If these signatures indicating participation in the development of the treatment plan are not obtained, then it must be documented in the client's record the reason the signatures were not obtained, including the reason for the client's refusal to sign. A copy of the treatment plan must be given to the client and legal guardian. ( )

ii. The treatment plan must be based on the findings of the assessment process. ( )

i. A specific plan for including the family or significant others; and ( )

j. Discharge criteria and aftercare plans. ( )

03. One Hundred Twenty Day Review. Treatment plans are to be reviewed with the client and updated as needed at least every one hundred twenty (120) days. ( )

a. The treatment plan review must assess and process the status, applicability, obstacles, and possible solutions of the client's goals, objectives, interventions, and timeframes of the treatment plan. ( )

b. Treatment plans for "medication management only" clients are not subject to a one hundred twenty (120) day review. ( )

04. Treatment Plan Renewals. A new treatment plan will be developed with the client every twelve (12) months. ( )

201. -- 299. (RESERVED)

300. FINANCIAL RESPONSIBILITY FOR MENTAL HEALTH SERVICES.
Individuals receiving adult mental health services through the Department are responsible for paying for the services they receive. The financial responsibility for each service will be based on the individual's ability to pay as determined under IDAPA 16.07.01, "Behavioral Health Sliding Fee Schedules," Sections 300 and 400. ( )

301. ADULT MENTAL HEALTH SERVICES.
The Department is the lead agency in establishing and coordinating community supports, services, and treatment for adults eligible for services under Section 102 of these rules. The following services, as defined under Section 010 of these rules are provided by, or arranged for the delivery of by, the behavioral health center in each region: ( )

01. Assessment. ( )

02. Assertive Community Services. ( )

03. Case Management. ( )

04. Crisis Intervention. ( )

05. Medication Management. ( )

06. Psychiatric Services. ( )

07. Outpatient Services. ( )

08. Rehabilitative and Community-Based Services. ( )

09. Residential Care. ( )

302. -- 399. (RESERVED)

400. WAIVERS.

01. Waiver of Certain Eligibility Criteria. Subject to funding, availability of adult mental health services or adult mental health providers, and the number of clients receiving adult mental health services through the Department, the Department may consider waiving, in its sole discretion, the eligibility requirement that applicants have a primary diagnosis of SPMI. ( )

02. A Waiver Decision Does Not Establish a Precedent. The Department's decision to grant a waiver, or not, to an applicant neither establishes a precedent nor is it applicable to any other applicant for a waiver. ( )

03. Waiver Decisions Are Not Subject to Review or Appeal. The Department's actions and decisions pertaining to waivers are not subject to review or appeal, administratively or otherwise, in accordance with *Maresh v. State*, 132 Idaho 221, 970 P.2d 14 (Idaho 1999). Waivers are not admissible in administrative hearings or proceedings under IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings." ( )

401. -- 999. (RESERVED)

000. LEGAL AUTHORITY.
Under Sections 16-2404, 16-2406, 16-2423, 16-2433, 56-202(b), 56-203B, 56-204A, 56-1003, 56-1004, and 56-1004A, Idaho Code, the Idaho Legislature has delegated to the Department the responsibility to establish and enforce rules and methods of administration needed to provide children's mental health services in accordance with the Children's Mental Health Services Act. ( )

001. TITLE AND SCOPE.

01. Title. These rules are titled IDAPA 16.07.37, "Children's Mental Health Services." ( )

02. Scope. This chapter defines the appeal process, scope of services, eligibility criteria, and application requirements for the provision of children's mental health services by the Department. ( )

002. (RESERVED)

003. ADMINISTRATIVE APPEALS.

01. Appeal from a Denial Based on Eligibility Criteria. Administrative appeals from a denial of children's mental health services based on the eligibility criteria under Section 107 of these rules are governed by the provisions of IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings." ( )

02. Grievances and Expedited Hearings. Grievances and expedited hearings related to non-Medicaid Youth Empowerment Services (YES) will be provided as described in IDAPA 16.05.03 "Rules Governing Contested Case Proceeding and Declaratory Ruling," Sections 750 and 751. ( )

03. Appeal of Decision Based on Clinical Judgment. All decisions involving clinical judgment, which may include the category of services, the particular provider of services, or the duration of services, are reserved to the Department, and are not subject to appeal, administratively or otherwise, in accordance with Maresh v. State, 132 Idaho 221, 970 P.2d 14 (Idaho 1999). ( )

004. INCORPORATION BY REFERENCE.
American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, (DSM-5), Washington, D.C., American Psychiatric Association, 2013, is hereby incorporated by reference under this chapter of rules. Copies of the manual are available from the American Psychiatric Association, 1000 Wilson Boulevard, Suite 1825, Arlington, VA 22209-3901. A copy of the manual is also available for public review at the Department of Health and Welfare, 450 West State Street, Boise, Idaho, 83702. ( )

005. -- 008. (RESERVED)

009. CRIMINAL HISTORY AND BACKGROUND CHECK REQUIREMENTS.

01. Compliance with Department Criminal History and Background Check. Department employees, applicants, transfers, reinstated former employees, student interns, contract employees, volunteers, and others assigned to programs that involve direct contact with children or vulnerable adults as defined under Section 39-5302, Idaho Code, must comply with the provisions in IDAPA 16.05.06, "Criminal History and Background Checks." ( )

02. Availability to Work or Provide Service. Certain individuals are allowed to provide services after the criminal history and background check is completed as provided in Section 56-1004A, Idaho Code, except when they have disclosed a designated crime listed in IDAPA 16.05.06, "Criminal History and Background Checks." The criminal history and background check requirements applicable to each provider type are found in the rules that state the qualifications or certification of those providers. ( )

010. DEFINITIONS AND ABBREVIATIONS A THROUGH E.
For the purposes of these rules, the following terms apply: ( )

01. Alternate Care. Temporary living arrangements outside the family home that may include licensed foster care, residential treatment, and other facilities licensed by the state to provide twenty-four (24) hour care for children in accordance with IDAPA 16.06.02, "Child Care Licensing," or IDAPA 16.03.14, "Hospitals." ( )

02. Alternate Care Plan. A component of the treatment plan for children in alternate care. The

alternate care plan contains elements related to the justification of the need for Alternate Care Placement, the provision of treatment while in Alternate Care Placement, the child's alternate care provider, education, immunization, medical and other information important to the day-to-day care of the child. ( )

03. Area(s) of Concern. A circumstance or circumstances that brought a child and family to the attention of the Department. ( )

04. Assessment. The gathering of historical and current clinical information through a clinical interview and from other available resources to identify the child's mental health issues, the child's strengths, the family's strengths, and the service needs. ( )

05. Behavioral Health. An integrated system for evaluation and treatment of mental health and substance use disorders. ( )

06. Case Management. A change-oriented service provided to families that assures and coordinates the provision of an assessment, treatment planning, treatment and other services, protection, advocacy, review and reassessment, documentation, and timely closure of a case. ( )

07. Case Record. Compilation of all electronic and hard copy documentation relating to a child who is receiving or has received children's mental health services including legal documents, identifying information, and assessments. ( )

08. Child. An individual who is under the age of eighteen (18) years. ( )

09. Children's Mental Health Services. The children's mental health services are listed under Section 100 of these rules. These services are provided in response to the mental health needs of children eligible for services under Section 107 of these rules and their families in accordance with the provisions of the Children's Mental Health Services Act, Title 16, Chapter 24, Idaho Code. ( )

10. Clinician. Any of the direct service personnel with a Master's degree working in regional Children's Mental Health programs, including master's level social workers, psychologists, counselors, and family therapists. ( )

11. Crisis Intervention. A set of planned activities for a child eligible for services under Section 107 of these rules designed to reduce the risk of life-threatening harm to self or another person. ( )

12. Crisis Plan. As part of the treatment plan, the individualized crisis plan is developed to prevent a crisis or prepare for a crisis situation and to keep the child and others safe. The crisis plan may include the child's trigger behaviors, preferred strategies for resolving a crisis, interventions to be avoided, and contact information of community resources and natural supports. ( )

13. Crisis Response. A service for a child that involves immediate actions taken to assess risk or intervene in an emergency as defined in Section 16-2403(6), Idaho Code. A determination of eligibility under Section 107 of these rules is not required for crisis response. ( )

14. Day Treatment Services. Intensive nonresidential services that include an integrated set of educational, clinical, social, vocational, and family interventions provided on a regularly scheduled, typically daily, basis. ( )

15. Department. The Idaho Department of Health and Welfare or its designee. The Department is designated as the State Behavioral Health Authority under Section 39-3123, Idaho Code. ( )

16. Desired Result. Behaviorally-specific description of the child's and family's circumstances when the factors that brought the child and family to the Department's attention, either no longer exist or are significantly reduced. ( )

17. Director. The Director of the Idaho Department of Health and Welfare or their designee. ( )

18. Emergency. Emergency, as defined in Section 16-2403(6), Idaho Code, means a situation in which the child's condition, as evidenced by recent behavior, poses a significant threat to the health or safety of the child, their family or others, or poses a serious risk of substantial deterioration in the child's condition that cannot be eliminated by the use of supportive services or intervention by the child's parents, or mental health professionals, and treatment in the community while the child remains in their family home. ( )

19. Extended Family Member of an Indian Child. As defined by the law or custom of an Indian child's tribe or, in the absence of such law or custom, a person who has reached the age of eighteen (18) and who is an Indian child's grandparent, aunt or uncle, brother or sister, brother-in-law or sister-in-law, niece or nephew, first or second cousin, or stepparent. ( )

011. DEFINITIONS AND ABBREVIATIONS F THROUGH K.
For the purposes of these rules, the following terms apply: ( )

01. Face-to-Face Contact. An interaction between Department staff and another individual. The interaction may occur in-person or by electronic means that includes both audio and visual technology that comply with HIPAA and 42 CFR Part 2. ( )

02. Family. A family is two (2) or more persons related by blood, marriage, or adoption. ( )

03. Family Support Services. Assistance provided to a family to assist them in caring for a child eligible for services under Section 107 of these rules. The purpose of family support services is to strengthen adults in their role as parents through the provision of services including: assistance with transportation, family counseling services, training, education, and emergency assistance funds in accordance with IDAPA 16.06.13, "Emergency Assistance for Families and Children." Family support services must be on the treatment plan. ( )

04. Federal Poverty Guidelines. Guidelines issued annually by the Federal Department of Health and Human Services establishing the poverty income limits. The federal poverty guidelines for the current year may be found online at http://aspe.hhs.gov/poverty/. ( )

05. Guardian. ( )

a. As set forth under Title 15, Chapter 5, Part 2, Idaho Code, an individual who has been appointed by a court of law to have and exercise the powers and responsibilities of a parent who has not been deprived of custody of their minor and unemancipated child; or ( )

b. The Department, an agency, or an individual, other than a parent, who is acting in the place of a parent (in loco parentis) or, has assumed legal responsibility for, legal custody of, or control of a child. ( )

06. Indian. Any person who is a member of an Indian tribe or who is an Alaska Native and a member of a Regional Corporation as defined in 43 USC 1606. ( )

07. Indian Child. Any unmarried person who is under the age of eighteen (18) who is: ( )

a. A member of an Indian tribe; or ( )

b. Eligible for membership in an Indian tribe and the biological child of a member of an Indian tribe. ( )

08. Indian Child Welfare Act (ICWA). The Indian Child Welfare Act, 25 USC 1901, et seq. ( )

09. Indian Child's Tribe. ( )

a. The Indian tribe in which an Indian child is a member or eligible for membership; or ( )

b. In the case of an Indian child who is a member of or eligible for membership in more than one (1) tribe, the Indian tribe with which the Indian child has the more significant contacts. ( )

10. Indian Tribe. Any Indian Tribe, band, nation, or other organized group or community of Indians recognized as eligible for the services provided to Indians by the Secretary because of their status as Indians, including any Alaska Native village as defined in 43 USC 1602(c). ( )

11. Inpatient Services. Mental health and medical services provided to a child admitted to a psychiatric hospital. ( )

012. DEFINITIONS AND ABBREVIATIONS L THROUGH R.
For the purposes of these rules, the following terms apply: ( )

01. Licensed. Facilities or programs that are licensed in accordance with the provisions of IDAPA 16.06.02, "Child Care Licensing," or hospitals licensed in accordance with IDAPA 16.03.14, "Hospitals." ( )

02. Medicaid. Idaho's Medical Assistance Program administered under Title XIX of the Social Security Act. ( )

03. Outpatient Services. Mental health services provided to a child who is not admitted to a psychiatric hospital or in a residential treatment setting. ( )

04. Parent. A person who, by birth or through adoption, is considered legally responsible for a child. The term "guardian" is not included in the definition of parent. ( )

05. Placement Agreement. A standardized, written agreement, signed by the Department and a parent or guardian, that outlines specific responsibilities of each party regarding the child's placement in alternate care. ( )

06. Residential Treatment. A treatment facility licensed as a children's residential care facility that provides twenty-four (24) hour care in a highly-structured setting delivering substitute parental care and mental health services. ( )

07. Respite Care. Time-limited care provided to children. Respite care is utilized in circumstances that require short term, temporary care of a child by a caregiver different from the child's usual caregiver. The duration of an episode of respite care ranges from one (1) partial day up to fourteen (14) consecutive days. ( )

013. DEFINITIONS AND ABBREVIATIONS S THROUGH Z.
For the purposes of these rules, the following terms apply: ( )

01. Sliding Fee Scale. A scale used to determine an individual's cost for services based on Federal Poverty Guidelines and found in IDAPA 16.07.01, "Behavioral Health Sliding Fee Schedules." ( )

02. Teens at Risk. Individuals attending Idaho secondary public schools who have been identified by school personnel or their designee as expressing or exhibiting indications of depression, suicidal inclination, emotional trauma, substance use, or other behaviors or symptoms that indicate the existence of, or that may lead to, the development of mental illness or a substance use disorder. ( )

03. Teen Early Intervention Specialist. A person with a master's degree in social work, psychology, marriage and family therapy, counseling, chemical dependency, addictive studies, psychiatric nursing, or very closely-related field of study contracted to work with teens at risk. ( )

04. Title XIX (Medicaid). Title XIX of the Social Security Act, known as Medicaid, is a medical benefits program jointly financed by the federal and state governments and administered by the states. This program pays for medical assistance for certain individuals and families with low income and limited resources. ( )

05. Treatment Foster Care. A service that provides clinical intervention for children eligible for

services under Section 107 of these rules within the private homes of trained, licensed foster families. ( )

06. Treatment Plan. The individualized treatment plan describes the child's strengths and needs, short and long-term treatment goals, desired outcomes, and the roles, strategies, resources, and timeframes for coordinated implementation of services and supports. The plan is developed with the child, when possible, and the child's parent or guardian. The treatment plan includes a crisis plan and plans for transitioning out of services or to adult services. The treatment plan also includes the alternate care plan, if the child is in alternate care. ( )

07. Wraparound. Wraparound is a planning process that brings together a team of professionals and citizens working together to support children eligible for services under Section 107 of these rules and their families. Members of the team include the child, family members, representatives of public and private agencies, civic groups, and other community members. The services and supports focus on the strengths of the child and family, are provided in the local community, and are customized to fit the individual culture of the family. ( )

014. -- 099. (RESERVED)

CHILDREN'S MENTAL HEALTH SERVICES
(Sections 100-199)

100. CHILDREN'S MENTAL HEALTH SERVICES.
The Department is the lead agency in establishing and coordinating community supports, services, and treatment for children eligible for services under Section 107 of these rules and their families. The following services, as defined under Sections 010 through 013 of these rules, are provided by or through Children's Mental Health field offices in each region: ( )

01. Assessment. ( )

02. Case Management. ( )

03. Crisis Response. ( )

04. Day Treatment Services. ( )

05. Family Support Services. ( )

06. Inpatient Services. ( )

07. Outpatient Services. ( )

08. Residential Treatment. ( )

09. Respite Care. ( )

10. Treatment Foster Care. ( )

11. Wraparound. ( )

101. TEENS AT RISK PROGRAM.
The Teens at Risk program is for individuals attending Idaho secondary public schools who have been identified by school personnel or their designee as expressing or exhibiting indications of depression, suicidal inclination, emotional trauma, substance use, or other behaviors or symptoms that indicate the existence of, or that may lead to, the development of mental illness or a substance use disorder. The Department may enter into contracts for Teens at Risk programs in cooperation with Idaho public school districts subject to Department appropriations and available funding for this program. The Department reserves the right to make the final determination to award a school district a Teens at Risk contract. ( )

01. Application. School districts may apply to the Department through a competitive application

process. The Department will provide written information to the State Department of Education and interested school districts on the amount of funding available, closing date for submission of applications, and information on how to obtain application forms and instructions by July 1 of each year that funding is available. Only applications submitted on the prescribed forms and consistent with Department instructions will be considered for evaluation. ( )

02. Contracting Process. ( )

a. A team comprised of at least one (1) Department staff person, a representative from the state Department of Education, a representative from the local school district, and a parent, will evaluate the applications from school districts for contracts for Teens at Risk programs. The evaluation criteria will include the demonstrated need for the program in the school district and the contribution the school district is providing to the program, with a preference for rural school districts. The Department will consider the team recommendations and make the final determination of contracts for Teens at Risk programs. ( )

b. The number of school districts awarded a Teens at Risk program will depend upon the amount of specific funding appropriated by the legislature for this program. ( )

c. The Department will enter into a written contract with each school district awarded a Teens at Risk program. The contract will set forth the terms, services, data collecting, funding, and other activities prior to the implementation of the program. ( )

03. Services. Teen early intervention specialists hired or under contract with the school district will be available to serve teens at risk within the school setting and offer group counseling, recovery support, suicide prevention and other mental health and substance use disorder counseling services as needed. Teens at risk who are not enrolled in public schools may only participate in services if assigned by a judge and with the permission of the local school administrator who administers the Teens at Risk program. Parents of teens participating in the Teens at Risk program will not incur a financial obligation for services provided by the program. ( )

04. Outcomes. The Department will gather data and evaluate the effectiveness of the Teens at Risk program. In accordance with Section 16-2404A(7), Idaho Code, the Department may contract with state universities or colleges to assist in the identification of appropriate data elements, data collection, and evaluation. Data elements used to evaluate the program may include: ( )

a. Teen arrests, detention, and commitments to state custody; ( )

b. Teen suicide rates; ( )

c. Impacts on juvenile mental health and drug courts; ( )

d. Access to mental health services; and ( )

e. Academic achievement and school disciplinary actions. ( )

102. -- 104. (RESERVED)

105. ACCESSING CHILDREN'S MENTAL HEALTH SERVICES.
Children's mental health services may be accessed either through an application for services or through a court order for services. An application for services must be signed by a child's parent or guardian. ( )

106. MENTAL HEALTH ASSESSMENT.
Once an application has been signed or a court order has been received for children's mental health services, the Department will schedule and conduct a mental health assessment. Each mental health assessment will be documented using the Department's Idaho Standard Mental Health Assessment Report at http://www.healthandwelfare.idaho.gov. A Department clinician will either complete a mental health assessment, or, at the Department's discretion, accept an assessment completed by another mental health professional. In order to be considered, assessments completed by other mental health professionals must have occurred within ninety (90) days prior to the date of application or court order. The Department clinician will gather additional information, as needed,

in order to complete the assessment process. ( )

107. ELIGIBILITY DETERMINATION.

01. The Department Determines Eligibility for Mental Health Services. The total number of children who are eligible for mental health services through the Department will be established by the Department. The Department may, in its sole discretion, limit or prioritize mental health services, define eligibility criteria, or establish the number of persons eligible based upon such factors as court-ordered services, availability of funding, the degree of financial need, the degree of clinical need, or other factors. ( )

02. Eligibility Requirements. To be eligible for children's mental health services through a voluntary application to the Department, the applicant must: ( )

a. Be under eighteen (18) years of age; ( )

b. Reside within the state of Idaho; ( )

c. Have a DSM-5 mental health diagnosis. A substance use disorder alone, or developmental disorder alone, does not constitute an eligible mental health diagnosis, although one (1) or more of these conditions may co-exist with an eligible mental health diagnosis; and ( )

d. Have a substantial functional impairment as assessed by using the Department's approved tool. ( )

03. Court-Ordered Assessment, Treatment, and Services. The court may order the Department to provide assessment, treatment, and services under the Children's Mental Health Services Act, Title 16, Chapter 24, Idaho Code and the Juvenile Corrections Act, Title 20, Chapter 5, Idaho Code. Subject to court approval, the Department will make efforts to include parents and guardians in the assessment, treatment, and service planning process. Parents or guardians retain custody of the child. ( )

04. Ineligible Conditions. A child who does not meet the requirements under Subsections 107.02 or 107.03 of this rule is not eligible for children's mental health services, other than crisis response. A child with a diagnosis of substance use disorder alone, or developmental disorder alone, may be eligible for Department services under IDAPA 16.07.17, "Substance Use Disorders Services" or IDAPA 16.04.11, "Developmental Disabilities Agencies," for substance use or developmental disability services. ( )

108. -- 109. (RESERVED)

110. NOTICE OF DECISION ON ELIGIBILITY.

01. Notification of Eligibility Determination. The Department will determine the child's eligibility for children's mental health services, in accordance with Section 107 of these rules, within thirty (30) calendar days of receipt of a signed application for services. Within five (5) working days of the determination of eligibility, the Department will send written notification to the child's parent or guardian of the eligibility determination. The written notice will include: ( )

a. The child's name and identifying information; ( )

b. A statement of the decision; ( )

c. A concise statement of the reasons for the decision; and ( )

d. The process for pursuing an administrative appeal regarding eligibility determinations. ( )

02. Parental Rights. If the Department determines that an applicant is eligible for children's mental health services through the Department, the Department clinician must inform the child's parent or guardian that they have the right to reject the services offered by the Department, unless imposed by court order. ( )

03. Other Information that Must be Provided to the Parent. The clinician must also inform the parent that fees may be incurred for certain services, in accordance with IDAPA 16.07.01, "Behavioral Health Sliding Fee Schedules," and that a parent has financial responsibility for the child. ( )

04. Reapplication for Mental Health Services. If the Department determines that a child is not eligible for children's mental health services through the Department, the child's parent or guardian may reapply after six (6) months or at any time upon a showing of a substantial, material change in circumstances. ( )

111. -- 114. (RESERVED)

115. TREATMENT PLAN.
A treatment plan will be developed by the Department, a parent or guardian, and the child, if appropriate, and may include the service provider or service providers. This plan will be specific, measurable, and realistic in the identification of the goal(s), relevant areas of concern, and desired results. ( )

01. Development of Treatment Plan. A treatment plan will be completed within fifteen (15) days of the date the child was determined eligible for children's mental health services. The parent or guardian must be given the opportunity to participate in the development of the treatment plan and sign it. The parent or guardian must sign the treatment plan indicating their agreement with service needs identified and their participation in its development. If these signatures, indicating participation in the development of the treatment plan are not obtained, the reason the signatures were not obtained must be documented in the record, including the reason for the parent's or guardian's refusal to sign. If the services are court-ordered and the parent or guardian refuses to sign the plan, the refusal must also be documented on the plan. If the services are voluntary and the parent or guardian refuses to sign the plan, the Department may close the case. ( )

02. Annual Development of Treatment Plan. The Department will develop a plan at least annually. The parent or guardian will be given the opportunity to participate in the annual development of the treatment plan and to sign it. ( )

03. One Hundred Twenty Day Review. Treatment plans are to be reviewed with the family at least once every one hundred twenty (120) days. ( )

04. Goals and Tasks. Treatment plans must include a long-term goal that identifies specific behavior changes, have measurable desired results, and have specific tasks that identify by whom, how, and when the tasks will be completed. ( )

116. OUTCOMES FOR CHILDREN'S MENTAL HEALTH SERVICES.
Outcomes for children's mental health services are measured through the administration of a satisfaction survey and the Department-approved standardized functional assessment tool. ( )

117. CASE RECORDS.

01. Electronic and Physical Files. The Department must maintain an electronic file and a physical file containing information on each child receiving children's mental health services. The physical file may include non-electronic documentation such as originals or copies of all court orders, birth certificates, social security cards, and assessment information that originates outside the Department. ( )

02. Storage of Records. All physical case records must be stored in a secure file storage area away from public access, and retained not less than five (5) years after the case is closed, after which they may be destroyed. ( )

a. Exception for Adoption Records. Complete family case records involving adoptive placements must be forwarded to the Department's central adoption unit for permanent storage. ( )

b. Exception for Case Records Involving an Indian Child. A case record involving an Indian child must be available at any time at the request of an Indian child's tribe or the Secretary of the Interior. ( )

118. USE OF PUBLIC FUNDS AND BENEFITS.
Public funds and benefits will be used to provide services for children eligible for services under Section 107 of these rules and their families. Services should be planned and implemented to maximize the support of the family's ability to provide adequate safety and well-being for the child at home. If the child cannot receive adequate services within the family home, the Department will arrange services to minimize the need for institutional or alternate care placement. Services will be individually planned with the family to meet the unique needs of each child and family. The Department will not require a parent or guardian to relinquish custody of the child in order to receive Department-funded services. ( )

119. FINANCIAL RESPONSIBILITY OF PARENT(S).
Parent(s) of a child eligible for services under Section 107 of these rules who is receiving outpatient services either directly from the Department, or through Department contracts with private providers, are financially responsible for services provided to their child and to their family, including court-ordered children's mental health services. The financial responsibility for each service will be in accordance with the ability of parent(s) to pay as determined under IDAPA 16.07.01, "Behavioral Health Sliding Fee Schedules." Parent(s) will not incur a financial obligation for services provided to their child through a Teens at Risk program. ( )

120. SLIDING FEE SCHEDULE FOR CHILDREN'S MENTAL HEALTH OUTPATIENT SERVICES.
The fee charged to parents for outpatient children's mental health services is determined using the sliding fee schedule under IDAPA 16.07.01, "Behavioral Health Sliding Fee Schedules," Section 300. ( )

121. FEE DETERMINATION FOR CHILDREN'S MENTAL HEALTH OUTPATIENT SERVICES.
Prior to the delivery of outpatient services, a "Fee Determination" form must be completed by a child's parent when requesting children's mental health services. The fee determination process includes the considerations found under IDAPA 16.07.01, "Behavioral Health Sliding Fee Schedules," Section 400. ( )

122. -- 199. (RESERVED)

ALTERNATE CARE PLACEMENT
(Sections 200-299)

200. AUTHORITY FOR ALTERNATE CARE PLACEMENT.
The Department may place a child into alternate care under either of the following conditions in Subsection 200.01 or 200.02 of this rule: ( )

01. Court Order. The Department may place a child into alternate care when the Department has been ordered by the Court to provide alternate care for a child. ( )

a. A placement agreement must be developed by the Department and the parent or guardian prior to the child's placement in alternate care. ( )

b. The treatment plan will identify areas of concern, goals, desired outcomes, time frames, tasks, and task responsibilities. ( )

c. The placement agreement entered into between the Department and a parent or guardian may be revoked with a twenty-four (24) hour notice by the child's parent or guardian. If notice is given by the parent or guardian, the Department will notify the court. ( )

02. Voluntary Placement. The Department may place a child into alternate care with the Department when a parent or guardian is no longer able to maintain a child eligible for services under Section 107 of these rules in the child's home and the Department determines that the child would benefit from alternate care and treatment services. ( )

a. A treatment plan, alternate care plan, and a placement agreement must be developed by the Department and the parent or guardian prior to the child's placement in alternate care. The treatment plan will identify areas of concern, goals, desired outcomes, time frames, tasks and task responsibilities. ( )

b. The placement agreement entered into between the Department and a parent or guardian may be revoked with a twenty-four (24) hour notice by the child's parent or guardian. ( )

201. PROTECTIONS FOR CHILDREN IN ALTERNATE CARE.

01. Statutory Requirements. The Department must arrange alternate care in accordance with the protections established in: ( )

a. The Children's Mental Health Services Act, Title 16, Chapter 24, Idaho Code; ( )

b. The Child Protective Act, Title 16, Chapter 16, Idaho Code; and ( )

c. The Indian Child Welfare Act, 25 USC 1901, et seq. ( )

02. Requirement for Licensure. A child that is placed in alternate care must be placed in a licensed foster home, licensed residential care facility, or in a licensed hospital. ( )

03. Out-of-State Placement. Placement of a child in an alternate care setting outside the state of Idaho requires that the Department comply with the Interstate Compact on the Placement of Children, in accordance with Section 16-2102, Idaho Code. ( )

04. Least Restrictive Setting. Whenever possible, the Department will arrange placement: ( )

a. In the least restrictive setting available that will meet the child's mental health treatment needs; and ( )

b. That is in close proximity to the parent or guardian. ( )

c. If the placement does not meet the requirements of Subsections 201.04.a. and 201.04.b. of this rule, the Department will provide written justification to the child's parent or guardian by way of the Alternate Care Plan that the placement is in the best interests of the child. ( )

05. Visitation for Child's Parent or Guardian. Visitation arrangements will be documented in the alternate care plan. ( )

06. Notification to Parents or Guardians of Change in Placement. ( )

a. The Department will provide written notification to the child's parent or guardian no later than seven (7) days after a child's change of placement. ( )

b. If an Indian child under jurisdiction of the court is relocated to another alternate care setting, similar notice must be sent to the child's Indian custodian, and the child's tribe. Wherever these rules require notice to the parent or custodian and tribe of an Indian child, notice must also be provided to the Secretary of the Interior by certified mail with return receipt requested to Department of the Interior, Bureau of Indian Services, Division of Social Services, Code 450, Mail Stop 310-SIB, 1849 C Street, N.W., Washington, D.C. 20240. In addition, under 25 CFR Section 23.11, copies of such notices must be sent by certified mail with return receipt requested to the Portland Area Director, Bureau of Indian Affairs, 911 NE 11th Avenue, Portland, OR 97232. If the identity or location of the parent or Indian custodian and the tribe cannot be determined, notice of the proceeding must be given to the Secretary, who will provide notice to the parent or Indian custodian and tribe. ( )

202. (RESERVED)

203. DATE A CHILD ENTERED ALTERNATE CARE.
A child is considered to have entered alternate care on the date the child is actually placed in an alternate care setting. All alternate care benefits, eligibility determinations, and required reviews are based on the date the child entered alternate care. ( )

204. TITLE XIX ELIGIBILITY.
Children placed in alternate care through the Department are eligible for Title XIX, if they meet the eligibility requirements as defined in IDAPA 16.06.01, "Child and Family Services." Application for these programs will be made by Department clinicians on the forms and in the manner prescribed by the Department's Division of Family and Community Services. ( )

205. ALTERNATE CARE LICENSURE.
All private homes and facilities in Idaho providing alternate care for children under these rules must be licensed in accordance with IDAPA 16.06.02, "Child Care Licensing," unless foster care placement of an Indian child is made with a foster home licensed, approved, or specified by the Indian child's tribe, or an institution for children approved by an Indian tribe or operated by an Indian organization. ( )

206. ALTERNATE CARE CASE MANAGEMENT.
Case management must continue while the child is in alternate care and include the following: ( )

01. Preparation for Placement. Preparing a child for placement in alternate care is the joint responsibility of the child's parent or guardian, the child (when appropriate), the clinician and the alternate care provider. ( )

02. Information for Alternate Care Provider. The Department and the child's parent or guardian must inform the alternate care provider of the alternate care provider's roles and responsibilities in meeting the needs of the child and provide the following information to the alternate care provider: ( )

a. Any medical, health, and dental needs of the child including the names and addresses of the child's doctor, dentist, and other health providers, a record of the child's immunizations, the child's current medications, the child's known medical problems, and any other pertinent health information concerning the child; ( )

b. The child's current functioning and behaviors; ( )

c. The child's history, past experiences, and reasons for placement into alternate care; ( )

d. The child's cultural and racial identity; ( )

e. Any educational, developmental, or special needs of the child; ( )

f. Names and addresses of the child's current or last school attended, including homeschool or alternate school, if applicable; ( )

g. The child's interests and talents; ( )

h. The child's attachment to current caretakers; ( )

i. The individualized and unique needs of the child; ( )

j. Procedures to follow in case of emergency; and ( )

k. Any additional information that may be required to meet the needs of the child. ( )

03. Consent for Medical Care. A parent or guardian must sign a Departmental form of consent for medical care and keep the clinician advised of where they can be reached in case of an emergency. Any refusal to give medical consent must be documented in the case record. ( )

04. Financial Arrangements. The Department is responsible for explaining the financial and payment arrangements to the alternate care provider and must complete the documentation required for payment to the alternate care provider. ( )

05. Contact Requirements. The child's parent or guardian, the clinician, the alternate care provider, and the child, if of appropriate developmental age, must establish a schedule for frequent and regular visits between the child and the family and the clinician or their designee. ( )

a. Face-to-face contact between the child and the clinician must occur at least monthly. An in-person visit must occur within the first thirty (30) days of placement and then the in-person visits must occur at a minimum of quarterly thereafter. ( )

b. Face-to-face contact between the child's parent or guardian and the clinician must occur at least monthly. ( )

c. Face-to-face contact between the alternate care provider and the clinician must occur at least monthly. ( )

d. Frequent and regular contact between the child, the child's parent or guardian, and other family members will be encouraged and facilitated unless it is specifically determined by the Department not to be in the best interest of the child. Such contact will be face-to-face if possible, with this contact augmented by telephone calls, written correspondence, pictures, and the use of video and other technology as may be relevant and available. ( )

e. When a child is placed in alternate care in another state, a Department clinician must maintain at least monthly contact with the child, the child's family, and the alternate care provider with whom they have been placed as long as the state of Idaho has the placement responsibility for the child, in accordance with Section 200 of these rules. The supervising agency in the state where the child is living will be requested to maintain monthly, face-to-face contact with the child and make quarterly reports to the Department in accordance with arrangements made through the Interstate Compact on the Placement of Children. ( )

06. Transition Planning. Planning for transition from alternate care will be developed with all concerned parties. Transition planning will be initiated at the time of placement and completed prior to the child's return home or to another living arrangement. A written Transition Plan is part of the Alternate Care Plan and the Treatment Plan. As part of transition planning, efforts are coordinated by the Department and the parents or guardians to expedite access to community and Department services. ( )

207. -- 221. (RESERVED)

222. ALTERNATE CARE PLANNING.
Alternate care planning is mandated by the provisions of Sections 471(a)(15) and 475, P.L. 96-272. ( )

01. Alternate Care Plan Required. Each child receiving alternate care under the supervision of the state must have a standardized written alternate care plan. ( )

a. The purpose of the plan is to facilitate the provision of mental health treatment services and the safe return of the child to their own home as expeditiously as possible, or to make other permanent arrangements for the child if such return is not feasible. ( )

b. The alternate care plan must be included as part of the treatment plan. ( )

02. Written Alternate Care Plan. The Department must have completed a written alternate care plan within thirty (30) days after a child has been placed in alternate care. ( )

a. A parent or guardian and the child, to the extent possible, are to be involved in planning, selecting, and arranging the alternate care placement and any subsequent changes in placement. ( )

b. The alternate care plan must include documentation that a parent or guardian has been provided written notification of: ( )

i. Visitation arrangements made with the alternate care provider, including any changes in their

visitation schedule; ( )

ii. Any change of placement, when the child is relocated to another alternate care or institutional setting as soon as possible, but no later than seven (7) days after placement; and ( )

iii. Their right to discuss any changes and to seek recourse if they disagree with any changes in visitation or other alternate care arrangements. ( )

c. All parties involved in developing the alternate care plan, including the alternate care provider, parent or guardian, and the child, if of appropriate developmental age: ( )

i. Will be asked by the Department to sign the alternate care plan that includes a statement indicating that they have read and understood the alternate care plan; and ( )

ii. Will receive a copy of the alternate care plan from the Department. ( )

223. -- 235. (RESERVED)

236. PARENTAL FINANCIAL SUPPORT FOR CHILDREN IN ALTERNATE CARE.
In accordance with Sections 56-203B and 16-2406, Idaho Code, parent(s) are responsible for costs associated with the care of their child in alternate care. ( )

01. Notice of Parental Responsibility. The Department will provide the parent(s) with written notification of their responsibility to contribute toward the cost of their child's support, treatment, and care, including clothing, medical, incidental, and educational costs. ( )

02. Financial Arrangements with Parent(s). Parent(s) are responsible to reimburse the Department for the costs of alternate care when their child is placed in alternate care in accordance with a court order or voluntary placement agreement. Parents are expected to contribute to the cost of their child's care, but parents will not be asked to pay more than the actual cost of care, including clothing, medical, incidental, and educational costs. ( )

237. SUPPORT AGREEMENTS AND SUPPORT ORDERS.

01. Support Agreement for Voluntary Placement. If the placement is voluntary, a parent must sign a support agreement that specifies the amount of support to be paid to the Department, when it is to be paid, and the address to which it is to be paid. ( )

02. Support Order for Payment of Involuntary Placement Costs. In the case of a court-ordered placement, if no support agreement has been reached with a parent prior to the court hearing, the Department may request the Court hold a support hearing to establish a support order for payment of involuntary placement costs. ( )

238. -- 239. (RESERVED)

240. INSURANCE COVERAGE.
The parent or guardian must inform the Department of all insurance policies covering the child, including names of carriers, and policy or subscriber numbers. If medical, health, and dental insurance coverage is available for the child, the parent must acquire and maintain such insurance. ( )

241. MEDICAL CARD FOR CHILDREN IN ALTERNATE CARE.
The Department will issue a medical card to cover medical expenses for each child placed in alternate care. ( )

242. – 243. (RESERVED)

244. MEDICAL EMERGENCIES.
In case of serious illness, the alternate care provider must immediately seek medical attention for the child and notify

the Department as soon as possible. A parent or guardian, the court in an emergency, or the Department, if it is the guardian of the child, has the authority to consent to major medical care or hospitalization in accordance with Section 39-4504, Idaho Code. ( )

245. DENTAL CARE.
Each child age three (3) years or older, who is placed in alternate care, must receive a dental examination as soon as possible after placement, but not later than ninety (90) days, and thereafter according to a schedule prescribed by the dentist. ( )

01. Costs Paid by Medicaid. If dental care not included in the state medical assistance program is recommended, a request for payment will be submitted to the state Medicaid dental consultant. ( )

02. Emergencies. Emergency dental services will be provided for children in alternate care and paid for by the Department, if there are no other financial resources available. ( )

246. COSTS OF PRESCRIPTION DRUGS.
The Department will purchase prescribed drugs, at the Medicaid rate, for a child in alternate care through participating pharmacies. ( )

247. MEDICAL EXAMINATION UPON ENTERING ALTERNATE CARE.
Within thirty (30) days of entering alternate care, each child will receive a medical examination to assess the child's health status, and thereafter according to a schedule prescribed by the child's physician or other health care professional. ( )

248. -- 250. (RESERVED)

251. DRIVERS' TRAINING AND LICENSES FOR CHILDREN IN ALTERNATE CARE.
Only a parent or guardian of a child in alternate care may authorize drivers' training, provide payment, and sign for drivers' licenses and permits. ( )

252. -- 282. (RESERVED)

283. PAYMENT TO FAMILY ALTERNATE CARE PROVIDERS.
Monthly payments for care provided by family alternate care providers are paid according to IDAPA 16.06.01, "Child and Family Services." ( )

01. Gifts. Additional payments for Christmas gifts and birthday gifts will be paid in the appropriate months. ( )

02. Clothing. Costs for clothing will be paid, based upon the Department's determination of each child's needs. All clothing purchased for a child in alternate care becomes the property of the child. ( )

03. School Fees. School fees due upon enrollment will be paid directly to the school or to the foster parents, based upon the Department's determination of the child's needs. ( )

284. ADDITIONAL PAYMENTS TO FAMILY ALTERNATE CARE PROVIDERS.
For those children who, as determined by the Department, require additional care above room, board, shelter, daily supervision, school supplies, and personal incidentals, the Department may pay the family alternate care provider an additional amount to that paid according to IDAPA 16.06.01, "Child and Family Services." The family alternate care rate is based upon a continuous ongoing assessment of the child's circumstances that necessitate special rates as well as the care provider's ability, activities, and involvement in addressing those special needs. ( )

01. Lowest Level of Need. A child requiring a mild degree of care for documented conditions receives the lowest level of additional payments for the following: ( )

a. Chronic medical problems; ( )

b. Frequent, time-consuming transportation needs; ( )

c. Behaviors requiring extra supervision and control; and ( )

d. Need for preparation for independent living. ( )

02. Moderate Level of Need. A child requiring a moderate degree of care for documented conditions receives the moderate level of additional payments for the following: ( )

a. Ongoing major medical problems; ( )

b. Behaviors that require immediate action or control; and ( )

c. Alcohol or other substance use disorder. ( )

03. Highest Level of Need. A child requiring an extraordinary degree of care for documented conditions receives the highest level of additional payments for the following: ( )

a. Serious emotional or behavioral disorder that requires continuous supervision; ( )

b. Severe developmental disability; and ( )

c. Severe physical disability such as quadriplegia. ( )

04. Reportable Income. Additional payments for more than ten (10) qualified children received during any calendar year must be reported as income to the Internal Revenue Service. ( )

285. -- 599. (RESERVED)

600. TREATMENT FOSTER CARE.
A family home setting in which treatment foster parents provide twenty-four (24) hour room and board as well as therapeutic services and a high level of supervision. Services provided in treatment foster care are at a more intense level than provided in foster care and at a lower level than provided in residential care. Services may include the following: participation in the development and implementation of the child's treatment plan, behavior modification, community supports, crisis intervention, documentation of services and the child's behavior, participation as a member of a multi-disciplinary team, and transportation. Placement into a treatment foster home for children eligible for services under Section 107 of these rules is based on the documented needs of the child, the inability of less restrictive settings to meet the child's needs, and the clinical judgment of the Department. ( )

01. Qualifications. Prior to being considered for designation and reimbursement as a treatment foster parent, each prospective treatment foster parent must accomplish the following: ( )

a. Meet all foster family licensure requirements as set forth in IDAPA 16.06.02, "Child Care Licensing"; ( )

b. Complete Department-approved treatment foster care initial training; and ( )

c. Provide a minimum of two (2) references in addition to those provided to be licensed to provide foster care. The additional references must be from individuals who have worked with the prospective treatment foster parent. The additional references must verify that the prospective treatment foster parent has: ( )

i. Training related to, or experience working with, children or youth with mental illness or behavior disorders; and ( )

ii. Demonstrated cooperation and a positive working relationship with families and providers of mental health services. ( )

02. Continuing Education. Following designation as a treatment foster home, each treatment foster home parent must complete fourteen (14) hours of additional training per year as specified in an agreement developed between the treatment foster parents and the Department. ( )

03. Availability. At least one (1) treatment foster parent in each treatment family home must be available twenty-four (24) hours a day, seven (7) days a week to respond to the needs of the foster child. ( )

04. Payment. The Department will pay treatment foster parents up to one thousand eight hundred ($1,800) dollars per month per child, which includes the monthly payment rate specified in Sections 283 and 284 of these rules. The payment will be made to treatment foster parents in accordance with a contract with the Department. The purpose of the contract is to make clear that the treatment foster parents must fulfill the requirements for treatment foster parents under the treatment plan referenced in Subsection 600.06 of this rule. ( )

05. Payment to Contractors. The Department may also provide treatment foster care through a contract with an agency that is a private provider of treatment foster care. The Department will specify the rate of payment in the contract with the agency. ( )

06. Treatment Plan. The treatment foster parent(s) must implement the portions of the Department-approved treatment plan for which they are designated as responsible for each child in their care. This plan is incorporated as part of the treatment plan identified in Section 115 of these rules. ( )

601. -- 699. (RESERVED)

700. RESIDENTIAL CARE FACILITIES.
Residential care facilities provide a more intensive setting than treatment foster care. Residential care facilities in Idaho are licensed under IDAPA 16.06.02, "Child Care Licensing" to provide residential care for children and staffed by employees who cover assigned shifts. Children placed in residential care facilities receive services that may include the following: assessment, supervision, treatment plan development and implementation, documentation, behaviorally focused skill building, service coordination or clinical case management, consultation, psychotherapy, psychiatric care, and twenty-four (24) hour crisis intervention. Placement into a residential care facility for children eligible for services under Section 107 of these rules is based on the documented needs of the child and the inability of less restrictive settings to meet the child's needs. ( )

01. Prior Authorization. Prior authorization must be obtained from an authorized representative in the Department's Division of Behavioral Health for placement of a child in a residential care facility where the Division of Behavioral Health is making full or partial payment. ( )

02. Payment. When care is purchased from private providers, payment will be made in accordance with a contract authorized by the Department, based on the needs of each child being placed and the services to be provided. ( )

701. -- 799. (RESERVED)

800. SIX MONTH REVIEWS FOR CHILDREN IN ALTERNATE CARE PLACEMENTS.
A review is to occur at the end of a six (6) month period for any child in an alternate care placement. The Department will conduct a case review to assure compliance with all applicable state and federal laws, and to ensure the treatment plan focuses on the goals of safety, permanency, effectiveness of treatment, and well-being of the child. The Department may request the court hold a review hearing for the child in accordance with Section 16-2407(3), Idaho Code. ( )

01. Notice of Six Month Review. The parent or guardian, foster parent of a child, or relative providing care for the child is to be provided with notice of their right to be heard in the six (6) month review. In the case of an Indian child, the child's tribe and any Indian custodian must also be provided with notice. This must not be construed to require that any foster parent, or relative providing care for the child be made a party to the review solely on the basis of the receipt of such notice. Participants have the right to be represented by the individual of their choice. ( )

02. Procedure in the Six Month Review. The parties who received notice will be given the opportunity to participate in the case review. ( )

03. Members of Six Month Review Panel. The six (6) month review panel must include a Department employee who is not in the direct line of supervision in the delivery of services to the child or parent or guardian. The review panel may include agency staff, staff of other agencies, officers of the court, members of Indian tribes, and citizens qualified by experience, professional background, or training. Members of the panel will be chosen by and receive instructions from an authorized representative in the Department's Division of Behavioral Health, to enable them to understand the review process and their roles as participants. ( )

04. Considerations in Six Month Review. Whether conducted by the court in a review hearing or a Department review panel, under state law, federal law and regulation, each of the following must be addressed in a six (6) month review: ( )

a. Determine the extent of compliance with the treatment plan; ( )

b. Determine the extent of progress made toward alleviating or mitigating the causes necessitating the placement; ( )

c. Review compliance with the Indian Child Welfare Act, when applicable; ( )

d. Determine the safety of the child, the continuing need for and appropriateness of the child's placement; and ( )

e. Project a date by which the child may be returned and safely maintained at home or placed for adoption, guardianship, or other permanent placement. ( )

05. Recommendations and Conclusions of Six Month Review Panel. Following the six (6) month review, written conclusions and recommendations will be provided to all participants, subject to Department safeguards for confidentiality. The document containing the written conclusions and recommendations must also include appeal rights. ( )

801. -- 999. (RESERVED)

16.07.39 – DESIGNATED EXAMINERS AND DISPOSITIONERS

000. LEGAL AUTHORITY.
Sections 16-2403 and 66-317, Idaho Code, authorize the Department to promulgate rules appointing designated examiners and designated dispositioners. Sections 56-1003 and 56-1004, Idaho Code, authorize the Director to adopt rules to administer a mental health program. ( )

001. SCOPE.
These rules set forth the qualifications, appointment requirements, appointment process, duration of appointment, revocation of appointment, and requirements for reappointment for designated examiners and designated dispositioners in Idaho. ( )

002. INCORPORATION BY REFERENCE.
American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, (DSM-5) Washington, DC, American Psychiatric Association, 2013, is hereby incorporated by reference under this chapter of rules. Copies of the manual are available from the American Psychiatric Association, 1000 Wilson Boulevard, Suite 1825, Arlington, VA 22209-3901. A copy of the manual is also available for public review at the Department of Health and Welfare, 450 West State Street, Boise, Idaho, 83702. ( )

003. -- 008. (RESERVED)

009. CRIMINAL HISTORY AND BACKGROUND CHECK REQUIREMENTS.
Each individual who is seeking appointment as a designated examiner or designated dispositioner, or both, must comply with the provisions in IDAPA 16.05.06, "Criminal History and Background Checks." An individual who is seeking appointment is available to practice as a designated examiner or designated dispositioner on a provisional basis at the discretion of the Department once the individual has completed the following: ( )

01. Submission Of Criminal History Check Application. An individual has submitted their criminal history and background check application; ( )

02. Application Review. The completed application has been reviewed by the Regional Behavioral Health Program Manager or the State Hospital Administrative Director of the region where the applicant intends to practice, and no disqualifying crimes or relevant records are disclosed on the application. ( )

010. DEFINITIONS.
For the purposes of these rules, the following terms apply: ( )

01. Advanced Practice Registered Nurse. An individual licensed as an Advanced Practice Registered Nurse under Title 54, Chapter 14, Idaho Code. ( )

02. Clinical Professional Counselor (LCPC). An individual licensed as a Clinical Professional Counselor under Title 54, Chapter 34, Idaho Code. ( )

03. Clinical Social Worker (LCSW). An individual licensed as a Clinical Social Worker under Title 54, Chapter 32, Idaho Code. ( )

04. Department. The Idaho Department of Health and Welfare. ( )

05. Designated Dispositioner. A designated dispositioner is a designated examiner employed under contract with the Department and designated by the Director. ( )

06. Designated Examination. An evaluation by an appointed mental health professional to determine if an individual is mentally ill and if the individual is either likely to injure themselves or others or is gravely disabled due to mental illness. ( )

07. Designated Examiner. A designated examiner is a psychiatrist, psychologist, psychiatric nurse, social worker, or such other mental health professional as may be designated under these rules. ( )

08. Director. The Director of the Idaho Department of Health and Welfare or their designee. ( )

09. Division. The Department's Division of Behavioral Health. ( )

10. Marriage and Family Therapist (LMFT). An individual licensed as a Marriage and Family

Therapist under Title 54, Chapter 34, Idaho Code. ( )

11. Masters of Social Work (LMSW). An individual licensed as a Masters of Social Work under Title 54, Chapter 32, Idaho Code. ( )

12. Physician. An individual licensed as a Physician to practice medicine under Title 54, Chapter 18, Idaho Code. ( )

13. Physician Assistant. An individual licensed as a Physician Assistant under Title 54, Chapter 18, Idaho Code. ( )

14. Professional Counselor (LPC). An individual licensed as a Professional Counselor under Title 54, Chapter 34, Idaho Code. ( )

15. Psychologist. An individual licensed to practice psychology in Idaho under Title 54, Chapter 23, Idaho Code. ( )

011. -- 199. (RESERVED)

200. MINIMUM QUALIFICATIONS AND REQUIREMENTS FOR APPOINTMENT AS A DESIGNATED EXAMINER.
To be appointed and practice as a designated examiner in Idaho, an applicant must meet the following minimum qualifications and requirements: ( )

01. Required License. Each applicant maintains their professional licensure for the duration of their appointment and be one (1) of the following: ( )

a. Physician; ( )

b. Psychologist; ( )

c. Advanced Practice Registered Nurse; ( )

d. Clinical Professional Counselor; ( )

e. Professional Counselor; ( )

f. Clinical Social Worker; ( )

g. Masters Social Worker; ( )

h. Marriage and Family Therapist. ( )

i. Physician Assistant. ( )

02. Required Experience and Abilities. Each applicant meets the minimum requirements and qualifications listed below: ( )

a. At least two (2) years of post-master's degree experience in a clinical mental health setting which includes: ( )

i. Assessment of the likelihood of danger to self or others, grave disability, capacity to give informed consent, and capacity to understand legal proceedings; ( )

ii. Use of DSM-5 diagnostic criteria; ( )

iii. Treatment of mental health disorders including knowledge of treatment modalities and experience

applying treatment modalities in a clinical setting; and ( )

iv. An understanding of the differences between behavior due to mental illness which poses a substantial likelihood of serious harm to self or others or which may result in grave disability from behavior which does not represent such a threat or risk. ( )

b. Knowledge of and experience applying Idaho mental health law based on the required training outlined under Subsection 200.03 of this rule including: ( )

i. Experience that demonstrates understanding of the judicial process, including the conduct of commitment hearings. ( )

ii. Experience preparing reports for the court and testifying before a court of law. Experience includes demonstrating an ability to provide the court with a thorough and complete oral and written evaluation that addresses the standards and questions set forth in the law; and ( )

iii. Knowledge of a client's legal rights. ( )

03. Required Training. Completion of: ( )

a. A minimum of six (6) hours of training, provided by a Department-approved trainer, on the role of designated examiners and the processes used in fulfilling the responsibilities of designated examiners. ( )

b. A minimum of four (4) additional hours observing a designated examiner conducting a designated examination. ( )

201. -- 299. (RESERVED)

300. MINIMUM QUALIFICATIONS AND REQUIREMENTS FOR APPOINTMENT AS A DESIGNATED DISPOSITIONER.
To be appointed as a designated dispositioner in Idaho, an applicant must meet the following minimum qualifications and requirements. ( )

01. Appointment as a Designated Examiner. Applicants for designated dispositioner are also appointed as a designated examiner by the Director. ( )

02. Required Experience and Abilities. Each applicant has received training on the available treatment alternatives, types of treatment available for appropriate placement, and level of care requirements all within Idaho. ( )

301. -- 399. (RESERVED)

400. APPOINTMENT OR REAPPOINTMENT AS A DESIGNATED EXAMINER OR DESIGNATED DISPOSITIONER.
Each applicant seeking an appointment or reappointment as a designated examiner or designated dispositioner, must submit the following information to the Regional Behavioral Health Program Manager of the region where they intend to practice or the State Hospital Administrative Director of the hospital at which they intend to practice. ( )

01. Complete an Application. Each applicant completes and signs an application using forms approved by the Department. ( )

02. Provide Verification of Credentials. Each applicant provides the Department with the following: ( )

a. A current resume that documents: ( )

i. The applicant's degree, the date the degree was awarded, and the school from which the degree was received; and ( )

ii. How the applicant meets the requirements under Subsection 200.02 of these rules. ( )

b. A copy of the applicant's license. If the applicant is an LMSW, they must also provide a copy of the supervision plan approved by the Board of Social Work Examiners; ( )

c. Evidence of completion of the required ten (10) hours of training within sixty (60) days prior to the date of application under Subsection 200.03 of these rules showing the date(s), place(s), number of hours of training, and the qualifications of the person(s) providing the training; ( )

d. Documentation of a criminal history and background check clearance completed within ninety (90) days of the date of the application. Department employees who have had continuous employment with the Department may use a previous background check clearance received through their employment with the Department. ( )

03. Regional or Hospital Recommendation. ( )

a. To be eligible for consideration and appointment or reappointment as a designated examiner or designated dispositioner, each applicant must receive a favorable recommendation from a Regional Behavioral Health Program Manager or State Hospital Administrative Director. ( )

b. Within thirty (30) days of the receipt of a completed and signed application, the Regional Behavioral Health Program Manager or the State Hospital Administrative Director of the region where they intend to practice will review the applicant's qualifications and, if satisfied, sign the application and forward it to the Division along with all the information provided by the applicant as required under Subsection 400.02 of this rule. ( )

c. Each Regional Program Manager and State Hospital Administrative Director agrees to honor recommendations for appointments made by another Regional Behavioral Health Program Manager or State Hospital Administrative Director. ( )

04. Final Decision on Appointment. ( )

a. Upon receiving a favorable recommendation under Subsection 400.03 of these rules, the Division will review each application for completeness and compliance with these rules. ( )

b. Upon completion of this review, the Division will make recommendations to the Director regarding appointments as designated examiner or designated dispositioner. ( )

c. The Director has the authority to appoint applicants for designated examiner or designated dispositioner who meet the requirements under these rules. ( )

d. The Division will notify each applicant in writing of the Department's decision within sixty (60) days of the date the application was received by the Division. ( )

05. Appointment. An appointed designated examiner or designated dispositioner may practice in any region of the state or at any state hospital at the discretion of the Regional Program Manager or State Hospital Administrative Director. ( )

06. Reappointment. ( )

a. The request for reappointment must be received by the Division at least sixty (60) days prior to the expiration date of the previous appointment of the designated examiner or designated dispositioner. ( )

b. If a designated examiner or designated dispositioner allows their appointment to expire, the applicant must follow appointment requirements under Section 400 of this rule. Department employees who have had

continuous employment with the Department may have the reapplication process waived. ( )

401. -- 499. (RESERVED)

500. DURATION OF APPOINTMENT AS DESIGNATED EXAMINER OR DESIGNATED DISPOSITIONER.

01. Appointment. Appointment expires one (1) year from the date of appointment, unless the designated examiner or designated dispositioner applies for, and is granted, a reappointment. ( )

02. Reappointment. Reappointment expires two (2) years from the date of such appointment. ( )

03. Expiration of Appointment Upon Leaving Department Employment. When an individual serving as a designated dispositioner leaves the employ of the Department, their designation of dispositioner is suspended, until such time that the appointment expires, or the individual is under contract with the Department as a designated dispositioner. ( )

501. -- 699. (RESERVED)

700. REVOCATION OF APPOINTMENT AS DESIGNATED EXAMINER OR DESIGNATED DISPOSITIONER.
The Department may deny, suspend, or revoke the appointment or reappointment of designated examiners and designated dispositioners, or both, under the following procedures: ( )

01. Emergency Denial, Suspension, Revocation of Appointment or Reappointment. The Department will deny, suspend, or revoke appointment or reappointment, without prior notice, when conditions exist that endanger the health or safety of any client. ( )

02. Written Request for Denial, Suspension, or Revocation of Appointment or Reappointment. In the absence of an emergency, a written request from the Regional Behavioral Health Program Manager or State Hospital Administrative Director will be made to the Division stating the reason(s) for the requested denial, suspension, or revocation of an appointment or reappointment. ( )

03. Grounds for Revocation of Appointment or Reappointment. The Department may deny, suspend, or revoke an appointment or reappointment for any of the following reasons: ( )

a. Failure to comply with these rules. ( )

b. Failure to furnish data, information, or records as requested by the Department. ( )

c. Revocation or suspension of the applicant's professional license. ( )

d. Refusal to participate in a quality assurance process as requested by the Department. ( )

e. Inadequate knowledge or performance as demonstrated by repeated substandard peer or quality assurance reviews. ( )

f. Misrepresentation by the applicant in their application, or in documents required by the Department, or by an appointee in which there is a criminal, civil, or administrative determination that they have misrepresented the facts or the law to the court or administrative agency. ( )

g. Conflict of interest in which an appointee exploits their position as a designated examiner or designated dispositioner for personal benefit. ( )

h. A criminal, civil, or administrative determination that an appointee has committed fraud or gross negligence in their capacity as a designated examiner or designated dispositioner. ( )

i. Substantiated disposition of a child protection referral or adult protection referral. ( )

j. Failure to correct within thirty (30) days of written notice, any unacceptable conduct, practice, or condition as determined by the Department to be detrimental to public health or safety. ( )

04. Appeal of Department Decision. Applicants may appeal a Department decision to deny, suspend, or revoke an appointment under IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings." ( )

05. Reapplication for Appointment. Following denial, suspension, or revocation of appointment or reappointment, the same appointee may not reapply for appointment for a period of one (1) year after the effective date of the action. ( )

701. -- 999. (RESERVED)